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Why don't young women go for Chlamydia testing? A qualitative study employing Goffman's stigma framework

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Many women who might be at risk of having the sexually transmitted infection (STI) *Chlamydia trachomatis* either delay going, or do not go, for testing. We aimed to examine the factors that either prevent or discourage Irish young women from going for Chlamydia testing. We conducted in-depth interviews with 35 women in the Republic of Ireland who were between 18 and 29 years of age. Accounts were analysed using Goffman's stigma framework. Study respondents strongly associated Chlamydia and Chlamydia testing with stigma and felt that only irresponsible, promiscuous risk takers were at risk of contracting the infection. Respondents saw themselves as responsible, moral actors who avoided risk and took good care of their bodies; they were therefore not at risk of having Chlamydia. Going for Chlamydia testing was seen as a risky activity that could shift respondents identities into a negative 'Other' category. Respondents feared that if they found themselves in this 'Other' category they would open themselves to bullying and ostracism. While a negative act from a medical perspective, for respondents the act of not testing was seen as a positive activity that helped to reinforce their identities as good, 'worthy' individuals and avoided negative social consequences that might otherwise arise from the testing process.

Keywords: risk; stigma; Chlamydia; opportunistic; qualitative; Ireland; sexuality

Introduction

Chlamydia trachomatis is a bacterial sexually transmitted infection (or STI) that can be transmitted through oral, anal or vaginal sex. It is a 'silent infection' in that up to 70% of cases are asymptomatic (Peipert 2003). Chlamydia increases the risk of transmission of HIV during unprotected sex (Malta *et al.* 2007) and, if left untreated, can lead to pelvic inflammatory disease and severe reproductive complications in women, such as infertility and ectopic pregnancy (Tilson *et al.* 2004); though recent research has suggested that the rate of progression of Chlamydia to pelvic inflammatory disease may be lower than previously thought (Low 2007). Chlamydia is easy to detect using a urine test and easy to treat through a short course of antibiotics.

Chlamydia is a disease of the young. US data report a relative risk for contracting the infection of 2.0 to 3.5 in women under 25 years of age when

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50 compared to women over 25 years old (Peipert 2003). In the UK, estimated prevalence rates for infection amongst young women range between 5% and 10%, depending on the target group studied (Peipert 2003, Adams *et al.* 2004), which is similar to other countries (Glasier *et al.* 2006). Medical risk factors for Chlamydia include being female (Stevens-Simon and Sheeder 2005), having intercourse at an early age and having more than one sexual partner in the past year (Peipert 2003).

55 Although it has become easy to test for Chlamydia, international research suggests that many young women who are at risk of having Chlamydia do not go for testing (Gotz *et al.* 2002, Fortenberry 2004, Chacko *et al.* 2004, 2006, Pavlin *et al.* 2008). Several reasons or barriers have been suggested, including: lack of knowledge about the asymptomatic nature of Chlamydia and the ease with which it can be detected and treated; *system barriers*, such as cost, inconvenient opening hours of health services and long waiting times; *societal barriers*, such as the stigma attached to STIs; and *interpersonal barriers*, such as judgmental and negative reactions on the part of clinic staff (Tilson *et al.* 2004). The stigma and shame associated with STI testing may have especially pernicious effects on young people's willingness to seek STI testing (Cunningham *et al.* 2002). STIs are often associated with deviant sexual behaviours and immorality, and young people may fear that they could become negatively labelled if they go for STI testing. It is important to note, however, that while these barriers may be important, young people may not interpret them in a homogeneous way. Variables such as class status and regional location (whether an individual is from a rural or urban area) may be important factors influencing how young people understand STI testing, and which barriers they think are either more or less relevant to their lives (Malta *et al.* 2007).

70 There is a need to better understand the complex issues underlying perceptions of risk and STI test decision-making amongst young women (Chacko *et al.* 2004). Internationally, most research studies on Chlamydia testing barriers, including those cited earlier, have been conducted with urban youth recruited from STI clinics (Pavlin *et al.* 2008, Goldenberg *et al.* 2008). The disadvantage of this is that these young people have already been proactive about their sexual health, through seeking out STI testing, and may have different perspectives on perceived risks and barriers to testing (identified in the previous paragraph) than young people who have not attended health services for STI testing. Understanding the perspectives of this latter group is therefore a priority (Chacko *et al.* 2004). We conducted semi-structured interviews with 35 young women recruited in a variety of community healthcare settings, and from rural and urban areas located in two regions of Ireland, who had never previously attended a health service for STI testing. Based on an analysis of these interviews, which draws on Goffman's (1963) work on stigma, this article explores why young women in Ireland do not go for Chlamydia testing.

90 **Stigma, identity risk and STIs**

According to Goffman (1963), a stigma is an attribute that discredits an individual or a group, diminishes them and renders them tainted and discounted, abject and inferior. Stigma is associated with what Goffman refers to as abominations of the flesh, the soul and the tribe (deviant bodily, mental/behavioural and ethnic/racial/national characteristics). These characteristics may be visible or invisible, controllable or uncontrollable.

