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"One-night stands" – risky trips between lust and trust: qualitative interviews with *Chlamydia trachomatis* infected youth in north Sweden

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Aim: The aim of the study was to get a deeper understanding of sexual risk-taking, by interviewing young people diagnosed with *Chlamydia trachomatis*. *Method*: This qualitative study was conducted at a youth clinic in Umeå, Sweden. Five young women and four men, aged 18–22, participated. In-depth interviews were performed. Open questions around certain themes were posed, such as thoughts about getting CT, sexual encounters, and attitudes towards condoms. Interviews were tape-recorded and transcribed verbatim. Data were analysed according to grounded theory. Norms, events, and emotions were explored. The goal was to develop credible and applicable concepts concerning sexual relationships, risk-taking, and experiences of CT. *Results*: Informants revealed that behind their sexual risk-taking was a drive to "go steady". Lust and trust were the guidelines if sex was going to take place. When discussing "one-night stands" gender stereotypes occurred. Females were expected to be less forward compared with males. We found an uneven distribution of responsibility concerning condoms. Males expected females to be "condom promoters". By catching CT, females experienced guilt, while males felt content through knowing "the source of contamination". *Conclusion*: An important public health issue is to implement how males should play an equal part in reproductive health. General CT screening of males is one suggestion.

Key words: Public health, qualitative interviews, Chlamydia Trachomatis, youth, sexual risk-taking, gender.

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BACKGROUND

Scandinavia is known for its liberal attitude towards sexuality. Love and intimacy between young people are discussed openly, and mostly accepted (1). In Sweden, sexual intercourse before marriage is common (2). Social tolerance has also been concerned with responsibility for the sexual health of young people. Sex education has been mandatory in schools since the mid-1950s and during recent decades youth clinics have been established, with the aim of giving young people a balanced and positive view of sexuality, including respect, responsibility, and gender equality (3).

Public health strategies to improve sexual health are cost-free programmes for treatment of sexually transmitted diseases (STD), partner notification (4), and *Chlamydia trachomatis* (CT) screening among females (5).

Despite social intentions and good knowledge among adolescents, there are still problems. The annual prevalence of CT among an examined population in Sweden (300–400,000 persons) ranges between 4% and 5%, with the highest prevalence among females (6). This makes CT the most common, curable STD in the Western world. Left untreated, CT can lead to serious ill health: salpingitis, epididymitis, infertility and arthritis (7). A review of youth and sexuality in Sweden indicates that CT is increasing among adolescents (8). This may relate to more rigorous testing, or changed sexual behaviour.

Youth is a period of identity formation, exploring freedom, and testing limits. This includes sexual activities and thereby risk exposure (9). An early sexual intercourse debut, multiple sexual partners and inconsistent condom use are associated with STD. Social context-bound factors related to sexual risk behaviour are smoking, alcohol habits (10–12), deviant peers, poor parental monitoring, or coercive parent–child interaction (13). Qualitative studies show that trust and commitment in relationships (14) are essential

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emotions involved in sexual risk behaviour, as well as the assumption that risks diminish when you know, like, or love the partner (9, 15–17).

AIM

The aim of this study was to get a deeper understanding of sexual risk-taking, by interviewing young people diagnosed with CT who were willing to share their personal experiences. We have explored and analysed from a gender perspective, the course of events, the norms, considerations, and emotions involved.

METHOD

To explore the phenomenon of sexual risk behaviour a qualitative approach was appropriate. Data were collected using in-depth interviews with few but well-penetrated cases. The analysis proceeded according to grounded theory (18), and precautions to enhance trustworthiness were included (19).

Setting

The study was performed at the youth clinic in Umeå, a university town with approximately 100,000 inhabitants, in the northern part of Sweden. CT testing and partner tracing are carried out at the clinic. Around 50 cases of CT are discovered yearly. One researcher (MC) worked at the clinic as a midwife.

Sampling of informants

During 1996, young people who currently were diagnosed and were being treated for CT were asked to participate. They received written and verbal information about the study.

Five young women and four men age 18–22 participated. Eight of them had met MC when coming for CT testing and/or treatment; one was recruited by another midwife. A 16-year-old boy was recruited, but cancelled because his mother disapproved. Five additional persons were asked to participate by other midwives. Three refrained and two never came to the agreed interview.

