Riskfyllda möten

– en studie om unga människors upplevelser av sexuellt överförbara infektioner och sexuellt risktagande
Riskfyllda möten
– en studie om unga människors upplevelser av sexuellt överförbara infektioner och sexuellt risktagande

Kina Hammarlund

Växjö University Press

Skriftseriedaktör: Kerstin Brodén
ISSN: 1404-4307
ISBN: 978-91-7636-653-0
Tryck: Intellecta Infolog, Göteborg 2009
Abstract


The overall aim of the present thesis is to contribute to the knowledge of young people´s experiences, thoughts and norms regarding sexually transmitted infections (STI) and sexual risk-taking. The specific aims are two-fold. The first aim is to explain and understand young Swedish men and women´s lived experience of an STI, in this case genital warts (I, II). The second is to explain and understand the values and attitudes of young men and women towards sexual risk-taking (III) and in relation to perceptions of gender (IV).

The theoretical perspectives are a reflective lifeworld approach, hermeneutic and gender perspectives. The thesis is based on individual interviews (I, II) and focus groups (III, IV).

The results show that a young person infected by an STI, will experience encounters at different levels. A person with an STI is forced to confront their own prejudices. Loss of innocence is highly significant and symbolic for women, while other person´s attitudes are more important for men (I, II). Also, being a disease carrier is of great significance, which has an impact on their views of future meaningful relationships (II).

Sexual risk-taking, such as it was expressed in the focus groups with young people, revealed a pattern that is described as a ‘game’. In that game, a dialogue might feel more intimate than intercourse. These teenagers often view their one night stand partners as objects, as opposed to love relationships where they are viewed as subjects, i.e. persons to be cared for. Engaging in sexual risk-taking often starts at a club where these teenagers pretend that they are spontaneous (III).

This game is further illuminated in a secondary analysis with a gender perspective. There are frequent misunderstandings between young men and women that are based on gender constructions, which derive from lack of communication. Hence, they have to take part in a balancing act while shaping their sexual identity and trying to maintain their self-esteem. For these young women, this also concerns not getting a bad reputation. In this act of balance, it is difficult to discuss sexuality and how to protect one’s sexual health (IV).

The discussion emphasises that a professional caring dialogue with young people about STIs and sexual-risk taking must have reference in the young person´s own reality. Thus, professional health care workers meeting a young person who is infected with an STI appear to face a challenging task. This involves helping reduce anxiety by defusing the situation, and at the same time to make the person understand the importance of using a condom in order to prevent STIs.

Key words: caring science, existential issues, focus group, gender perspective, hermeneutic, lifeworld, patient perspective, sexual risk-taking, sexually transmitted infections, teenagers, young people
Till Zofia, Anna och Malin
Förord

Sex år har nu gått sedan jag började med vad jag kallar min ”doktorandresa” vid Institutionen för vårdvetenskap och socialt arbete vid Växjö universitet. Det har varit fantastiskt spännande och utvecklande år, som ibland kan liknas vid att åka berg- och dalbana. Stundtals har jag varit uppe på toppen av lycka och stundtals djupt nere i svackor och tänkt att ”detta kommer nog inte att gå”. Nu är jag alltså framme vid resans mål och det är jag oändligt glad och stolt för. Kanske lite mognare och en del klokare.

Det är många personer jag vill komma ihåg som funnits runt mig och hjälpt mig i arbetet med denna avhandling. Så många att jag troligen har fler personer att vara tacksam mot, än vad jag minns. Denna avhandling är på många sätt ett Produkt av alla de personer jag mött under dessa år, för utan er hade det inte blivit någon avhandling

Jag har haft förmånen att ha två handledare. Min huvudhandledare, professor Maria Nyström, som varit min akademiska ledstjärna sedan min magisteruppsats påbörjades i Borås år 2000. Ett tack i ett förord kan inte på något sätt göra rättvisa för den tacksamhet jag känner gentemot dig Maria och din handledning. Jag säger ändå – tack Maria för all din kunskap du delat med mig och för kloka reflektioner i med- som i motvind och för allt ditt tålamod.

Min andra handledare docent Ingela Lundgren- tack Ingela för allt du tillfört, din klokskap och dina varmende ord när de som bäst behövts.

Forskarutbildningen i Växjö startade tack vare professor Karin Dahlberg som under min doktorandtid i Växjö alltid tagit sig tid att svara på mina funderingar och bjudit in till köket i Pajebo. Tack Karin för alla intressanta forskarkurser och en fantastisk forskarutbildning.

Jag vill också tcka Växjö universitet, Institutionen för vårdvetenskap och socialt arbete för min doktorandtjänst samt till alla er lärare på institutionen för att ni alltid fått mig att känna mig välkommen på skolan och i kafferummet.


Ur denna gruppe har en person delat mitt forskarliv i vått och torrt, dag som natt i Växjö på pensionatet Frus T och på flera konferenser, och det är Annelie Johansson Sundler. Ett speciellt tcka och en stor kram till dig Annelie för våra livsvärldsdiskussioner, alla öl vi druckit tillsammans och våra roliga tågresor.


Två personer har hjälpt mig extra mycket med att skaffa informanter och det är samordningsbarmorska Pia Gustafsson och överläkare Per-Anders Mjörnberg. Ett stort tcka för den hjälp.De

Några personer har bistått mig vid fokusgruppsintervjuerna. Tack till Susanne Källerwald, Kristina Byström och Susanne Gustavsson för att ni skrev så penna
glödde under intervjuerna! Tack också Susanne K för att du avsatte tid och var min diskussionspartner när jag skulle bena upp Sartre.


Att skriva artiklar på engelska har för mig inte varit helt lätt. Tur att det har funnits personer runt mig som hjälpt mig med det engelska språket. Ett stort tack till Jill Edvards, Julie Jomeen, Frode Slinde, Merwyn Gifford, Linda Lovecraft samt min dotter Zofia Hammerin

Jag vill också tacka mina arbetskamrater vid Högskolan i Skövde, Institutionen för vård och natur, enheten för Folkhälsa för fin arbetsgemenskap och för all den förståelse ni visat mig under doktorandtiden när jag inte kommit på möten eller varit för stressad för samvaro.

Högskolan i Skövde, Institutionen för vård och natur får också ett stort tack för den doktorand tjänst jag har haft under de senaste 2,5 åren.

Tack till Agneta Ellström-Andersson för granskning av avhandlingens medicinska innehåll och till Yvonne Hirdman för genomläsning av det genusteoretiska perspektivet och för uppmuntran att göra en analys med ett genusperspektiv.

Ekonomiskt bidrag för min avhandling har givits från fler håll. Förutom Skaraborgs institutet som jag redan nämnt, vill jag tacka Kamratföreningen Sahlgrenssringen, Ingrid Ursings fond, FoU på Skaraborgs sjukhus, Sjukköterskeföreningen för hud och venerologi, Svensk förening för psykosocial obstetrikt och gynekologi (SFPOG) samt Svensk sjukköterskeförening (SSF) för att ni trodde på min forskning.

Mina underbara vänner får en stor kram! Min mamma Barbro, som varit en förebild ifråga om studier, får också en stor kram. Några speciella tack till mina allra närmaste: min älskade make Ingemar som i vått och torrt skjutsat mig och hämtat mig på tågstationen efter alla otaliga forskningsresor, min fantastiska dotter Zofia och svärför Herre, tack! Kärleksknockout drabbade mig 2008 när jag fick min lilla dotterdotter Agnes, som bara genom att finnas till är juvelen i mitt liv.

Sist men inte minst, mina underbara bonusdottrar Anna och Malin och deras familjer som också visat sin kärlek långs vägen. Tack för allt ni ger mig! Avslutningsvis finns det 47 personer som får mitt sista stora, stora tack, och det är de modiga informanterna. Tack för att ni ville och vågade dela med er av dessa era innersta känslor om något så privat som sexualitet. Ni var modiga!
Originalartiklar

Denna doktorsavhandling bygger på följande artiklar som i avhandlingen refereras till med romerska siffror:


III. Hammarlund, K., Lundgren, I., & Nyström, M. (2008). In the heat of the night, it is difficult to get it right – teenagers’ attitudes and values towards sexual risk-taking. *Qualitative Studies on Health and Well-being, 3*(2), 103–112.

IV. Hammarlund, K., Lundgren, I., Ekenstam, C., & Nyström, M (in manuscript). What’s Gender got to do with It? An Analysis from a Gender Perspective of Swedish Teenagers’ Attitudes and Values towards Sexually Transmitted Infections and Sexual Risk-Taking.

Artiklarna publiceras med tillstånd av respektive tidskrift.
# Innehåll

Inledning .......................................................................................................................... 5  
Bakgrund .......................................................................................................................... 8  
  Historiskt perspektiv på sexuellt överförbara infektioner .................................................. 8  
  Sexuellt överförbara infektioner ..................................................................................... 9  
  Kondylom .................................................................................................................... 10  
  Att leva med kondylom ............................................................................................... 11  
  Unga människor och sexuellt risktagande .................................................................. 12  
  Unga människors attityder till kondom ......................................................................... 14  
  Barnmorskans roll i det sexuella och reproduktiva hälsoarbetet .................................. 15  
Forskningens problemområde och syfte ........................................................................ 17  
  Beskrivning av problemområdet .................................................................................. 17  
  Syfte och delsyften ........................................................................................................ 18  
Avhandlingens teoretiska utgångspunkter ....................................................................... 19  
  Livsvärldsperspektiv .................................................................................................... 19  
  Hermeneutik .................................................................................................................. 20  
  Genusperspektiv .......................................................................................................... 22  
Datainsamling ................................................................................................................ 24  
  Individuella livsvärldsintervjuer ................................................................................. 24  
  Deltagare i studie I och II ............................................................................................. 24  
  Fokusgruppsintervjuer ................................................................................................. 25  
  Deltagare i studie III och IV .......................................................................................... 26  
Analysmetoder ............................................................................................................... 27  
  Allmänna principer för empirisk hermeneutik ............................................................... 27  
  Tillvägagångssätt i studie I, II och III .......................................................................... 28  
  Sekundäranalys och perspektivistyd tolkning ............................................................... 29  
  Etiska överväganden .................................................................................................... 31  
Resultat ............................................................................................................................ 33  
  Studie I .......................................................................................................................... 33  
  Studie II ........................................................................................................................ 35  
  Studie III ....................................................................................................................... 37  
  Studie IV ....................................................................................................................... 39  
  Resultatsammanfattning ............................................................................................... 42  
Diskussion ....................................................................................................................... 44  
  Resultatdiskussion ........................................................................................................ 44  
  Riskfyllt möte – individperspektiv ............................................................................... 44  
  Riskfyllt möte – grupperspektiv .................................................................................. 47  
Metoddiskussion ............................................................................................................. 52
Reflektioner över valet av informanter ................................................... 52
Individuella livsvärldintervjuer .............................................................. 52
Fokusgruppsintervjuer .......................................................................... 53
Reflektioner kring sekundäranalysen .................................................... 53
Förförståelsen som metodologiskt dilemma ........................................ 54
Tillförlitlighet och generaliserbarhet ..................................................... 55
Avslutande reflektioner ........................................................................ 56
En narcissistisk ungdomskultur? ........................................................... 56
Implikationer för vården ..................................................................... 57
Referenser ............................................................................................. 59
Inledning

Under flera år arbetade jag som barnmorska på en ungdomsmottagning. Där mötte jag ofta tonårsflickor som fått kondylom, också kallat könsvårtor, som är en könsjukdom orsakad av humant papillomvirus. Den hjälpte de fick från ungdomsmottagningen begränsades många gånger till att de själva fick sköta behandlingen som bestod i att pensla vårtorna med en flytande vätska.

Jag funderade ofta på hur deras liv gestaltade sig efter att de lämnat ungdomsmottagningen med veteskap om att de nu bar på en könsjukdom, och att de skulle genomgå en, ibland flera, behandlingar. vilka tankar och funderingar väckte diagnosen? Vad innebar det för dem att leva med kondylom? Hur svarade vården upp mot deras behov av stöd och hjälp? Räckte det med att informera om det vi i vårdet tyckte var viktigt, eller missade vi möjligen det som var väsentligt när man överraskats av negativa konsekvenser av sin sexualitet?


Litteraturen inom området visade att unga människors förhållningssätt till sexuellt överförbara infektioner (STI) ofta handlar om att "stoppa huvudet i sanden". Unga människor som för andra gången söker vård för en könsjukdom, tycks inte ha använt kondom, trots att de redan vid första tillfället fått information om att kondom skyddar mot smitta. Att bara få information verkar således inte ha påverkat deras sexuella risktagande i positiv riktning (jfr Tydén, 1996; DiClemente et al., 2002).

I de två första studierna analyserades intervjuhuvudställingen från unga kvinnor och män1 om hur det var för dem att drabbas2 av en könsjukdom. Den könsjukdom som får tjäna som exempel, är den som jag funderat mycket över i mitt arbete.

---

1 Unga kvinnor/unga män – används i föreliggande avhandling som en övergripande term för informanterna.

2 I föreliggande avhandling kommer begreppet "drabbas" att användas, istället för "att få". Anledningen till detta är "att få" kan tolkas mer positivt. Man får en sak, t.ex. en present.
som barnmorska, dvs. kondylom. Den kan upplevas som extra obehaglig efter-
som den visar sig i form av genitala vårtor.

Resultatet av de två första studierna visade att erfarenheter av en könssjukdom inte självlklart ökar motivationen för att använda kondom, trots att upplevelsen av könssjukdomen verkade sätta djupa spår. kanske var det så att ungdomarna själ-
va hade ett oreflekterat och hittills oartikulerat svar på frågan om varför de inte
använde kondom?

Fenomenologen Edmund Husserl menade att vi måste gå till ”sakerna själva” för
att förstå detta (Bengtsson, 1988/2001). ”Saker” är i det här fallet alltid saker för
någon. Det handlar med andra ord om hur något erfars av ett medvetande, ett
subjekt. Med det här sättet att se på ”saken” blev det i den tredje studien angelä-
get att undersöka ungdomars attityder3 och värderingar4 till sexuellt risktagande5.
I den tredje delstudien försöker jag därför få svar på frågan om varför ungdomar
väljer ett riskbeteende trots all information angående smittorisk. Med hjälp av
fokusgruppsintervjuer tecknades en bild av de värderingar och attityder som ut-
vecklas i grupper av ungdomar.

I fokusgruppsintervjuerna verkade emellertid många utsagor avslöja olika attity-
der beroende på om det var en ung kvinna eller en ung man som uttalade sig.
Därför blev det angeläget att även försöka förstå betydelsen av de genussmönster
som tycktes finnas i grupperna. Ungdomarna kunde t.ex. uttala sig relativt kate-
goriskt om vad som var ”tillåtet” för flickor respektive pojkar. Detta gav upphov
till en ny forskningsfråga: hur kan de attityder och värderingar som finns bland
svenska tonåringar gentemot sexuellt överförbara infektioner och sexuellt riskta-
gande förstås utifrån ett genusperspektiv? I den fjärde delstudien genomfördes
därför en sekundäranalys av de tidigare genomförda fokusgruppsintervjuerna
med ett genusperspektiv som teoretisk utgångspunkt.

Avhandlingsarbetet påbörjades således inte med en färdig planering av fyra
delarbeten. I stället formulerades nya forskningsfrågor successivt, utifrån ett em-
piriskt intresse som väckts av föregående studier. Med ett sådant förhållningssätt
har jag försökt att vara följsam mot det som visat sig i data, och det mönster av
innebörder som vuxit fram ur analysarbetet.

3 Attityder – en varaktig inställning som byggs upp genom erfarenheter och kommer till uttryck i att

4 Värderingar – att sätta ett positivt eller negativt värde på något eller resultatet av att utföra en sådan
handling. Resultatet har i allmänhet formen av ett omdöme, en åsikt eller en uppfattning (National-
encyklopedin, 1996).

5 Sexuellt risktagande – orsakas enligt Berg (1998) av sociala, individuella och biologiska faktorer
och är en del av den normala såväl som den icke normala utvecklingen. Detta kan leda till både po-
sitiva och negativa konsekvenser.
Min önskan är att avhandlingen ska kunna bidra till en fördjupad förståelse av hur det är för en ung människa att drabbas av en könssjukdom, samt de attityder och värderingar som påverkar unga människors sexuella risktagande. Sådan förståelse kan förhoppningsvis utgöra en grund för ett förebyggande arbete som handlar om betydligt mer än att ge information om kondomanvändning för att minska antalet könssjukdomar.
Bakgrund

Historiskt perspektiv på några sexuellt överförbara infektioner

Idag finns många sexuellt överförbara infektioner. I den historiska tillbakablick som nu följer ges exempel på tre av dem: gonorré, syflis och kondylom.


Kondylom är en av vår tids äldsta sexuellt överförbara infektioner. Ordet kondylom kommer från det gamla grekiska ordet *condylomata* som betyder 'runda svulster'. Sjukdomen identifierades redan under antiken både i skönlitterära och medicinska skrifter och beskrevs så som veneriska vårtor (Oriel, 1971). Dess smittsamhet vid sexuellt umgänge ansågs hänrör att könsumgångar mellan män och pojkar. Om vårtorna var stora och omfattande kallades de *ficus* (fikon) och...


Den 1 januari år 1919 trädde lagen om ”åtgärder mot utbredning av könssjukdomar” (Lex Veneris) i kraft i Sverige. Varje läkare blev nu skyldig att till en sundhetsinspektör rapportera de fall som diagnostiserades. Denna lag omarbetades år 1968 till den lag som idag kallas smittskyddslagen (Thyresson, 1991).

**Sexuellt överförbara infektioner**

Fokus för föreliggande avhandling är hur sexuellt överförbara infektioner (STI) erfärs av unga kvinnor och män samt deras attityder och värderingar gentemot STI och sexuellt risktagande. Som exempel på en STI handlar således de två första delarbetena om en specifik könssjukdom, kondylom. Könssjukdomar, i mer allmän mening, har de senaste åren i Sverige, liksom i övriga världen, ökat med en hastighet som beskrivits som epidemisk (Weinstock, Berman & Cates, 2004; Smittskyddsinstitutet, 2007). Det finns mer exakta siffror för ökningen av vissa könssjukdomar i Sverige, såsom klamydia och HIV, då dessa faller under smittskyddslagen. Antalet klamydiafall har under de sista tio åren ökat från 10 000 till 42 000 fall år 2008. Trots att kondylom inte lyder under smittskyddslagen, anser sig Smittskyddsinstitutet kunna fastslå att de två vanligaste könssjukdomarna i Sverige idag är klamydia och kondylom (Smittskyddsinstitutet, 2007).

Kondylom

Idag vet man att kondylom\textsuperscript{6}, eller könsvårtor orsakas av särskilda typer\textsuperscript{7} av humant papillomvirus (HPV). HPV är ett mycket vanligt förekommande virus. Om vissa typer av viruset får fäste på händer eller foter kan ge det upphov till fot- och handvårtor. När genitalslemhinnan infekteras av HPV räknas detta som en sexuellt överförbar infektion. Forskning visar att cirka 50 olika typer av HPV kan infektera den genitala slemhinnan (Daejin, et al., 2007; Sperber, Brewer & Smith, 2007).


Förekomsten av HPV-infektioner ökar i alla länder, men sjukdomen kan vara svår att kartlägga. En svårighet med att få fram exakta siffror är att en person kan ha en latent infektion som bara kan upptäckas med analys av DNA eller cytologprov (Ghedamssi, et al., 2000; Lacey, 2005). I Sverige lyder inte kondylom under smittskyddslagen. Som redan nämnts innebär detta att det inte finns någon

\textsuperscript{6} Kondylom heter på latin \textit{condylomata accuminata} och kallas på svenska könsvårtor eller genitala vårtor.

\textsuperscript{7} Jag är medveten om att begreppet ”typer” i inledningen av detta stycke förekommer ett flertal gånger. Detta är dock den korrekta benämningen, varför det är svårt att byta ut begreppet.

Då infektionen orsakas av ett virus måste kroppen själv läka ut den. Dock finns egenbehandling i form av lösning eller kräm, som syftar till att reducera mängden vårtor, och helst att ta bort dem. En annan behandling är avlägsnande av vårtorn med kirurgisk teknik såsom laser, kryo (frysning) eller diatermi (bränna) (Lacey, 2005).

Nyligen har två vaccin mot HPV, med syfte att förebygga livmodershalscancer, lanserats. Dessa vaccin är verksamma mot HPV typ 16 och 18. Dessa två typer av HPV står för 70 procent av all livmodershalscancer (Sperber, et al., 2007). Det ena vaccinet är även verksamt mot de typer av HPV som orsakar kondylom, typ 6 och 11.


**Att leva med kondylom**


Både män och kvinnor som smittats med kondylom verkar också tycka att det är svårt att berätta för sin partner, blivande partner och vänner om sin smitta. De kan också vara bekymrade över risken att smitta en nuvarande eller framtida partner (Voog & Löwhagen, 1992). Många kvinnor berättar om sin sjukdom för en väninna eller mamma (Padham-Porterfield, 2005), medan männen ofta tycks välja att inte anförtro sig åt någon alls (Ireland et al., 2005).


Denna kärleksideologi börjar enligt svensk forskning att överges numera. Vi lever idag i en tid med generellt högre sexuellt risktagande än under tidigare decennier. En mer accepterande hållning till tillfälliga sexuella kontakter ger en ökning av antalet personer som har erfarenhet av detta (Helmius, 1998; Häggström-Nordin, Hanson & Tydén 2005; Christiansson, 2006). I Sverige avspeglar sig detta i en kraftig ökning av klamydia de sista tio åren, och det är ungdomar
mellan 15 och 29 år som står för 87 procent av de anmälda fallen (Forsberg, 2006).


9 One-night-stand används här i betydelsen ”engångsligg”, där åtminstone en av parterna inte har för avsikt eller förväntan att etablera ett längre sexuellt eller romantiskt förhållande.
Bland unga män har idag ett nytt begrepp vuxit fram, knullkompis, kallat "KK". Detta innebär en sexuell relation till en vän, utan en egentlig kärleksrelation. Den här företeelsen har nyss uppmärksammat inom forskningen. Häggsström-Nordin et al. (2005) genomförde en studie om KK bland 519 tredjeårs- gymnasiister i Västerås. Trettiotvå procent av flickorna och 49 procent av pojkarna hade erfarenhet av KK.

**Unga människors attityder till kondom**

Som tidigare nämnts kan kondom utgöra ett skydd mot STI-smitta. Det finns emellertid flera forskningsresultat som visar att framförallt män ändå väljer bort kondom. En av de vanligaste anförda orsakerna till detta är att den minskar känsligheten hos penis och därmed gör samlaget mindre tillfredsställande (Skidmore & Hayter, 2000; Darj & Bondestam, 2003; Flood, 2003). Uttrycket ”som att tugga kola med paper på” illustrerar problematiken. Liknande uttryck finns i många länder, och i engelsktalande länder säger man ”It’s like taking a shower in a raincoat”. Ekstrands studie (2008) visar t.ex. att ungar som ger uttryck för sådana åsikter menar att användande av kondom vid samlag ändå ger dem en känsla av att ”ha handlat rätt”. Dessa känslor känns mentalt ”sköna”, och de håller i sig längre än de sexuellt ”sköna” känslorna vid det oskyddade samlaget.


domer. Ett stort mått av riskförnekande finns också med i bilden. De unga tänker ofta ”det händer inte mig”.