Goffman refers to individuals who do not have any deviant characteristics as 'normals', individuals who do not deviate from the expectations of society or their social group (Goffman 1963, p. 5). Normals generally experience their bodies and identities as 'absent' or unproblematic. Goffman describes individuals with visible deviant characteristics as having *discredited* stigma, displaying visible signs of their difference. Individuals who have invisible characteristics are termed *discreditable*. If they control and manage their discreditable attribute they can pass as 'normal'. If they do not, they will become stigmatised. Discreditable individuals can therefore manage stigma. Their central concern is deciding how to manage the risks that could lead to them becoming discredited. Individuals with discreditable characteristics often worry that they will suffer rejection from 'normals'. Scambler and Hopkins (1986) refer to this fear as felt stigma, and instances of active prejudice against stigmatised individuals as enacted stigma.

Though stigma is often seen as a characteristic residing within individuals, Goffman (1963) argues that a language of relationships rather than attributes is needed when talking about stigma. The characteristics that social groups consider to be deviant and deserving of stigmatisation often change over time. People with epilepsy, for example, are less stigmatised now than they were in the past because the social meanings of the condition have changed (epilepsy is now seen as a medical condition rather than a sign of demonic possession). This indicates that stigma may be socially defined, and can become either more or less salient depending on what is considered to be normal or acceptable in particular social contexts.

If stigma resides in social interaction rather than in individuals, why do some individuals or groups stigmatise others? Stigma reinforces social norms and strengthens and homogenises groups by expelling unwanted or undesirable characteristics; characteristics that are thought to pose a threat or risk to the group or its individual members, creating a boundary between 'us' and 'them' (Phelan *et al.* 2008). This usually serves to confirm the moral superiority of the stigmatising group, and reinforce their claim to normalcy (Goffman 1963). The stigmatising of 'Others', therefore, is an identity-producing practice. Normal identity, that which does not deviate from social expectations, is produced through the enactment of marginalising practices and exclusionary operations (Nairn *et al.* 2006).

The consequences of stigma for stigmatised individuals are never pleasant. Stigma spoils identities. Though it emerges from and is most strongly associated with a particular attribute or practice, once it is acquired it diffuses outward to contaminate, and hence globally devalue, an individual's entire identity. Stigma is parasitic and difficult to remove once affixed (Diken and Lausten 2005). It is also magnetic, in that it attracts negative attributions. For example, in the past people with epilepsy (stigmatised for having seizures) were also condemned for being hypersexual and aggressive (Jacoby *et al.* 2005).

Stigma leads to a general downward placement of the stigmatised individual in a status hierarchy (Link and Phelan 2001). This can encourage direct and indirect social and economic discriminatory behaviours by others that substantially reduce the life-chances of the stigmatised individual (Jacoby *et al.* 2005). This pattern of rejection is enabled by fact that the stigmatised individual is seen by 'normals' as 'not quite human', as dirty and dangerous, or as risky. Consequently, normals are justified in their treatment of the stigmatised person (Jacoby *et al.* 2005). The emotional consequences of this rejection can be severe. A stigmatised woman often sees herself as lacking (Goffman 1963). As a member of society, she internalises

society's standards and judges herself by them (Cunningham *et al.* 2002), commonly experiencing shame at her inadequacies. This shame can be intensified by the negative emotional reactions of others, such as the feeling of disgust that others communicate when they come into contact with a contaminated individual (Curtis and Biran 2001).

Sexually transmitted infections

Certain behavioural conditions are more likely than others to attract stigma in modern Western cultures (Foley and Patel 2001). The reactions of 'normals' are likely to be most negative and intense where the condition is contagious, where there is a perceived risk to others, where the condition results from controllable and preventable practices and where the symptoms of the condition are ugly or repellent (Curtis and Biran 2001). Sexually transmitted infections such as Chlamydia fulfil all of these requirements. A UK Royal Commission report in 1916 urged clinicians to be aware of the 'fear of disgrace and desire for concealment' that accompanied STIs (Foley and Patel 2001). More recent surveys of young people have found high levels of shame and stigma associated with STIs (Cunningham *et al.* 2002). STI related stigma is especially acute for women. In many Western societies, men have traditionally been expected to be sexually active and women chaste (Marston and King 2006). A woman may be seen as promiscuous if she has an STI diagnosis, or is even known to have attended the health services for an STI test. This may risk her reputation (her social identity as a 'normal' respectable woman) and brand her with the label of slut or whore (Marston and King 2006). Understandably, people may consequently be wary about attending health services for STI testing (Malta *et al.* 2007). This anxiety may be especially strong for the adolescents and young adults who are most at risk of acquiring STIs (Cunningham *et al.* 2002).

The Irish context

To understand STI related stigma it is therefore helpful to understand the wider social contexts in which stigma is embedded (Joachim and Acorn 2001). Ireland has traditionally had quite negative attitudes towards sex and sexuality. Until recently, sex was a largely taboo topic within Ireland, an attitude stemming from the Catholic Church's influence over Irish sexuality (though the taboo was enforced by all levels of Irish society) (Inglis 2006). A 1929 censorship law banned erotic literature in Ireland as well as any information about birth-control. Artificial contraceptives were banned in 1935 (and legalised again in the 1970s) and in the same year the Public Dance Halls Act sought to control the threat of unsupervised dancing, considered to be too risky and sexy for the Irish populace (Inglis 2006). The conservatism of Irish sexuality fell most heavily upon women. Irish women were traditionally expected to be submissive, caring and modest; rooting out and destroying promiscuous women is a long-cherished Irish tradition (Inglis 2002).

