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**The pedagogy of the clinic: Health professionals
and women with viral sexually transmitted
infections**

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Abstract

This study investigates sexual health teaching and its effects. The focus is on how the health clinic works as a pedagogical environment where lessons are offered by clinicians to women patients (often unwittingly) about morality, femininity and the body. Of central concern is the question of how health professionals might contribute to women's quality of life after a viral STI diagnosis. I use examples of the reported engagement between clinicians, women and the two most common viral STIs, the human papilloma virus (HPV) and the herpes simplex virus (HSV).

To consider the effects of the myriad beliefs that inform clinical teaching I draw from poststructuralist feminist discourse theory. For data collection I used in-depth email interviews, a research method that allowed participants with viral STIs to 'speak' more freely than might be possible in face-to-face interviews. The method also readily enabled me to interview sexual health clinicians and other women within a wide geographical area, in New Zealand, Australia, North America and England.

My research findings include the insights that: by the time women seek out medical care for a viral STI they have received considerable social 'education' that STIs are categorically different from other conditions; although clinicians emphasise the normalcy of viral STIs they tend to have limited knowledge of the difficulties women face in disruptions to sexuality after a diagnosis. Liberal views about sex do not necessarily make the negotiation of safer heterosexual sex and prevention of STI transmission easier for women. Women found it helpful when clinicians addressed *both* the medical 'normalcy' of viral STIs and their potential to disrupt women's sense of self, sexual and social relationships.

In public health education, gynaecological examinations are presented as a routine and essential practice, yet my study found that such examinations are often difficult for women. Research addressing women's reasons for non-compliance with screening emphasises 'underlying' psychological categories of 'anxiety' and 'poor coping'. Minimal attention is paid to the effects of clinicians' interventions upon women's decision-making. My findings indicate that women's screening compliance is influenced by clinicians' gender, (in)attention to power relations, rapport-building, attentiveness to bodily (dis)comfort, and technical skill. In striving for non-judgmental, scientific teaching, clinicians were often unaware that their talk inevitably constituted viral STIs as 'moral' infections. Clinicians may best contribute to women's lives by acknowledging that medical discourse is only one part of the fragmentary and contradictory education women receive about bodies and selves.

Dedication

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Chapter One:

‘Everyday’ infections: Why pedagogical complexities?

Introduction: Teaching by clinicians

Primary health care clinicians are the main providers of sexual health care and education in New Zealand. While their regular consultations may not usually be understood as educative, they have a key role as *teachers*, providing their ‘student’ patients with key information and advice about bodies. Typically, primary clinicians’ educational focus is health promotion - with a dual purpose: to enhance the health and wellbeing of the individual present for the consultation and to contribute to the overall health of the population. Deborah Lupton, a widely-published Australian medical and public health commentator, describes health education as

...a form of pedagogy, which, like other forms, serves to legitimize ideologies and social practices by making statements about how individuals should conduct their bodies... (Lupton, 2003, p. 35).

Lupton’s view of health education as ideological points to the shifting, contextual nature of the practice of health promotion. This idea is largely antithetical to the more traditional view of health promotion driven by objective science. The idea of sexual health education as a subjective practice underpins my study, which is specifically focused on examining how, and what clinicians teach women about their sexual and social practices upon contracting a viral sexually transmitted infection (STI).

My research focuses on moments of teaching and learning between clinicians and women and within women’s lives outside of the clinical consultation. I am interested to examine what clinicians teach (and learn) and what women learn (and teach) about sexually transmitted infections (STIs). I use examples of the engagement between clinicians, women and the two most common viral STIs, the human papilloma virus (HPV) and the herpes simplex virus (HSV). I have chosen the diagnostic categories of these two common infections in order to illustrate the complexity of health teaching and learning that occur even in medically ‘routine’ contexts.

Both STIs, HSV and HPV, are common in medical terms; they are endemic infections in sexually active adults both in New Zealand and internationally (Professional Advisory Board of the Australia and New Zealand HPV Project, 2007; Professional Advisory Board of the Viral Sexually Transmitted Infection Education Foundation, 2007). For an overview of key medical facts about these viruses see Appendix One. Health professionals who specialise in sexual health typically proffer the clinical point of view that HSV and HPV are, for the most part, relatively innocuous infections - the ‘bread-and-butter’ of sexual health work.

Central to my research is the question of how health professionals might be able to contribute to women's understanding of a viral STI diagnosis to reduce or prevent deterioration in women's quality of life. As I discuss in more detail shortly, clinicians' teaching primarily emphasises reassuring women that these endemic infections are extremely common and most often relatively innocuous, thus rendering them relatively normal. For many women though, these infections are socially uncommon and abnormal. In this chapter and integral to the thesis I critically assume – and examine – three 'truths' about why the provision of medical knowledge does not readily 'solve' the problems women encounter with a viral STI diagnosis. On the one hand, medical science in contemporary western culture carries the pedagogical authority to determine to large extent societal beliefs about what constitutes health and illness. On the other hand, the social and cultural meanings associated with sexuality and sexual health commonly fall outside medical determinants. Thirdly, while medical science is ostensibly about objective facts, the orientation and *application* of medical knowledge inevitably entails overt or covert moral and social positions that reflect contemporary social beliefs.

Pedagogical effects of clinicians' and patients' divergent understandings of viral STIs

My research derives from my clinical observations that medical 'facts' do not fit neatly into people's lives. I began my involvement with sexual health teaching, firstly in the nursing role of health advisor at a public sexual health clinic in New Zealand from 1996-1998. I continue to work in a part-time capacity for The New Zealand Viral Sexually Transmitted Infection Education Foundation, a government-funded organisation, as an email nurse-counsellor and as a member of the Professional Advisory Board. Early on in my sexual health work I noticed that the provision of medical information about sexual health was not an objective process. I was alerted to clinicians' desire to shape the meaning attributed to a viral STI diagnosis. The assertion that there is a 'correct' meaning involves an inevitable engagement with power relations and moral judgments when clinicians convey apparently factual clinical information.

In this section, I provide an outline of my observations that led to my research interest and the theoretical framework for this study. I highlight my clinical experience as it was through my struggles with clinical teaching that I became aware of pedagogical dilemmas and literature gaps that inform my research question: How does the health clinic work as a pedagogical environment where lessons are offered about morality, femininity and the body?

Through working at a sexual health clinic, I discovered contested meanings not only between clinicians and people who attended the clinic, but also amongst the clinicians themselves. Although people with HSV and HPV are considered to have a 'genuine' medical condition, the key area where the viewpoints of health professionals and patients may differ is in terms of the significance or otherwise of the personal distress and relationship problems experienced by some after either diagnosis.

Patient advocacy groups emphasise that it is reasonable and 'normal' for people to encounter difficulties in adjustment to a diagnosis. Even so, medically oriented literature calls upon a plethora of categorisations of 'psychological morbidity', such as anxiety and depression, through which to make sense of people's failure to adjust well to a diagnosis. Charles Ebel (2003), an American well known internationally in relation to HSV advocacy, comments that the discrepancy in meaning is the most contested topic between health professionals and advocacy groups. Ebel notes that professionals who specialise in the area of sexual health commonly question both the extent to which an HSV diagnosis is traumatic for the majority of people and the possibility of skewed representation by advocacy groups in over-dramatising the impact of the diagnosis.

John Green, an English physician in the sexual health field, emphasises the gap in understanding between professionals and patients as one of the "difficult tasks" (Green, 2004, p. 62) encountered in lecturing health professionals about the impact of the herpes diagnosis. Interestingly, Green attributes this difficulty in comprehension specifically to junior health professionals, whereas Ebel's comments relate to his experiences in presenting advocacy data at a conference specifically for specialists in the HSV field. My clinical experience concurs with Ebel's assertion that medical perceptions are not inevitably moderated through clinical familiarity and seniority.¹

Discursive differences amongst clinicians

My observation since I began working in the sexual health field is that some clinical experts dismiss people's accounts that do not concur with medical classification. Candice Oster's comments from her PhD research conducted in two Australian sexual health clinics are pertinent here:

As individuals working within the context of an STI clinic, the doctors and nurses are constrained in their utterances by internal mechanisms for maintaining the circulation of biomedical discourse. Their utterances are limited...by the academic discipline of biomedicine within which they are enmeshed (Oster, 2003, p. 83).

Oster's comment about 'utterances' is interesting in that she highlights how the parameters of 'scientific' thought may act to limit clinicians' engagement in an enquiry process about points of view that fall outside the biomedical domain. My examples below illustrate the sorts of constraints

¹ The task of enhancing the delivery of quality medical care to people with HSV or HPV is currently addressed at a local level. The New Zealand Herpes Foundation (NZHF) was established in 1995 by Claire Hurst, a nurse who had worked at the Auckland Sexual Health Service, and a group of interested patients and health professionals. NZHF was established as a result of Hurst's consternation that patients' perceptions of the difficulties encountered subsequent to the diagnosis of genital herpes were not being addressed by health professionals in primary care or specialist services. The NZHF role expanded to include similar representation for the health care of people who have contracted HPV. The organisation is known as The New Zealand Viral Sexually Transmitted Infection Education Foundation. The structure of this organisation, a partnership between patients and health professionals, is used internationally as a template for establishing comparable organisations. In 2006, Hurst was awarded a Queen's Service Medal for services to sexual health.

clinicians encounter in an attempt to privilege ideas other than those that fit beneath the umbrella of medical discourses.

Although in the clinic in which I worked clinicians did agree that HSV and HPV are for the most part relatively unproblematic medically, divergence of opinions occurred in relation to the appropriate response to distress that commonly accompanies a diagnosis. I was interested to note that clinicians' personal experiences of a viral STI infection did not result in a predictable effect on their clinical intervention orientation. During my time working in the sexual health clinic, a number of professionals told me they had either HSV or HPV infection. Their own diagnosis did not automatically dovetail with a particular educational style with clients. 'Common ground' was not conferred through a shared diagnosis. I make the point about personal experience as my research is not about neatly delineating differences between medical and lay perceptions. Some clinicians appeared to incorporate the medically-common-equals-insignificant meaning into their personal lives and others struggled with the knowledge that viral STIs are *socially uncommon* and not fodder for romantic and social dialogue.

Two key teaching interventions were used relatively consistently by different clinicians during the time I worked at the sexual health clinic. One group stressed the medical 'facts' about the relative innocuousness of these viruses. Contracting a viral STI was vigorously 'normalised' as an epidemiological inevitability for a large proportion of sexually active adults. Clinicians in the 'give-them-the-facts' group translated the meaning of persistent distress into a category of individual psychological dysfunction, such as 'anxious', 'neurotic' or 'the worried well.' Similar to my anecdotal observations, in her PhD study, Oster (2003) notes that if patients do not concur with the medical assessment of the 'normal' level of distress appropriate for an HSV diagnosis, some clinicians attribute psychological disorders to account for the mismatch. Oster quotes a clinician:

Some very difficult clients are ones who, whether they have herpes or not, have got a lot of knowledge and perhaps have a slightly obsessive trait in their personality, and it sort of reminds me of that saying that a little knowledge is dangerous, I mean they think they know everything and they think they've got it all clearly worked out in their own mind...and they have quite deeply, deeply ingrained misconceptions...about herpes and what they need to do about it...(Dr Callen, Clinic A:10) (Oster, 2003, p. 89).

The above quote from Oster's research typifies the sorts of comments I often heard when working at the sexual health clinic. There is a belief amongst some sexual health clinicians that people are in the grip of an ideology – a false consciousness – from which they can be rescued through the provision of correct facts – a secular salvation of sorts.

The orientation of another group of health professionals with whom I worked was the perception that attitudes towards sexual health reflect contemporary cultural beliefs rather than distinctly individual perceptions. The teaching work of the clinicians in this second group focused more on integrating current medical information with the social and relationship dilemmas posed by people

with HSV/HPV. My teaching approach was shaped by the intervention style of this group after repeated experiences taught me that providing accurate medical information alone often had limited effectiveness in reducing people's distress.

Clinicians working at the clinic both overtly and covertly acted to promote their pedagogical ideal in ways that shaped follow-up and referral processes and the extent to which education and support was offered. For example, some clinicians refused to refer people to a local support group because they believed that support groups only 'fed' the idea that a viral STI was a problem. This pedagogical 'line in the sand' was highlighted to me in 2002 when I gave a presentation at a sexual health conference on the topic of health professionals counselling people who had been diagnosed with genital HSV. Just prior to my presentation, a senior sexual health physician glibly told me that he would not attend my session. His parting words to me were, "Catherine, tell them to get over it". I dedicate the remainder of the thesis to an exploration of why teaching 'facts' alone fails to enable women to "get over it" and why 'the facts' are never just the facts; they always include subjective, contextual knowledge.

My focus on women

Although HSV and HPV infect women and men, my research concentrates on women's learning about viral STIs. The education material available for people who have contracted HSV or HPV is primarily gender-generic rather than gender-specific. In both health promotional material and academic medical research articles gender is most often emphasised where relevant to physiological differences, such as medical considerations in pregnancy and the relevance of genital anatomy to transmission (Professional Advisory Board of the Australia and New Zealand HPV Project, 2007; Professional Advisory Board of the Viral Sexually Transmitted Infection Education Foundation, 2007). Prior to commencing my thesis, in the course of hundreds of hours of clinical contact as a nurse-counsellor, through email, telephone and face-to-face conversations with women and men, I noticed that the diagnosis of HSV or HPV carries gender-related relevance beyond physiological considerations. For women, beliefs about femininity, sexuality, health, morality and responsibility influence the effect of a viral STI diagnosis. These matters interest me because I consider these beliefs that specifically link to ideas about how to be a woman are overlooked when clinicians devise educational interventions.

Foregrounding language and meaning

In order to consider the effects of the myriad beliefs that inform clinical teaching I draw from a popular form of poststructuralist feminist discourse theory. My intention is to use theoretical tools to extend my thinking about practical teaching dilemmas. Therefore, while the origins of the tools are important, it is their contemporary applicability to my study that is my focus rather than the complex and at times incompatible alignment of feminist and poststructural theory (Ramazanoglu, 1993). I am particularly interested in the theoretical position usually taken by poststructuralists, that the language people use shapes their reality. For my study, this means that women's reports of the

effects of having contracted a viral STI must always reflect a pre-existing range of linguistic and cultural constructions of STIs, sex and femininities.

A feminist poststructuralist approach popular in the field of education is one that considers all meaning to be fluid and contestable within any socio-culturally available set of meanings (Weedon, 1987/1997). When any problem is not pre-determined and fixed, there may be multiple ways to address pedagogical complexities in the mix of women as patients, clinicians and viral STIs. This means that there is no singular 'correct intervention that through its delivery will have sustained relevance over time. It also means that simply using different *language* may change people's lives because it provides the opportunity *to think differently* about taken-for-granted ideas:

If language is indeed the place where identities are built, maintained and challenged, then this also means that language is the crucible of change, both personal and social. A person may feel trapped, restricted or oppressed by her or his identity as, say, 'mother', 'homosexual' or 'mental patient'. Poststructuralist theory would see language as a major site where these identities could be challenged or changed (Burr, 1995, p. 43).

Health professionals regularly and consciously use language in an effort to shift the detrimental connotations associated with viral STIs. This language assumes that social effects of STIs are best spoken about in the empirical terms of science and medicine. For example, in a pamphlet entitled, *Herpes...Myth VS Fact*, the following claim is made:

Myth: It is shameful to have herpes.

Fact: No, it is very common and any one who has ever had sex can get genital herpes. It's not about being clean, dirty, good or bad – it's about being normal and sexually active (The New Zealand Herpes Foundation, 2008).

The use of the words 'myths' and 'facts' draw on a traditional view that assumes a clear distinction between 'facts and myths' (that they are opposites and mutually exclusive) and that uses the word 'fact' to refer to 'what is the case.' The reader is meant to assume that she can rely on the 'fact' above as being the case, and the myth as being untrue. Chris Weedon (1987/1997), using a feminist poststructural analysis, suggests that we read the use of terms such as myth and fact as an attempt to mobilise scientific discourse, and to reassure the reader that they can know the 'truth' about, in this case, the shame of STIs. The scientific truth is that it is not shameful to have an STI, and that it is normal – even natural – to have an STI.

The example of the myth/fact pair shows the binary logic that typifies western patterns of thinking. Weedon (1987/1997), drawing from Jacques Derrida, asserts that thinking outside of hierarchical oppositions provides space to consider alternate meanings that loosen the certainty about 'the way things are'. Derrida contends that it is possible for multiple meanings to exist in what he calls a "peaceful co-existence..." (1981, p. 41). In this study I suggest that a process of deconstruction offers pedagogical opportunities. Ramazanoglu and Holland additionally argue that:

[d]econstruction serves to wrench meanings from their taken-for-granted contexts and identify their effects (Ramazanoglu & Holland, 2002, p. 89).

I use both the above notions of deconstruction in Chapter Four - endeavouring to think outside of binaries and to unsettle meaning. I show how clinicians attempt to force reconciliation by women to a singular meaning of viral STIs – that they are common/normal - and to abandon notions of uncommon/abnormal. I consider an alternative: that effective clinical teaching does not require resolution of the binary by rejection of one 'side'. Similarly, in Chapter Six I illustrate how useful it might be for clinicians to allow that genital examinations are medically commonplace and yet peculiarly intrusive for women, instead of education driven by an insistence that examinations are 'normal'.

Deconstruction is possible because meanings are always precarious and fluid. Weedon (1987/1997) suggests the meaning carried by language that shapes the construction of shame and its effects will have considerable variation culturally as will the discourses that shape the notion that it's normal to be sexually active. The above myth/fact pair about whether or not herpes is shameful would fail for example, for a woman for whom it is imperative to appear virginal on her wedding night. It is not difficult to see that the use of scientific discourse in this situation is problematic in that it sets up a truth that is in contradiction with the truth of a woman's experience.

Led by Weedon, I have also turned to the work of French philosopher, Michel Foucault, to enable me to consider women's sexual health experience outside of the domain of categorisations regarding 'normal' women and 'natural' sexuality. Foucault describes discourses as "...practices that systematically form the objects of which they speak" (1972/1969, p. 49). Foucault encourages us to view language as always and inevitably shaping the extent and the limits to which it is possible to think about any topic including experience. Foucault's idea of discourse is now quite widely used by feminist scholars interested in how realities come to be. It is the case that the term, discourse, is used in a rather more simplified way than Foucault's – and it is this more simplified constructivist version that inspires my work. Vivien Burr describes discourses in the following manner:

A discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a version of events (Burr, 1995, p. 48).

This notion of discourse enables consideration of the plethora of ideas that shape the meaning of clinicians' and women's understandings (and experiences) of viral STIs and construct HSV and HPV in diverse ways. A discursive analysis can be utilised to show how viral STIs in contemporary New Zealand are formed in contradictory ways; a clinician might understand the infection as a minor nuisance and a woman might see the same condition as a social disaster, or vice versa. A discursive approach rules out arguments for or against the true meanings of something such as an

STI and focuses on why it can be a confounding task to teach about apparently simple health topics.

The point Vivienne Burr (1995) makes is that the objects of discourse do not pre-exist, awaiting discovery and classification. On the contrary, discursive practices create the object's meaning, which Burr – following Foucault – does not see as usefully distinct from the object. For example, the new HPV vaccine is being marketed strongly as an anti-cancer vaccination rather than as an STI vaccination. When the vaccine is understood as protection for women from cervical cancer rather than protecting women from contracting the STI, HPV, it becomes a different 'object' – one that is a more acceptable treatment for young women. People's practice follows directly: they allow their daughters to be vaccinated, to protect them from cancer. If the drug is understood as an STI protection the drug becomes different in their minds, and may be less likely to be used. The differing ways the drug might be constructed socially and morally with subsequent effects upon girls' access to the vaccine has shaped the public health messages about the vaccine (Frazer, Cox, Mayeaux, Franco, Moscicki, Palefsky, Ferris, Ferenczy et al., 2006).

My endeavour in addressing multiple, and at times conflicting, discourses on STIs such as HPV is to indicate that there is not a singular teaching intervention that can be applied generically with good effect. Abandoning the search for the perfect teaching model and instead engaging with a non-unitary approach to meaning may expand the possible ways of approaching clinical teaching.

In an exploration of discourses in relation to viral STIs I draw broadly from the poststructuralist feminist rejection of essentialist categories that define femininity and masculinity. With regards to teaching women about viral STIs, I consider it a useful practice to critique traditional 'objective' understandings about bodies, sexuality, femininity, morality and hygiene and instead to consider the implications of women's lived experiences as a product of prevailing discourses of selfhood and sexuality.

In my study, women's experiences of their bodies are shaped by discourses. I do not see their experiences merely as the natural 'feelings' of bodies but as "a textual corporeality that is fluid in its investments and meanings" (Shildrick & Price, 1999, p. 1). For example, a woman with an uncomfortable recurrent genital herpes lesion might 'feel' the sensation – the quality of the pain - differently depending whether the virus was contracted while being raped or in another quite different sexual context. The discomfort of 'a small graze,' when it is known to be a herpes lesion, may be felt differently, subsequent to diagnosis. The categorisation of body-experience such as physical pain does not always have a fixed biological determinant but rather is often (probably usually) discursively mediated. I take the position that there is not a universally applicable understanding about the meaning of HSV and HPV as experienced by women in relation to their bodies.

Discourses of femininity and the problem of viral STIs

Factual educational advice and material from clinicians may not 'translate' with ease into women's lives. Women who have contracted either HSV or HPV do not necessarily concur with the medicalised interpretation that they have a common, readily manageable infection. Cultural discourses of femininity – of how to be the right sort of woman – do not readily gel with an STI diagnosis. In using the term 'discourses of femininity' (Griffin, 2004), I highlight the multiplicity of contradictory beliefs and values that contribute to ideas about how to be feminine. I concur with Christine Griffin's (2004) critique that there is nothing definitively essential or intrinsically normal about the process of becoming a woman:

...it is always produced and negotiated...in particular historical and political moments. "Normal" femininity is constituted in part through a series of contradictions, especially around tensions between "good girls" and "bad girls," that tend to get played out with respect to representations of femininity and sexuality (Griffin, 2004, p. 29).

The discursive tensions that arise in the mix of women, sexuality and STIs are addressed by several researchers, specifically in relation to women who have contracted HSV and HPV (Lee & Craft, 2002; Nack, 2000). A chronic STI disrupts the 'morality' of conventional femininity. Such conventions require the appearance of being sexually unknowing, in search of a coupled life, not preparing for the possibility of sex, being trusting rather than questioning and focusing on the happiness of the male (Holland, Ramazanoglu, Sharpe, & Thomson, 2000). Traditional gender training of women emphasises the role of women as nurturers and care-givers, who are responsible for the health of others in their intimate circle, rather than solely responsible for their individual health (Seymour-Smith & Wetherell, 2006). It is possible that the moral dimensions of transmission anxiety are amplified for women given that transmission may be interpreted, by both women and by others, as a failure in the duty of responsible care.

It is not only discourses of conventional femininity that make an STI diagnosis difficult to incorporate into notions of the desirable way to be a woman. Sinikka Aapola, Marnina Gonick and Anita Harris (2005) analyse the impact of new discourses influencing young women's sexuality, particularly discourses emphasising the expression of sexuality as positive and central to identity. The authors point to the limitations of the apparent liberalising of bodily conventions for women. The desirable body is white, thin and young. The desirable body requires access to technology and consumer culture in order to be maintained as an aesthetic object for the pleasure of others. The desirable body, furthermore, is, paradoxically, required to perform the presentation of being sexually knowing and yet "...it should betray no sign of wear..." (Bartky, 1990, p. 69). Contracting a viral STI is commonly 'read' by both women and men as a sign of being 'used goods', reducing the value of the woman to that of a less-than-ideal sexual object.

Discourses of femininity and disciplinary power

For many women, contracting a chronic viral STI is experienced as a transgression of the 'body project,' which requires the presentation of a disciplined and contained body that is under self-control. In my clinical experience I notice that this loss of control is often much more disconcerting for many women than the manifestation of the symptoms per se; the inability to accurately predict, measure and control recurrences and possible transmissibility can be a source of personal shame and disgust for women. While the legislative power of institutional monitoring of women's sexual health has diminished considerably over the past two centuries, legislated surveillance has been supplanted by self-scrutiny and assessment. Susan Bordo (1993b) argues that it is difficult for women to avoid some preoccupation with self-measurement:

Viewed historically, the discipline and normalization of the female body – perhaps the only gender oppression that exercises itself, although to different degrees and in different forms, across race, class, and sexual orientation – has to be acknowledged as an amazing, durable and flexible strategy of social control (Bordo, 1993b, p. 166).

In the course of my clinical work, many women with whom I have spoken describe 'disciplining' sexual desire by placing exclusionary criteria upon themselves. A woman may decide she no longer has a right to 'be in circulation' sexually, or that she may only have a sexual relationship with a person with the same infection. As an email nurse-counsellor for The Viral Sexually Transmitted Infections Education Foundation I receive emails from time to time from people arguing strenuously for the organisation to host a dating website so people with HSV/HPV can find an infected partner. This practice of segregation, while sometimes initiated in response to the reaction of another, may well occur not as a direct result of external negative judgement, but rather as the result of the woman's expectation of a negative judgement. Women's direct engagement in voluntarily curtailing their choices is an example of Bordo's point that women participate directly in their own oppression.

The belief that the STI-infected body needs disciplining is often shaped more by social rather than medical discourses. For example, in a qualitative study of nineteen women in Sydney, NSW, who had an HPV diagnosis on a cervical smear result, McCaffery and Irwig (2005) note the significant impact of non-medical factors that contribute to women's distress. Kirsten McCaffery and Les Irwig's results indicate that anxiety associated with an STI diagnosis is often linked to the social stigma of STIs, with the connotations of multiple partners, rather than to the medical implications of the diagnosis. That is, discursive norms of shame and stigma are particularly powerful in impacting on women's experience of STIs.

In the course of my professional work as a nurse and counsellor in the area of sexual health, I too have noted several persistent themes that appear to correlate non-medical (including ideas such as social stigma) discourses about STIs to detrimental sexual health outcomes for women. Clinically, I sometimes observe an apparent connection between women contracting a viral STI and an increase in what is medically considered to be sexual health risk-taking behaviour; casual sexual

partners and sex without a male partner using a condom. Women tell me they perceive (medically) risky sex a lesser risk to the relationship and to their identity as a woman than to enquire about the sexual health of a male partner and to risk being 'found out' as a woman who has an STI.

Australian researchers Candice Oster and Julianne Cheek (2008) observe that some women participants with genital herpes describe the goal of being seen by a potential sexual partner as sexually desirable supersedes other possible goals such as negotiating safe sex and considering whether it is a morally desirable choice to tell a partner.

The impossibilities and riskiness of sexual health talk remain commonly unacknowledged in sexual health promotion messages. For example, in a pamphlet entitled, 'A Patient Guide: HPV (Wart Virus) in Perspective', the following advice is given:

Speaking with current or potential partners gives them the opportunity to understand about wart virus and put it in perspective as a common skin infection that generally poses no major health threat (Australia and New Zealand HPV Project, 2007, p. 11).

The medical ideal of pragmatic talk between partners is unlikely to be realised in women's lives where sexual health talk entails a threat to identity. In my years in the field of sexual health work I continue to find it fascinating that in lay accounts of the presence of an STI, the assumption of epidemiological 'truths' such as those in the quote above are consistently submerged under 'truths' about character flaws. A number of studies indicate that when women make a positive character assessment of their male sexual partner, they assume that he does not have an STI. In a study of one hundred women in England, with a mean age of 29 years, Green, Fulop and Kocsis (2000) found that a proportion of women had confidence that 'knowing' their partner was enough information to accurately assess his sexual health, even though they expressed no knowledge of the partner's sexual health status. Similarly, in a very small qualitative study of university-educated women in USA aged 30-50 years, perceptions of STI risk were linked to character (Watson & Bell, 2005). Clinicians who try to reduce the non-medical effects of a viral STI diagnosis are up against the common belief that character rather than epidemiology accounts for contracting an STI.

Women are likely to have encountered the idea that sexual health equates with personal attributes before they have contracted an infection. Virginia Braun and Nicola Gavey (1999) make the point that the way STIs are commonly understood socially underscores the division of women; "...a dichotomy between sexually 'good' and sexually 'bad' women" (1999, p. 204). Not surprisingly some women believe that once they have contracted HSV or HPV they are now flawed and will be seen by others as 'dirty' and 'damaged goods.'

Through the anonymous mediums of email and telephone counselling, I observe women's perceptions of the diagnosis impact on a sense of entitlement: entitlement to satisfactory medical care, entitlement to concerns about a male partner's sexual health history, entitlement to proceed with intimate sexual relationships and with pregnancy. There are a group of women whose opinions are not captured when research participants are accessed via clinical settings. Some women avoid

medical care that involves STI diagnosis disclosure subsequent to a diagnosis. Green (2004) comments:

Unfortunately, it seems that a minority of patients fail to adjust to genital herpes infection, even over several years. Little is known about long term 'non-adjusters', even whether they are a distinct group or the extreme of a continuum (Green, 2004, p. 60).

Green's comment is significant in several respects. The notion of 'non-adjusters' implies the medical assessment that genital HSV is an infection to which it is normal to adjust. In my clinical experience, I find that women know when they have been 'written off' by clinicians because they have not 'come to terms' with the diagnosis in the 'appropriate' way. Green's comment is relevant to my decision regarding research methodology and method, addressed in Chapter Three. I use a feminist methodology, recognising power differences in my efforts not to take an 'expert' approach to the women I interviewed. I use the research method of in-depth email interviews, in part to attempt to interview women who do not routinely seek medical care subsequent to a diagnosis.

Studies demonstrate that women may conceal a diagnosis, not only from a sexual partner but also from a clinician. For example, in a study of 142 adolescents in San Francisco, Cunningham, Tschann, Gurvey, Fortenberry and Ellen (2002) report that amongst females, non-medical factors, such as the stigma and shame associated with STIs, negatively influence sexual health disclosures to clinicians. Young women participating in the study expressed the fear that clinicians would think less of them if they discussed topics related to sexual behaviour. Clinicians and women have knowledge about viral STIs and yet the information held by each group may be only partially relevant, or irrelevant to the other group.

In order to illustrate the social and cultural construction of sexual health discourses, I use examples below of the role of popular media in teaching women about sexual health. These examples illustrate that by the time a woman receives a viral STI diagnosis she has already received considerable informal education about the detrimental moral connotations of STIs.

Teaching by media: The invisibility of STIs

The commonplace adult experience, epidemiologically speaking, of contracting a viral STI, is rarely spoken about or portrayed in any public medium. Women who contract HSV or HPV do not see evidence that either of these infections are common. The representations of people's lives in film, novels, magazines, art and theatre not infrequently use heroic metaphors to explore other less common though much more publicised health conditions such as cancer, infertility and even HIV (human immunodeficiency virus). The cause of women with genital herpes or genital warts is rarely acknowledged, let alone championed. As a reader of many popular women authors I am still waiting to discover even a minor character commiserating with a pal about a herpes recurrence or wart treatment. Interestingly, contracting HIV, a virus that renders the infected person 'deviant,' is

more 'speakable' than herpes or HPV. The glamour and tragedy often conflated with 'dangerous lifestyles' in the media are seemingly not transferred to people with HSV and HPV.

HSV and HPV happen to the most 'ordinary' of people (heterosexual, monogamous, married), not to any identifiable group marginalised in ways that are constructed by the media as politically interesting, vulnerable and oppressed. Often the only place people have ever heard the word 'herpes' uttered is at the pub or on radio, where this word is the crux of a ribald joke. Women have told me they have felt unable to defend the reputation of another woman being 'outed' as having herpes when jokes such as the following are told:

Why did the dumb blonde name her dog herpes?

Because it wouldn't heel.

How can you tell if you're staying over at the wrong girl's apartment?

The towels in her bathroom are labelled 'His' and 'Herpes.'

In social contexts women are likely to receive the message that it is undesirable to have a viral STI. The 'political correctness' that shapes contemporary HIV representation has not yet flowed on to STIs in general. Gilman (2007) explores the irony that HIV, currently the most medically 'serious' STI to contract, has become less stigmatised than other STIs. The cause of people with HIV is championed by celebrities and powerful political figures. People uninfected by HIV identify with HIV-infected people by wearing the red ribbon on World AIDS Day on December 1st each year. Women with HSV or HPV do not see such symbols of acknowledgment and support.

Neither do women see their experiences reflected at the cinema. The 'safer sex' messages of public sexual health campaigns are wildly at odds with media representations; a point made by Australian medical researchers (Gunasekera, Chapman, & Campbell, 2005). Their research analyses the portrayal of sex and recreational drug use in the most popular movies of the last 20 years. Movies analysed are those with a general audience rating, post-1983 – that is, in the HIV era. Despite the depiction of intercourse in a third of these movies, there is, almost without exception, an absence of any sexual health talk or any depiction of negative consequences, such as an unplanned pregnancy or STIs.

Anecdotally, in my sexual health counselling conversations with people who have contracted STIs, media representations of spontaneous sex powerfully influence ideas about what factors make for 'normal' and 'romantic' sex. People often refer to the portrayal of sex in popular films when talking with me as a way of explaining one of the reasons why talking about sexual health is daunting; STI talk in no way meets the criteria of normal, romantic and spontaneous.

Teaching by media: STIs in the spotlight

Media representations of HSV and HPV swing from the extremes of complete absence of the social relevance of STIs to sensationalism. For example, in The New Zealand Herald headlined *Cervical cancer vaccine on the way: 11-year-olds could be offered jabs within eight months* the Australian National Party president, Barnaby Joyce, links the vaccine to increased license for promiscuity: “There might be an overwhelming [public] backlash from people saying, ‘Don’t you dare put something out there that gives my 12-year-old daughter the license to be promiscuous’” (M. Johnston, 2006, p. A1). The quote selected by the journalist represents a theme I continue to address in this chapter and Chapter Two and Five; that STIs are markers of female character. The quote also reflects common societal discourses about the sexuality of girls and women: firstly that sexual desire is inevitably problematic for girls; secondly that girls are unable to manage sexual desire and thirdly, desire is controlled through fear. Once fear is gone, chaos (promiscuity) is inevitable. The idea that women’s sexuality is a disruptive force has an ancient history and a strong presence in contemporary Western beliefs (Hatty & Hatty, 1999).

I have indicated some key tensions that inform my research. I have begun to show the discursive incongruities that highlight why there is no straight-forward pedagogical solution for teaching women about HSV and HPV. Education is complicated by the way meaning is discursively produced. I have illustrated the production of contradictory social themes; at one extreme, the virtual ‘blackout’ of representation of the endemic nature of viral STIs in the lives of sexually active adults and at the other extreme, the floodlight of notoriety associated with STIs.

In between these polarities health professionals in the sexual health field try to advocate the normalcy of STIs. In the same newspaper article cited above (M. Johnston, 2006, p. A1), Ian Frazer, a leading doctor and researcher responsible for the development of the HPV vaccine, is quoted: “This [HPV] is such a common infection, it’s sort of normal” (M. Johnston, 2006, February 20). Given that the idea that STIs could be normal may never have occurred to a woman prior to diagnosis, clinicians have perhaps something of a Herculean task in attempting to influence the meaning of HSV and HPV. In order to begin to address how clinicians shape public sexual health education I now continue with the opening theme of the chapter; that public health education is a pedagogy that legitimates certain ideas and dismisses others. I now situate the ideology that shapes sexual health promotion within the neoliberal politics that inform New Zealand healthcare.

Neoliberalism: Good women make good citizens

Although medical teaching ostensibly constitutes viral STIs in scientifically objective terms, sexual health education is political. The public health promotion goals of healthy individuals and populations are informed by neoliberalism, a framework of political reasoning that creates a society based upon individual responsibility and personal choice (Galvin, 2002). New Zealand health care and that of many western nations is currently structured according to neoliberal goals (Prince, Kearns, & Craig, 2006). I briefly mention this political context, because the politics of neoliberalism

guide sexual health teaching in New Zealand. The notions of individual responsibility and personal choice are incorporated routinely into public health messages.

I consider how clinicians' teaching is discursively produced, legitimised by apparently discrete 'objective' medical knowledge and also by politics informed by the moral agenda inherent in neoliberal theory. Even the simplest healthcare advice, such as information in the public brochure provided by the Ministry of Health National Cervical Screening Programme is framed within neoliberal terms:

All women aged 20 until they are 70 who have ever been sexually active should have regular smears....You will need to contact your smear taker to get your results....The cost of a cervical smear test will be what you would normally pay to see your doctor or nurse. Some community organisations offer a free or low-cost service (National Cervical Screening Programme, 2007a).

The above piece of information demonstrates the active governing of individual responsibility. As women we are left in no doubt that we are to organise ourselves, our finances and our access to resources (transport, scheduling an appointment, rearranging other commitments) so that we are able to participate as "the 'good citizen'...someone who actively participates in social and economic life, makes rational choices and is independent, self-reliant and responsible" (Galvin, 2002). To participate in public health as the good citizen, women need to recognise that feeling well is not an adequate measure of health. Women have the responsibility to stay healthy and not be a financial drain on the state. The demonstration of individual responsibility in the 21st century requires women to actively participate in health screening programmes; each woman is "a potential victim requiring careful monitoring..."(Lupton, 2003, p. 34). The point I make here is that although health care messages ostensibly teach women useful, up-to-date factual information – have a smear and reduce the chances of developing cervical cancer - the facts never stand alone. Public health information exhorts women to make decisions that are in line with the neoliberal agenda of individual responsibility.

The implementation of neoliberal discourse at the level of the cervical smear brochure demonstrates that the science of the cervix and the effects of the human papilloma virus only play a partial role in constructing the significance of screening. The cervical screening brochure cover states: "my health, my body, my future" (National Cervical Screening Programme, 2007a) – the implication being that the choice to be healthy is primarily within the hands of women – our responsibility and within our grasp. The message conveyed is the expectation of women acting on knowledge. The accountability of women to 'choose' health is additionally emphasised in the photograph on the brochure cover. A group of five women of different ethnicities ranging in age from teens to seventies beam with apparent good health. One holds two glasses of water, another has a towel slung round her neck as if she has come from a workout. Another holds what look like textbooks. The message conveyed is that of informed women incorporating health advice into their

daily lives. Discourses of femininity and morality - of how to be a 'good, responsible' woman, how to be a sexual woman – are integral to a brochure ostensibly about the facts of cervical screening.

I draw attention to the contradictory discourses that occur within public health promotion; a discourse of science to a large extent conceals the moral agenda of public health discourse. I now examine the discourse of morality that occurs within medical discourse that confounds primary health care initiatives to constitute viral STIs as common and 'almost normal.' Although scientific medicine has displaced earlier beliefs about the causes of illness such as foul air and corrupt morals, neoliberal health policies and health promotion serve to re-moralise health and illness. In the following section I very briefly trace the (never complete) de-moralisation and re-moralisation of health.

Health, lifestyle choice and moral culpability

The pairing of health and morality has a long history and a contemporary relevance in shaping beliefs about the physical wellbeing of individuals. European medical philosophy began to gradually emerge from the control and authority of the Church from 9th century and became an increasingly secular undertaking. Accordingly, the attribution of disease altered. Illness became a problem of the body rather than a problem of the soul (Hatty & Hatty, 1999). The solution to disease became correct diagnosis and medical treatment. Scientific medicine gained tremendous credibility with the discovery, for example, of the antitoxin for diphtheria in the late 19th century and the introduction of penicillin in 1940's. Brandt (1997) refers to the shift to secular knowledge about disease causation as a process of "de-moralization" (1997, p. 57) that alleviated the burden of the sinful connotations accompanying illness.

The attribution of moral causes of some diseases and illnesses has never waned completely; Brandt (1997) notes that mental illness, alcoholism and sexually transmitted infections continue to have strong moralistic connotations. In the late twentieth century with the reduction and eradication of many epidemic diseases there has been a shift back towards the moralisation of illness. A radical shift has occurred in disease and illness causation through the implementation of sanitary measures, vaccinations and antibiotic treatments. Chronic illnesses rather than epidemics have become the major cause of death in Western countries. Chronic illnesses have a complex or unknown aetiology and the search for causes has shifted from hunting for micro-organisms to the identification of risks. Leichter (2003) traces the shift in the late 20th century back towards the moralisation of health as the identification of risk factors became linked to the behaviour of individuals.

Public health interventions focus on the responsibility of individuals for 'lifestyle choices.' Leichter (2003) asserts that risk factors attributable to social and economic conditions beyond the control of the individual are recognised in public health research but are given less credence than beliefs that ill-health is to a large extent self-inflicted. Health, according to Leichter, is prized symbolically beyond the comfort of physical wellbeing:

...it symbolizes a secular state of grace. As such, good health constitutes affirmation of a life lived virtuously (Leichter, 1997, p. 359).

Contracting either HSV or HPV transgresses the neoliberal ideal of exercising control over one's health. In chapter five, I discuss the 'fall from grace' in detail. I explore discourses of femininity that shape women's desire to 'produce' perfect health and the ways the constitution of a viral STI diagnosis may this goal. I use discourse theory to address the contextual differences for clinicians and women without implying that either group is cohesive or homogenous. I aim to show pedagogical complexities without assuming that any group is in the grip of an ideology. I am particularly interested to demonstrate that clinicians do not have ownership of the 'true' reality of what viral STIs mean and that infected women are not "...passive victims of systems of thought..."(Mills, 1997, p. 27) – that there is sense to be made of women's understandings of viral STIs.

'Objective' facts and STI classification as a subjective practice?

In order to situate the certainty with which clinicians claim truth status for medical knowledge, I briefly sketch the emergence of the discourse of neutral, objective medical thought and associated systems of classification. Modern medical discourse emerged in 19th century with the discovery of specific causes for pathology (Gabe, Bury, & Elston, 2004). Medical discourses reflect the principles of the Enlightenment: of progress and the ability to gain mastery over the natural world and the assumption that neutral, objective facts await discovery and systems of classification. For example, a currently undisputed medical fact is that facial and genital herpes are caused by the herpes simplex virus. Facial herpes though is not usually classified medically as a sexually transmitted infection. An STI is categorised by how the infection is contracted, not by how it is transmitted. Therefore, although herpes is commonly passed from mouth to genitals through oral sex, only one partner, the one with the genital infection, has an STI.

The medical categorisation of 'sexually transmitted infections' is inculcated into western medical discourses to the extent that the category 'makes sense' and yet it is arguably a bit of nonsense. I find, anecdotally, that people are often shocked that numerous STIs are readily transmitted without the person having what they think of as sex. The artificial category of bodily infection delineated as sexually transmitted then shapes the way it is possible to think about STIs. Sara Mills (2003) demonstrates the subjective nature of classification procedures, which are inevitably exclusionary to the point that it is difficult to think about a category in any other way. In Chapter Four I draw from feminist poststructuralists' use of the Foucauldian concept of normalisation and Derrida's concept of classification to illustrate the effects of clinicians' taken-for-granted insistence upon certain constructions of viral STIs over others.

Classification has demonstrable effects in people's lives. An example of a common effect of classification from my clinical work is that the person with genital herpes feels shame for having an STI but the person with 'cold sores' typically is not burdened by societal notions of having a 'dirty'

infection. Discourses are at no time neutral in their effect. Discourses powerfully influence the parameters of what it is possible to think and what range of actions is permissible (Mills, 2003). Foucault comments on the constitution of objects through discourse; an explanation that I find useful to account for the subjective nature of classifications:

...we must not imagine that the world turns towards us a legible face which we would have only to decipher; the world is not the accomplice of our knowledge; there is no prediscursive providence which disposes the world in our favour (Foucault, 1981, p. 67).

Throughout my research I show how the apparently “legible face” of HSV and HPV according to categorisation by medical discourses is confounded by a number of other overlapping discursive categorisations, such as discourses of femininity and morality. In clinical settings, numerous mediums convey medical discourses. As Burr (1995) states, discourses are not only formed by written and spoken words. Discourses are evident in diagrams and photographs. Rather than images objectively clarifying facts for women, images aid the classification of STIs and inform women in specific ways about how to relate to the body, sex and STIs.

A point that illustrates the way images operate is that in most people, the symptoms of HSV and HPV are so mild that they are indistinguishable in a photograph. It may seem facile to remark that the very appearance of normalcy is excluded from medical pictures – that the statistical absence is not represented. Medical photographs and diagrams of HSV and HPV require that examples from the more extreme end of symptoms are used, in order for there to be something to see even though such symptoms relate to a minority of people. Photographs underscore the belief that HSV and HPV typically have adverse symptoms, rather than the converse, that in most people there are no symptoms.

Another example of an image as piece of ‘discursive work’ is that of a clinician showing a medical photograph of a herpes lesion or genital wart to a woman with a diagnosis of a viral STI. The pictorial text is coherent with the medical discourse; that of disease located within a bodily part that is conceptualised as separate to the whole body and separate from the thoughts and emotions of the person inhabiting the body. The way the body is represented then affects what is considered legitimate and/or appropriate to say and teach about the body.