Barnmorskans roll i det sexuella och reproduktiva hälsoarbetet


Eftersom vårdvetenskaplig forskning riktar intresset mot människan i vården, genomförs ofta studier av patienters erfarenheter och upplevelser. Ur ett vårdvetenskapligt perspektiv är det av stort värde att få ta del av berättelser från de människor som smittats. Med sådan kunskap finns en möjlighet att förbättra
barnmorskans information och bemötande för att kunna förebygga en fortsatt ökning av könssjukdomar.
Forskningens problemområde och syfte

Beskrivning av problemområdet

När en barnmorska eller annan professionell vårdgivare möter en ung människa som fått en könssjukdom är det viktigt att utgå från en förståelse av patientens situation. Det är förstås endast den unga människan själv som kan berätta om sina personliga erfarenheter och vilka känslor en könssjukdom väckt. Men för en konstruktiv dialog behöver den professionella vårdgivaren även allmän kunskap om hur unga människor kan uppleva situationen.


I de två första delstudierna exemplifieras erfarenheter av att leva med en könssjukdom av en virulent dito, kondylom. Genom att kondylomen finns på kroppen, kan det, förutom att påverka den unga människan fysiskt, även inrymma en vidare påverkan av livet i stort. Eftersom en virulent könssjukdom inte kan behandlas med antibiotika kan den kvarstå under lång tid. Det är därför betydelsefullt att försöka förstå den existentiella dimensionen av att leva med en oberäknelig könssjukdom som kan komma tillbaka och som leder till att man inte vet om/när man själv är smittsam.

En könssjukdom föregås vanligtvis av ett sexuellt risktagande. När detta avhandlingsarbete startade fanns större studier där sexuellt risktagande undersöks via standardiserade instrument. Dock undersöker inte dessa studier hur unga männi-

9 Existentiella frågor behandlas ofta inom den vårdvetenskapliga forskningen kring sjukdom, lidande och död.
skor i mindre grupper resonerar och tänker kring könssjukdomar och sexuellt risktagande. De normer som styr det sexuella risktagandet torde uppstå i interaktion mellan människor, och således formas i grupper av ungdomar. För att försöka fånga den unga människans tankar, känslor och motiv för det sexuella risktagandet, är det därför viktigt att både förstå inflytandet från jämnåriga och föreställningar kring manligt och kvinnligt.

**Syfte med delsyften**

Målsättningen med föreliggande avhandling är att bidra till en fördjupad förståelse över hur det är för en ung människa att drabbas av en könssjukdom, samt de attityder och värderingar som påverkar unga människors sexuella risktagande. Det övergripande syftet är tudelat. Det första syftet är att förklara och förstå unga svenska kvinnors och mäns levda erfarenhet av att ha fått en könssjukdom, här exemplifierat med kondylom.

Det andra syftet är att förklara och förstå de normer kring sexuellt risktagande hos unga svenska kvinnor och män som skapas i grupper av jämnåriga samt i relation till de föreställningar om manligt och kvinnligt som förekommer i ungdomsgrupper.

Avhandlingen bygger på fyra delstudier, för vilka följande specifika syften formulerats:

**Delstudie I**
Syftet är att analysera och beskriva unga svenska kvinnors levda erfarenheter av kondylom.

**Delstudie II**
Syftet är att analysera och beskriva unga svenska mäns levda erfarenheter av kondylom.

**Delstudie III**
Syftet är att förklara och förstå svenska tonåringars attityder och värderingar gentemot sexuellt överförbara infektioner samt sexuellt risktagande.

**Delstudie IV**
Syftet är att ur ett genusperspektiv förklara och förstå svenska tonåringars attityder och värderingar gentemot sexuellt överförbara infektioner samt sexuellt risktagande.
Avhandlingens teoretiska utgångspunkter

I avhandlingen förekommer tre teoretiska perspektiv: livsvärldsperspektiv, hermeneutik samt genusperspektiv. Dessa tre beskrivs nedan.

Livsvärldsperspektiv

Avhandlingsarbetet ingår i en vårdvetenskaplig tradition med ett etiskt medvetet patientperspektiv\(^\text{10}\) och livsvärlden som grund för såväl vårdarbete (Dahlberg, Segesten, Nyström, Suserud & Fagerberg, 2003) som forskning (Dahlberg, Dahlberg & Nyström, 2008).


Öppenhet är ett viktigt begrepp inom livsvärldsforskning. Det innebär att forskaren har en äkta vilja att se, höra och förstå. Det handlar om respekt och odmjukhet inför det som ska studeras. Forskaren bör alltså vara följsam och flexibel. Ett

\(^{10}\) Ett etiskt medvetet patientperspektiv innebär en respekt för patientens värdighet och integritet. Det är patienten som är den främsta experten på sig själv, sitt lidande och välbefinnande, och sin livssituation. Det etiska i patientperspektivet bidrar till att patienterna kan känna förtroende för och i vården (Dahlberg, Segesten, Nyström, Suserud & Fagerberg, 2003, s. 21).
öppet livsvärldsperspektiv hos forskaren gör det möjligt att beskriva världen så som den upplevs av människor (Dahlberg, et al., 2008).

Att välja ett livsvärldsperspektiv som kunskapsteoretisk utgångspunkt för en empirisk studie, innebär alltså ett försök att systematisera och begreppslägga denna ”självlaklara” verklighet. Av detta följer att den verklighet deltagarna i studien uppfattar som sin framträder mot bakgrund av tidigare erfarenheter i såväl historisk, som kulturell och social mening (Bengtsson, 1988/2001). Ett livsvärldsperspektiv inom forskning betyder således mer än att fänga en bild av verkligheten som bygger på objektiva mätbara iakttagelser (Dahlberg, et al., 2008).

**Hermeneutik**


En av Sveriges mest kända empiriska hermeneutiker Per-Johan Ödman manar till en reflekterad ödmjukhet och betonar att:

En tolkning utförs på en bestämd tid och på en bestämd plats av en människa som befinner sig mitt i historien (Ödman, 1994, s. 18).
Genusperspektiv


Ordet genus refererar i denna delstudie till de föreställningar om skillnader mellan manligt och kvinnligt som följer av sociala och kulturella konstruktioner. Intresset riktas mot normativa idéer, attityder och aktiviteter som uppfattas som ”passande” för en persons biologiska kön. Med andra ord handlar det om kvinnliga och manliga kännetecken som är socialt accepterade inom en kultur, i det här fallet den västerländska kulturen i allmänhet och den svenska i synnerhet. Det handlar således om de sociala relationerna inom vilka individen och gruppen agerar (Connell, 2006).


Betydelsen av genus kan identifieras på alla samhällsnivåer. Genusmönster skapar identitet och tillhörighet på en individuell nivå, och blir till tankemönster som maniysteras i arbete, lagar och organisationer på en social och ekonomisk nivå. Följaktligen påverkar genusordningen det mesta i samhällslivet, t.ex. hur vi klärs oss, våra relationer, vad vi väljer att studera och arbeta med (Thurén, 2003). Om vi för samman genus- och åldersindelningar framkommer mönster som t.ex. visar hur pojkar och flickor i gymnasiet förväntas bete sig. Resultatet av denna genuspåverkan blir ett antal inlärningsmönster, där flickor och pojkar lära sig hur de bör vara. Väl etablerade blir mönstren självuppfylland (Josefsson, 2005). Genom att människor vet vilka handlingar som får önskvärda eller icke önskvär-
da konsekvenser, handlar människor indirekt i enlighet med rådande genusrading (Connell, 2006).


Teorin om hegemonisk maskulinitet har haft en stor påverkan på forskningen kring män, genus och social hierarki. Den har ofta använts för att förstå mäns handlingssätt i relation till sin hälsa, och den har visat sig vara viktig för att förstå mäns sexuella risikotagande (Connell & Messerschmidt, 2005).

\[\text{ równocześnie} \]

1 Hegemoni - den makt över en människa som en ledande klass utövar vid sidan av sin ekonomiska och politiska dominans (Nationalencyklopedin, 1992).
Datainsamling

I det här avsnittet beskrivs först de individuella livsvärldsintervjuerna, därefter deltagarna i studie I och II. Därefter följer en beskrivning av fokusgruppsintervjuer och deltagarna i studie III och IV.

Individuella livsvärldsintervjuer

Intervjuerna i studie I och II inleddes med en öppen och relativt bred intervjufråga med avsikt att stimulera den intervjuade att reflektera över det som var av intresse för respektive studie. Forskningsfrågan löd: Kan du berätta för mig om hur du upplevt att ha kondylom? De intervjuade uppmunrades inledningsvis att beskriva fritt och utförligt med egna ord. Min roll som intervjuare var att under intervjun utgå från intervjupersonens svar, och ställa följdfrågor som stimulerade till ytterligare reflektion, som i sin tur tydliggjorde erfarenheterna av hur det är att leva med kondylom.


Deltagare i studie I och II

Inför den första delstudien (I) kontaktades en samordningsbarnmorska för tre ungdomsmottagningar. Hon förmedlade kontakt med tre barnmorskor, en från vardera mottagning. Primärvårdscheferna gav sitt skriftliga medgivande. Inklusionskriterier för deltagande i den första delstudien var unga kvinnor med en etnisk svensk bakgrund, som var diagnosiserade med kondylom sedan minst tre månader. Anledningen till det etniska inklusionskriteriet var att utesluta stora variationer förknippade med kulturella skillnader, som jag inte ansåg mig tillräckligt insatt i för att hantera under tolkningsarbetet. Informanterna hade alltså levit

---

12 Däremot tillfrågades ingen informant om sin sexuella läggning, varken inför datainsamlingen eller under intervjuerna.


**Fokusgruppsintervjuer**

Data i studie III och IV utgörs av fokusgruppsintervjuer. Dessa innebär ett förberett och arrangerat samtal som genomförs i en grupp, vars deltagare utsetts särskilt för att fördjupa sig i ett ämne.


Att intervjua fokusgrupper är en forskningsteknik som bygger på idén att tankar, känslor och handlingar uppstår i interaktion mellan människor (Bryman, 2002). Det är således inte själva interaktionen som studeras, utan den mening och innebörd som skapas genom växelverkan mellan deltagarna i gruppen. När en delta-

---

13 Totalt var det tre olika doktorandkollegor som hjälpte mig under fokusgruppsintervjuerna. En doktorandkollega var med vid två fokusgruppsintervjuer. De andra två var med på en var.
gare i gruppen uttrycker en åsikt, kan den åsikten väcka en tanke hos en annan deltagare som ger respons på detta. Det i sin tur genererar en kommentar från en tredje deltagare i gruppen. Detta samspel ger förhoppningsvis rik data.

Deltagare i studie III och IV

Delstudie tre (III) inleddes med en provfokusgrupp med fyra unga kvinnor i åldern 20 till 22 år. Genom denna provfokusgrupp kunde jag som forskare träna min roll som moderator, då detta var helt nytt för mig. Jag fick också en möjlighet att observera om mitt ämne var svårt att tala om, något deltagarna i denna grupp inte verkade anse. Dock medgav de att ämnet inte var något som de talade med varandra om i vardagen. Dessutom gav de feedback på mitt sätt att intervjua, vilket jag hade nytta av i de senare intervjuerna.


Elevernas etniska bakgrund eller sexuella preferenser var inte med som inklusionskriterier, och det var heller inget jag som intervjuare tog upp. Varje gruppinsintervju bandinspelades och pågick mellan 60 och 120 minuter. Transkriberingen utfördes av forskningssekreterare.

Delstudie IV är en sekundäranalys av de fokusgrupper som ingår i studie III. Denna analys har genomförts med ett genusperspektiv som teoretisk utgångspunkt för tolkningsarbetet.
Analysmetoder

Här beskrivs först några allmänna principer för empirisk tolkning. Därefter följer en mer preciserad beskrivning av hur analysen genomförts i studie I, II och III. Sist redogörs för sekundäranalys och perspektivstyrd tolkning, samt tillvägagångssättet vid analysen av studie IV.

Allmänna principer för empirisk hermeneutik

Principerna för den hermeneutiska analysen i föreliggande avhandling har beskrivits av Nyström (2003; 2008).


När hela datamaterialet kännas bekant lämnas helheten till förmån för en analys av textens delar. Innebörder identifieras i olika textavsnitt. De innebörder som tycks spegla något gemensamt försammån till lite större delar, som sedan tolkas.

I tolkningsarbetet ingår förklaringsmoment på det sätt som Ricoeur (1976) förespråkar. En sådan förklaring kan t.ex. handla om traditionens betydelse och om rimligheten i de tolkningsförslag som växer fram. Andra förklaringar hämtar hjälp av teoretiska konstruktioner och tidigare forskning. Observeras bör dock att

---

14 Tolkningsprocessens pendlande mellan helhet och delar kallas hermeneutisk spiral. Detta begrepp betecknar att förståelsen börjar och slutar öppet och successivt ökar i abstraktionsnivå.

15 Samlat begrepp för meningsbärande enheter och innebördstema.
I vissa fall är det en fördel att använda flera olika teorier för att motverka att en teori blir alltför framträdande i tolkningsarbetet. Det kan fungera bra att använda delar av en teori för att utveckla en tolkning, utan att de övriga innebörderna knyter an till teorin i sin helhet. Det är dock viktigt att teorier eller tidigare forskningsresultat används så sent i analysarbetet som möjligt. Skälet till detta är, som tidigare nämnts, att det alltid är innebörden i data som är det viktiga, inte teorin/teorierna.

16 I vissa fall är det en fördel att använda flera olika teorier för att motverka att en teori blir alltför framträdande i tolkningsarbetet. Det kan fungera bra att använda delar av en teori för att utveckla en tolkning, utan att de övriga innebörderna knyter an till teorin i sin helhet. Det är dock viktigt att teorier eller tidigare forskningsresultat används så sent i analysarbetet som möjligt. Skälet till detta är, som tidigare nämnts, att det alltid är innebörden i data som är det viktiga, inte teorin/teorierna.

17 De olika tolkningsnivåerna och tolkningsnivåerna diskuterades kontinuerligt med mina handledare och vid doktorandseminarier.
Därefter startade den delen av analysprocessen där en minsta gemensamma näm-
ner söks som ytterligare kan förklara de olika deltolkningarna. Här handlade det
alltså om att formulera en huvudtolkning.

Under hela tolkningsarbetet kontrollerades logiken i det system av deltolkningar
och huvudtolkning som presenteras som resultat. Med begreppet inre logik avses
en kontroll av att deltolkningarna varken motsäger varandra eller huvudtolkning-
en. Med yttre kontroll avses att jag som forskare hela tiden pendlar mellan pri-
mårdatala och mina tolkningar (Ödman, 1994). Detta innebär att alla moment i
samtliga tolkningar har kontrollerats så att inga data är direkt motsägelsetfulla
visavi de tolkningar som presenterats som resultat i studierna.

Sekundäranalys och perspektivstyrda tolkning

En sekundäranalys innebär att man analyserar redan insamlad data. Dessa har
alltså samlats in för annan studie och med annat syfte. Sekundäranalysen genom-
förs antingen af forskaren bakom den ursprungliga datainsamlingen, eller av en
annan forskare som har tillgång till samma data. Nu ställs en ny forskningsfråga
till data (Heaton, 1998). Metoden har hittills inte använts så ofta för kvalitativa
data, och det finns metodologiska och etiska frågor att ta ställning till (Heaton,
1998; 2004). Dessa diskuteras på sidan 31 under rubriken etiska överväganden,
samt i metoddiskussionen.

Heaton (1998; 2004) menar att det finns olika former av sekundäranalys och be-
skriver de olika formerna utifrån fokus på analys och vilka originaldata som an-
vänds. En forskare kan som originaldata använda data från en enda kvalitativ
studie, flera kvalitativa studier eller en blandning af kvantitativa och kvalitativa
studier. Vid analysen kan ett nytt fokus eller perspektiv användas. I studie IV har
data från studie III använts och dessa har analyserats med ett nytt perspektiv.
Heaton (1998) beskriver detta som en retrospektiv analys där hela eller delar av
data används med ett nytt syfte, som inte var formulerat för den ursprungliga
studien.

Enligt Thorne (1998) finns det fem tydliga former af sekundäranalyser. Den för-
sta beskrivs som analytisk utvidgning, vilket innebär att forskaren genomför en
sekundär analys af sina egna data med en utvidgad eller ny frågeställning. Nästa
variant är retrospektiv tolkning som innebär att man använder existerande ut-
skrifter från en databas för att ur en originalstudie djupare analysera redan upp-
komna teman. Den tredje typen kallas "armchair induction". Denna beskrivs som
en induktiv textanalysmetod, applicerad på existerande data, som samlats in af
annan forskare. De två sista af dessa fem former är ämnade för kvantitativa data
och berörs inte närmare här (Thorne, 1998).

Arbetsmetoden i min sekundäranalys består även denna gång af tolkning. Det
som skiljer studie IV från övriga studier i avhandlingen är att jag överger det
öppna livsvärldshermeneutiska förhållningssättet till förmån för ett teoretiskt ställningstagande, där genus ses som socialt konstruerat.

Jag har således inte som i studie I–III först analyserat data och därefter sökt efter förklaringar i olika teorier. I studie IV har jag redan från början aktivt letat efter innebörder som kan relateras till sociala konstruktioner kring genus. När en teoretisk tolkningsram läggs in så här tidigt i analysarbetet innebär det förstås att öppenheten försvagas till förmån för det i data som stämmer med det valda perspektivet.

Etiska överväganden

Samtliga informanter till studie I och II tillfrågades av barnmorska respektive läkare om de ville delta i studierna. De fick också ta del av ett brev med information om forskningens syfte, att deltagandet var frivilligt och att intervjamaterialet skulle behandlas konfidentiellt. Således bistod vårdpersonalen med urvalet löpande, allt eftersom de på mottagningen hade kontakt med en ung kvinna eller man som motsvarade respektive studies inklusionskriterier. Informanterna till studie I och II gav alla sitt skriftliga medgivande. De bestämde själva var intervjuerna skulle äga rum och de kunde när som helst välja att avsluta intervjun. Om de efter intervjun ångrade sitt deltagande skulle materialet förstöras.

Att tala om att man smittats av en könssjukdom kan inbegripa att tala om sitt sexualliv på ett mycket personligt sätt. Detta kräver att forskaren är speciellt hyg och för frågor som berör informanternas integritet. Under arbetets gång har jag som forskare försökt uppmärksamma detta extra noga, samt varit mån om att skapa en tillåtande och förtroendefull atmosfär.


Deltagandet har således byggt på informerat samtycke samt autonomiprinципen och konfidentialitet. Med konfidentialitet menas här att den specifika information som framkommer i respektive intervju, inte kommer att kunna spåras till enskilda informanter. Forskningsetiskt tillstånd för studie I och II erhölls i samband med den inledande datainsamlingen (Dnr Ö 274-00 och Dnr Ö 022-03).

Inför fokusgruppsintervjuerna i studie III fick de valda skolklasserna muntlig information om syftet med min forskning. De informerades om att deras deltagande var frivilligt, och att de som ville vara med, skulle kontakta sin lärare. All vidare kontakt hölls därefter med respektive lärare. Jag fick aldrig några namn på deltagarna. Tid och plats för fokusintervjuerna bestämdes av informanterna. Före intervjun gavs ytterligare information om konfidentialitet, och att varje informant när som helst kunde avbryta sitt deltagande. Vid tiden för datainsamlingen krävdes inte formellt etiskt tillstånd för denna form av studier.

18 Autonomiprinципen innebär att alla människor så långt som möjligt har rätt att bestämma över sitt eget liv och sitt eget handlande. Här i betydelsen att informanternas när som helst hade rätt att avbryta sitt deltagande.
Resultat

Det system av tolkningar som utgör varje delstudies resultat presenteras i artiklarna i form av deltolkningar och huvudtolkning. Deltolkningarna presenteras här i mycket förkortad form. Avsikten med detta är att ge större utrymme åt den tolkning som omsluter hela materialet, dvs. huvudtolkningen.

Studie I

The lived experience of genital warts: The Swedish example

Studie I syftar till att analysera och beskriva unga svenska kvinnors levda erfarenheter av kondylom. Analysen ledde fram till följande sex deltolkningar;

Att bli offer för sjukdomen
När de unga kvinnorna förstod att kondylomen kunde komma tillbaka, kändes det som att de förlorat en viktig del av sin frihet. De upplevde sig som hjälplösa offer.

Att uppleva sig själv som äcklig
Vårtona ingav de unga kvinnorna en känsla av äckel och förakt som de vände mot sig själva och sina kroppar. Självföraktet tycktes hindra den unga kvinnan från att vara bitter på den man som smittat henne. Detta kunde leda till känslor av skam och nedstämdhet.

Att bortse från sin egen livsstil
Ingen av de unga kvinnorna ansåg att de haft många sexualpartners, trots att de visste att de haft fler sexualpartners löpte större risk att få en könssjukdom. På så sätt kunde de fortsätta se sig själva som ”ordentliga flickor” och andra som får könssjukdomar som ”dåliga flickor”.

Att träda in i kvinnovärlden
Flera av de unga kvinnorna hade aldrig tidigare varit gynekologiskt undersökta. Efter undersökningen upplevde de en befrielse och beskrev att de gått från att vara barn till att bli kvinna.
**Att lära känna sin kropp**
Allt eftersom kvinnorna vände sig vid att själva genomföra behandlingen, började de lära känna sina egna kroppar allt mer. Detta verkade ge dem en känsla av trygghet inför framtiden.

**Att dela en upplevelse**
Att inte vara ensam om sin diagnos upplevdes som en lättnad. Att berätta för en väninna som också haft ”oturen” att få en könssjukdom, kändes ofta tryggt. Det var dock viktigt att behålla kontrollen över vem som får reda på könssjukdomen.

*Den jämförande analysen av de sex deltolkningarna ledde fram till följande huvudtolkning:*

**Att förlora sin symboliska oskuld**


Men förlusten kan också vara förenad med de unga kvinnornas initiering in i en vuxen sexualitet via de gynekologiska undersökningarna. Den levda erfarenheten av att få vård för kondylom kan symboliskt betraktas som initiationsrit, som i en förlängning tjänar som en övergång till mognad. Parallellt med känslor av skam växer nämligen de unga kvinnorna. Från att ha upplevt att något kändes fel i deras underliv, till att ta ansvar för den konsekvens deras sexualitet lett till, förefaller de unga kvinnorna genomgå en mognadsprocess.
**Studie II**

To contract genital warts – a risk of losing love? Experiences of Swedish men living with genital warts

Den andra studien syftar till att analysera och beskriva unga svenska mäns levda erfarenheter av kondylom. Den ledde fram till följande sex deltolkningar:

**Kondylom skapar ett behov av kontroll**

**Reaktionerna beror på tidigare fördomar**
För vissa av de unga männen var kondylomen förenade med känslor av skam och rädsla. För andra var upplevelsen inte alls svår. De var bara irriterade över vårtorna, och att de behövde söka medicinsk hjälp. Skillnaden i hur man upplevde sina kondylom verkar ligga i de fördomar man tidigare hyst mot andra som fått könssjukdomar.

**Kondylomen för upp de egna fördomarna till ytan**
Män som inte tidigare talat med någon om sin könssjukdom, var ofta rädda för att bli dömda på samma sätt som de tidigare dömt ut andra som drabbats av könssjukdomar. Detta gav dem anledning att reflektera. Om de lyckades förändra sin attityd, såg de även mer ödmjukt på andra i samma situation.

**En kompetent sjukvårdare kombinerar professionell distans med ett personligt förhållningssätt**
De unga männen ville möta professionella vårdgivare som svarade på deras frågor utan en fördömande attityd. De ville också att konsultationen skulle vara personlig samtidigt som de bara ville vara en i mängden som drabbats av könssjukdomar. En sådan professionell vård hjälper dem att reducera känslor av skam och stigmatisering.
Ängslan och genans skapar behov av inkännande vårdpersonal
Behovet av empatiska vårdare var starkt hos de unga män som var rädda och heterade över sina kondylom. De män som mest var irriterande över sin könssjukdom uttryckte mindre behov av ett bra möte inom vården.