The shifts of the past decades, as Ireland has moved from being a traditional, agrarian island to a globalised, open economy, has seen a liberalisation in Irish society's attitudes towards sexuality and a move towards interpreting sexuality in terms of personal responsibility, risk and choice. It would be erroneous, however, to see Ireland as a completely liberal country. Many young people still feel embarrassed about being seen to buy or carry condoms and many remain highly discomforted

about talking about sex with their parents (Ferguson and Hogan 2007). A sexual double standard still exists within Ireland, with women being more likely than men to be labelled for having multiple sexual partners (Inglis 2002). Additionally, the new secular moral framework based around personal choice and responsibility that has developed around sexuality could lead to individuals who transgress this framework (for example by engaging in risky sexual activities) to be stigmatised for being careless and irresponsible (Inglis 1998). 200

Method 205

This study was part of a larger project to develop and pilot a national opportunistic screening service for Chlamydia.¹ The aim of this study was to explore barriers and enablers to Chlamydia testing from young adults' perspectives and to use this information to tailor screening services and make them acceptable and accessible to young people. For example, if young people cited systems barriers, such as the opening times of General Practitioner (GP) clinics, as an important obstacle, we could propose offering screening tests in the evenings or at weekends. Given the lack of previous studies and the lack of hypotheses to test quantitatively, a qualitative approach was utilised to explore and identify young people's perspectives on enablers and barriers to Chlamydia screening. In order to investigate young people's experiences in adequate depth, semi-structured interviews were used. 210 215

We recruited young adults from six GP (primary care) settings and two family planning clinics: two GP and one clinic in Dublin, the capital city of Ireland, and four GP (two urban and one rural) and one clinic in Galway in the west of the country. These settings and the young people attending them (for other services) were selected as typical of settings and target group that would be offered opportunistic screening if it was introduced in Ireland. Understanding their perspectives was a priority. Young women were eligible to take part in this study if they were 18–29 years of age and had attended a community healthcare setting in the past year. As it turned out, no respondent recruited for this sub-study had ever previously attended a health service for an STI test of any sort. Thirty-five young women were interviewed, including at least three respondents from each of the identified settings. Respondents who took part in the study were provided with a €30 (c. US\$40) gift token to compensate them for their time. 220 225

The first named author, a PhD sociologist specialising in interview methods, carried out 30 of the interviews. The PhD sociologist (who was male) received training in interviewing women about sexual health matters. Five interviews were carried out by public health specialists who received training in conducting qualitative interviews. Nineteen interviews were carried out in person and 16 were carried out over the telephone. Interviews lasted an average of one hour. A non-directive approach was used to allow respondents to shape their own accounts. Interview questions examined: why respondents had not sought STI testing; who they considered likely to contract STIs such as Chlamydia; and what images and connotations Chlamydia had for them. Interviewing continued until we deemed data saturation to have been reached. 230 235 240

Interviews were fully transcribed and data were thematically analysed. Significant key words, phrases and themes were labelled with summary words or codes for subsequent analysis. All codes that were thematically similar were grouped together, and labelled with a summary code, called a category. By categorising codes and

grouping them together it was possible to see how different codes in the same category related to each other. As categories were developed we began to develop an explanatory framework that could be used to explain how different categories related to each other. This framework was based around Goffman's (1963) work on stigma. Goffman's approach fitted our data well because stigma was a term that respondents consistently and explicitly referred to in their interviews, and because the international literature on STIs noted that stigma is a significant barrier to STI testing. The concept therefore had internal validity (from respondents' accounts) and external validity (from the international literature), and it had strong explanatory potential.

Findings

The unreality of Chlamydia and STIs

Respondents (recruited from a number of different healthcare settings: student health, family planning, rural and urban GPs from different regions of Ireland) described occasionally engaging in (or having engaged in the past) activities that we considered to be medically risky (in that these activities could theoretically increase the likelihood of STIs being transmitted to or by during sexual intercourse). Typically, these included respondents having sex while they were drunk, having one-night stands or having sex without using condoms. Risky sexual activities also included having sex with partners whose past sexual history respondents were doubtful or uncertain about:

When I was in college I had a one night stand with a guy and we didn't use a condom (Late 20s, rural GP).

I used condoms on and off with my boyfriend. I was on the pill so we weren't using condoms all the time. It was kind of always our intention to do so but it doesn't always work out like that (Early 20s, urban GP).

I was thinking that obviously there had been times where I wasn't 100% careful and I try to be as much as possible, but I suppose over the years when you're in college there may have been times where you didn't use condoms and stuff like that (Late 20s, rural GP).

Most respondents considered these practices to be somewhat risky, though not very much so. Several factors reduced respondents' perceptions of the riskiness of their practices; the fact that they only occasionally engaged (or had engaged) in these activities; the fact that they trusted their sexual partner(s); and the fact that neither they nor their partners displayed signs or symptoms of disease:

I don't think when it's [unprotected sex] only been with one other partner it's that bad (Early 20s, urban GP).

I would have talked to him about his previous partners and he knew all of his partners. His previous partners were long term, they weren't one night stands (Early 20s, urban GP).