Discourses and legitimacy: Seeing is believing

A further example of the exclusory effects of classification within sexual health medical discourse, medical imagery such as diagrams and photographs, typically present pieces of the body in asexual, non-erotic terms. It is possible that commonplace visual aides are powerful texts (such as the anatomically labelled vulva and female pelvis that greet me at eye level as I go for my smear) that wordlessly shape and instruct people about what it is permissible, even normal, to ask and to feel about sexuality and sexual health.

Clinical diagrams in the sexual health clinic are used to assist discursively in what Anthony Pryce (2000, p. 105) terms “the deployment of repetitive sanitizing practices to neutralise the risk of the clinic being contaminated by the erotic.” I understand Pryce’s notion of sanitising practices to be those acts, including visual and speech acts that demarcate the clinician as an expert who deals with ‘objective’ information about biological sex and STIs separate from the emotions and desires of the individual’s sexuality. Kapsalis (1997), a performer and health educator, provides an in-depth examination of the discursive representation of female gynaecology. In a summary of medical textbook graphics Kapsalis emphasises the inevitable role of images in teaching people how to think about the body:

In creating and using texts, both alternative feminist health advocates and medical practitioners are involved in organizing knowledge about female bodies. Administering health care requires such organization. But a strong analysis of the consequences of various ways of organizing visual, written, and tactile information should be made a central part of medical pedagogy (Kapsalis, 1997, p. 111).

In my clinical experience both in midwifery and sexual health, I have found that despite the direct relationship between sexuality, reproduction and STIs, medical visual texts do not provide an opening for women to talk about the implications for (non-medicalised) sexuality. In Chapter Six I consider women’s accounts of speculum and genital examinations. I am interested in the pedagogical effects of clinicians’ use of texts (brochures and procedural observation on video screens) in an effort to increase women’s compliance with cervical screening follow-up. I show the way that the emphasis upon treating and teaching about bodily parts inadvertently leads to gaps in the education and care of women.

Clinicians as sex experts: Sex as science

According to Foucault it is no surprise that in western countries it is quite possible to have detailed discussions about sex without ever broaching the erotic. Foucault considers that historically there have been two key ways different cultures have produced what is known as the truth about sex. Foucault (1976) attests that for most cultures, the pleasure of sex and the truth of sex are combined. He terms this mix ‘ars erotica.’ In western civilisations though, sexual knowledge is constructed according to confessional practices whereby an expert determines the legitimacy and limits of what can be thought and said about sex, a production of the truth about sex, which Foucault terms ‘scientia sexualis.’ Foucault traces the shift from religious confessional practices within the Christian church to secular institutions. According to Foucault, medical practices utilise confessional practices. He describes contemporary confession as:

...a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile...(Foucault, 1976, pp. 61-62).

Clinicians are unlikely to consider that in their everyday work they are moral arbiters or secular confessors. The apparent objectivity of patient education inevitably incorporates neoliberal values of the responsibility of the individual to monitor their own health and to change their behaviour to modify health risks towards self and others. Neoliberal discourses mean that certain statements made by clinicians make sense and for a patient to ask questions or offer a contrary point of view may be difficult, contravening the implicit understandings of neoliberal health messages. For example, in the previously quoted HPV pamphlet, the following advice is given:

If you are considering a new relationship and have warts, you should discuss this with your partner and use condoms or dams until the warts have cleared (Australia and New Zealand HPV Project, 2007, p. 11).

Neoliberal discourses of health and responsibility make it very difficult for women to feel able to ask (neoliberally reprehensible) questions such as:

Given that most people will contract HPV at some stage, why does it matter if I might pass it on?

I hate the feel of condoms – does it matter if I contract warts if I don't get my partner to use one? How big a deal is it anyway?

In chapter seven I use Foucault's notion of the confessional to consider the subject positions clinicians and women take up discursively in constructing the scope and limits of what counts as legitimate that can be said about women's sexuality and viral STIs.

Conclusion

In this chapter I have begun to address why teaching something relevant about even very common sexually transmitted infections is fraught with difficulty. Clinicians who specialise in the field of sexual health may teach in ways that have limited applicability for women consulting them. The problem is not as simple as a misunderstanding between medical and lay knowledge that can be remedied through the provision of the correct information. As I have argued, there is not a marked division between medical and lay knowledge, between the apparent objectivity of the former and the ostensible subjective nature of the latter. Public health education is shaped by morality and yet clinicians endeavour to de-moralise viral STIs while simultaneously re-moralising these infections.

There is no clear indication that the provision of accurate medical information alone creates a trajectory of knowledge that improves the social and sexual lives of women. Although on the one hand a viral STI, in medical terms, may be 'no big deal,' on the other, the policing and presentation of a perfectly healthy body is commonplace for women, with a focus upon grooming, pruning, screening. The current parameters of being a 'good' woman are not less complicated than for women of previous generations. The criteria now include the performance of the sexual body as a desirable commodity but without any tell-tale traces of sexual experience such as STIs.

The role of media representations detracts from the awareness of just how common it is for women to contract viral STIs. Sexual health in the media is typically either an invisible topic or else receives hyper-visibility, linked with deviancy and social problems. Although many clinicians work to normalise STI's – that these infections are frequently part of adults' sexual lives – the message of relative normalcy is not one that is necessarily readily taken up in the lives of women.

I now move on to examine the literature that addresses the discursive representation of viral STIs and in turn shapes teaching interventions. I discuss relevant research pertaining to changing discourses of sexuality, femininity, hygiene and embodiment in order to show the complex and ever-shifting discursive terrain that influences what women learn about viral STIs. I use the literature to indicate that it is quite possible to teach apparently accurate information about viral STIs that has limited relevance to women's lives. I demonstrate gaps in the literature that, if addressed, may have useful pedagogical implications.

Chapter Two:

Viral STIs and representations of morality, femininity and the body

Introduction: Looking beyond medical discourse

In this chapter I use medical, feminist and popular literature to show the pedagogical gaps that my study endeavours to address. To show the way lay publications aim to provide 'user-friendly' medical information I use an example of an article about genital herpes in a women's magazine. There is a subtext of discourses of femininity that shapes the way the significance of herpes is discussed and yet these discourses are not addressed directly. Similarly, I argue that the mismatch between medical discourse and the production of femininity is not addressed in medical literature. The visibility/invisibility is problematic because managing sexual health and producing femininity are not easily reconciled. The examples of genital hair removal, condom use and oral sex are used to show this tension between sexual health and discourses of femininity.

I continue to discuss the effects of the classification of women's distress as psychosocial. This focus has led to inattention to women's bodily experiences. I propose that women's decision-making in relation to HSV/HPV treatment and follow-up is shaped to some extent by what happens to their bodies during examinations. HSV/HPV education may be enhanced through a critical focus upon discourses of femininity and morality and through attention paid to women's reports of the effects of gynaecological procedures.

Sexual health representation: An example from a women's magazine

In order to examine the interplay of discourses that shape teaching women about viral STIs, I refer throughout this chapter to a sexual health article entitled *Herpes*, in a New Zealand online women's magazine, *Gloss* (Goodchild, 2009). I have chosen the article because it strikes me as an 'ordinary' example of sexual health articles in women's publications, where the author endeavours to convey medical information to a lay audience. The article is useful for showing the everyday discursive production of sexual health, sexuality, the female body and individuals' responsibility for 'healthy choices.' The magazine is billed as "tailored to the interests and needs of women aged 15-50..." (<http://www.gloss.co.nz/About-Us.html>). Immediately under the article title is the following photograph as shown in Figure 1 of a young woman's torso (Dphotographer, 2007).

Figure 1. Photo accompanying *Herpes* article



The medical representation of bodies through photographs and diagrams is discussed at length by Terri Kapsalis (1997). Her analysis led to my interest in the messages conveyed through the images used in sexual health education and the representation of viral STIs. I use Figure 1 to illustrate several points raised in Chapter One. The image constitutes links between women's sexuality and herpes. Although the article is an attempt to educate and 'empower' women about how to reduce their chances of contracting genital herpes, I 'read' the image as producing particular meanings about women's bodies and sexuality with the overall effect of making women's management of sexual health difficult. The image and the article indirectly reflects but does not address the invisibility of the double-bind women face – the imperative to be sexual, to look sexually attractive and yet to take personal responsibility to avoid any STI consequences.

Led by Kapsalis (1997), I consider that the image of the woman's body in Figure 1, by the tilt of the woman's hips, the adorned navel and scant attire, could be read as 'sex positive', affirming the expression of women's sexuality, and by extension, that dealing with sexual health is 'normal.' The textual message at first glance perhaps positively normalises herpes. The use of Figure 1 appears to be a stark contrast to the message conveyed in Figure 2, the image for the cover story of a Time magazine in 1980's (Wallis, 1982) that links herpes to heterosexual shame and punishment.

Figure 2. Time magazine cover



The body in Figure 1 potentially conveys problematic meanings for women. The body typifies the (for many women unattainable) contemporary desirable feminine body that is white, young, slim and smooth. I read the pelvic tilt and adorned pierced navel as permission for women to express sexual desire/availability, but for sexual expression to be within certain parameters. As a point of interest, the image is immediately identifiable as a non-medical photograph. If it were a photo in a medical text, the hips would be level and the pelvis would be straight-on to the camera, conveying the idea that the image delivers 'objective' information to a de-eroticised medical gaze. The body would not be positioned in any overtly sexual way. The piercing would only be included if it was of medical significance.

The woman's arms and hands in Figure 1 are absent as if her body is being 'served up' as an object to be touched by another, rather than to be touched by herself. Contemporary sexual autonomy for women requires the participation in a "sexual lifestyle [that] enables the presentation of oneself as both a desiring subject and a desirable product" (Harris, 2005, p. 40). The image represents the subject/object conundrum well. I wonder whether the white bikini was selected purposely – a colour long associated with purity and virginity. Harris' point is helpful for analysing Figure 1 and the accompanying *Herpes* article. The desiring subject, with sexual control and autonomy is promoted. Yet the limits of such self-regulation imposed by the production of the self as a desirable object are present, although not overtly, in the image, or in the article. I outline an example of the way everyday practices of femininity are in conflict with the production of sexual health.

'Good grooming' practices and STIs

The body in Figure 1 privileges 'good-looking' pubes over sexual health. Genital hair removal has become a mainstream practice associated with both erotic appeal and good hygiene. Yet the skin micro-trauma that occurs with waxing or shaving potentially enhances the acquisition of genital infections and the spread of the area of genital wart infection through autoinoculation (Dendle, Mulvey, Pyrlis, Grayson, & Johnson, 2007). The image used for the 'Gloss' article is a sexual health contradiction. It is most likely that the absence of any visible pubic hair is achieved through waxing or shaving.

The lack of concord between social and medical discourses of hygiene and cleanliness is illustrated by anthropologist Mary Douglas. In the 21st century what counts as dirt is only partially shaped by knowledge about pathogenic organisms.

...dirt is essentially disorder. There is no such thing as absolute dirt: it exists in the eye of the beholder....Dirt offends against order. Eliminating it is not a negative movement, but a positive effort to organise the environment (Douglas, 1966, p. 2).

The presence of pubic hair is increasingly a source of disgust for women. It is the new 'dirt' to be eliminated from the genitals. In my review of the literature I find the medical tolerance, even

support, for women's reasons for genital hair removal – aesthetics and hygiene - curious. This acceptance is quite at odds with the medical rejection of women's insistence upon the dirt and disorderliness of viral STIs and emphasises the way societal contexts shape of medical teaching.

A recent study of 235 Australian female undergraduate students aged 17 to 40 years indicated that 60% of the women remove some of their pubic hair. Of this group, 48% remove most or all pubic hair (Tiggeman & Hodgson, 2008). Young women presenting themselves as a sexually desirable product seem to require the removal of pubic and genital hair to varying degrees, and yet the practice is associated with the (undesirable) acquisition of infections including viral STIs (Dendle, Mulvey, Pyrlis, Grayson, & Johnson, 2007; Trager, 2006). I find it fascinating that these medical authors, despite outlining numerous 'costs' to depilation, including life-threatening infection caused by streptococcus and herpes simplex virus in one instance, do not caution against the practice of complete genital waxing. In keeping with neoliberal discourses, the 'balance' of individual responsibility and personal choice is emphasised. After outlining a woman's near-death experience and subsequent scarring with labial adhesions, the authors comment that

[d]espite her traumatic experiences, the patient was keen to undertake further removal of pubic hair. The desire to be beautiful is as old as civilization itself...(Dendle, Mulvey, Pyrlis, Grayson, & Johnson, 2007, p. e30).

The desire to be beautiful is accepted non-critically and I read the use of the word, 'civilization' as endorsement of the practice as valid, as if it is a practice in keeping with the civilising of society. Despite the case study of a woman nearly dying subsequent to having full pubic/genital hair removal, Dendle et al (2007) do not associate the practices with sexual beautifying practices now considered barbaric in the west, such as the foot-binding of girls or female genital mutilation. Similarly, Virginia Braun (2005) and Lenore Tiefer (2008) note that surgeons conducting female genital cosmetic surgery position their work as responsive to women's desire for 'appearance medicine' that result from media representations of desirable genitalia. The 'need' for surgery, as described by surgeons, is generated by cultural, media-generated practices that make the vulva more visible and are ostensibly outside of the control of surgeons. There may be some irony in the fact that clinicians downplay the impact of viral STIs upon women's sense of being sexually desirable and yet defend and participate in the social desire for genital beauty that have no basis in medical 'fact.'

I also draw attention to links between women's sexual health and changing ideals of genital attractiveness because sexual health education primarily focuses exclusively on sexual practices rather than on the broad, altering constitution of 'clean,' desirable genitals. Sexual health teaching is compromised when the context of desirable femininity is not addressed. My point, raised in chapter one, is that the way infections are classified – as sexually transmitted – along with the construction of normal sexuality and normal femininity – powerfully shape the way it is possible to think about the body, from the focus of research through to representations in women's magazines. Far from medicine operating separately ('objectively') in relation to contemporary culture, medical

discourse is integrally shaped by a neoliberal discourse of individual rights and responsibilities. Jonathan Trager, a (male) paediatrician and author of an article about adolescent girls' hair removal practices, is at pains to support rather than critique the practice. He states:

Clinicians caring for patients with a pubic hair removal problem can make a tremendous impact on their patients' quality of life. One should never be judgmental as pubic hair removal is an intimate personal act about which the patient may have strong feelings (Trager, 2006, p. 123).

The above is a concluding comment that comes after some 'hair-raising' material about the adverse effects of pubic hair removal. The author advises clinicians to become expert in providing advice about hair removal practices and products. The desire of young (11 and 12 year olds) girls and women to participate in the practice is not problematised and the clinician is not positioned as having the power or authority to shape the practice except in the area of becoming an expert with regards to providing advice about improved hair removal technique. There is no mention of the potential role of media and pornography in shaping hair removal practices – the practice is framed as a personal and gender-neutral act although the article is entirely about females. The support of 'intimate and personal' practices is given greater importance than helping women to have a microbiologically healthy, infection-free pubic and genital area.

Trager's (2006) comments are a useful illustration of Foucault's notion of disciplinary power. It is not a matter of powerful doctors imposing their will upon women. Women are not being held down against their will, having their pubic hair wrenched from their bodies. In an act of self-surveillance or self-discipline, women are 'choosing' pubic hair removal. In relation to public norms, Trager advises clinicians to find ways to work with the practice, even though it is clearly a practice that contradicts medical knowledge about cleanliness and health.

There is very limited medical literature on the effects of the practice of pubic and genital hair removal. A number of clinicians have told me how problematic they think the practice is for women's sexual health and I have heard the topic discussed at international clinical meetings. Typically clinicians have told me of their inability to deter people from genital hair removal as it is considered by most who engage in the practice to be 'essential' to aesthetics. It is clinicians' anecdotal talk that first drew my attention to the 'sea change' that has occurred over the past ten years in New Zealand whereby hair removal is now the norm for Pakeha women under the age of thirty. Listening to clinicians describe the radical increase in this practice led me to think about the possible connection between hair removal and women contracting viral STIs. Women are significantly more likely to contract genital herpes than men (Dickson et al., 2006) and approximately 75% of women have been exposed to at least one HPV infection in their lifetime (Burchell, Winer, de Sanjose, & Franco, 2006). Medically the susceptibility to infection is accounted for due to the greater permeability of women's genital mucous membrane compared to the skin of most of male genitalia.

The medical focus on transmission continues to emphasise barrier methods (primarily condoms) and the role of medication in avoiding the effects of STIs. It is the 'sex' part of sexual health that receives research emphasis – perhaps in keeping with the classification of HSV and HPV as sexually transmitted. Yet women are increasingly engaging in a *cosmetic* practice that traumatises the genital area and might make viral STI transmission more likely.

Women, sex, sexual health and age

At a glance, Figure 1, the image in the 'Gloss' article, *Herpes*, links HSV and youth (2009). Although the magazine states its aim to reach the needs of women aged 15-50 years old, the image implies that herpes is a young woman's problem. The image also suggests normalised societal discourses that sex 'belongs' to young women and that women who are older are less sexual and therefore less likely to contract viral STIs, which is not the case.

Adolescents and young adults are the focus of sexual health research. Media representations emphasise young women as an at-risk group because they engage in risky sexual practices (Batchelor, Kitzinger, & Burtney, 2004; Jackson, 2005). Although in New Zealand bacterial STIs, particularly chlamydia and gonorrhoea, peak in the adolescent age group (A. Johnston, Fernando, & MacBride-Stewart, 2005), the incidence of genital herpes is low amongst adolescents and women in their early twenties. The incidence of HPV is also significant for women beyond their teens and early twenties. Although HPV peaks in young women around the age of 20, HPV continues as an infection of lifelong relevance. HPV increases slightly in women over the age of 65, reflecting either new infection or reactivation of infection acquired earlier in life (Burchell, Winer, de Sanjose, & Franco, 2006).

Figure 1 does not necessarily 'speak' to women in the age group most likely to contract HSV. Genital herpes is an infection associated epidemiologically with increased acquisition as women age. In the Dunedin cohort study of 1037 people including 432 women (Dickson et al., 2006), incidence rates of HSV-2 have increased with age. The cohort was first tested for HSV-2 at the age of 21 years using a blood test for antibodies and the incidence was 4.3% for women (and for men 2.7%). At 26 years of age the incidence increased to 15.3% (and for men 7.1%) and at 32 years of age the incidence was 22.5% (and for men 14.6%). The authors recommend that

“[h]ealth promotion and treatment to control HSV-2 infection should be aimed at all ages, not just at the young” (Dickson et al., 2006, p. 87).

While the recommendation to shift the age-focus of sexual health promotion is a useful analysis, there are no recommendations regarding the implications of the significantly higher increase amongst women compared to men. The difference is accounted for in general terms:

This is most likely explained by different patterns of age mixing among men and women, with women tending to have older partners, and different transmission risk: men to women

transmission is more efficient than women to men transmission (Dickson et al., 2006, p. 89).

Dickson et al (2006) appear to support the notion that there is a biological explanation for the efficiency with which HSV infects women compared to men. There is no enquiry about what happens, for example, in the sort of sex women may have with older male partners that might enhance micro-trauma to the mucous membrane: rough sex, unwanted sex, unlubricated sex, sex while the woman has another infection such as a yeast infection. The fact that women's ability to more easily negotiate condom use increases with age is mentioned as a reason for the gradually closing gap in the incidence between women and men. Condom use is ubiquitously discussed in medical and popular literature in relation to STI transmission reduction and safer sex practices. As I discuss in the following section and address further in chapter five, condom use 'makes sense' biologically but is often problematic in relation to ideals of femininity.

Condom use and STIs

The public health sexual education mantra of sex-with-a-condom is often highly problematic for women. Condom use is yet to become de rigueur for heterosexual sex and yet is most commonly discussed in health promotion material as a 'normal' practice. The *Gloss* article, *Herpes*, in the section on prevention of HSV infection states:

The most important way to protect oneself against Herpes type 2 is to use condoms at all times (Goodchild, 2009).

In my clinical experience I find that women typically blame themselves if they contract a viral STI and have had recent sex with a male who has not used a condom. The health promotion messages perhaps incorrectly give women the idea that other women are insisting on consistent condom use, whereas the research literature points to different reality of condom use, a point I discuss shortly.

There are several discourses of sexuality that stand out in relation to health promotion and condoms relevant to my study. Firstly, heterosexuality is assumed. It is far less common to find any research or discussion about safer sex practices for lesbian women. The *Gloss* article does not mention the availability of latex dams (flavoured pieces of latex that can be placed over the genital area for oral-genital or oral-anal sex, available at pharmacies).

Secondly, the wearer of the condom is often not mentioned, as if the information is self-evident. The *Gloss* article does not mention that condom use might be problematic. The absence of reference to the complexities of condom negotiation for heterosexual women leaves the reader with the neoliberal message of gender-neutral, individual choice and responsibility. Nicola Gavey and Kathryn McPhillips (1999) note that safe sex campaigns that target women when advocating condom use do not take into account how problematic the role of condom-initiator is for women. In a small qualitative study of New Zealand women aged from 22 to 43 years, they draw from poststructuralist feminist theory to demonstrate that female control over condom use is complicated

by incompatible discourses of femininity and romance. The traditional construction of feminine sexuality is of passivity rewarded with love and protection. Gavey and McPhillips contend that slogans of women taking responsibility for condom use reproduce the traditional discourses of women's sexual responsibility, to regulate men's sexual desire, aided by the relative absence of their own sexual desire compared to men's sex drive. Women are also expected to be vocal and assertive about their requirements; behaviour that contradicts the receptive rather than the active nature of conventional feminine heterosexuality. Gavey and McPhillips analysis echoes research by June Crawford, Susan Kippax and Catherine Waldby. They note the contradictions that impact upon condom use:

...condom use is understood with reference to competing discourses – of sexual safety and risk, and gender relations. In the former condoms signify safety, in the latter condoms signify infidelity, lack of trust, promiscuity, an absence of love, a lack of commitment (Crawford, Kippax, & Waldby, 1994).

The difficulties for women in reconciling both physical and emotional 'safety' when considering condom use are typically overlooked in public health promotional material. Standard condom messages (Goodchild, 2009) normalise condom use, as if the practice is routinely taken-up by heterosexuals, which is not the case. As Basil Donovan, a well-known Australian sexual health physician notes:

Male condoms have...been adopted on a major scale only for commercial sex, for anal sex between men in developed countries, and less so, by young heterosexual men in settings where condoms have been actively promoted and distributed. In the latter case, the major incentive for the use of condoms has been the avoidance of HIV or pregnancy rather than for protection against other STIs (Donovan, 2004, p. 552).

Heterosexual condom use is most typically seen as a sign of 'dangerous' or casual sex with someone who is potentially or identifiably a sexual health risk: prostitutes, injecting-drug users and gay men. As indicated in chapter one, women commonly judge sexual health risk based on their knowledge of the male and/or upon women's positive character assessment of him (Green, Fulop, & Kocsis, 2000). Males also may not agree to condom use. My clinical experience concurs with anecdotal reports in the literature, that women may be raped and hurt emotionally in the attempt to insist on condom use (Gavey, McPhillips, & Doherty, 2001).

The use of condoms to protect against STIs is often an anathema to mature women who experienced their youth before the 1980's, where unplanned pregnancy was the key risk of unprotected sex. Figure 1, the image used in the *Herpes* article does not 'speak' to mature women and yet women in their 40's and upwards are more likely than younger women to be naive about the potential for sexual health problems and the relevance of condom use. Women in the 'mature' age group are less likely than younger women to have experience with condom use and are more likely to have difficulties broaching the topic of safer sex (Nusbaum, Singh, & Pyles, 2004; Watson

& Bell, 2005). Anecdotally, in my clinical work I have had numerous conversations with women in their 40's and older where either they or their male partner has HSV. Women describe condom use as problematic for the following reasons: the male has never used them before; he is unable to sustain an erection with a condom on; she and/or he are unfamiliar with condom use and find their use embarrassing or unpleasant. In Chapter Five I highlight the limitations of condom education when women are not asked how possible it is to incorporate condom use into the production of their feminine sexuality.

The rise of oral sex: HSV and HPV implications

One further point about the public health emphasis on condom use: the message focuses upon (hetero)sexual intercourse, whereas oral sex is becoming a major cause of HSV and HPV transmission. A considerable number of studies have been conducted both by medical and feminist researchers with regards to why condom use has not been adopted universally as a safer sex practice. The medical literature predominantly reflects the normalisation of penetrative heterosexual sex as a biological activity and the feminist literature typically critiques the “coital imperative” (see for example McPhillips, Braun, & Gavey, 2001). Either way, the focus on ‘real sex’ has captured the research arena with the effect that the increasing implications for women between oral sex and HSV/HPV acquisition are rarely addressed. Celia Roberts, Susan Kippax, Mary Spongberg and June Crawford assert that

[t]he lack of scientific information regarding oral sex...is tied up with particular research priorities and limiting models of sexual practice (Roberts, Kippax, Spongberg, & Crawford, 1996, p. 108).

Although there is a body of medical literature on HSV acquisition through oral sex, I have found few in-depth feminist critiques on the power relations of women’s participation in oral sex practices. Anecdotally I have been told by many women that even though they saw that a male partner had a ‘cold sore’ on the mouth (HSV-1) they did not feel able to decline receiving oral sex. Often the fear of hurting the partner’s feelings by telling him he has a sexually transmissible infection was more risky to intimacy and romance than the risk of contracting HSV genitally. The *Herpes* article mentions avoiding contact with someone with ‘cold sores’ and as with the advice regarding condom use, there is no mention of how problematic the instigation of advice might be.

From a medical perspective, Laura Duberstein Lindberg, Rachel Jones and John Santelli (2008) make the point that oral sex is one of the noncoital sexual activities that is less studied than vaginal intercourse, associated with “an aura of taboo and prurience” (Duberstein Lindberg, Jones, & Santelli, 2008, p. 231). I have often wondered whether it is more difficult, given the construction of women’s sexual desire, to research oral sexual experiences in women; receiving oral sex perhaps may be associated more with being a desiring woman rather than passively submitting to penetrative sex. I also have noted for a number of years that I receive a large number of emails in my nurse-counselling role from people enquiring about the oral sex transmission of STIs – often

just after they had had a medical appointment. Typically penetrative sexual transmission of HSV or HPV has been raised (if at all) by the clinician but oral sex is rarely addressed. Anecdotally women seem much more able to enquire about intercourse than oral sex when consulting a clinician face-to-face.

Whether or not women experience oral sex as desirable, oral sex is a sexual practice that is on the increase, particularly among young adolescents and is commonly a precursor to penetrative sex (Cornell & Halpern-Felsher, 2006). Oral sex is typically considered safer than intercourse by lay populations in terms of posing no pregnancy risk and less STI risk. Oral sex is also less likely to be considered 'real sex'; the increase in oral sex may in part be in response to programmes that advocate abstinence (Duberstein Lindberg, Jones, & Santelli, 2008). As oral sex increases, so does the prevalence of genital HSV-1 and oral cancers caused by HPV (Leichliter, Chandra, Liddon, Fenton, & Aral, 2007). The decrease in the acquisition of HSV-1 in childhood (oral 'cold sores') means that young people are more likely to contract HSV-1 genitally through receiving oral sex (see Appendix One for clarification regarding the effects of prior antibodies from 'cold sores' to genital HSV-1 acquisition). Findings from a recently published Waikato study showed that HSV-1 is a major cause of genital herpes and the younger the women in the study, the greater the likelihood that they had contracted HSV-1 rather than HSV-2 (Gray, Morgan, & Lindeman, 2008). The acquisition of HSV-1 genitally is usually associated with oral sex.

The acknowledgment of the prevalence of oral sex and the connection of the practice to HSV and HPV acquisition is not discussed in patient education material to any extent compared to transmission through penetrative sex. Oral sex is treated as a secondary heterosexual sexual practice with the focus upon STI transmission through vaginal intercourse. In a poststructuralist feminist analysis of oral sex practices Roberts et al (1996) point out that the lack of information regarding oral sex and STI transmission is not about a deficit in medical understanding, but rather a reflection of research priorities and cultural ambivalence about the status of oral sex as 'real' sex. Donovan draws from epidemiological and economic public health discourses in his reasoning about the practical focus of STI education and classification:

In practice, infections are treated as sexually transmitted only if in doing so may provide a net clinical or public-health benefit; typically the fewer the resources, the shorter the list of infections (Donovan, 2004, p. 545).

An example of how the above classification works in practice is that I typically receive emails from young adolescent women or their mothers, where the young woman, who may be a virgin, has contracted HSV-1 through oral sex and yet she and/or her partner had no idea that 'cold sores' could be sexually transmitted. There is limited publicity that 'cold sores' can be passed to the genitals. When I have raised this point with sexual health physicians, the usual response is that the potential for stigmatising people with 'cold sores' could become a public health nightmare, given that such a high proportion of the population have HSV-1 facially. Currently, 'cold sores' have little

stigma and their prevalence is often used as a comparison by clinicians to de-stigmatise genital herpes – a point I discuss in more detail in Chapter Four.

I consider that the negotiation of oral sex is as complex, if not more so, than women's experiences in negotiating male condom use for intercourse and has implications for STI transmission. I contend that the traditional construction of femininity – of being sexually responsive rather than actively desiring – makes it particularly difficult for some women to ask clinicians about oral sex and STIs.

'Normal' femininity: A precarious position

I now discuss another significant aspect of the representation of viral STIs. HSV and HPV continue to be represented in popular literature as a mark of 'otherness', as other than the norm of the healthy, responsible, desirable and closely-held-in-check desiring woman. It is ironic that although the *Herpes* article opens with comments about the prevalence of HSV, the author 'speaks' to 'normal' women – women who have not yet contracted genital herpes, rather than to women who have contracted HSV. The illusion is maintained that women can protect the boundaries of their bodies from viral STIs, despite the evidence given in the article that the task is nigh impossible.

Contrary to patient information literature that normalises the presence of viral STIs in the lives of sexually active adults, it is the absence of infection that is normal in popular literature. The absence of infection is most commonly associated with good management of the sexual body – sexual control and responsibility - rather than with good luck with the roll of the epidemiological dice. The contradiction of awareness of the high incidence of genital herpes but nevertheless the personal fault in contracting the infection is evident in a quote from a 32-year-old woman participant in Danielle Newton and Marita McCabe's (2008) research:

But I've learned to accept herpes as part of my life and as I've learned how common it was...I grew to realize through my carelessness, I was lucky I didn't end up with something much worse (Newton & McCabe, 2008, p. 866).

Newton and McCabe (2008) use the quote to comment on the woman's adjustment over time, whereas my interest is drawn to the way the woman's words position her behaviour as "carelessness", indicating personal failing rather than lack of epidemiological knowledge, which allows for a position of being both infected and responsible.

As well as advocating condom use, the *Herpes* article advises: "[l]imiting the number of sexual partners minimizes ones risk as well" (Goodchild, 2009). In Chapter Five I analyse how complicated it can be for women to determine what constitutes the right number of partners – where the line is between a reasonable number of partners and 'promiscuity'. Given that STIs and notions of promiscuity are so strongly linked, I find that it is an easy step for any women who contract a viral STI to determine that her behaviour is promiscuous; that contracting a viral STI indicates 'going over the limit.'

In the 21st century, sexual health protection through female restraint predominates as a core sexual health message. Advances in medical science with the development of the HPV vaccine have drawn attention to the thin veneer of acceptability of female sexual desire. As discussed in Chapter One, recent media coverage regarding the introduction of the HPV vaccine highlights the ongoing societal debates about the reduction of STI risk with a vaccine. The presence of infection is commonly framed up as the mark of deviant sexual behaviour. The following image is used in a *Time* magazine article provocatively entitled, *Defusing the war over the “promiscuity” vaccine* (Gibbs, 2006).

Figure 3. Image accompanying HPV vaccine article



In keeping with the metaphor of warfare in the article's title, the image shows a 'bull's-eye' superimposed on a girl's body with the central target in the proximity of the girl's cervix. The syringe perhaps represents a missile aimed at the problem - but is the problem HPV or promiscuity? (In reality, the injection is given into the arm, not the abdomen). Although the article's title positions the author as being on the side of 'defusing' the opposition to the HPV vaccine, I read the accompanying image as evoking the eons-old story of young women's sexuality as a trouble-spot to be targeted and that venereal disease is synonymous with female prostitutes or other similarly 'contaminated' women (Hatty & Hatty, 1999).

So far I have considered the factors that may mean a viral STI diagnosis complicates a woman's life – the way she thinks about herself and her body. Yet the steps to attempting to avoid contracting a viral STI also complicate women's lives as they simultaneously attempt to adhere to norms of femininity, heterosexuality and romance. Common representations of women, as evidenced in the *Herpes* article and in Figure 1, show the ideal woman as sexually desiring and sexually experienced yet 'clean' – unblemished by an STI. She may not be wearing a white bridal gown but she is wearing a white bikini. Sex and sexual attractiveness are typically depicted as the domain of youth; young women who are able to manage the juggle of condom enforcement, meticulously manicured pubes, smooth, taut surfaces. The *Herpes* article only addresses those women who have not yet contracted herpes. There is no mention of how women with the virus are to go on living with the infection. The failure to address the possibly large readership of women with genital herpes perpetuates the belief that women with a viral STI are other-than-normal women. I consider that the 'Gloss' article illustrates the sort of 'routine' teaching women receive socially that reinforces that a viral STI contravenes health, aesthetics, self-care and control. Women who are

unable to 'take on board' clinicians normalising of viral STIs are not being contrary; they are unable to match the social 'truths' - the stigma of viral STIs - with the medical 'facts.'

Stigma

In medical literature, the difficulties that people encounter subsequent to contracting a viral STI are made sense of primarily through extrapolations from Erving Goffman's (1963) sociological stigma theory, laid out in the now seminal text, *Stigma: Notes on the management of spoiled identity*. Goffman's theory proposes a demarcation of 'insiders' and 'outsiders.' Goffman contrasts 'normals' with those people who have an attribute that is discrediting. According to Goffman, some people have overtly identifiable differences that mark them as different and discredited; people who are obese, who have an obvious disability or birth mark. By contrast, many people 'pass' as 'normals' and yet have some condition or lifestyle that, if it were known, would discredit the person.

In medically-oriented research, a stigma discourse is readily applied to all manner of bodily differences. Alcoholism, gambling, gay or lesbian sexual orientation and sexually transmitted infections are examples of differences that may render a person discreditable. I consider that the term, 'stigma,' has become such an overarching definition for the problems people with viral STIs face that the use of the term limits a detailed exploration of what factors constitute the experience of stigma, as if a finding of stigma means the problem has already been identified. For example, in an English medical study, Jo Waller, Laura Marlow and Jane Wardle (2007) hypothesise that

[w]omen who know that HPV is sexually transmitted will expect to experience higher levels of stigma, shame and anxiety if they test positive for the virus than women who are not aware of the mode of transmission (Waller, Marlow, & Wardle, 2007, p. 155).

The research findings indicate that if women know that HPV is sexually transmitted they experience higher levels of shame and stigma. By the article's conclusion the reader is none the wiser as to how shame and stigma are experienced in women's lives. Even though the article is specifically about women, stigma and HPV there is no mention about the specifics of women's sexuality that account for the stigma. The study implications suggest that educating women about the prevalence of HPV seems to reduce women's negative feelings – even though the specific content of the negative feelings has not been elicited.

The following excerpt from the conclusion of an English research project (Bickford, Barton, & Mandalia, 2007) illustrates my point that 'stigma' is a common research finding and yet the term is not 'unpacked' to offer clinicians interventions that might make a useful difference to patients' lives. The study involved 70 participants; 98.5% heterosexual and 72.5% were women. No gender distinctions are made in the research findings. The conclusion states:

Stigma, by promoting non-disclosure, can be seen as encouraging transmission. Reducing stigma could increase disclosure and, therefore reduce the transmission of HSV to sexual

partners by enabling greater risk-reduction behaviour (Bickford, Barton, & Mandalia, 2007, p. 592).

The authors note that stigma is linked to anxiety and feelings of isolation, shame and fears of rejection. Again, the detail of how these generic concepts of disruption shape people's lives is not addressed. The absence of any detailed medical study about the specific effects upon sexuality that I notice in HSV/HPV research is also commented upon by feminist researchers in their study of twenty Canadian women living with HIV. Maria Gurevich, Cynthia Mathieson, Jo Bower and Bramilee Dhayanandhan (2007) do not use the term 'stigma' directly but their research is an example of the sort of deconstruction of stigma that may give clinicians a clearer understanding of the effects of the diagnosis. They note "...a predominant discourse of disciplining bodies, desires and subjectivities...which centres on restrictions imposed by an HIV-positive diagnosis" (Gurevich, Mathieson, Bower, & Dhayanandhan, 2007, p. 9). In detailing the effects of disciplining bodies, they draw the following discursive constructions from women's accounts:

...diminished spontaneity, foreclosed (provisional) sexual freedom, foreclosed power, foreclosed flirtation, inciting violence, (un)natural sex, responsibility imperatives, muted/mutated sexuality, and diminished intimacy (Gurevich, Mathieson, Bower, & Dhayanandhan, 2007, p. 9).

This sort of deconstruction may be far more useful for clinicians in their endeavour to address women's difficulties in relation to an STI diagnosis than the knowledge that 'stigma' is at the root of the problem. I concur with Gurevich et al's (2007) assertion that women are engaged in disciplining bodies and desires. I have already drawn attention to complex patterns of women's self-surveillance – of bodily presentation, of normal feminine behaviour - that may confound the simplicity of a stigma/de-stigmatising approach through an emphasis upon relative normalcy determined by prevalence. I address clinicians' efforts to destigmatise viral STIs through normalising in Chapter Four, where I show the limitations of the practice. The 'traditional' view in the medical literature, that STI stigma is directly linked to notions of sexual morality is sometimes apparent although not consistently borne out in feminist literature. Rather, much broader themes of self-policing in order to live up to ideals of femininity are evidenced. These themes are explored in Chapter Five, where I discuss themes of femininity and self-surveillance.

I consider that the *Herpes* article promotes a paradox of a highly prescriptive account of what it means to be a sexually active and sexually desirable woman with the illusion that it is possible, through vigilance, to avoid contracting a viral STI. Women participate actively in practices of bodily surveillance, positioned as both the controller and the controlled. Bordo (1993a) asserts that women voluntarily co-operate with the normalising practices of femininity. Through the obedient submission to normalised practices, women may experience themselves as powerful and in control of their bodies.

The key problem with using stigma theory to analyse women's accounts of the effects of contracting viral STIs is as follows: a discourse of stigma is readily applicable precisely because women occupy precarious territory even in the course of living lives that readily conform to contemporary notions of normal femininity (such as serial monogamy, heterosexual orientation, romantically 'trusting' a male sexual partner and not asking for him to use condoms). Just contracting a viral STI in the course of performing 'normal' femininity is enough to shift a woman from 'normal' to 'outsider.' Stigma 'makes sense' but research into stigma rarely goes very far in deconstructing the concept in a way that is helpful to clinicians. Foucault's concept of self-surveillance produces a different starting point than the binary of Goffman's stigma theory in which a person is either stigmatised or not. Foucault (1977/1991) begins with the concept that practices of self-policing are part of 'normal' life, not reserved for those people who perceive themselves to be 'marked' or tainted.

Relationships and a viral STI diagnosis

As I have discussed, I have found that there is very little about how people manage sex and sexual relationships in medical research articles about sexual health. This relative absence is mirrored in the *Herpes* article where women are taught to understand their bodies via a limited medical discourse. Although Figure 1, the image that accompanies the article conveys complex messages about women's sexual bodies, Goodchild attempts to write from the privileged position of medical expert (2009). Her article does not address the practicalities of the real-life dilemmas women encounter juggling the complexities of femininity, sexuality and sexual health, morality and relationships.

The following medical study is an example of research that omits a depth of enquiry which could potentially produce results relevant to clinical teaching. A London-based study by Green et al (2003) involving 26 women and 24 men with a diagnosis of genital herpes showed that seventeen participants had not had a sexual relationship since diagnosis and five remained in a relationship because of the infection. The findings are interesting because here is a group of people whose sense of choice is substantially altered subsequent to a diagnosis. Yet Green et al do not provide any further detail about why the diagnosis has been so life-altering. The information given stops at: "Seventeen respondents had not entered a relationship because of herpes..." (Green et al., 2003, p. 43). Stating the over-arching problem as herpes means the reader is not given any information about what it is about herpes that is problematic. Is it the actual recurrences? Is it the fear of transmission? Is it the worry about disclosure and rejection? Is it about a changed sense of sexual attractiveness?

The significance of gender differences upon the effects of viral STI diagnoses is absent from Green et al's interview-based research (2003) and research participants are not referred to by gender. In feminist research previously mentioned in this chapter concerning HIV infection Gurevich et al (2007) indicate that women are far more likely than men to curtail sexual activity with another person subsequent to infection. Gurevich et al's analysis of women's accounts highlights women's

focus upon responsibility towards the protection of others that considerably curtails many participants' sexual decisions. Women in their study did not think they were able to exercise the same sexual freedom as HIV-positive men. Gurevich et al describe the conundrum for women in their study that commonly limited the formation of intimate sexual relationships subsequent to HIV infection and I consider that women with HSV/HPV also face these dilemmas:

Contradictory discourses that, on the one hand, position the 'average' woman as nurturing and responsible, and on the other hand, position women as 'dirty, diseased and irresponsible', pose great problems for disclosure (Gurevich, Mathieson, Bower, & Dhayanandhan, 2007, p. 12).

Anecdotally I find that women who have contracted HSV or HPV are also often caught in the contradiction that they think of themselves as responsible and yet their bodies have evidence of irresponsibility. In relation to Green et al's (2003) study I am curious about the gender of the five people who remained in a relationship and attributed the decision to having contracted HSV. In my clinical work, I have spoken with a number of heterosexual women who remain in abusive relationships because of the belief that no other male will have them.

Green et al comment on findings that "...five reported having herpes had prevented them from leaving a relationship" (Green et al., 2003). The phrasing in Green et al's article, that "having herpes had prevented them from leaving" is a problematic simplification. Herpes the virus does not literally stop people from doing anything. Very few people are chronically incapacitated physically by the effects of HSV. In terms of educating people who have genital herpes, the point that people may remain in an otherwise unwanted relationship because of the 'common ground' of both having HSV seems significant. For most people it is the construction of HSV that has people making decisions they would otherwise not have made.

Sexual and relationship upheavals that adversely affect desire are not related to symptoms per se have been noted by other authors. Karolynn Siegel, Eric Schrimshaw and Helen-Maria Lekas (2006) note in a study of HIV-positive women that changes to patterns of sexual desire were primarily attributable to effects other than physical symptoms. Siegel et al draw attention to effects reported by women such as an altered sense of attractiveness, the reduced pleasure from protected sex and transmission anxiety contributing to a decline in sexual desire.

Similarly, in my clinical conversations with women regarding HSV/HPV effects, they have told me about all manner of practices that they have 'dreamed up' in an attempt to reduce transmission. These practices are highly intrusive upon sexual intimacy. Examples are: a male partner wearing underpants and a condom while having intercourse to reduce the chance of contracting HSV from his female partner, a male partner sleeping above the top sheet in bed when his female partner had an HSV recurrence, a couple restricting their sexual activity to her giving him oral sex as he did not want to risk contracting HPV from her, all manner of washing rituals before and after sex, often involving harsh chemicals. In my clinical experience my understanding is that clinicians who

provide education are likely to provide education in 'broad brush strokes' rather than enquiring about the particulars of disturbances to sexual expression and practices subsequent to a diagnosis. For the most part, couples are left to 'translate' medical advice into their sexual practices, sometimes with seemingly bizarre results.

The examples in this section serve to show why 'stigma' has limited usefulness as a concept in understanding the complexity of women's sexual health unless the term is used as an entry point for rigorous deconstruction of women's accounts of their sexual lives after infection.

Psychosocial bodies and the absent corporeal body

Research into the stigma of viral STIs also appears to have eclipsed what a diagnosis and subsequent examinations might mean for a woman's sense of the corporeal body. Women's sense of health and wellbeing, the relationship with the body and with subsequent engagement in sexual activity are points I illustrate in this section and explore further throughout my data analysis. The body is startlingly absent except when genitals are present as an objective body part. Feelings are primarily understood in medical literature as psychological processes in the mind rather connected to bodily experiences. I explore the invisible body and women's taken-for-granted participation in gynaecological examinations in Chapter Six and show that the body's omission is commonplace rather than unusual. Consideration of how clinical interventions involve the comfort of women's bodies is lacking in medical research. The body is subsumed and psychological feelings are given precedence in western medical discourse and research. Donovan comments:

The bulk of the genital herpes morbidity in adults is psychosocial, leading to lower mental health scores and reduced work effectiveness (Donovan, 2004, p. 551).