Tankar på en kärleksrelation gör männen sårbara
Tanken på en framtida kärleksrelation innehåller nu också vissheten om att man själv kan vara smittbärare. En kärleksrelation inbegriper en önskan om att få vara unik och en speciell person för den de är förälskade i. Ställda inför det faktum att de kanske kunde förlora möjligheten till kärlek, gjorde alla männen i studien sårbara, oavsett vilka tidigare attityder gentemot könssjukdomar de haft.

Den jämförande analysen av de sex deltolkningarna ledde fram till följande huvudtolkning:

**Att se på sig själv med den Andres blick**
Insikten i att de drabbats av kondylom påverkar de unga männens sätt att se på dåtid, nutid och framtid. Föreställningarna om dåtid präglar upplevelserna av nutid. Om smittbärare påverkas även framtid. En tidslinje länkar samman alla tre tidsdimensionerna. När de unga männen förstod att de skulle vara smittbärare en lång tid framöver, började de fundera över sig själva som objekt för andras fördomar.


Skam kan således uppstå när männen ser på sig själva utifrån. De verkar inte vara medvetna om att det som de ser i den Andres blick, ofta har beröringspunkter med deras egna föreställningar om vilka som drabbas av könssjukdomar.


Den existentiella innebörden i att vara smittad med en könssjukdom blir således helt beroende av vad de unga männen ser i den Andres blick och kanske framförallt, vem som utgör den Andre. Rykte och anseende står ofta på spel inför vänner, medan självrespekt och integritet är i blickpunkten vid vårdkontakter.

Samtliga män i studien vill också återfå kontrollen över sina liv. Men för dem som upplevt skam och oro är vägen längre, eftersom de behöver bearbeta sin egen inställning till könssjukdomar. Om de klarar detta skapas ett mer tolerant synsätt. De män som förefaller leva i självbedrägeri är däremot inte tvungna att möta sina egna föreställningar förrän en kärleksrelation utmanar dem.

Studie III

In the heat of the night it is difficult to get it right – teenager's attitudes and values towards sexual risk-taking

Den tredje studien bygger på fokusgruppintervjuer, men analysprocessen är den samma som i studie I och II. Analysen, som syftar till att förstå tonåringars attityder och värderingar gentemot sexuellt överförbara infektioner samt sexuellt risktagande, ledde fram till följande fyra deltolkningar:

Vanligt är lika med mindre farligt och mindre skamligt
Det faktum att en könssjukdom är vanligt förekommande och går att bota med antibiotika, som t.ex. vid klamydia, gör att ungdomarna ser den som lindrig.

Alkoholen används som ursäkt för att slippa ta ansvar
Ungdomarna tror inte att risken är stor att de själva ska smittas och få en könssjukdom, trots att de utsätter sig för risken via tillfälliga sexuella förbindelser. Alkohol gör det lättare att tänka på detta sätt och berusningen gör att de slipper ta ansvar.

Dialogen känns mer intim än själva samlaget
Det är viktigt för ungdomarna att leva i en illusion som innebär att var och en är noga utvald. Den illusionen innebär bl.a. att de inte kan visa att de tänkt på sexu-

---

19 I studie III, IV och i diskussionen används växelvis begreppen tonåringar respektive ungdomar för att variera språket. Åldern på samtliga deltagare är 18 till 19 år.
ella kontakter före mötet med denna speciella person. Dialogen kring ansvaret för den sexuella hälsan verkar bygga på intimitet. Verbal kommunikation tycks t.o.m. kräva mer närhet än själva samlaget.

**Att se partnern som ett objekt gör det möjligt att slippa ansvar i relationen**

*Den jämförande analysen av de fyra deltolkningarna ledde fram till följande huvudtolkning:*

**Att spela ett spel**
Tonåringar i grupp talar om attityder och värderingar gentemot tillfälliga sexuella kontakter som ett spel där det finns vissa regler att följa. Spelets regler, som är oartikulerade och ofta oreflekterade, följs av både pojkar och flickor. Främst tycks pojkarna acceptera spelets regler för att de inte vill gå miste om ett tillfälle. Även i frågan om att smitta en person med en könssjukdom kvarstår uppdelningen mellan objekt och subjekt. Ungdomarna anser att det är stor skillnad mellan att smitta en tillfällig partner och att smitta sin flick- eller pojkvän.


En verbal dialog verkar däremot vara komplicerad. Den kan till och med kännas mer intim än själva samlaget. Om en sådan dialog kommer till stånd, minskar dock risken för objektifiering av den andre. Detta leder till att det blir svårare att bortse från ansvar.

Den existentiella innebörden i detta kan förstås ytterligare med hjälp av den existentialistiskt-fenomenologiskt inriktade psykiatrikern Ronald Laing (1974). Rädslan för att bli avvisad beskriver Laing så här:


Hela spelet kan enligt Laing beskrivas som knutar, härvor, hopblandningar och trassel. Innebörden i spelet kan belysas ytterligare genom en hänvisning till detta relativt kända citat:

*De spelar ett spel. De spelar att de inte spelar ett spel. Om jag visar att jag vet att de spelar ett spel, bryter jag reglerna och jag blir straffad. Jag måste spela deras spel, som om jag inte såg spelet* (Laing, 1974, s. 7).

**Studie IV**

*What’s gender got to do with it? An analysis from a gender perspective of Swedish teenagers’ attitudes and values towards sexually transmitted infections and sexual risk-taking*

Den fjärde studien syftar till att ur ett genusperspektiv förklara och förstå svenska tonåringars attityder och värderingar gentemot sexuellt överförbara infektioner och sexuellt risktagande. Här analyseras samma data som i delstudie III, dvs. de fyra fokusgruppsintervjuerna, men med en ny forskningsfråga. Tolkningarna formuleras med hjälp av ett genusperspektiv. De ledde till följande fyra deltolkningar:
Sex kan vara både mål och medel
För flera av de unga kvinnorna förefaller det som om sex ibland är något de så att säga ”får på köpet” när det är närhet de söker. Detta kan vara svårt för dem att förmedla till en ung man som har samlag som målsättning.

Förutfattade meningar blir till sanningar
Osäkerhet och upplevelser av att något är för pinsamt att diskutera t.ex. kondom-användning, leder till rädsla för att partnern ska känna sig beskyld för att vara smittbärare. Genom att ungdomarna inte vågar tala med varandra utvecklas detta till en del förutfattade meningar om vad respektive kön tänker och tycker om kondom.


Vetskap om en eventuell könssjukdom kan väcka rädsla och sårbarhet
För de unga kvinnorna känns det ofta lättare att kontakta en ungdomsmottagning än för de unga männen. Pojkarna kan därför uppleva det svårare att testa sig för en eventuell könssjukdom än flickorna. En del av pojkarna upplever tiden medan de väntar på provsvaret, som psykiskt påfrestande. Bakom det som ser ut som en bristande ansvarskänsla som den unga mannen uppfattar genom att inte gå och testa sig för en eventuell könssjukdom, verkar det således ligga en sårbarhet och en rädsla för att bli sjuk.

Kvinnliga och manliga sexuella erfarenheter värderas olika
Den unge mannen förväntas ta initiativ till sexuella kontakter. För att underlätta detta försöker han skaffa sig så mycket sexuell erfarenhet som möjligt. Inför den manliga kamratgruppen visar han upp sina prestationer och blir bekräftad i sin manlighet.

Medan männen, påhejade av sina manliga kamrater, öppet söker sexuell erfarenhet, kan de unga kvinnorna uppleva sig begränsade i sin sexualitet då de överskuggas av hotet om att få dåligt rykte. Skillnaderna i hur och för vem man berättar eller visar sin sexuella erfarenhet verkar således ligga i villkoren för respektive kön.

20 Med ordet sex avses ’samlag’ enligt informanterna själva.
Den jämförande analysen av de fyra deltolkningarna ledde fram till följande huvudtolkning:

**Uppfattningar om vad som är kvinnligt och manligt ger upphov till missförstånd**

Missförstånd, som kan göra en ung kvinna och en ung man till främlingar för varandra, kan förklaras av de föreställningar som finns om kvinnligt och manligt inom ungdomsgruppen. Problemet förstärks av att unga män i stor utsträckning tycks söka bekräftelse hos varandra. Deras maskulinitet verkar bli ifrågasatt, inte minst av dem själva, om de som individer försöker tänka på ett sätt som inom den egna gruppen riskerar att betraktas som ett ”femint tankesätt”. En ung man i tonåren kan vara helt upptagen med att ”bli man”. En viktig byggssten i den processen är att andra män bekräftar honom. Unga kvinnors feminina identitet verkar mer byggas upp genom en vilja att vara till lags. Detta för att dels undvika dåligt rykte och dels för att få ingå i en kärleksrelation.


Ungdomar av båda könen verkar alltså agera och bygga upp sina självförtroenden på ett sätt som är socialt accepterat inom det genus de tillhör. Med detta följer en balansakt där det både är viktigt att hålla det sexuella självförtroendet uppe, och att inte få dåligt rykte. En ung kvinna måste skaffa sig sexuell erfarenhet utan att visa det för mycket utåt, medan en ung man öppet försöker skynda på och skaffa sig så mycket sexuell erfarenhet som möjligt, för att inte verka sexuellt oerfaren.

Bristen på kommunikation över genusgränserna är således påfallande. Detta leder till missförstånd som ytterligare försvävar möjligheten för genuina möten. Utvecklingen av en sexualitet som hör samman med förmåga till ansvar och om- sorg om den andre, kan därmed lätt skjutas åt sidan till förmån för ett förhållningssätt som utgår från behovet av lustfylld bekräftelse.
Resultatsammanfattning

Föreliggande avhandlings resultat visar att när en ung människa drabbas av en könssjukdom leder detta till riskfyllda möten på flera nivåer.

Resultatet från de individuella intervjuerna visar att den unga kvinnan eller mannen nu tvingas att möta sig själv i sina fördomar. Den unga kvinnan har i sin föreställningsvärld delat upp kvinnor i ”rediga och ordentliga” respektive ”promiskuösa”. Själv räknar hon sig till de ”rediga och ordentliga” kvinnorna. När hon så drabbas av en könssjukdom kommer hennes föreställningsvärld i gungning och hon tvingas möta sina fördomar. Hon kan nu välja att antingen bearbeta dem eller hitta ett sätt att åtminstone känslomässigt förneka innebörden i att vara smittad. Oftast väljer den unga kvinnan ett nytt möte i form av en vänninna. I detta möte speglar hon sig och kan få stöd i sin förnekelseprocess. Hon kan därigenom hålla kvar sin föreställningsvärld och vara kvar i ”de ordentliga värld”.

Den unga mannen tvingas på samma sätt som kvinnan, till olika möten. Han blir objekt för andra och ser sig själva med den Andres blick. Om han går igenom en mognadsprocess i mötet med sig själv, innebär det att han nu ser hur lätt det kan vara att drabbas av en könssjukdom vid oskyddade sexuella kontakter. Efter detta dömer han inte andra människor på samma sätt som han gjort tidigare.

Dock finns det män som inte genomgår denna mognadsprocess, utan väljer att i mötet spegla sig i en kamratgrupp. Denna kamratgrupp bekräftar honom och ser könssjukdomen som ett tecken på sexuell erfarenhet och manlighet.

Den existentiella innebörden i att vara smittad med en könssjukdom blir således helt beroende av vad de unga männen ser i den Andres blick. När den Andres blick kommer från en person som kan ge kärlek, ökar samtliga informanters utsatthet och sårbarhet.

sexuellt. Kondomanvändning stör ”spelet” och mötet mellan ungdomarna blir därmed ett riskfyllt möte.

Ett riskfyllt möte innebär slutligen att förekomsten av sexuellt överförbara infektioner och sexuellt risktagande kan förstås i relation till det samhälle och de föreställningar som finns om genus bland ungdomar. En ung man i tonåren är upptagen med att ”bli man” och en viktig bygsten i den processen är att andra män bekräftar honom, möter honom. Ett sätt att bli bekräftad är då att visa att man är sexuellt aktiv och framgångsrik hos motsatta könet. Detta kan leda till riskfyllda sexuella möten som kompliceras av missförstånd och felaktiga antaganden. De föreställningar om genus som finns i ungdomsgruppen leder till att en ung kvinna försöker skaffa sig sexuell erfarenhet utan att visa det för mycket utåt. En ung man å andra sidan försöker öppet skynda på och skaffa sig så mycket sexuell erfarenhet som möjligt, så att han inte verkar sexuellt oerfaren.
Diskussion

Diskussionen delas in i tre delar. Först diskuteras avhandlingens resultat, följt av metoddiskussionen. I de avslutande reflektionerna behandlas frågan om en narcissistisk ungdomskultur samt implikationer för vården.

Resultatdiskussion

**Riskfyllt möte – individperspektiv**

Att drabbas av kondylom är för de flesta unga människor en svår händelse som inbegriper att självbildens påverkas på olika sätt. De individuella intervjuerna ger en bild av hur de unga kvinnorna och männen möter sig själva. Flera bar på en bild av sig själva som gjorde det svårt att koppla samman den egna livsstilen med det faktum att de drabbats av kondylom. Denna svårighet ledde till att de tvingades att möta sig själva och sina fördomar när de smittades av en könssjukdom. I detta möte valde de olika förhållningssätt för att gå vidare.

För de unga kvinnorna tycktes mötet innebära att de förlorade sin oskuld ur ett symboliskt perspektiv. Detta kan förstås som att kvinnan miste en symbolisk oskuld när hon tvingades möta sig själv som ”oren” efter att ha drabbats av en könssjukdom. Denna ”orenhet” kan även upptäckas av andra (studie I).

En ung man tvingas på samma sätt som kvinnan att möta sig själv när han drabbas av en könssjukdom. Han blir objekt för andra och ser sig själv med den Andres blick (studie II). Både kvinnorna och en del av männen hade, innan de smittats, delat in personer i ”vi och dom”. ”Vi” är ordentliga personer som haft otur att få en könssjukdom, och ”dom” är promiskuösa personer som ofta ägnar sig åt ”one-night-stand” (studie I och II).

En ung kvinnas strategi för att återupprätta sin självbild blir att anförsit sig åt en nära väninna och med hennes hjälp fortsätta att förneka sitt sexuella risktagande. Hon kunde därigenom ha kvar sin indelning i ”vi och dom” (studie I).

En ung man går ibland igenom en mognadsprocess i mötet med sig själv, vilket innebär att han nu ser hur lätt det kan vara att drabbas av en könssjukdom vid
oskyddade sexuella kontakter. Efter detta dömer han inte andra människor på samma sätt som han gjort tidigare (studie II).

Resultatet visar dock att det också finns män som inte går in i en mognadsprocess, utan i stället speglar sig i en kamratgrupp som bekräftar honom och ser könssjukdomen som ett tecken på manlighet (studie II). Bland de unga kvinnorna fanns inga liknande förhållningssätt. Könssjukdomen verkade aldrig tolkas som ett tecken på kvinnlighet (studie I).

Forskning rörande människor som fått andra könssjukdomar såsom genital herpes21 eller klamydia, visar på liknande resultat. I några studier ansåg informanter att det var ”smutsiga”, promiskuösa personer som raggade upp partners på barer som fick en könssjukdom. De applicerade nu sina egna fördomar på sig själva och ansåg att det var så andra människor betraktade dem om de fick reda på deras könssjukdom (Lee & Craft, 2002; Piercy, 2006; Bickford, Barton & Mandalia, 2007).

Unga människor tycks också avvärja insikten att deras livsstil kan leda till att de smittas av en könssjukdom (studie I och II). Liknande slutsatser har andra forskare kommit fram till (jfr Tydén, 1996 och Christiansson, 2006). För de personer som i sitt yrke träffar ungdomar, via skolhälsovård, ungdomsmottagning eller annan vård, är detta av stor betydelse. Unga människor bör ges möjlighet att diskutera dessa fördomar och förstå att det är bland dem själva, i deras ungdomsgrupp, i kretsen av deras egna kamrater, som könssjukdomarna sprids.

De som drabbas av kondylom tycks ofta uppleva starka känslor av skam, skuld, rädsla, äckel och orenhet, vilket kan tolkas som ett existentiellt lidande (studie I och II). De unga kvinnorna i studie I ger uttryck för ett självförakt och anklagar sig själva för sin smitta.


---

21 Genital herpes är en virusrelaterad könssjukdom.

Att leva med en könssjukdom kan således vara förenat med en känsla av stigmatisering. Resultatet visar att informanterna är oroliga för att det ska bli allmänt känt att de har en könssjukdom och är rädda för vad andra ska tänka om dem (studie I och II). De unga männen tror att det kommer att bli svårt att berätta för en framtid kärlekspartner, och detta väcker deras rädsla för att bli avvisade (studie II).


Resultaten i föreliggande avhandling visar på vikten av att forskning om hur unga människor påverkas av en könssjukdom påverkar planeringen av vården. Den unga människans upplevda lidande ställer krav på den professionella vården. Det förefaller viktigt för den smittade att professionella vårdgivare har en förmåga att avdramatisera situationen, och minska stigmatisering. Dessutom önskar de som smittats att vårdpersonalen ger ett intryk av att kondylom är något de ofta kommer i kontakt med, och att detta inte är negativt laddat. Vidare bör en professionell vårdgivare skapa en sådan kontakt med patienten att det upplevs som en inbjudan. Om patienten står helt ensam i sin situation, kan detta indikera vikten av uppföljningsbesök (studie II).


Detta kan innebära en balansgång för den professionella vårdgivaren. Att minska patientens ångest och avdramatisera situationen, samtidigt som det är angeläget att patienten förstår vikten av att i framtiden använda kondom för att förhindra smitta, kan nog uppfattas som ett lite motsägelsefullt vårduppdrag.
**Riskfylt möte – grupperspektiv**


Männen i de individuella intervjuerna samt i fokusgruppsintervjuerna ger dock uttryck för ett annat sätt att se på sexualitet vid förälskelse (studie II och III). Här talar de om att de är måna om den unga kvinnan, och de vill absolut inte smitta henne med en könssjukdom. De upplever då också större sexuell njutning samt ger uttryck för att det är viktigt att kvinnan också upplever njutning (studie III).


Ett sådant riskfyllt möte som det ovan beskrivna saknar etiskt förhållningssätt utifrån Lögstrups (1994) beskrivning av det etiska kravet. Han menar att vi i mötet med andra människor lägger en del av vårt liv i den andres händer. Då förväntar vi oss att den andre ska ha omsorg om det. Frågan är hur det påverkar den unge mannen på sikt, att använda kvinnan som ett objekt för sin egen sexuella tillfredsställelse.


När tonåringarna inför den tredje delstudien intervjuades i grupp framträdde skillnader mellan unga kvinnor och unga män. Männen upplevde det t.ex. svårare att testa sig för en eventuell könssjukdom än unga kvinnor, med motiveringen att det kan vara psykiskt påfrestande att vänja på provsvaret (studie IV). Detta kan tolkas som bristande ansvarsstärka gentemot en blivande sexualpartner. Den unga mannen sätter sina egna känslor i första hand och väljer den lättaste utvägen, i detta fall att ”stoppa huvudet i sanden”. Ett annat sätt att se på den unga mannens óvilja, är att det bakom valet att inte gå och testa sig, verkar ligga en sårbarhet och en rädsla för att bära på en smitta. Möjligen kan även den traditionella mansrollen lägga hinder i vägen för männens att söka vård. En man med en sjukdom uppfattas inte som en ”riktig” man; att han är sjuk gör honom svag och sårbar, och det är inte förenligt med bilden av mannen som osårbar och stark (Ekenstam, et al., 2002; Wennberg & Berg, 2007).

De unga männen kan alltså uppleva det så svårt att söka vård, att inte ens om de blir kontaktade av en f.d. sexualpartner som berättar att hon har en könssjukdom, vill de gå och testa sig (studie IV). De unga kvinnorna tycks vara helt omedvetna om att de unga männen är så rädda för att undersöka om de bär på en könssjukdom. De tror att det är något en ung man gör med lätteth.


Spännande är då att notera att resultaten i denna avhandling visar att den unga mannen tvärtom säger sig respektera en ung kvinna om hon ber honom använda kondom (studie IV). Viktigt är ändå att inte ansvaret för kondomanvändningen helt och hållet vilar på den unga kvinnan. Detta ansvar bör vara jämnt fördelat och de hinder som ungdomarna berättar om är viktiga att diskutera på arenor där ungdomar möts. Spelet de spelar håller både kvinnan och mannen fast i stereotypa genusmönster.

49

Denna kunskap är mycket viktig och något som bör finnas med i undervisningen inom sex- och samlevnad på skolorna. Kanske kan det vara så att unga människor vill använda kondom i mycket större utsträckning än vad som idag sker, men de vågar inte föreslå det pga. rädsla att dra på sig partnerns missnöje.


För att bedriva sex- och samlevnadsundervisning i skolan behövs således kunskaper om genusmönster. Enligt RFSU och deras skolprojekt (Bergström & Foxhage, 2001) är sådan kunskap själva nyckeln i det preventiva arbetet för att förebygga könsjukdomar och oönskade graviditeter. Det är viktigt att samtali förs med ungdomar inom de områden där en ojämna maktbalans råder mellan pojkar och flickor. Begrepp att utgå ifrån i detta arbete kan enligt Bergström och Foxhage vara ”hora/slampa”, ”bock/player” och ”bögår”.


Således tycks de genuskonstruktioner som existerar i samhället idag emellanåt hindra män och kvinnor från att känna in sina äkta känslor och agera utifrån dessa. Kanske finns det unga kvinnor som någon gång önskar att ha ett one-night-stand men som inte vågar agera i enlighet med de känslorna för risken att bli stämplad som slampa. Och det kan eventuellt finnas män som föredrar att bara hänga med någon utan att det leder till ett samlag, men upplever förväntningar på sig att alltid vilja ha sex, annars finns risken att bli betraktad som omanlig. Både män och kvinnor förefaller fångade i genusmönster som hindrar dem från att känna, tänka och agera som individer, oavsett de yttre förväntningar som ålagts dem pga. biologiskt kön.


Denna eventuella förändring är emellertid inte synlig i föreliggande avhandlingsresultat. Men för att genusmönstren ska luckras upp är det angeläget att på de arenor där vuxna möter ungdomar, såsom skolor och ungdomsmottagningar, ge möjlighet till diskussioner om ”manligt” och ”kvinnligt”. Det är viktigt att hjälpa ungdomar att reflektera över socialt konstruerade gränser som visar vad som är ”tillåtet” för flickor respektive pojkar och varför det är så. Då kan kanske de fasta rollerna luckras upp lite fortare, och en ung kvinna respektive ung man kan få handla som individer och själva få välja hur de vill agera sexuellt.
Metodiskussion

Metodiskussionen inleds med reflektioner över valet av informanter. Därefter följer reflektioner över datainsamlingsmetoder samt sekundäranalys. För det öppna livsvärldsperspektivet i de hermeneutiska delstudierna diskuteras förförståelseproblematiken samt studiernas tillförlitlighet. Avsnittet avslutas med några tankar kring generaliserbarhet.

Reflektioner över valet av informanter

I den första studien med unga kvinnor märktes en stark vilja att få berätta, och i långa stycken av intervjun satt jag bara och lyssnade. När det så blev dags att söka manliga informanter för studie II blev det svårare, trots att jag vidgade mitt datainsamlingsfält. Därtill var vissa av dessa intervjuer svårare att genomföra än de i studie I, då några av männernas näst på mina direkta frågor och därefter svarade relativt kortfattat. Det var därför något mödosammare att få innebördsrika data.