The informants lived in Umeå. Four of them were in senior high school. Five had finished senior high school. Four of these were working and one was unemployed. Seven of them were raised by both biological parents while two were raised by single mothers. Five informants had stable relationships and four were single at the time of the interview. Four of the females used oral contraceptives. Two females attended the clinic for partner notification while three came for a routine check-up. All the males came as part of partner notification. Their sexual orientation was heterosexual. Age at first sexual intercourse varied from 14 to 20.

The interviews

Interviews were carried out at the youth clinic and lasted from one to two hours. Open questions around certain themes were posed, such as thoughts about getting CT, sexual encounters, and attitudes towards condoms. The interviews were tape-recorded and transcribed verbatim by MC.

Data analysis

Interviews were read line by line, and the text was broken down into parts. Each part was given a name (open coding), using concrete words that described an event, experience, or emotion (18). Open codes were sorted, interrelated, and grouped to build categories. In the axial coding, categories relating to consequences or conditions, when acting in certain ways, were integrated. The goal was to develop credible and applicable concepts concerning sexual relationships, risk-taking and experiences of CT.

One year later, each informant was invited to discuss the preliminary analysis. Six of the informants participated, one girl and one boy refrained, and one telephone follow-up was carried out. The informants corrected or confirmed concepts and interpretations, and talked about their present life situation. Notes were taken and included in the final analysis, enhancing the validity of findings.

The Medical Ethical Research Committee of Umeå University approved the study.

RESULTS

What did these young people say about their experiences regarding partner-seeking and risk-taking? The findings are presented as a story line. It begins with the presumptions for and context of the ''accidental meeting'', why and how it happened, and then the aftermath. Each subheading corresponds to concepts emanating from the coding of the material, illustrating the course of events from the informants' perspective.

To have a relationship

Informants identified themselves as ordinary people and their ideals as universal. An essential drive in their behaviour was to find a partner. Although it was contradictory, the salient motive for one-night stands was to go steady, and the motive for sexual risk-taking was that you must rely on your feeling/intuition (have trust). The first contact could be the starting point of

a steady relationship, which in turn was a premise for many desirable achievements: to be confirmed, feel confident, and give and receive love.

The informants described what partnership could imply, such as sleeping and waking up together, the special eye contact from the partner as a gesture of appreciation, and togetherness:

A long relationship that makes you feel secure. Yes, I'm sure that I love her and I know that she loves me . . . I think that's the best, when you come that close. She is my best friend. (Boy 21 years)

The accidental meeting

Intimate relationships always have a prelude. For the informants a discotheque or pub was often the arena of the first passes, but they denied that "going out" was part of a dating strategy. Instead they emphasized that the purpose was to meet friends, dance, drink, and have fun. They "never planned" to take someone home, or to have sex. By scrutinizing this unintentional coincidence, strategies to help fate were revealed.

Different tactics were used. Both males and females described allowing a presumptive partner to be the initiator, or using more active ways to get in contact:

It could be that you had seen somebody downtown, had been checking him out, found him cute, made eye contact with him, and then he is there when you are out. I don't have to drink alcohol to be able to walk up to a table, or to somebody, it's the atmosphere. You walk up to him; maybe you flirt with him, take a look at him, sit down and talk. (Girl 19 years)

She described how she proceeded to find out whether this boy was someone to rely on, by letting her feelings guide her. If it was nice to talk, laugh, and they had things in common, she felt secure. If her intuition told her that he was not interested, she made a fast subtle exit. One male described himself as the initiator of all his relationships, and that was the way he wanted it to be. When he was interested, he tried to call the girl's attention towards him, by flirting and making the first move. Although the young men and women had contact-seeking manners in common, they were all aware of accepted gender roles. Boys were expected to be "in charge", to "take chances", and to "sleep around", girls to be glad, interested, and attentive, but not too assertive.