The investigation of psychosocial factors will produce psychological disruptions to measure, but what is measured may not be directly related to the specific problems women experience with viral STIs. Looking for psychosocial problems is similar to researching 'stigma' whereby 'anxiety' and 'depression' are identified, but not in relation to broader meanings that include the significance of the body, gender and sexuality. Karen Blomberg, Anette Forss, Britt-Marie Ternstedt and Carol Tishelman (2009) comment that nursing's increasing focus on psychosocial and interpersonal aspects of care have led to nurses losing touch with the corporeal body. Their research involved thirty Swedish women with abnormal cervical smear results in a longitudinal study over 30 months. Qualitative interviews were used to gain an understanding of women's bodily experiences rather than a concentration on psychosocial distress. I find this research focus upon the body rather than upon psychological concepts is uncommon. In their study, women frequently reported pain while having a biopsy taken. Women vividly describe having to manage the pain their bodies undergo. For example, one woman, Mona, is quoted:

...And you have to try and lay as still as possible so they get it right. Not get hysterical and kick her away, because that's exactly what one wants to do, kick her away...you feel

foolish because they're poking around in one end, and the tears are pouring out the other end....But it really did hurt (Blomberg, Forss, Ternstedt, & Tishelman, 2009, p. 482).

With the mix of the physicality and emotion that the procedure elicits, Mona is working very hard to manage her body. Mona has described an awareness of multiple sensations she undergoes – prodding and tears pouring. The researchers describe Mona's account as moderate compared to some women's descriptions and yet typical of many women's responses. Blomberg et al's (2009) research gives many valuable pointers to clinicians to be aware of how women are managing. Yet the research regarding women's participation in cervical screening and follow-up reveals a tendency towards identifying psychosocial distress and educating women accordingly; a point I illustrate in the following research report example and in Chapter Six.

Jo Waller, Kirsten McCaffery, Henry Kitchener, James Nazroo and Jane Wardle (2007) evaluate the impact upon women of taking part in repeated testing for HPV. The authors work in the fields of public health and epidemiology and obstetrics and gynaecology. This English research involving in-depth interviews with thirty women is an example of the absence of attention paid by researchers to women's reports of physical pain and discomfort during examinations. The women participating in this study had repeated speculum and colposcopic examinations. The authors comment that some women had concerns about the actual procedure of colposcopy, separate from anxiety about biopsy results. For example one woman reported:

I was more worried about the procedure I think. At that moment in time I was worried about the procedure. I hadn't thought past the result. I thought more about how it was going to hurt and whether I'd have to take time off work all that kind of stuff (Waller, McCaffery, Kitchener, Nazroo, & Wardle, 2007, p. 201).

The authors make no reference to the potential for women to find procedures unpleasant or painful. Similar to other studies, Waller et al (2007) are focussed on looking for evidence of anxiety related to the associations of HPV with the stigma of STIs and the fear of cervical cancer. Research in the field of anxiety and HPV testing almost uniformly overlooks women's anticipated and actual bodily feelings involved in procedures. How have women's bodies become so overlooked in gynaecological examinations? I discuss this question in detail in Chapter Six. In brief, although there has been considerable feminist protest about the medicalisation of women's bodies, particularly in relation to sexuality and reproduction, cervical screening and follow-up treatment has become a 'normal' and obligatory part of being a woman (Bush, 2000; Howson, 1999). Official literature such as patient education material focuses on normalising cervical smear and colposcopic procedures:

The colposcopist paints a liquid on your cervix, which will show up any abnormal cells. It may sting a little. Some small tissue samples may be taken from areas that look abnormal (a process called a biopsy). When the tissue is taken, you may feel a quick, sharp pinch (National Cervical Screening Programme, 2007b).

Women who experience colposcopy and biopsy as extremely unpleasant will not be able to prepare for the possibility of strong bodily feelings by reading currently available New Zealand pamphlets. Nor will women necessarily recognise their bodily reactions on reading the brochure subsequent to the procedure. Anecdotally, my understanding of the conclusions women draw is that either the operator failed or that as a woman they failed to tolerate a routine procedure. The lack of attention given to women's bodily experiences in research may also be mirrored in women's actual clinical encounters. Possible effects include women who have less-than-desirable experiences and as a result they may be deterred from routine follow-up.

Conclusion:

This chapter first addressed how difficult it is for women to maintain sexual health and simultaneously to experience normative femininity. I have used an article about genital herpes in an online women's magazine and the accompanying image of a young woman's body (Figure 1) to illustrate the tensions for women – to look sexually appealing and available and yet to avoid an endemic infection. The example of genital hair removal is used to show that making sense of beliefs about clean and dirty genitals is not a simple matter of biological science for women or for clinicians. It is something of a paradox that, as shown in chapter one, clinicians rigorously normalise viral STIs and yet in this chapter I show that clinicians also defend women's right to judge genital hair as dirty and not appealing.

I used the examples of condom use and oral sex to illustrate the simplicity of sexual health messages and the complexity for women in their implementation. Women are routinely urged to take responsibility for their sexual health and yet to do so may go against the grain of dominant discourses of femininity and romance. The provocative media in relation to the new HPV vaccine shows the ongoing western cultural unease about women's sexuality; on the one hand women are told to take responsibility for their sexual health but, on the other, to do so gives women licence to be (dangerously) sexual.

Once women have contracted a viral STI, the concept of stigma is commonly used in medical research to account for the adverse changes women report.

I have shown how the term, 'stigma' is used and yet is not analysed and therefore has limited usefulness for clinicians in considering interventions that may make a difference to women's lives. I have drawn from feminist research in the field of women and HIV to show the sort of analysis that indicates the disruptions that occur for women in their everyday lives. The idea that women exercise self-surveillance that constrains their sexual lives is also relevant to women with HSV/HPV.

Finally, I discussed the absence of the body in HSV/HPV research. In-depth discussion of the corporeal body is remarkably rare. The repeated emphasis in medical research on psychosocial findings of generic anxiety and depression does not address the specific experiences women have

when their bodies are examined by health professionals. I consider that this omission is significant, given the importance to women's health of participation in screening and treatment. The research gap is also relevant because clinicians may be unaware of the extent to which their role and behaviour may detract from women seeking healthcare.

In my study I endeavour to expose the discourses that shape teaching and learning about infections that are so common one might think there is nothing left to say about them. The combination of medically commonplace conditions combined with taken-for-granted conventions of femininity means that there is the potential for pedagogical moments that might enhance women's lives to be overlooked.

Chapter Three:

Voices of experience: Email interviews with women and clinicians

Introduction: Email interviewing for 'sensitive' research

In order to investigate discourses of morality, femininities and the body that shape teaching and learning about viral STIs, I conducted in-depth qualitative email interviews. The interviews involved 26 women with an HPV or a HPV diagnosis along with 12 clinicians (for full participant details see Appendix 2)². The interviews took place over approximately seven months and were predominantly completed between August 2007 and February 2008, with very high retention of participants through to interview completion³. With each participant the interviews entailed an exchange of an average of four to six emails. The email interviewing method generated rich data. In this chapter I describe why I chose the method, and how I implemented the interviews and analysed these data.

Given the paucity of research that uses in-depth qualitative email interviewing, I describe the process of data collection in detail. I also draw important distinctions between email and face-to-face interviews for researchers to consider. The method requires the researcher to be able to communicate warmth, humour, care and interest in the absence of bodily cues. Meticulous planning, rigorous attention to technical and ethical details, timely responses from the researcher, and the researcher's emotional resilience in engaging concurrently with multiple participants at different stages of the interview process are also vital to successful implementation.

In this chapter I address three areas that are important to consider for the ethical generation of 'rich' data that has potential applicability in clinical practice. Firstly, I introduce the concept of 'sensitive research'. In devising an appropriate research method my priority was to choose a method enabling attention to the potential vulnerability of participants while facilitating the collection of rich data. I was mindful that interviewing women about sexual health inevitably includes questions that may elicit information and memories considered private and possibly emotionally difficult.

Secondly, I address the practicalities of conducting 'sensitive' research in the process of data collection through in-depth email interviews. I describe the research literature that shaped my choice of method and the process of conducting the interviews. Through email correspondence I was fortunate to receive advice from academics internationally who had utilised the method. My

² Appendix 2 includes the ages of women participants with an HSV/HPV diagnosis, as age is pertinent to some aspects of the data analysis. Clinicians' ages are not included. As a small, specialist group it is possible that by providing their ages they might be identifiable to the reader.

³ Although I actively sought participation and had initial enquiries from male clinicians, only female clinicians chose to participate.

goal was to ensure that the email interviewing method I used was both ethically rigorous and 'user-friendly' to participants with rudimentary email and internet skills.

Thirdly, I describe my use of thematic analysis, the method I used to analyse the data in order to draw attention to findings I consider most pertinent to my research question and which Chapters Four to Seven explore indepth.

'Sensitive' research: Is it or isn't it?

The concept of 'sensitive' research guided both my decision to conduct indepth email interviews and how I engaged with my participants from recruitment to interview completion. The term 'sensitive' research has been used by a number of researchers to describe the ethical and practical considerations involved in interviewing participants about areas of their lives in which they are vulnerable and/or marginalised. Pranee Liamputtong (2007) draws attention the increasing amount of research being undertaken in areas of research that involve aspects of people's lives that render them disadvantaged.

Sensitive research most commonly pertains to topics considered to be within the private domains of people's experiences. The topics are deemed sensitive in that divulging information may be accompanied by a sense of real or potential risk of harm emotionally, physically or legally. Potential participants may perceive that research involvement could be incriminating or discrediting. Sensitive topics include such research areas as ethnic and sexual minorities or 'hidden' populations whose behaviour is illegal and/or associated with socially 'delinquent' activity.

Women with HSV/HPV are part of a socially diverse 'hidden' population who are not readily identifiable as a group for interview purposes. Interviewing women who have contracted a viral STI involves asking women about aspects of their health, sexuality and relationships that are deemed private. As I have discussed in Chapter One, women's disclosures about sexuality and sexual health are potentially discrediting. Liamputtong (2007) considers that additional communication skills and awareness and management of ethical complexities are required by researchers when they engage in sensitive research. Liamputtong indicates that participants are more at risk of experiencing emotional harm when participating in 'sensitive' research compared to participation in research that is not "emotionally laden" (Liamputtong, 2007, p. 6).

I highlight that it is not possible to predict whether or not the research is "emotionally laden" nor which participants will experience the research as such. I considered my interviews potentially more 'sensitive' when women participating had a viral STI diagnosis; but I did not necessarily know who these women were. Clinicians who participated in the research were not asked if they had ever had a viral STI diagnosis although they could divulge this information if they chose. This option was raised in participant information sheets for clinicians.

I considered that interviewing clinicians did not directly entail 'sensitive research', as the research questions related to an area of work that, in the field of sexual health, is routine and can be discussed readily with colleagues. However, throughout my interviews with them I was mindful that any questions I asked might invoke traumatic memories of particular women's circumstances. Research questions were also potentially relevant to their personal lives; to their own sexual health encounters with other clinicians. Two clinicians working in the area of sexual health chose to participate from a personal perspective and made comments in response to questions about clinical practice that connected personal and professional aspects of their lives. Their comments below illustrate that contracting a viral STI may be a 'sensitive topic' in the personal lives of women who work in the field of sexual health:

Part of the reason why the diagnosis took me by such surprise and caused me distress was the fact that I am, in fact, a ... sexuality educator. I've got my MA in psychology with emphasis in sexuality. The toughest part in dealing with the diagnosis was feeling like "I should have known better" or should have been able to avoid the issue. Of course, I know that such an idea is not truly "rational" because we can't control what other people do, what they choose to tell us or what they choose to lie about, and we can't control the fact that people may intentionally mislead us. But, from an "emotional" perspective, it was tough on me (Charlene, clinician, HSV diagnosis, 32 years old).

The STI clinic was very helpful for me - I trusted them because I know that's what they deal with every day and they don't judge - here's a little twist for someone working in this field - I was hesitant about talking to anyone I actually knew professionally because I didn't want to admit that I had an STI - we're [clinicians] supposed to be able to prevent that - I did eventually talk about it, but I think it is a barrier - we worry about being judged (Jeannie, clinician, HPV diagnosis, 37 years old).

The above comments highlight the importance of researcher attentiveness to the contradictions within women's lives; that a topic about which a woman has professional 'objectivity' and confidence may be experienced quite differently when it affects them personally. For Charlene and Jeannie, as health professionals who had contracted a viral STI, communication about the infection is a 'sensitive' topic because the infection represents a failure of sorts. Two clinicians who participated from a clinical perspective chose to tell me that they also had experienced a viral STI diagnosis and had quite different understandings of its significance:

Personally, my husband was with me when I was first diagnosed, and I guess that plus my nursing knowledge made it no big deal. Of course I was disappointed, knowing it could recur, but it seemed unimportant compared to other things that can happen. I do get minor recurrences quite frequently, but they are no more stress-inducing than having periods! (Jessica, clinician, HSV diagnosis).

I have tried to give you some of the stuff I speak to patients in an average setting. I speak to patients from the perspective of a health professional but also a normal person – hence

things like “most of us are having sex” or “member of a club” but do not refer to myself or my circumstances personally. I do not allude to the patient whether I have had these infections or not but try to model the message that I am trying to convey that this is an issue for all people and I would be no different. I have had CIN/HPV of course! And to my knowledge have not had genital HSV. I only tell you this to emphasise that my motivation to counsel patients well is born from the damage I have seen over the years and not from my own personal past distress (Kate, clinician).

For Jessica, the combination of clinical knowledge and partner support eased her diagnosis by making it “no big deal.” Kate describes the sense she has that her profession does not separate her from sexual health experiences any woman might face. Kate also emphasises the ease she has with the diagnosis of HPV; that the clinical information about the prevalence of HPV enables her to think of HPV as part of a ‘normal’ woman’s life. The above quotes from clinicians illustrate an absence of uniformity in participant responses; that a researcher cannot predict ahead of time the extent to which an interview will be sensitive or not. Before commencing interviews I considered how the questions I would ask might trigger other sensitive topics in participants lives. This preparation may enhance the researcher’s readiness to respond ethically and empathically to interviewees and may spare the interviewer “the ouch! factor” (Alty & Rodham, 1998) of the unexpected in an interview.

Prior to conducting interviews I anticipated that I would encounter a breadth of disclosures beyond the boundaries of talking about STIs. Although sexual health is a discrete discipline for health professionals, I have repeatedly noticed in a clinical context that the topic of sexually transmitted infections may link to myriad aspects of women’s lives: childhood sexual abuse, coercive sex and rape, infidelity and other relationship hurts, non-disclosure of the diagnosis to sexual partners, pregnancy desires and fears, parenting decisions and comparisons with other seemingly unrelated life hurdles. Indeed broad themes beyond STIs did appear in women’s accounts:

I look at an attractive man and think he won’t want me or [I] compare myself to women who appear to have everything going for them. It’s a battle. When I was 27 I terminated a pregnancy and felt that somehow I was “marked” and put myself through emotional torture over it as well (Victoria, HSV diagnosis, 37 years old).

Male doctors, well, some are lovely and polite, but I have refused to be examined for personal reasons (surviving abuse/rape) (Rachel, HPV diagnosis, 28 years old).

The diagnosis fits with a very old/early message I received in my life journey. My mother was ill after my birth and subsequently the family was split up and fostered out for a time. I grew up believing that the meaning of this was that I was in some way 'toxic.' The herpes diagnosis absolutely plays into this old message as you can imagine (Leila, HSV diagnosis, 51 years old).

Overall, the devastation of death [father and mother-in-law] relates to the devastation of receiving the diagnosis and yet, it's [HSV] not life-threatening. How crazy is that? But, you know your life will be different: you will have to bear the outbreaks, future partners' rejections, your own self-esteem issues etc. And life without your parents or mother-in-law will be different as well. It [the diagnosis] almost felt as if it was a death sentence in a way (Rose, HSV diagnosis, 45 years old).

These examples illustrate the diversity of 'sensitive' topics to which a researcher may need to respond: experiences of loss, hurt and grief and of being diminished as a woman by certain events. Conducting 'sensitive' research that provides rich data requires skillful communication on the part of the researcher to 'roll with' whatever participants bring to interviews. Below is an example of a carefully considered response; an excerpt from my reply to Rose, quoted above. Rose is also a clinician, although not in the area of sexual health and our conversations commonly moved between the personal and the professional:

Catherine's response to Rose:

I really appreciate you taking the time to reply – I wonder if you have to summons up a lot of energy to be in the 'right' sort of space to answer, as your answers seem to reach into so many strands of your life. Your emails highlight the way in which the meaning of one experience shapes another and another so that there is no singular meaning of any clinical condition – that the meaning for each person is part of the whole picture of their lives. This perspective of the layers of meaning – what shapes meaning - is often obliterated from most medical texts, apart from some lip service about holistic care. You have endured the loss of such significant people from your life; losses that at least have public sanction and so can be spoken of and mourned. With HSV, the losses have been invisible to almost everyone and compounded through the silence of clinicians, which perhaps reinforces the feeling that HSV is 'unspeakable.'

In the above quote I use a number of communication strategies: acknowledgement - "I really appreciate," curiosity and tentative enquiry – "I wonder," summarising – "many strands of your life," and offering something of my own thoughts in commenting upon the distinction between publicly sanctioned and invisible griefs. As part of my discussion about the implementation of email interviews I illustrate in more detail aspects of rapport-building communication skills that have the potential to enhance the email interviews. Prior to an elaboration of detailed aspects of the research process I provide relevant background information about 'computer mediated communication' (CMC) to situate the accessibility and relevance of the internet to women's lives. This discussion supports my claim of the suitability of email interviews for this research project.

Method choice: Researcher suitability

When I began my thesis I imagined that I would conduct face-to-face interviews. While conducting an initial literature review, I found a small number of studies⁴ involving 'sensitive' research where in-depth email interviewing had been used, with the authors concluding that the method was highly successful both in terms of participant satisfaction and data collection. Email interviewing is part of a range of online research methods known as computer mediated communication (CMC). The term CMC refers to the use of computers for direct text-based interaction to obtain qualitative and quantitative (survey) research data. In the research literature CMC is compared to the 'gold standard' of face-to-face (FTF) communication for obtaining qualitative data (Mann & Stewart, 2000); a comparison I discuss later in this chapter in relation to my choice of research method.

After reading articles about email interviewing I decided that email interviewing had the potential to attend to the wellbeing of participants while enabling me to collect pertinent data. I was also keen to participate in use of a research method about which very little has been written, compared to literature about FTF communication for obtaining qualitative data. I already had a considerable transferable skill-base with online conversation about sensitive topics. The sorts of research and communication dilemmas the above researchers highlighted were for the most part familiar topics I had already engaged with in my work as a nurse-counsellor.

Transferable skills: From email nurse-counsellor to email interviewer

By the time I began my thesis research I had accrued approximately 1000 hours of email nurse-counselling experience working for two sexual health organisations. My practice had been regularly audited by the professional advisory boards of both groups. In the late 1990's I commenced working as the email nurse-counsellor for the two websites of the government-funded Viral Sexually Transmitted Infection Education Foundation; I continue to work in this capacity. Between 2003-2007 I additionally worked for another not-for-profit international health information company,

⁴ I refer to the following five researchers' work a number of times in this chapter:

- Australian researcher Debbie Kralik (Kralik, 2000) used email interviewing over a period of 12 months to explore midlife women's experiences of chronic illness. Kralik is a nurse and academic. Eighty women were recruited and participated to varying degrees.
- Cheryl Tatano Beck (2005) is a USA-based nurse and academic who used email interviewing to study women's accounts of traumatic births. Tatano Beck had a total of 40 participants; 38 women chose to be interviewed by email and 2 women participated by postal mail.
- Judith McCoyd (social work researcher) and Toba Kerson (2006) conducted a USA-based study contrasting email, telephone and face-to-face interviews. Women were interviewed about pregnancy terminations after a diagnosis of a foetal abnormality. Of the 30 participants, 20 used the email method.
- American clinical nurses Carrie Adler and Yosepha Zarchin (2002) recruited 7 women who were on bed rest for pregnancy complications at the time of the study to participate in an online focus group.
- Illingworth (2001) is a sociology lecturer at University of Stirling in Scotland who used email interviews to collect data from women who had undergone infertility treatment. Illingworth mentions the relevance of her personal experiences with assisted reproductive technologies.

the International Herpes Alliance, established as the patient education 'arm' of the medical research-oriented International Herpes Management Forum www.ihmf.org.

Given my lengthy professional life involving FTF communication and my growing clinical practice as an email nurse-counsellor, I conclude that in-the-flesh meeting is not 'naturally' superior to CMC communication in terms of a felt sense of benefit and human connection. Before addressing the detail of conducting email interviews I give a brief overview of the academic debates in relation to accessibility and relevance of the internet in relation to women and health.

The 'digital divide': A problem for researchers?

The 'digital divide' is the concept used in CMC literature to highlight the potential obstacles to internet usage and therefore the unequal access to the information, communication and research participation opportunities (Lewis, Eysenbach, Kukafka, Stavri, & Jimison, 2005). Disparities in access may include socio-economic, ethnic, generational and gendered aspects. There is a body of 'digital divide' studies that emphasise that people who are 'conventionally' marginalised economically, and in terms of race and sexual orientation cannot be assumed to be inevitably excluded from internet technology. Similarly geographic isolation, illness or disabilities do not correlate neatly with inequitable internet access.

Three studies conducted in USA by Bharat Mehra, Cecelia Merkel and Ann Peterson Bishop (2004) conclude that the 'digital divide' metaphor has limited significance. These studies address access of low income families, sexual minorities and African-American women. In an Australian study of the use of technology by people with disabilities, Seymour (2001b) considers internet use may enable more egalitarian research practices, enhancing research participation. For example, people with disabilities may be more able to 'speak' their experiences through email rather than in a FTF interview. There may be less hurdles to participation when participants control contact and interview location. Similarly, in an Australian study of people who have a head injury by Jennifer Egan, Lesley Chenoweth and Donna McAuliffe (2006), the participants report a preference for email rather than face-to-face interviews. One participant in their study, when asked of the preference for online compared to FTF interviews comments poignantly on previous participation in FTF interviews:

....I have needed breaks (because of pain) and the 'not many more' (questions) reply is insulting, it invalidated my feelings and request for a break, like my pain was not more important than their finishing in a certain time frame. Naturally my interest wanes as a result, I want to finish so will by-pass questions or be a bit glib in my response (Egan, Chenoweth, & McAuliffe, 2006, p. 1288).

The above comment illustrates the point that FTF interviews may be far from ideal for participants and may impact adversely upon researcher credibility and the quality of data collected. Email interviews address the 'face-to-face divide'; providing an inclusiveness not possible 'in the flesh'. In

their Australian-based study of women living with chronic illnesses, Kralik et al (2000) were able to include women who would otherwise have been excluded from interviews due to rural isolation or illness.

Women's access and use of the internet

Statistically women equal or outnumber men in their use of the internet despite the myriad reasons for their initially slower uptake compared to men. New Zealanders are amongst the highest internet users in the world. By the end of 2004, 79.8% of people in New Zealand were using an Internet connection at a variety of locations including home, work, libraries and Internet cafes. Women make up 53% of these users (InternetNZ). Most pertinent to my research, women predominate in the area of seeking health information online. Sanjay Pandey, John Hart and Sheela Tiwary (2003) indicate a number of studies, including their own research, that link women's traditional role in the responsibility for family health with the contemporary use of the internet.

In my email nurse-counsellor role, my statistics demonstrate that consistently between 60 to 70% of e-mails are sent by women. Interestingly, and in line with the research on women's role in family health, the e-mails I receive are often written on behalf of other family members, particularly male partners. In a small USA study, Suzanne Dickerson's (2003) findings show that women typically use the internet as an ally, to help streamline busy lives, which includes going online as the first 'port-of-call' in the management of family health. Using the internet as a precursor or an adjunct to a medical consultation has become a routine part of many people's lives. Most clinicians in my study made direct reference to the role of the internet for health information in the lives of the people they see as patients. The emphasis was on providing suitable sites and cautioning people about misinformation and 'horror' stories and images:

The internet as a source of information is now commonplace and necessitates that the clinician check with the client about what they may have learned from the internet and clarify any misinformation or questions that might arise. (Just as the clinician would seek to clarify pre-existing beliefs, myths etc. from other sources - media, friends, etc) (Edith, clinician).

Re[garding] the internet: I try to persuade my patients to look only at appropriate sites. Often women have looked at numerous sites, some of which give incorrect and imbalanced information, and sometimes worst case photos which are very distressing. I think that the internet can be a particular problem in those who have a tendency to STI phobia (Betty, clinician).

Despite clinicians' reservations about the role of the internet as a source of health education material for patients, the emancipatory opportunities of internet use by people living with disabling and stigmatising conditions and chronic illnesses are well documented.

Internet use for health information

Part of my decision to use CMC as a research method is informed by the knowledge that it is common for people experiencing all manner of health disruptions to use the internet for information, support and activism. I anticipated that women would respond to my research advertisement placed on several websites. There is a familiarity with internet and email that often precedes the decision to participate in CMC research; participants in CMC research are often recruited from a variety of online resources. People who experience stigma associated with a condition may turn more readily to the internet than those who do not experience stigma. In a USA survey (Berger, Wagner, & Baker, 2005) of 7014 people living with a stigmatised condition (anxiety, depression, herpes or urinary incontinence) the results demonstrate that this group were significantly more likely to use the internet than people with a non-stigmatising health condition. Internet usage involved accessing information and making contact with health professionals by the internet. The authors suggest that the internet may provide useful educative and outreach opportunities. One of my participants describes the components of ease and privacy afforded by the internet in finding information and support:

When I used the internet I didn't have to worry about anyone seeing me as I have a laptop at home. To start with I just typed in the word, herpes. Then I narrowed it down to herpes support, which then gave me lots of sites to look at. There is a website where you can ask questions or chat to people. I think online talking is very good as you can speak to people in the same situation who are having the same problems etc, as not everyone can get to a local support group or to their doctors/health clinic to talk to anyone if they have a problem or a question. Personally I have found it helpful to hear other people's experiences with having herpes and starting new relationships (Maddy, 24 years old, HSV diagnosis).

Maddy's description shows how little internet knowledge is required in order to tap into a resource that provides a spectrum of experiential knowledge from people who have contracted the virus and who are managing the practical realities of sexual relationships. Participation in 'ehealth' virtual communities, social networks made possible through the use of electronic media, are part of the everyday experiences (Hamilton & Bowers, 2006). These groups are readily accessible to people with minimal internet searching skills. For example, Yahoo!Groups (www.yahoo.com) lists thousands of support groups in the health and wellness section.

The internet is also appealing in terms of its affordability. Another participant in my research commented:

Actually I found the herpes website to be most informative as the doctor is too expensive just to go to for a chat (Claire, 29 years old, HSV diagnosis).

In my study almost all the women reported the use of the internet as a resource in relation to their diagnosis. While a detailed debate about the role of the internet in health education is beyond the

scope of this chapter, my point is that it is commonplace for many women to use the internet to access health information, and in doing so, to be recruited to participate in my research. While qualitative research using CMC is an emerging field, the world-wide-web has a long history as a tool to research health and support opportunities (Mehra, Merkel, & Bishop, 2004; Pandey, Hart, & Tiwary, 2003).

I have discussed the extent to which internet use is part of women's everyday lives and includes seeking health information and support. I now discuss why the internet is a useful tool for accessing research participants and provide details of recruiting women and clinicians for my study.

Recruitment: Access and inclusion

The politics of the recruiting women who have encountered health problems is an important consideration in terms of the choice of research method. In their study of women who had terminated pregnancies, McCoyd and Kerson (2006) discuss the 'gate-keeping' practices they encountered by health professionals who either did not support the research project and/or considered that as health professionals they were in the best position to judge which women would cope with research participation. The authors comment that the notion of protecting patients easily conflates with silencing women. Recruitment rapidly expanded when research information was put directly into the hands of women affected through posting an email request for participants on a relevant email list.

Similarly, in a study about women's use of reproduction technology, Illingworth (2001) asserts that power relations between researchers and clinicians may impact adversely upon recruitment. She notes that researchers' dependence on clinicians in initial participant recruitment may thwart researchers' access to interviewing women FTF. In her study, she encountered clinicians' 'gate-keeping,' which led to her decision to interview women by email. A senior consultant at the local fertility treatment centre impeded access at every turn as he did not agree with her research proposal. I was interested in the reports of the effects of 'gate-keeping' by clinicians in terms of researchers' access to participants and the rights of women to speak of their experiences. I wanted to advise women about my research without clinicians acting as intermediaries. Clinically I have seen 'gate-keeping' in action; I have possibly been a 'gate-keeper.' I was aware that my research interest is known amongst clinicians in New Zealand; that some consider the work that I do is important and others think I am colluding with and exacerbating the social problems women face by 'making a fuss about nothing.'

Subsequent to my data collection I read of Oster's (2003) struggle to recruit interviewees with HSV for FTF interviews for her PhD study. The three recruitment processes she used were linked to involvement and reliance upon a sexual health clinic: clinicians were to inform potential participants, recruitment letters were sent to people with an HSV diagnosis and a poster was placed on a clinic notice board. Recruitment was ongoing over a ten month period and resulted in

thirteen participants. Oster (2003) links this slow recruitment with the difficulty of talking about HSV, but it is possible that clinicians' perceptions of the study may have affected recruitment. It is also possible that people have reservations about participating in research that appears to be in any way linked to the clinic they attend, for confidentiality reasons. Also, the researcher may appear to be affiliated with a service about which the person has reservations.

Another reason why Oster (2003) may have struck recruitment difficulties is that many people who have HSV do not consult doctors after an initial diagnosis, or do so sporadically; for most people there is no clinical reason to seek out regular medical care. In contrast to Oster's recruitment difficulties, ten weeks after advertising my research online, I already had secured thirteen women and seven clinician participants and was well underway with interviews. The interview phase of my research was largely completed within seven months although I continued to complete interviews over the course of the next year as I had negotiated the option to ask clarification and follow-up questions. I now describe how I prepared for interviews and recruited participants.

Meticulous planning: The key to participant recruitment

Months of planning and consultation went into the preparation to conduct in-depth email interviews. I was surprised to find that this method had not been used at The University of Auckland before and I therefore presumed that I would need to demonstrate evidence of a diligent consultation process to ensure my application for ethical approval was granted. Through email correspondence I was fortunate to receive very generous support and advice from academics locally and internationally who were familiar with the method (see Acknowledgements).

Prior to commencing recruitment, and for perusal by The University of Auckland Ethics Committee, I had prepared a webpage (see Appendix 3). The webpage provided people with detailed information about the research and links to PDF documents such as the participant information and consent form. My goal was for participants to have as much control as possible over the decision to consider participation before they contacted me. The webpage was posted on the University of Auckland website and could be accessed directly or through the homepage of my lead supervisor, where I was listed as one of the doctoral candidates under her supervision. This link was important in order to establish my credibility. An email advertisement was also prepared to be used within the body of an email; not as an email attachment (see Appendix 4) with an easy mouse click to the webpage⁵. The advertisement also worked as a hard-copy flier. Another crucial step prior to recruitment was to set up suitable email access (a designated email address for interviews only) and internet security for the duration of my interviews. The participant information form (see Appendices 5 and 6) gave participants step-by-step information about how I would ensure data security and my requests for their own management of our email correspondence to protect their privacy. All women were asked to provide a pseudonym before the completion of the interview process, which was used in attributing participant quotes. Consent (see Appendices 7 and 8) was

⁵ The body of an email is more likely to be read whereas an email with an attachment may be deleted unopened in case it contains corrupt files.

obtained by participants' email confirmation that they had read the terms outlined in the participant information sheets and the consent form.

Once I had received approval from the Ethics Committee and had the technicalities of the interview process organised, my advertisement was linked to the webpage of the New Zealand Herpes Foundation and the New Zealand HPV Project; the websites of the New Zealand Viral STI Education Foundation. I also emailed the advertisement with the webpage link to a number of academics, current and past colleagues. I asked them to consider forwarding the email to any collegial and women's groups to which they were linked. A request for participants was also circulated on the emailing list of postgraduate students at The University of Auckland. I had a number of other options for recruitment; for example posting on other websites, and requesting involvement from staff at Family Planning Clinics and sexual health clinics but these options were not necessary. I decided to 'roll out' the call for participants step-by-step as I wanted to include every woman who made contact; I thought it might be upsetting for a woman who had decided to participate from a personal perspective to be told, "no thanks." Through this somewhat regulated approach I interviewed every woman who sought to participate. When I was satisfied that I had achieved 'saturation' in the data collection I then had the links removed from the relevant websites and recruitment ended.

Clinicians were recruited via email. Claire Hurst, coordinator of the Viral STI Education Foundation circulated my advertisement to health professionals on several sexual health emailing lists and additionally requested that these professionals further circulated the advertisement. I also directly emailed sexual health professionals requesting that they distributed my advertisement. Clinicians were recruited without difficulty.

I now discuss the technicalities of the email interview process and then go on to address significant communication points that specifically pertain to conducting email interviews.

The interviews: Staying on-track from beginning to end

I developed a series of sixteen interview questions for women with HSV/HPV (see Appendix 9) and thirteen questions for clinicians (see Appendix 10). The practical and technical aspects of interviews with women with HSV/HPV were the same/similar to interviews with clinicians. After establishing that the prerequisite participant information and consent form had been read, I asked women and clinicians to respond to the initial group of questions. I emailed approximately four questions at a time. The first email included a set of demographic questions (details in Appendix 2). The following quote is from an email I sent one of the women participants with HSV/HPV and is typical of the tone I aimed to convey about there being no right or wrong answer to questions:

Catherine:

...thanks so much for reading through the preliminary documents – participating in research can be quite a time commitment and I appreciate you considering that my

research may be worth the effort. I have a series of questions about experiences with health professionals and later a series of questions about other aspects of living with HSV. You are welcome to answer the questions in any way that feels right for you and you are also welcome to digress and make comments that are not related specifically to the questions – the questions are really like stepping stones to get a process started and to provide me with a bit of a framework.

From my prior emailing experience and CMC literature review I was aware of the importance of emailing in a manner that conveyed appreciation, care and interest. Women and clinicians replied to the first group of questions and in my second email I commented on and sometimes asked further about points they had raised. I then posed the additional 'set' questions. I found it useful to have a set number of 'formal' research questions that enabled me to indicate how far through the interview we were so participants could anticipate the ending of the interview.

The opportunity to question participants further gave me greater certainty that I was representing participants' ideas within the intended context. As all participants had the emails of our correspondence I did not supply participants with final copies of the interview material. Participants knew that anything they wrote to me might be used in the thesis, unless they specifically requested that I withheld portions of information. An example of the clarification process is as follows:

Catherine's comment/question:

Your comments about your GP stood out to me - that once you received this diagnosis you realised that there were limitations to the relationship that you hadn't experienced previously. When you said, "I was too devastated to think that [the diagnosis] was correct," do you think your doctor had any idea of the effect of the word, 'herpes,' upon you - did you appear upset or did you keep the upset hidden?

Jessica's reply:

She didn't have any idea of the impact on me and I kept my tears until outside (Jessica, HSV diagnosis, 56 years old).

The ongoing clarification process made possible through the immediate availability of the interview material and the ongoing nature of the email interview process meant that I was able to include data in my analysis chapters confident that the quotes were congruent with the participants' intentions. I withheld names of health professionals, clinics and localities mentioned by participants as additional protection of confidentiality. I corrected minor grammatical errors where the meaning was clear, to aid the clarity and flow of comprehending participants' ideas. Wherever the sentence structure made comprehension confusing, I requested clarification before the identified portion was used in the analysis. Within the transcripts there were very few typographical errors and some

women commented on the enjoyment of the care they took to spell-check their replies and re-read their comments prior to submission.

I decided to make the process of ending the interview clear as a number of email researchers had commented upon how difficult it was to end an email interview – unlike exiting a room, it could be hard to decide when the conversation was over. Illingworth (2001) reports that she did not negotiate an actual ending of the interviews and so intermittent contact with some participants had continued in a way she found problematic. Rather than have a ‘ragged’ tailing-off I had a clear ending with agreement that I would email each woman and clinician again three months after the interview as a ‘check-in’. This enabled participants to add to (or delete) aspects of their narratives and make comments about the interview process.

The potential for a ‘smooth’ interview process is enhanced with attention to practicalities. In relation to data management, when I replied to participants I began a new email. I did not use the ‘reply’ facility on the email. In part this step was a security decision so that if a woman ever did leave an email accessible to another person our whole interview would not be revealed in one email. The practice also made the handling of the data easier. In the subject line of the email I used the system of numbering the emails – ‘research conversation one’ – and so on, which made transferring the emails into chronological Word documents a much easier process than looking at email dates.

I cannot over-emphasise to any would-be email interviewer how significant it is to have a highly organised system for keeping track of participants’ narratives and their emails. It is vital to know where participants are in the process and who is awaiting a reply. With email interviewing the interviewer is ‘holding’ numerous conversational threads simultaneously. I made reminders to myself about additional personal aspects of their lives raised by participants. It is potentially very important to the fostering of email rapport to be mindful of factors in women’s lives – from a history of sexual abuse to a recent hospitalisation, death in the family, a sick child, a new job or holiday coming up. What follows are examples of the way I indicated to women that I was keeping track of who they are as individuals in the interview process:

Catherine:

Thank you for getting back to me. I’m glad the exam is over and fingers crossed for the results! Your email makes me recall that in the 1980’s and early ‘90s women’s groups had ‘hot’ and ‘cold’ files on doctors – the latter being doctors to be avoided. Your GP sounds like she should be warmly recommended!

Catherine:

Thanks so much for your reply. It sounds like you’re a very busy mother, with a little one. I know that feeling of grabbing time while a child sleeps.

Catherine:

I'm sorry that you had what sounds like such a shockingly awful time – to be attacked sexually by someone you know is an experience that women tell me is overwhelming in so many ways. There are other women participating in these interviews who have also had experiences of rape and of sexual abuse in childhood....

I agree with Kralik et al (2000), that an important part of building rapport for each participant is to be acknowledged as an individual and separate from other participants in their relationship with me as the researcher. The above comments assure women that the researcher is paying attention to them and not doing some sort of cut-and-paste interview. These points about attention to detail, conveying care and respect also apply to my interviews with clinicians. The following are examples from my correspondence with clinicians, where I acknowledge constraints of time and the pressure of clinical work:

Catherine:

Hi, Karen and thanks for checking in – I knew you were having a busy time and hope you had a good time in [city]. Karen, when you reply, can you let me know how long each reply takes you as you are one of the first health professionals to participate and I want to make sure that the process isn't too time consuming – I'll re-jig the questions if it is.

Catherine:

It sounds like something of a daunting work experience, to find yourself currently in the position of being able to offer a lesser quality of care than was your earlier experience.... [due to service cutbacks] I hope that you are well supported as you try to spread your skills to cover the gaps – it sounds like you are working hard to ensure that people don't 'miss out' and I imagine that this at times may be something of an exhausting project. It sounds like having colleagues who also have a passion for the work is sustaining for you.

As part of rapport-building with clinicians I included responses about my own clinical practice, where my comments led on from points raised by the clinician. I particularly wanted to acknowledge the often Herculean task clinicians have, trying to make a positive difference to women's lives within the brief span of an appointment:

Catherine:

Thanks so much for your reply – a lot of food for thought about the process of being present for people who are distressed. Your thoughts took me on a trail of thinking of people throughout my nursing career....

Catherine:

The cheerleader metaphor sounds most apt and makes me recall so many experiences of feeling like I have done quite an intense workout in the course of clinical work. Is that a metaphor that just sprang to mind, or one that you've considered previously in terms of your work?

Replying in a timely manner is another key aspect of rapport-building. Participants knew that I would respond to their email within two-to-five days. If for any reasons the reply might be delayed, I informed participants. Usually I did not reply to an email the same day. My practice in attending to replies was that I would print off the reply as a Word document, remove identifying information and create an identification code. I would then read the email several times, thinking about what I was being told. I would highlight the points I wanted to comment on or ask more about. I allowed 45 minutes to 90 minutes for each reply. Although email conversation is most typically associated with swift repartee this was not the approach I took.

Each email reply was carefully crafted as part of my commitment to an ethical and respectful process; this method is definitely not a short-cut interviewing method. Although the method spared me the time of transcribing interviews, each interview with a woman took me in the vicinity of six to eight hours to complete, excluding the extra time needed for data collation and protection. Kralik et al (2000) describe a similar process in terms of researcher time commitment. On my participant information sheet the interview time-frame was stated as taking approximately four-to-eight weeks but this varied greatly, depending upon other commitments in participants' lives.

The interviews with clinicians were typically swifter and their replies shorter than interviews with women with a diagnosis. Clinicians usually adhered to the questions asked, although a few elaborated at length. I had negotiated with all participants that I would send a check-in reminder if I had not heard back within a week. In order to complete the interviews with clinicians I sent most one or two reminders. In hindsight, I think I was asking too much of clinicians for whom my research was in all likelihood not a top priority. No clinician commented that the interview was too long, but if I interviewed clinicians again I would streamline the process to one or two emails only.

Rapport-building and the therapeutic dimension of interviews

Email interviews allow for the building of rapport in ways that are not necessarily possible in other interviews. Kralik (2000) reports that women in her study had a preference to the correspondence method. Her participants reported enjoying the process of time to ponder a response, especially given that they were trying to put into words experiences that they rarely voiced in their everyday lives. My participants with an HSV/HPV diagnosis similarly reported the preference they had to make and receive a considered response:

To write answers instead of speaking them has probably been easier for me, because that helps in the reflective process. I feel I have given as accurate an account as I could have,

in fact more accurate because had this been a structured interview, face-to-face, I think I would have had to deal with a variety of emotions as each question was asked, which may have affected my responses considerably. I wasn't left unsettled [by the email interview], which again I think I would have been had this been face-to-face....I think you communicated a good amount of compassion through your replies to my responses, and I felt safe throughout the entire process (Sophia, HSV diagnosis, 51 years old).

Interviewing process via email - what I like is the anonymity so you can be perhaps a bit more forthright/honest than face to face. I didn't have body language interfering like it can sometimes... or have anyone interrupting me (also can be quite disruptive). I can rework...my words so that they best reflect what I am trying to say.... Also, I felt I could cry and not be embarrassed about it (like I am in face-to face-situations) because no one could see me...I think we have developed a relationship despite the lack of visual feedback so I think it is a valid practice (Dianne, HPV diagnosis, 33 years old).

A number of women in my study made comments about how they thought they had participated much more fully in the email interview than they imagined they would have in a face-to-face interview. In her study, Kralik (2000) comments that the rapport with the researcher was also considered of benefit to the participants, with the opportunity to have 'companionship' in the discussion of complex and often minimised or invisible dilemmas that had previously been unvoiced. This opportunity enabled some participants to move away from practices of self-blame and to recognise the major contribution of contextual limitations to the distress of living with chronic illness. Women in my study also commented on the value of participation, for example:

The research process, and corresponding with you, was very cathartic for me. It helped me organise my thoughts in a coherent manner and address issues that were bothering me. It also helped me, through a process of self-discovery, to put HPV in context (Ann, 36 years old, HPV diagnosis).

There has been great value for me in doing the research. You have responded to what I have written in a helpful and healing way. I at last feel I have a voice and have been heard (Jane, 71 years old, HPV diagnosis).

I have endeavoured to ensure that the portions of participants' conversations used in the data analysis chapters retain the 'voice' of the individual participants in terms of the context and intentions of their comments. I have 'cleaned' the data minimally for readability so that spelling and grammatical errors in the original texts do not detract from what the participant was saying.

With regards to participants having a 'voice,' I found it interesting that none suggested that they would have preferred a face-to-face meeting. Participants' reports regarding the positive aspects of 'disembodiment' stand out because the comments contrast with the possible disadvantages of online research highlighted by researchers. Given that CMC studies are rigorously critiqued and contrasted with face-to-face interviews I briefly discuss the key points raised in the literature.

The disembodiment debate

The debate regarding the disembodiment of the online encounter is raised ubiquitously concerning the validity of online research. The key question raised relates to authenticity and has two key components. Firstly, there is the question regarding the extent to which CMC data may differ from FTF generated data, given the absence of the multitude of non-verbal cues and participants presumed increased opportunity to edit responses (Mann & Stewart, 2000). I have already discussed the possible benefits of email interviews; the women in my study reported editing in rather than editing out information. The absence of the researcher being able to 'read' emotional cues is considered to be a potential detractor in CMC qualitative research. In her research involving people with disabilities, Wendy Seymour (2001b) questions this "corporeal enthusiasm" (2001a, p. 156) as an adherence to qualitative conventions rather than a pertinent grounds for disqualifying CMC research. McCoyd and Kerson (2006) note that women who chose the e-mail option commented on the positive aspect of the invisibility of these cues; that participants were spared the increased vulnerability of becoming uncomfortably emotional in front of a relative stranger. McCoyd and Kerson (2006) report that women nevertheless used textual descriptions and symbols to convey feelings elicited during their interviews. One of my participants made the following comment:

I think the interview online is better than a face-to-face one, only perhaps because other women would feel more free to explain such personal details, and feel less embarrassed....Just my personal opinion, but a face to face interview would in a sense give less information. I think I would be just smiling and nodding my head to any questions you had... Quite simply, I would be discussing my private parts with a stranger, and perhaps that has never really been done for more than just clinical analysis... (Rachel, HPV diagnosis and possible HSV, 28 years old).

Rachel raises an important point; that a face-to-face interviewee may have a lot to 'manage' in the interview process, with the combination of talking about a private topic, dealing with embarrassment and trying to relate to the interviewer. I consider that Rachel's comments and those previous highlight that the email interview appears to enable women to engage in a dialogue with me. By removing the FTF component women are relieved of the potentially stressful parts of the interview process and perhaps more able to reap some benefit from participation.