Individuella livsvärldsinintervjuer

För mig har mina femton år som barnmorska givit mig en trygghet och vana vid samtal av privat karaktär. Min yrkeserfarenhet innebär dessutom att jag är van att lyssna på intima detaljer och kan visa med mitt kroppsspråk att jag är beredd att ta emot deras berättelse. Denna trygghet har jag försökt förmedla till informanterna.

Fokusgruppsintervjuer


En ytterligare frågeställning för denna avhandling var om en datainsamling med fokusgruppsintervjuer kan ha en livsvärldsansats som grund. Detta var något jag diskuterade vid flera tillfällen, både på seminarier med andra doktorander samt med mina handledare. Jag fann att det meningsmönster som uppstår i interaktionen, gör individen till sitt eget. Det påverkar på så vis individens sätt att se på sexuellt risktagande, och blir till en del av hennes livsvärld. Dessutom är det förmodligen så att de värderingar och attityder ungdomarna gav uttryck för var något som fanns i deras livsvärld. Dessa tankar sammantaget gjorde att mitt ställningstagande blev att även fokusgrupperna kunde finnas inom livsvärldsperspektivet.

Reflektioner över sekundäranalysen

Under arbetet med analysen av fokusgruppsintervjuerna i studie III, såg jag hur ungdomarna föreföll styrd av för dem gällande genussmönster. De sa ofta ”typiskt killar” eller ”det kan inte en tjej göra, då blir hon kallad hora”. Detta fick mig att fundera över om sociala genuskonstruktioner kunde påverka det sexuella risktagandet. Därmed växte en ny forskningsfråga fram, och valet föll på att göra en sekundäranalys i studie IV av samma data som i studie III.


**Förförståelsen som metodologiskt dilemma**

Innan intervjuerna för delstudie I genomfördes, blev jag av min huvudhandledare uppmunad att skriva ned min medvetna förförståelse för att ha detta som hjälp när jag problematiserade och försökte kontrollera förförståelsens inflytande över tolkningsarbetet. Dessa anteckningar hjälpte mig mycket under analysarbetet. Framförallt under den första studien då det hermeneutiska förhållningssättet var nytt för mig. Inför studie II handlade förförståelseproblematiken till stor del om att inte låta resultatet av den första studien helt styra nästa studie.

Min huvudhandledare gjorde mig också uppmärksam på att det fanns ”barnmorskeglasögon” i mina följdfrågor. Här handlade det vanligtvis om ledande frågor som tycktes ha med min yrkesbakgrund att göra. Det var inledningsvis svårt att släppa det här ”expertperspektivet”, och det tog lite tid att utveckla ett mera öppet förhållningssätt. Problemet diskuterades, och med hjälp av detta lyckades jag utveckla en följshet mot data som gjorde det möjligt att låta nästa forskningsfråga bygga på den föregående. Inför fokusgruppsintervjuerna och dess analys hade detta problematiserande förhållningssätt blivit mer självklart än vad det var i de första två studierna.
Tillförlitlighet och generaliserbarhet


Förhoppningen är att föreliggande avhandling tydligt visar att respektive delstudiers huvudtolkning bekräftar sina deltolkningar och vice versa. För att läsaren ska kunna bedöma hur tolkningsarbetet hänger ihop med ”verkligheten” har deltolkningarna styrkts med citat.

Ett livsvärldshermeneutiskt forskningsresultat är förstås inte generaliserbart i statistisk mening. Detta innebär dock inte att resultatet bara är tillämpbart för den undersökta gruppen. Genom att undersöka så många variationer som möjligt nås en fördjupad förståelse av det undersökta fenomenet, som just p.g.a. en rik variation och fördjupning kan vara tillämpbar utanför det sammanhang där studien är genomförd. Det urval som gjordes inför fokusgrupperna byggde emellertid på att man ville tala om sexuellt risktagande och könssjukdomar. De ungdomar som var blyga, inte har någon sexuell erfarenhet etc. kanske valde att inte vara med. På så sätt är det möjligt att resultatet bara speglar en del av ungdomskulturen.

Under tiden som avhandlingsarbetet pågått har flera studier i ämnet sexuellt risktagande och sexuellt överförbara infektioner publicerats22. Var och en av dessa är viktiga kunskapstillskott som i diskussionsavsnittet fungerat som en horisont mot vilken mina egna resultat reflekterats och diskuterats. Det ökade forskningsintresset inom området gynnar förmodligen möjligheten till att tillämpa forskningsresultat kring upplevelser av att leva med en STI och sexuellt risktagande i en relativt vid mening.

___

Avslutande reflektioner

En narcissistisk ungdomskultur?

Resultaten i föreliggande avhandling, att sexuella möten är riskfyllda, föder nya frågor. Det synes som om många ungdomar verkar brista i hänsyn och ansvar både till sig själva och till varandra. I tillfälliga sexuella relationer, som präglas av att de spelar ett spel, verkar de sakna långsiktigt tänkande. En del av dem förefaller välja det som är lättast för stunden, och som tjänar deras behov av uppmärksamhet och erkännande. Detta för tankarna till en ”narcissistisk23 ungdomskultur”. I en sådan kultur ser inte ungdomarna varandras perspektiv, utan var och en koncentrerar sig på sitt eget. Detta gör dem upptagna med sig själva, sitt eget rykte och sina egna möjligheter till sexuell tillfredsställelse, och de ser inte den andra människan.

En allvarlig konsekvens av detta är att det inte tycks vara speciellt viktigt om man smittar en tillfällig sexuell partner med en könssjukdom. Att däremot bekymra sig när det kommer till en kärleksrelation, ingår också i det narcissistiska förhållningssättet. Kärleksbehovet är stort och inför risken att bli avvisad är det egna känslor som står på spel. Rädslan för att bli sårad eller lämnad tycks vara stark. För flera av informanterna i de olika delstudierna verkar den genomgående tanken vara ”What’s good in it for me?”


De senaste årens omställningar i samhället har varit betydande. Konkurrensen om uppmärksamhet och framgång startar allt tidigare i livet. Många av dagens unga kan ha utvecklat svårigheter att engagera sig när de själva inte är i centrum.

Skidmore och Hayter (2000) menar att samhället gått från en ”public view” till en ”ego-centric view”. Detta leder till att en ung människa relaterar till världen utifrån sig själv i ännu högre grad än tidigare. Bara när det passar i samman-

hanget och gagnar en själv, tillskriver man en annan person vissa kvaliteter. Följden av detta kan t.ex. bli att om man inte önskar använda kondom, tillskrivs den tillfälliga sexuella partnern samma önskemål och egenskaper. ”Eftersom jag ingen könssjukdom har, så kan inte hon/han heller ha det.”

Relationsspelet, som blev tydligt i studie III, handlar om den lättaste vägen till lust. Tendensen att undvika obehag och en ovilja att ta itu med svårigheter var tydlig. Ett exempel är de unga män som väljer bort att testa sig för en könssjukdom för att det är psykiskt påfrestande.


**Implikationer för vården**

En ung människa som drabbats av en könssjukdom står ofta helt ensam med känslor och existentiella frågor. Den professionella vårdaren kan då bli en mycket betydelsefull person för den drabbade att spegla sig i, få hjälp av att bearbeta känslor och att diskutera sina existentiella funderingar med. Dessutom kan en
person som drabbats av en könssjukdom ha kvar negativa känslor länge, varför det är bra om den professionella vårdaren följer upp patienten.


Föreliggande resultat visar betydande skillnader i utsagor bland män i individuella intervjuer jämfört med männen i fokusgruppsintervjuerna. I de individuella intervjuerna är skillnaden mellan kvinnors och mäns utsagor inte lika stora. Däremot förefaller män ha en jargong och ett grupptryck mellan sig i fokusgruppsintervjuerna. Det är därför viktigt att ur vårdvetenskaplig synvinkel inte låsa sig vid forskningsresultat sprunget ur gruppen ”kvinnor” eller ”män” och glömma bort individperspektivet. Det är av stor betydelse att professionella vårdgivare möter patienten på individnivå oavsett kön.
Referenser


Smittskyddsinstitutet, Epidemiologisk årsrapport 2007. Västerås: Editas AB

Socialstyrelsens föreskrift SOSFS 2006:22.


THE LIVED EXPERIENCE OF GENITAL WARTS: THE SWEDISH EXAMPLE

Kina Hammarlund, RN, Midwife MSc
Department of Health Science, University of Skövde, Skövde, Sweden, and Växjö University, Växjö, Sweden

Maria Nyström, RN, MSc, PhD
Ersta Sköndal University College and Växjö University, Växjö, Sweden

Our aim in this study was to analyze and describe young Swedish women’s experiences of living with genital warts. Interviews with 10 young women, aged 16–21 years, were interpreted within a lifeworld hermeneutic tradition. The women experience themselves as victims of a disgusting disease. Furthermore, they appear to disregard the fact that their own lifestyles could be a risk factor for contracting venereal infections. On the other hand they get to know their bodies better after the gynecological examinations where the treatment begins. Their loss of innocence is considerable; thus it seems fair to compare this experience with earlier epochs’ ideas about loss of virginity due to the first intercourse. Consequently the young women also start looking at themselves as adults, and they take responsibility for the consequences of their sexuality.

Genital warts, caused by human papillomavirus (HPV), has been known since ancient Greek and Roman times (Becker, Stone, & Alexander, 1987). Human papillomavirus is today one of the most common sexually transmitted infections in the Western world (Chandler, 1996; Strand, Rylander, Evander, & Wadell, 1993). It is estimated that over 50% of sexually active men and women aged 15 to 49 years have been infected with genital HPV at some point in their lives (Manhart & Koutsky, 2002).

Received 1 March 2003; accepted 3 November 2003.
Address correspondence to Kina Hammarlund, Stockvägen 115, S-541 62 Skövde, Sweden.
E-mail: kina.hammarlund@ihv.his.se
The incubation time of HPV is relatively long, from 3 weeks to 8 months (Keller, Egan, & Mims, 1995). Over 38 different types of small DNA viruses are known to infect the genital tract. Only two types (HPV 6 and 11) are clearly linked with genital warts (Manhart & Koutsky, 2002). Infections associated with some HPV types have a high risk of progressing to cervical cancer (Tyring, 2000).

The research concerning HPV infections typically focuses on the epidemiology, the pathogenesis and the treatment. How people live with and adapt to this stressful disease has not received the same attention (Taylor, Keller, & Egan, 1997). Lehr and Lee (1990), however, described that many women experienced their genital warts as a trauma that could bring about mental or emotional stress. The emotional impact of genital warts is often longstanding and profound (Persson, Dahlöf, & Krantz, 1993). It is important for health care professionals to understand the emotional aspects of contracting genital warts when meeting the patient (Maw, Reitano, & Roy, 1998); several authors demonstrate that women feel guilt and shame about their bodies (Filiberti et al., 1993; Keller et al., 1995; Lehr & Lee, 1990). According to Reitano (1997) 37% of HPV infected individuals believed that their genital warts still had a negative effect on their sexual lives one year after diagnosis. To contract genital warts also can lead to anxious feelings about the treatment and confusion and anger concerning the sexual transmission (Tinkle, 1990). On the other hand, Redfern and Hutchinson (1994) found that women often blame themselves, which could lead to depression and feelings of being “dirty.” Cultural aspects also may have a great impact on individual experiences. Consequently, it is fair to assume that in order to provide adequate caring intervention health care providers must understand young women’s experiences of living with genital warts in a cultural context. Our aim in doing this study was to analyze and describe young Swedish women’s experiences of living with genital warts in Sweden.

**METHOD**

**Theoretical Framework**

Our study was conducted within a lifeworld approach. Husserl (1913/1998) made explicit the problems concerning the difference between research and everyday life. His lifeworld theory became a new foundation for science. He made it clear that we could not escape the lifeworld either within or outside science. Instead, a lifeworld approach attempts to do justice to the everyday experience, but in a systematic and methodical way. Dahlberg, Drew, and Nyström (2001) have proposed a lifeworld paradigm for research in the health care area. In a lifeworld paradigm
openness is the central idea. Openness is the epistemological concept that allows us to see the “things themselves,” that is, to have an open mind in research interviews and analysis of data in order to observe what is really there. Accordingly, to practice openness the researcher must encounter the informant in such an immediate way that the person is secure enough to reveal her or his experience of the everyday world in all its complexity and variety. To make this possible, the researcher must view the informant as a unique individual and genuinely be interested in the individual’s stories. Finally, lifeworld research is always focused on the meaning implicit in the data.

The lifeworld theory in this study was influenced by the interpretative approaches of Hans-Georg Gadamer (1995) and Paul Ricoeur (1976), two leaders in the hermeneutic tradition. Gadamer claims that gaining truth is not possible just by using a scientific method. Only by being aware of the pitfalls in the process of interpretation is it possible to avoid merely seeing what is already understood. The concept of preunderstanding is thus central in Gadamer’s philosophy. Preunderstanding is an intentional structure that is activated when we regard something as something. Preunderstanding is affected by tradition; it could be said that all interpretations are grounded in a common experience of being human in a certain tradition. Preunderstanding also can be seen as a horizon, because it points to the breadth of vision one must have to understand another person. To acquire a horizon means that one learns to look beyond what is close at hand. Total objectivity is impossible in any kind of research. Using a hermeneutic approach to empirical research, we must be attentive to our preunderstanding and its importance on all the interpretations we make. All researchers must reflect upon their preunderstanding and its influence upon their interpretations in order to discover something new or understand something in a new way. Openness was not enough, however, in the whole process of understanding underlying meaning of the data in this study. Ricoeur (1976) suggests a distancing, questioning, and critical approach in order to illuminate the “surplus of meaning” in such situations. Consequently, the open reading was matched by a critical reading with the intention of finding explanations that could further develop the interpretations. Theory was used to further explain the interviewee’s statements. Hermeneutic inquiry also guards against subjectivism, and hence some criteria of quality for valid interpretations must be fulfilled (see below).

Data Collection

Our research was carried out in Sweden. Ten young Swedish women participated in the study, all of whom had grown up in Sweden of Swedish
parents with no foreign origin in their family. Their ages were between 16 and 21 years, and all had been diagnosed with genital warts. The number of interviews was not decided beforehand. Data collection was ended when, according to the research question, no more salient variations were found.

Data were collected in three guidance centers for young people in three different cities. Professional care providers in the guidance center explained the study to young women and asked them if they would participate. All that were asked agreed to be interviewed.

The reason for choosing young participants was based on the assumption that young women are vulnerable concerning identity and self-esteem. Second, it was based on the fact that the highest rates of genital warts occur among men and women aged 18–28 years (Maw et al., 1998). Third, Swedish participants who had grown up in Sweden of Swedish parents with no foreign origin in their family were chosen to exclude complications with cultural differences.

The interviews followed the principles of an open lifeworld approach (Dahlberg et al., 2001). Thus the goal of the interview was to get the interviewee to reflect upon the way in which the venereal disease affected their existential situation. The initial question was, “What is your experience of living with genital warts?” The young women were then encouraged to describe all their feelings about and their experiences of living with genital warts. Hence, this approach is characterized by openness and pliability to the research phenomenon on the part of the interviewer, in order to give a valid picture of human experiences. The one-to-one interviews, lasting one to one-and-a-half-hours each, were audiotaped and later transcribed verbatim.

An interpretative approach (i.e., no predetermined hypothesis) was used to identify meanings and patterns that emerged. As mentioned above the scientific openness of Gadamer (1995) complemented Ricoeur’s (1976) distancing, questioning, and critical approach to influence the whole interpretative process.

Analysis

The first step of analysis involved reading the transcribed interviews several times to get a sense of the whole. The second step was to identify similarities and differences in how the informants experienced themselves and their life situation after the diagnosis of genital warts. From this step 99 meaning units appeared in the data. The meaning units were then organized into different themes by relating them to one another. Thirteen main common themes emerged from this reading. In the third step of analysis we sought preliminary meanings within each theme. We formulated
tentative interpretations and compared them for similarities and differences to illuminate conceivable underlying meanings of general importance. Discrepancies of general importance in the interpretations were clarified by referring back to the interview text or by raising questions concerning negative influences of preunderstanding. At this stage of the analysis, the open reading was matched by a critical reading to find explanations that could further illuminate the underlying meaning in the data.

In the fourth step, the relevance of the tentative interpretations was estimated by using some criteria of quality (Dahlberg et al., 2001). First, valid interpretations must be consistent. Interpretations of parts were thus compared with interpretations of the whole. We moved repeatedly back and forth between the parts and the whole to determine whether there were any discrepancies between the understanding of the parts and that of the emerging interpretations. Furthermore, the interpretation we developed seemed to explain all substantive data. Other interpretations that contradicted or contested the explanations were not found.

Six interpretations were finally selected, each of which illuminated different aspects of the existential meaning in the data. In some interpretations, theory was used. These theories are described in the findings. Finally all tentative interpretations that were found to be valid were compared with one another with the purpose of finding a common denominator, an interpreted whole, for all data of general importance. Hence, our interpretation seemed to explain all the data.

Ethical Considerations

Written and oral information about the study was given to each woman, and confidentiality was assured to all participants. The analysis was conducted in such a way that the integrity of the women was maintained. The ethics committee of the University of Gothenburg approved the study.

FINDINGS

Initially six different aspects of the young women’s experiences were described. Later the connection between these six interpretations was investigated and the following interpretation became apparent.

Being a Victim

It was a painful experience for the young women to discover that the genital warts could return. When the young women realized that no one could assure them when they would be cured, they felt that they had lost
an important part of their freedom. Striving for control can be seen as an attempt to regain the loss of freedom. To gain control over recurrence, the young women examined themselves frequently to see if they had developed any new warts:

I must examine myself every day to see if there are any new warts. Before it was many times per day and I applied the treatment very often. Oh, it was really terrible. I wonder how long I will be able to keep on like this; it has been a year now.

When these young women lost their feeling of control over the disease they appeared to feel like helpless victims: “It lingers over me all the time, and I only hope that the warts will not come back right now. They come whenever they want, so I cannot control them.”

**Experiencing Self-Disgust**

The young women felt strongly that their warts were disgusting. They turned that feeling toward themselves and their bodies, which tended to lead to shame and self-contempt: “I am not clean, I do not feel clean, I haven’t felt clean since I got the diagnosis 6 months ago.”

Perhaps it is the self-contempt that stops the women from being bitter over the men who infected them. It seemed obvious that they put the blame on themselves. “I have to blame myself; it feels like a punishment or something like that.”

Consequently the women also turned their aggressions toward themselves and saw themselves as dirty. Instead of accusing the men who infected them, they seemed to blame themselves, therefore being in danger of depression, self-contempt, and shame.

**Disregarding the Causality of One’s Own Lifestyle**

The young women knew that those who have had many sexual encounters were more likely to get venereal disease, but none of them considered themselves to have had many sexual encounters. They did not believe, therefore, that their own lifestyle was the reason for their genital warts:

It was a venereal disease, only the girls that have been with many guys get them. That is not the way I see myself. I haven’t had many different guys. It didn’t make sense.

Because the women did not identify with the group who gets venereal disease, they looked for other reasons they contracted genital warts. One woman said, “The reason I got genital warts was accidental.”
It seems that these young women had to preserve their innocent self-image. To do so, they appeared to use denial as a psychological defense mechanism. According to Anna Freud (1966), denial means to avoid paying attention to unpleasant experiences. The defense implies consequently that the women do not have to confront themselves with the reality. They can thereby see themselves as an exception: someone that was just unlucky. Others who get venereal diseases are, on the other hand, “bad girls.”

**Entering a Woman’s World**

Many of the young women had never experienced a gynecological examination before they got genital warts, and they were very frightened of the thought of such an examination: “It was the first gynecological examination I ever had done and I was very nervous before it took place.”

All the women were relieved after the examination: They felt that they had grown from being a child to being a woman. Hence, the examination seemed to be some kind of initiation ritual that frightened them at first, but later on gave them a sense of maturity; it was a step into the adult world. According to Margaret Mead (as cited in Gardner, 1982), the initiation rite is a ceremony with which a society marks the passage of a youth from childhood to adulthood. Some cultures perform violent ceremonies in which the sexual organs are subjected to stress. Such ceremonies are less frequent and more implicit in Western cultures. But Gardner (1982) presumes that Western youth themselves will organize rites that are devoted to marking the route to adulthood. If that is the case the young women in this study might experience that they were initiated into the women’s world through the shared experience of the gynecological examination. “You get a confirmation that you are a woman, you are not a child anymore. I felt proud.”

**Getting to Know One’s Own Body**

As the young women got used to the gynecological examinations, they also got to know their bodies. They perceived this as something positive, and the examination became a natural opportunity to learn more about their vagina. To be able to treat themselves, they have to look at their vagina in a mirror to see where the warts are located: “Before, I didn’t know much about my vagina, or how it looked. Now I know exactly how I look down there. I have got to know my body much better.”

Getting to know one’s body also seemed to create a sense of security for the future. The young women were able to understand more easily problems concerning the body in general and particularly their vagina.
To have have surrendered themselves to someone in the exposed, weak position that a gynecological examination requires seemed to give the women enhanced strength. Presumably this knowledge about the female body also strengthened their identity as women.

Sharing an Unfortunate Experience

Not being alone with their diagnosis was a relief and a comfort for the young women: “It felt good that it was so common. Even if I don’t know in person anyone else who has got it, I feel that way. I’m only one of many.”

These feelings were intensified when the women shared the experience with someone else, a carefully chosen person. Most of the young women chose to tell one particular friend who also had had a venereal disease: “One of my best friends told me that she had it and then I could tell her that I did too. But I didn’t tell anyone else.”

The young women trusted this person to keep the information confidential. It seemed to be important that they be in control over who learned about their venereal disease:

If it would get out in this town, so everyone would find out, I would get such a reputation. They would say, “Oh, has she got it? Is she like that, being with different guys all the time?”

The young women look for proof that others could get a venereal disease. Preferably these other women would be as much of a “family girl” as they considered themselves to be. This opportunity for identification with another woman in the same situation seemed to be a way to seek fellowship and to see themselves as one of those unfortunate women who got a venereal disease. The ultimate proof that even a “good girl” can get a venereal disease comes through the realization that even royal people can get it. “Anybody could have it. The person doesn’t necessarily look sloppy. It could be anybody, like the queen, anyone.”

Concluding Interpretation: Symbolic Virginity

Contracting genital warts is a difficult and far-reaching occurrence in a young woman’s life. To deal with the anxiety and to maintain control over the situation, she creates an image in her mind of what a person is like who gets a venereal disease. This image is what Sullivan (1953/1997) called a “not me” experience, one that has nothing to do with her. She only discusses her genital warts with one chosen friend, someone who also had the misfortune to be struck by a venereal disease. Because the friend is not a “bad girl,” the young woman can retain the feeling of not being a “bad girl” herself.
Thus the young women seemed to rescue their innocence and self-esteem by denying that the venereal disease had something to do with their own lifestyle. If psychological defense mechanisms, such as the rationalization do not occur, it becomes difficult for the women to maintain their innocence and self-esteem. Instead, self-contempt and depression can occur. Most apparent is the loss of the image that the young women have of themselves as “well behaved” and thus invulnerable to a venereal disease. Their self-image was disturbed when their identity as a “good girl” was threatened.