Despite the fact that many respondents had had unprotected sex at some point in their lives, none of the women who took part in the study had ever previously attended a health service for Chlamydia testing, or indeed STI testing of any kind. Why was this? There were a number of reasons. STIs such as Chlamydia were 'unreal presences' for many respondents. Though they knew that they could (theoretically)

contract Chlamydia, they did not see themselves as being ‘at risk’; consequently they did not go for testing. There was an underlying sense of disbelief in their accounts that they could or would contract an STI:

Myself I wouldn’t think I am at risk at all (Early 20s, urban GP).

I’m probably fine (Late 20s, rural GP).

A number of factors contributed to this feeling of unreality. As noted, respondents did not indicate to us that they had ever experienced any symptoms that might lead them to believe that they could have an STI (though discussions with interviewees revealed that most of them knew that STIs were often symptomless):

I think people have it in their heads that they don’t have anything. They like to think that they’re not diseased! Because of the fact that there’s no symptoms for a lot of them they wouldn’t think that they had it in the first place because they don’t have any symptoms (Late teens, urban GP).

Another was that respondents had a general sense of ‘personal specialness’, a feeling that they could be hurt neither by disease nor injury. Respondents constructed what Giddens (1991) refers to as ‘protective cocoons’ around themselves; psychological filters that screened threatening events and risks from their awareness (such as the possibility that they could acquire Chlamydia):

You never think it’s going to happen to you (Late teens, urban GP).

Respondent: I never believe it could happen to me and that’s a bit ridiculous. I’m no more special than anybody else. It could happen to me as easy as anybody else.

Interviewer: But you don’t believe that?

Respondent: No (laughs) (Late 20s, rural GP).

A third factor was the relative insubstantiality of Chlamydia in their lives as compared with other sexual risks. Pregnancy was respondents’ principle concern. Pregnancy’s imaginative dominance stemmed from several factors: parents and educators inculcated the consequences of pregnancy in respondents at an early age, whereas STIs were glossed over. Pregnancy was a visible presence and talked about in respondents’ social networks whereas STIs were closeted. Respondents could empathise with young people who were pregnant, in the sense that they could imagine themselves in their situation. They had trouble empathising with individuals with STIs:

Pregnancy is more real. Young people see it more often. You can literally see it with their friends and things like that. STIs are something so hidden (Early 20s, urban GP).

I never thought about Chlamydia all. Never. It was always pregnancy you were thinking of. Nothing else (Late 20s, urban GP).

Who gets Chlamydia?

The principle reason, however, why respondents did not feel that they were at risk for acquiring Chlamydia was that they felt that it was mainly ‘other’ people who contracted STIs. Who precisely these ‘others’ were varied between respondents. Some felt that ‘others’ were other students, some that all teenagers constituted ‘others’; but they had a number of common features. ‘Others’ were seen as being

highly sexual and as being willing to have sex with multiple partners in a short space of time. They were needlessly risky, in that they were willing to have unprotected sex with strangers. They showed consistently poor judgment with regards to sexual partners. Some respondents used pejorative terms such as 'slut' and 'skank' to label these individuals, though such terms were more often used by young women who came from lower socio-economic areas. Individuals with STIs were viewed as being members of a tainted and inferior category (all the worse because those who acquired an STI were often seen to have voluntarily placed themselves in this category through their own careless, risky actions). They were discredited in respondents' eyes:

Interviewer: So can you tell me who gets Chlamydia?

Respondent: I suppose somebody who goes out on a Saturday night looking for a one night stand. I don't know. Somebody who's constantly changing sexual partners. Sleeping around basically. Someone who has no qualms about sleeping with someone, leaving the next morning and never seeing them again (Late 20s, rural GP).

Respondents interpreted their own practices and identities in a more positive light. Respondents stressed that they were risk-avoiding individuals who did not regularly engage in promiscuous behaviours. Though (as noted) there were times when respondents themselves engaged in (what we considered to be) risky sexual activities, these activities were seen as momentary aberrations rather than symptoms of a defective character. These activities did not coalesce to form stable patterns of immoral activity. Furthermore (with the exceptions of the few respondents who had had one-night stands), respondents stressed that they when they did engage in 'risky' activities (such as not using condoms) they usually did so in the context of fairly stable, monogamous relationships where they 'knew' their partner (were able to accurately assess their partner's risk and moral status):

I'm in a stable relationship now so I'm not at risk for getting anything like Chlamydia (Late 20s, rural GP).

Respondents stressed that they were fundamentally 'good' people, seeing themselves as (what we termed) 'responsible moral agents' or 'normals'. Their framing of their own practices drew on understandings that in contemporary Western societies 'good' individuals avoid unnecessary risks (Lupton and Tulloch 2002), and that 'good girls' (Braun and Gavey 1999) are not excessively sexual outside of stable relationships (i.e. they do not continually sleep around):

I suppose [people who need to go for testing] probably aren't respecting themselves and their partners if they do have to take the test. It's just a moral issue (Mid 20s, urban GP).

Well I think that I personally wouldn't be promiscuous at all so I wouldn't feel like I was high risk and wouldn't need to go for a test. I think if other people are promiscuous or have many partners they should definitely go all the time (Late teens, urban GP).