Secondly, in terms of authenticity there is the question of representation; the extent to which people are who they say they are, for example in terms of gender, age and life experiences. This aspect of representation is raised by Mann and Stewart (2000) in their handbook for online research as a possible problem of online interviewing. They suggest that participants' demonstration of insider-knowledge may be considered by the researcher a possible 'test' of authenticity.

In preparing to conduct my research, I did not anticipate the issue of authenticity would feature. It would take a lot of knowledge to pretend to have a viral STI or to be a clinician in the sexual health

field. It would also take a lot of imagination for a male to pose as a female as, given the anatomical differences, the examination and treatment processes differ.

My role as a clinician/researcher

In my role as a researcher I drew from my clinical experience and ethically I did not consider that I would be able to separate the two roles. Early on when devising my interview method I decided that I had to declare my clinical role to participants; a decision based upon my sense of professional ethical accountability and to ensure that participants had as informed a choice as possible about whether to 'talk' with me. A PhD psychology student suggested to me that this step might adversely affect what women recounted about clinicians. I did not think I could sustain a deceptive interviewer role as an entirely 'naïve enquirer.' Given that I have talked with hundreds of women in clinical settings about HSV and HPV, I thought women might decide I could be more 'worthwhile' talking with online than a complete 'outsider.'

In the participant information sheet I alerted participants to possible 'psychological discomfort' they might experience by participating in the study (see Appendix 5). I provided points to consider that might mean it was preferable for women to decide not to participate. For women who decided to proceed I also had local and international referral plans in place, should additional support be necessary.

Based on my clinical experience I knew that part of the juggle would be to manage what women told me beyond a data-gathering exercise. For example, I anticipated it was likely that some women would be shaping their lives around entirely erroneous medical information from clinicians about viral STIs, some women would request information, and some women would make disclosures where I would feel compelled to provide referral and follow-up options. All the above situations did occur. I provided information as I know that it is often hard for women to find out information that may make a positive difference to their lives. I made sure that I offered any information in a tentative, limited way, so as not to appear directive.

I considered that it was part of my ethical obligation to ensure women had access to services they may not have been aware of or may not have known how to access. Several women asked me about a support group and/or the opportunity to talk on the telephone to a support group member; 'coming-out' steps they had never taken before and found very helpful. One woman had found previous couples' counselling unsatisfactory and asked me about my knowledge of therapists who work in the area of sexuality. I gave her possible options as well as ideas of questions to ask therapists ahead of a session by telephone to see if they might be 'suitable.' Several women, upon reflection, changed their doctors as a result of writing to me about the frustrations they had with their care.

I consider that it is most likely that the communication skills I have developed over the course of my professional life contributed greatly to the outcome of the interviews; that both the participants and I found the process beneficial.

Analysing the data: Thematic analysis

In order to analyse these data I used a qualitative method known as thematic analysis (Braun & Clarke, 2006); a method that is compatible with constructionist approaches. Thematic analysis involves the identification, analysis and presentation of themes within data to go beyond commonsense accounts. I used thematic analysis as a form of discourse analysis. As I discuss in Chapter One, my research intention is to foreground language and meaning. While 'discourse analysis' is more commonly used as a methodological term to describe such work, I preferred to use the term 'thematic analysis' to foreground the clinical applicability of feminist and poststructuralist theory, and avoid the distraction of some of the academic and methodological tensions within these theoretical fields. Thematic analysis provides a broad framework that enabled me to focus on the practice implications of discourse, particularly with regards to power relations, without becoming caught in methodological debates that abound in this field. Braun and Clarke (2006) describe what counts as a theme:

A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun & Clarke, 2006, p. 82).

The key themes I selected from the data are presented in the next four chapters and address the following: the ways the classification of viral STIs shapes clinicians' education practices and women's learning; the influence of women's notions of appropriate femininity in shaping the meaning of viral STIs; the (extra)ordinariness of gynaecological examinations and the moral 'work' that takes place in clinical consultations. These themes draw in part from Foucauldian notions of disciplinary power and poststructuralist feminist use of the Derridean concept of deconstruction. I describe in detail the systematic process by which I decided the key themes.

Braun and Clarke (2006) describe two data approaches; an inductive or a deductive analysis. In making these distinctions they emphasise that 'in reality' it is not possible to analyse data in an "epistemological vacuum" (2006, p. 84). An inductive analysis is ostensibly not driven by the researcher's theoretical interest. I agree with Braun and Clarke's assertion that it is impossible for researchers to be outside of some sort of theoretical position. Ramazanoglu and Holland (2002) assert that any interpretive approach inevitably has constraints shaped by the researcher's politics. A deductive approach is driven more clearly by the researcher's theoretical interest.

I used both an inductive and a deductive approach. An exclusively inductive approach was not possible given my familiarity with my research topic. I have worked as a nurse, midwife and counsellor and studied women's sexual health and sexuality for many years, read broadly in the

field and conducted a Masters dissertation using a feminist, social constructionist approach to women's talk about sexual desire. However, the themes addressed in Chapters Six and Seven were not themes I had considered selecting before the reading and re-reading of my data.

The following extract from one of my interviews is an example of the ongoing interweaving of, on the one hand, the 'expert' knowledge I brought to the interviews from being with so many women clinically that shapes the interview and on the other hand, the orientation towards curiosity and uncertainty about what something means to a particular woman:

Catherine's comment/question:

Rachel, you mention this clinician as a 'lady doctor' and I therefore imagined that perhaps the fact that she is a woman meant something to you – perhaps that having a woman doctor to negotiate procedures with is somewhat different from a male clinician? I of course don't want to 'put words into your mouth' and gender may not make an important difference for you. So my question is: do you think that because she was a woman it made a difference to your experience of her examining you?

Rachel's reply:

The doctor, well, it did make a difference that it was a female doctor. But I think if it was a caring and professional male, gender would not have to matter. More important is the manner or personality of the doctor or nurse putting things in side your personal (to me sacred) places. Gender is important in some respects from a patient's perspective. I am more comfortable with a kind and gentle personality, who can reassure me things are going to be fine. These qualities are presumed (by me) to be held by female doctors doing these types of examinations. Male doctors, well, some are lovely and polite, but I have refused to be examined for personal reasons (surviving abuse/rape) (Rachel, HPV diagnosis, 28 years old).

In the interview with Rachel I did not pretend to be clueless about why she might prefer a woman doctor; I considered that to do so would be disingenuous as any clinician would know that women often prefer gender matching; I imagined Rachel would expect me to know that. She had also previously told me that she has been sexually assaulted. However, I did not assume to know her particular stance on the current subject and her answer brought new information that I could not have accurately guessed. The topic of parts of the body being sacred was new to our discussion, as her ideas about inherent female qualities.

Coding

Email interviewing was invaluable for coding for several reasons. I immediately had the women's words to reflect upon and so I coded each interview as I went along, and before I replied to any email. I was able to question and clarify to ensure that, as closely as possible, I was representing women's thoughts in the context in which they were meant. The latter opportunity is not so readily

manageable in a single FTF interview where the researcher is responding to a large volume of information all at once from the interviewee. I now describe my coding practice and go on to discuss the themes developed from these codes.

I chose to code manually and made decisions about coding that took the extracts beyond a clumping of overtly similar pieces of text. Therefore I chose names for the codes that did not necessarily employ the words that women had used to describe their experiences. For example, for Rachel's reply above I gave multiple initial codings: examinations, sacred parts, clinician gender. I also coded the piece as an example of disciplinary power. The latter category relates to Rachel's statement that she took a position about being examined by male doctors.

While coding, I looked for what I called 'absences' as well as the presence of descriptions. This is a practice I brought from the way I listen to therapeutic conversations, drawing from Bird's (2000; Bird, 2004) teaching. For example, I noticed a common absence of women or clinicians referring directly to or naming the genital area. I gave the following piece an initial code of 'absent genital area':

Luckily for me my job, which is riding horses all morning, does not seem to trigger any outbreaks. Although when I had my first outbreak which was also my most severe I was in agony. I couldn't tell anyone and we were too busy for me to take time off so I just had to carry on. I couldn't even go to the toilet properly or sit on the sofa comfortably let alone ride a horse, but luckily all is ok so far (Maddy, 24 years old, HSV diagnosis).

I wondered whether the absence of direct reference to genitals was about us both knowing what she was talking about, or about politeness, or not having the words, or about something else altogether. As I continued to collect the data about the 'absent genital area' my awareness expanded to include the point that most participants – whether clinicians or women with HSV/HPV – did not mention the process of genital and pelvic examinations, even though examination is an integral part of a diagnosis. I was then able to raise the topic with participants, as a result of the coding. The coding process was aided by keeping a regular diary of what I noticed in emails.

Themes in the data

Ultimately the code, 'absent genital area' became incorporated into the key theme of chapter six; 'examinations.' The chapter themes of classification, self-surveillance, examinations and the confessional evolved as I read and re-read the data and thought about what I most wanted the data to do; I most wanted to show why something ordinary and apparently simple can nevertheless be complicated pedagogically. The first two data chapters, four and five, address the broader themes of that shape everyday understandings about medical diagnoses, health, sex and femininity and the latter two chapters, six and seven, address in more detail the intricacies of teaching and learning that take place between women and clinicians. Within each chapter I present the sub-themes that I have analysed from each of the themes. As Braun and Clarke (2006) discuss, the

identification of sub-themes demonstrates the tensions within the themes, which need to be addressed but not necessarily reconciled in the analysis. For example, within the 'examination' chapter, I analyse the range of women's perceptions of clinical examinations, from examination-as-self-empowerment, to examinations-as-compulsory-gynaecology.

Conclusion

I have made considered decisions about my research method and methodological approach that provide a strong platform from which to analyse my data. My topic is a piece of 'sensitive' research and as such benefited from the professional skills I brought to the interview process. My familiarity and relative ease with talk beyond social conviviality has been highly advantageous.

In this chapter I have given an overview of the field of 'sensitive' research. In particular I have drawn attention to the myriad life experiences women relate in the process of making sense of what a viral STI diagnosis means personally. I have emphasised that a researcher cannot accurately predict the sensitivity or otherwise of a topic for individual participants. In my research I did not know whether or not the topic was personally 'sensitive' to most of the clinicians who participated and I took extra care in my emails as a result.

I have described the literature about in-depth email interviewing that shaped my decision to conduct email interviews. I have discussed and illustrated why email interviews were deemed an acceptable interview method to women in my study. I have given examples of my participants' views about email interviews; ideas that differ from literature that cautions against qualitative interview methods outside of face-to-face conventions. I have emphasised the effort required on the part of the researcher, both technically and emotionally, in order to generate rich data and for participants to deem participation worthwhile. In particular, I have emphasised that, as a clinician/researcher, it was of equal importance to me that there was a potential benefit to my participants, as well as the goal of generating data to answer my research question. I turn my attention to the data in the following four chapters.

Chapter Four: Classification

Introduction: The impossibility of 'objective' clinical teaching

In this chapter I examine a common practice reported by clinicians in my study; that of 'normalising' viral STIs through an emphasis on the epidemiological and physical characteristics of viral STIs. HSV and HPV are both constituted as common and for the most part medically innocuous. I demonstrate the way this practice of 'normalising' works to shape and constrain what it is possible for clinicians to acknowledge about the effects of viral STIs. The practice has the effect of clinicians both 'down-playing' the distress common to viral STI diagnoses and endeavouring to rectify the emotional impact of the diagnosis through a 'corrective' practice of providing up-to-date facts.

Although no clinicians completely disregarded the emotional, social and embodied impact of HSV/HPV diagnoses, women's knowledge of these effects was subordinated in clinicians' accounts. The medical 'measure' of appropriate classification was privileged. In this chapter I contrast the certainty clinicians have in relation to the meaning of HSV/HPV compared to the instability of meaning I identify in both clinicians' and women's accounts. Clinicians' ostensible certainty about disease classification is illustrative of medical discourse. Lupton (2003) draws attention to the way diseases are treated as "...independent entities which may be located within the patient's body and treated separately..." (Lupton, 2003, p. 92). Clinicians in my study primarily educated women to relate to HSV/HPV as relatively innocuous, genitally compartmentalised infections that, through a rational approach, could be held impervious to psychosocial meanings.

In order to consider the instability of meaning, I draw theoretically from Derrida's concept of differance; the impossibility of transparent, fixed representation of meaning. I utilise the work of feminist writers Caroline Ramazanoglu and Janet Holland (2002), Margrit Shildrick (1997) and Chris Weedon (1987/1997), who utilise aspects of Derrida's concept to demonstrate that any definition is reliant upon the suppression of something antithetical to it. The term 'normalise' carries traces of the opposite – of the acknowledgement of the abnormal. A delimited meaning is only possible if the other term is repressed, and yet erasure is not possible.

In this chapter I show that normalising practices do not suppress the social 'abnormality' of viral STIs, in either clinicians' or women's accounts. My aim is to demonstrate that normalising practices that emphasise accurate medical facts potentially limit teaching and learning opportunities. Normalising only allows for a partial acknowledgement of women's definitions of the effects of viral STIs if women do not concur that the diagnoses are relatively normal. Jane, a woman diagnosed with HPV in her mid-60's, made the following comment, which illustrates that normalising leaves unaddressed the effects of the diagnosis:

None of my health professionals have discussed the mixture of grief, intimacy, sexuality and sexual health. I am beginning to realise just how unhelpful the whole process has been, and why I had shut down about it all. Nobody wants to know and I'm beginning to think that the medical profession don't understand about it (Jane, HPV diagnosis, 71 years old).

As I discuss later, Jane's comments are typical of the opinions of a number of women in my study; that clinicians only have limited knowledge about what viral STI diagnoses mean for women. I contend that the problem of understanding is not about 'good' or 'bad' clinicians per se. Rather, oppositional language, which is integral to western systems of thought, does not readily enable clinicians' to conceptualise the complex interweaving of medical, social, cultural and gendered discourses that shape meaning. The latter process is called deconstruction; the decentring of hierarchical oppositions. Weedon (1987/1997) describes deconstruction as a process whereby a reversal of oppositions shows how discourses work to achieve their effects. My intention through the data analysis is to show the interplay of discourses that affect the efficacy of clinicians' habitual teaching practices.

In addressing the hierarchical normalising practice I draw from Foucault. There is no singular "legible face" to be deciphered in relation to the meaning of a diagnosis, no specific refinement or ordering in pedagogical approach that will bring women into complete agreement that the facts about HSV/HPV adequately account for the effects of these viruses (1981, p. 67). I show that despite normalising practices there are no clear-cut medical or lay "legible faces." My assertion of absence of a "legible face" is at odds with medical practices of classification; of the establishment of statistical norms that can be generalised to populations (Foucault, 1973/2006). A broad discursive approach is contrary to the medical classification of diseases, which is directed towards the identification of pathological causes and their effects.

Rather than education about understanding the pathology of HSV/HPV inevitably 'making sense' to women, women's learning about viral STIs occurs through multiple encounters during diagnosis and treatment. These encounters involve the many ways meaning is conveyed: through verbal and non-verbal communication with people – health professionals, friends, family and others; within all manner of texts, electronic and other forms of media; and within organisations. In this first data analysis chapter I discuss the dominance of the medical discourse in clinicians' accounts of viral STIs and the lack of 'fit' with women's lives. In this and subsequent chapters I continue an elaboration of the discourses that shape both clinicians and women's explanations.

Following Lupton (2003), in taking a social constructionist approach I am not questioning the reality of the diagnoses of HSV/HPV. Rather, medical knowledge is "...a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly renegotiated" (Lupton, 2003, p. 12). For example, one clinician with many years experience as a sexual health physician made the following comment about the improvement in changing attitudes of clinicians that indicates a subjective, historical change:

I have generally felt things were better. When our local expert in the 70s/80s in [city], [clinician's name] treated women he was very critical of [women's] past sexual behaviour and its contribution to cervical cancer. I find all the ob[stetric] and gynae[cology] doctors have now lost that pejorative approach, which is much more helpful for women (Camilla, clinician).

I use the above comment from Camilla to draw attention to the effects of the production of meaning by clinicians that changes over time. Clinicians themselves actively participate in the generation of meaning outside of diagnostic classifications. In my study, the absence of a pejorative attitude towards women is understood by clinicians as an accurate and objective approach that demonstrates the competence to convey 'real' meanings. I concur with Shildrick's critique of medical certainty about bodily facts:

My intention is to contest the authority and apparent certainty of the real, not in order to deny materiality, but to insist that there is never a direct, unmediated access to some 'pure' corporeal state (Shildrick, 1997, p. 14).

In order to analyse the meanings of HSV/HPV, clinicians' use of normalising is used to emphasise direct, 'real' categorisations about the physical body. For the most part, clinicians asserted that the current teaching by well-informed clinicians arises out of access to up-to-date, objective facts, and that potentially problematic teaching occurs when undertaken by ill-informed, 'judgemental' clinicians. For example:

Health professionals with poor knowledge, a judgemental attitude and poor people skills are particularly unhelpful. E.g. I had a patient come in the other day with genital warts. She had seen her GP and had left there with the impression that these would cause cervical cancer, she would have to have a smear every year, that she would have to have a biopsy and that treatment was really difficult and painful. She was in a total state by the time she saw me and I had to spend a long time undoing some of that damage (Betty, clinician).

In Betty's account, the woman being "in a total state" is connected to being given inaccurate information. Clinicians' emphasis on their role in conveying the relative normalcy of viral STIs was evident in the majority of clinicians' accounts. Clinicians did not appear to notice the inevitability of moral judgment in accounts of clinical work when the clinician's attitude demonstrated having the woman's 'best interests' in mind. The following quote captures a clinician's orientation towards normalising HSV for the imagined benefit for a woman's life and the importance she places upon clinicians' possible influence in the provision of correct facts:

When starting at [workplace] in the early 90's the psychotherapist used to run information and support meetings for clients and general public about genital herpes - advertised in the Herald [newspaper]. One evening I remember a woman, who having listened to correct information over a 2-hour period, shared with the group about her decision to avoid sexual

relationships and most particularly to avoid pregnancy lest she infect another. She was at this time in her early 40's and felt that she had experienced in the most gut-wrenching awful way - 'lost years'. It seems these debilitating decisions had been made following her receiving extremely pessimistic, ill-informed information from her GP. To this day I feel like weeping to recall this story I could write pages of scenarios but I think the overwhelming theme I want to portray is that of women making decisions that deny themselves satisfying sexual relationships and create unnecessary intense psychological distress because of a genital viral condition (Annalise, clinician).

Annalise's comments underline that clinicians' use of classification practices may be used with the intention of producing desirable effects in the lives of women, not an authoritarian imposition of meaning. In so doing though, no clinicians in my study indicated that they were taking up a moral position in relation to the meaning of the classification of the infections. In all instances clinicians positioned their interventions as based on the application of facts with the goal of 'dismantling' the fictions about viral STIs. Yet Annalise's account makes reference to beliefs about factors that create a meaningful life – a sexual partner, having children, satisfying sexual relationships. In Chapter Seven I explore in detail the moral dimensions of women's clinical consultations; in this chapter I focus on clinicians' normalising interventions and clinicians and women's accounts that do not fit with this practice.

Annalise's comments also indicate that individuals are 'fitted' into categories rather than each individual's response being treated as a new situation.

This aspect of intervention is completely taken-for-granted in contemporary western medicine. Although clinicians work with individuals, the orientation of clinical medicine is towards generalisable standards of intervention that work at the level of populations rather than individuals (Foucault, 1973/2006). The 'rules' of generalisation are integral to western medical explanatory systems. The medical practice of generalisation results from the comparative examination, measurement and categorisation of all aspects of people's bodies and lives to determine 'norms' and 'deviancy.' Foucault describes the Western medical practice of determining what is normal:

In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives (Foucault, 1973/2006, p. 40).

Foucault describes the ordering of bodily experiences as an aspect of technologies of disciplinary power. People's behaviour, apparent choices, desires and pleasures are shaped through surveillance at all levels of society; from the legalities and policies of legitimate institutions to self-surveillance. Western constructs of individuality and self-determination mask the ways in which people are co-opted to participate in conformity. Normalisation in the Foucauldian sense operates to produce particular thoughts, feelings and beliefs about a given situation. People are most often

unwittingly constrained in terms of the boundaries of what it is possible to think about and imagine due to the limits of what counts as legitimate knowledge.

Tensions in relation to diagnostic classification occur particularly where meaning is contested. Although HSV and HPV are 'real' medical conditions, practices of normalisation may have the effect of dismissing women's accounts. Oster's (2003) analysis in her qualitative Australian study of people with genital herpes indicates that patients who were unable to conform to clinicians' normalising practices were pathologised:

Through maintaining the primacy of the biomedical lesion, the psychosocial aspects are seen to be out of proportion with the biomedical 'reality' and are thus conceptualised as unnecessary and even pathological. Through this process, psychosocial significance is ultimately rendered insignificant (Oster, 2003, p. 126).

Oster (2003) also contends that HSV is trivialised as a medical condition and therefore as a physical condition its effects are also not taken seriously. Oster's points are illustrated in Sophia's comments. Initially her doctor was supportive of her reaction to the diagnosis but over time she was aware that she became something of a 'problem patient,' both in relation to her 'failure' to adjust to the diagnosis and to tolerate the symptoms:

...as time went on and I seemed to be having recurrences that were more frequent than the literature 'promised' (like "once the primary attack has passed it is highly unlikely that most people with The Virus will suffer any further attacks" - yeah right!), my GP would sigh every time I saw him. He finally prescribed oral Zovirax [anti-viral medication] but made it clear to me, as if he needed to, that there was no cure and that I had to learn to live with it (Sophia, HSV diagnosis, 51 years old).

The clinician's sigh is perhaps the clearest indication to Sophia that she was failing to make the correct adjustment to the diagnosis. The sigh is also an example of how the exhortations of normalisation in the Foucauldian sense saturate everyday life. The message is most often presented as 'common sense', about 'doing what's best for your own good and the good of your family', the moral instruction on how to think and act is somewhat veiled or invisible. In the following section I discuss an aspect of generalisation; a practice whereby clinicians 'normalise' viral STIs, with the effect that it is difficult for women to voice alternative classificatory systems in relation to viral STIs. As a point of clarification of terms: the term, 'normalise' appears to be used by clinicians to convey the sense of relative normalcy of certain conditions and of a range of appropriate emotions in response to the diagnosis. The Foucauldian notion of normalisation relates to the taken-for-granted collective cultural ideas and classification practices about 'the way things are.'

Using 'facts' to normalise viral STIs

In reading the transcripts of interviews with clinicians, I was stuck by the frequency with which clinicians used the term, 'normalise,' to define a key strategy used towards the goal of reducing

women's distress in relation to the diagnosis. For example, Margaret describes normalising genital herpes by comparing the similarities of the genital infection to facial herpes, which is also very common and usually without symptoms:

My own response is to...put it into a manageable perspective e.g. "yes, it does stay in the body, but that does not mean you are always aware of it." Then I often talk about the number of people who carry oral cold sores acquired as children who would never be aware of the virus' presence in an effort to 'normalise' this statement (Margaret, clinician).

While Margaret's 'normalising' through comparison with herpes on the face 'makes sense' in terms of pathological classification, it does not readily 'work' in that only genital herpes is classified as sexually transmitted and so the comparison is not an easy match. Another clinician, Helen, also makes the prevalence-equals-relatively-normal link in the following comment:

Stats [statistics] can be a wonderful tool for normalising (Helen, clinician).

In my study the medically endemic nature of HSV and HPV led clinicians to link notions of normalcy with prevalence. In the following comment, Karen normalises viral STIs, asserting that the possibility of contracting a viral STI makes rational sense in the same way that it is rational to anticipate that children exposed to other children's infections will become ill:

I always try to minimise or normalise the implications of viral STIs....I liken it to sending your child to day-care and getting upset if they come home sick. Being sexually active means unavoidable contact with other peoples skin, we live in a world full of bugs and there are some bugs that cannot be avoided (Karen, clinician).

In describing her normalising approach, Karen details a routine standard intervention. In her account it is clear that medical normalisation is used to provide the 'rational' context in which to make sense of a viral STI diagnosis, that daycare equals bugs for children and sex equals bugs for adults. In so doing, the social, emotional impact is subordinated; understood in relation to medical meaning rather than having discrete, credible meanings outside of medical classification. For example, in Karen's comments below, biology comes first and relationship effects are addressed last:

My approach to counselling is to educate the patient about the biology of virus first, i.e. how they got it, symptoms, how the virus behaves, rates of recurrence, treatment and management options. Then I go through the transmission issues, how it is spread, and the concept of shedding and methods of prevention. Lastly I go through partner issues and relationships (Karen, clinician).

Clinicians' use of normalising viral STIs is not surprising. The western philosophy of medicine emphasises oppositions and segregation of bodily parts. Oppositional language separates conditions into categories of *either* serious *or* innocuous. Classification practices typically do not

enable the acknowledgement that conditions may be both relatively innocuous *and* problematic. Derrida contends that philosophical oppositions do not allow for "...the peaceful co-existence..." (1981, p. 41) of differing meanings within a pair of concepts. Clinicians in my study appeared to struggle to incorporate ideas that a diagnosis could be both medically innocuous and socially devastating, even though they gave accounts of the latter. Annalise describes the lack of 'fit' between 'normalising' and some women's experiences:

It's always a bit fraught to consider the concept of 'normalising' a diagnosis given that it seems so far from normal for so many clients and if not dealt with sensitively one can risk 'minimising' instead (Annalise, clinician).

In Annalise's comment there is acknowledgement that engagement with the normalising practice may be a major stretch for women that entails a risk of clinicians disregarding women's understandings. Normalising is nevertheless a key teaching tool in her educational approach. Annalise goes on to say:

Given that though I will, in a quite matter of fact way, tend to talk about the causative virus being same as that that produces cold sores. Having included the client in a brief conversation about cold sores and what they know about them (I've never spoken with anyone who doesn't have some knowledge) I then describe the same process of cold sores in the genital area. Depending on client reaction I endeavour to emphasise that, for the most part, HSV in either site is an easily managed medical condition... (Annalise clinician).

I repeatedly noticed clinicians' efforts to fit viral STIs within one half of a normal/abnormal binary were being confounded and yet most clinicians did not draw attention to the contradictions and lack of 'fit'. For example, Margaret, a clinician quoted earlier engaged in practices of normalising also commented:

There are some other diagnoses that I think are more difficult to verbalise to women, e.g. cancer, but these 2 viruses [HSV/HPV] are high on the list of the most difficult diagnoses to impart to women. I have met women who have clearly had the diagnosis given to them in a way that has had a very negative impact on their view of their situation. I regard the handling of this clinical situation as being something of a 'clinical emergency' in terms of allowing adequate time to address the impact the diagnosis is making on the woman at the first encounter, as my impression has been that this consultation will often set the scene for the way she will view the virus for the rest of her life (Margaret, clinician).

There is a paradox in Margaret's account, that an infection that can so readily be normalised in medical terms can, in terms of a woman's response, be called a clinical emergency. One clinician clearly indicated the use of normalising through medical facts and an acknowledgement of the limitations of the practice:

Factual information offered in a competent manner by the professional without stumbling over the difficult questions such as, "will I have this for life?" and "will I give this to everyone I have sex with from now on?" assists in building the client's competence in managing the condition (Edith, clinician).

Although Edith prioritised giving factual information, she acknowledged that women may have a myriad of other ways of making sense of what they are being told, and that the clinician has a limited role in influencing the extent to which women find facts useful and relevant:

I don't think the clinician should be too egocentric about their overall influence. Often the interaction is only 15 minutes and in some cases the clinician's influence is minimal as the client is self-absorbed digesting the diagnosis, fitting the diagnosis into their own life view and trying to figure how the diagnosis fits into the framework of their relationships (what ever those may or may not be) (Edith, clinician).

In the use of the term, 'life view,' Edith's comment is one that incorporates the notion that there is more than one (valid) way to understand a diagnosis. One clinical psychologist made no references to normalising practices and instead privileged the usually subordinate aspect of viral STIs – the emotional effects upon women:

I come from the perspective that these are sensitive diagnoses and acknowledge the woman's courage in seeking help for her symptoms. I inquire about the journey which got her to the point of seeing me as this is usually fraught. I expect to bear witness to her emotional distress (Sue, clinician).

In Sue's account, the prevalence of distress and the sensitivity of the diagnosis are privileged. The provision of medical information is placed within the context of the clinician's confidence to talk about sensitive topics; being able to manage the discussion of experiences that are abnormal for women:

Ensure you are equipped with the communication skills to raise and discuss sensitive topics. Ensure you are equipped with up to date information and resources on facts/effects and treatment/management so you can be effective as a professional and gain her confidence (Sue, clinician).

The orientation of clinicians towards acknowledging the social and psychological impact of infections appeared to be that education is the key to overcoming women's problematic meanings of the diagnoses – that the problems arise from an information deficit both in the woman and within her social group. For example, one clinician described her thoughts about the effects of sex education in schools:

I will often talk about how unhelpful any sex education that they had at school or society's perception is. We all get taught to be SAFE and the motivation seems to be to avoid

getting all these DEVASTATINGLY AWFUL infections –so kind of like if we are a good and careful person it won't happen to us and will only happen to the BAD IRRESPONSIBLE ones. This is a very unhelpful way of educating and creates a lot of harm (Kate, clinician).

Kate's comments illustrate Derrida's point about the impossibility of erasure –there are always competing discourses that contradict clinicians' efforts to insist that viral STIs are part of normal life. In an explanation of the impossibility of erasure of the marginalised 'other' half of the binary, Derrida states:

...what is called meaning...is already, and thoroughly constituted by a tissue of differences, in the extent to which there is already a text, a network of textual referrals to other texts, a textual transformation in which each allegedly 'simple term' is marked by the trace of another term, the presumed interiority of meaning is already worked upon by its own exteriority...(Derrida, 1981, p. 33).

In health-care, as in every-day lay language use, the language of binary oppositions is used to make sense of experiences. The process of 'making sense' though is only possible through the (usually unspoken) 'other side' of the dichotomy: normal/abnormal, clean/dirty, and healthy/diseased. The following comment made by Kate, a clinician with many years experience in the sexual health field demonstrates Derrida's point about the ever-present traces of other texts. The interweaving of a subjective moral position into an explanation of the 'science' of transmission in an imagined clinical scenario indicates the efforts by the clinician to suppress/deny the 'validity' of other ways of making sense of viral STIs other than normalising their presence. In so doing Kate indicates that present in society are other definitions of these infections. Kate's position is also particularly interesting in that her description readily demonstrates Foucault's notion of disciplinary power – that power is always present and is in all forms of relationships. Even when clinicians are passionate advocates for the wellbeing of women, they are nevertheless implicated in power relations, in producing moral validity to certain 'facts' and discounting other information that might inform a woman's life:

With respect to HPV in particular I emphasise how common this infection is and say something like – if you're sexually active we all will be exposed to this virus and most of us will get infected with it "welcome to the club" type thing - It's just that the majority of members aren't aware they belong because most people have this infection silently. With respect to HSV I always address the burden the patient might now be carrying of potentially infecting future contacts by saying something like – as this is common and most people who have it don't know it is totally illogical for some one to reject you if you tell them; they might already have it and or will certainly be just as much at risk from someone who says they haven't had herpes... so good luck to them!!! And usually add that as up to 80% of people have oral HSV and most people practice oral sex - well heh!!!! The only way to avoid this infection is to never have sex EVER. Of course I advise them to be able to pass on the facts about these viruses as well to their partners and encourage them to refer

them to the correct website or appropriate clinics and not just their GP who may not be up to date (Kate, clinician).

Clinicians participating in this study repeatedly describe a strong commitment to the wellbeing of women; normalisation practices are used for the perceived purpose of enhancing the quality of life for women. From women's perceptions though, it is quite possible that clinicians produce unintended effects by their assertions as women may be silenced if their experience falls outside of the normative prescription. For example, a woman who has contracted HSV or HPV may well not relate to Kate's explanation and may consider that it makes logical and/or moral sense to her that she would reject a partner who said he/she had a viral STI, if she were able to choose not to have the infection.

Women's accounts of viral STI classification

Women in my study had experienced a wide range of responses from clinicians (as I discuss in the following two chapters), and so not all women had encountered clinicians normalising viral STIs. Where women had met clinicians who normalised HSV/HPV, they described the way epidemiological statistics were used by clinicians to convey a conflation of common and normal. I draw from women's comments to demonstrate that women notice clinicians' use of generalisations and the normalising of viral STIs and that these practices have effects upon women. In the following quote, Maddy, a 24 year old woman with a recent diagnosis of genital herpes discussed what it is like for her to be told how to relate to the diagnosis:

My doctor asked me if I was upset because I'd had another outbreak, I said yes. His reply was, "don't worry it's very common." I've heard that a hundred times [from clinicians]; the first time is a little comfort but that wears off after you hear it in reply to every concern or upset that you have about your diagnosis, I think he thought that I shouldn't be that upset because he was telling me lots of people had the same problem and that should instantly make me feel better (Maddy, HSV diagnosis, 24 years old).

Although in the interview process Maddy was able to identify what aspects of the consultation experience were unsatisfactory for her, she was unable to tell her general practitioner and instead decided to attend a sexual health clinic. Her following comments highlight the complexity of everyday practices of classification; she was both comforted and also disquieted to have her version of HSV-related experience discounted. It is difficult, if not impossible for women to resist being co-opted into partial agreement or silent resignation when these classification practices are engaged by clinicians who demonstrate an ostensibly non-judgemental and caring approach:

They are very good at this at the [clinic]. In fact my nurse kept calling me flower! It was comforting as it felt like she genuinely wanted to help me feel better and understood how I was feeling.... Personally I felt like I had been given life-changing news and whilst they

were helpful and supportive at the clinic I felt very scared and alone with my thoughts and worries when I left (Maddy, HSV diagnosis, 24 years old).

Maddy's account demonstrates the tension between the reassurances of relative normalcy by clinicians and yet Maddy's inability to fully comply with a classification of the diagnosis that requires her to align her perception of her experiences with a previously established medical norm. Maddy remarks on the nurse calling her 'flower' – an endearment that perhaps engenders a sense of being whole and fresh and perfectly formed rather than damaged in some way by the diagnosis. The metaphorical normalising of Maddy as a young woman is, I imagine, appealing to Maddy and therefore difficult to refute with an alternate description of the effects of the diagnosis. Women's sense of an inability to comply with clinicians' normalising perspectives, and also the difficulty of countering a medical classification was common to a number of participants. Part of the difficulty in questioning the lack of 'fit' may be that women are also 'trained' in oppositional thought as part of western philosophical systems.

In the above quotes, Maddy's reflections on the appreciation and discomfort she experienced at the sexual health clinic indicate the tensions inherent in the clinicians' attempts to marginalise and silence the voicing of the abnormal aspects of viral STIs. Although the clinicians offer an appealing perception in relation to genital herpes, Maddy is not able to fit her experience within the classification offered to her. Maddy's experience could perhaps be more congruently accounted for if clinicians adopted an orientation that did not attempt to suppress the potential for STI's to be socially abnormal. This perspective would allow for the perception that HSV is common to clinicians and uncommon in Maddy's life experience, and that HSV is life-changing news for Maddy although not perceived as such by clinicians. It is probable that the construction of binary oppositions in clinicians' language contributes to missed pedagogical moments as both parties most commonly assert one side of a binary opposition, that a viral STI is either normal or abnormal.

Women question the credibility of medical knowledge

In this study, women attempted to find 'validity' in their experiences outside of the clinical encounter, to make sense of their understandings that did not fit with normalising categorisation. Maddy, like other women in this study, sought recourse through the internet to find other people who have a similar 'measure' of what the diagnosis means. For example:

I think online talking is very good as you can speak to people in the same situation that are having the same problems....Personally I found it helpful to hear other people's experiences of having herpes and starting relationships (Maddy, HSV diagnosis, 24 years old).

Maddy's comment indicates that other lay people's personal knowledge has a credibility that is not over-ridden by medical explanations. Like other women in this study, in seeking out other people's

lived experiences, Maddy had to manage information that called into question clinicians' normalising practices:

I was all ready to tell my boyfriend about having herpes....I thought I'd check the internet for extra facts in case he had any questions. I read a paragraph that said something along the lines of "yes there is a very good chance that people will reject you for having herpes, but eventually you will find someone to love you for who you are." So when things started to go wrong with the conversation that paragraph kept coming back into my head and I totally bottled out of it. I ended the conversation, cried my eyes out, threw up and the next time I saw him he was back with his ex-girlfriend and that was that basically (Maddy, HSV diagnosis, 24 years old).

Maddy's comment demonstrates that medical knowledge is not inevitably given more credibility than the knowledge from her own or other people's lived experience. Maddy believed that the comment on the internet carried a validity that had a powerful effect in dissuading her that herpes is a relatively normal condition. The comment made sense to her, given her knowledge about how her social group think about people with STIs:

The only things that have probably influenced my experience of having this virus is things I had seen and heard when I was younger about STD's like all of the stigma and jokes about people being dirty or easy if they had an STD. Even now at work I hear jokes all the time about it or rumours that so and so has this STD or another, it's a total nightmare some days....making the mistake of confiding in the wrong person would mean the whole of the town knowing and that's my only good thing that I have got left [good reputation] (Maddy, HSV diagnosis, 24 years old).

Although clinicians tried to normalise HSV, Maddy demonstrates knowledge that is contrary to clinical classification. In her social group, knowledge that she has a viral STI could render her an 'outsider' with a stigmatised sexual reputation. The key point about the relevance of construction of binaries to clinical encounters is that this means of classification limits the parameters of the clinician's teaching in terms of women's experiences that fall outside of the classification boundaries. The following example illustrates the gaps women notice in clinicians' teaching. Amanda described how the clinician's focus on managing symptoms did not address what for Amanda were the 'real' difficulties with the diagnosis; how to tell a partner:

I raised the tell/not to tell thing with a doctor once, I think she just said that I really should tell (which I know), but would be good to have more discussion on practical things like that.... Emotional impact - don't think I was told anything about how it would/might affect me, and then my relationships - which would have been super useful, as I think there is almost more emotional than physical impact. I've had maybe 6 episodes (genital only) over 4 years, so it's pretty infrequent, but the partner thing is much harder to deal with. I can deal with being a bit sore "down there" (ha-ha, terminology!) for a few days, but the

potential relationship fallout/emotional stuff is much more out of your control (Amanda, HSV diagnosis, 23 years old).

For most women in my study, telling a partner about a viral STI was the most problematic aspect of the diagnosis, not the symptoms per se. It is quite possible that clinicians' normalising of viral STIs offers little if anything to women's dilemmas about how to speak to a partner. In the following account, Sally also described how the classification of a viral STI as 'common' has not matched her experience and has led her to consider that clinicians' knowledge about the effects of the diagnosis is deficient:

I have found having the virus so terrible and to know it is common is no help to me, makes me feel like a number and professionals don't know the impact it has on some women. It would help if the aciclovir [anti-viral medication] helped me but it didn't and I am terrified I will have to talk to my doctor about it; he is lovely but plainly I am embarrassed and awkward admitting it to anyone... it was extremely hard to tell my current partner who thought it was no big deal! I think perhaps people that don't have it see it as that...it is hard to live with as every outbreak I feel dirty and like a failure that I have let myself get run down. Strange I know but its like living with a huge secret and especially since I got it from an abusive ex, every outbreak it reminds me of the things he did to me (Sally, HSV diagnosis, 36 years old).

As the above example demonstrates, clinicians' attempts to reassure women about the diagnosis by using generalisations may be unhelpful. Sally is one of a minority of women who have frequent recurrences. As well as the physical discomforts, Sally has categorised the 'truth' of her experience in the context of deviancy rather than normalcy and lives with the effects of this categorisation. Education may therefore not be applied in the specific areas in which women perceive the problem of the diagnosis.

I asked women what they thought about the practice of normalising viral STIs. The apparent objective stance of normalising viral STIs is called into question by Katrina. She indicated that normalising entails clinicians taking up a moral position in relation to STIs and she does not agree entirely with what she sees as the possible pedagogical effects of this approach. Katrina is a woman now in her sixties who has had genital herpes since her twenties:

First, the idea of normalising genital HSV can be a double-edged sword, to my way of thinking. If it's presented ... as 'just another skin disease that ____% of the population already has,' then I think that might tend to create a general atmosphere of complacency which to me is not an attitude we, as a society, need in the realm of disease control!.... There could be a middle-ground attitude...but overall, my opinion is that HSV should not be taken lightly as "just another skin ailment,"....as if it's going to go away one day! It isn't, ever. Conversely, to normalise HSV as 'just another skin ailment' might help people feel less stress from it, as long as they are properly informed as to the reality of it - that it is not

going away - ever, that it is contagious, etc. So I believe there can be a healthy medium to take away some of the stigma of the 'dirty' feelings one may have when they first contract this, and help them to know they are not dirty, not alone and there is help and hope for them (Katrina, HSV diagnosis, 61 years old).

Katrina draws attention to what she sees as the possible dangers of a normalising practice. She considers that (moral) complacency may be brought about through normalising an infection and the responsibilities that belong to the infected person. In her critique, Katrina has attempted to take a position outside of a normal/abnormal binary, using the concepts of a "middle ground attitude" and "a healthy medium."

Although women in my study did not necessarily speak directly with clinicians about the contrary positions they held about the meaning of viral STIs, women often told me of their opinions that contested the generalisations and medical classification of viral STIs. The following comment is made by a young woman who has had numerous invasive medical and surgical procedures subsequent to abnormal vulval changes related to HPV infection. Her comments counter the medical perspective of the relative innocuousness of HPV and she re-categorises her experience of the infection:

I thought I would bring to your attention an article from the Canadian Medical Association Journal.... The link to the article is <http://www.cmaj.ca/cgi/rapidpdf/cmaj.070944v1>

I haven't read the whole article yet, but the first page was enough to make me angry. If I have understood the article correctly, the authors are saying that there is no need for a vaccination programme because there is no epidemic of HPV and that because cervical cancer can be caught early basically HPV doesn't cause much damage. So the information I've seen that says possibly 75-80% of people have had contact with the HPV viruses is incorrect? And that statistic doesn't worry the authors? But from a more personal perspective, and more upsetting for me, is that all the pain and suffering I have been through has been completely minimised by these health professionals (and their opinions have been given an aura of professionalism by being published in a medical journal). I haven't had full-blown cancer so my experiences aren't worth preventing? It makes me so angry! (Dianne, HPV diagnosis, 33 years old).

Dianne's frustration with the article's contents is an example of the way classification and generalisation practices in medicine have the effect of legitimating certain knowledges and dismissing others. Dianne cites the power of clinicians and of medical publications to assert what count as facts. Below is an excerpt from the article (mentioned above), in which the authors caution against the early implementation of public funding of an HPV vaccine. The following description of HPV effects illustrates that HPV classification may not bear any relation to the ways women might classify the implications of an infection:

Invasive cervical cancer typically follows a slowly progressive course that can be halted at one of various stages. The dramatic decrease in deaths from cervical cancer in Canada, even before the development of any vaccine, represents a public health success. Research attributes this to improved reproductive health practices and the widespread availability of publicly funded programs for Papanicolaou smear testing. In fact, the public funding of such programs has also significantly reduced health inequities for women (Lippman, Melnychuk, Shimmin, & Boscoe, 2007, p. 1).

In the above quote, the important classificatory features that may be generalised to populations are clear: public funding for regular cervical smears and early intervention prevent cervical cancer deaths. The statement is also an example of the apparent simplicity of a descending analysis. The over-arching problem is cervical cancer and the solution is publicly funded screening reducing health inequities. In an ascending analysis, the intervention of screening and early intervention, while saving women's lives nevertheless may create additional burdens that accentuate rather than reduce women's awareness of health inequities. In Dianne's experience, with pre-cancerous changes on the vulva rather than the cervix, halting the slowly progressive course has myriad meanings, including the following:

Just because I didn't have full-blown cancer doesn't mean I wasn't badly affected. I have someone cutting me in my private places on a frequent basis. I wonder if health professionals realise that 'small' procedures done frequently can be as traumatic or more traumatic as 'major' procedures done infrequently....Another aspect that I think may be underestimated by gynaecologists is that these operations change you physically 'down below' and that this has an emotional impact. Maybe in my case (because of the problems I had and needing two operations) the changes were a bit extreme, but I had to learn that the vaginal area I grew up with was now quite different. It took a long time for me to get my head around that (actually, I am still trying to get my head around that). Just because the area is not in full view doesn't mean we feel less trauma (Dianne, HPV diagnosis, 33 years old).

For Dianne, the attitude that early intervention precludes the need for vaccination fails in her situation. Even where the classification and generalisation apparently 'works', the numerous 'abnormal' effects of such interventions as successful screening programmes are not mentioned in the above article (Lippman, Melnychuk, Shimmin, & Boscoe, 2007, p. 1). Women may well not concur with the notion of reduced health inequities as they engage in screening: additional encounters with clinicians, the inconvenience and financial impact of appointment schedules and time off work, repeated genital examinations, altered relationships with their own bodies, with sexuality and with sexual partners.