It seems that these young women considered losing their virginity to be a symbolic event. They are no longer virgins only when their chaste state can be detected by others, for example, when they contract a venereal disease, rather than at their first intercourse. When their mothers and grandmothers were young, the first intercourse was surrounded by hush-hush. It was talked about with very few people because the risk of being considered a “bad girl” was obvious. Now, the young women live in a society where it is more the lack of sexual experiences that can lead to feelings of inferiority. When a venereal disease strikes them, paradoxically, feelings of shame arise. They lose their symbolic “virginity” by becoming infected by something disgusting. But the loss of virginity also might be about being initiated into the adult world through the gynecological examination. During such circumstances the lived experience of genital warts can be a variation of a coming of age ritual, which in the end can serve as a transition to maturity. Thereby, a paradox occurs. Parallel to the feeling of shame, the young women grow throughout the process. From experiencing that something is not right in their vagina, to going to a gynecologist, getting confirmation that it is real, going through a gynecological examination, treating themselves, and finally by taking responsibility for the consequences of their sexuality, their identity seems to change. During this process, they go from a feeling of loss of their symbolic virginity. But they gain as women, they take a bigger step into the adult world, and they get to know their bodies. They take responsibility for the consequences of their sexuality.

**COMPARISON WITH EXISTING THEORY**

Our study illuminated what it is like for young Swedish women to live with genital warts. Because this issue is probably dependent on culture even more than many other existential questions, the study is limited to young women who have their roots in Sweden. The result show that the young women’s lives are affected in a very significant way, in spite of the reputed Swedish sexual emancipation.
The women’s feelings of shame seem to be related to the image they have of people who get venereal disease. The “romanticized” image of their own sexuality appears to be an important reason that venereal disease continues to increase among teenagers in Sweden.

Another interesting and perhaps a surprising conclusion is that there does not seem to be any big differences between young Swedish women and young women from other Western countries, when the Swedish attitude to liberation is tested. Other young women in similar situations in other Western countries probably share feelings of guilt, shame, disgust, and self-contempt.

International studies confirm that many young women who have venereal diseases also try to defend their self-image of being “good girls.” Redfern and Hutchinson (1994) found that many women considered themselves less sexually active than their friends, in spite of frequent venereal diseases. They did not see themselves as promiscuous. According to Tydén (1996) many young people are so-called risktakers. After an information campaign, young people showed an increase in knowledge about venereal diseases, but they made no recognizable changes in their behavior. In an American study conducted by Sawyer and Moss (1993) even after young men had found that they could be infected with a venereal disease, they still chose not to seek help. This study also showed a decrease in using condoms and a reluctance to go to a clinic for regular check-ups concerning venereal diseases.

A Swedish study confirmed that teenage girls often dismiss the thought that their sexual habits could cause venereal diseases. Even if the girls were well informed about venereal diseases, it did not affect their sexual behavior. The study also showed that feelings of impurity, disgust, and self-accusation could be related to the experience of getting a venereal disease (Andersson-Ellström, Forssman, & Milsom, 1996).

The negative feelings thus appear to resemble one another in different countries in the West. As implied earlier, it is reasonable to assume that Sweden is one of the most sexually liberated countries in the Western world. Still, women in the whole Western world apparently experience venereal infections in similar ways. Hence, young Swedish women seem to be liberated only when their sexuality does not lead to any negative consequences. According to Hwang and Nilsson (1999) many young women have a general tendency to blame themselves, and they also can feel helpless. Young men, on the other hand, blame someone else. As a consequence many sexual experiences still appear to give young men a sense of status and young women a bad reputation. It is fair to assume that this could be another reason for the young women in the study to deny that their own lifestyle is connected to the risk of contracting a venereal disease.
We also can consider this problem as a study about identity, in line with Erikson’s theory about the eight stages of human development (Erikson, 1950). During adolescence, the young person identifies herself as a unique creature by joining together earlier memories from her childhood to an adult identity. Young people are in the middle of an important period of trying to find their identity. Formation of identity is an active construction, an integration of physical givens, sexual learnings, significant identifications, useful psychological defenses, and so on. In achieving an ultimate sense of identity, individuals who have negotiated the identity crisis achieve a sense of inner continuity with who they were before and who they will become. At the same time, they reconcile their own self-conceptions with the expectations and norms of the surrounding community, and particularly with the desires of significant persons in their lives. During this phase, other people function as mirrors, providing the information the teenager needs to gain an image of who they are or should be. Many young women seek this mirror in a close girlfriend. In that way the young women are supported in keeping a positive identity. When they realize that genital warts are a common infection, they find comfort in not being alone in their misfortune.

It is also productive to discuss the findings of this study as a significance of the subjective body. According to Merleau-Ponty’s lifeworld theory the body and world are inseparable; the body is a subject that experiences lives and acts in the world (Bengtsson, 1998). The body cannot be moved around in the room in the same way as we move a vase or a table. It is the body, the subject, that moves the items. So “the own body is not an item, but all actions and experiences subject as such” (Bengtsson, 1998, p. 48). As a consequence we can never escape or run from our body, because the body is throughout our lives present in everything we do.

Hence, if a young woman experiences her body as something disgusting, her access to the world and the people in it changes. A health care provider must pay attention to the patients’ “lived body.” In other words, the health care provider must proceed from the young women’s existential situation, which deals with how she looks at herself in her lived body and in her lifeworld. An experience of shame and disgust must be taken seriously so that the young woman gets an opportunity to participate in her own health process.

CONCLUSION

Professional care providers need to consider that genital warts often have both an emotional/existential and a medical meaning. It is also important that the care provider take the patient’s negative feelings very
seriously. If not, this can lead to lower self-esteem and negative bodily perception, sexual problems, problems with relationships, and stress. The worst scenario is perhaps a confusion of identity. According to Erikson (1950) the alternative to identity formation is role diffusion. Distraught by the strong demands made on them, by others as well as themselves, young people beset by role diffusion run away, either physically or spiritually, withdrawing from their surroundings into despair.

So how can health care providers help a young woman who feels ashamed about having genital warts? Written information at the time of diagnosis can help an upset young woman to think by herself about what issues she would like to discuss with the care provider. As no one wants to experience being an outsider, it is urgent that she feels like she belongs to a group. It seems to be important that the infected group is large, so the women are a part of a larger community. To be able to read brochures in which other young women in the same situation describe their experiences possibly can be a support for these women.

The experience of being infected with a venereal disease is so strong that it needs to be shared with someone. Besides the written information there should be an opportunity for a caring dialogue. According to many nursing theorists (for example, Peplau, 1991), a patient’s developmental process is encouraged and facilitated if the care provider is adept at allowing a caring encounter. Friberg (2001) also points out that patients in all nursing contexts ask both explicit and implicit questions and that they seek confirmation concerning their experiences and conceptions. Hence, the health care provider must meet these young women in a caring manor, and help them to understand more about themselves. It is likely they could go more easily into their identity as young women who take responsibility for their sexuality.

An important conclusion of our study is that neither treatment nor caring interventions can have a base in the patient’s perspective if the health care providers do not take on the patient’s lifeworld. We can never see on a x-ray or measure with laboratory tests how a woman experiences her illness and how it affects her lifeworld. But if we see the patient from a lifeworld perspective we are not only interested in the biological body but also in the person’s “living and lived body” (Dahlberg et al., 2001).

**FURTHER RESEARCH**

It appears that many of the feelings surrounding contracting a venereal disease are similar in different Western countries. But perhaps the experience can be different between adolescents and adult women, and also between men and women. If that is the case such factors can have a
great impact upon patients’ abilities to take an active part in their health care. More lifeworld studies can deepen our understanding. The young men, for example, must not be forgotten. How do they experience a venereal disease? Women blame themselves and believe that it was their own fault. What about the young men? Whom do they blame? Another important area for study is how young people from non-Western cultures experience the problem of contracting a venereal disease.

REFERENCES


Tydén, T. (1996). It will not happen to me. sexual behaviour among high school and university students and evaluation of STD-prevention programmes. *Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine, 595.*

To Contract Genital Warts—A Risk of Losing Love? Experiences of Swedish Men Living with Genital Warts

KINA HAMMARLUND
University of Skövde
Växjö University

INGELA LUNDGREN
University College of Borås
Växjö University

MARIA NYSTRÖM
University College of Borås
Växjö University

Using a life-world hermeneutic approach, this study focused on the interviews with eight Swedish men living with genital warts. The men expressed a need for control over their situation, a control that was easier to maintain if the warts were invisible. Some of the men expressed prejudiced attitudes toward those who contract a venereal infection and their own feelings of shame appeared to correlate with these prejudices. In their meetings with health care providers, the men viewed a competent health care provider as someone who combined professional distance with a personal approach. Finally, the fact that men saw themselves as disease carriers was of great significance to them and influenced their views of future meaningful relationships.

Keywords: Swedish men, genital warts, human papillomavirus (HPV), life-world method, hermeneutics, existential experience, sexual health

Several reports demonstrate that sexually transmitted infections (STI) are increasing in the Western world (Maw, 2004; Schofield, Minichiello, Mishra, Plummer, & Savage, 2000). Among STIs the human papillomavirus (HPV) is becoming more widespread among the sexually active population throughout the world (Baer, Allen, & Braun, 2000; Fleischer, Parrish, Glenn, & Feldman, 2001; Schneede, 2002). According
to the Centers for Disease Control and Prevention (CDC), in 1996 there were over 24 million Americans infected with HPV (Fleischer et al.). Different epidemiological studies indicate the highest incidence of the infection is among young people between 18 and 28 years (Fernández-Esquer, Ross, & Torres, 2000; Heley, 2003). In the first ten years of sexual activity, point prevalence rates approach 25% and the lifetime risk of acquisition may be as high as 80% (Heley, 2003).

Genital warts, also known as condylomata acuminate (other names include penile warts, venereal warts; Condyloma), are caused by the human papillomavirus: benign cellular outgrowths with HPV Types 6 and 11 causing 90% of genital warts cases. Genital warts are highly infectious and can be difficult to treat (Heley, 2003). If left untreated, they can spontaneously regress, persist, or grow (Zanotti & Belinson, 2002). Risk factors for HPV among males are multiple casual sex partners, smoking more than 10 cigarettes per day, not using a condom, and previous STI contagions (Dillner, Meijer, von Krogh, & Horenblas, 2000; Fernández-Esquer et al., 2000; Wen, Estcourt, Simpson, & Mindel, 1999).

Although these risk factors are well known, previous research shows that both sexually experienced and inexperienced young people fail to identify their risk for contracting a STI (Dell, Chen, Ahmad, & Stewart, 2000). According to Hammarlund and Nyström (2004), young women with genital warts appear to disregard the fact that their own lifestyle could be a risk factor for contracting venereal infections. Condom use in Sweden has decreased by 50% over the last thirty years. In 1967, for instance, 38% reported they used a condom during their last intercourse; in 1996, the figure dropped to 15% (Voog & Löwhagen, 1992).

A STI can affect a woman’s life at an existential level. It can create stigma and generate feelings such as shame, dirtiness, and disgust (Hammarlund & Nyström, 2004). The physiological distress for a patient with genital warts is often much greater than the medical effect of the disease (Voog & Löwhagen, 1992).

There has been relatively little focus on men’s experiences and feelings after contracting genital warts. Without such knowledge, it can be difficult to meet a male patient’s needs, and to encourage responsibility in not spreading the virus. It also seems reasonable to assume that professional and caring encounters make it easier to consider one’s sexual behavior and responsibility toward future sexual partners. To be able to create such encounters, it is necessary to explore the experiences of genital warts from the infected person’s perspective.

The purpose of this study is therefore to analyze and describe the existential meaning of living with genital warts for a small group of Swedish men. This knowledge can assist in efforts to prospectively alter behavior and prevent disease transmission.

Method

Theoretical framework

This study used a life-world hermeneutic approach. Life-world-based research focuses on the “lived” experiences of the phenomena under study (Nyström, 2006; Smith, 2007). In hermeneutic research, interpretation is key. The focus for this approach is
thus to describe meaningful ways of understanding a phenomenon (Dahlberg, Drew, & Nyström, 2001).

Hans-George Gadamer (1995), one of the most prominent theorists in the hermeneutic tradition, emphasized openness as a pre-condition for understanding something that is not already present in a person’s pre-understanding. In this study, the first author (KH) tried to be aware of and suppress her pre-understanding from a previous study with a similar research question but one that focused on women with genital warts (Hammarlund & Nyström, 2004). To do this, the authors discussed the possible effects of preconceived notions and ideas about the study’s subject matter. According to Gadamer, researchers must be open to what is not immediately given, to see what he calls “the otherness” in data, i.e., something not previously understood (Dahlberg et al., 2001). In order to accomplish this, Paul Ricoeur’s (1976) distancing, questioning, and critical approach to find overt and hidden meanings in the data was used; an approach that complemented Gadamer’s notion of scientific openness. According to Ricoeur, it not only is important to understand, but we must also try to explain phenomena and their meanings in the process of interpretation.

Data Collection

The primary researcher (KH) interviewed eight Swedish heterosexual men, aged 19–31. Five had been diagnosed with genital warts in the past year, another had a relapse after being without warts for three years, one man had his genital warts on and off for three years, and one had suffered from chronic genital warts for nine years. The primary author consciously chose to interview men with different life experiences of genital warts. The youthful age range was chosen because HPV prevalence in men peaks between 16–35 years (Dillner, Meijer, Krogh, & Horenblas, 2000). The informants had all grown up in Sweden and came from a Swedish background. The reason for this choice was to exclude complications with cultural differences concerning attitudes toward sexuality.

Professional care providers working at a guidance centre and a clinic for sexually transmitted infections in two cities in Sweden provided 12 young men information about the study. To be included in the study, the following criteria were specified: a physician’s diagnosis of genital warts, the infection had to be at least six months in duration, and, lastly, the man had to be willing to be interviewed and share his story. Of the 12 initially contacted, four did not want to participate because they felt the subject too private and intimate, while eight met the criteria and became the basis for the study. Three chose their home for the interview, one at the guidance center, and four in the principle researcher’s office. The informants did not appear to know each other.

The life-world interview encourages the interviewees to reflect on their venereal infection and its consequences for their life situation. The initial question was, “Can you tell me about your genital warts and how it started?” This question was purposely open-ended to help the men to reflect on their lived experience with genital warts. Each one-on-one interview lasted approximately 45–60 minutes, was audiotaped, and transcribed verbatim.
Analysis

The transcribed interviews were read several times to gain a sense of the whole. Meaning units were then developed following the research question. This process allowed eighty-eight meaning units to become apparent. Next, these meaning units were compared to each other and then organized into sub themes by relating them. After this process, 31 sub themes remained. The sub themes were then organized according to similarities and themes were structured. Five main common themes and four-to-seven sub themes from each theme emerged from this process. We referred back to the interview text during the entire process of analysis.

In the next step, six interpretations were formulated to illuminate overt as well as partially covert meanings in the data. During this process, we returned to the themes and sub themes in order to ensure that all data of general importance were included in the six interpretations. Influences of the authors’ pre-understandings were discussed.

We further investigated whether the six interpretations could explain all the data in a reasonable way, and whether any data contradicted an interpretation that was assessed as valid. No interpretations were found that could better explain the data behind a valid interpretation.

Finally, all interpretations estimated as valid were compared with each other in order to find a consistent system of interpretations as well as a lowest common denominator, i.e., a main interpretation. The main interpretation is a comprehensive understanding that further explains all data of general importance for the research question. That question posed was “How do you experience living with genital warts?”

Ethical Considerations

Interviewees were given both written and verbal information on the study and confidentiality was assured. The human body can be experienced as very private and thus it is important the researcher acts in a way that preserves the participants’ privacy. In this study, the interviewer (KH) was sensitive to this in trying to create an atmosphere of confidentiality and encouragement. Gothenburg University’s ethics committee approved the study.

Results

First, the six interpretations, each which illuminates different aspects of the research question, are described. We then suggest a concluding interpretation that further explains the meaning in all the interpretations.

Having Genital Warts Creates an Urgent Need to Decide How to Handle One’s Reaction

The interviewees’ self-image seemed to be affected in different ways when they realize that they had contracted a venereal infection. For some, it appeared to improve
their powers of attraction to the opposite sex since sexually transmitted infections sometimes seemed to serve as proof of sexual achievement. These participants did not blame anyone else for their genital warts; instead, they simply realized they could have lessened the risk of contamination by using a condom. This insight did not affect their self-image in a negative way.

Not all the interviewees conveyed such attitudes, however. For some, the infection was uncomfortable and embarrassing. The venereal infection was experienced as unfair because they did not consider themselves sexually promiscuous. “It is so terribly unfair, because people who know me know that I’m not the type to get VD. I no longer know whether there is a special type,” commented one of the men.

These young men thus thought about their sexual behavior. Some considered themselves less judgmental than before and began to think about their prejudices regarding who contracts venereal infections:

I have changed my attitude toward people who get VD. It was rather easy to get it, so I can’t look down on anyone because of the infection anymore. Now these are normal people to me, no different from anyone else. It is just bad luck.

Hence, while those who experienced genital warts as a proof of their sexual capacity made jokes about it, others appeared to be more thoughtful and re-examined their lifestyle.

All the young men in the study thus seemed to sense urgency in handling their reactions, but in different ways. If the warts were visible, the situation was more difficult to control, as this example illustrates:

The days I have visible symptoms are harder to get through. If they are visible you can point at something and say, “I have genital warts.” Later when they are gone, you can’t be sure. It feels better because you can’t see them and point to the symptoms, then it feels less certain.

Most Reactions Depend on Previous Prejudices

For some of the interviewees genital warts were connected with feelings of shame and fear:

When I was diagnosed with genital warts, I thought my life was over. I locked myself in. I didn’t want to speak to anyone. I didn’t go to school, instead I stayed in bed thinking, thinking, and thinking…. I didn’t know anything about VD and I thought I’d die soon. Before I had been to the doctor and asked all my questions, I was so scared.
For others, especially those who spoke openly about venereal infections, the experience of contracting genital warts appeared not to be traumatic at all. Illustrating this perspective, one man reported, “I belonged to a world and a circle of friends where it was okay to have one-night stands…. I was just like the others I hung out with and could identify with them.”

These men did not talk about shame and fear, but said the warts annoyed them. They were irritated because they had not used a condom and thus had to seek medical treatment:

I had no other thoughts except that I had done something very stupid.
I knew very well that I should have used a condom.… The whole thing was very irritating. I can’t control it and that annoys me. You have a plan and like to have control of that plan, now you have to change that plan.

What is it that determines whether genital warts become a prescription for sexual success something you have to take into account when you change partners and do not use a condom, or a failure, a shock that arouses strong negative feelings? The differences in attitudes seem to be connected with previous attitudes toward venereal infections. Those who previously thought that only “other people” contract venereal infections have to reassess many of their own life values. One interviewee noted, “People who get VD are people who have a lot of sex—unprotected sex—and I didn’t consider myself to fit in that category.”

**Genital Warts Bring Prejudices to the Surface**

Some interviewees spoke openly about their earlier prejudices toward those who contracted venereal infections. Others seemed more or less to unconsciously put their own prejudices in other people’s mouths. “I think,” noted one man, “many people look down on those who have or have had VD, as bad people. You shouldn’t say it, but you categorize them as sleazy.” When this same man spoke about women with venereal infections, his judgment became even harsher. “It is easier to categorize girls than boys. I guess that has to do with some very old tradition…. It is hard to explain.”

This man also tried to explain his attitude. According to him, prejudices are part of social attitudes, especially toward women:

It must be something that goes far back. Like women always have been a minority in all big issues, like the right to vote, women have been housewives, all that kind of stuff. I think it comes from that and then it like stays put.

The fact that this man did contract a venereal infection became a gateway to further reflection. He went on to say, “Now I think that everyone is lumped together…. People with VD, I looked down on them at the start, but now they are like me.”
Similar reflections occur in several interviews. Behind decisions not to tell anyone about the infection can be a concern about not being subject to other people’s prejudices. As one man noted, “Now they stigmatize me as I once stigmatized them.”

Presumably, this anxiety reflects the young men’s own prejudices, at least before they were infected. One interviewee did not reveal anything about his warts to his friends since he feared their reactions and the disclosure of his secret in public. “If I was in a bar, for example, if I had told someone, I was afraid that a friend would say something. That he would tell someone else in a moment of thoughtlessness.”

It is fair to assume that this is the same attitude as behind the choice not to talk to anyone except one or two very close male friends. Venereal infections remain something very personal because it is a negative side effect of sexual relations. Even if it is possible to speak about positive sexual experiences, it is not “glamorous” to have the misfortune to contract a venereal infection.

The fear of being exposed to other people’s prejudices also gave the men cause for thought. Reflection formed part of the process of reassessing perspectives. Thus, they seemed to struggle with the prejudices they currently held, and it was important for them to revise their own prejudices before revealing their genital warts to others.

It is probably important to succeed with this conscious strategy, otherwise their own condemnation could reflect back on their own self-image. By working with their attitude in general, their feelings toward their own venereal infections might change. If successful, it might become possible to view other types of failure with humility:

As stupid as it may sound, this has brought some positive things. I feel that I learned a lot, that I have grown mentally. You shouldn’t take things so seriously; I have sorted out a lot of stuff in my mind. After a while, you gain distance to everything and that solves the problem.

It seems reasonable to assume that a revision of prejudices can have a positive outcome, generally, as some men experienced a sense of growth and increase in maturity when they were forced into a situation that made them feel less judgmental:

In a strange way, you become more self-confident…. I feel more mature, more grown-up in a way…. I think I know more about who I really am, I am more self-confident in everything I do. I don’t know if this is only related to the genital warts, but I think there is a pretty strong connection.

A Competent Health Care Provider Combines Professional Distance with a Personal Approach

The healthcare consultation was described as an important experience because of the venereal infection: it is more embarrassing when the consultation is for a sexually transmitted infection than, for example, for a broken arm. This becomes particularly important for those who did not know their diagnosis before the consultation. The meet-
ing with the physician should be non-judgmental and time for questions is essential. The physician should also be prepared to answer sensitive questions. As one man noted, “The visit was informal and the information was factual. The doctor gave the impression that he liked his job and knew what he was doing.”

The men also wished to attend a specialist clinic where physicians had many years of experience in diagnosing and treating young men with genital warts. “You get proper treatment,” commented one man who went on to say, “There are no sour expressions; you can see that they are experienced. They know what to do when you meet them.”

Since it can be embarrassing to show your genitals, the interviewees felt comfortable as anonymous patients in a clinical environment where the physician regarded genital warts as an everyday occurrence. At the same time, they wanted the consultation to be personal. This combination of wanting to be treated anonymously yet at the same time desiring a personalized consultation was viewed as the competent professional element in the consultation:

He [the physician] joked about the clinic. We talked about the shame and laughed about dark alleys at night and things like that. It was very good. It was personal contact. Then he told me what kinds of treatments were available.

Consultations with physicians outside specialist clinics were not satisfactory:

It was another doctor who prescribed the medicine the first time and who did not seem as professional. The knowledge that a doctor at a STD clinic and the staff work with this the whole time is a comforting thought.

Thus, for a consultation to be perceived as “professional,” the physician helps the man to reduce the drama surrounding the fact that he has contracted a venereal infection. A physician who is accustomed to conducting such examinations and who approaches the situation with confidence, allowing time for questions, is successful in achieving this. The ability to switch between joking and making serious conversation in accordance with the patient’s needs is a further sign of this competence. It seems much easier to regard the situation with optimism if treating genital warts appears to be an everyday occurrence. By reducing the drama of the issue, healthcare professionals can assist their patients in feeling less shame and negativity.

Feelings of Anxiety and Embarrassment Increase the Necessity for Caring Encounters

Reducing the drama of the situation as described in the interpretation above seems to be especially important for those men who are afraid and embarrassed:

The doctor came in, we joked a little, and I immediately felt at ease, it was like a load off my mind. Earlier I was so scared, so scared. I guess he saw that I was terrified and could hardly talk, just tremble…. He talked about sexually transmitted infections with the same
lightness as everything else we talked about and I felt okay; there are no limits here, it’s cool.