Respondents therefore disidentified from people with STIs and STI testing. This refusal to identify with individuals who had STIs had positive implications for respondents' identities. Said (1995) notes that this process is not merely the result of one identity seeking to reject an 'Other'. Rather refusal to identify with 'Others' is essential to the very process of identity construction. Who the individual sees him or herself to be is very much dependent upon who they define themselves not to be:

I don't hang around with young women who sleep around. They'll get off [initiate contact with a person of the opposite sex with an intention of having some intimate contact] with anyone. Which is why I try and stay away from it as much as possible (Late teens, urban GP).

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Disidentification was often couched in negative emotional terms. As 'Others', STI testers violated the norms of being and identity to which respondents ascribed. They were not 'good girls'. They were dirty; consequently their moral and physical filthiness triggered disgust and loathing in respondents. Such negative emotional reactions had positive categorising effects, however, in that they forcibly differentiated these respondents from STIs and those would attend for STI testing, drawing a line between morality and cleanliness and immorality and degradation:

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There's a guy in our circle of friends got crabs and everybody knew about it. It was kind of like a joke, oh don't touch him he has crabs. I don't know how to describe it. I couldn't imagine being like that. If I had crabs I would be sick, physically sick. The thoughts of it makes me sick. If I had a disease like that on my body, it's disgusting (Late 20s, rural GP).

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STI testing and consequences for identity

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Respondents saw Chlamydia and STIs as being 'Other' people's problem. 'Others' were viewed as disgusting promiscuous risk-takers. In contrast, respondents saw themselves as being risk-averse moral actors. In effect, respondents placed themselves in a normal risk-free category, and people with Chlamydia in another discredited risky one.

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These categories were not immutable, however. Respondents felt that it would be possible to slip between categories, the consequences of which could be damaging. A normal identity could become a 'dirty' identity. Slippage could occur by engaging in the constitutive identity practices of the Other category, which *included* going for a Chlamydia test. Going for a Chlamydia test would therefore be a risky identity practice, even if this test was being taken for peace of mind:

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There is a risk of going for a test. There's a big risk of it. You're afraid to be called a slut or a slag for going for an STI test, even if you were just doing it for a check up (Late 20s, urban Family Planning).

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I guess going for a test ... people think it says something about who they are. You're easy or just not careful. It's irresponsible. Even though it's accidental. It just says you're promiscuous (Late teens, urban Family Planning).

Embarrassment was an important feature in respondents' narratives. Respondents expressed fears that the figures that they cut before clinical and non-clinical audiences would be spoiled if they were to attend a health setting for STI testing, which could lead others to form an undesirable impression of them, or judge them inadequate:

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It's [STI testing] still a very private issue and you'd be afraid you'd even know a nurse in there [STI clinic]. You'd be embarrassed (Mid-20s, rural GP).

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The risks of Chlamydia testing were perceived to be particularly acute for women. Respondents felt that Chlamydia testing risked hurting women's identities more than it would men's identities. Many of the pejorative labels that some respondents used to refer to STI testers have no direct male equivalent. Males were seen by females as

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able to distance themselves more effectively from STI-related stigma because of sexual double standards (women being expected to be less sexual than men):

445 More-so with girls than with boys there might be a perception that you're dirty or something. They just don't want to let people know they've been sleeping around or they might have something. It's just STIs have this perception of being a dirty thing to have (Early 20s, Dublin).

450 For females more-so it would effect their reputation. More people putting them in a class, she's dirty. Whereas if somebody said that to a fella he'd probably just laugh at them and tell them to piss off (Early 20s, Dublin).

455 There was some evidence (albeit coming from a minority of respondents) that testing positive for an STI like Chlamydia might not automatically discredit a young woman's identity *if* her previous activities had shown her to be a 'good girl' (a risk avoiding, moral actor). If she was a typical 'Other', if she regularly engaged in risky sexual activities, however, then her identity would be devalued. In the following narrative it is interesting to note how few partners a woman would need to have to have to claim a good girl identity and avoid being discredited in the face of a positive Chlamydia test:

460 Interviewer: So if a girl came back positive for something like Chlamydia would that put her in [a negative] category straight away?

465 Respondent: It depends if she was known for sleeping around. If she only had one or two partners and got Chlamydia people might feel sorry for her more than anything. But if she was sleeping around people would be like, oh she was going to get that anyway (Mid-20s, urban GP).

Respondent heterogeneity

470 While sharing similar concerns, it is important to note that female respondents were not homogeneous. Identity concerns about Chlamydia testing were strong amongst female respondents from rural backgrounds recruited from GP practices and relatively weaker amongst college educated respondents recruited from urban family planning clinics in Dublin. Traditionalist Catholic sexual moral discourses may be stronger in rural areas than urban locations. It may also be that respondents from rural areas have less anonymity and privacy relative to their urban counterparts and experience more community surveillance of their sexual and health and service seeking practices. As such they may be more conscious of the risk of engaging in discrediting practices such as going for Chlamydia testing:

480 I know I'm from down the country and there'd be holy war with something like that [being known to go for STI test]. You know small communities. Because everyone knows everyone. Again it does conjure up images of promiscuity and being stupid as well (Early 20s, urban GP).

485 For some girls [stigma] probably would be [a concern]. It depends on how comfortable you are with your sexual activity. I wouldn't mind (Late teens, urban GP).