Classification of women's distress

All clinicians in my study commented about the adverse emotional impact of HSV/HPV diagnoses upon women. As I have illustrated, normalising is used primarily as a counter-balance to 'correct' the weight of social meaning. Social meanings were not considered to be 'true' in the way that normalising was presented as the 'truth.' Given that HSV/HPV are classified as physical infections - genitally-located viral STIs – there is no definitive psychological or psychiatric classification for women's distress. As outlined in Chapter Two, the psychological and social effects of the stigma of viral STIs are commonly acknowledged in numerous medical articles. For example:

The stigma associated with herpes is likely to play a role in the perception of a diagnosis of genital herpes. It will thus influence disclosure of a diagnosis as well as a partner's interpretation of that disclosure (Bickford, Barton, & Mandalia, 2007, p. 589).

In my study, the emphasis on normalising viral STIs appeared to be an educational priority for most clinicians, as if too much acknowledgement of the problematic aspects might 'feed' the problem of them being understood socially as abnormal. One clinician commented:

I suppose I am judgemental about support groups although I guess my prejudice is not "evidence based." I think support groups may not amplify [problems] per se but may reinforce angst and dependency (Edith, clinician).

In my clinical experience, Edith's attitude is not uncommon amongst clinicians. It is a common idea that talk amongst peers about the social effects of the diagnoses, left unshaped by medical normalising, is likely to amplify distress rather than reassure and educate people about how to relate to HSV/HPV. In the interviews, there was wide variation in the way clinicians' classified women's reactions to HSV/HPV diagnoses. Common classifications included psychological responses attributable to the woman herself; either normal grief responses or abnormal reactions. The effects of social stigma were the other main explanatory system when classifying the cause of women's distress.

As discussed in the Chapter One, I have observed clinically that the classification of women's distress impacts on clinicians' teaching interventions and the extent to which women are given an opportunity to voice the effects of the diagnosis. Although medically the practice of normalising stood out as a cohesive approach taken by almost all clinicians to convey facts about viral STIs, there was no similar cohesive approach to making sense of women's distress. No clinician questioned the classification practices they used to account for women's distress, even though with practices of medical classification they stressed that their clinical interventions were based on up-to-date medical criteria. The following examples show the range of classification practices in relation to emotional responses. Edith locates the client's specific response to a viral STI diagnosis within the context of the general coping mechanisms of the woman concerned:

I believe clients cope as they cope with other crises in their lives. Some are staunch, others less so (Edith, clinician).

Karen uses a general model of the 'normal' process of grieving, indicating an evolving step-by-step process towards becoming more settled with the diagnosis:

After a new diagnosis, the response to the diagnosis does change over time. People seem to work through various stages of a grieving process, where they go from denial to disbelief to anger and then acceptance or willingness to talk about it or find more information (Karen, clinician).

By contrast, Sue indicates that the changes that occur for women with a viral STI diagnosis are not contingent upon the way a woman might have related to a non-STI diagnosis:

I think gradual acceptance can occur and a woman can learn to live with these chronic conditions. However there will always be a socio-cultural difference between the impact of living with these diagnoses and other non-sexual chronic conditions (Sue, clinician).

The normalising process, which often entails comparisons with infections that are not sexually transmitted in effect acts to deny the extent to which the link with sex is powerful in shaping meaning. J. Dennis Fortenberry, (2004) an adolescent sexual health specialist, comments that sexual behaviour commonly carries stigma due to connotations of personal choice and responsibility – that STI stigma is secondary to the primary stigma that frequently surrounds sex. The inability of some women to at least outwardly incorporate the normalising of a viral STI as both medical and socially relatively socially manageable led some clinicians to categorise the response to be abnormal to some degree:

Some people invest a lot of energy in their distress (Claire, clinician).

Claire's comment implies a certain amount of upset appropriately matches a viral STI diagnosis and beyond a certain point the distress is excessive. This assessment is in keeping with Foucault's (1973/2006) notion of the use of statistical norms against which to measure people's behaviour in order to determine normalcy or deviancy.

The following response to one of my standard questions to clinicians illustrates the usually unquestioned entitlement to assess normal and abnormal responses:

Catherine's question: Does the diagnosis have much of an effect on women's subsequent decision-making in relation to sexual health, sexual relationships and pregnancy decisions? (Please include examples if any come to mind).

Clinician's answer: There was a period when it was fashionable to have a caesarean section with a history of recent herpes - and I had one patient who was completely hysterical about needing and wanting this - (hysterical about most medical things actually).

I think management now is based on greater understanding of the diseases - e.g. risk to fetus more with first episode of HSV in pregnancy not recurrent etc.... I have one patient who has been with me a long time who had to have a hysterectomy in her 20's for invasive cancer of the cervix followed by radiotherapy. I have never in all these years heard her complain.... Sometimes women with the most severe disease are accepting and sensible and people with no significant effects are overwhelmed (Camilla, 68, clinician).

Camilla's comments are a useful illustration of the way clinicians classify the responses patients have to diagnoses. In this instance women's behaviour is categorised as, on the one hand, sensible and on the other, hysterical. In my clinical experience, categorisations of this type are part of the everyday talk amongst clinicians, rather than being unusual. Women participating in this study are well aware of the consequences of being labelled a 'problem patient' and often work hard to comply with a standard of behaviour considered to be appropriate to a clinical encounter. The self-surveillance by women in relation to clinical consultations about chronic pain is commented upon by Anne Werner and Kirsti Malterud (2003) in a Norwegian study entailing interviews with ten women:

Their efforts reflect a subtle balance not to appear too strong or too weak, too healthy or too sick, or too smart or too deranged. Attempting to fit with normative, biomedical expectations of correctness, they tested strategies such as appropriate assertiveness, surrendering, and appearance (Werner & Malterud, 2003, p. 1409).

Werner and Malterud's findings are relevant to my study. Prior to contracting a viral STI, women have learnt how to 'perform' as patients; how to avoid behaviour that is likely to be deemed unacceptable; women know that there are 'normal' standards. A clinician, Sue, comments on the 'work' women do to appear credible:

...many of these women are 'in hiding' regarding their condition. My comment about 'downplaying' is probably along the lines of...women wanting to be 'credible patients'. I do this myself! I, and many clients, are very aware of how easily women who present with anxiety about their health quickly become labelled with hypochondriasis, somatisation etc. We [as women in the patient role] therefore being skilled at assessing the doctor and giving them what they want to hear in a package they can work with. This is therefore ... about wanting to avoid being pathologised due to the severity of our emotional responses to a condition or diagnosis (Sue, clinician).

Sue's comments have pedagogical implications. Women may be so busy adjusting their behaviour to outwardly convey a match between the clinician's assessment and their own that they may be limited in what they believe is safe to disclose. Clinicians may be unaware of the extent to which women are preoccupied with coping with the clinical encounter, 'reading' the clinician and working to appear 'normal' in the eyes of themselves and the clinician. Dianne's comments illustrate the

'work' for women in simultaneously managing strong emotions and assessing the clinician's attitude:

It's hard to remember exactly what happened during my appointments.... my memories lack clarity because of the strong emotions I had at the time....she [gynaecologist] gave me the facts and while she seemed to be sympathetic, making all the right noises, there didn't seem to be much genuineness behind them. I think it was my 'gut feeling', i.e. my instincts that told me that. That suggests her body language or tone of voice wasn't quite right....I'm sure at the time I came across as dealing with it [diagnosis] just fine. But underneath I was scared and feeling very alone (Dianne, HPV diagnosis, 33 years old).

Ironically, even if women do take up clinicians' classifications, this orientation towards medical measures does not ensure that women will be treated as 'normal.' In the following excerpt, Jeannie, a woman with HPV, described the work of managing her medical knowledge about her body. She indicates that appearing too 'in control' of the clinical encounter is potentially as problematic as demonstrating loss of control:

I think women who do their homework or just have some knowledge about health get labelled as trouble-makers. A lot of doctors don't like to have their authority questioned, even when they really don't know what they're doing. So they turn it around on the woman and tell her she's just being a hypochondriac. To me, that's not the point. The point is that I want to understand what's happening in my body so I can take care of it in the best possible way (Jeannie, HPV diagnosis and clinician, 37 years old).

Women's clinical encounters readily involve the performance of 'normal' behaviours in order to avoid being pathologised. The performance may act to constrain women from disclosing information and from gaining answers to questions. The desire by women to be seen as credible means that clinicians may have only a limited understanding of the effects of their teaching.

Conclusion

In this chapter I have shown that the parameters of what is said by clinicians about viral STIs in clinical consultations are shaped to a large extent by clinicians' practices of normalising infections. I have contextualised this practice as an example of the workings of western philosophical thought whereby dualistic classifications privilege certain terms and subordinate other terms. In this instance, the relative medical normalcy of viral STIs is given primacy compared to the social abnormality experienced by women. The chapter also demonstrates the way medical generalisations operate to classify diagnoses and the appropriateness or otherwise of women's interpretations. Therefore, although clinicians meet with individual women, medical responses are shaped by social categorisations rather than being tailored towards women's idiosyncratic situations. This aspect of population-based classification is integral to medical knowledge to the

extent that clinicians confidently assess the normalcy or otherwise of women's reactions to diagnoses.

Women do not necessarily adopt the normalising classifications proffered by clinicians. I have given examples of the ways women in this study questioned and rejected medical categorisation. Although women do not necessarily align their experiences with clinicians normalising practices, I consider the emphasis on normalising is likely to have detrimental effects in terms of teaching and learning. I have given examples to show how skilled women are in 'reading' clinicians' expectations of how women should perform as good patients. Women may judge that voicing their difficulties may risk the label of 'problem patient.'

In my study, clinicians have provided detailed descriptions of the way they normalise viral STIs. Women therefore are clearly 'briefed' about the appropriate way to relate to a diagnosis. Although normalising is ostensibly about facts, my examples show that normalisation is connected to moral judgements about how rational and sensible or otherwise women are. Women may choose to comply outwardly in order to be understood as normal rather than risk exposing their assessment that the diagnosis is abnormal and problematic. Part of this compliance may entail women not asking questions about aspects of the diagnosis that do not fit with the medical classification of their problem.

Chapter Five:

Self-Surveillance

Introduction: The normalcy of self-surveillance

As the previous chapter demonstrates, clinicians working within the sexual health field go into great detail to convey to women that an STI is not abnormal. The emphasis on normalcy and 'down-playing' the diagnosis of a viral STI contradicts broader western cultural realities about morality, femininity and the body. It is 'normal' for women to be enculturated to some extent in practices of policing the presentation of their bodies. A viral STI just adds another dimension to the rigour of patrolling the body.

In this chapter, I explore women's self-surveillance of their bodies, sexuality and femininity as a taken-for-granted practice prior to and after contracting a viral STI. In particular I link the activities of self-surveillance with attaining ideals of behaviour and presentation considered to be 'appropriately feminine' by women themselves and by their perceived 'audience' (family, friends, and sexual partners). Sandra Bartky draws attention to "those disciplinary practices which produce a body which in gesture and appearance is recognizably feminine (1990, p. 67)." My intention is to explore the ubiquity of everyday disciplinary practices of feminine sexuality rendered more complex subsequent to contracting an STI. The examples demonstrate why clinicians' attempts to normalise viral STIs is a fraught project.

Examples in this chapter also illustrate how the Foucauldian concept of self-surveillance has useful applicability in understanding the impact of a viral STI diagnosis. All women live in some sort of relationship with cultural prescriptions of femininity, which are multiple and contradictory. Examining discourses of self-surveillance that shape the meanings of viral STIs offers a different perspective from the 'traditional' medical use of Goffman's (1963) sociological stigma theory (discussed in Chapter Two). Foucault's conceptualisation of self-surveillance contends that practices of self-policing are normal and not reserved for those people who perceive they are 'marked' or tainted.

The ordinariness of self-surveillance

Foucault's notion of the dual roles of observer/observed, controller/controlled is pertinent to understanding women's 'every-day' self-surveillance:

He who is subject to a field of visibility, and knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection. By this very fact, the external power may throw off its physical weight; it tends to the non-corporeal; and, the more it approaches this limit, the more constant, profound and permanent are its effects; it is a perpetual victory that avoids

any physical confrontation and which is always decided in advance (Foucault, 1977/1991, pp. 202-203).

In the performance of appropriate feminine subjectivity, most women are engaged to some extent in assessing behaviours that are considered normal. In the following example, Jeannie commented on the awareness she has both of her own and others judgments about surveillance in relation to 'normal' femininity – including normal sexuality and the normalcy of being perceived as a desirable wife and responsible guardian of her fertility to ensure motherhood:

...most of us [women] feel a lot of judgment (whether perceived or real) about our sexual activities - I think it must be very hard for men to be honest about having an STI but is it for the same reasons? Would they feel judged as dirty or slutty? I think women feel that much more than men do - I think men are expected to have a lot of partners and can be open about the fact that they do whereas women still usually feel the need to hide that fact. For women it's more complicated in that the questions around long-term relationships, pregnancy and child-bearing come up in relation to STI's - of course it's an issue for men but I think it's more abstract for men whereas for women it's often a very real and very immediate question - will this affect my ability to get pregnant? Will I be putting my future children at risk? Will I ever be able to get married and have kids if I have an STI? (Jeannie, HPV diagnosis, 37 years old).

Jeannie's reflections show that women's assessment of themselves as "dirty or slutty" comes from both external judgment and from women's critique of their own behaviour. In Jeannie's description, this level of self-surveillance appears to be accepted as part of managing being a woman, not that self-scrutiny and the imagined scrutiny of others that is unusual or even entirely undesirable. Jeannie connects women's sexual decision-making with possible long-term, unwanted effects that make self-policing important. The normalcy of engagement with self-surveillance is what renders these practices "...constant, profound and permanent..." (Foucault, 1977/1991, pp. 202-203) in their effects.

Women self-surveil and thereby participate in the production the desirable femininity. The concept of 'the male in the head' (Holland, Ramazanoglu, Sharpe, & Thomson, 1998) is useful to illustrate Foucault's point about the dual roles of observer/observed and controller/controlled. In their study of young people's sexuality, Janet Holland, Caroline Ramazanoglu, Sue Sharpe and Rachel Thomson (1998) devised the term, the 'male in the head' to describe the everyday ways in which women participate in self-surveillance by internalising and reproducing male-dominated conventions of masculinity and femininity. Jeannie's comments above show that male dominance is reproduced in the process of women constituting their behaviour as appropriately feminine. Men who have multiple partners are successfully masculine whereas successful femininity requires women to police and/or hide their behaviour to avoid a "dirty or slutty" reputation. Sophie also commented on the 'double-standard':

As for the diagnosis I certainly don't believe that men go through the same humiliation as us women. Maybe if you're a male then it is OK to have a STD. Is this something about being very 'macho'? If a woman sleeps around then she is a slut, the guy a super stud (Sophie, HSV diagnosis, 42 years old).

The above comments by Jeannie and Sophie show that Foucault's notion self-surveillance does not work comparably across genders. The differing constructions of masculinity and femininity are powerful in shaping the ways in which self-surveillance is applied.

'Performing' femininity: The centrality of sexual subjectivity

Butler (1999) considers femininity a 'performance' that must be successfully achieved in order to be feminine. Femininity is a fabrication without a 'real' ontological core, but rather "...manufactured and sustained through corporeal signs and other discursive means" (Butler, 1999, p. 173). In my study, participants demonstrate the taken-for-granted 'performance' of sexuality as central to the constitution of female subjectivity. Charlotte's comments show a constitution of sexuality whereby the performance of sexuality and sexual health is linked to being intelligent, confident and self-respecting:

Catherine's question: Do you think your group of friends shared/share your beliefs of women's sexuality as normal and healthy?

Charlotte's response: Yes I do, my female friends are all intelligent, confident young women (the latter, I believe, is in part because our friendship circle has always placed importance on building friends' self esteem and countering disparaging comments made by others about body shape or behaviour) and have the strength to stand up to negative comments....I think that my views on sexual health are a direct result of having self respect, an attribute I would link to my upbringing (Charlotte, HPV diagnosis, 23 years old).

Charlotte's attitudes are an example of Harris' (2004) depiction of 'girlpower.' A feminine sense of self for young women now encompasses ideals of independence, ambition, resilience and the capacity to create and control one's own life. Sexual expression is affirmed as a normal, integral aspect of girlpower.

Although women in my study described differing degrees of ease or difficulty with sexual expression, all participants appeared to consider that heterosexual sex was part of normal adult life. Lenore Tiefer (1995) credits Foucault with the critique of sexuality as a biological norm and an essential human quality. Instead, sexuality is conceptualised as socially constructed within specific social and historical contexts:

The modern view of sexuality as a fundamental drive that is very individualized, deeply gendered, central to personality and intimate relationships, and lifelong (literally womb-to-

tomb) would be quite unrecognizable to people living in different civilizations (Tiefer, 1995, p. 19).

An approach that questions the validity of the centrality of sexuality though is unlikely to salve the distress experienced by women whose deeply-felt sense of tentative and evolving sexuality is impinged upon even further by the effects of a viral STI diagnosis:

I feel really sad that at a time of my life when I am coming to terms with being a sexual being and feeling more at ease with myself and better able to relate sexually, that I now have this diagnosis that gets in the way of that development. I am moving to a place where I see sex is as valid a way of relating as any and more pleasurable than most, but.....
[Punctuation in the original] (Leila, HSV diagnosis, 51 years old).

Charlotte and Leila's comments are illustrative of inextricability of women's sexuality and sense of self. Stevi Jackson asserts that the empirical connections between gender and sexuality should not be neglected because

[t]hey are important in order to appreciate the ways in which sexual practices, desires and identities are everywhere embedded in non-sexual social relations (2006, p. 105).

Jackson point about the embedded connection between sexual and non-sexual relations is useful for understanding why an infection on one part of the body, the genitals, has such 'global' effects for Leila – that the diagnosis “gets in the way of development” as a sexual being and of being “at ease” with herself. Similarly, Charlotte links her positive views on sexuality and sexual health with overall “self-esteem.”

The instability of sexual subjectivity

Even/especially when sexuality is conceived of as normal and natural, there is nevertheless limited stability for women in terms of how to act and be. For example, Lees (1993) describes the tightrope young women must walk in the management of their sexual reputation:

...girls lose confidence because their identity rests to such an extent on their sexual reputation, which is precarious and crucial to them. Girls walk a narrow line: they must not be seen as too tight, nor as too loose....'Nice girls don't' is a phrase all girls understand, even if standards of sexual morality are more liberal (Lees, 1993, p. 29).

Amanda's comment below illustrates Lee's point about the “narrow line.” Amanda's self-assessment indicates a level of surveillance in which she produces a measurement of her sexual activity. She positions herself and her sexuality as normal in relation to two implicitly undesirable extremes; promiscuity and prudery:

I would consider myself fairly typical of a girl my age as far as when I would start sleeping with someone, not promiscuous but not a prude! (Amanda, HSV diagnosis, 23 years old).

Interestingly, in this study a number of women in their twenties identified that prudery impacts negatively on feminine subjectivity. By implication, contemporary femininity no longer requires women to police the retention of virginity. The line of appropriateness has shifted. While they do not have to be a virgin, they cannot be seen to have too many partners. To be a virgin has become a problematic identity for some women. Instead, appropriate femininity requires women to hover between inexperience and being overly-experienced. Rachel's account illustrates the tightrope of promiscuity and prudery:

I am concerned with the multiple partners my friends and associates have each month.... I am hardly the perfect angel to preach, but I am regarded by my friends (of both sexes) as "Frigid", or someone with "Morals" for sleeping with a total of 14 men in my whole life time, and stating I feel ashamed of it [having this 'high' number of sexual partners] (Rachel, HPV diagnosis, 28 years old).

Rachel's comments highlight an important point, that self-surveillance does not necessarily produce a clear 'measure' of 'appropriate' femininity. Her friends classify her as 'frigid' because of (in their assessment) the low number of partners she has had, whereas she considered the number unacceptably high. Her comments illustrate Fiona Stewart's (1999) argument that discourses that shape female sexuality are fluid and changing. Stewart's Australian research involved interviews with 20 young women aged 17-18 years old. Her analysis shows the reconfiguration of contemporary discourses of femininity and sexuality that make space for female initiative and desire and that subvert the conventional significance placed upon love and romance. Stewart also contends that access to alternative discourses of femininity is not clear cut; that some young women in her study were ambivalent about breaching predominant conventional discourses.

My analysis reiterates the fluid and at times conflicting discourses of contemporary femininity. The slipperiness of meanings can take women by surprise. Charlotte (the girlpower girl) is quoted earlier in this chapter with her description of the positive links she made between self-respect and sexuality. In her comments below, Charlotte reflects upon the way in which conventional beliefs about female sexuality surfaced unexpectedly when she was diagnosed with HPV:

The diagnosis of HPV can feel like a punishment for past promiscuity. I am still amazed that I experienced these doubts and insecurities — they hit me despite my supportive friends and healthy self esteem. I believe this is because there is still strong (if implicit) cultural conditioning to value female sexual purity and worry about having an appropriate 'number' (a count of all your sexual partners). Of course, this exists alongside an increasingly eroticised female culture (epitomised by young women who proudly wear the playboy symbol). No wonder we are so confused sometimes! (Charlotte, HPV diagnosis, 23 years old).

Charlotte's comments encompass the contradictions to which women are currently subject, as both conventional and contemporary discourses intersect with contradictory messages about sexual

purity and sexual autonomy. Harris (2004) also points out this contradiction within contemporary girlpower discourses. Harris describes media representations of young women that emphasise the 'dark side' of girlpower – of girls who have gone too far, and become delinquent by engaging in disordered consumption. These young women are depicted as having made bad choices. I contend that girlpower confidence does not mean that young women are impervious to the notions of personal failure associated with contracting a viral STI.

The new eroticism: Freeing desire or captured by consumerism?

Harris (2005) asserts that the new eroticism of young women's bodies in film, magazines and music is not only an expression of young women's enactment of feminist messages. Harris considers that the monitoring and regulation of young women's sexuality is now produced through its link with consumer choice. The apparent sexual autonomy Charlotte describes in the previous quote, with young women wearing the Playboy symbol, is part of what Harris describes as a "...kind of accessorising of the sexual lifestyle that enables the presentation of oneself as a desiring subject and desirable product" (Harris, 2005, p. 40). Young women are not freed from surveillance. Instead, they are subject to new regulatory practices as they become valuable participants in consumer culture. This consumerist orientation, of 'packaging' the sexually desiring body creates problematic regulatory elements. Although western culture for young women may seem 'sex positive,' Harris attests that

...these new discourses of desire reproduce many elements of hegemonic relations (for example, through a splitting of sex and romance, and an obsession with display and the gaze) which belie their revolutionary claims (Harris, 2005, p. 40).

Harris' contention that new discourses reproduce 'raunch culture' is important to my argument about why consumerist sex-positive messages do not have the effect of normalising viral STIs. A clinician, Annalise, commented at length on the impact of media representations of women's bodies; the increased policing of the body and any 'flaw' – including an STI - as representing failure to achieve a desirable level of bodily perfection. Annalise's comments echo an observation I have made in interviewing the broad age-range of women participating in this study, that younger women do not necessarily more easily take up ideas that viral STIs are relatively normal:

I really don't think I can answer well as far as proportion of women undergoing some adjustment after a diagnosis. I do note... that for those women who seem to me to be more 'identified' with the concept of perfect body image the imagined 'fall from grace/perfection' is harder to come to terms with.... I do see women, particularly younger (< 30/25 ish) ones very affected by modern concepts of the pristine body promoted in all forms of media. As a nurse doing female genital examinations it would be rare to see pubic hair in this group, I estimate about 75% are semi-to-fully waxed or shaved. The current 'prescription' for the perfect body seems to me to include removal of all body hair other than head hair, a flawless complexion that is now not only 'enhanced' by cosmetic creams, make-up etc but

more and more includes the 'normalising' of the use of surgical intervention to achieve this, e.g. 'botox parties', breast implants etc. The tight, taut body regularly worked on in vigorous gym sessions is possibly less about healthy aerobic activity and more to do with achieving what the ghastly American-type TV infomercials espouse about 'tight buns' flat tummy etc. (Annalise, clinician).

Annalise connects the difficulties women may face subsequent to contracting a viral STI to a disruption to the project of achieving an idealised body. Rather than the 'fall from grace' of contracting a viral STI being linked to moral failure, the 'fall' is about evidence of a less-than-pristine body. The preferred body is linked to consumer lifestyle; demonstrably under control through the use of multiple products. In the performance of normative feminine identity and the production of sexual attractiveness, Annalise describes young women engaged in behaviours that are considered normal and appropriate – from genital hair removal to surgical interventions. Anoop Nayak and Mary Jane Kehily (2008) describe the contemporary normalcy of what they call 'hyper-femininity':

The work of 'doing' girl is no longer hidden in the margins of the domestic or the confines of the bedroom. The burgeoning of the beauty industry...testifies to the work ethic of appearing gendered as a committed endeavour involving serious amounts of time and money (Nayak & Kehily, 2008, p. 184).

The notion of a work ethic in the production of hyper-femininity means that how young women are led to feel like a 'good girl' has shifted. Being 'out there' about sex may be desirable but a viral STI contravenes hyper-femininity.

Annalise's next comments demonstrate this shift in the work of 'doing' girl. In Annalise's estimation, young women are not necessarily freer in their relationship with their bodies than older women. Annalise's comments about the influence of pornography are interesting; that pornographic images may create new normalising standards with which young women feel pressured to comply. Annalise's comments draw attention to the significance of other contingencies, far outside of STI stigma, such as pornography, which shape the meaning of sexual attractiveness and normative sexual practices:

A friend of my daughter's (aged 20) recently challenged my negative attitude to the 'Brazilian' wax [removal of all genital hair] stating it was a simple extension of what I myself already do, i.e. shave my underarms and legs. Food for thought and yet I still feel uncomfortable with the idea of the genital area being involved. I think my discomfort stems from some thoughts I have about the impact of pornography on this practice. You ask what I sense about the possible meaning attached to the hairless genital area being a significant part of a relatively new 'normal' sexual body. I really do wonder about the time-frame of this practice seeming to coincide with the infiltration of the internet for large numbers of the populace. In my work with adolescents as a public health nurse (2001-03) I was

interested/shocked about the easy access young people have to pornographic images. Young males in particular can thus be 'informed' about the female body in what I feel is quite a skewed way by the sheer volume of material (so much more than previous generations of Playboy magazine secret pursuers) and take this [absent pubic hair] to be 'normal'. Other behaviours also are more and more expected to be considered normal sexual practice because of internet porn e.g. anal sex for females when in fact from my experience as a sexual health nurse this is far from the case. Very few women have anal sex and my impression of those that do is that there has usually been a request (often with a degree of coercion) from a male partner (? as a result of their internet 'learning').
(Annalise, clinician)

Annalise's thoughts on the influence of pornography and the internet upon shifting ideas of normative bodily presentation and sexual practices make a useful illustration of Butler's (1999) suggestion that discourses shape the apparent materiality and naturalness of the body and bodily practices. Nayak and Kehily (2008) develop Butler's notion of performativity and describe the shifting 'choreography' of gendered practices; the reconfiguration of the boundaries of unacceptable and desirable. Annalise's remarks fit with this concept of the fluidity of gender ideals in relation to bodily presentation and sexuality.

Annalise was the only clinician interviewed who made substantial links between constructions of embodied femininity and difficulties posed by a viral STI diagnosis. I asked all clinicians whether they noticed any similarities or differences in the effects of the diagnosis for women as compared to men and most clinicians had only brief comments. The comments that were made related to women being more likely than men to make an adverse moral assessment about their sexual behaviour in relation to the diagnosis. I have used examples to demonstrate a new morality applied to the body. Consumption and presentation may for some women supersede conventional notions of sexual morality.

Prioritising 'appropriate' femininity over sexual health

Given the importance of protecting appropriate femininity, women's sexual priorities may not encompass the possibility of transmitting or contracting a viral STI. Transmission-risk reduction and/or preventing further STI acquisition is not necessarily of over-riding importance for women. In the following example, Leila highlights a conundrum she faces when she considers whether to talk about sex and sexual health. The problem is not the stigma of STIs per se, but the risk to appropriate femininity. For many women in my study, the idea of discussing sexual health was linked to conventional discourses of femininity. Talk with a partner was a 'dangerous' topic linked to appearing sexually knowing and desiring. This 'danger' may be reinforced not only in families but also in sexual education curricula, where sex education focuses on sexuality as a problem to be managed, rather than as a positive aspect of youth (Allen, 2005):

Catherine's question: Prior to contracting the virus what experience, if any, did you have in talking with potential or current sexual partners about sexuality and sexual health?

Leila's response: I have always struggled with this. In part because I grew up believing that "nice girls don't" and if you are talking about it, clearly you are intending to [have sex]. Therefore you are not a nice girl. I still really struggle with this one, even now. I am more confident in talking about sex itself, but not sexual health (Leila, HSV diagnosis, 51 years old).

To talk about sex and sexual health is to engage in a potentially hazardous activity that may disrupt the presentation of 'appropriate' femininity. Leila's account illustrates Holland, Ramazanoglu, Sharpe and Thomson's (1998) use the term, 'disembodied femininity,' the modest femininity that produces a passive body alienated from active desire. In the following example, Tania describes how the goal of sexual health for herself or a partner is subsumed by ideals of feminine sexuality. Achieving these ideals includes maintaining the illusion of being less sexually experienced than she is, and in taking a traditionally feminine role of following the male lead, and exercising caution in terms of initiating the subject of condom use. Tania initially places the non-disclosure of a viral STI in the pragmatic context of HPV being a common virus:

If I was asked if I had an STI, I would say no in the belief that this is so common a virus, no harm would be done (Tania, HPV diagnosis, 35 years old).

The pragmatism about viral STIs is perhaps only a part of why sexual health talk is not part of Tania's sexual relationship repertoire. To speak about sexual health ventures dangerously close to the territory of talking about sexual experience. As Tania notes, women's maintenance of the illusion of inexperience is a requisite of being perceived of as a sexually 'safe' woman who is not considered to pose an STI risk:

I think the feeling [amongst mature-aged men] is that kids who sleep around need to go into that disease issue, but the older ones [men] don't think they are promiscuous even if they are, and the women look more innocent than they are, so the guys believe them to be almost-virgins (and therefore "safe"). We women just want to believe a man will know everything and look after us, so we are hopeless here! (Tania, 35 years, HPV diagnosis)

Tania's comment of maintaining the 'almost-virgin' illusion is illustrative of Gavey and McPhillips (1999) contention that a traditional discourse of heterosexual romance impinges upon women's ability to negotiate sexual health with male partners. Feminine sexuality is constituted as passive and responsive to the lead of the male partner. Tania eloquently described the conundrum for herself and her peer group who are sexually active with multiple partners and sometimes engaged in group sexual encounters. Presenting as an 'almost-virgin' requires Tania to engage in self-surveillance to present as relatively sexually unknowing. To discuss sexual health risks an appropriately feminine subjectivity. Tania indicates that there is the risk of appearing to know too

much about sex and also appearing more interested in satisfying her sexual desire than the relationship:

It is hard to think about what I would do if I decided to have another casual partner. I have bought some condoms, and would probably just use that. I would be more likely to wait until I know someone well before leaping into bed I think, and then the topic could be discussed well prior to the activity taking place! I could never ask at the time.... It could put the guy off – especially if the woman is looking for a long term partner, he could think she is a short-term type of person (Tania, 35 years, HPV diagnosis).

Tania's comment highlights the point that STI stigma is not necessarily the stumbling block for women in addressing sexual health. Talking with a male partner about the option of condom use is seen as potentially de-eroticising and unromantic. Talk about condom use risks being perceived as both a sexually-experienced woman and one who is interested in casual sex rather than in relationship commitment. Femininity involves a self-surveillance that to some extent precludes sexual health talk in order to maintain a suitably feminine demeanour. Gavey, McPhillips and Doherty (2001) cite the plethora of public health slogans that exhort women to insist on condom use that overlook the discursive constraints for women rendering these messages irrelevant or undesirable. Heterosexual sex without condoms is strongly linked to ideals of commitment and trust, and evidence of 'true love' (Holland, Ramazanoglu, Sharpe, & Thomson, 1998).

Unless clinicians have an awareness of the potential clash between the goals of sexual health promotion and a woman's perceptions of appropriate femininity, the clinician may give advice which is inapplicable. Although clinicians in my study frequently mentioned condom use no clinicians made reference to how problematic condom use is for women. I found that condom use was 'normalised' by clinicians as if there was a predictable link between medical advice and condoms being used:

Jessica's comment: And we try to encourage use of condoms in all new relationships until they feel they can discuss it with their partner (Jessica, clinician).

Catherine's question: I notice your comment about advising women to have a partner use a condom in a new relationship. In your practice, how do you find women get on, asking a male partner to use a condom? Have you found any ways of talking with women that perhaps empower them to have a partner use a condom?

Jessica's response: Mmmm. I haven't actually asked. I guess I just always encourage them to use condoms until they're in a committed relationship where they're willing to take the risk of exposure to viruses. I explain that a sexual health check can only tell them if they have a bacterial infection, and that they may never know whether they've been exposed to viruses unless they break out in the herpes blisters, get genital warts, or have cell changes on their smear. I just hope that it makes it clear to them that there is always a

risk, even if they and their partner have had a sexual health check it doesn't mean they don't carry the viruses (Jessica, clinician, 47 years).

It is evident from Jessica's reply that, as a clinician she dedicates time to discussing sexual health with women in some detail, and yet there is an absence of enquiry into how possible it is for women to act upon advice. Jessica's practice of non-enquiry may not be uncommon amongst health professionals. In a London-based study (Oakeshott, Kerry, Hay, & Hay, 2000) of general medical practices, condom use was promoted to 1382 women. The education strategy by nurses and general practitioners was a ten-minute practice-based teaching session, a leaflet about condom use and the provision of condoms. In evaluations one-to-three months after the session, there was no difference in subsequent condom use. The only significant behavioural change noted was that of doctors and nurses; condom promotion was shown to be possible at the time of cervical smear-taking. I find this study fascinating in terms of clinical teaching; that clinicians adopting new teaching strategies may have no impact on patients despite clinicians undergoing a sustained behavioural change.

The clinician, Jessica, and the above research trial focus on the risk of STI transmission, whereas there is considerable research, both in medical and feminist literature that indicates how 'risky' condom use is for women and that condom use is far from a universal practice in heterosexual relations. For example, in a literature review of female initiated methods of HIV/STI protection, the limitations of public health messages that emphasise female empowerment, choice and resistance to male control are discussed (Mantell et al., 2006). They recommend that health professionals need to engage with understanding local and regional gender relations in order to tailor relevant strategies.

I am particularly interested in the language used by clinicians in discussion about condom use. Jessica's reply is typical of the language used by clinicians: "In the discussion of condom use I just always encourage them to use condoms," where the gender of the condom wearer is rendered invisible. The implication is that the couple are using a condom, which misses the politics of the riskiness of sex-talk and that the male partner has to agree to wear the condom. Male partners using condoms and having a check-up implies having conversations about sex and sexual health; not an easy task for women who are more familiar with a lifetime of 'normal' discretion and silence about these topics.

The cautiousness with which women approach any disruption to feminine identity may be read very differently by clinicians. In the following response, a clinician links the demonstration of cautious behaviour with a focus on STI risk reduction including subsequent condom use (gender of condom user not specified):

Catherine's question: Does the diagnosis have much of an effect on women's subsequent decision-making in relation to sexual health, sexual relationships and pregnancy decisions? (Please include examples if any come to mind).

Claire's response: Some women are very cautious but others don't use condoms to prevent further STIs, depends on their general approach to life a bit (Claire, clinician).

Jessica and Claire's clinical perceptions are in keeping with the focus of public health risk analysis which assesses risk behaviours in relation to epidemiology and advice is offered accordingly. The notion of caution is perhaps linked to the idea that 'rational' women will take a safer sex approach after receiving education. The emphasis on teaching people to make 'rational' decisions in relation to sexual health and condom use is typical of sexual health education programmes (Allen, 2005).

In a New Zealand school-based study of 42 adolescents, Gillian Abel and Lisa Fitzgerald (2006) conclude although well-versed in health promotion discourses of safer sex, these discourses are resisted when they are incompatible with desired sexual identity. Tania's comments (the 'almost-virgin') illustrate that sexual health education does not undo caution in the management of appropriate femininity; which is a priority that supersedes sexual health caution. The cautiousness with which Tania approaches any sex-talk makes sense in the lives of many women; talking about sex and sexual health has never been ordinary or normal. A circumspect approach has been the norm and a more 'assertive' approach is imagined to have undesirable consequences.

Self-Surveillance: Growing up with silence and whispers

In the previous chapter, I addressed clinicians' normalising of viral STIs. The normalisation of STIs may be an exotic notion if nothing about menstruation, sexuality or fertility has ever been an 'ordinary' topic of family conversations; if silence about the body had always been present. In the following two accounts both Rose and Rachel notice the absence of talk about bodies. What interests me about their accounts is the contextualising of their mother's attitudes. Both Rose and Rachel make sense of their upbringings with the use of humour, placing their experiences well within the bounds of normalcy through identifying inter-generational differences between themselves and their mothers:

It really is interesting/humorous how now as an adult and having children of my own, I reflect often on my upbringing and chuckle at what I used to do to "gain" information about life. As the youngest of eight children, I never heard the words sex, intimacy, body, etc., in our house, let alone the dinner table. Heck no. My parents were so private, as a child, I once wondered how they even conceived eight children. I once remember taking a glass to my bedroom wall, to theirs, as I wondered if they were maybe "doing it." Funny, huh? In hindsight, it would have been great if I had been able to talk to my mum about what I was going through, but then again, I think it was the generation she was from. She had me at 42 and I'm 45 now (Rose, HSV diagnosis, 45 years old).

Rachel also contextualises this body-silence as ordinary; she believes her experiences are unlikely to differ from those of her friends. She comments on religion and culture as influences that reinforce her mother's silence:

I don't think any of my friends spoke with their mothers about sex or sexual health at any stage. I was lucky enough to have the puberty class teach about periods during form 1, when I was 11yrs old. I got mine exactly that day, and didn't have any questions for my mother, school covered everything. Much to her relief, I just asked if she could take me to buy some pads from the supermarket :-) [smiley face] She was more uncomfortable about buying them than I was.... Anyhow, she was scratching her head and looking surprised when I asked her to take me to get some pads. I reassured her, and said for her not to stress, that they are teaching us about puberty at school. It was never discussed, she just asked me to sing out if I needed panadol.... I think perhaps most women have grown up from generations who put such a silence to discussion on a woman's private parts. It could have been a religious thing influenced, that is slowly becoming less evil to discuss. Not sure of this, but it is a culture taboo, perhaps in my mother's generation, that does contribute to layers of messages in my life making having HPV or HSV a dirty shameful thing at first (Rachel, HPV diagnosis, 28 years old).

Both Rose and Rachel's reflections describe their upbringing in ways that demonstrate the production of discourses of conventional femininity. Holland, Ramazanoglu, Sharpe and Thomson's (1998) concept of disembodied femininity – detached from desire and alienated from the physical body – is used to describe the 'ordinary' rather than extraordinary absence of the body in many young women's talk about sexuality. Rose and Rachel conceive of their upbringings as ordinary enough, although Rose is parenting differently from her own parents, in part due to the effects of having contracted HSV:

I knew even before having a family that I wanted to be much different than my parents in how they raised me, particularly in the area of sex, our bodies and open communication. Yes, I loved them [parents] dearly, but I wanted to be a much more open person. Interesting how HSV initially changed that thinking in the area of sexuality for me [talking about sex became more difficult] but has given me the confidence to approach that subject more openly with my own children. I hope that my children never have to live in such "private pain" like I did. I want them to be able to feel comfortable in approaching me and talking to me (Rose, HSV diagnosis, 45 years old).

For Rose, the experience of contracting HSV from her first sexual partner when she was 25 years old led her to question the usefulness of the sexual conventions of her upbringing. The 'disembodied femininity' of her upbringing made a viral STI diagnosis harder to bear as she did not feel able to confide in any of her family or question clinicians in detail. Over time, Rose's constructions of femininity and sexuality have shifted to include positive associations with her own sexual desire, with 'openness' about her own embodiment and her children's experiences of their bodies.

For another participant, Miranda, her diagnosis of HSV alerted her to the silence in her own growing-up experience. Miranda now considers that the silence was problematic in that anything

connected to sex, including the possibility of STIs, had an unreal quality. She recounts the conflicting beliefs that are made apparent in responding differently to her adolescent daughter's sexuality. Miranda's fifteen-year old daughter wanted to be sexually active with her male partner and to take the oral contraceptive pill. Miranda made a doctor's appointment and accompanied her daughter. Miranda experiences herself as breaching codes of feminine sexual conduct and yet persists despite her discomfort in order to assist her daughter:

We saw another doctor a young male doctor. He commended me on my attitude. There again I looked up different agencies about what is the prevailing attitude to sex for 15 year olds. But there didn't seem much available. As a sole parent it's making these kinds of decisions, which is the hardest. A hard line on my part would not be enforceable. I wasn't comfortable talking to women that I knew. I wasn't looking forward to seeing my own doctor, because what would she think? Here's me and my 15-year-old daughter requesting the pill, it looks like we're a couple of town bikes. Not rational thinking I know. And it's not true. My mother never mentioned sex to me. We certainly never had conversations about safe sex or boys. My experience with HSV has made the health risks more real for me and enabled me to talk to my daughter (Miranda, 48 years, HSV diagnosis).

The above account demonstrates a number of strands in self-surveillance. Miranda has her own sexuality, her mothering practices and her relationship with her daughter's emerging sexuality under close scrutiny. The tension for Miranda of being viewed negatively as a sexually active single parent leads her to fear that her support of her daughter will result in being deemed a 'bad' mother and the 'town bike' (i.e. promiscuous). Miranda also draws attention to the historical and contemporary silences in her life with regards to sex and sexual health. There was silence from her mother on the topic of sexuality. Miranda has not been able to discuss her daughter's choices with friends. Miranda has not told her daughter that she has HSV. The diagnosis though has been a catalyst for conversations and acts of support that may not have otherwise been initiated, even though Miranda's description includes considerable ambivalence about the decision-making process.

In an Australian study of 30 mothers' addressing reports about sex and sexual health talk with their adolescent children, the authors (Rosenthal, Fieldman, & Edwards, 1998) report that virtually all mothers felt that some topics were off-limits. However, there were no examples of the complex interconnections between the mothers' sexual subjectivity and the effects upon what counted as off-limits.

I consider that Miranda's description vividly captures the dilemmas she faces as a mother, making sense of and managing her own and her daughter's sexuality, shaped by conflicting discourses of morality, responsibility and 'good' mothering. Although a discourse of stigma would neatly fit Miranda's experiences, one of the problems with a stigma discourse is that it inevitably cuts out the historical layers of women's lives; layers of silence and self-scrutiny, layers of events that add to

the sense of being a less-than-ideal woman. The stigma of STIs may only have partial bearing on the beliefs about failure that may accompany a viral STI diagnosis.

Diverse influences other than sex-STI-stigma link

The lives of women offer up a kaleidoscope of experiences in order to account for the impact of a viral STI diagnosis. I am interested in the limited relevance of STI stigma per se in accounting for women's distress as women describe diverse factors that shape meaning. As I have mentioned, a problem with stigma discourses is that the notion of stigma assumes a minority position of 'outsider.' Leila's following account of factors that shape the meaning of a viral STI diagnosis are not at all uncommon or unusual for women: a 'broken' family, abuse of some sort, being overweight by conventional standards, and beliefs that female sexuality is bad. In response to an interview question, Leila poignantly detailed the layering of experiences that contribute to the scrutiny to which she subjects herself. The complexity of her life means that so much that contributes to self-surveillance falls outside of the simplicity of the stigma of an STI:

Catherine's question: Are there any factors from earlier in your life that may have shaped the meaning of experience in some way?

Leila's response: Oh heaps: lots about being powerless, being abused, being used, and not having control. Lots of social messages about a woman being sexual = a woman being bad. Also stuff around fat people being bad and undesirable impacts on this as well. Who I am as a woman, as a sexual being, and as a person all impacts on this diagnosis. I can't separate it out from all of this.... The diagnosis fits with a very old/early message I received in my life journey. My mother was ill after my birth and subsequently the family was split up and fostered out for a time. I grew up believing that the meaning of this was that I was in some way 'toxic'. The herpes diagnosis absolutely plays into this old message as you can imagine (Leila, HSV diagnosis, 51 years old).

Leila makes the point that it is impossible to separate out the impact of the HSV diagnosis from other experiences in her life. In Leila's account, the significance of contracting a viral STI is not only in relation to her sexual sense of self. Rather, the meaning is linked to the numerous ways in which she has felt disempowered. Leila's comments are important in 'unpacking' the discrete classification that pairs STIs with sex. The detrimental connotations associated with STIs may be linked to experiences that have nothing to do with sex. It is perhaps useful for clinicians to consider enquiring about the effects of past trauma or abuse upon the meaning of the current diagnosis.