It's the guy who should initiate the flirt, and girls might be regarded as promiscuous if they have similar manners. For me, I don't know. I am flattered if a girl is the initiator, but it will not end up in a stable relationship. (Boy 18)

Girls too initiated contacts, or "they each went halfway". For many this was considered okay, but the undertone was that girls behaving in that way invited casual sex. One male described an episode when a girl walked up to him and kissed him, without saying a single word. He did not disapprove, but it made him hesitate:

If I noticed or realized that something was going on . . . It would make me more reserved. I would wait a while before dating . . . (Boy 21)

Although the informants denied intentions to date, by going out they entered arenas that supplied pathways to intimate relationships. Boys and girls searched for confirmation in close relationships, but there were gender-specific patterns for what action was suitable.

Prerequisites for sex: lust and trust

In the end two feelings provided the main impact as to whether the accidental meeting would continue or not: lust and trust. The informants navigated intuitively on the basis of these feelings. A good indicator for an aftermath was "the kiss", another was unanimity in reasoning.

There was this girl. When kissing . . . all of a sudden it felt wrong . . . I thought . . . this is all wrong. Wrong perfume, wrong clothes, everything. (Boy 20)
You don't go home with a guy just because he is hot . . . a lot depends on his views and opinions on different things. (Girl 18)

Informants described how the aftermath could be "a cup of tea", "one-night stands", or the "beginning of a relationship". Love and sex were considered closely connected in stable relationships, but sex in itself could also be appropriate.

Lust, "feelings for the person", was important for intimacy. Most females did not desire sexual intercourse on the first date. They preferred small talk, and enjoyed fondling, which gave them equal or more satisfaction compared with penetration.

For girls it is of less importance to have sexual intercourse, but most of the time you end up having sex anyway. (Girl 18) . . . but going out to a club, it is pretty obvious what is going to happen if you follow someone home. (Girl 18)

The young men described intercourse as something that strengthened their manhood, and easily gave sexual satisfaction, especially in situations with few emotions involved. Fondling was looked upon as more intimate and nothing to practise with a "stranger".

For informants, sex on the first date could be acceptable, but it was rarely the start of a lasting relationship. One girl had longed for a boyfriend. By drinking, going to parties and bringing home "dubious persons" she had "one-night stands". These gave negative experiences that she now regretted. Another girl too, felt that sex on the first date had ruined her chances of a stable relationship. In fact, both males and females said that to establish a relationship you should postpone the first intercourse:

A girl who wants a stable relationship and then goes to bed with him right away, after that he won't give a damn about her. That's the way it is and therefore it is better to wait. If he is interested he will stay. (Boy 21)
For me, nothing turned into a relationship with anybody when I went to bed with them the first night. They look upon you like a toy they can take home from the pub. (Girl 18)

Trust: Flirting, joking, dancing, and talking were important inputs for "getting to know each other". During this initial phase the informants described how they invested in playing their part of the game well. By searching for consensus in opinions they tried to find out if this was a person to trust.

Sometimes feelings were congruent, with neither desire nor trust, and it was easy to say no. Sometimes a casual partner induced mixed feelings, lust and doubts, especially among the females. One girl wanted to "be in love" and be sure of a continuation before intercourse:

Yes, to begin with I wanted to, but at the same time I didn't. Then those feelings turned up; maybe we can learn to know each other ... So it was mixed emotions ... We kind of small talked and then made love and it was so cosy ... and then afterwards ... it felt strange. I thought: what now? (Girl 20)

One male thought sex was a chance to take without thinking of continuation; to enjoy the opportunity and then leave. Sex was no big affair when he was not in love with the person. The problem with this behaviour showed up when he had a stable relationship:

For me it's not an obstacle but it is for my partner. The one I'm in love with, I'm together with, and the one I have sex with, that's only sex. If I fall in love I have to solve it the next day, but I think the chance is very small, because I'm already in love with another girl ... (Boy 18)

For girls sex could also be pure desire and adventure:

... it was incredibly exciting. It was the first time I did something like that without being in love with the guy ... he was very handsome and he was older, yes, ... an experienced guy ... he stayed with me a couple of hours ... and I did things with him I had never done before ... it was like a game ... I think it was my greatest memory ... so incredibly new, exciting and forbidden ... (Girl 19)

How could it happen to me? Guilt and shame

The informants had never imagined that they could catch an STD. But they did. Looking back, they considered themselves to be informed and cautious. They knew that condoms gave protection, and they had the intention to use condoms when having sex with "strangers". They were aware of the risks of having sex with "jetsetters" who were possible candidates for sex with many different people. The crucial point was that they only had sex with people they "knew". But "to know somebody" varied from months to weeks or hours.