Respondents from working class backgrounds also had stronger anxieties about STI testing than respondents from more middle class, affluent areas:

It [Chlamydia test] would make you feel like a dirty bitch (laughs) (Late 20s, urban GP).

Skeggs (1997, p. 74) notes that young women from working class backgrounds are often represented by the media and by individuals from other class backgrounds as being profligately sexual, as in the phrase: ‘the tart is the sign of the working class woman’. Women from lower socio-economic backgrounds, who get positioned outside the norms of niceness, struggle continuously against this positioning. Skeggs argues that that they are locked in a constant battle to be seen and acknowledged by others as being respectable. Chlamydia testing would disrupt this process, tying working class respondents’ identities to sex, signifying to themselves and other that they were ‘sluts’, no matter what their efforts were to the contrary. Avoiding testing, therefore, though a risky strategy from a medical perspective, would be a respect-producing strategy, a means of maintaining identification with a desired subject position.

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Marginalisation

Respondents believed that, once an individual’s identity had been contaminated by STI stigma, the social consequences could potentially be severe. The individual’s social status would be degraded and they would be forced down the social hierarchy:

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People won’t respect you as much. I think your reputation would be damaged (Late teens, urban GP).

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This would expose the individual to the marginalising and exclusionary practices of normals. In effect, it would open the individual to the risk of experiencing systematic bullying and intimidation:

Respondent: Even if you hear about someone who has an STI, the first thing that comes into your mind is that they’re sleeping around even if they’re not like.

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Interviewer: Yeah?

R: So just to have understanding people and that’s it really.

I: What would actually happen around here if somebody actually had a reputation for sleeping around?

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R: It would be wrote on toilet doors, people giving out their phone numbers and if they had a Bebo² site. Like, you’d often see it on a Bebo site people texting and calling them names and stuff and saying well this one’s been with that one and she’s been with him and him and they’d name them.

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I: Really.

R: Yeah.

I: Has this ever happened in the past?

R: Yeah. Only last week like I was in the pub across the road and there was girls names all wrote on the doors calling names and saying they’d been with so and so and writing their phone numbers all over the door (Mid 20s, urban GP).

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Never identities

Because of the perceived material and identity risks of STI testing, it is perhaps unsurprising that respondents had not attended a health service for Chlamydia testing:

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I think a lot of people won’t think about testing because it is horrific. I’m not going to think about that. There’s no point because I don’t have an STI. I have had unprotected

sex in the past although I've been careful, well that's not being careful obviously but like I haven't had many partners and I'd know people first. I could have exposed myself to an STI but I just wouldn't do it [test] (Late 20s, rural GP).

It is clear that not seeing themselves at risk, or seeing themselves as at risk but still refusing to undergo an STI test, had positive effects for respondents. Mullaney (2001) notes that just as the behaviours that individuals engage in are central to identity construction, so also are the actions that individuals do not engage in. The absence of action says something about whom the individual think he or she is and about the social cosmology that he or she operates within. Mullaney refers to identities constructed through avoidance as 'never identities'. Respondents' refusal to undergo testing enabled them to construct 'never gender identities' as normal, respectable young people. Not testing allowed respondents to be 'good girls' rather than 'dirty girls'. Avoiding testing was therefore a more positive than negative act for their identities.

Context

We asked respondents how they believed their feelings about STIs and STI testing had developed. Respondents made reference to the traditional Catholic conservatism of Ireland. Frequent and emotionally charged references were also made to respondents' parents and to family backgrounds. Older adults had a powerful imaginary, judgmental presence in respondents' accounts, including among older respondents who were in their late twenties:

I look at my parents or in-laws and I just know they'd be horrified if they knew I went for an STI test or my younger brothers. They just don't want to think about younger people having sex. So if you had gone for an STI test obviously you're saying you're sexually active and I think a lot of people wouldn't want the older generation to know about that (Late 20s, rural GP).

My mother always said when I was growing up, respect your body. Don't show your body off in an inappropriate way, don't go to mass in a short skirt or low top. A lot of people first impressions is what they see obviously. And they get this, 'oh she's that kind of girl' if they think you're sleeping around or especially if you've had to go for an STI test (Mid-20s, rural GP).

Furthermore, as can be seen in many of these narratives, respondents also often interpreted STIs as much in terms of risk as morality. For example, rather than condemning STI testers for engaging in the 'wrong' practice (a moral accusation) respondents frequently accused testers of not taking personal responsibility for their health, of not engaging in the individualised risk reducing practices of late modernity (Giddens 1991). It may well be that Catholic moral discourses continue to underpin the schema through which young people interpret STIs, though the vocabulary that young people use to express their feelings about STIs has changed. From the data acquired by this study, however, it seems that both religious-moral *and* secular-risk frameworks are influencing young women's attitudes towards STIs and Chlamydia testing, with the negative and positive dimensions of each framework (responsible/moral, irresponsible/immoral) being mapped onto each other and equated with the two key subjectivities produced by and involved with Chlamydia testing: the good girl and the bad girl, respectively.