In another example of the broad classificatory connections women make, Victoria draws a comparison between the effects of the meaning of a viral STI and an earlier termination of pregnancy. Victoria measures the sense of failure to achieve appropriate femininity compared to some imagined woman who is 'unspoiled' and has 'everything going for her.' Victoria is a health professional (not in the area of sexual health) and yet her knowledge of the prevalence of STIs and

terminations does not 'protect' her feminine subjectivity; she feels abnormal even though her experiences of an abortion and a viral STI are common:

Since my diagnosis in 2004, I had basically been avoiding the issue of child-bearing, thinking I was spoiled and basically ruled out a relationship. Basically living in emotional isolation....I look at an attractive man and think he won't want me or [he will] compare me to women who appear to have everything going FOR THEM. It's a battle. When I was 27 I terminated a pregnancy and felt that I was somehow "marked" and put myself through emotional torture over it as well (Victoria, HSV diagnosis, 37 years old).

In my study I contend that clinicians direct their efforts towards normalising and destigmatising viral STIs and yet somewhat miss the point that the concept of stigma and the solution of destigmatisation may only partially address the difficulties faced by women. From childhood, women receive a barrage of messages about the narrow parameters of appropriate femininity. Although there is apparently more freedom for girls and women, new forms of self-surveillance now exist. Victoria's experience, of feeling 'excluded' from normal femininity is common for women. The opportunities for women to fail the 'femininity test' increase in tandem with the more evident sexual liberties available: pubic hair is the new dirt, 'confidence' is expressed through compliant consumerism, and 'raunch culture' that promotes sexual freedom does not protect women from the notions of inappropriate femininity when unplanned pregnancies and STIs occur.

Sexuality, sexual desire and viral STI talk

In my study clinicians typically stated that it is desirable for women to talk with a sexual partner about a viral STI. Women participating in the study commonly indicated that talking with a male partner was the most difficult aspect of having contracted a viral STI. Women also indicated that when advised by a health professional to talk with a partner, there was no acknowledgement of how complicated it might be to attempt to constitute oneself as desiring and desirable and incorporate sexual health talk. An example I introduce shortly, of Katrina's account of negotiations with a partner, is illustrative of the breach to discourses of romance and the pressure of the 'coital imperative' that women may encounter in talking about sexual health. Based on my clinical experience, I consider that Katrina's description is not unusual and yet in my study I found that clinicians knew little about the complications an STI adds to women's experiences of desire and heterosexual relationships. Perhaps the focus on normalising viral STI's contributes to the absence of talk about women's sexual bodies and sexual desire. I asked all clinicians the following question:

Catherine's question: Does the diagnosis tend to influence women's experiences of sexuality and sexual desire?

What follows are a selection of clinicians' responses that capture the types of replies given in the study:

Edith's response: I have not had experience of women declaring that they had changed their sexual practice or related changes in desire. But I don't specifically ask (Except it is wise to use condoms when experiencing an outbreak or prodromal symptoms) (Edith, clinician).

Jessica's response: I haven't had anyone mention this to me sorry (Jessica, clinician).

Margaret's response: I imagine that it [the diagnosis] would, but I cannot recall a consultation in which this has been discussed. That may be an omission on my part to approach the topic, and a reminder that we should explore this more, rather than simply ask about recurrences! Anecdotally though I have heard of women who have avoided sex because of the knowledge that they carry the virus (Margaret, clinician).

Betty's response: I don't often get into this topic in any depth, but yes I think it does. Many women report feeling dirty and put off sex, especially if there are genital warts present. Concerns about transmission also affect the ability to relax and enjoy sexual contact (Betty, clinician).

I find the contrast curious, between clinicians ubiquitous normalising of viral STIs and yet the limited or absent clinical enquiry about the effects of the diagnosis upon women's sexuality and sexual desire. How can clinicians assess the relevance of the pedagogical effects of normalising if women are not asked about whether the diagnosis has changed any aspects of sexuality and sexual desire?

The following account by Katrina, about managing a recurrence of genital herpes and negotiating bodily boundaries with a male partner, is a useful illustration of how much 'work' may be involved for a woman in communicating with her partner and refusing unwanted sex. A herpes recurrence does not make saying "no" to sex any easier than if she did not have an infection. Katrina provided me with an extended account of what she called the "effects of herpes on personal love/physical relationships." I have separated her narrative into sections in order to include discussion throughout her account. Katrina began with a description of the sexual pressure from regular partners despite her having a possible herpes recurrence and declining sex:

I've found that men don't like to hear, "Oh, I can't tonight, as I have a sore spot and am not sure if it's an oncoming outbreak or just a sore spot from maybe wearing tight jeans - whatever but I prefer to err on the side of caution - for the good of both of us." I've been accused of lying to get out of having sex. How insulting is that, especially when I have been otherwise honest with the man about everything (Katrina, HSV diagnosis, 61 years old).

McPhillips, Braun and Gavey's (2001) description of the term, 'coital imperative' is useful in contextualising the response Katrina has experienced. Her account is not unusual and reflects the taken-for-granted heterosexual assumption that real sex is penetrative sex. I consider Katrina's comments also illustrate the male sex drive discourse (Hollway, 1989), that men are always

interested in sex and that they are entitled to having their sexual needs satisfied. Katrina's account shows the coercive pressure she has been under to have intercourse: "I've been accused of lying." I concur with Gavey, McPhillips and Doherty (2001), that public health messages that encourage women to be assertive are simplistic, denying the difficulties women may endure in resisting unwanted sex. Katrina went on to mention the effects upon her own feelings of desire when she has a recurrence:

Yes, there are other ways to enjoy sex without just having intercourse [does not elaborate further]. Another aspect of having herpes is that if I do have a confirmed outbreak, and having said the foregoing sentence, I then do not feel sexy or appealing (Katrina, HSV diagnosis, 61 years old).

Katrina's comment indicates that she does not experience sexual desire or experience herself as desirable when she has a recurrence, so that even if there are other ways of having sex, she does not feel like being sexual. The above point is one that I find is absent in the research literature: how women feel about their bodies in relation to having a viral STI is not necessarily related to a partner's acceptance or otherwise of the infection. Regardless of a partner's perception of the relevance of a viral STI, women have their own judgements that translate into bodily feelings. As Katrina's account details below, a partner's acceptance is not an uncomplicated matter – 'acceptance' may readily blur into pressure to be sexually available:

I had been with a man who also has herpes type 2 but he rarely got an outbreak. However, he did get one and the following ensued: First, my "rule" is not to engage in intercourse until sores are completely healed over. This means no pinkness in skin color being evident. To me, that is not completely healed. Am I wrong? So he said he was all healed up and I asked to look at the spots. They were still pinkish and I was adamant they were not completely healed because, also, not enough time has passed for complete healing. Of course, he got upset and made me feel I was being ridiculous. He said, "You have it (herpes) anyway and I will use a condom so what is the problem?" I said, "I do not want to take the chance of picking up another strain and more so, I don't want to go through the pain of a possible outbreak you could maybe cause." (Were his lesions further down than they were located, I would have said OK but I knew if I went ahead and acquiesced to his desires, I would feel inhibited and would not be able to enjoy the whole thing). He was spoiled in his ways, however, and a bit demanding to have frequent sex. So....the "telling" issues don't seem to stop even if both partners have the nasty little bloodsucker in their body (Katrina, HSV diagnosis, 61 years old).

As I reflect on the above passage I think of what uncommon behaviour Katrina exhibited in the persistence with which she resisted her partner's pressure to have intercourse and the entitlement she took up to examine his body. Her account illustrates that even though she was not positioned by the passivity of heterosexual romance discourses (Gavey & McPhillips, 1999), she has to be persistently emphatic to have her point of view heard. I now wonder what the "of course" relates to

in Katrina's comment, "Of course, he got upset and made me feel I was being ridiculous." The "of course" may perhaps relate to her earlier comments about the ordinariness and expectedness of the pressure men put on women to be available for sex; the coital imperative and the priority of his desire over hers. Interestingly, Katrina had established these HSV surveillance practices from her own extrapolations from material she had read. No clinician had ever discussed viral transmission with her in the twenty-five plus years she has had HSV. Similarly to other women, Katrina is therefore not surprisingly engaged in sexual regulation practices that are more stringent and at odds with current clinical advice based on research evidence.

Katrina's account is very useful in highlighting the lengths women may have to go to in order to manage sexual desire and STIs within a heterosexual relationship. Katrina's experience invalidates the apparent simplicity of the advice from clinicians to talk with a partner about sexual health. Heterosexual sex already entails complexity for women. Women are positioned by the interplay of the male sex drive discourse and the coital imperative and as such acting on their own desire or lack thereof may be difficult or impossible. In Katrina's accounts, a herpes recurrence is not even treated as a 'real' reason to avoid intercourse and there is no evidence that her partners are interested in the effects of the lesion on her sexual desire.

Conclusion

This chapter addresses why clinicians' educational practices of normalising viral STIs do not readily fit with the ways women police their bodies. I demonstrate that normalising STIs is not a simple matter of liberating women from conventional discourses of feminine sexuality that emphasise moral purity and responsibility. The 'new' femininities, evidenced in slogans such as 'girlpower' emphasise autonomy, personal choices and sexual empowerment. Yet the commercial prescriptiveness of a hyper-feminine, disciplined body is disrupted by a viral STI diagnosis. There is no clear trajectory of sexual liberation that correlates with young women being more able than older women to incorporate a viral STI into their sense of appropriate femininity.

Clinicians in my study emphasise a 'rational' approach to sexual health that has limited relevance for many women's lives. The example of attitudes towards the use of condoms clearly indicates that clinicians and women measure what counts as risk-taking very differently. For clinicians, women initiating condom use is about reducing the risk of STI transmission. For women, initiating condom use risks breaching the passivity of the discourse of romance, in which women follow the male lead, responding to desire rather than being a desiring subject.

While women in my study indicated considerable knowledge about the impact of viral STIs upon sexuality and feelings of sexual desire and desirability, most clinicians, apart from Annalise, had few comments to make about these effects. A number of clinicians indicated that they did not ask women about any sexual changes. It is an interesting paradox that clinicians normalise viral STIs and yet do not have an in-depth knowledge or enquiry process about the dilemmas women experience after a viral STI diagnosis.

Chapter Six:

Examinations

Introduction: Erasing the extraordinary in pelvic examinations

In this chapter I continue a discussion of the pedagogical effects of clinicians' normalising practices, using the example of genital and speculum examinations. In health promotional material and medical research literature, compliance with examination is routinely contextualised as being in women's 'best interests.' I demonstrate how the constitution of the examination as a normal, ordinary clinical intervention, essential for the production and maintenance of health, shapes both public health information and the direction of medical research. I contend that the experience of examination is less-than-normal and less-than-ordinary for many women. I am interested in the pedagogical effects of the rigorous normalising of examinations. I consider that the insistence that examinations are normal paradoxically limits what clinicians might learn from women that could indeed make examinations more 'routine' and manageable for women.

In my study, women had a considerable amount to say about factors that contributed towards an examination being an extraordinary rather than an ordinary event, for example: the disruption to privacy, shame in relation to having something 'wrong' in the genital area that has sexual connotations, associations with past negative sexual experiences, the gender of the clinician, the attitude and proficiency of the clinician, the level of discomfort or pain of the procedure and/or lesions, and the examination setting. I found that most medical research exploring women's difficulties with examination procedures focuses almost exclusively upon women as the problem. Psychosocial barriers are typically investigated and research involves testing various psycho-educational interventions. Exploration of the dynamics of clinician-patient relations and what women feel in their bodies are usually absent. My critique of medical research is informed by my years of clinical work. I am passionately interested in the importance of women's engagement in cervical screening and follow-up, in terms of reducing morbidity and mortality. As an oncology nurse in the early 1990's I nursed women who died of cervical cancer and/or endured the indignities of radiation treatment to the cervical area. From that time I have been concerned about the delivery of primary health care, including screening.

I again draw from Derrida's (1981) concept of differance to illustrate that the insistence that examinations are normal does not erase other meanings. Part of what is complex about the 'abnormality' of examinations for women is that women do not necessarily simply avoid having these procedures. Women seek examinations out of obligation, the desire to be healthy and to receive treatment. In this sense, the meaning of examinations for women is fluid, with neither normalcy nor abnormality necessarily being the privileged term. Following Weedon (1987/1997), I am interested in decentering the hierarchical oppositions of normal/abnormal in order to consider possible benefits for women when meaning is not fixed.

In order to understand the rigid fixing of meaning in contemporary public health discourse, Foucault's concept of self-surveillance is also useful (1973/2006). Entire populations are trained in monitoring and participating in particular bodily practices. For most women, cervical screening is an 'obligatory' part of adult life. Screening is ordinary in that it is just another aspect of myriad practices of bodily surveillance discussed in the previous chapter. Participation by the 'good citizen' is not guaranteed though. Factors that impede the effectiveness of public health self-surveillance messages are the focus of many research studies. A meta-analysis of factors that influence anxiety in women undergoing colposcopy illustrates that efficient public health is dependent upon training individuals to be self-regulating:

It is important that the level of anxiety associated with undergoing the different stages of screening process be kept to a minimum...because it bears a relation to compliance (Tahseen & Reid, 2008, p. 90).

The reduction of anxiety is positioned as significant in terms of the effects upon the compliance of populations, rather than upon the comfort of individual women being a priority per se. The term, compliance, also indicates that surveillance requires women's cooperation. I am interested in the ways discourses of femininity shape public health and medical literature and also women's engagement with examinations. What follows is an examination of the textual representations of the normalcy of examinations and women's accounts of the obligation to participate.

The examination: Normal rite-of-passage?

It is possible that, like me, other women are co-opted into participating in surveillance and diagnostic medicine as part of being a 'responsible' (female) citizen; as a woman who 'takes care' of her health. Participation in cervical smear screening is presented in contemporary public health literature as something of an essential 'rite of passage' into womanhood, with an ongoing engagement that only ends late in life. In the following excerpt from a pamphlet widely circulated within New Zealand the implication is that screening is a normal aspect of all women's lives:

Who should have cervical smear tests? All women aged 20 until they turn 70 who have ever been sexually active should have regular smear tests....Having regular smear tests every three years is the best way of finding and treating abnormal cell changes and preventing cervical cancer from developing (National Cervical Screening Programme, 2007a).

The above quote reflects the 'new' orientation of public health education; women's bodies are no longer clearly healthy or ill. Instead, women's bodies are 'at risk.' Discourses of femininity include women relating 'responsibly' to the 'at risk' body. In my reading of the interviews I noticed women's compliance with examinations as a normalised practice of femininity. Lupton (2003) asserts that the rhetoric of public health is such that initiatives to inform people about risks are seen as benevolent rather than controlling, and therefore power relations are invisible. Women 'volunteer' to have their

bodies scrutinised rather than considering themselves coerced. In the following quote, Dianne explains the 'normal' interplay between self-examination and examinations by professionals; women are enculturated to be their own examiners and to make their 'private parts' public at least to health professionals:

...in terms of how it's different to the consultation process for other conditions - yes, it's more difficult than having a broken arm looked at, or having bad acne, or a rash. Yet women are used to getting smears and we do our own breast checks and such; I think we are used to having our private parts poked at and prodded. For my generation and younger women, we have been told to get checks frequently; we are raised to get Pap smears and eventually mammograms. It's awkward but you get on with it. What I found was that it's not until they find something unusual that suddenly it becomes REALLY uncomfortable. That's when professionals need to be sensitive, truly caring, patient and knowledgeable (Dianne, HPV diagnosis, 33 years old).

The normalcy of participation, to tolerate the awkwardness and 'get on with it' has an aspect of moral obligation; of implied mandatory participation. Participation is also constructed as an act of power on the woman's behalf. Lupton (2003) describes the new 'work ethic' entailed in the self-scrutiny of the body. People feel good about themselves when they are 'working' on their health as an active project. Dianne lists the regular checks of breasts and cervix that are part of the ordinary 'work' of being a woman.

Dianne's description separately categorised bodily parts, as if breasts and 'private parts' are objects distinct from who she is as a person. The separation is possible to maintain until, in Dianne's account, a problem with these parts becomes "REALLY uncomfortable" emotionally. This separation echoes the Cartesian separation of mind from matter where the body is relegated as a machine to be studied. Ramazanoglu and Holland (2002) contend that

[t]he dominance of reason put the reasoning mind in a position of mastery. The 'knowing subject' – the conscious self who reasons – could master the 'object of its knowledge' – the matter to be known (Ramazanoglu & Holland, 2002, p. 28).

In Dianne's account, the rationality of having examinations for the most part takes precedence over the discomforts of being "poked at and prodded." In my study, women's constructions of genital examinations moved between the rationality of normalising medical discourses and to a greater or lesser extent emphasising other meanings. I concur with Harding's (1997) critique of the limitations of feminist writing that places the medicalised body in opposition to normal/natural body, as if deconstructions of women's bodies can and should be wrested from medical discourses and liberated through privileging 'the natural.' Harding's research relates to the construction of the bodies of post-menopausal women and the use of hormone replacement therapy. Her analysis is germane to deconstructing women's accounts of examinations:

...it is hard to isolate examples of medicalisation from its absences, and to distinguish a medicalised body from an unmedicalised body. Indeed, owing to the power of medical discourse to frame experience of bodily processes, the unmedicalised body is a sheer impossibility (Harding, 1997, p. 145).

I am interested in the tensions that occur in relation to the discursive constructions that shape the bounds of what women think and feel about examinations. I begin by demonstrating representations of genitals as separate from the reasoning minds of women. The separation is to the extent that any distress women might experience with examinations is considered to be a psychosocial problem, rather than about what is happening to their bodies.

Examinations: Mind over matter

Medical discourses are constituted as empowering women and yet may have the effect of making it difficult for them to question possible ambivalence about what happens to their bodies. Popular Australian author, Kaz Cooke, has a section on girls' and women's health in her latest book, *Girl stuff: Your full-on guide to the teen years* (2007). In Cooke's book aimed at young teens, the text supports the enculturation of women from puberty onwards to become the compliant, uncomplaining object of the medical 'gaze.' Cooke's orientation towards girls' bodies is an example of the mastery and separation of the rational mind over the body. There is a detailed description of the steps involved in having a speculum examination, including the reassurance that:

Male and female doctors see patients' girly bits all day long and are very used to it – one of the reasons they are able to tell you whether everything is normal is because they see so many different people's bits (Cooke, 2007, p. 430).

The easy parlance with the use of the term, 'girly bits' interestingly tends to replicate biomedical discourses in several ways: 1) women are not represented as whole, embodied people but rather, the genitals are represented as separate entities. 2) The gender of the practitioner is not problematised in any way and the male gender leads in the gendering of apparently suitable practitioners for the task of examination. The text therefore indicates that it is normal for a male, in the medical role, to look at a woman's genitals. The implication is that it is sensible – rational – for girls to find the male and/or medical gaze unproblematic. 3) Also implicit in Cooke's description is the desexualisation of the genitals; that the clinician is looking to determine the normal from the abnormal, not the desirable from the undesirable. Cooke does not suggest that there might be any reason for girls and women to have a gender preference in terms of the practitioner, and yet female gender preference is common where procedures involve 'intimate' health problems (Zuckerman, Navizedeh, Feldman, McCalla, & Minkoff, 2002). In the next chapter I address the illusion created by the notion of medical rationality; that clinicians treat women's genitals as 'neutral' bodily parts separate from their sexuality and sexual choices.

The following comment by one of the women in my study appears to conform to the notion that having an examination is a rational, unremarkable event. The addendum about the gender of the clinician perhaps hints at a caveat about the worry-free perspective on the procedure:

Examinations don't worry me I know we need them and that they don't take long so I just get on with it! Although I do have issues about seeing a male doctor for this! (Claire, HSV diagnosis, 29 years old).

Claire's comments are compatible with the current prevailing attitude represented in both popular literature aimed at a lay audience of women and in medical research literature, that examinations are a necessity to be approached with a matter-of-fact attitude. The sort of tension Claire indicates – on the one hand normalising examinations as an insignificant experience and yet on the other hand there being significance about the gender of the clinician – is the sort of tension that is downplayed in medical literature. For example, women's possible gender preference and choice is implied rather than stated in the brochure of The National Cervical Screening Programme:

Most of the above services have women smear takers (National Cervical Screening Programme, 2007a).

There is a stark contrast between medical and social discourses in relation to the meaning of men looking at women's genitals and yet public health material and research literature curiously draws almost no attention to the effects of these discourses in relation to women's compliance with examinations. In my study a number of participants mentioned the significance of gender. Amanda's comments imply that she is very aware of the significance:

My main GP [general practitioner] is male, but I will always book in to see another female GP for examinations. My male GP is great, as is the female, but definitely feel more comfortable with a woman for those examinations - plus you figure that they can understand more about anything that may happen, as they have the same equipment! (Amanda, 23 years, HSV diagnosis).

It is of considerable interest to me that the perspective that women might find the procedure and/or the practitioner difficult in some way is downplayed or absent in the literature. In Cooke's (2007) account, it is the comfort of the clinicians is emphasised – doctors are “very used to it” – privileging the expert comfort of clinicians as if clinicians' comfort mitigates women's discomfort. By contrast the comfort of adolescent girls and young women's expertise about their own bodies is not mentioned. Vivien Lane and Jocalyn Lawler (1997) explore similarly significant language used in Australian cervical smear brochures to highlight the objectification of women's bodies and the silence with regard to any notion that women's lived experiences might contrast with the medicalised representation of the procedure. Lane and Lawler draw attention to the passivity to which the vagina and cervix are reduced, with no indication of agency on the part of the woman; no alternatives are suggested, only 'going-along-with' the procedure. Cooke's use of language also

perpetuates discourses that disembodiment women. The mention of the feelings a woman might have are limited to the physicality of the isolated vagina, rather than the feelings of an embodied woman. In discussing the insertion and opening of the speculum the following comment is made:

Because your vagina is very stretchy, this shouldn't hurt, but may feel odd and uncomfortable (Cooke, 2007, p. 432).

The description of the vagina's stretchiness takes on the universalising accounts common to medical descriptions, where unifying themes are emphasised over the diversity of women's experiences. Cooke's description of the feelings of an isolated vagina is perhaps best contrasted with several women's accounts of being examined, where the stretchiness or lack thereof of the vagina does not equate with women's comfort:

The follow-up appointment yesterday went well. I was very anxious about having the invasive side of things causing me pain because I was previously raped at 14, and again in an abusive relationship at 25. The doctor and the nurse were very supportive and checked my understanding of what having an abnormality means, and told me that I am the boss when they are doing the procedure. I was quite happy how things went, and proud of myself for doing better than expected.... I am sure as heck, that if I had not been a survivor of any trauma, I would be in a sense traumatised to some degree [by an examination]. Hard to explain, but it is emotionally invasive, because for a women (perhaps men too) it is the most emotional part of a body (Rachel, HPV diagnosis, 28 years old).

Rachel's assessment of the examination going well for her displays the complex interplay of factors that shape the experience. In her account, the physical body – the vaginal sensation - is not separated from associations with a past rape and a previous abusive relationship, from the relationship with the practitioners who are present and from the being able to comprehend the meaning of the tests. The efforts made by the clinicians to include her experience in the procedure and to give her ownership of her own body – “I am the boss when they are doing the procedure” – is not in evidence in the research literature that grapples with the question of women's reticence about pelvic examinations. In a meta-study of risk factors for non-adherence to follow-up for abnormal cervical smear tests, the authors (Eggleston, Coker, Prabhu Das, Cordray, & Luchok, 2007) comment that there is little research addressing the influence of the individual characteristics of the clinician. In my study women repeatedly mentioned the influence of clinicians' 'bedside manner' and technical skill upon the experience of being examined.

In reading studies by medical researchers who attempt to make sense of women's reluctance and anxiety about examinations, I am startled that what appear to me to be the ordinary, obvious problems are not researched – that women find the physical aspects of the procedure and/or the practitioner unpleasant and uncomfortable. Instead of research focussing on women's bodies - the clinician-patient communication about bodily comfort, the type of plinth and position women prefer,

whether women like their body draped or how the speculum is inserted - the research focuses on educational strategies to overcome women's psychosocial problems that impact on compliance.

Examinations: The absent embodied woman

Considerable medical research focuses on interventions to overcome women's distress and reluctance in relation to participating in cervical screening and follow-up. I discuss an English research project undertaken by Samina Tahseen and Peter Reid (2008) in some detail as I consider this study typifies the absence of enquiry in relation to women's bodies. The purpose of their study of 50 women was to identify 'baseline' anxiety in women prior to their first colposcopy (microscopic examination of the cervix in which binocular equipment and video-screen display are additional to the use of a speculum). Women were asked to comment on various pre-determined interventions aimed at anxiety reduction with the goal of reducing future procedural anxiety.

The interventions in Tahseen and Reid's (2008) study exemplify the notion that engagement with medical rationality potentially overcomes the 'irrationality' of psychological distress. The interventions also illustrate Cartesian dualism whereby the consideration of the material body is absent. The key interventions tested by staff were: the use of an information leaflet, the opportunity for women to see what was happening during the procedure on the video display, exploration of the effects of medical terms and explanation by the colposcopist doctor and explanation/reassurance by the colposcopy nurse. (I find it a curious distinction that the doctor explained while the nurse explained and reassured). In Tahseen and Reid's (2008) study there is no evidence that women were treated as experts about the causes of anxiety. Rather, with reference to previous research, the assumption was made that anxiety related to the link between cervical abnormalities and cancer. In the article there is undefined reference to women's anxiety about the actual procedure but no discussion about what particular aspects. Perhaps unsurprisingly, the research article (Tahseen & Reid, 2008) concludes with the comment:

The higher the index level of anxiety regarding colposcopy, the less likely women were to find either the leaflet or the video-screen display helpful. Research should be predominantly focused on the 'very anxious' women in an attempt to find any useful measure to reduce their anxiety as they seem to have very low satisfaction with any existing arrangements (Tahseen & Reid, 2008, p. 93).

I find it fascinating that 'rational' educational interventions were the focus of the study rather than any attention to women's physical comfort and the relational aspects of the consultation experience. In my reading of the above conclusion the failure of the interventions may serve to pathologise 'very anxious women' – those women who cannot live up to the 'good patient' ideal and frustrate the attempts of clinicians to educate them. Before I proceed with further examples of the absent body in medical research, I use the experiences of one of the 'very anxious' women in my study whose detailed comments serve to illustrate the pedagogical notion of women-patients as teachers.

The following comment from Charlotte provides a wealth of information for researchers and clinicians about why clinicians' well-intentioned interventions fail to be experienced as useful by women. Although describing herself as well-educated and confident sexually (i.e. a 'rational', girl-power gal) Charlotte found she was unable to engage with the medical information she received during a colposcopy examination. Charlotte explained that she had gone to a 'super-clinic', a clinic with many doctors, as she thought she would be too embarrassed to see her long-time family GP who she knew professionally through her work and knew his son. The stress-reduction she anticipated through anonymity did not occur:

I already found the smear tests to be an extremely unpleasant experience [due to pain caused by the speculum insertion and the positioning of her body]. I was often shaky and upset afterwards and thus a female friend would drive me in - for support and so that I could spend the return trip recovering. The 'stirrups' position put me on edge and I always found the test itself very painful. I never really understood how serious the 'abnormal' cell issue was and just hoped that being checked every six months kept it under control. Although the doctors did make some attempt to help me understand the problem, for example by showing me what they saw during the test on a television screen and explaining it, I never found this communication effective. Explanations given during the test were hard to absorb because I was usually in pain. I tried to ask questions afterwards but the answers to my questions were usually in quite technical medical language and I never felt that I understood exactly how worrying these 'abnormal' cells were (Charlotte, HPV diagnosis, 23 years old).

Using Tahseen and Reid's (2008) notion of 'baseline anxiety,' Charlotte's 'baseline' distress prior to the colposcopy relates to memories of and therefore anticipation of procedural pain and the bodily discomfort of being in position that put her "on edge." The combination of being "on edge" and experiencing pain at the time of the procedure meant that she was not able to relate to the information she is given. If Charlotte had participated in Tahseen and Reid's study I anticipate that she would have been one of the 'very anxious women' for whom no interventions worked. In Charlotte's account, clinicians' key strategy of offering explanations with the use of video-screen technology was ineffective. The use of unfamiliar medical language added to anxiety and confusion, but according to Charlotte, any explanation during the procedure was likely to be ineffective as her attention was taken up managing pain. In reading of Charlotte's experience, I was alarmed about her undergoing a procedure that was painful for her and wondered about the clinicians' levels of awareness and responsiveness to Charlotte's distress, a discussion of which follows later in the chapter.

In Tahseen and Reid's (2008) study although 58% of women found the video display helpful for anxiety reduction, they report that other women found it was not helpful or increased anxiety. It would be interesting to know how many women in the study were coping with distress caused by pain, rather than 'psychological' anxiety about the procedure. The limited usefulness of women

being able to watch a video display of the procedure is reported in a study by Alexandra Howson (2001). Howson interviewed twenty-three Scottish women subsequent to having a colposcopy examination and approached her data using a feminist poststructural discourse analysis. Almost none of her participants found viewing the monitor screen useful, although they imagined other women would find the option helpful. I find this point very interesting as it seems to indicate that women imagine that a medicalised educational approach should be helpful and that they are exceptional in finding the video display of their cervix unhelpful.

Charlotte decided she would return to her male GP after the 'super-clinic' experience failed to provide the comfort she imagined would come with anonymity. Her comments about the contrast between the 'super-clinic' experiences compared to seeing her GP add to a growing picture of the contextual considerations that may enhance or detract from pedagogical moments:

I do know that I eventually worked up the courage to approach my GP about smear tests and over my confusion regarding the seriousness of my 'abnormal' cells. He made me feel extremely comfortable during his examination and the test was no longer painful. It was much less embarrassing lying on a doctor's bed rather than being in a chair with your feet in 'stirrups'. He also used a smaller speculum which took away the pain. He appeared much more confident and competent than doctors I had been examined by at the super clinic (one of whom had told me, during a particularly protracted and painful test, that he could not find my cervix - not a statement that encouraged my trust in his abilities) (Charlotte, HPV diagnosis, 23 years old).

As I have previously discussed, Tahseen and Reid (2008) concluded their research study still perplexed as to how to improve the satisfaction of 'very anxious' women. In Charlotte's comments above, the doctor's inter-personal skills and technical ability are mentioned as having direct bearing upon why she felt "extremely comfortable." The relative normalcy of the examination "bed" compared to the unfamiliarity of a chair and stirrups also reduced "embarrassment." Charlotte continued to describe her knowledge of the procedural and environmental aspects that also impacted significantly upon the examination experience:

Catherine's question: Based on your experiences, what is the 'prescription' you would like to give health professionals about an ideal consultation process in relation to women with HSV or HPV?

Charlotte's response: For the examination: a warm room, a doctor's bed rather than a chair and stirrups, and the smallest speculum possible for the patient. Explain what you are going to do before the examination starts and let the patient know what is coming at each step of the process but do not explain medical details during the examination. The patient is uncomfortable and probably just wants the examination to end. For the diagnosis: use simple language and preface a technical explanation with facts about how common HPV is and that it will usually heal itself. This [emphasis on how common HPV is] will lessen the

immediate stress of the diagnosis and the patient will be better able to absorb other details. I believe that I would have been more able to absorb and understand information in my GP's office because it is a comfortable (warm, carpeted, and not too 'clinical' in appearance) and familiar environment. The super clinic had the classic 'hospital' appearance, with cold white floors, stark surroundings and a constant rotation of new, unfamiliar faces. Given that I had also just had to take my clothes off and undergo an unpleasant examination in this environment, I was further ill-at-ease. Being given the opportunity to read further about HPV in an environment of my choice was very valuable for me (Charlotte, HPV diagnosis, 23 years old).

I consider that Tahseen and Reid's (2008) results would have differed if interventions focused upon creating a 'familiar' environment, attention to the effects of disrobing, women's physical comfort with room temperature and bodily positioning, pain management and clinicians' inter-personal skills. Charlotte contextualised the above factors as contributors to her wellbeing and ability to attend to educational information. With a few specific questions, Charlotte and other women contributing to this study were readily able to provide detailed descriptions of how clinicians could make a difference to women's experiences (and perhaps therefore the likelihood of women attending appointments).

I consider that the contrast between Tahseen and Reid's (2008) research findings and Charlotte's knowledge about interventions that make a difference is significant. The contrast highlights that interventions that appeal to a 'rational' educational approach to anxiety reduction leave unaddressed the myriad interventions in relation to women's bodies that may make a considerable difference to anxiety reduction. The contrast also shows the way the construction of a problem limits an enquiry process. In Tahseen and Reid's study, anxiety is constructed as a psychological problem of the mind and the interventions are restricted to shifting (correcting) women's thought processes.

In another typical example of the absence of attention to the bodily experiences of women, Katherine Eggleston, Ann Coker, Irene Prabhu Das, Suzanne Cordray and Kathryn Luchok (2007) undertake a meta-analysis of quantitative 26 research studies related to women's participation or avoidance of follow-up cervical screening after an abnormal Pap smear. The authors emphasise the importance of follow-up to prevent avoidable deaths from cervical cancer. Finding out why women do not return for follow-up is considered to be a highly significant public health matter. There is no direct mention of whether actual procedural aspects of women's experiences of pelvic examinations affected 'compliance.'

It is possible that quantitative analysis does not enable researchers to identify the nuances of clinical care and attention to detail that influence women's decision-making. For example, the closest the above authors (Eggleston, Coker, Prabhu Das, Cordray, & Luchok, 2007) of the meta-analysis get to women's difficulties with examinations is to note that in several studies women identified embarrassment about pelvic examinations and worries about examination and treatment.

There is no elaboration about what aspects of these factors had effects upon women's decision-making. Embarrassment and procedural worries are discussed in the meta-analysis under the heading of 'psychosocial factors' rather than, for example, 'clinicians' procedural competencies' or 'physical discomfort/pain.' The psychosocial categorisation of procedural embarrassment and worry implies that the difficulties women experience with examinations 'belong' to women. Women are the problem and the focus of research, rather than clinical practice being the place of detailed investigation. In my review of the medical literature, the hunt continues to isolate factors in women's 'psychological make-up' to account for examination reluctance. In summarising the influence of psychosocial factors identified in their meta-analysis Eggleston et al conclude:

In order to reduce clinic no-shows, we need a better understanding of the interactions among anxiety, distress, effective coping, and support as they affect adherence (Eggleston, Coker, Prabhu Das, Cordray, & Luchok, 2007, p. 328).

In a discussion of future research directions, Eggleston et al's (2007) recommendations are similar to the recommendations made by Tahseen and Reid (2008). Eggleston et al suggest even more in-depth knowledge is required about the match between the content of educational pamphlets and whether these pamphlets are culturally appropriate to the audiences in which they are used. Both studies are fascinating examples of how women are positioned as the problem and interventions focus on efforts to find the right 'key' to appeal to women's rational understanding. Research focus on how women experience their bodies and how clinicians interact with women and women's bodies is missing.

Again, the 'psychosocial' is the emphasis of an exploration of 'coping style' in a study about mammography and cervical screening participation undertaken by Cecelia Barron, Martha Foxall and Julia Houfek (2005). In this USA study using data from 85 women, the notion of 'coping' is conceptualised entirely within the individual psychology of the woman, rather than in relation to contributing factors from clinicians and aspects related to the procedure:

Screening distress is conceptualized as a habitual response to thinking about or participating in cancer screening and may result in avoidance of cancer screening participation so as to regulate distress (Barron, Foxall, & Houfek, 2005, p. 249).

In the above study, coping is conceptualised as an internal, stable psychological construct and relates to how women manage stress in their lives. Coping is not conceptualised as a relational, contextual construct occurring as a result of interactions with clinicians and the clinical environment. Women's generic, pre-existing coping style is considered relevant to screening participation. The only situational aspect of screening distress that is explored in Cecilia Barron et al's (2005) study is whether women screen to reduce cancer-related anxiety or whether they avoid screening to avoid the possibility of distress that would come with cancer being found. Again, women's bodies are absent as are the effects of clinicians' interactions; and yet all women I know personally who talk about mammography talk about the apprehension of anticipating their breasts

being squeezed between metal plates for the procedure and the significance of the kindness and competence or otherwise of the radiographer.

In another example of 'the absent body', a quantitative study of 660 women's completion of cervical screening and treatment by English psychologists Sheina Orbell and Martin Hagger (2006), participation is linked to 'self-regulation theory' and the theory of planned behaviour. Again, women's cognitive processes are assessed and there are no questions that address what women have experienced in previous examinations that deter their involvement. Women are not asked about the role clinicians' play in the decision to continue or avoid treatment. The absence of the role of clinicians reminds me of the common absence of any mention of men in pejorative media rhetoric about the high number of women seeking abortions; women are the problem and therefore the site of interventions.

Women in my study discussed at length the effects of clinicians' attitudes upon 'coping' with procedures. Although some women in my study would probably have met Tahseen and Reid's (2008) category of baseline high anxiety and Barron et al's (2005) category of high screening distress they indicated the clinician interventions that had made the examination more or less tolerable. In the following account, Jane mentions the effects of sexual trauma upon the examination experience and the difference made by a nurse's approach:

Childhood sexual abuse and rape at eleven definitely affects the emotional and physical response [to examinations]....It never quite lets me go, the past resurfaces and the betrayal [husband going to sex workers]. It looms as the time comes round and the doctor's appointment card is delivered in the box....I have a small wooden cross I hold [during follow-up examinations] and the last time the nurse rubbed my arm and said how well I was doing. This was all very helpful. It was also something to do with the nurse's attitude. Very empathetic (Jane, HPV diagnosis, 71 years old).

Although Jane has told me she does experience worry in relation to abnormal cervical cells, it is the actual examination procedure that she dreads and has to find ways to manage. Jane links the distress and the work of coping specifically with past sexual trauma, rather than describing herself as someone who has generalised anxiety and coping difficulties. It is clear in her above comments that the touch, words and tone of the nurse's interactions enabled her to tolerate the procedure, practices that are not indicated routinely in medical research.

In another example of the invisibility of the role of clinicians in ameliorating or exacerbating distress, the previously mentioned New Zealand Cervical Screening brochure also implies that embarrassment is the pre-existing emotional state of the woman, rather than embarrassment arising out of the clinical interaction:

Some women may find the test uncomfortable but it does not usually hurt. If you are embarrassed or nervous about having a cervical smear, tell your smear taker how you feel.

You can take a support person with you if you want to (National Cervical Screening Programme, 2005).

In the above paragraph, women are discursively constituted with the responsibility for informing clinicians how they feel, rather than the onus placed upon clinicians to find out how women feel. Given the construction of cervical smears as a normal responsibility for all women, I consider that women may have difficulty informing the smear taker of any ambivalence about the procedure unless asked directly.

As I have already demonstrated, the key approach in medical research studies is to overcome women's reticence about examinations with education, as if an information deficit is the major stumbling block. The medical representation of the body and the normalcy of medical procedures however may be quite at odds with women's understandings of their bodies as sacred.

In one study, in which 26 Maori and 'Pacific' women were interviewed, the authors (Lovell, Kearns, & Friesen, 2007) link women's nervousness and embarrassment about the exposure of the body during screening to the sense that the sacredness of the body was being compromised. In another study conducted in New Zealand, the authors (Jameson, Sligo, & Comrie, 1999) conclude that nearly all 'Pacific' women experienced reluctance to expose their body and shame in doing so. Again, the sacred nature of the body is discussed as an aspect of why screening is problematic. I have not found any other studies referring to women mentioning the body as sacred. I am interested as to whether in the above studies the women were asked directly about links with the sacred and screening. Given the general enculturation of Pakeha and western women into surveillance that emphasises a rational, disembodied approach, I wonder how possible it is for many women to mention spirituality and the body. In relation to the rationality of medical discourse, notions of bodily sacredness are easily conflated with irrationality. Ramazanoglu and Holland comment:

...the common sense of the West has been slow to dispense with Cartesian dualisms. Scientific reason became very powerful through being defined in opposition to what is outside reason (passion, prejudice, madness, subjectivity, superstition, magic, tradition)...(Ramazanoglu & Holland, 2002, p. 28).

Sarah Lovell, Robin Kearns and Wardlow Friesen (2007) conclude that Pacific women are more likely than other cultural groups to see the body as sacred whereas I question whether as a group the women in their study may more readily articulate a discourse of sacred femininity and/or whether the researchers associate certain ethnic groups with embodied spirituality in ways that shaped the interview process. One Pakeha women in my study used the word, sacred, to describe her genital area:

I think my genital area is a sacred part of my body that connects or influences my emotions. The fact this part of my body does that so often, makes it something different,

and has a sacred presence. Sacred meaning also [it's], difficult to explain. The influence it [sacred part] has is never quite the same, but it is changing to adapt with my body, or even telling my body that it does not like something. Having injury to my sacred area, is almost difficult to describe what it does to my mind, but having a STI pain or burning sensation often enough, brings up the feeling of panic and fight... (Rachel, HPV diagnosis, 28 years old).

Interestingly, Rachel went on to say that she did not experience embarrassment with examinations anymore. For her, the sense of invasion of the sacred is a different experience from feelings of embarrassment. Rachel has described how her emotions are influenced by her 'sacred' body parts. The notion of the sacred body as teacher is an anathema to medical discourse. Rachel's distinctions led me to question the accuracy of reports in the above two studies, of Pacifica and Maori women's 'embarrassment' with examinations. I consider it is possible that the use of the word, embarrassment, is conflated with notions of 'the sacred' leading to researchers' cultural mis-translation of the meaning of screening reticence.

How have you found examinations in the past?

The interventions I suggest clinicians might experiment with involve simply asking women a few direct questions prior to the beginning of the examination procedure, while women are still clothed. In 2007 I gave a presentation about 'taboo talk' to a group of gynaecology oncology nurses. I emphasised that women are often unable to initiate a discussion of difficulties with examinations and that clinicians need to take this role in order to enable women to have an optimal experience. The following are an example of explanatory remarks and questions I suggested that clinicians could use. These points are based on my clinical observations and comments made by women in this study:

- How have you found examinations in the past?
- Is there anything that made the experience easier or more difficult for you?
- Is there anything particularly that you'd like me to do that you think may help in some way?
Some women like to chat and be distracted and other women like some help with concentrating on deep breathing and relaxation. Some women like a hand to hold.
- Many women have told me of past experiences that make having an examination particularly intrusive – all sorts of seemingly unrelated experiences can have an effect – perhaps painful periods, a difficult birth, a pregnancy termination, and unwanted sexual experiences. Is there anything in your history that you think would be helpful for me to know about to support you through this procedure?
- Many women want to know what this procedure means in terms of their sexual, intimate life. Is it OK if I go over a few points with you?
- If you want me to stop the examination at any time for any reason, do you think you will be able to tell me or signal to me?

The very experienced group of nurses with whom I spoke were not familiar with women being asked about examinations and were intrigued about the possibilities the questions held as a tool to enable them to better support women. Some nurses were anxious about their lack of skill in asking and responding to such 'intrusive' questions, in contrast to their experience alongside women undergoing invasive procedures.

Both women and clinicians in my study reported that examinations could have adverse effects. I address women's adverse experiences not as an exercise in 'pointing the finger' at 'bad' clinicians but rather to support my contention that the problem with examinations is only partially about women's anxiety and coping strategies. I consider that a pertinent research focus is the difference clinicians' interventions make to examinations.

One of the clinicians participating in this research indicated her worry about women's past experiences of being hurt as part of an examination and yet thinking that the hurt was normal:

A comment about how clients manage an unsatisfactory examination - I suspect strongly they simply go elsewhere as that is certainly the feedback I get about why a lot of women choose the service I work for in preference to others. It is rare for women to comment or complain as I think this is, for many, just one more hassle in an already stressful situation. Sometimes clients will comment at the end of the examination that they "didn't realise it wasn't supposed to hurt." They will certainly comment if they have experienced my examination as gentle and I am left wondering what other experiences might have been like for them (Annalise, clinician).

Annalise's observations of the rarity of women complaining directly and instead seeking out another clinician are borne out in comments by other clinicians and women in this study. The question of why women typically proceed with examinations rather than interrupting the examination midway is one I attempt to address shortly. In the above studies I have discussed, there was no mention of women only partially completing a procedure – women either did or did not participate. The importance of the clinician's role in shaping women's perceptions of an undesirable examination experience is mentioned in the following comments by a clinician:

A primary outbreak or a severe recurrence [of genital herpes] would make any [external] examination hard to tolerate. I believe that practitioner skill and connection with the client, is still vital in the pelvic /speculum exam. A nurse recently went for a smear, all NAD [no abnormalities detected] and was left with the speculum in while the practitioner disappeared behind the curtain. This was a traumatic experience from a person who knew the procedure, understood the necessity and had no concerns prior to the appointment. Another example: women managing to walk in and out of the room having had the procedure, and the practitioner not making eye contact. My point is that even without a diagnosis we need to be aware that this is an invasive process for many women.... I do

believe this behaviour has more to do with the clinicians' awareness and comfort with their own sexuality. Busy just doesn't cut it (Helen, clinician).