When stricken by the fact, the CT infection raised a wide range of negative emotions: shock, fear, sadness, shame, guilt, filthiness. The males did not react as strongly as the females: "it was not fun" but was still a curable disease.

Two salient concepts, guilt and shame, were elicited. By separating these, gender differences occurred. It takes two to transmit infections, but girls shouldered guilt and worried about having infected others:

It feels easier to accept that you have caught it from somebody than to face the fact that you have transmitted it to others. (Girl 18)

The boys did not feel guilty but rather content with knowing "the source of infection":

She called me and said: You might have been contaminated by me ... and I did not become angry or anything ... it is another thing if they don't tell you and then five years later you get to know from whom you caught it. (Boy 20)

Most informants felt shame, but acted differently. The females sought support from their mothers, sisters, and friends while males did not confide. Some had not mentioned it to anybody. According to one boy, people preferred to talk about fun things instead of failures:

You don't want people to know that this guy had chlamydia. Chlamydia is a sexually transmitted disease, and even if my generation is open-minded about sex, it is still taboo. I would not even tell my mother. (Boy 18)

Should have used it, but ...

The condom issue was discussed. Informants weighed up the pros and cons. They had been informed that condoms protected against venereal diseases and they had had good intentions. They knew intellectually that they "should use it, but" ... there were inhibiting circumstances.

There was a contradiction between spontaneous and planned sex. It was embarrassing to disclose expectations of sexual intercourse in buying condoms, and carrying them with you. It was hard to interrupt the "love game" and use condoms at that point.

The young boys described different reasons for not living up to their good intentions. One boy had condoms at home, but did not use them at his sexual intercourse debut. He felt sure that she was "clean" too, and caught chlamydia. Another male made a similar mistake. He used condoms in his first relationship, but in the next he relied on the girl and did not experience support from her:

She was not exactly a condom-promoter, and I think she thought that condoms ruined it a bit. (Boy 20)

The females, on the other hand, expressed difficulties and ambiguities in asking for and promoting condom use. For them it was a question of whose responsibility

it was. By using oral contraceptives they had played their part in preventing unwanted pregnancies, and they expected the boy to play his part in protection, voluntarily:

> If they have got one they can put it on, but otherwise … I don't demand it. One should, but I don't and I don't know why. Once, a guy, he just took it and put it on. It went without saying and that is great that a person makes it so natural, he probably does it every time. (Girl 18)

For both parties, with her using the pill, asking for a condom was an expression of distrust, and that was inconvenient in intimate situations. One boy claimed that he usually was very good at using condoms, but in his latest relationship he did not:

> She said that she didn't have anything and I knew that I didn't have anything and she was on the pill so I couldn't find any reason. But obviously we had something. Both of us got chlamydia. (Boy 18)

The informants put a lot of effort into believing that "this is a good person", and relying on the idea that he/she was "clean". As soon as positive emotions occurred, when they liked, trusted, or loved somebody, risk-calculation automatically diminished:

> The girl lying there next to you, and someone that you are fond of – you don't expect her to have a venereal disease. (Boy 21)

DISCUSSION

On method

The informants caught CT and therefore spoke of their own experiences, but there are limitations to doing research on patients. They might feel dependent on the researcher and withhold information. Interviews about sexuality are sensitive and can be difficult unless they are based on mutual trust, the cornerstone in qualitative research (20). These informants were patients to the interviewing researcher and visited the clinic several times for other matters. This prolonged engagement and follow-up session helped to make data credible and improved the findings. However, to generalize findings from a qualitative study can be problematic. The informants might have been special – for instance more talkative and more interested in sexuality than those refraining from participation. Volunteers in sexual research may also have a more positive attitude towards their own sexuality, feel less sexual guilt, and have more sexual experience (21).