In comparison, those who were irritated by the warts, but not embarrassed, appeared to have less need for comfort and trust in healthcare consultations. “I don’t care which doctor examines me. I just want a diagnosis and treatment,” noted one of the participants.

In contrast, those who felt a great deal of shame appeared to have kept their awkward questions to themselves for a considerable time and emphasized the importance of a consultation with a neutral, respectful, male physician regarding their warts:

You feel so very lonely when you’ve got VD. It’s not something you can discuss with just anyone. Once you get to the doctor, you want to talk about it as much as possible. You have thousands of questions.

These informants wanted to be part of an anonymous crowd afflicted by genital warts that the healthcare professionals meet every day:

Just knowing that a guy like that doctor at the STD clinic and the staff work all day long with venereal infections that is comforting…. You feel embarrassed and even though they have professional confidentiality, you are still afraid that there will be a nurse or someone else you know.

There thus seems to be a connection between anxiety and embarrassment and a necessity for a caring encounter, even without the attitude that the patient is unique in contracting genital warts.

The Meaning of Love Makes the Men Vulnerable

When the young men did think about a future partner, in a genuine loving relationship, they had to realize the virus would remain in their body, making them carriers of the infection—a realization that hit them hard:

From what I know, the genital warts will remain there, latent, it’s not certain that they’ll go away. That is really negative if I meet a girl I really want to be with. She will wonder what kind of guy I am. She might think that I’ve had a lot of sexual partners. I think that is negative. That’s almost as embarrassing as having genital warts—that you’ve had a lot of sexual partners.

The interviewees were also concerned about their reputation. If it became common knowledge that they had contracted genital warts, their possibilities for love might
be affected negatively. Here is how one of the men saw it. “Explaining about your warts is not a great pick-up factor. You want to protect your reputation.”

They also contemplated about whether or not they should tell a partner about the virus:

She might think that I’ve been unfaithful. That would be the worst thing, if she were a girl you really want to build a future with.

Moreover, they expressed their fear about infecting a girl they were seriously in love with. A consequence for at least some of them might be to avoid love, to make sure that they did not transmit the infection to a woman they love:

It feels hard that the infection remains in your body when you go out and date girls…. You will stay away from some girls because of that. I mean girls that you can see yourself having a relationship with. You can infect her and it is easier to infect someone you are not serious about.

Why are not all sexual partners worth this concern? The answer might be found in the young men’s fear of being rejected by someone to whom they become close.

Thoughts of having a venereal infection when searching for love seem to make all men vulnerable. When faced with the risk of disappointment in love, it does not help to know that genital warts are common or that your friends laugh at the situation. A love relationship involves a desire to be unique and special to the person with whom they are in love. Faced with losing the prospect of love made all interviewees vulnerable irrespective of their previous attitudes toward genital warts.

Concluding Interpretation: Seeing One’s Self with the Other’s Look

When a young man contracts genital warts, his whole self-image, consisting of the present, the future, and past, is affected. Attitudes from the past imprint his experience in the present. In addition, as a disease carrier, his future will be affected. A timeline links all three eras. When the young men in this study understood they were afflicted with a venereal infection that might be contagious for a long time, they seemed to change from subjects who judge others with venereal infections to objects of others’ judgment.

In *Being and Nothingness*, Sartre (1943/2003) illustrates what happens when a person is transformed from a subject into an object. According to Sartre, we experience

---

1 According to Sartre, we experience others as objects until we are exposed to the Other’s look. The freedom of being master of the situation is taken away from the person who becomes the focus of the Other’s look. The “look” turns the recipient into an object, which gives the Other an opportunity to judge, with no possibility for the exposed individual to influence the judgement of him or herself. The shame of having lost the freedom to another subject is the fundamental idea of being exposed to the Other’s look.
another person (the Other) as an object of our judgments until we become exposed to the Other’s look. Then we are transformed to objects of the Other’s judgment. If we experience shame, for instance, we do so because we become exposed to the Other’s look. In the Other’s look, the men encounter notions about those who are afflicted with a venereal infection and why. In relation to the Other, they experience shame. They do not seem to reflect on the fact that what they see in other’s look often has points in common with their own previous notions about venereal infections.

Those who previously had a reproachful attitude toward people who contracted venereal infections are consequently more ashamed than those who outwardly, toward their friends, seem proud of their active sexual life. The latter try in their fundamental attitude to flee from the shame and, before the Other, give an appearance of a certain pride, which Sartre describes as self-deception. In vain, the men try to impress the Other to, if possible, regain their lost freedom, the freedom lost by being in self-deception.

The men who feel ashamed seem more vulnerable in their contacts with professional care providers. For them it is important that a care provider combines professional distance with a personal approach and reduce the drama of the issue.

Those who in their self-deception regard venereal infections less “seriously” do become irritated about having to seek healthcare, but to them the single most important aspect is that the physician is competent in treating sexually transmitted infections medically. Thus, in order to understand the meaning of being afflicted with genital warts, the young men seem to search in the way they are seen by the Other. However, in doing so, they do not understand that they sometimes meet themselves and their own prejudices.

For each individual man, the existential meaning of being afflicted with a venereal infection therefore depends on what they think they see in the Others’ look and, perhaps foremost, who the Other represents.

When the Other’s look comes from a person who can provide love, the informant’s vulnerability and exposedness increases. The man who sees fear of a venereal infection in the eyes of his loved one, fears being abandoned. The attempt through self-deception to regain subjectivity could fail when meeting a person who can provide love. The self-deception then becomes obvious when these men, standing before the possibility of a loving relationship, also become vulnerable.

Shame and pride may also vary depending on whom the Other represents. Reputation and status are at risk with friends, but self-respect and personal integrity are the focal points in contact with professional care providers. When facing the risk of losing love, the variation in the interview material ceases, which is probably because the deepest existential meaning of being afflicted with genital warts is found precisely here.

If the woman the man loves still looks upon him with love after being told about the contagious venereal infection, the shame as well as the threat to his self-esteem is overcome. However, if her look shows rejection, the man’s fear of losing love is confirmed. Instead, the men could choose different strategies to prevent an encounter with the Other, an encounter that could lead to a love relation.
Thus, all the informants want to regain their lost freedom, regardless of what emotions the genital warts may have given rise to. However, for those informants that experienced shame and anxiety, the path is longer than for those claiming they have not. Not only do they have to seek a physician and go through treatment, they also have to deal with their attitude toward venereal infections on a more existential level. Under this process, which appears to be demanding they sometimes, isolate themselves from friends, school, and work. If they manage this adaptation, they gain a more mature and tolerant view of the world around them. On the other hand, those men who appear to be living in self-deception are not forced to face their notions until a possible love relationship contrives to challenge their project. It is then that they may be forced out of their self-deception and face a possible revaluation of prior conceptions about what, in the deepest existential sense, it means to have genital warts.

Discussion

Contracting a sexually transmitted infection means, at least for most of the men in this study, feelings of shame. Shame, however, does not necessarily mean something negative. The sense of shame is closely connected to conscience and tells us when something is right or wrong (Kjellqvist, 1993). Perhaps some feelings of shame are necessary to increase responsibility in not spreading the virus to others. If this is the case, it seems important for healthcare providers to discuss this matter with their patients. The healthcare provider also has to take into account that when patients with genital warts have prejudices about people who contract a STI, they want the healthcare providers to reduce the drama of the issue. These findings correspond well with Chandler (1996) who writes that the anxiety level of the patient will be reduced if the clinic has a warm, friendly, and relaxed atmosphere and if the attitudes from the staff are not judgmental, put the patient at ease, and is caring and helpful.

One of the main topics for the men in this research concerned the fear of rejection related to when to tell a new partner about the HPV. Our study shows that fear of rejection is stronger than any concern about not infecting a partner. This supports the findings of Taylor, Keller, and Egan (1997), who asked persons who had lived with HPV for one year what advice they would give to newly diagnosed individuals. Only 16% of the respondents advised newly diagnosed people to inform a partner, because of the fear of rejection once the partner becomes aware of the infection. Keller, von Sadovszky, Pankratz, and Hermesen (2000) interviewed 48 individuals with HPV and asked them if they had disclosed their HPV to their partner. Among those informants who still lived in the same relationship as before they were infected by HPV, 95% said yes. Among those men who had new a relationship, only 45% had disclosed their HPV infection to their partner. The reason for not telling a partner was a fear of being rejected.

According to Newton and McCabe (2005), the decision to disclose a STI or not has a profound impact on a relationship. It affects the degree of trust, intimacy, and communication in the relationship. It is important that the health care professional bare this
in mind when meeting HPV patients. It can be challenging for the patient to disclosure to partners and therefore the healthcare professional need to bring up the subject for discussion.

Voog and Löwhagen (1992) conducted a study about men and the psychosexual aspects of living with genital warts. Their findings are similar to ours: most men worry about the risk of transmitting the disease to their partner and about uncertainty regarding when the disease is gone and not contagious. Voog and Löwhagen also found that only 17% of the men had used a condom for their most recent intercourse. Wulff and Lalos (2004) conducted research on condom use and found that the use of condoms was lower in some categories, which they define as subgroups. These subgroups were persons with many sexual partners, earlier experience of STIs, and in age groups above 25 years.

A major challenge for those working with sexual health and sex education is how to design effective education. This study shows that a possible question people ask themselves when diagnosed with a STI is how this could happen to me. How could I contract a venereal infection? Research conducted on young women with genital warts in Sweden (Hammarlund & Nyström, 2004; Tydén, 1996) has revealed similar results. Hammarlund and Nyström found that the women in the study were shocked about contracting genital warts and had strong prejudices about the kind of women who contracted a STI. They wanted to distance themselves from such girls because they saw themselves as respectable girls. This means that sex education and its goal to promote a healthy sexual lifestyle must help people understand that everyone who has sexual relationship with a new partner has the possibility of contracting a venereal infection. Succeeding in this education requires not only the provision of information that young people need, but also that teachers and healthcare professionals working in this field talk to young people about attitudes and behavior toward sexuality.

The sexual behavior of young people will follow them into the future if they contract a sexually transmitted viral infection. Informing young people that they need to use a condom in new sexual relationships is not sufficient if the goal is to change a person’s sexual behavior. It is necessary to go into depth on this subject and it is important that young people can discuss their sexual habits and the consequences of changing sexual partners many times. Hence, this appears to be a challenge for professional healthcare providers. It is essential that the issue is not handled in a moralizing way, it should rather help young people become more aware of what risk they expose themselves to when changing sexual partners. Teachers, health care providers, and other professionals that work with young people must dare to discuss sensitive matters in greater depth when society is becoming more overtly sexualized. Many teachers and healthcare providers seem to be very focused on medical information. We recommend that sex education consist of more profound issues such as love, respect, and responsibility. What a young person does today may influence his or her life tomorrow. The increase in sexually transmitted infections in the Western world is problematic for society as the whole as we face the consequences of STI as bacterial infections can cause women to become infertile or to develop cervical cancer due to malignant HPV.
References


Tydén, T. (1996). *It will not happen to me*. Comprehensive summaries of Uppsala dissertations from the Faculty of Medicine.


Zanotti, K., & Belinson, J. (2002). Update on the diagnosis and treatment of the human papillomavirus infection. *Cleveland Clinic Journal of Medicine, 69*(12), 948-961.
In the heat of the night, it is difficult to get it right—teenagers’ attitudes and values towards sexual risk-taking

KINA HAMMARLUND, Ph.D. Student1, INGELA LUNDGREN, Associate Professor2 & MARIA NYSTRÖM, Professor2

1University College of Skövde, and Växjö University, Sweden, 2Borås University College, and Växjö University, Sweden

Abstract
This study, using a hermeneutic approach, is based on data from four focus group interviews with 25 Swedish teenagers participating, ranging from 18–19 years of age. The aim is to gain a deeper understanding of teenagers’ values and attitudes towards sexually transmitted infections (STIs) and sexual risk-taking. The teenagers seem to seek an excuse to fend off responsibility and deny their sexual risk-taking, an excuse provided by drunkenness. Under the influence of alcohol, teenagers are not too shy to have sex but remain embarrassed to talk about condom use. It seems as though the dialogue feels more intimate than the intercourse when it comes to protecting ones sexual health. To be able to act out in this sexual risk-taking the teenager often views the partner in a one-night-stand as an object, as opposed to a love relationship where they view their partner as subject, a person they care for. Engaging in sexual risk-taking often starts at a club where the teenagers go out to socialize and drink alcohol. They then play a game and a part of the game is to pretend that they do not play a game. In this game, certain rules are to be followed and the rules are set up by the girl, mainly to protect the romantic image of being carefully selected and thereby protected from being stigmatized as “sluts” or “whores”.

Key words: Focus groups, adolescent, attitudes, sexually transmitted infections, risk-taking, sexual health

Introduction
Sexually transmitted infections (STI) are increasing all over the Western world. For the infected person STI is a physical burden associated with emotional distress (Hammarlund & Nyström, 2004; Hammarlund, Lundgren & Nyström, 2007). For society, it is an economic burden due to the costs of treatment, sick leave and in some cases hospital care (Mason, 2005; Phillips, Dudgeon, Becker & Bopp, 2004). In the USA, 50% of all new HIV infections occur among people younger than 25 years (Robin, Dittus, et al., 2004). Every year 3 million teenagers in the USA are infected by an STI, meaning one out of four sexually active teenagers contract an STI every year (Tortolero, et al., 2005). There is a strong correlation between the number of sexual partners and the chance of contracting an STI. Women with five sexual partners or more, have an eight times higher risk of contracting an STI compared to women who have only one sexual partner (Joffe, et al., 1992). In Sweden, there has been an increase among teenagers having intercourse on their first date. In 2003, 26% of girls and 28% of boys aged 18–19 stated that they have had intercourse on their first date. This represents an increase for the girls since 1989, when only 15% stated that they had intercourse on their first date. The prevalence for boys has remained relatively stable since 1989 when rates were 25% (Herlitz, 2004).

Condom use can prevent most sexually transmitted infections. With STIs being as common as they are today, condom use is not only a question of preventing pregnancies; it is a question of retaining sexual health and protecting future fertility.

Whilst teenagers today usually have the knowledge that using a condom will protect them from...
contracting an STI, condom use is decreasing (Wulff & Lalos, 2004) and many teenagers will not use condoms during occasional sexual contacts. Clearly, this will expose them to a risk of contracting STIs (Forsberg, 2005), which raises the question; what is the reason for this risk-taking? Moreover, what are the teenagers’ attitudes towards STIs and casual sexual contacts? This knowledge is best accessed via teenagers themselves and a dialogue between teenagers about sexual health may elucidate their attitudes towards sexual risk-taking. Since teenagers mostly socialize in groups, this approach attempts to contribute to the knowledge about teenagers and sexual risk-taking from the group perspective. The knowledge can be of use to health care professionals who usually meet the teenagers on an individual basis when the teenagers are what we can describe as “out of her/his context”. To enable a discussion about sexual health with a teenager it is essential to try to see her/his perspective and to meet the teenagers “where they are” trying to understand their thoughts and lived experience (Dahlberg, Segesten, Nyström, Suserud, & Fagerberg, 2003). Sexual health among teenagers has its relevance for caring science, since the teenagers will grow up to be adults. If we cannot reduce STIs among young people today the consequences in the future might be infertility and different health problems involving several different health care professionals. Hence, the purpose of this study is to gain a deeper understanding of teenagers’ values and attitudes towards sexually transmitted infections (STI) and sexual risk-taking.

Method

Theoretical basis

This study was based on a hermeneutic approach influenced by Gadamer (1995) and Ricoeur (1976). Interpretation is the key issue for data analysis. It is important in this tradition to be attentive about one’s pre-understanding and its influence upon the interpretations (Gadamer, 1995). To do this, the authors reflected upon the possible effects of pre-conceived notions and ideas about the study’s subject matter.

Paul Ricoeur (1976) developed an interpretation theory where understanding and explanation overlap and interact with each other. Ricoeur also points out the importance of the open reading being matched by a critical reading with the intention of finding explanations that could further develop the interpretations.

Focus groups interviews

Data was collected using focus group interviews, a method developed by Robert Merton and Paul Lazarsfeld in the 1940s (Hylander, 1998; Wibeck, 2000). From the beginning, it was mostly used in marketing research, but it has its basis in social science. It can be used to investigate values, attitudes and the complex phenomena that originate from social interaction (Hylander, 1998). Every focus group should have an explicit purpose—a focus. No further control should be kept over the group, for example, the moderator should not use prepared questions, and the participants should freely express their thoughts, ideas, and experiences concerning the given subject (Hylander, 1998; Strid & Eriksson, 1999; Wibeck, 2000).

For most people their own sexuality, along with their associated attitudes and values concerning sexuality, is a sensitive matter. Focus groups, however, have a tendency to work out well in situations were the participants’ inhibitions could be released in an allowable group climate. When one participant speaks freely, it encourages others to do so as well (Hylander, 1998; Robinson, 1999; Wibeck, 2000). Another rationale for the use of focus groups is that the interaction taking place between the participants makes it possible to elucidate the more complex dimensions concerning different attitudes and group norms. This dynamic is not possible to elicit in, for example, individual interviews. Interaction in the group is an essential part of the method and the participants encourage each other to ask questions, exchange thoughts and comment on each other’s experiences/opinions (Robinson, 1999).

To conclude, focus groups can be a useful methodology when peoples’ attitudes and motives for their actions are investigated (Wibeck, 2000).

Participants and data collection

The participants were in their last year of high school and 18-19 years of age when this study was carried out. Contacts were made through the headmaster and teachers and they provided the first author (KH) time to visit the class and inform the students of the project. The only inclusion criteria were that the student should voluntarily participate in the focus group. Students were recruited from two different high schools and from both practical and theoretical educational programs.

Four focus groups interviews were carried out by the first author (KH) with assistance of one Ph.D. student from another research project, who observed and took notes. In total, 25 teenagers from four different educational programs participated.
Group one: Eight boys from the Health Care program
Group two: Four girls and four boys from the Social Science program/economics
Group three: Four boys from the Technology program
Group four: Five girls from the Child Recreation program

Every group interview was audio taped and lasted between one and two hours.

The reason for choosing this age group is that the average age of having the first intercourse in Sweden is 16.8 years for girls and 17 years for boys (Forsberg, 2005) and thereby it can be assumed that the interviewees have some experience to contribute to the discussion.

The groups were not mixed across programs or schools (i.e. same classmates in the same focus group), since Wibeck (2000) recommends homogeneous groups when the researcher aims to achieve intimacy in the group to facilitate the discussion. The teenagers had been in their classes together for almost three years.

Data analysis

The analysis began with an open reading of the transcribed interviews. When reading the interviews it is important to be open-minded to the text and for the meanings they convey. The researchers pre-understanding must be set aside in a way not overshadowing the emerging meaning of the text, thus making it possible for the researcher to see the “otherness” in data (Gadamer, 1995). In hermeneutic research, the analytic process consists of a movement between whole- parts- whole. In this study the focus group interviews were the original whole, the analysis the parts and the result forms a new whole (Dahlberg, Dahlberg & Nyström, 2008). After reading the interviews several times, 27 meaning units were formed according to the aim of the study. In the third step, all the meaning units were compared and those related to each other were put together to identify sub-themes. At this stage, the data was shortened while still preserving its core. Patterns and connections were sought after and questions were asked regarding the material. What in this data is interesting? What stands out? How are the different themes related to each other? From this step, nine sub-themes emerged. We referred back to the interview text during the entire process of analysis to make sure the meaning units and the later sub-themes reflected the central meaning in the focus interviews. After this, the nine sub-themes were studied more carefully. We discovered that data could reach a higher degree of explanation with explicit interpretations and started a process to abstract the text further for interpretation of the meaning. Since the data stayed on a more substantial level, the interpretations came closer to the meaning of the data. At the end of this process, four plausible themes remained (Dahlberg et al., 2008).

The analysis was completed with a concluding interpretation, a suggested meaning to understand teenagers’ attitudes and values towards sexual risk-taking. Finally, we referred back to the data to ensure that there was no contradiction between the concluding interpretation and data.

Ethical considerations

The focus groups were carried out in a small town in southern Sweden. All students in the classes involved were given verbal information about the study from the first author when she visited the class. The teenagers were informed that their participation was voluntary and if they wanted to participate, they were to contact their teacher. Further contact was kept between the teacher and the first author. The first author was never given the names of the participants from the teacher, only the numbers of informants who were going to participate. The time and place of the interviews were chosen by the participants themselves. Before the interviews started, the participants were given additional verbal information and were informed of their right to leave the focus group if they wished to.

Result

Common equals less dangerous and less shameful

The STI most frequently referred to, yet consider the least dangerous by the teenagers, is Chlamydia. The fact that it is common combined with readily available antibiotic treatments makes this infection seem mild. The teenagers never talk about the fact that the infection can be asymptomatic and that the bacteria is often spread by unknowing individuals.

Whilst there is some notion that Chlamydia might lead to problems later on in life these thoughts are very vague.

I don’t think you care all that much about milder STIs like Chlamydia and such. If you happen to get it, it can be cured really quickly. Sure, maybe you could get problems in the future, but I don’t know. It’s not something you think about. ⧫

But like Chlamydia, it has become so common, so that is not something you consider dangerous.
Like gonorrhea and herpes, that I think is worse, you do this kind of ranking.

The dominance of Chlamydia within the teenagers' accounts can be seen as a result of their lack of or minimal knowledge about other STIs, which are generally shrouded in a fog of ignorance. This can be because Chlamydia is the only infection subject for a routine check-up, including almost all teenagers who visit a youth clinic in Sweden.

If you go to the youth clinic to get your pills they almost always test for Chlamydia, but they do not test for anything else as far as I know.

You do not have the same knowledge about other venereal infections on the whole.

The general increase and high prevalence of Chlamydia appears to make the teenagers feel less stigmatized than they might have felt with other less common STIs. There is some sort of security and companionship to be one among many who are diagnosed.

I mean, if more people have it, then it is okay to talk about it in one way. You do not feel so much shame talking about it.

The reaction of the boys to a friend with an STI reinforces that suggestion. This is dependent, however, on the severity of the STI. If the STI is one they consider less dangerous, they joke about it, give the friend a pat on the back and make comments like "Good luck with that!". This strategy could be viewed upon as a positive empathic gesture, a way to defuse the issue.

Why couldn't you make a joke about it? It just gets difficult if you go around thinking about it all the time. Then it's better to try and joke about it.

Alcohol use—fending off responsibility and denying a risk

The teenagers' risk-taking when it comes to STIs seems to be connected to alcohol. The teenagers say they do not reflect upon their own risk of being infected because of their drunkenness. Thus, it appears that drinking alcohol can be used as an excuse not to be responsible. The teenagers mean their responsibility vanishes in the haze of alcohol.

I mean you don't care about condoms if you're drunk.

If you have alcohol in your body you do not consider the risks.

The boys say that a condom would reduce the sexual pleasure. When having a one-night-stand, they seem to think mostly of themselves. There is very little consideration of protection from STIs neither individual nor mutual. Pleasure and lust supersede responsible sexual behavior. One might say that some of the boys are more oriented towards sexual gratification then towards relationships.

If you meet a girl in a club, you want to get as much pleasure as possible. I mean, I don't throw on a condom. You don't think about condoms. I mean sure, it's much safer, but you still don't think about it. It doesn't fall into my head anyway.

Both the boys and the girls do not believe the risk of them catching an STI is very great, even though they put themselves at risk by having transient sexual encounters. Thinking in this way and denying their own risk behavior, diminishes feelings of responsibility.

No, I guess it's like with everything else, like cancer for instance, it doesn't happen to me. I can drive my car really fast, but nothing happens then either. Why should it happen to me? If it's like a million people it happens to, why should it be me? I think there is a greater chance of winning the lottery.