Infrastructure

From the interviews that we conducted it appears to us that identity concerns (stigma, embarrassment, respondents seeing themselves as the types of people who were at risk of contracting Chlamydia) were the main factors influencing respondents' decisions not to seek STI testing. Infrastructural factors (cost/location/opening hours of STI testing services) also occupied places in some respondents' accounts, however. Several respondents indicated that on occasions after they had engaged in risky sexual activities they had thought more concretely about the practicalities of going for STI testing. However the perceived inflexibility and inconvenience of the public STI testing system in Ireland, and the cost of the private system, in the absence of STI related symptoms, put these respondents off following through on their desire to go for testing. We hypothesise that infrastructural factors were less important in respondents' accounts as a whole because respondents closed off the idea of STI testing before they needed to think about the practicalities of where they would go for testing, who would test them and so on:

I thought I should go and get checked out and then you just kind of put it to the back of your mind and think oh I'll do it sometime but I'd tried making an appointment before in the Hospital and they said the waiting list was really really long. I think it was a few months you had to wait and I think something had come up in the meantime and I couldn't actually make the appointment so I just cancelled it (Late 20s, urban GP).

Discussion

Limitations of the study include the fact that we did not capture the experiences of men between 18 and 29 years of age, or the attitudes of women under 18 years of age, both of whom are groups who themselves are at a high risk for contracting Chlamydia. Standard provisos about the representativeness and generalisability of qualitative findings apply. Another limitation of the study is that we only examined the attitudes of young women who were already attending health services; the attitudes of young women who do not regularly attend health services may be different from those presented here.

The purpose of this paper was to explore why young women in Ireland do not attend health services for Chlamydia testing. Malta *et al.* (2007) note the importance of identifying barriers to STI-related care of the sort noted in this paper. As far as we are aware this is the first study to address this topic in Ireland; it is also one of the few international studies to address this topic by recruiting young adults from a variety of community healthcare settings, rather than from STI clinics, thus including settings that might be used in a national STI screening programme (Chacko *et al.* 2004, Goldenberg *et al.* 2008).

Our findings support previous work that has been conducted with young adults who have been offered Chlamydia screening. These studies found that young adults often do not see themselves as being at risk for developing STI's like Chlamydia (Santer *et al.* 2003), and have strong concerns about the risks that STI screening could pose for their identities (Scoular *et al.* 2001, Mills *et al.* 2006). Our study builds on and qualifies previous work in three ways, however. First, it highlights the positive role that engaging in medically risky practices (such as *not* going for STI testing) can have for young women's identities. Previous research on health risk

supports this finding (Mitchell *et al.* 2001). Berg *et al.* (2004) for example found that young women expose themselves to the risks of tanning so as to develop 'normal' identities and Balfe (2007) found that young adults with diabetes often engage in risky alcohol consumption practices in order to develop identities as normal students. This research demonstrates that what may seem to be an irrationally risky (in the sense of hazardous) practice out of context may actually (or at least, also) have a productive and positive subject-producing effect (Balfe 2007). Risky acts enable individuals to claim particular identity rights (Jones and Candlin 2003). It is important to note, however, that while these young women may have been engaging in what could be conceptualised as medically risky activities, they often saw themselves as attempting to avoid risk (albeit identity risk).

② Second, our study highlights the diversity that exists between young women, that young women are not homogeneous in terms of their attitudes towards the perceived risks of STI testing. We found that, although Chlamydia related stigma was a concern for many of our respondents, young women from rural and lower socio-economic backgrounds often felt that Chlamydia testing posed a greater identity risk than highly educated urban respondents who were recruited from family planning clinics. In 2010 we will be conducting a national questionnaire survey with young adults in Ireland exploring their Chlamydia screening location preferences and their feelings about Chlamydia screening. This will enable us to quantify the regional differences reported here and examine if they are statistically significant in a national sample.

Third, our study highlights that young women's feelings about Chlamydia-related stigma and risks develop and operate in particular social and cultural milieus. Young women in our study made reference to Ireland's Catholic past when discussing their feelings about STI testing. It was more unexpected to note, however, the role of family, particularly parental, influences on young women's attitudes. It was also interesting to note the frequency with which respondents interpreted STIs in terms of a secular risk framework rather than a religious-moral framework (as evidenced by their associations of STIs with personal irresponsibility, for example). As we noted, we believe that risk and religious frameworks are operating simultaneously to influence young women's attitudes towards STI testing.

Previous qualitative research on young women's attitudes towards Chlamydia screening supports the findings of this study. This research (mainly conducted with young women in United States and the United Kingdom; Pavlin *et al.* 2006) has found that many young women do not see themselves at risk for contracting Chlamydia, for reasons similar to the ones reported here: thinking that partners can be trusted because they are 'known' (though the definition of known can vary considerably, partners may sometimes be known for only a few hours) (Pavlin *et al.* 2006); feeling invulnerable to infection because of assumptions that only promiscuous individuals can contract STIs (Duncan *et al.* 2001, Mills *et al.* 2006); absence of symptoms and only 'occasionally' engaging in medically risky sexual activities (Santer *et al.* 2003, Chacko *et al.* 2004); and seeing themselves as being in monogamous, stable relationships (Lorimer *et al.* 2008). Reasons why young women do not see themselves at risk that are identified by this study, but are less often mentioned in the international literature on Chlamydia testing, include feelings of personal specialness and invulnerability to risk, and being primarily concerned about pregnancy.