Gender norms and sexuality

Transition from adolescence into young adulthood means partner-searching, part of social and emotional maturation (1). The informants' experiences rhymed well with Giddens's descriptions of sexual encounters as "detours on the way to an eventual love relationship" (22). They seemed to take for granted that the ultimate goal was a relationship – the heterosexual norm. More distressing were the stereotypes disclosed regarding gender. It is generally endorsed that girls as well as boys can enjoy premarital sex in Sweden, but this was only partly confirmed. In the prelude, during the sex act and in the aftermath, the expectations, conditions, and course of actions were different. Girls are not supposed to be demanding and it is up to the boy to make the first "move". Girls have a narrow field of action. According to Jeffner, females challenging the hegemonic norms concerning gender and heterosexuality can lose their reputation and be labelled "whore" (23), while there is a higher level of tolerance concerning boys' behaviour and sexual debaucheries (1). Motives for sexual intercourse given by men can be to have fun, pleasure, or to relax, while for women motives are often based on love, commitment, and emotions (24). In our study, we could see females provoking the general norm, by talking about lust and enjoying sex with a casual partner – not even being in love with him. But it was not only "new and exciting but also *forbidden*". We saw a clash concerning what lustful sex was; many young women in the study preferred fondling, while boys strengthened their manhood when practising penetrative sex.

Sexual intercourse among heterosexuals can also be seen as gendered power relations (17). We found an uneven distribution of responsibility when condoms were discussed. Gender differences made it difficult to negotiate safer sex for the girls. They used oral contraceptives, and had thus taken responsibility for unwanted pregnancies. But using the pill decreased the likelihood of using condoms. This pattern is confirmed in other studies (17, 25). Males in our study expected the females to be the "condom promoters", a risky expectation, with the consequence that most males will not use condoms (26).

The construction of risk and trust

Youth in itself implies feelings of immortality. Thoughts such as "it won't happen to me" have also been found in a study by Tydén (7), and can be seen as prerequisites for unsafe sex. In Giddens's terminology (27) they were "unaware of the dangers they run", or took an "acceptable risk".

Their risk calculations were based on intuition and emotions. Explanations that they only had sex with people they knew, liked, or loved are to be found in other studies (15, 16). But strong and positive feelings towards a partner do not protect against STD (25). They hesitated to trust strangers, or people with mul-

tiple sexual partners. This might have influenced their risk perception, such as seen in another study (26), but trust makes one see STD from a distance. We agree with Giddens's statement (27); "all trust is blind trust" and one ingredient of trust is "lack of full information". Sexual encounters are often non-verbal communication. To question a partner's past sexuality would therefore ruin the construction of trust (17).

The female scapegoat

Catching a venereal disease affected the informants emotionally. In this study the concepts guilt and shame need to be discussed as they had more extensive gender association. Recent theory and research (28) has pointed out that shame results from a negative ideal ("we are who we don't want to be"), while guilt has to do with misguided behaviour ("I *did* that thing"). Shame is painful, often leading to a desire to escape or hide, while guilt is more likely to lead to a desire to confess, apologize, and repair the damage done. In this study, similar to other studies (29), guilt and shame were more common among the females. A recent article illustrates how females diagnosed with CT felt stigmatized, felt guilt, and feared negative reactions from partners (30). This may depend on gender expectations. Girls are brought up to be caring and responsible, and here too they worry about the harm they might have caused others. Some boys found CT shameful, but it was "no big deal". They did not feel guilty, instead rather content with the fact that they had been contacted by "the source" – that is, became partner notified – and had the chance to get a rapid cure. Whether this can be generalized to all boys is hard to say, as the boys in this study were recruited by partner notification. CT screening of males could change this general pattern of responsibility. We do not know the current reasons given for not screening males: are they financial, cultural, or medical?

CONCLUSION

As long as CT screening is focused on females, the risk is that girls are defined and see themselves as "sources of contamination", while boys do not see themselves as transmitters; instead they become infected by the source. We can see an obvious risk that females will remain "scapegoats". Our findings highlight the potential harm that preventive measures focusing mainly on girls can do. It is important to speak out clearly regarding transmission and infection – it takes two to be infected and protection must be a shared responsibility. Public health interventions should be directed towards encouraging males to play an equal part in sexual health. CT screening of males is one important step in that direction.

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