It is something that will not happen to me.

The dialogue feels more intimate than the intercourse

According to the boys, condoms can be difficult to bring with them when they go out at night. Whilst both their hope and intention is to have a sexual encounter, it is not acceptable to reveal that prior to the event, i.e. before they leave home. This is due to the fear of the girl rejecting them if she discovers this. What appears to be important for the teenagers is to maintain the illusion of partners being carefully selected. The illusion is that they did not think about sex before meeting this person and they are overwhelmed by lust in that special moment when they meet this “right” person.

A further explanation is one of uncertainty in the non-planning. Boys do not seem to have enough confidence to believe they will meet a girl and that the encounter will result in a sexual contact. Making preparations such as bringing a condom
tempts fate and so decreases the likelihood of being chosen.

It is a bit unpractical, I guess you could say. There are a lot of people who don’t want to bring it. *

You don’t really dare to believe that you’ll find someone and then you don’t dare to believe anything is going to happen. *

Therefore the boys especially seem on the one hand to be constantly prepared to seize sexual opportunities when they occur, but on the other feel they are unable to actively anticipate such opportunities and feel they should give an image of sexual encounters being unplanned.

However, some of the girls have somewhat ambivalent feelings towards the phenomenon of a one-night-stand, a finding that does not feature in the boys’ accounts. At first, the girls say it is okay to have one-night-stands but later on, several of them say that they personally cannot imagine a sexual relationship and not being in love.

But I’m the kind of person who really wants feelings, lots of feelings involved when I have sex. I don’t want to go around with a bag over my head. Just meeting someone in a club who does want to go home with me, you know... I don’t want to be like that. I want to be someone who has feelings and is in love. *

When the teenagers talk about unprotected sex it is not the possibility of contracting an STI that is the greatest threat, instead it is an unwanted pregnancy.

I think more people think about pregnancy then venereal infections. *

Venereal infections are more taboo, oh my God it does not exist, kind of. So you are more afraid of getting pregnant. *

It seems more neutral and less emotionally charged to suggest condom use for preventing a pregnancy. To suggest a condom for birth control makes it possible to stay in the illusion of being the one and only for each other in the past, the present and in the future. Condom use for birth control does not involve the person’s previous sexual activity as it does if someone suggests it for preventing an STI. When linked to STI prevention, additional people like the former sex partners, impinge on the intimacy of the situation. To protect oneself against a pregnancy has more positive connotations, meaning you see your partner as fertile and that is important for the self-esteem.

One aspect of risk-taking when it comes to STIs seems to lie in the insecurity between the teenagers. The condom has to be brought out, resulting in interference in the sexual act. On top of that, a young man might be worried that the woman will “go out of the mood” and consequently he will lose his erection. It appears that talking about protecting ones sexual health is more connected with intimacy and closeness, than to actually having sex. The whole event of the one-night-stand seems to rest on a fragile foundation built on lust and words about responsibility act as a hindrance to lust.

But we really liked each other... or were in love... liked each other a lot, and then it felt more okay to ask. Instead of, if you had like a one-night-stand, I mean like, no I can’t ask. You always can, but it would feel a bit... Stupid, I don’t know... *

To view the partner as an object makes the non-caring relationship possible

Mainly according to the boys, there is a big difference between a sexual relation with a one-night-stand and a sexual relation with a boyfriend/girlfriend. The relationship with a person with whom they have had a one-night-stand is objectified; it is not who they are having sex with that is important, rather the act of sexual lust that itself. The sexual lust dominates as they become aroused leading to acting out the lust with whoever is available and preferably also attractive. Thus, mutual feelings of care and infatuation are not a requirement for a one-night-stand.

I mean, in a club you hunt for girls; there is no more to it. It can be a one-night-stand but it will not result in a love relationship. If you want that you should not try to find someone in a club. *

The teenagers contrast this with the ultimate sex with a boyfriend/girlfriend with who they are in love. In this case, they want to give sex and sexual pleasure and this is where the mutuality comes in. It is this person whom they care about and for whom they want to take responsibility.

But there are two things. One is having sex with a girl you like, that’s nice, and the other is going out and taking whoever is available and having sex with her. There’s nothing more to it you don’t see each other again, it’s two different things. When
you meet the girl out and go home to have sex, it's more just to have sex. But if you have a partner you're dating, then it's more ... yeah, showing your love by having sex.

Similar to the previous interpretation it is evident that for some of the girls it is not only objectified sex. It seems that underneath there is a hope that through the sexual act they can go from object to subject and the sexual relations are attempts to get the interest of a man with whom they are in love.

Then maybe you try to get close to the guy that way, now we have sex and then he might get interested in me.

In the subjective love relationship there is something more involved, besides the sexual pleasure, something beautiful and intimate concerning mutual warm feelings. The sexuality is perceived as being more special when it is linked to love and security. When it is with a boyfriend/girlfriend whom they are in love with, the meaning of sexuality is altered and it becomes a way to express warm feelings. Sexuality becomes something the teenagers wish to have because of an infatuation, as opposed to a one-night-stand, which is a wish for sex linked to being so sexually aroused that almost anyone would do.

Then it's the fact that it feels good and all that, but it's also the fact that you're in love with the person. I mean, it becomes nicer then, more feelings and closeness.

If you have a boyfriend and you really trust each other it's really different. If you just meet someone for a night then they both probably know what they both want, you know?

Furthermore, in the question of infecting someone with an STI the division of object and subject still stands. The young adults consider it to be a great difference between infecting a person they meet in a club, have sex with and never see again and infecting a boyfriend/girlfriend.

If you infect a one-night-stand, what the hell, it doesn't matter. If she gets really pissed, you don't want anything to do with her anyway. But if you infect your girlfriend, then ... then it's ... shit ... .

I mean, you don't have to talk to a one-night-stand ever again in your life, but if you infect someone you really care about, then you have to talk about it and be reminded of it ... afterwards.

Concluding interpretation—playing the game

The teenagers seem to regard casual sexual contacts to be a game where there are certain rules to follow. The rules are set-up by the girls and both boys and girls have to follow these rules. The boys agree to the rules because they do not want to lose an opportunity of having a one-night-stand. One of the rules for the boys to follow is to pretend they have not thought about sex prior to meeting this girl in the club. In fact they have been thinking of a one-night-stand before leaving home. They cannot reveal this because a part of the game, even if it is a one-night-stand, is supposed to be spontaneous and an unplanned here-and-now event, exemplified by immediate and overwhelming feelings for this very special girl. She wants to hold the illusion that she is carefully selected for her own qualities. This rule may be seen as a rule of protection for the girls, to protect them from being stigmatized as sluts or whores. The result of this is that the boys cannot bring out a condom because that is connected with planning and not a part of the game. Conversely, it is not supposed to be a planned or engineered event. If the image of not planning and being carefully selected is a part of that game, they are willing to play the game as long as the result is positive, i.e. intercourse. By this role STI does not exist, how can it when the girl is carefully selected? Therefore, a side effect of this game is the teenagers not having to take responsibility for their sexual health. The game has different sides and if the teenager plays the game, which includes their partner being the selected one, then it is easier to suggest condom to prevent a pregnancy then to protect ones sexual health. Condom use to prevent a pregnancy means the girl can protect her reputation and play her part of the game by pretending it is a love relation where marriage and children will come in the future.

Underneath the surface of the game, the boy is objectifying the girl and has no intentions of a serious relationship with her. As one boy says, “She does not mean more to me than a spot on the wallpaper.” The boys are thus separating a one-night-stand from a love relationship and saying they will not meet their future wife in a club.

The ability to handle intimacy and closeness with another person is often difficult to achieve and requires a dialogue and courage, particularly when, as these accounts suggest, it is outside the norm of teenage behavior. Alcohol in this game acts as a kind of bridge, a lubricant to help them follow through with the closeness they seek in order to fulfill their desire for sexual experiences. The intoxication provided by alcohol, gives them both the courage to approach the opposite sex, and it helps them avoid...
thinking of the danger of STI's. This denial, in turn, allows them to be exclusively guided by their lust. The teenagers encounter difficulties in initiating dialogues with this person, in particular in relation to discussions about condoms. This dialogue seems to be more private than the intercourse itself. If a person initiates a real dialogue with someone at an intimate level, that person can go from object to subject and leading to responsibility being less easy to disregard. In addition, such dialogue may lead to a deeper intimacy, which further on might lead to the requirements of taking responsibility for the lust and taking responsibility not to infect anyone with a venereal infection.

According to the phenomenological-existential psychiatrist Ronald Laing (1974), both men and women wish to be longed for and both are longing for the other's desire. Behind everything lies a strong fear of rejection. As Laing describes it:

Jack is afraid of Jill. Jill is afraid of Jack. Jack is even more afraid of Jill if Jack thinks that Jill thinks that Jack is afraid of Jill. Since Jack is afraid that Jill might think that Jack is afraid Jack pretends that he is not afraid of Jill so that Jill can be even more afraid of Jack (p. 83).

The whole game is according to Laing knots, tangles, muddles and ties.

The girls play their part of the game by pretending they do not see they boys are playing the game. The whole game can be described by referring to this rather well known quotation from Laing (1974).

They are playing a game. They are playing at not playing a game. If I show them I see they are, I shall break the rules and they will punish me. I must play their game, of not seeing I see the game (Laing, 1974, p. 7).

Discussion
This study shows that Chlamydia is now so common among young people that they consider it mild and less dangerous than herpes, for example. Another finding from this study is that it is more difficult to speak about using a condom for the purpose of preventing an STI than it is to suggest its use for preventing a pregnancy. There are rarely deep feelings involved in a one-night-stand and if asked to use condom meant that opportunity for sex is put aside, than few people would take that risk if it meant that the chance of having sex would be lost. There is a delicate balance. On the one hand, the teenagers want to be experienced before meeting "the right person" but on the other hand, they do not want to contract an STI or become the subject of a rumor concerning contracting an STI. Young women, in particular, are concerned with being labeled in derogatory terms, such as "easy" or "slut".

There seems to be several factors working together contributing to the current increase of STI cases. One of these factors is a rapid and acute increase in contemporary sexual contacts (Edgardh, 1992; Forsberg, 2005; Helmius, 1998; Jarlbro, 1989), the teenager do not think that they themselves will be infected by a venereal infection (Hammarlund & Nyström, 2004; Tydén, 1996) and as this study shows; the fact that the so called one-night-stands often occur under the influence of alcohol.

Using Becker's (1963) theory of labeling it seems very important for a teenager not to be marked as an outsider and be someone who is excluded from the group. Whilst becoming infected with Chlamydia does not mean exclusion, becoming infected with a venereal infection that is considered dangerous, odd or deviant, which then becomes public knowledge appears to be a real fear amongst teenagers and is firmly connected with both exclusion and branding. They are afraid of becoming the target of rumors. This might provide one possible explanation of why they do not see any other venereal infection than Chlamydia, as possible to contract. Their denial is a protective response, which allows them to be "normal" and stay in the group.

For approximately the last 200 years, from the latter half of the 18th century, people in Europe have had what is known as a "romantic love ideal". This includes, among other things, a love ideology stating that sexual relations and sexual acts only belong in a love based relationship (Giddens, 1994). Over the last few decades there has been an erosion of this love ideal, revealed by evidence that young adults no longer link sexuality and love as strongly as before. This can be observed in the increasing number of temporary sexual encounters (Edgardh, 1992; Forsberg, 2005; Helmius, 1998; Jarlbro, 1989). Zetterberg shows that in 1967, 85% of the people in the survey agreed with this statement: “Those who are in love with each other may have sexual relations even though they are not married” (Zetterberg, 1969, p. 21). Hereafter, a substantial change has occurred demonstrating an erosion of the strong link between love and sexual relations (Herlitz, 2004; Forsberg, 2005). Herlitz (2004) states: “Intercourse should only occur in solid relationships”; responses to that question in 1989, among young adults aged 18–19, revealed that 53% of the boys and 71% of the girls totally or partially agreed. In 2003, the numbers were 31 and 42% respectively.
From the research described above, we conclude that teenagers today are more inclined to have occasional sexual contacts, which seem reinforced by this current study. This creates demands in different areas, such as schools and youth clinics. These institutions need to develop educational programs, which are fit to address the new level of risk-taking amongst teenagers. If teenagers have the opportunity to reflect and discuss their occasional sexual relations in a confirmatory manner, without fear of rejection and, without grown ups moralizing, maybe they would not feel the need to polarize the objective one-night-stand versus the loveable subjective sexuality. We consider that there has to be a nuance here, allowing the teenagers to take responsibility for their own, as well as their partner's sexual health when they engage in one-night-stands.

Research shows that there is no link between increased condom use and increased STI information (Birgersson & Norestig, 2005; Marston, Juarez & Izazola, 2004). Wulfert and Wan (1993) state in their study that changes in sexual behavior are not a direct result of knowledge concerning condom use. Teenagers know that a condom helps preventing STIs but this knowledge does not necessarily make them use a condom. People integrate knowledge with expected results, how they feel emotionally, which can be socially influenced by earlier experiences. Therefore, we can draw a conclusion from earlier research that information about STIs does not influence teenagers' risk behavior in a great way. For teenagers in this study, some reasons for not using condom emerged. Our research results confirm previous studies, which have been carried out in the same area. One of these results is that the teenagers do not know their partner in a one-night-stand well enough to raise the subject of a condom due to the delicacy of the subject. This result is in line with Birgerson and Norestig (2005) and Svensson, Östergren, Merlo and Råstam (2002) who states that young women are afraid to get branded as slutish if they are well prepared and take a condom in their handbag. The fear of that branding is greater then the fear of an STI. There is also a possibility that the girl or boy shows that he/she will consider her/his partner as a potential disease carrier for venereal infection by wanting to use a condom. Holland, Ramazanoglu, Sharpe and Thomson (1998) state that a condom can not be seen as neutral but involve different values and attitudes depending on whether you are a girl or a boy. To suggest using a condom, for the young women, can carry the meaning of distrust towards their partner or that they show sexual experience. For women, this sexual experience can be something negative since there still are prejudices concerning sexual equality.

The young men state that using a condom reduces the sexual pleasure and to put on a condom leads to an interruption in the love act, which in itself is embarrassing (Flood, 2003).

Schools, youth centers and other places for teenagers ought to give plenty of support in what teenagers primarily find difficult—to improve their ability for intimacy and how to cope with the feelings, which arise in close relations, secondarily to give information about STI. The last mentioned information uses fear as a ground for changes. However, the teenagers are driven by their lust and their urge to explore their sexuality they must find a way to cope with information based on fear. They then use something which Weinstein (1980) describes in his theory as “unrealistic optimism”. This means that human beings expect other people to have setbacks and misfortunes/mishaps, but not themselves. Research concerning people’s risk to be involved in car accidents, crimes and different diseases show that they estimate their own risk to be lower than the average and that the more negative consequences an event brings, the less people think that it will happen to them (Weinstein, 1980). Therefore, by denying their risk behavior, which can lead to negative consequences, the teenagers think that it will not happen to them. Through this denial, they are less inclined to take responsibility for their own sexual health.

Thus, the teenagers do not see their own risk of being infected with an STI. Previous research show similar results, that teenagers favor their own self-image and think that it will not happen to them (Birgersson & Norestig, 2005; Hammarlund & Nyström, 2004, Tydeén, 1996). Skidmore and Hayter (2000) contribute to an interesting discussion where their research shows that young people put themselves in the centre of their own social network. They use the expression “ego-centric society” and mean that to know oneself becomes the most important thing and out from that benchmark everyone else is measured. The society has gone from “public person” to an “ego-centric view” (Skidmore & Hayter, 2000). This can be put in relation to our results concerning the fact that many teenagers today wish to explore their own sexuality, without greater considerations/respect to the other person’s experience. It is not important to protect your partner’s sexual health or to view her/him as a subject.

The question becomes, how can positive messages be given, that connects what we consider the most difficult task towards becoming a mature human being? Namely, how it is to be honest to oneself and
ones partner regarding needs and wishes concerning sexuality, so that sexuality during adolescence do not have to stand opposite to caring and love, no matter how short or long the relation will be. How do we make the teenagers care about a partner and show reciprocity even for a one-night-stand partner? It is important that a teenager does not repudiate the feeling of care for a partner if they have a one-night-

Methodological considerations

There are positive factors with group interaction but there are negative factors as well. One of them is what we can call intra personnel factors, which mean certain personal features that can affect the whole group. For example, an outgoing person who is perceived as intelligent and friendly can make other people in the group become more positive to her/his ideas than they would have been if that person were considered unfriendly. Another factor is that the group members want to be accepted in the group and to feel solidarity within the group. This may be a problem if the solidarity turns out to be too strong leading to a so-called collective thinking, meaning the members experience there is a right way of thinking about a phenomenon (Wibeck, 2000). Although, when a participant is confronted with the others opinions and she/he has a different opinion, the participant may become more reflective towards her/his own standpoint and be forced to analyze her/his opinion more radically than in an individual interview (Hylander, 1998).

In this study when data was collected and carried out, another doctoral student was present taking notes and observing together with the first author (KH). After a group interview ended, the first author and the “helper” discussed the climate in the group and the interaction. Especially in the two groups consisting of teenage boys, a collective thinking sometimes occurred. Despite this, they also argued against each other in these two groups as well as in the other groups. Sometimes a person could tell a short story, for example, about obstacles connected with buying a condom and after that another teenager could say “That reminds me about….” and then another short story would be told. Afterwards, they discussed these two stories and reflected upon the stories. Each focus group interview contained strong debates, fruitful discussions and interaction as well as sometimes-mutual agreement.

Qualitative studies must always be interpreted in relation to the context; in this study Swedish teenagers engaging themselves in sexual risk-taking. However, the fact that the result is contextual does not imply that they would be inapplicable and have no meaning in other contexts. Application of the results to new contexts could be understood as an entailing open-ended process of understanding, which is also depicted in the metaphor of the hermeneutic circle (Dahlberg et al., 2008). Therefore, it is plausible that the results from this research may also be applicable for other contexts.

The gender perspective has not been focused on in this article since that is something that runs through the data consistently and it deserves a completely new analysis. This will be presented in a future study.

Conclusion

All people who in their daily work meet young people and provide health education or health counseling, must find other approaches beyond information giving to reach adolescents and to bestow upon them a responsibility about their sexual health. It is of great importance that the education or the counseling does not become the use of informative but frightening propaganda, without support from the young people’s lived experience.

Furthermore, we consider that in health education and health counseling it is of great significance that research findings are utilized. Results where teenagers themselves speak about the barriers connected to condom use should be discussed. This can take place through a clear gender perspective in health education and health counseling by working with case description, attitude training, and discussions.

If we want to stop the STI epidemic and to save young people from becoming infected, we must take research result emerging from the teenagers themselves most seriously and work from there.

Acknowledgements

The financial support of the Skaraborg Institute for Research and Development is gratefully acknowledged.

References

Strid, L., & Eriksson, K.-Å. (1999). Fokusgrupper, en metod i kommunalt kvalitetsarbete (Focus groups, a method in community based developmentwork). Svenska Kommunförbundet, Katarina tryck AB.
What’s Gender got to do with It? An Analysis from a Gender Perspective of Swedish Teenagers’ Attitudes and Values towards Sexually Transmitted Infections and Sexual Risk-Taking.

KINA HAMMARLUND
University of Skövde
Växjö University

INGELA LUNDGREN
University of Gothenburg
University of Skövde
Växjö University

CLAES EKENSTAM
University of Gothenburg
Växjö University

MARIA NYSTRÖM
Borås University College
Växjö University

Abstract

This study is a secondary analysis that uses an interpretative approach based on data from four focus group interviews with a total of 25 participants, ranging from 18 to 19 years of age. The aim is to explain and understand attitudes and values towards STI’s and sexual-risk taking among teenagers in Swedish present-date society by using a gender perspective.

According to the findings, neither men nor women dare suggest using a condom when having casual sexual contacts. The reasons behind this fear appear to be supported by gender constructions that are based on misunderstandings, which in turn derive from prejudices and lack of communication. A common underlying issue among these young men and women seem to be that they all try to act in order to build up their self-esteem according to the social standards of the group where they belong.

This might result in a balancing act where both the men and women have to participate while shaping their sexual identity. At the same time, they have to try to maintain their self-esteem and not get a bad reputation. In this act of balance, it is difficult to discuss how to protect one`s sexual health.

Key words: Gender, sexually transmitted infections, risk-taking, sexual health.
Introduction

Increase in sexually transmitted infections (STI’s) among young people all over the Western world makes their sexual health a growing concern for health care professionals (Tortolero, Markham, Parcel, Peters, et al. 2005). In Sweden, HIV is not yet established among young people but is a future fear for many health care workers. Chlamydia infections have increased every year since 1997, and the largest increase is in young people, 15-24 years of age. The number of reported cases of Chlamydia infection in Sweden in 1997 was 13,905. Ten years later, the number is 48,033 (Swedish Institute for Infectious Disease Control, 2008). Out of the 3 million American teenagers who get infected by an STI every year, 40 % of the infected girls come back within a year with a new STI (Kershaw, Ickovics, Lewis, Niccolai, Milanm, & Ethier, 2004). Today’s teenagers know that condoms will protect from STI’s, but in spite of that, condom use is decreasing (Wulff & Lalos, 2004; Forsberg, 2005).

Research shows that there are gender differences in sexuality. In fact, men and women are expected to act differently within the sexual arena (Johansson & Lalander, 2003; O’Sullivan, Hoffman, Harrison & Dolezal, 2006). To be able to decrease STI’s, Christianson (2006) suggests that men should play an equal part in sexual and reproductive health. In order to make that possible, it might be necessary to investigate the way men do not play an equal part today, which is why it is likely that this could be done by an analysis from a gender perspective.

In many situations in society, masculinity is considered more important than femininity. This creates a gender hierarchy, also known as the patriarchal order, which forms an unfair society where men collectively have more power than women. This order is arbitrary and varies over time and culture. However, most societies have a gender order or a gender system where females and males are often regarded as contrastive (Connell, 2006; Hirdman, 2003; Johansson & Lalander, 2003). What is more, in the gender order of the Western society the man is expected to act “actively” and the woman “passively” when it comes to sexual relations (Connell, 2006; Hirdman, 2003; Johansson & Lalander, 2003).

Fundamentally, gender is about how bodies and their reproductive capacities are regarded in social processes. This is a very complicated process that does not yield to simple dichotomies. In fact, gender is an encompassing word that designates thoughts as how femininity and masculinity put imprints on the surrounding world. Also, it entails the uncovering of existing social patterns (Connell, 2006; Hirdman, 2003). According to Hirdman (2003), dualism is “built-in as the most powerful cornerstone in the whole gender thinking” (p.14). Instead, Hirdman (2003) suggests that we try to understand and use the word ‘gender’ as thoughts/habits/ideas about human beings that in itself is a human invention. In this way, we could artificially try to erase the existing strong divisions between men and women and instead reach an understanding that goes beyond the dualism of sex versus body.

The gender orders are not static but change every time humans play an active part in creating gender patterns (Connell, 2006). With respect to that, Pease (2000) questions if it is right to categorize all men in the category,”men”. This raises the question: What is a “man”? Does that mean that all men are alike? And is it the same for “women”? Of course, not all men and women are alike as individuals, but in terms of gender, which is a social construction, this creates certain patterns for how people are supposed to act. Thus, this very gender construction is the main subject for this article.

As a result, all people who work with teenagers should engage themselves in trying to decrease the incidence of STI’s among young people. This is important due to the
fact that young people are a key group who have their fertile life ahead of them. Also, they are in a stage of life where they search for their identity. Experimenting with sexuality can be a part of that search (Helmius, 1998, Häggström-Nordin, Hanson & Tydén, 2005).