From Helen's comments I draw attention to several points for consideration that uncommonly receive mention in research literature. Firstly, once women have 'committed' to an examination, women may not feel able to protest about an undesirable examination experience at the time the examination is happening. In her example, Helen cites the experience of a nurse, knowledgeable about examinations, who nevertheless, in the patient role, made no protest about being left with a speculum in place. Secondly, Helen's comments contrast with Kaz Cooke's (2007) assertion that clinicians are very familiar and at ease with examinations; looking at women's genitals. Instead, Helen indicates that clinicians may well be ill-at-ease with their own sexuality and that this discomfort may affect the examination. How interesting it would be to research Helen's contention – is clinicians' high anxiety and difficulty coping with personal sexuality associated with women's examination distress?

My assertion that clinicians need to initiate questions about past examinations in order to ensure an optimal experience for women is illustrated in my following discussion with Charlotte, the young woman who initially went to the 'super-clinic' and then returned to her family GP. In what follows I ask the wrong question because I did not realise that Charlotte did not know that an examination with a speculum is not meant to be a painful procedure:

Catherine's question: Did the doctor at the super clinic appear to acknowledge the pain and distress for you during the examination when he couldn't see the cervix? Do you think at any stage you would have felt able to tell him to stop or would the situation, with the relative powerlessness, have not made this possible?

Charlotte's response: I assumed that the discomfort and pain I experienced during the examinations was an inevitable part of the process...because I was usually focusing on not crying, I never took in any information and would nod as if I understood because I wanted the doctor to move on and finish the process (Charlotte, HPV diagnosis, 23 years old).

Charlotte's comments are very disquieting. Earlier she described how she was offered the observation of the video screen to see what was happening to her body but there was no enquiry about her comfort. Given by this time she had had a number of examinations for cervical abnormalities related to HPV, it appears that the practitioner in the above example is not alone in the absence of discussion about comfort and pain. Why does Charlotte go along with a patently awful experience? It is possible that discourses of normal feminine heterosex conflate with the normalcy of examinations in ways that make saying no difficult, if not impossible.

In the public health literature about speculum examinations, the smear test is described as an uninterrupted process that has a beginning, middle and an end. Changing one's mind half-way through is not mentioned as an option (National Cervical Screening Programme, 2007a). Similarly,

the assumption of 'going-along-with' is evident in Kaz Cooke's (2007) step-by-step outline of the examination procedure. The up-beat, 'girl-power' tone of Cooke's writing masks the inherent message that the girl or woman, in the patient role, is to be compliant with each of the steps without comment, negotiation or protest. The option of saying "no" or "stop" at any time is not presented.

Through indicating step-by-step forward momentum, the instructions for the modern-girl spreading her legs for the insertion of the speculum are not so far removed from the supplicant heroine of a *Mills & Boon* romance. Despite attempts by clinicians to erase any hint of sexuality from the procedure, the texts are interesting in replicating traditional heterosexual narratives, with the implication that once a woman has committed to the 'action', she will not resist. It is possible that continuation is powerfully linked to beliefs about the woman's responsibility to follow-through with sex once there has been any step of initiation towards heterosexual penetration. Terri Kapsalis (1997) is a performer and health educator whose book, *Public Privates: Performing Gynecology From Both Ends of the Speculum* explores the practices and representations of gynaecology. Kapsalis draws from Adrienne Rich's iconic notion of compulsory heterosexuality and Butler's (1993) concept of the compulsory performativity of 'woman' in her assertion that

[t]he compulsory performance of woman...requires both mandatory heterosexuality and mandatory gynecology, events that must be accepted and endured without complaint (Kapsalis, 1997, p. 14).

I consider that examinations, similarly to heterosexual sex, take place on a blurry continuum of consent and coercion. Initial consent may act as one of the numerous pressures women experience to continue with contact that transitions from wanted to unwanted (Holland, Ramazonoglu, Sharpe, & Thomson, 1992).

I am curious as to the data that would be generated if the 'non-compliant' women in the studies discussed in this chapter were instead asked:

- Have you ever had an examination that you wished you could stop before the health professional had completed the procedure? If, so, why?
- Have you ever interrupted a clinician carrying out an examination you experienced as undesirable? If so, how?
- If you have continued with a procedure you wish you had felt able to stop, what factors hindered you from interrupting the procedure?
- Have any of the above factors affected your later decisions about clinicians and examinations?

Several women in my study told me in detail about horrific examination experiences that sounded tantamount to assault. These examinations were conducted by both male and female practitioners and had lasting effects. While these sorts of experiences may be considered exceptional, I consider that they illustrate part of a continuum of what occurs to women that deters them from

future examinations. I provide a portion of Sarah's account as a counterpoint to the invisibility of the examiner in the medical research literature cited above in this chapter. Sarah told me of her harrowing experience some five years earlier, when she contracted genital herpes through being raped by her new partner. She limited her resistance to the rape as she did not want her children to wake and be frightened. She was further traumatised under the auspices of a clinical examination. In my analysis of her devastating experiences, I draw on the concepts of compulsory heterosexuality and compulsory gynecology. In reflecting on Sarah's experiences of being raped by her male partner and being subjected to verbally abusive clinical care by a male physician, I am reminded of Nicola Gavey's research, *Technologies and Effects of Heterosexual Coercion*. Gavey's abstract opens:

I am concerned here with explicating some of the ways in which sexual coercion, including 'unwanted sex', takes place within heterosexual relationships (Gavey, 1992, p. 93).

In terms of the following account of Sarah's experience, I paraphrase Gavey's words to represent my reading of Sarah's medical encounter:

I am concerned here with explicating some of the ways in which gynaecological coercion, including 'unwanted gynaecology' takes place within clinical relationships.

Sarah was raped by her known male partner of the time and then emotionally violated in the consultation she had subsequently with her known male GP. In my opinion the effects of these sorts of profoundly relevant events that occur in women's sexual and gynaecological experiences are usually missing from research into women's 'embarrassment' and 'worry' about gynaecological examinations, rendering the research meaningless in terms of clinical applicability:

One night he told me he [partner] wanted to share me with some mates. I was shocked and said "no." He was not too happy with this response and removed the condom, sodomised me and ejaculated in my vagina. This terrified me as I was not on the [oral contraceptive] pill. I never thought of anything else.... A few more days later I was in so much pain I could hardly walk or pee. I went to my normal GP [general practitioner] where he examined me. A few months earlier I had asked [the GP for a prescription] for some condoms and now was made to feel I had got what I deserved for sleeping around. He basically said those words. I remember thinking at the time that I wasn't sleeping around. At the time I was so scared and humiliated to say anything to him. I thought about it when I got home and realised he must have assumed because I got condoms a few months before I was having sex (Sarah, HSV diagnosis, 41 years old).

Sarah did not complain to the police about the rape or to any medical disciplinary body about the treatment by her GP that left her "scared and humiliated." I consider that Sarah's silence is illustrative of what Gavey terms

...the compliance with normative heterosexual narrative scripts which demand our consent and participation irrespective of our sexual desire. Thus, while women may not engage in conscious and deliberate submission, disciplinary power nevertheless produces what can be seen as a form of obedience. While an individual male's behaviour in the interaction is not insignificant, the operations of power involved may transcend his particular actions (Gavey, 1992, pp. 328-329).

I consider that what happened subsequently is indicative of operations of power that transcend the specific actions of the male GP. When Sarah went to an emergency clinic because she was unable to urinate due to swelling caused by the inflammation from the infection, she recalled the following:

The nurse was wonderful and explained a bit about herpes. I finally received a booklet on herpes. She made me feel normal not a 'fallen woman'. She also suggested I look for a female doctor.... I knew there was a female GP nearby and I was lucky enough to get in to see her that morning. In tears I explained what had happened and how the other doctor had made me feel [scared and humiliated]. She gave me more information and referred me to several web sites. Then organised for all my notes [from the GP] to be sent to them and I had no contact with that doctor ever again (Sarah, HSV diagnosis, 41 years old).

I find it interesting that the female nurse apparently made an assessment that the problem with the clinical encounter Sarah had with her GP was about gender, not about gender-neutral unprofessional behaviour. The solution was the advice to change to a female doctor. The female doctor then became aware of Sarah's awful experience. Although Sarah felt encouraged and empowered to protest by changing doctors, and experienced herself as being supported by them, the clinicians' responses are perhaps illustrative of compliance with normative heterosexual narrative scripts whereby all the women involved – Sarah, the nurse and the new doctor – produce a form of obedience by not actively complaining about the disgraceful treatment Sarah received. In my clinical experience, both clinicians and women predominantly deal with unwanted gynaecology in similar ways to women's accounts of unwanted sex. There is a level of tolerance and lack of overt protest that normalises these undesirable experiences rather than categorising them as outrageous and abnormal.

Conclusion

In this chapter I have begun to address some of the factors that render invisible the reasons why women avoid examinations. I have demonstrated that the focus of medical research is upon women's compliance. The research I have critiqued emphasises women's 'psychosocial' problems, such as anxiety and difficulties coping, with little if any attention to bodily discomfort or the influence of clinicians' behaviour and technical skill. This mind/body separation and the problematising of women rather than clinicians have led to research that focuses almost exclusively on psychological notions of coping and anxiety. In order to influence compliance amongst 'anxious' non-coping women, research interventions focus on the use of 'rational' educational tools, such as pamphlets,

and procedural explanations aided by the use of a video-screen for women to observe the procedure. In the medical research there is no 'breakthrough' educational intervention that has made considerable inroads upon ensuring women's compliance.

I have discussed the striking lack of attention to the effects of clinicians' interventions upon women's decision-making that is apparent in medical research. I have also shown the remarkable absence of research attention to what clinicians do to women's bodies and say to women as part of examination procedures that have effects upon women.

In contrast, women have described in great detail the specific experiences that have generated distress either prior to and/or during procedures. These women did not describe themselves as generally anxious or non-coping in the broader aspects of their lives; aspects of the examination procedure and the examiner's behaviour shaped women's accounts. Women have also readily provided examples of useful interventions by clinicians that made a positive difference to tolerating examinations.

I consider that women's expertise is a valuable resource in devising interventions that may positively affect women's decisions about examinations and follow-up. The medical emphasis on 'rational' education strategies to overcome resistance to screening has led to a very limited set of interventions. I have suggested research questions that privilege women's bodies, bodily experiences and perceptions of clinicians' interactions. I also recommend that clinicians turn 'the gaze' towards an examination of the effects of clinical practice. Clinicians in my study report their awareness of the adverse experiences women have and yet there is a level of tolerance for less-than-optimal care of women within the health profession that renders invisible the active role clinicians play in exacerbating or ameliorating women's discomfort and distress.

There are several important themes I have raised in this chapter that are beyond the scope of this study to do more than briefly mention. I have indicated that clinicians' gender may have effects upon 'coping' and 'anxiety' – a factor that receives limited attention in medical research. Another important aspect I have mentioned is that although examinations are choreographed as a desexualised procedure, separate from both clinicians and women's sexuality, the procedure is about sex and sexuality. Women are having examinations because of sexually transmitted infections. Women do not erase the sexual link in regards to examinations in the way clinicians purport to do. I contend that clinicians' talk indicates that the link between sex and examinations is an aspect that clinicians manage rather than erase. In the next chapter I illustrate the inevitability of moral understandings of sexuality shaping interactions between women and clinicians.

Chapter Seven:

The Confessional

Introduction: Clinicians as moral educators

In this chapter I focus on the teaching role of clinicians and illustrate their role as moral educators. I propose that the latter role is not necessarily problematic. The conflation between 'objective' medical science and moral assessments may lead women to give positive as well as negative reports about consultations. I use Foucault's notion of 'the confessional' in order to analyse the moral component of clinical consultations (1976, p. 150). Foucault attests that the historical Christian practice of confession, and in particular confessing sex, has not vanished with the secularisation of contemporary Western society. Instead, the confessional tradition has transformed into a "confessional science" (Foucault, 1976, p. 64) whereby clinicians and those who consult them seek to uncover the 'truth' about sex, especially the morality of sexual practices and sexual thoughts.

Although clinicians in my study emphasise the normalcy of viral STIs and their role in conveying objective facts, women who seek healthcare for an STI conceptualise the consultation as a 'moral event.' This is different from other consultations, not only because they are about the usually private nature of the pelvic area. In my interviews with women there is unevenness to the attribution of personal responsibility and moral burden to diagnoses related to the genital and reproductive areas of the body. STIs are typically constructed as more 'dirty' and therefore more 'taboo' than other conditions, such as a urinary infection or diarrhoea caused by food poisoning. In order to explore this distinction I incorporate Mary Douglas' (1966) anthropological notions of 'dirt' in the analysis of women's accounts of an HSV or HPV-related consultation as a 'confessional' experience. My particular interest in this chapter is in considering the potential pedagogical benefits for women if clinicians were to consider that they are inevitably engaged in addressing morality with women in some form in sexual health consultations.

Science and the Confession

The mix of apparent objectivity and altruism is evident in many accounts by clinicians with the moral component an ever-present but unacknowledged aspect of clinical teaching. The intertwining of morality and science is a fascinating paradox. In Chapter Four I discussed clinicians' use of medical science to normalise viral STIs and in effect to dismiss the historical and contemporary social links between STIs and morality. I concur with Lupton (2003) that

[w]hile medicine is predicated on scientific principles of objectivity and the ethical tenet of altruism, moral values are suffused throughout the medical encounter (Lupton, 2003, p. 134).

It is possible that altruism towards patients renders invisible the every-day moral judgements made by clinicians. In my study clinicians and women typically acknowledged health professionals' moral judgements only when the attitudes expressed were considered detrimental. For example, in Helen's following comment, a 'judgmental' comment is constituted as moralistic whereas a positive judgment is not considered a judgment at all:

Health professionals definitely influence, although sadly not always positively. Any form of comment that could be taken as judgmental can have long term effects (Helen, clinician).

In a similar vein, Karen's comments overlook the moral component of talk by clinicians, whether or not the effects are considered positive or negative:

Of course, a professional, non-judgmental and respectful manner is extremely important in how patients perceive they are being treated and this can have lasting impact on their experience (Karen, clinician).

The altruism evidenced in clinical practice is an example of the workings of power in the clinical relationship. The altruistic clinician/Confessor has a powerful and unavoidable role in shaping moral meaning. Foucault describes the Confessor as

...the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile...it exonerates, redeems, and purifies him; it unburdens him of his wrongs, liberates him, and promises him salvation (Foucault, 1976, pp. 61-62).

As I illustrate in this chapter, women and clinicians find confession satisfying. Confession occurs within a power relation that may produce feelings of relief and wellbeing. Foucault's assertion of the western cultural desire for the liberating effects of confession equate with my clinical observation of the relief that people often describe subsequent to a sexual health related disclosure. To tell a sexual secret is often a great unburdening and an experience that perhaps approximates a secular version of religious absolution. Foucault's assertion below points to the desire to confess that subsequently brings an embodied, physical sense of release:

The obligation to confess is now relayed through so many different points, is so deeply ingrained in us, that we no longer perceive it as the effect of a power that constrains us; on the contrary, it seems to us that truth, lodged in our most secret nature, "demands" only to surface; that if it fails to do so, this is because a constraint holds it in place, the violence of a power weighs it down, and it can finally be articulated only at the price of a kind of liberation (Foucault, 1976, p. 60).

This deeply engrained obligation to confess is evidenced in the work of a sexual health clinic. People do not routinely run screaming from consultation rooms, horrified that a complete stranger is asking them systemised questions about their genitalia and their sexual practices. Rather, with

varying degrees of ease, embarrassment or distress, people 'confess.' I did not have a Catholic upbringing but early in my work at a sexual health clinic the images from innumerable movies of people engaged in the practice of confession would often come to mind as I witnessed the breadth of emotions provoked in patients by these conversations. Sexual health clinicians are frequently privy to accounts of people's sexual lives that are not told to anyone prior to or after consultation. The key aspect of the similarity I noticed between the cinematic portrayals of confession and my conversations was that of people feeling delivered of a burden.

In my time working at the sexual health clinic, I never spoke to my colleagues about our role as 'Confessors.' To do so would have seemed at odds with our objectivity and 'liberal' politics – it was a mismatch I could not put words to at the time. On the surface at least, the world of a sexual health clinic is poles apart from anything as morally prescriptive as religion. I now consider that although the clinical confessional does not announce itself, the consultation works through the same mechanisms of power that make it work in a religious context – the uncovering of a secret, release from a burden through absolution from the clinicians and the possibility of a new life through redemption. The following comments from women indicate the productive nature of the consultation/Confessional; producing thoughts and feelings women consider desirable:

In the reply to my question, Miranda indicates that she would find it desirable for a clinician to take a moral position regarding the meaning of HSV:

Catherine's question: What questions, if any, are difficult to ask health professionals? Why? Are there any topics you would find it helpful for a health professional to initiate in a conversation related to HSV that would ease the way for you?

Miranda's response: I don't find it difficult to ask questions. I think [for clinicians] to emphasise that it [HSV] is manageable [would be helpful]. The big bogey for me is that it's not curable. It's an alien thing inhabiting my body, and no amount of exercise and good nutrition will get rid of it. It's a link to some unidentifiable shameful past. It feels like that and I'm not a promiscuous person, who wittingly has been in unsafe situations. I really needed reassurance from my doctor that I will manage, life will be normal (Miranda, HSV diagnosis, 48 years old).

From Miranda's description, she would welcome the authoritative position of a clinician's judgement. The clinician/Confessor's assessment has the potential to help Miranda's efforts to bring together currently disparate beliefs. Miranda wants to believe that she is still a 'good' woman. There is tension in her description in terms of how to make sense of her own culpability. On the one hand having contracted a viral STI is "a link to some shameful past." On the other hand, "I'm not a promiscuous person, who wittingly has been in unsafe situations." Miranda's comments reflect the desire to have a clinician's assistance to reconcile and reassure her about the question of culpability. The question of personal responsibility is not a unique individual question but reflects

a neoliberal discourse of health and morality. In an analysis of 'healthy lifestyles' Howard Leichter (2003) contends that the question at the centre of health promotion is:

... [t]o what extent [are] morbidity and premature mortality self-inflicted, the result of uninformed, careless, and avoidable personal behavior? (Leichter, 2003, p. 603).

In her reference to exercise and good nutrition Miranda indicates that she knows about the 'prescription' for good health self-responsibility but in this instance it fails to deliver her to the moral 'high ground.' She imagines that a clinician can help her reconcile the meaning of the diagnosis in a way that will return her to a normal life.

In the next quote, the usefulness of the conversation for Jane relates to the clinician's willingness to engage in a conversation that addresses morality and associated grief. Jane comments on having "such a good talk" with her gynaecologist. Jane has had pre-cancerous changes on several colposcopies (magnified visualisation of the cervix). Jane, when in her mid-60's, found out she had HPV just weeks before her husband was diagnosed with a terminal illness and died soon afterwards. The detection of HPV led to her husband's disclosure that he had had numerous sexual partners in the course of their marriage. For Jane, finding out that she had an STI that was devastating, primarily because of what the infection meant in relation to disruption to her memories of the marriage rather than in relation to the cervical abnormalities:

I had the colposcopy yesterday and had such a good talk with my woman gynaecologist. She gave me time and attention and asked the right questions – e.g. "would it have made a difference if your husband didn't die and you had been able to talk it [the extra-marital liaisons and infection] through with him?" There is no doubt that it would have helped. I said so little - at the time his dying became the main focus of everyone's attention. That [the infidelity] is the issue I am currently dealing with and it just won't go away. It is the effect on relationships (Jane, HPV diagnosis, 71 years old).

Similar to other women participating in this study, Jane's positive perception of "time and attention" relates to the clinician's ability to ask questions which relate to morality rather than to pathology. For Jane, finding out that her husband had frequented brothels was far more significant than abnormal cervical cells.

From Jane's remarks it is unlikely that she experienced the conversation as having a moral component. She and the clinician were just having "such a good talk." The invisibility of confessional practices in clinical settings is an example of Foucault's (1976) assertion that the confession is experienced as a relief – the surfacing of truth, released from constraint. The benefit of unburdening to a clinician is the subject of reflection in the following example. Sarah has never had a conversation with a clinician about how to continue her life after contracting HSV and yet she imagines a conversation that went beyond medical 'facts' would be very helpful:

Catherine: Have health professionals ever initiated a conversation with you about the possible effects of living with the virus (physically and the emotional impact) on sexual relationships? (This question includes whether health professionals have raised the topic of any advice about telling/not telling a partner).

Sarah: I have never had this question asked. This is the kind of question that if the health professional initiated would be so beneficial, as long as they had the back-up knowledge. For me this [contracting HSV] has been life-changing and a lot of soul-searching, sometimes with no answers. I have also put on so much weight [since the diagnosis] and at times hate myself so much (Sarah, HSV diagnosis, 41 years old).

From my reading of Sarah's comments, "the back-up knowledge" relates to the importance of clinicians having current medical 'factual' information. Yet she primarily alludes to the clinician's role in assisting in finding answers to questions beyond the physiological. For Sarah, more importantly, she indicates that some moral companionship would be of benefit, to try to make sense of the life changes, self-hatred and soul-searching that have accompanied the diagnosis. Sarah's comments illustrate why the scientific normalising of viral STIs may only be partially successful in reducing the distress of the diagnosis. The facts do not address her altered subjectivity since the diagnosis. Although the women in the above quotes imagine and experience the beneficial effects of clinicians addressing morality, the women in my study did not appear to be aware of clinicians' moral judgments.

Foucault's definition of morality is useful for considering why the teaching of moral codes is not transparent and instead is often inconspicuous, merged with 'objective' scientific education.

Foucault describes morality as

...a set of values and rules of action that are recommended to individuals through the intermediary of various prescriptive agencies such as the family (in one of its roles), educational institutions, churches and so forth. It is sometimes the case that these rules and values are plainly set forth in a coherent doctrine and an explicit teaching. But it also happens that they are transmitted in a diffuse manner, so that, far from constituting a systematic ensemble, they form a complex interplay of elements that counterbalance and correct one another, and cancel each other out on certain points, thus providing for compromises or loopholes (Foucault, 1985, p. 25).

For the most part rules and values in relation to sexual health were also unacknowledged by clinicians. Instead medical science is positioned as superior and in opposition to societal moralising about sexual health. This finding echoes my clinical experience. During 1996-1998, when I worked at the sexual health clinic, our interactions with patients were discursively constituted within the language of liberal humanism, informed by proponents such as Carl Rogers (1989). Core Rogerian concepts of therapeutic interaction include such values as 'non-judgmental acceptance' and 'unconditional positive regard.' Liberal humanism is an essentialist philosophy in which humans

'self-actualise' by metaphorically peeling back layers of masks in order to connect with the 'real' person within (Waterhouse, 1993). Rogers' liberal humanist philosophy, whilst stressing the importance of individual freedom and self-determination, omits recognition of the inherent power relations within clinical consultations and all aspects of people's lives.

As I have discussed in Chapter Four, omission of acknowledgement of power relations is significant in that clinical conversations are value-laden; there are prescriptive approaches to how women should 'self-actualise' subsequent to a viral STI diagnosis. I have, subsequent to my time working in the sexual health clinic, reflected on the extent to which clinicians act as moral adjudicators, drawing from the values of liberal humanism and yet apparently unaware of this philosophical positioning. Only one clinician described in some detail how she purposely uses the power of medical authority to offer an alternative discourse of health and morality, rather than attempting to cancel out a 'negative' societal moralising with the application of medical facts to normalise viral STIs:

This [when women experience the diagnosis as negative] is one of the few times that I consciously use my power as a doctor – employing that almost-bordering-on “doctors are God-like myth” and the power of the doctor patient relationship, to make a very clear statement and I say it slowly and clearly and with emphasis and repeat it as many times as necessary. I am aiming for even the most distressed person to at least be able to leave this appointment with a clear message that no matter what they are believing (my life is over, I'll never have sex again, I am a bad, damaged person etc. etc.) that the doctor knows otherwise and therefore they presumably have at least one piece of information that holds hope and a way forward. I do not expect them to be OK now as am very aware that their current reaction should not be dismissed or minimised – I just let them hear that I know they **will be** OK (Kate, clinician).

Kate's description of a typical way of talking with women who experience a diagnosis as difficult illustrates an acknowledgement rather than dismissal of the moral meaning of the diagnosis. She offers an alternative version of morality and subjectivity, that women are not damaged, bad people. Her comments illustrate Foucault's (1976) concept of the confessional. Kate uses her authority in an effort to prescribe a moral meaning, to console, forgive and to liberate women. She offers 'salvation' from what several women described to me as a 'life sentence.' It is interesting that Kate describes her orientation to her work as 'non-judgmental' – that the complexity of the 'moral work' of the consultation is conceptualised as moral absence rather than presence. Instead, she summarises the direction of optimal sexual health interventions that promote

...inclusive, realistic, non-judgmental approaches/environments. The real issue is societies' attitudes to the side-effects of SEX and promoting a realistic and healthy attitude to the pros, cons, ups and downs of being a healthy sexually active person etc etc (Kate, clinician).

I am interested in the pedagogical effects of clinicians describing their interactions as non-judgmental. This term is used as an explanation for their intricate conversations with women orientated towards optimising women's wellbeing through offering an alternative moral discourse to negative moralising about viral STIs. I wonder how possible it is for clinicians who do foster a positive alliance with women to teach other clinicians what it is that they actually do when the catch-all phrase of non-judgmental in no way captures the moral components of their clinical teaching.

The absence of any mention of clinicians' discomfort with the ambiguity of their non-judgmental role has been noted by other researchers. An English study by Sue Peckover (2001) addresses practices of surveillance by home-visiting nurses who follow up women and children where domestic violence has been reported. Peckover uses a feminist, poststructuralist framework to analyse data from interviews with 24 health visitors and 16 women. Peckover describes the subtlety of confessional practices; the non-coercive establishment of social relationships with mothers led clinicians to describe their work primarily in non-hierarchical terms, stressing their role in the empowerment of women.

Lealle Ruhl (1999) explores the relative invisibility of moral judgment in relation to the medical surveillance of pregnancy. Ruhl examines the way the science of statistical risk masks clinicians' efforts to regulate moral choices. Ruhl traces the links between responsibility, rationality and morality that blur the boundaries of science and morality:

Responsibility is equated with the capacity to behave rationally...a decision to follow the path with the greatest possibility of benefit with the least risk. In this sense, responsibility talk within liberal regimes is also morality talk; behaving responsibly is a moral act (Ruhl, 1999, p. 96).

Ruhl's notions of the way moral judgment is discursively constituted under the umbrella of rationality is useful for making sense of why clinicians are able to consider their interventions to be unbiased. Repeatedly, clinicians in my study accounted for their interventions by emphasising medical objectivity. Karen discussed the concept of 'clinical objectivity' as if this term were an apolitical position, free from subjective judgment:

...by this [clinical objectivity] I mean the ability to maintain a friendly detachment, provide professional unbiased advice to the patient without being influenced by their distress, domestic situation or agendas. I try to follow a fairly standard routine with patients: usual medical history, full sexual history and risk assessment, examination, do tests, explain diagnosis and plan of management. I then deal with the specific issues or questions that are troubling them, educate the patient so that they understand the reasons why infections behave in certain ways and the rationale for management...it is important, as clinicians, not to become too involved in the patients' personal difficulties or decision-making processes such that you end up colluding with them so-to-speak in order to help them

extricate themselves from a potentially difficult situation. It is the clinician's job to provide the patient with information which is correct, up-to-date and to help the patient put the information in context or in perspective. One [patients] can get a lot of information from reading or on the internet but it helps more to be able verbalise concerns and have a conversation with someone [clinician] who helps you put issues in perspective (Karen, clinician).

The apparent objectivity of the clinical consultation is, in Foucauldian terms, a subjective and ritualistic practice that takes place within a power relationship. The standard routines, such as sexual history taking and risk assessment, are aspects of 'the confessional', codified to extract information according to the clinician's assessment of what counts as significant knowledge about the person.

I draw from Karen's comments to demonstrate the way the consultation has a ritualised form: "medical history, full sexual history and risk assessment, examination, do tests, explain diagnosis and plan of management." The confession is familiar and routinised. Even a woman who is consulting a clinician about a sexual health condition for the first time will recognise the confessional pattern as similar to other medical consultations. The clinician as Confessor is an example of Foucault's (1980) notion of power/knowledge, whereby the clinician's questions indicate the hierarchy of the most valid and important 'facts' to be discovered and discussed. In Karen's account, the patient's 'turn' follows subsequent to the clinician's 'interrogation':

I then deal with the specific issues or questions that are troubling them, educate the patient so that they understand the reasons why infections behave in certain ways and the rationale for management.... (Karen, clinician).

Given the power relations of the clinical encounter, it is perhaps more difficult to 'confess' the troubling questions if these areas have not been covered in the clinician's assessment. Most commonly, STI transmission with regards to sexual practices other than heterosexual, vaginal intercourse are not raised by clinicians.

Truth-telling and risk

For many women patients, to ask a question that falls outside the parameters of the appropriate knowledge-base already established by the clinician is to risk being constituted as morally questionable, as a 'risky' woman rather than a 'normal' woman. To ask a question tells the Confessor something about one's 'true nature.' Foucault's point is useful for considering why it might be experienced as risky for patients to ask questions and to raise worries:

...if I tell the truth about myself...in part it is that I am constituted as a subject across a number of power relations which are exerted over me and which I exert over others (Foucault, 1988, p. 39).

In the following response to my question, Jeannie, a woman who has HPV and who is also a sexual health educator, describes the worry of being constituted as a sexually active and sexually interested woman. Her worry is that if the doctor does not have the similar degree of ease about sexuality as she has, the doctor might find her desires and behaviours unacceptable. This example continues a key theme of this chapter, which is that women come to a consultation with awareness of the link between morality and STIs. Clinicians cannot simply erase discourses of morality with the over-riding emphasis on clinical objectivity. The consultation is a 'moral occasion' for both parties:

Catherine: What questions, if any, are difficult to ask health professionals? Why? Are there any topics you would find it helpful for a health professional to initiate in a conversation related to HPV that would ease the way for you?

Jeannie: For me, anything that is specifically physical-health related is not so hard, but when it starts to touch on sexual activity it gets harder - detailed questions about how will this affect my partner and what types of activities should we not be doing are pretty tough - I am very, very open about sexuality because I talk about sex for a living, but I find that in a situation with a health professional, I get worried that they will not be on the same level and will either judge me for being so open or will be uncomfortable and will bluster their way through it and give me bad information. I have spoken to many women who feel the same way - the questions are there but it's hard for them to ask anything for the fear of even admitting that they are sexually active - even though that's obvious. It would be much easier for me and, I'm quite sure, for everyone if the questions were brought up by the health professional so that the patient knows it's okay - to say something like, "this diagnosis or condition can have some effects on your sex life and your partner or partners. Most women who have this have some concerns about that. Are there any questions you have that you'd like to talk about?" (Jeannie, HPV diagnosis, sexuality educator, 37 years old).

In Jeannie's comments there is a taken-for-granted belief on the part of the woman in the patient role to tell the truth – to confess – in response to the clinician's questions. The implication is that although there is "the fear of even admitting they are sexually active" that this admission is the correct step. From Jeannie's account it appears that there is an obligation to respond with answers to "detailed questions about how will this affect my partner and what types of activities should we not be doing" Although she describes the process as "tough" she does not indicate that there is anything out-of-the-ordinary about the process. Foucault's argues that the provision of detailed accounts of anything related to sex and sexual practices are normalised. Discussion and questions about the quality of relationships in relation to STIs is considered to be within the realm of a routine consultation:

It is no longer a question of simply saying what was done – the sexual act – and how it was done; but of reconstructing, in and around the act, the thoughts that recapitulated it, the

obsessions that accompanied it, the images, desires and modulations, the quality of the pleasure that animated it (Foucault, 1976, p. 63).

The clinician's right to know the intimate details of a person's life is taken-for-granted. It is part of the western cultural obligation to tell the truth about matters conventionally considered private. The expectation of the clinician's right to know means that although some women report withholding information, there is unease in keeping back information, to do so is a transgressive action:

My most recent consultation with a new primary care doctor was for another problem but I happened to be a new patient so she took a medical history. I was really not going to confide that I had been diagnosed with HSV, yet I told her I had terminated a pregnancy, was not sexually active or taking any birth control. She absolutely did not ask me if I had a history of STIs even though she does vaginal examinations. I just didn't want to tell her because I have a gynaecologist and I feel that's his area. I had this feeling that somehow it would be found out, or that I was withholding information. It [telling the new doctor] would be another place where I felt I was 'labelled' (Victoria, HSV diagnosis, 37 years old).

Victoria describes the tension between her perception that there is a moral obligation to tell and the desire to withhold information. She weighs the risk that she might be "found out" for "withholding information," as if the information rightfully belongs to the clinician. Rather than questioning the clinician's right to know every detail of her body, Victoria justifies not telling by indicating that the clinician is responsible for extracting the confession: "She absolutely did not ask me if I had a history of STIs." Victoria's decision to withhold information because of the risk of being "labelled" is a useful point for further illustrating Foucault's (1988) idea that telling the truth constitutes people within power relations. Although it may have been advantageous for the clinician to know about the diagnosis, for Victoria, there is greater benefit in withholding information. Similarly, Peckover, (2001) in her study of health visitors and women who had experienced domestic violence, notes that women acted to resist being labelled as a 'bad' mother. Peckham reports that some women went to great lengths to hide evidence of depression and continuing abuse in order to discursively produce themselves as good mothers. In other research that examines confessional practices in medicine, Elizabeth Wheatley's (2005) observational study of staff and patients in cardiac rehabilitation settings highlights the contingency of the 'truthfulness' or otherwise of patients' confessions. In the endeavour to constitute themselves as 'good' patients, self-reports about diet, smoking and exercise were routinely evasive.

Victoria, quoted above, resists being constituted as a woman with herpes in her relationship with her new doctor. The label is one she associates with a level of deviance that is more problematic than being constituted as a woman who has had an abortion. Victoria's remarks imply that for her there is a difference between the disclosure of an abortion compared to the disclosure of a herpes diagnosis. In my study, a number of women told me about why a viral STI is different from other medical conditions. I address this difference because I consider it demonstrates a tension in clinical consultations. Although clinicians may believe that they approach the consultation in an objective,

non-judgmental way, women are under no such illusion about what the consultation means to them; the 'dirtiness' of a viral STI is different from the 'dirtiness' of a urinary tract infection. More is at stake for women in terms of a risk to the constitution of appropriate femininity in some consultations than others.

STI 'dirt': 'Matter out of place'

Although any medical consultation will have aspects of a confessional process, in many consultations the topic does not risk the way the woman's sense of self is constituted. Disclosing a sexual health problem is a potential risk to appropriate femininity. In addition to the discourses of femininity and morality that shape the meaning of viral STIs Mary Douglas' (1966) notion of 'dirt' is useful for conceptualising why STIs are a 'special' topic for confession. Douglas claims that there are cultural systems that define what is dirty that transcend biological explanations and bodily management:

If we can abstract pathogenicity and hygiene from our notion of dirt, we are left with the old definition of dirt as matter out of place. This is a very suggestive approach. It implies two conditions: a set of ordered relations and a contravention of that order. Dirt then, is never a unique, isolated event. Where there is dirt there is a system. Dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements (Douglas, 1966, p. 45).

The effects of the classification of dirt are particularly evidenced in the moral 'weight' applied to sexual activities of the body and infections associated with these activities. The dirtiness relates to links with sexual activity rather than with the bodily parts that may be associated with sex. Dianne's following account provides a clear illustration of Douglas' notion of the cultural power of the systematic ordering of dirt that may have little to do with pathogenicity and hygiene:

I can walk into a GP's office and say, "I have depression, help me", or "I have endometriosis, help me", because these are somewhat beyond my control. People feel sorry for you. There's no guilt. It's now acceptable to have depression (a big change from when I was first diagnosed at sixteen). Vaginismus is difficult because you have to admit you are a sexual being and that what other people can do naturally you have difficulty with. So that's been difficult to discuss but thankfully I had a good relationship with my GP and could get it out into the open. But with HPV it's been different again. There's an aura of sin around it, of uncleanliness. It's something that nobody talks about. I find it very difficult to say, "I have HPV", so I'm less likely to go back to a health professional for follow-up for the HPV itself (I have to go back for checkups to watch for precancerous cells) (Dianne, HPV diagnosis, 33 years old).

Dianne's moral assessment across the spectrum from being the victim of depression and endometriosis to transgressive behaviour evidenced by contracting HPV, illustrates the contribution

that the 'sex' part of sexually transmitted infections makes to the burden of the HPV diagnosis. For Dianne, the key difficulty with a viral STI diagnosis is not related primarily to taboos about orifices and functions of the pelvic and genital area in general. The difficulty is with the margins of the body plus sex. I concur with Douglas' notion of the 'dangerousness' of the body's margins. Additionally I emphasise that while the margins of the body are potentially vulnerable to 'weighty' meanings it is the activities associated with these margins, rather than the margins per se that are most problematic:

...all margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolize its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind (Douglas, 1966, p. 150).

I draw from Douglas' concept of the unevenness of notions of dirtiness. Although margins of the body are commonly associated with danger these dangers are not equal. The unevenness of the dangerous associations Dianne has with the margins of her body is apparent in her account. She describes a continuum of sorts as she indicates the levels of moral accountability for depression, endometriosis, vaginismus and HPV. With the experiences of depression and endometriosis Dianne's account positions her as a victim of sorts. The circumstances are beyond her control and therefore she can ask for help, anticipate people's sympathy and is devoid of guilt. Her mind and her uterus are without fault.

Dianne classifies vaginismus somewhat differently as this problem is linked to two paradoxically problematic moral ideas: 'confessing' to being sexually desiring and yet also 'confessing' to not being able to be sexually active like a 'normal' woman. These ideas about what is normal/deviant illustrate Douglas' point about the vulnerability of bodily margins to the unevenness of meaning. Dianne's use of language positions her as responsible for desire and for being able to perform sexually. However, contracting HPV is at the other extreme of the continuum from the 'victim' of depression and endometriosis: "There's an aura of sin around it, of uncleanness." Dianne's use of the word, "sin," indicates a level of personal culpability that is not felt with the other conditions of the body's margins, endometriosis and vaginismus. The "sin" and uncleanness Dianne associates with HPV illustrates Foucault's point that sex is historically the key theme of practices of confession, because sex, particularly sexual pleasure, is the 'cause' of sin. The moral associations Dianne has with having contracted HPV reflect Douglas' key concept that a pathogenic causal agent is only ever a part of the meaning that is made in determining whether something is classified as 'dirty' or not.

Dianne's comments, which link sex and STIs with sin and uncleanness, are not unique to her. These beliefs are part of a cultural system that classifies STIs as having a different sort of dirtiness than other bodily 'dirt.' The 'dirt' associated with sex is most likely to be met with moral censure. By contrast the 'dirt' of sweat and tears may have positive connotations, a child in the grip of the 'dirt' of chickenpox (caused by the herpes zoster virus and medically classified as part of the herpes

'family') may elicit tenderness and sympathy, an adolescent incapacitated with glandular fever (caused by Epstein Barr virus – another 'member' of the herpes 'family') may receive gentle teasing for having contracted 'kissing disease.' Sophia's response to my question below highlights Douglas' point that the perception of the 'dirty' body is more about the contravention of a social system rather than being about the particular pathogenic agents:

Catherine: How similar or different is the consultation process compared to experiences consulting health professionals about other conditions?

Sophia: It was different for me because it was of such a personal nature, being an STI and my body. It was easier to go to the doctor about a bladder infection than it was to discuss herpes.... to have a bladder infection was a different concept psychologically because it wasn't to do with having sex, so I didn't feel 'dirty' or ashamed of myself when I was asked to pee into a dish or had a swab taken (Sophia, HSV diagnosis, 51 years old).

In Sophia's account she makes the distinction between a bladder infection and a herpes infection. The herpes infection is of "such a personal nature" because of the sex link. The link brings to the fore connections with notions of dirt and shame. For Sophia, the link says something about who she is as a person, whereas the bladder infection does not. By contrast, in the absence of the sex link, a bladder infection does not have any of the burdensome connotations as herpes and is "a different concept psychologically." In Sophia's estimation, the pathogens of a bladder infection, while contravening health, do not contravene a moral system and therefore are not as 'dirty.'

The above examples in this chapter illustrate what appears to be a teaching conundrum. Women consider that a viral STI is substantively different from other genitally-related infections or problems and therefore the consultation is a 'moral occasion' of sorts. Clinicians disavow the moral component of the construction of viral STIs, while describing interventions that are in part a covert moral interrogation. The extent to which clinicians extract a 'confession' from women and provide a moral prescription is obscured by a belief in the objectivity of medical science. Therefore clinicians may not routinely consider how they might engage with the 'moral occasion' of a consultation to women's greater benefit.

Clinicians prescribe moral work

I consider that clinicians are usually unaware of the extent to which a moral agenda is part of clinicians' conversations with women. The ethic of care, the idea of being alongside women and working in partnership with patients, obscures clinicians' recognition of the moral positions they hold. In the following comments, Helen emphasises humanistic themes of personal responsibility and personal growth. Helen's description of the options, pitfalls and metaphorical salvation for those who tell rightly illustrates again the clinician as "...the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile..." (Foucault, 1976, pp. 61-62). Helen is the Confessor, prescriptively outlining a definitive moral code with regards to the responsibility of the person with genital herpes to tell a partner:

... many people I have worked with have handled the diagnosis, worked through their fears, met fabulous partners, and learnt to communicate well early in a relationship because of the diagnosis.... I have heard from partners who have been devastated that they haven't been told [about a partner having genital herpes], had believed that they had an open, honest trusting relationship, and the damage from not telling has been huge; in some cases catastrophic, leading to the end of the relationship. This [level of upset] in comparison to perhaps telling a new partner, and them rejecting them at an early stage in the relationship - if a partner can't handle a 'cold sore' in the wrong place how would they handle BIG issues in life. I have had people tell me of potential partners that have bailed [out], but overall once the pain of rejection is over, relief that they didn't spend years with that person. So yes I explain options, but overall my approach is with tell if there is potential for a future in it. I also use the tack of, what would you want someone to do if they knew? All of this is of course tempered with the statistics of the numbers of people with HSV that are unaware (Helen, clinician).

Although Helen indicates that epidemiological data 'tempers' the preceding factors she outlines, the moral obligation to tell and the incitement to practice forms of self-regulation prevails. I examine Helen's comments in further detail to highlight the position of clinician as Confessor. Helen repeatedly emphasises the importance of telling the truth, that the benefits and responsibility to tell outweigh the possible detrimental effects of telling. Even seemingly unpleasant effects of telling are framed up by Helen as potentially positive. For example, a partner's inability to accept the truth of a viral STI is a measure of the partner's possible inability to tolerate other life hurdles.

Helen indicates that certain moral attitudes regarding the self and relationship values require cultivation as 'healthy' and desirable practices: "I have heard from partners who have been devastated that they haven't been told [about a partner having genital herpes], had believed that they had an open, honest, trusting relationship, and the damage from not telling has been huge; in some cases catastrophic, leading to the end of the relationship....So yes I explain options [with regards to disclosure of a viral STI to a partner], but overall my approach is with: tell, if there is potential for a future in it [the sexual relationship]". In her comments, Helen indicates that the act of not telling a partner is the antithesis of openness, honesty and trust. These are qualities that are commonly valorised as desirable relationship traits in contemporary western society (Gavey & McPhillips, 1999).

Helen draws from the Christian principle of 'do unto others': "I also use the tack of, what would you want someone to do if they knew?" The moral work to be undertaken is to overcome resistance to disclosure in order to achieve a desirable level of moral conduct. Helen describes the way in which telling a partner can act to reveal the potential of a partner in terms of long-term commitment – hinting that the reward and consolation for disclosure of a viral STI is the early discernment of whether lasting love and happiness is possible. From my years of clinical experience, I consider Helen's comments are commonplace, typical of clinicians who are passionate about their work and

want 'the best' for the people who consult them. Clinicians are inevitably engaged in moral work, regardless of their commitment to an ethos of care. I contend that the confessional activities of advice-giving, with admonition for those people who do not 'measure up' morally and with subtle and not-so-subtle allusions to the punishments involved are 'ordinary' aspects of health professionals' interactions with patients. The comments by clinicians quoted in this chapter thus far point to a taken-for-granted role of clinician as an expert interpreter of the true meaning of a diagnosis and its' (moral) implications. Foucault (1976) explains the normalisation of the authority of those people who are able to validate scientifically what counts as the truth:

If one had to confess, this was not merely because the person to whom one confessed had the power to forgive, console, and direct, but because the work of producing the truth was obliged to pass through this relationship if it was to be scientifically validated. The truth did not reside solely in the subject who, by confessing, would reveal it wholly formed. It was constituted in two stages: present but incomplete, blind to itself, in the one who spoke, it could only reach completion in the one who assimilated and recorded it (Foucault, 1976, p. 66).