Stigma has also been identified in the Chlamydia literature as a key influence on young women's test-seeking behaviours (Duncan *et al.* 2001, Chacko *et al.* 2004,

Mills *et al.* 2006, Pavlin *et al.* 2006, 2008). The international research here has mainly concentrated on the negative aspects of stigma as a barrier to care. The findings of this study are, we believe, the first in the literature on Chlamydia testing to stress the positive effects that Chlamydia related stigma can have for the identities of young women who do not seek testing. In this study, stigma was not simply a barrier that prevented respondents from testing; it was also a means through which they differentiated their selves and their practices from disgusting, dirty Others. 690

One point worth considering when examining the data presented in this paper is the interaction between interviewer and interviewee. Researchers (Riessman 2002) have noted that during interviews respondents often attempt to present positive images of themselves to interviewers, a process that Riessman calls 'performing a preferred self'. Respondents may avoid providing interviewers with information that they think would portray them in a negative light. This may have been a factor, for example, when we explored respondents' past sexual practices. The stress that respondents placed upon the moral aspects of their practices (stressing that unprotected sex with known partners was not 'that bad') or emphasising that they had had sex with partners who were not one-night stands might have been an attempt by respondents to construct or present themselves (and their sexual practices) to the interviewer as individuals who were engaged in appropriate, rational and justifiable sexual health practices in the face of a perceived 'threat' to the contrary (the interviewer's questions). Respondents may therefore have tailored their answers to present a positive image of themselves to the interviewer. They might, for example, have downplayed the 'riskiness' of their sexual practices, or the numbers of their previous sexual partners. Along these lines, and though not an issue explored in this paper, a review of our field notes reveals that some respondents indicated to the interviewer after their interview was over that they would seek testing in the future, despite having spent much of their interview associating testing activities with stigma and 'Others'. We believe that these statements were attempts by respondents to present themselves in positive lights to us, to stress to us (healthcare professionals) that they were risk-avoiding responsible citizens who took care of their health. In general, however, we believe that while respondents may have been putting on a front to some degree, or at least downplaying the extent of some their activities, the attitudes reported here probably correspond fairly accurately to their true attitudes about STI testing; similar findings have been reported in a number of studies across a number of countries giving the results strong external validity. 700 705 710 715 720

As noted, this study is part of a wider project that is seeking to develop a national Chlamydia screening pilot service in Ireland. The findings of this paper confirm the importance of undertaking initial qualitative research as a prelude to the design of a pilot STI screening service, so as to understand more clearly the attitudes of young people and how they might respond to such a service. It is not sufficient for health policy makers, managers and practitioners to take an exclusively health service and system's perspective in designing and rolling out sexual health services. An exclusive focus on how to maximise availability and accessibility, while neglecting the need for some degree of social engineering (or at least concurrent attention to these social and societal dimensions) so as reduce the negative connotations that many young adults associate with STI testing, is likely to fail. Our findings suggest that if Chlamydia screening is to be rolled out nationally in Ireland clinicians and policy-makers will need to emphasise: that young women can be at risk for Chlamydia even if they feel 725 730

they know and trust their partners and display no symptoms of infection; and that Chlamydia testing is a ‘good’, ‘cleansing’ and responsible activity that many young women engage in for health-promoting reasons (i.e. stressing the moral and normative dimensions of testing).

The study recruited respondents from only two types of primary care centres (GPs and family planning clinics) and from only two regions of the country. It is possible that young women attending other settings and from different regions of Ireland may have reported some different or additional reasons for not going for testing. Supporting the representativeness and importance of our findings are similar findings in young women in the UK, suggesting that the attitudes may be quite widespread, or at least in similar developed countries (Duncan *et al.* 2001). The consistency of responses across the sample and in particular settings support the view that responses were reflecting and providing insight into more widely held views among young women in Ireland. We also believe that future studies will need to interview groups of young men. By focusing exclusively on young women we risk missing the perspectives of a group that is equally involved in the transmission and acquisition of Chlamydia infection.

Conclusions

The findings presented here suggest that young women are reluctant to attend health services for STI testing because they do not feel that they are at risk of contracting STIs, and because of the stigma that they associate with STI testing services. The paper adds to our understanding of stigma by highlighting the productive psychological and social effects and benefits that young people can obtain by not seeking care. These findings need to be factored into the design and delivery of health services and programmes. Efforts and resources that go into establishing pilot STI screening services which do not take into account and address these factors may be not be as successful as they would wish to be.

Future research should investigate the reasons why young men (between 18 and 29 years of age) do not go for STI testing, and the reasons why young women under 18 years of age do not do so (though there might be ethical issues around accessing juvenile populations). It would be helpful if future research on this topic with young women between 18 and 29 years of age focuses on discrete sub-groups of young women, such as young women from working-class or middle-class backgrounds. This will enable us to build up a more comprehensive picture of young women’s attitudes towards STI testing, and will help us to determine whether or not the limited resources that are available to change and address behaviours that may result in poor health could best be targeted at particular groups of young women, i.e. those that are most concerned about STI testing.

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Notes

1. There are two types of population screening: systematic screening, where every member of a given population is invited to come forward for testing; and opportunistic screening, where a doctor or other health worker offers members of a population a test while they are attending a health service for a matter unrelated to the test. Ireland lacks unique patient-identifiers that could be used to identify and invite entire populations to come forward for systematic screening. Therefore opportunistic screening was deemed to be the most feasible approach to test in this country.
2. Bebo is a social networking website on the Internet.

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