One way of working with decreasing STI’s might be to invent a useful tool. This could be done by focusing on the issue from a gender perspective. Therefore, the aim of the present study is to explain and understand attitudes and values towards STI’s and sexual risk taking among teenagers in Swedish society today from a gender perspective.

This knowledge is also important from a caring science perspective since the increase of STI’s not only influence the affected individuals physically and mentally, but it can also have long term secondary effects such as life-threats as human immunodeficiency virus (HIV), cancer (HPV) or future infertility (Chlamydia) (Andersson-Ellström, 1996; Novak, 2006).

Method

From a previous study on the subject, “Teenagers attitudes and values towards sexual risk-taking” (Hammarlund, Lundgren & Nyström, 2008), a new research question was generated. Connected with gender constructions and sexual risk-taking, it became the subject of research for this article.

This study is a secondary analysis performed on data collected in 2006 by the first author (KH). Secondary analysis, also called reanalysis, re-use or recycling data, is a research approach that makes use of pre-existing research data for the purpose of investigating new questions that were not in focus of the original data collection (Law, 2005; Åkerström, Jacobsson & Wästerfors, 2006). According to Bryman (2002), interesting data can be analysed in many different ways, and if a new research question is posed to the data it can lead to new interpretations. Thus, a secondary analysis has a novel purpose compared to when the data was first collected.

This means that the analysis was performed with a new specific research question: How can attitudes and values towards STI’s and sexual risk-taking among young Swedish teenagers be understood from a gender perspective?

Posing a gender question means illuminating some aspects in the data that are connected to gender. When doing this analysis from a gender perspective, it is important to reflect upon from what point of view the analysis is made: farmers in India, women in Africa, or men in New York? All of these answers will probably give us very different perspectives. Therefore, once again I want to clarify that this analysis is done from the perspective of young people living in Sweden.

Data collection

The data contains a total of four focus groups. The informants were teenagers in their last year of college, 18-19 years of age. In total: 25 individuals; 16 boys and 9 girls. Three groups were single-sexed and one was mixed.

Ethical considerations

Most problems concerning secondary analysis and ethics are related to confidentiality, when full name and date of birth of the informants are included or when other researchers perform the analysis than those who collected the data (Bryman, 2001; Law, 2005). In this article, all data has been collected by the first author. No names or dates
of birth have been included. Therefore, it seems fair to assume that this study has similar ethical issues as a primary study. As the inquiry in this study concerns the analysis of a text instead of individuals, confidentiality could relatively easily be maintained. Moreover, in the analysis we do not report any findings that could threaten the participants’ integrity.

**Data analysis**

The interpretative analysis started with a re-reading of the texts from all focus groups in order to gain a general sense of the whole in relation to the new research question. In the next step, the data as a whole was divided into parts. Similarities and differences in gender experiences were identified, and meaningful statements were marked and brought together into themes. Structure and patterns were interpreted as an attempt to see the impact of gender. This step resulted in four different interpretations. In order to further develop and illuminate the interpretations, more parts of gender theories were used. Finally, the four interpretations were further abstracted and a main interpretation emerged.

**Results**

First, the four interpretations are described. Each of them illuminates different aspects of the research question. Then, we suggest a concluding interpretation that further explains the meaning of all of the interpretations.

**Sex can be regarded both as a means and as an end**

For several young women, it seems as if “sex”, here: intercourse is not something they always want to have when they meet someone at a club and go home together. Rather, it appears as if it is something they get, whether they like it or not, when they seek intimacy. This could be difficult for a young woman to explain to a young man. One of the interviewed women put it this way:

> Maybe you just want to sleep next to the guy and then you kind of get the whole package.♀

The young women express that they sometimes long for a boyfriend rather than a one night stand. Sometimes, they view sex as a means to get a young man interested in them. This could later develop into a love relationship. Thus, the gender patterns seem to concern the young women who believe that men must “get sex” in order to give intimacy:

> Many insecure girls let the boy sleep with them so that he will stay or because they do not dare to let him wait because then he might leave.♀

On the other hand, the young men seem to think that it is acceptable to separate sexuality and love. This appears to be accepted in the group of young men:

> That is to say that in a club you hunt girls, but there’s nothing more to it. It can be a one night stand, but not a steady relationship. If you want that, you shouldn’t go to a club.♂
Femininity seems to include aspirations towards a kind of experience of entirety where sexuality and feelings are linked to each other. As a consequence, the women are more oriented towards a love relationship. One aspect of this “love-seeking” is that they are afraid to hurt the man when they engage in occasional sexual contacts.

I could never pick up a guy at a club, like, “come on, let’s go home and fuck”. I want to know that person, not just meet someone that I’ll never see again. It’s much nicer if you are in love with the person you have sex with. ♂

If you do that, go around and have sex for your own sake, you could hurt someone. ♀

According to Connell (2006), one explanation might lie in the expectation that the man has placed upon himself. This includes always wanting sex, being prepared for intercourse, being active and the instigator. If a man expresses that he prefers to “make out” and not have intercourse, he might be afraid of being perceived as unmanly. As is stated by Kimmel (1994), this is one of a man’s greatest fears: *Masculinity must be proved, and no sooner is it proved that it is again questioned and must be proved again* (Kimmel, 1994: 122). Thus, the risk of being looked upon as not masculine enough seems to influence the common value-system in male groups where men try to impress each other. This is also confirmed by the young men in the study:

It’s this guy mentality; you get every chick on your hook, sort of. ♂

Surely it’s his own business if he wants to fuck the whole poultry-farm. ♂

Another explanation to why sex is often regarded as a means by women but as an end for men is that the norm of men’s peer-groups seem to be one of domination. In connection to sexual risk-taking, a condom could be something that is associated with un-masculinity since it can cause the man to lose his erection when the condom is handled and put on:

To go up and find that thing, then try to put it on, which can be tricky, and then you might have lost your erection. It’s gone down, sort of. ♂

**Preconceived notions become truths**

Insecurity and embarrassment, for example when the use of a condom should be discussed, could lead to a fear that the partner will interpret this as an accusation of having an STI:

It feels like an attack to stop and say; I think we should use a condom because I don’t know if you’ve been tested. What about if he says, “what the hell are you saying?” ♀

Not being able to discuss this issue also means that preconceived meanings about what men and women think about condoms tend to direct their behaviour:
It’s a bit insecure on both sides. The girl might think that the boy doesn’t want a condom. And at the same time, the boy might think that the girl doesn’t want one. Or that she’s on the pill and then it’s cool anyway. ♂

In general, the young women want the men to take responsibility for condoms, but at the same time they think it is hard for them to do so. But what is more, the women tend to take responsibility for the men’s pleasure by thinking that a condom would reduce his sexual pleasure:

You really wish that the guy would do that. But I think that they often have difficulties in expressing what they want. Because they don’t think it’s as good with a condom. ♀

Bringing up the intricate problem of condom use requires courage and strong self-esteem, which not all young people have. Also, the young women tend to believe that the men will be dissatisfied if they ask. Their presumption of less male sexual pleasure and of being subject to their partners’ presumed disapproval takes a lot of courage:

Not many girls will have the authority to say, “I’m not going to do anything if we don’t use a condom”. I mean, an insecure girl really wants the guy to like her. She would accept anything he says or does just to be popular. She wouldn’t do anything to make him unhappy. ♀

I don’t know many girls who would dare to suggest using a condom. There aren’t many girls who would say, “Let’s use a condom, end of discussion.” … One would think that the guy might be offended and think, “do I have to wear a condom, this will not be fun then”. ♂

However, the men have another opinion. Their statements clearly indicate that they would react positively and feel respect for the girls who suggest a condom in a casual sexual situation.

I would say that she’s careful and at the same time serious. You would respect her if she asks for it. You show her that respect, that’s my opinion. ♂

It’s a smart and positive thing if a girl suggests a condom, and I would use it. ♀

Thus, the situation seems paradoxical. If a young woman wants the man to use a condom, she appears to change from being a sexual object to a subject that deserves respect. Thereby, she comes closer to the relation that she sometimes desires.

The knowledge of a potential STI can evoke fear and vulnerability

Young women often have easier access to a youth clinic than men since the women might need prescription of birth-control pills or to discuss menstrual problems. As a routine check-up, they could be tested for possible Chlamydia infection and thus receive a gynaecological examination that confirms that there appears to be no problems. Sometimes they bring a best friend for support, even if the friend does not have to be there herself.

However, men rarely visit a youth clinic. They say that it could be stressful to visit a youth clinic or a district health care centre to get tested for a possible STI. One
thing that holds them back is the time it takes to wait for the test results, which they find mentally demanding and anxiety provoking:

I once did a test that included everything. A blood sample and all that and got checked for HIV. And it really got to me. I went around thinking, “Oh my God, what happens now?” I was really worried and that was mentally a very exhausting process. This might be why people choose not to have a test. Waiting for the results is difficult, so maybe you just don’t have the test; you stick your head in the sand instead. ♂

However, behind the visible lack of responsibility for not transferring a possible STI, there seems to be an existential anxiety and vulnerability, and in extent, a fear of being sick or even die. In fact, this is opposite from what the women think:

I don’t think it would be difficult for a guy. They just say; “I got a letter from the youth clinic that says I have to go and get tested”. I don’t think it’s difficult for them. ♀

However, this is an incorrect assumption. A man’s fear could be so great he might not get a test even if he is contacted by a girl who suspects she infected him with an STI. Instead he could go on thinking, “it won’t happen to me”.

One time it was a girl who contacted me and said that she might have infected me. It wasn’t a notifiable STI, but anyway I didn’t bother to have a check-up, I totally ignored it. I was thinking, “This can’t be happening to me.” ♂

Keeping the fear at bay could be interpreted as a type of denial. This process appears to be collective, as denial is strengthened within the peer group. The “laddie” attitude, where the men joke with each other, play down the risk of getting infected:

There were seven or eight of us and I said that I had to go to the STD clinic on Thursday. They all started laughing and when I said I had to go for treatment, they laughed even more. ♂

The consequences of this gender difference could be that men continue to infect others, since that fear could be a hindrance to seek treatment.

Sexual experiences of women and men are valued differently

As described earlier, a young man is often expected to take the initiative and to be the active one who “knows all about sex”. The consequences could be that the man tries to obtain as much sexual experience as possible. Acting sexually and “getting as many girls as possible” would make his male friends view him as someone who “knows his thing”. Thus, it would be in his peer group that he shows his sexual achievement, which is affirmed in his masculinity:

If a boy has slept with many girls, you value that in a positive way. ♂

A guy would say, ”You’re so cool and can get every girl you want. He is awesome, a player.” ♂
Also, the young women ascribe other rules to men than for themselves. This means that in the gender pattern there is a difference in female and male sexuality:

It’s always been like that. The boys’ sexuality has always been more cool, to fuck many girls. ♂

The young men seem to adjust to these sexual rules in order to pretend to be more sexually experienced, especially when they meet a girl with whom they later fall in love. Also, it appears important for them not to come about as ignorant in terms of sexuality, even though this could affect their self-esteem in a negative way. As is described earlier, sexual experience is connected to masculinity, and it entails that those who are sexually inexperienced appears less masculine and do not receive the desired respect from the male group.

I think that if you’ve been with a girl, like, for the first time, and that was a bit of a sexual flop, and after her you meet a girl whom you fall in love with, then I don’t know what I would do if she’s more sexually experienced than me. Then I don’t know if I would like to be involved in a love relationship with her. ♀

You want to have sex with quite a few before you meet the right girl, so you know what you are doing. ♂

Seeking this sexual experience can become evident through the scenario of a young man who goes from girl to girl, hoping to get a positive response from one of them.

But I think one lowers the gatepost. I think you do that if you go out only to pick up a girl. You approach a good-looking girl and she doesn’t want you, then you try with another good-looking girl and she rejects you too. Most of the good-looking ones have boyfriends. Then you kind of lower the gatepost after a while and go for anyone who won’t say no. ♂

This young man can tolerate this level of humiliation because he knows the rules of the game in his gender-stereotyped male group. And above all, he seeks confirmation from this group. This creates a gulf between the young men and women’s worlds:

I think that guys who run from girl to girl don’t care if they get a no and embarrass themselves, they just run to the next girl. They have no pride, instead they don’t give a shit, and they’re desperate. ♀

According to Pease (2000), there is a common belief that men always want to have more sex than women. As a result, a young man could go from one woman to another trying to get a partner the night without such behaviour being a threat to his masculinity. His masculinity can only be threatened if a man is picked up by a woman and he says no.

Hence, a man must win his masculinity and have it confirmed by other men. In the existing gender patterns, a man’s relationship with a woman demonstrates masculinity, but this masculinity is mostly defined through his friendship to other men. According to this explanation, the man has a constant fear of being seen as un-masculine by other men (Kimmel, 1994).
One consequence could be that while a man has constant support from his peer group when he openly seeks sexual experience, a young woman is restricted in her sexuality and is overshadowed by the threat of being stigmatised as a "slut" or a "whore":

For the boys it’s something to brag about, but for a girl it’s more likely to mean that she’s a whore instead.

It’s so accepted; that’s just the way it is. It feels like everybody has these values and it’s accepted. If a girl has fucked five or ten guys, then she’s a "slut".

Therefore, the young women appear to assume that they will be stigmatised if they have "too many sexual contacts", which is a very important explanation to why they do not always have the courage to suggest using a condom. For these women, it is difficult to find the balance when they seek sexual experience. They would not be characterised as ‘successful’ by men or other women if they have many sexual contacts.

A girl who changes sexual partners often, or if she’s what we call sexually active, yes, quite a ‘loose’ girl, I think these girls get venereal infections very easily.

These men consider it possible to judge a young woman by her appearance and if she has a venereal infection. The criteria for that seem to rise from stereotype images:

You have prejudices about women in short skirts, very low-cut tops, lots of make-up and very blonde hair.

Of course you think she’s an easy target if she wears shiny boots and a leather mini skirt.

The difference between who and to whom one discuss sexual experiences seems to lie in the different presumptions of men and women. For a young man, almost everything is allowed, as long as it happens with the opposite sex.

One of the interviewees says that she is a lesbian, and it is interesting to note that her thoughts in fact differ from the heterosexual young women’s attitudes:

I don’t think it’s such a bad thing to be called a slut; I don’t mind being called that, because I don’t think it’s a negative thing if a girl is a slut. … I can call a guy a slut and then I don’t say it in a deprecating way. … I can call a girl “a player” and I don’t mean anything bad. If I happen to have had too much sex with too many in a short time I can say, “What a ‘player’ I am.” More like a joke.

Thus, this interviewee has incorporated the young men’s perspective into her own self-image, but she has also balanced it. On one hand, she has incorporated this male norm and views herself positively when she has many sexual contacts. On the other hand, she does not seem to judge women or men if they have many sexual contacts.

Concluding interpretation – The social construction of gender generates misunderstandings

A common denominator and concluding interpretation is that misunderstandings highlight fundamental differences in how men and women relate to each other. Many
misunderstandings can be explained with reference to the emergence of gender stereotype patterns.

For example, the misunderstandings are reinforced by the fact that young men to a large extent seek confirmation from each other. A young man in his teens appears to be preoccupied with “becoming a man”, which includes other men noticing and affirming him while achieving that.

Also, misunderstandings could include using a condom. Here, both the man and the woman want the other to suggest it, but neither of them dares to do so. This fear could be explained by the gender construction, where both partners seem to make assumptions about each other. The young women do not seem to realise that they will be viewed as respected persons if they ask the men to use a condom. However, these assumptions appear to be misunderstandings that result from prejudices and lack of communication. Accordingly, this contributes to the increase of STI’s.

Moreover, a common underlying component among young men and women appears to be that they all try to act in a way that bolster their self-esteem in ways that are socially accepted in their gender groups. Thus, this is a balancing act for men as well as women while they investigate their sexuality. During this process, it is important to keep up their self-esteem and to not generate a bad reputation. A woman has to obtain her sexual experience without showing it off too much. A man has to try to hurry to receive as much sexual experience as possible. Thus, the social gender constructions generate a pattern of misunderstandings that to a large extent direct young people’s sexual behaviour.

Discussion

The findings of this study suggest a strong identification with stereotypical gender roles, which could lead to the fact that young people engage in more sex than they actually want to. As it appears, the young women try to please the men, and the men seek affirmation from other men. This could be due to the fact that neither men nor women have the courage to say no when they do not feel like having intercourse. This could lead to more one night stands, which in turn could lead to an increase of STI’s if condoms have not been used.

The findings further suggest that a young woman needs self-esteem to have the courage to ask a young man to use a condom. According to Gardner, Frank, & Amankwaa (1998), there is a strong correlation between lack of self-esteem and frequency of STI’s. Young women with high scores on a self-esteem scale tested negative for STI’s more frequently than a group of young women with low levels. This could inform us about the work that needs to be done in schools and other areas where young women spend a lot of time. For example, teachers and health care providers in youth centres face a challenge here. Gardner et al’s study could be combined with the results from the present study, which revealed that young men feel respect for young women that suggest condom use. This is something of which young women need to be aware. However, by this we do not imply that women should have the full responsibility for condom usage.

Being a young man in today’s society appears to involve a fragmented male identity: One foot is rooted in the male peer-group and the other in a love relationship. Johansson & Lalander (2003) mean that young men, unlike young women, often stay together in a group and”populate public life”. In public life, they need to be heterosexual men, so as stereotypes of masculinity thrive in this environment.
Johansson (2005) discusses “situational masculinity”, which means that a man would try to act on equal footing in a love relationship, but extreme sexism might exist in his peer group. Gender patterns among young men’s peer groups could affect individual men to experience alienation towards his own feelings. In the male peer group, a man has to try to become masculine and impress his male friends, yet in a love relationship he has to answer for himself as an individual being. This schism could make him feel detached from his inner self.

Previous research indicates that a man might experience constraint when he is expected to always be active and take sexual initiative. Also, he might experience a strong pressure from other men to be sexually active since there is a fear of being regarded as un-masculine. The worst case scenario would be if he were taken for a homosexual by showing disinterest in heterosexual intercourse and prefer to stop on “second basis” (Pease, 2000; O’Sullivan et al, 2006).

Thus, several factors appear to contribute to the increase in STI’s. The first, and perhaps most important factor, is that the attitude in teenagers to casual sex has changed in the past few decades. For many teenagers today, one night stands are acceptable, which results in more temporary sexual contacts than twenty years ago (Forsberg, 2005). The present study also reveals that some young women engage themselves in casual sex, even though they want a boyfriend. They seem to think that this is a way of getting one. Sometimes they just want to be close to a man and have him sleep next to her. However, one question to ask concerning these result is whether the women gave me this answer because they know that the existing gender patterns expect them to, or if these are their honest intentions and true feelings.

On the other hand, the study shows that young men do not explicitly say that they are involved in casual sex without emotional attachments. But as is mentioned earlier, O’Sullivan et al. (2006) in fact found that men reported engaging in sexual activity against their personal preferences. In O’Sullivan et al. (2006), men appeared to be reluctant to admitting engagement in unwanted sex for fear of appearing unmasculine. This is probably connected to the fact that men struggle to uphold their masculinity and “making oneself become a man” In this process, it is reasonable to presume that sexual experience is included. According to O’Sullivan et al. (2006), men were six times more likely than women to have had a recent one night stand. However, the accuracy of this statement is something we can only speculate about.

Another way to view these result is that the existing gender patterns do not allow women and men to act from their genuine individual feelings. There are probably women who like occasional one night stands but do not respond to this feeling due to the risk of being stigmatised as a “slut”. And there are certainly men who prefer to “make out” with a girl instead of having intercourse but who experience expectations of always wanting sex, or otherwise risk being regarded as is not “masculine enough”. Thus, men as well as women seem to be trapped within gender expectations that prevent them from feeling, thinking and acting like individuals.

Also, many young men and women appear to avoid the fact that their sexual risk-taking can result in an STI. One way to handle this denial is to think, “I am a good girl/boy and it will not happen to me”. Some young people think that they need to have many one night stands in order to contract a venereal infection, and at least the female participants do not consider themselves as having many one night stands (Tydén, 1996; Hammarlund & Nyström, 2004). Another part of the denial process is to think that HIV is merely an African problem, and consequently that Western people do not risk contracting it (Christianson, 2006). Furthermore, nowadays Chlamydia is so common
that it seems to be a part of the game, and consequently, less dangerous the more common it becomes (Hammarlund et al. 2008).

Findings from this study further indicate that some young men might have an unconscious fear of being tested for an STI. They do not discuss STI’s with other men and they do not visit youth clinics to the same extent as women. Other research supports similar results (see for example Birgersson & Norestig, 2005). According to Novak (2006), in 2003 women comprised 73 percent of the total number of Chlamydia tests in Sweden. When a youth clinic in Sweden invited young men and women for a health control that included a STI check-up, only five percent of the males accepted the invitation, compared to 40 percent of the women (Andersson-Ellström & Hederos, 1991). In Sweden, it is possible to order a free Chlamydia test over the Internet. This approach seems to appeal to men, since 42 percent of the orders are from young men (Novak, 2006).

According to the teenagers in this study, the venue for developing temporary sexual contacts is the local club, which is a place where they can socialise, dance and buy drinks. In such surroundings it is accepted to initiate sexual meetings. Thus, the club appears to provide young men and women with the sense of an “escape zone”, which has its own rules that would not be accepted in other places, such as in school or at work.

Connell (2006) describes four dimensions of gender relations in modern society: power, production, emotional and symbolic relations. A closer look at a situation in a club discerns three of these: power, emotional and symbolic relations.

Here, the relation of power is the power that men have over the women. By threaten them with stigmatisation; the women are put in place by fearing the rumour of being called a “slut”. Furthermore, this relation is visible in the gender patterns “active” and “passive”. The young women are not supposed to “pick up” a man; simultaneously the man should “conquer” women.

The emotional relation is present in the shape of desire and sexual game. Finally, symbolic relation is the image that is mainly drawn by men where young women infected with an STI are wearing short skirts, leather boots, have blonde hair, lots of make-up, etc.

To be able to decrease STI’s, professionals must discuss attitudes and values in schools, health care clinics, youth centres and so on. It is highly important that young people are aware of the gender construction and how it affects their sexual risk-taking.

Another aspect of gender is that the gender patterns of the present study do not allow persons to deviate from the male/female norm. If so, he/she risks exposing him/herself to possible reprisals. The message is clear: Do not step outside the limits of your gender. The norm is to maintain the prevailing gender perspective, and everyone is expected to act accordingly.

According to Novak (2006), there are five cornerstones of successful STI prevention: knowledge, norms/values, empowerment, supportive environments and gender equality. Novak puts it, “To be able to improve the prevention of STI’s one has to take into account the gender-based dynamics within the sexual relationship of men and women” (p. 14). This is in line with the results of this article, which is why we need gender-based approaches when combating STI’s.

Conclusion

The strict gender construction needs to be challenged. Both women and men can broaden their gender repertoire and work against stereotyped male and female gender
patterns. Gender cooperation would support interpersonal relationships and love relations that are not based on prejudices. With the prevailing gender construction, men are more or less forced into static patterns to which they cannot always live up. If gender constructions were less rigid, men as well as women could be encouraged to share their inner feelings instead of expressing themselves through their sexuality. If so, they would not have to resort to gender specific behaviours that based on assumptions that neither can be confirmed nor falsified. Also, such a development would allow women to take a greater responsibility for temporary sexual contacts, which is definitely something that would promote sexual health in young men and women.

Acknowledgements

Many thanks to Raewyn Connell for improving this manuscript. The financial support of the Skaraborg Institute for Research and Development is gratefully acknowledged.
References


Swedish Institute for Infectious Disease Control, report on the Internet, February, 2008.


Acta Wexionensia