Helen's description of telling a partner is an example of the Confessor who is able to constitute the completion of a process of validation. The patient has a partial knowledge that is transformed into full understanding through confessional practices. The position of the Confessor who accurately interprets meaning to bring about resolution is demonstrated in the following example where Jessica, a clinician, describes her typical intervention when a woman has a new diagnosis of a sexually transmitted infection. From her description it is clear that Jessica holds the idea that she is more able than the woman to accurately convey the most appropriate meaning to be made of the diagnosis. The desire of the clinician is to be as helpful as possible to the woman and to ease the way with her partner. However, it is also an example of the inherent power relations of the clinical encounter whereby the clinician knows best how to make sense of an STI:

The worst thing for them [women adjusting to a diagnosis of HSV/HPV] is always trying to tell their partner - usually because of preconceptions and attitudes toward STDs in the past. I offer to see their partner with them to be the messenger if they want, so that I can answer any questions the partner may have, and try to make it all matter-of-fact rather than emotional (Jessica, clinician).

Jessica privileges her ability of assist the confessional process with a partner by relaying information in a "matter-of-fact rather than emotional" manner, as if the former carries more weight; the voice of scientific validation. Emotion in women is linked to (moral) preconceptions and attitudes about STIs and, in Foucauldian terms, is constituted as incomplete and blind to itself. By contrast, the clinician's ability to present information with an absence of emotion is conceptualised by Jessica as a process of completion by scientific means.

In the following interview segment, Annalise, a clinician, describes a clinical encounter, which I use to illustrate Foucault's (1976) notion that the Confessor is the conduit of verification, the one who enables people to move from an incomplete to complete and true understanding:

I also remember a female client in her 40s earlier this year who had been courageous enough to commence a new relationship after a separation and divorce from a long-term marriage. She had contracted genital herpes in the marriage and had in recent months been coming to terms with the possibilities of how that might have occurred! She was tearful about this [possibility of husband's infidelity] during our conversation even though she was ostensibly just attending for a sexual 'WOF' [warrant of fitness] before having sex for the first time with her new partner. She tried to describe to me how confused she was about her emotional connection with the virus and how difficult she had found it to tell this new man. At one point she said the tears were about how grateful she was that he had taken the news so well and was so supportive. She had obviously 'educated' him well so he was able to be realistic about managing the virus and I was able to give her good feedback about how this open, honest communication boded well for a healthy start to their time together (Annalise, clinician).

In my reading of Annalise's account, the client is constituted as a 'good woman' – "courageous" – showing moral responsibility by coming in for a sexual health check-up as a 'warrant of fitness'; 'permission' to be sexually active again. The moral practice of sexual self-denial until having had the go-ahead from a clear set of sexual health tests is a standard public health message. The clinician also guides the client to consider the transformative possibilities of her actions. Through appropriate moral conduct (disclosure exemplifying "open, honest communication") Annalise reassures the woman that the likely reward is a "healthy" relationship. Annalise's account demonstrates the integral and yet often invisible relationship between scientific 'objectivity' and the moral prescriptiveness of clinical encounters. As the clinician Annalise shapes the meaning of the conversation: "I was able to give her good feedback." In Annalise's commentary on her clinical work, she is the Confessor, helping the woman to interpret the feelings of confusion and to decipher the sense to be made of the situation.

Conclusion

This chapter illustrates the routine interventions by clinicians that are typically constituted as rational and scientific, free from moral judgment. Clinicians in my study consider that 'judgmental' clinicians are those who convey an overtly negative moral assessment that adversely affects women. I consider that discourses of morality shape all sexual health consultations, that rational approaches obscure moral agendas. Foucault's notion of the confessional is useful for analysing the relative invisibility of clinical practices of interrogation. The confession is an integral part of the examination process extracted without force. As Foucault (1976) describes, the desire to disclose is so deeply ingrained within people that to answer probing questions may be experienced as pleasurable and even transformative, rather than as an invasion of personal freedom.

Even when morality is not mentioned, women assess that a sexual health consultation involves 'moral work' – that they are required to account for their health problems in ways that are substantially different from non-sexually-related health problems. Women bring to the consultation considerable knowledge about morality, health, sex and dirt. Part of the work for women is deciding what information they will disclose or withhold. This decision-making may be shaped by a preference to be constituted as a 'good woman' that overrides possible treatment benefits from disclosure. The moral components of clinical talk are at times a source of comfort and relief for women.

I propose that clinicians may be better able to support and educate women if they are able to engage other colleagues and women in discussions that acknowledge the inevitably subjective, moral 'terrain' of STIs; that there are multiple meanings that shape the possible moral implications of contracting, transmitting and living with the knowledge of a viral STI. Clinicians' belief in a non-judgmental, scientific teaching approach renders clinicians unaware of their engagement in the constitution of viral STIs as 'moral' infections.

Chapter Eight:

Pedagogical possibilities in clinical practice

Introduction: Clinicians, education and the ‘everyday’

My study arose directly from my clinical observation that teaching women about ‘everyday’ viruses is potentially a complicated matter. This complexity is largely hidden from view and critique by clinicians and women because of the dominance of medical discourses for ‘making sense’ of happens to the body. Discourses of femininity, morality and health are embedded in medical discourses and ‘common-sense’ understandings of ‘the way things are’ and as such are difficult to notice. My study has addressed the pedagogical gaps that may occur when clinicians and women only partially share ‘common ground’ about the meaning and effects of a diagnosis. My study was shaped by the notion that clinicians are in a position to contribute positively to women’s quality of life subsequent to a diagnosis, particularly since many women have few opportunities to talk elsewhere about viral STIs, or to see their experiences reflected socially. The desire to be helpful to women may be thwarted inadvertently through clinicians only validating knowledge that reflects medical discourse and rejecting the effects of other meanings. For example, clinicians may offer reassurance that condom use lowers transmission risk, whereas the introduction of condoms may pose new sexual negotiation dilemmas for women.

In this final chapter I review the key findings and provide recommendations for clinical practice. I discuss the study limitations and indicate areas for further research. In concluding the study I emphasise the potential for practical applicability of my research findings. In this respect, the chapter is orientated towards imagined practitioners rather than an academic audience. Throughout my doctoral journey, clinicians have asked me, “What have you found? What should we be doing/saying differently?” Although my recommendations are tentative, I resist being hesitant in offering suggestions for clinical practice as I my findings show that there are small yet significant changes clinicians could incorporate into their practice without overall systematic change that may benefit some women.

Carla Willig (1999) critiques a common gap in discourse analytic work, whereby analysis is not followed by practice recommendations. Willig addresses three areas where application of discourse analysis has been addressed: as a social critique, as empowerment and as a guide to social reform. My study provides a social critique of discursive processes showing that clinicians’ and women’s understandings about viral STI myths/facts do not match. I am particularly interested in the relevance of discourse analysis as empowerment, and the possibility of localised change. My study shows the constraints for women and clinicians when medical discourse is the dominant lens through which women’s lives are considered subsequent to STI infection. I also show how women’s and clinicians’ talk is shaped by multiple, predominantly unacknowledged discourses. According to Willig’s idea of discourse analysis as empowerment, it is quite possible for change to happen from

the bottom-up – in this instance, in clinicians' consulting rooms, rather than waiting for a revolution in the delivery of medical care:

Discourse analysis as empowerment directly addresses the question of application....Discourse analysts who adopt this [empowerment] approach identify and promote discursive strategies for resistance. Discourse analysis as empowerment promotes action at a grass-roots level rather than top-down interventions, and it promotes organizations which facilitate such resistance....it is a tool to bring about social change (Willig, 1999, p. 13).

In order to highlight possible changes at a grass-roots level, I incorporate illustrative data in this chapter. My intention is to keep the focus on the ways viral STI diagnoses produce 'real life' effects for women and clinicians.

Medical discourse and the classification of viral STIs

My study critiques the apparent objectivity of medical discourse and the authority of medicine to teach the 'truth' about what infections mean. I use the idea of discourse, drawn from poststructuralist, feminist approaches that reject inherent, essential meanings and instead draw attention to the contradictory, conflicting and fluid constitution of experience (Weedon, 1987/1997). An example of this more complex notion of experience is that of Dianne, a woman who has had complications from HPV infection. She described her usual practice of telling people that she has had a 'cancer scare' rather than an STI. Cancer is a different 'object' than an STI and for Dianne carried less embarrassment than a health problem associated with sex:

I've shared my diagnosis with very few other people. At most I say I had a cancer scare and that's it. Luckily people don't ask many questions because I feel embarrassed about saying I have a sexually transmitted disease. My family knows I had a cancer scare in my 'nether regions' and that's it (Dianne, HPV diagnosis, 33 years old).

Dianne's construction of her experience as a 'cancer scare' enables her to account for the disruptions to her life (time off work for appointments, times of distress) with a version of events that protects her from the stigma associated with STIs. As I emphasise in Chapter One, the classification of viral STIs is not a simple matter of different knowledge between clinicians and lay populations. In the following example, Helen, a clinician, made an observation about women with chronic genital warts that appears to reflect a discourse of morality and neoliberal personal responsibility/culpability:

I have met women [who] appear to be holding on to their warts also as a punishment (Helen, clinician).

Helen's theory, that the persistent presence of warts reflects women's belief that they deserve punishment, is at odds with medical facts about HPV. Her point illustrates my argument throughout

the thesis, that although clinicians' work is ostensibly shaped primarily through attention to the objectivity of medical science, the way clinicians think about viral STIs and engage with women is subjective. I am not implying that subjective practice is inferior to striving for 'objective' knowledge but rather that it is a (subjective) fact of clinical life.

Chapter Four illustrates the effects of clinicians' common insistence upon normalising viral STIs. The social and embodied impact of the diagnoses for women is treated as subordinate to this medical 'truth.' Clinicians' practice of normalising viral STIs was undertaken from the position that this intervention is beneficial for women, and liberates women from societal 'wrong' thinking. However, women in my study were often ambivalent about the normalising of viral STIs –the practice was both reassuring and also did not alter the 'fact' that their lives had changed subsequent to the diagnosis:

I would love to have heard that it [HSV] was common, the day I read that I felt such a relief.... For me this [infection] has been life changing and a lot of soul searching, sometimes with no answers. I have also put on so much weight and at times hate myself so much (Sarah, HSV diagnosis, 41 years old).

When I asked the doctor at the sexual health clinic ... if I should stop having sex or tell my partners, she was pretty blasé about it – everyone has it, no need to etc.... I lost one relationship because of the diagnosis, one that was very important to me. That was the hardest part (Ann, HPV diagnosis, 36 years old).

Sarah and Ann's comments show that medical information does not relieve them of significant alterations to personal experiences. Why is it that HSV and HPV are not classified as common *and* complicated? The classification of viral STIs - as relatively normal rather than abnormal - is an example of oppositional language typical of western thought, where the meaning of one aspect of the binary is dominant over the other, rather than existing in what Derrida calls a "peaceful co-existence..." (1981, p. 41). With a deconstructive approach, instead of giving primacy to the normalcy of HSV and HPV, the recognition of a continuum in the normalcy to abnormality of the diagnoses becomes more possible. As discussed in Chapter Four, when viral STIs are classified as relatively normal, women who do not adjust 'appropriately' to the diagnosis are commonly pathologised as unreasonably distressed.

Yet by the time women seek out medical care for a viral STI they have received considerable social 'education' that STIs are categorically different and more abnormal than other conditions. Chapter One draws attention to the position of STIs in media representations – there is rarely anything 'everyday' about STIs in movies, newspapers, fiction-writing or magazines. Either viral STIs are completely invisible as if they are non-existent or hyper-visible and linked to moral panic. The red ribbon campaigns and the promotion of destigmatisation of HIV do not have a flow-on effect to people with HSV/HPV (Gilman, 2007). Most women in my study knew few, if any other people who had a viral STI and felt that the infection set them apart from others, rather than giving them the

sense of, 'welcome to the club.' Leila's experience illustrates a significant point, that statistics do not automatically alleviate the loneliness and isolation of a diagnosis:

Living with herpes is actually a very lonely process I have found.... I can't imagine other diseases that affected 20-25% of the population being so hidden and secret. We are not generally a society that shuts up about something so prevalent, are we? (Leila, HSV diagnosis, 51 years old).

Leila's comment below indicates that the social deviance associated with a viral STI means that the consultation is qualitatively different from a consultation for any other condition. Although she has gone to the doctor to consult about the STI, the shame and embarrassment affect her ability to manage the consultation to ensure that she receives the care and information she came for:

The experience of consulting a GP about sexual health issues as aversive to other issues looks the same on the outside - the process is the same for the doctor (maybe). It is the subjective experience of the patient that is totally different. I feel levels of anxiety that just do not apply if I am presenting for a cold or similar. I sit in the waiting room feeling exposed, even though the experience is the same as on other visits. I worry about who has access to my notes - other GPs in the practice, the nurse etc.... To actually raise the issue with the doctor is very difficult and provokes feelings of shame and embarrassment (Leila, HSV diagnosis, 51 years old).

Leila's point, that she did not consider herself anxious per se but that the anxiety was specifically linked to the diagnosis was reiterated by many women in the study. The experience of specific anxiety and shame connected to an HSV/HPV consultation is contrary to medical literature that attempts to make links with 'intrinsic' anxious personality traits and problems subsequent to diagnosis (Barron, Foxall, & Houfek, 2005).

In my study I did not find any clear distinctions that youth and possible exposure to more liberal discourses about women's sexuality made viral STI consultations easier:

It's [HSV] far more embarrassing than anything else I've gone to the doctor for....it's more embarrassing because there is an element of responsibility for it. I obviously slept with someone who carried it, so its because of my actions that it occurred (Amanda, HSV and HPV diagnosis, 23 years old).

I review discourses of femininity shortly to account for the disjuncture between the apparent liberalisation of sexual morality and the continuing difficulties young women may encounter with a viral STI diagnosis. Many women participants mentioned similar experiences to those identified above by Leila and Amanda: of shame and embarrassment in waiting rooms, fears about violations of their privacy, an altered relationship with the clinician subsequent to the diagnosis because of wondering what the clinician *really* thinks of them. Leila's comment that the consultation "looks the same from the outside" highlights a point made in Chapter Four, that women typically work hard to

perform as a 'normal' patient despite the distress they might experience (Werner & Malterud, 2003). Clinicians cannot accurately gauge women's distress because women want to be 'credible' rather than 'problem' patients. Significantly, a clinician's positive attitude towards a woman does not necessarily act to mitigate shame:

My GP was great in those initial weeks, then two months later I saw him at the local shopping mall and the effect on me was interesting - again I felt ashamed of myself - there was someone standing there in public who actually knew that I had herpes! Now the logical part of my brain said "don't be an idiot, he's not going to shout it to the world" but that didn't take the shame away (Sophia, HSV diagnosis, 51 years old).

Leila's statement about the difficulty of asking any questions and/or raising the topic of the diagnosis was one made by most women participants. A resounding theme was that women wanted clinicians to take the initiative and to ask them about the physical, emotional, sexual and social effects of the diagnosis – something women found too difficult. Women described 'reading' clinicians' body language and the words they used as a measure of the clinician's level of comfort with sexuality talk, in order to assess the clinician's credibility as an educator and the relative emotional safety of the consultation for asking questions. Jeannie, a woman with HPV who is also a sexuality educator told me about an instance that illustrated the problem of some clinicians' discomfort with the topic of sex:

I was 29 years old! Does she [my doctor] honestly believe 29 year old women don't have sex until they're in a serious relationship? No, she doesn't. She's just scared to talk about sex....She took a swab to test for a number of STI's and she acted like she was apologizing for even suggesting that it be done. So what's the message there - if you get an STI you're a slut and I certainly don't mean to imply that by doing this test? I think a lot of women feel that way [as if they are a slut] so these kinds of interactions must be very hard on them. To me it was funny. But what wasn't funny was that I knew I couldn't get what I need from her (Jeannie, HPV diagnosis, sexuality educator, 37 years old).

It is of interest to me that Jeannie, a woman who described herself as sexually confident, had such a vivid memory of the clinician's discomfort (the event occurred nine years earlier); that there are sometimes lasting effects from clinical encounters that serve to shape and limit women's subsequent choices. Jeannie's comments also show that it is not enough for a clinician to be a competent swab-taker and diagnostician. Jeannie wanted the clinician to relate to her as a 'normally' sexually-active woman and in her account constitutes herself as such. The above quote illustrates the point that it is not possible for clinicians to 'stick to the facts.' Clinicians are never too busy to incorporate a conversation about the effects of morality and femininity upon the diagnosis – because these conversations happen unwittingly. Within the limited interaction with the clinician, Jeannie was subject to discourses of morality and appropriate femininity by the apologetic way the clinician asked her about sex and administered the STI tests.

I consider that clinicians' credibility is enhanced with women when they are able to demonstrate some understanding of the contextual, gendered aspects of women's sexual health.

Performing appropriate femininity: A viral STI gets in the way

Women in my study saw their sexuality and sexual expression as central to feminine subjectivity. A viral STI diagnosis was typically disruptive to notions of appropriate femininity, whether or not sexuality had prior positive or negative connotations for women. Reactions to a diagnosis were not a simple matter of sex attitudes predictably shaping STI attitudes. It indeed appears to be the case that a viral STI diagnosis, with the common associations of multiple partners and risky behaviour, disrupts the constitution of conventional femininity: of seeking coupled life rather than sex per se, and of being led by romance rather than desire (Holland, Ramazanoglu, Sharpe, & Thomson, 2000). However, the more apparently 'sex positive' discourses available to young women do not automatically alleviate the burden of an STI diagnosis. Aapola, Gonick and Harris (2005) discuss the ways the notion of a desirable body is shaped by technological and consumer culture. The prescription for the appropriate 'packaging' and presentation of the body is no less rigorous than for previous generations of women.

The focus on bodily presentation for young women may mean that even in an ostensibly sex-positive social circle, a viral STI is a mark of a 'fall from grace.' In Chapter One I introduce Leichter's (1997) concept about the 'new' health; that performing good health is symbolic of virtuousness, of being a good person. In Chapter Five, I use the description by a clinician, Annalise, to show how the desire for a flawless body is disrupted with a viral STI diagnosis. She detailed how what counts as a flaw, what counts as 'dirty' means that young women are potentially just as vulnerable to constructing adverse connotations about a diagnosis as older women despite perhaps more liberal views about sex. Annalise's examples of the impact of hair removal practices and internet pornography are illustrative of the convoluted relationship between notions of what is 'dirty' and what is normal. For instance, anal sex is the new normal and pubic hair is the new dirt. Viral STIs are the old and new dirt, especially as genitals are on view more than ever before. As the 'old dirt' a viral STI disrupts women's constitution of themselves as morally pure, and as 'new dirt,' a viral STI disrupts the 'work' of the new virtue – the production of flawless bodily surfaces. Either way, viral STIs are readily constituted as dirt. I use Mary Douglas' point to indicate that the definition of 'dirt' continues to defy medical categorisation:

If we can abstract pathogenicity and hygiene from our notion of dirt, we are left with the old definition of dirt as matter out of place (Douglas, 1966, p. 45).

The 'dirt' of STIs remains even when sex per se is constituted as healthy. Liberal views about sex are not seamlessly conferred to STIs and nor do liberal views about sex make the negotiation of safer heterosexual sex, including oral sex, and STI transmission reduction easier for women. Condom initiation by women is problematic to the performance of femininity and sexual health talk is unromantic. Neoliberal public health messages exhort women to take responsibility for their

health (Gavey, McPhillips, & Doherty, 2001) and yet to do so may be considered by women more 'risky' than unprotected sex. Even where women experience themselves as the 'innocent victim' in contracting a viral STI, the traditional gender training of women to nurture others may affect the entitlement to acknowledge the disruptiveness of the diagnosis:

Getting the diagnosis of HPV/VIN 2 [vulval pre-cancerous changes caused by HPV] obviously had some big effects. What I remember the most is how my boyfriend reacted. He was completely overwhelmed by guilt. You see, he was my first sexual partner and so the odds of me having gotten the virus from him are pretty high. He basically felt that he had given me a death sentence. And as many women do, instead of me being able to come to grips with my own feelings and the situation, I became involved in helping him (deal with his feelings). So I put on a brave face and muddled my way through (Dianne, HPV diagnosis, 33 years old).

Dianne's description of her attention taken up with comforting and reassuring her male partner illustrates my point that women learn how to 'do' femininity long before they receive medical advice about how to manage a diagnosis. Dianne incorporated her probably long-standing knowledge about what women do into decisions about how to deal with the diagnosis in her relationship.

Examinations

Part of 'doing' femininity – of being a responsible woman, means having regular pelvic examinations, which increase in number subsequent to the diagnosis of a viral STI, particularly an HPV diagnosis:

...a pelvic examination [is]... an 'inconvenience' but part of the female job description (Sophia, HSV diagnosis, 51 years old).

In my study I noticed a relative absence in research literature of the effects of actual examination procedures and clinician behaviour upon women's sense of wellbeing and subsequent decision-making about follow-up examinations. In the case of HPV diagnosis, the lack of follow-up may mean that cervical pre-cancerous lesions progress to become cervical cancers. Public health promotion brochures (National Cervical Screening Programme, 2007a) normalise pelvic examinations and downplay the possible problems and reservations women may have about screening. Chapter six examines the medical literature, in which it is evident that women's absence from further screening and treatment is a major public health concern. Medical research focuses on these 'problem women,' and their decision-making is explored in relation to the effects of anxiety and coping (Barron, Foxall, & Houfek, 2005; Eggleston, Coker, Prabhu Das, Cordray, & Luchok, 2007; Tahseen & Reid, 2008). I found a startling lack of enquiry about what women experienced during examinations, in their bodies and in relation to practitioner interactions, which may have affected their decision to attend follow-up care.

The medical literature addresses the binary of women's participation or non-participation through non-attendance. There is never a cohort of women who leap in protest from the examination couch. Once women commit to the procedure they typically stay. I consider that this compliance may affect future attendance decisions, as women feel compelled to complete the procedure once they 'commit' through showing up for the appointment. Medical descriptions of the examination process for lay audiences are presented as an uninterrupted step-by-step process with ongoing compliance by women. In Cooke's (2007) guide for young women and in public health material about cervical screening and colposcopy (National Cervical Screening Programme, 2007a, 2007b) women are not instructed/encouraged to say "no" at any stage in the process. I contend that there are similarities between the commonplace heterosexual expectations that initial consent means ongoing consent does not need further negotiation (Gavey, 1992) and the expectation that women will comply through an examination.

The medical research literature that attempts to identify why women do not attend follow-up appointments typically concludes with recommendations for further studies to examine teaching tools such as patient brochures and the use of real-time videos of cervical procedures (Barron, Foxall, & Houfek, 2005; Eggleston, Coker, Prabhu Das, Cordray, & Luchok, 2007; Tahseen & Reid, 2008). There are no recommendations that clinicians' communication and technical skills may impact upon women. Further research in this field could entail interviewing clinicians who have a high rate of women returning to recall appointments, to ask them what they do in the examination process that may account for women's choice to re-attend. Women could also be interviewed about whether the quality of the examination experience influenced repeat attendance. I include the following quote from a clinician, Annalise, of her description of the attention to the young woman in her care. I contend that further research that interrogates this type of clinician-focussed data rather than 'problem-patient'-focussed data, may point to interventions that could alter women's screening recall uptake:

I was reminded how excruciatingly difficult it can be for clients when a young client, aged 17, expressed how embarrassing she found having to remove underwear and have a stranger examine the most intimate part of her body. Although I haven't needed to do so often I suggested she use a small cover cloth to help shield eyes/face and reassured that other people had also found this helpful. Speaking in a very matter of fact way about using this cloth was useful and she found comfort in being able to so distance herself enough to cope. In these types of situations it is always a fine 'art' to feel the correct pace to proceed with the examination. Too fast and it's too pressured and too slow can extend the process beyond the client's time comfort zone.... This need to create some separation from the physical experience of gynaecological exam is interesting and I've noted a not uncommon behaviour among younger clientele of using their cell phones as 'support.' Either holding it in a 'just in case' manner (just in case I get a call, need to txt or need to pretend to!) or actually physically texting while I take swabs. Using hands to cover the face is another common behaviour that seems to help (Annalise, clinician).

Annalise is a clinician who has a high rate of young women returning for follow-up care. It is possible that the ways she ‘teaches’ young women to manage the feelings (emotional and physical) invoked by the examination process provide women the skills whereby they are able to imagine coping with future examinations. Annalise ‘normalised’ the woman’s discomfort when she suggested a cloth for her face and reassured her – “other people have found this helpful.” Annalise also described her interventions as a “fine art,” and yet exploring the art of clinical practice is sorely missing from medical research, where instead women’s psychosocial problems are the focus. Annalise’s description indicates that her perception was that the woman’s embarrassment was to be expected and that it was her job as the clinician to educate and guide the woman in dealing with the distress. Similarly, in Chapter Six, I use a quote from Rachel, a young woman with a history of rape and extreme difficulty tolerating examinations, who described the skilful way clinicians engaged with her to make the examination tolerable. Prior to the procedure they educated her that she was in charge of the examination – “[they] told me that I am the boss when they are doing the procedure” (Rachel, HPV diagnosis, 28 years old). In the medical research referenced in this section there are no indications that negotiating the examination process with women has been explored. I suggest that a shift in research focus may lead to at least partially answering the confounding question of why education fails to convince some women to return for screening follow-up.

Confessional

Although clinicians emphasise the science underpinning their teaching, clinical engagement inevitably involves a moral discourse; attention to health, and in particular sexual health, is shaped by a neoliberal discourse that stresses individual responsibility and personal choice. Women in my study told me about the loneliness of the sexual and moral dilemmas they encountered, and the relief on the rare occasions when clinicians did directly address the effects upon their lives beyond symptom management. Most women had not ever had a conversation with a health professional about the implications for sexual relationships, even though they had been diagnosed with a viral STI. How curious that it is possible to talk about STIs without discussing sex; that the science of the lesion displaces talk about the ‘real life’ effects of the diagnosis. Few of the highly experienced sexual health clinicians in my study indicated that they talked about the effects of the diagnosis on sexuality. I asked clinicians the following question:

Catherine’s question:

Does the diagnosis tend to influence women’s experiences of sexuality and sexual desire?

Edith’s response:

I have not had experience of women declaring that they had changed their sexual practice or related changes in desire. But I don’t specifically ask. (Except it is wise to use condoms when experiencing an outbreak or prodromal [earning ‘warning’] symptoms) Edith, (clinician).

Margaret's response:

I imagine that it would, but I cannot recall a consultation in which this has been discussed. That may be an omission on my part to approach the topic, and a reminder that we should explore this more, rather than simply ask about recurrences! (Margaret, clinician).

Jessica's response:

I really haven't had anyone mention this to me sorry (Jessica, clinician).

Betty's response:

I don't often get into this topic in any depth, but yes I think it does. Many women report feeling dirty and put off sex, especially if there are genital warts present. Concerns about transmission also affect the ability to relax and enjoy sexual contact (Betty, clinician).

Clinicians' replies indicate that women do not routinely ask about the effects upon sexuality and desire and even highly experienced clinicians do not necessarily routinely enquire. This absence is an interesting contrast, given the emphasis on normalising viral STIs and the problematising of women who do not cope with a diagnosis long-term. Clinicians' normalising practices are ideological; based on teaching women the 'right' way to think about viral STIs without knowing about how STIs shape women's sense of sexual self. I suggest that, similarly to women with HIV (Gurevich, Mathieson, Bower, & Dhayanandhan, 2007; Siegel, Schrimshaw, & Lekas, 2006), little is known about the effects of a viral STI diagnosis upon women's sexuality. Women are told what a diagnosis means, not asked what it means.

Foucault (1976) highlights western confessional practices whereby a person in a position of authority receives a 'confession' and engages with the confessor "...in order to judge, punish, forgive, console, and reconcile...(1976, p. 62). I found that women and clinicians appeared unaware of the moral discourse operating within consultations unless the conversation was experienced as having adverse effects. Clinicians who had 'sex-positive,' liberal attitudes considered their interactions 'non-judgmental' – and an appropriate orientation to the work. In Chapter Seven I use examples to show 'the confessional' at work in clinical encounters where women and clinicians incorporate moral discourse unwittingly, with reportedly beneficial outcomes. Moral 'work' is integral to clinical conversations; not just reserved for the overtly complex ethical dilemmas of clinical practice.

Research method

In order to undertake this study I needed a research method that allowed participants to speak as freely as possible. I sought access to participants with viral STIs without having to manage the potential 'gate-keeping' by clinicians. I also wanted to interview highly experienced sexual health clinicians spread over a wide geographical area, in New Zealand and Australia. Conducting email interviews enabled me to achieve these goals in a timely manner, with minimal disruption and

inconvenience to my participants. The private, reflective time in the interview process allowed for women with HSV/HPV to comment on the personal benefits derived from the study:

I think I have mostly thought about these experiences on a personal & emotional level, and your questions & comments encourage me to think about it more objectively - I begin to see myself as part of a larger group with common experiences. Also I have been thinking about how I don't always identify unacceptable behaviour on the part of professionals without time to think and discuss things with people I trust. I am thinking about the experiences in a slightly more distanced, interested and curious-observer way, which allows me to think about the process without being overwhelmed by the emotions (Leila, HSV diagnosis, 51 years old).

The interview process involved feelings of empowerment for a number of women. Through discussions about clinical consultations some women decided to change their general practitioner to a practitioner who was comfortable talking about sex and STIs, seek out a support group, and discuss the infection with other women or partners or clinicians. A number of women in the study made comments similar to Leila, above, that participation brought an opportunity to think and discuss, and broke the sense of isolation and the acceptance of the status quo.

Recommendations for clinical practice

Based on my research findings, I recommend that clinicians experiment with incorporating the following points into the consultation process:

- In clinical teaching, acknowledge and address both the medical 'normalcy' of viral STIs *and* the potential for these infections to disrupt women's personal subjectivity, sexual and social relationships. HSV and HPV are socially uncommon in that these infections are rarely presented in any media/literature as part of everyday life and instead are linked to deviancy. The use of statistics does not simply resolve women's grief or sexual/relationship problems. Clinicians' practice of discrediting the stigma of viral STIs as unscientific does not translate smoothly into women (or their sexual partners) transforming their view.
- Initiate questions about the effects of the diagnosis upon women's lives, especially addressing the impact upon sexual relationships and sexual practices. Even an established clinician/patient relationship may be altered from a woman's perspective once she knows the clinician knows she has an STI. The clinician's questions indicate to the patient that they are conversant with talking about STIs and sexual practices and give women information about the relative emotional safety of raising sex-related topics. This recommendation does not mean clinicians have to become 'sex therapists.' Simple questions, such as, "have there been any changes within your sexual relationships since the diagnosis?" may then guide clinicians in the incorporate of medical 'facts' where they specifically relate to women's circumstances.

- It is helpful for clinicians to indicate that they are aware that gender shapes the effects of the diagnosis. Clinician comments such as “many women have told me that oral sex transmission is a worry,” or, “many women have told me that condom use is a problem,” signal to women that the clinician is in familiar conversational territory. Rather than telling women to disclose to a partner and/or to have a male partner use condoms, instead ask, “How possible is it for you to imagine telling a sexual partner?” “If you were to ask a male partner to use condoms, are there any difficulties you think you would encounter?” Through these sorts of interventions, clinic-based education may become more applicable to women’s lives.
- Consider that genital/pelvic examinations may be less-than-normal for some women. Ask women about previous experiences, particularly any pain/discomfort and negotiate changes to the procedure that may enhance the process for women. Include the question of preferred gender of the clinician. Coach women to complain during the procedure and to ask for the examination to stop, either temporarily or completely. Even women who have previously been relatively comfortable about examinations may experience the procedure differently once they have something ‘wrong’ with their genital area.
- Many women benefit from the opportunity to communicate with other women who have contracted a viral STI. Clinicians do not offer women the ‘real life’ ‘truths’ about the infection that women want to know – like how women *really* tell a partner. Rather than clinicians giving ‘blanket’ warnings about the internet, it is useful for clinicians to demonstrate knowledge of internet resources and to recommend specific websites. Women will use the internet regardless of what clinicians say so showing an awareness will more likely enable women to disclose internet use to clinicians. Similarly, although clinicians in my study had a wary approach to support groups, women with HSV unanimously remarked about the benefits of group contact.

Research limitations and possibilities

There are a number of limitations to this study, which in turn may provide direction for future research. It may have been more useful for me to interview clinician/patient ‘pairs’ about the same consultation experience, in order to more clearly identify pedagogical gaps. Women in the study had rarely accessed clinicians with a sexual health specialty practice. For the most part they consulted with general practitioners and generalist gynaecologists, whereas the clinicians in my study all had years of sexual health experience.

The focus of my study was the experience of HSV/HPV diagnosis primarily within the context of heterosexual relationships. I did not ask women in my study to define their sexual orientation as women’s sexual experiences often do not fit with the orientation binary. However, no women told me of same-sex relationships. The topic of lesbian women’s sexual health is under-researched. From my email nurse counselling role I am aware that dealing with viral STIs in same-sex relationships is also complex.

Given clinicians' normalising of viral STIs it would be interesting to research general population samples to identify the extent to which this message (that viral STIs are endemic and relatively innocuous) is taken up outside of sexual health clinics. This research could be a useful counter-balance to the research that focuses on women with infections who do not appear to 'cope' with the diagnosis, as if the problem is an intra-psychic rather than a social one. Although clinicians may frame up telling a partner as a positive step, I have emailed and telephone- counselled many potential partners of women with HSV/HPV who continue to associate these infections with stigma, risk and promiscuity despite my educational 'reframing.'

The area of further research of most interest to me is in relation to women's experiences of examinations. I have highlighted gaps in the medical literature in Chapter Six, and earlier in this chapter I have indicated a research possibility. I contend that addressing clinician/patient interactions in the examination process may influence women's decisions to seek follow-up care. For relevance to the New Zealand context, attention to the potential for differences between ethnic groups would be an important focus.

Medical research into the personal and social problems of viral STIs tends to be narrowly focused on the stigma of STIs as a result of their associations with sex. I consider that broader understandings of stigma are needed in order to understand why apparently more liberal, tolerant societal ideas about sex do not readily transfer to STIs. Discourses of femininity and the rise of 'healthism' – the ever-more rigorous policing of health and potential risk factors – may help to explain the persistence of stigma.

My research interest – why teaching about seemingly ordinary, common conditions is complicated – may be applicable to considering pedagogical gaps in teaching about other health conditions. My study shows that making sense of the 'ordinary' offers opportunities for clinicians to resist pathologising patients and instead to address other factors that confound the seemingly straight-forward relationship between teaching and learning.

A limitation of my study, a small qualitative piece of research involving primarily New Zealand women and clinicians, is that the findings are not necessarily generalisable. For example, in western, English-speaking countries, clinicians' normalisation of viral STIs relates primarily to health professionals in the United Kingdom, Australia and New Zealand. Medical and patient literature from USA tends to have a far greater emphasis on HSV/HPV as epidemic rather than endemic infections and therefore a different focus on prevention, testing and treatment. However, given that a considerable amount of sexual health STI stigma research is generated in USA, I have heard clinicians dismiss these findings as part of American conservatism and irrelevant to New Zealand women. Therefore, local research such as this study, is necessary to begin to draw attention to women and sexual health in the South Pacific region.

My participants were predominantly Pakeha (New Zealand European). Interviewing women from a wider variety of ethnic, religious and cultural groups in New Zealand may have produced different results and clinical recommendations.

While waiting for the revolution

I have considered my research findings from the perspective of discourse analysis as social critique and empowerment. Willig (1999) also identifies that discourse analysis may guide reform that is applicable within existing institutions. The above clinical recommendations and research directions may enable interested clinicians to alter significantly the focus of viral STI teaching within current clinical situations. I have the opportunity as a member of the professional advisory board for The Viral Sexually Transmitted Infection Education Foundation to incorporate recommendations into guidelines used by clinicians throughout New Zealand and Australia. As an email nurse-counsellor I am able to incorporate the findings into my email correspondence. I have already had the opportunity to begin to speak about my research findings to both professional and public audiences and to incorporate some of the recommendations into a blog on a viral STI website. I will have further opportunities to present my recommendations at conferences and seminars.

Conclusion

A poststructuralist, feminist theoretical approach to discourse analysis usefully shows pedagogical gaps between clinicians' teaching and women's learning. This thesis illustrates that the teaching conundrum is not as simple as clinicians adopting 'non-judgmental,' sex-positive approaches to sexual health education. Clinicians who work from these perspectives may unwittingly silence the women they seek to help, as their educational strategies may confer legitimacy to certain topics while dismissing others. Clinicians' conviction that medical knowledge – 'objective' understanding – provides the key answers to women's difficulties overlooks the effects of the social 'teaching' women receive about morality, femininity and responsibility. Clinicians may best contribute to women's lives by acknowledging that medical discourse is only a part of the fragmentary and contradictory education women receive about bodies and selves.

Appendices

Appendix One: Overview of key medical information about HSV and HPV

Herpes simplex virus (HSV)

What follows is a brief description of the current medical significance of HSV and HPV. There are two types of HSV, known as type one (HSV-1) and type two (HSV-2). HSV-1 easily infects the facial area and is the cause of 'cold sores' on the lips. Most people are unaware that they have HSV-1 as the majority of people have few, if any symptoms. In the mid-1900s, serological tests indicated that HSV-1 infection was almost universal amongst adults (cited in Xu et al., 2006); i.e. almost everyone had HSV-1 whether or not they had symptoms. Historically, HSV-1 has been contracted facially in childhood, most commonly through receiving a social kiss from a person with a 'cold sore'.

Facial HSV-1 'protects' against contracting HSV-1 genitally as antibodies prevent re-infection. However, HSV-1 has consistently decreased in children and adolescents. The decrease is in part attributed to public health messages, for example about the risks of sharing food and drink bottles. Without antibodies to HSV-1 prior to becoming sexually active, many people now contract HSV-1 genitally in adulthood (Cowan, Copas, Johnson, Ashley, & Corey, 2002; Gray, Morgan, & Lindeman, 2008). People only contract HSV-1 genitally if they have not previously contracted HSV-1 facially. HSV-1 may be passed to the genital area through a person with a 'cold sore' giving oral sex to a partner. In the situation of contracting genital herpes through receiving oral sex a person has a diagnosis of genital HSV-1. Genital herpes of either type is contracted through sexual activity, not necessarily through intercourse per se.

HSV is passed on through skin-to-skin rubbing. HSV-2 is contracted through genital-to-genital sexual contact. HSV-2 is rarely passed to the facial area through oral sex and HSV-2 is not associated with recurrent 'cold sores' (Wald, 2004b). The acquisition rate of HSV-2 increases with age and is most rapid during early adulthood. A cohort study of 1037 people born in Dunedin, New Zealand in 1972 or 1973 has included HSV-2 antibody blood tests from the time the participants were 21 years old. At the age of 21 years, 4.3% of women and 2.7% of men had HSV-2 antibodies and by 32 years of age 22.5% of women and 14.6% of men tested positive. (In the case of HSV, antibody positivity means the person has contracted the infection) (Dickson et al., 2006).

For the majority of people who have contracted genital HSV the infection is medically innocuous; approximately 75% of people have either no symptoms or such mild symptoms that the infections goes unrecognised (Wald, 2004a). People are not routinely screened for HSV as the mass screening for an infection considered to be endemic within the population is not economically viable. Although transmission is most likely when a person has symptoms, HSV may be passed on to a partner in the absence of obvious symptoms. Diagnosis is made through clinical examination of lesions and confirmed by laboratory testing of swabs taken from lesions. Blood antibody testing is another diagnostic tool.

Currently there is no cure or vaccine for HSV. Oral antiviral medication is available and is used by a minority of people who have genital HSV; usually those with problematic recurrences. Antiviral medication may also be used to reduce the likelihood of transmission to an uninfected sexual partner. People in New Zealand do not have access to the most up-to-date antiviral medications as the government pharmaceutical funding authority, Pharmac, continues to control the importation and availability of medications. In New Zealand, access to antiviral medication is controlled as a prescription medicine.

There are two particular areas in which genital herpes is medically significant. Firstly, neonatal herpes (contracted during birthing process or within the first six weeks of life) is a rare but potentially devastating infection in terms of morbidity and mortality (Barnabas, Carabin, & Garnett, 2002; Brown, 2004; Gardella et al., 2005; Handsfield et al., 2005; Sandhaus, 2001). Secondly, there is a substantial link between HSV and the subsequent risk of contracting human immunodeficiency virus (HIV) through sexual activity (Celum, 2004; Celum, Levine, Weaver, & Wald, 2004; Corey, Wald, Celum, & Quinn, 2004). Although the incidence of HIV amongst women in New Zealand is currently low, there is a steady rise in the number of people in New Zealand who contract the virus through heterosexual transmission (AIDS Epidemiology Group, 2005). Given the prevalence of adults with genital herpes, the relationship between HSV and HIV may become pertinent to New Zealanders sexual health in the coming years. Women are approximately three times more likely than men to contract genital HSV (Cowan, Johnson, & Ashley, 1996) due to the permeability of the genital mucous membrane. The correlation between HIV and HSV has particular significance for women given the higher incidence of HSV in women than in men.

Human papilloma virus (HPV)

As with HSV, HPV is endemic in sexually active populations and yet most people are without identifiable symptoms. Once women become sexually active, rates of infection are high. As with HSV, HPV may be passed through genital skin-to-skin contact in the absence of actual penetrative sex. At least 80% of sexually active people have been infected with HPV at some stage (Koutsky, 1997). Different HPV types cause genital warts or abnormal cell changes in the genital area. Although in most women, the HPV infection resolves spontaneously and is medically unproblematic, cervical abnormalities including cervical cancer are caused by a subset of HPV types. Worldwide, cervical cancer is the second most common cause of malignancy in women, both in terms of incidence and mortality (Professional Advisory Board of the Australia and New Zealand HPV Project, 2004). A vaccine has been developed to target four key HPV types that cause warts and cervical cancer. The vaccine is now available internationally and locally (Frazer, Cox, Mayeaux, Franco, Moscicki, Palefsky, Ferris, A et al., 2006). In New Zealand the vaccination has been incorporated into the schedule of free vaccinations available to children and will be administered to girls at the age of eleven years old.

Currently there is no cure for HPV. There are a number of self-applied and practitioner-applied treatments for genital warts. It is not possible for a clinician to determine whether, in the absence of

symptoms, the virus is dormant or potentially infectious. There is no treatment for HPV in the absence of visible symptoms. (Professional Advisory Board of the Australia and New Zealand HPV Project, 2007). In order to monitor the effects of HPV upon the cervix, all women from the age of twenty are advised to have a cervical smear test once every three years, and more regularly if any abnormalities are detected (National Cervical Screening Programme, 2007a).

In heterosexual and male-to-male penetrative sex, the transmission of both HSV and HPV is reduced by a male partner using a condom. However, because both these viruses may be present on the genital and pelvic skin that is not protected by latex, transmission may still occur (Professional Advisory Board of the Australia and New Zealand HPV Project, 2007; Professional Advisory Board of the Viral Sexually Transmitted Infection Education Foundation, 2007).

Appendix Two: Participant Details

Women participant details

No.	Participant name	Participant age	Ethnicity	Country of participation	1st Diagnosis	Time since diagnosis	2nd Diagnosis	Number of clinicians consulted	Role of professionals	Interview completed yes/no
1	Amber	22	Caucasian	USA	HPV	3 months		2	doctors	Y
2	Charlotte	23	NZ/Euro	NZ	HPV	3 years		2	general practitioners	Y
3	Amanda	23	NZ/Euro	NZ	HSV	40 months		2 1	general practitioners family planning doctor	Y
4	Maddy	24	Euro	England	HSV	5 months		2 2 1 1	general practitioner sexual health nurse sexual health doctor counsellor	Y
5	Rachel	28	NZ/Euro	NZ	HSV	3 months		1 1 1 1	practice nurse general practitioner colposcopy doctor colposcopy nurse	Y
6	Claire	29	NZ/Euro	NZ	HSV	26 months		2	general practitioners	N

7	Zoe	29	NZ/Euro	NZ	HPV	2 weeks	HSV	1	not stated	Y
8	Charlene	32	Caucasian	USA	HSV	7 months		1 1	gynaecologist women's health doctor	Y
9	Dianne	33	NZ/Euro	NZ	HPV	2 years		2 1 1	gynaecologists physiotherapist psychologist	Y
10	Tania	35	Euro	NZ	HPV	15 years		2 1 1	general practitioners gynaecologist hospital gynaecologist	Y
11	Sally	36	Euro	NZ	HSV	8 years		3 1	doctors counsellor	Y
12	Ann	36	Caucasian	CANADA	HPV	2 months		2 2 1	general practitioners dermatologists sexual health doctor	Y
13	Victoria	37	Caucasian	USA	HSV	3 years 4 mo		not stated	not stated	N
14	Jeannie	37	Caucasian	CANADA	HPV	5 years		2 1 1 1	general practitioners colposcopy doctor nurse sexual health doctor	Y
15	Margarita	38	Latin/Cuban	USA	HPV	1 week	HSV	1	gynaecologist	N
16	Alana	40	NZ/Euro	NZ	HSV	29 months		2	gynaecologists	Y

								1	neurologist	
17	Sarah	41	NZ/Euro	NZ	HSV	6 years		5 1 1 1	general practitioners A&E doctor sexual health doctor counsellor	Y
18	Sophie	42	British/Euro	NZ	HSV	17 months		1 1 1	general practitioner nurse counsellor	Y
19	Rose	45	Caucasian	USA	HSV	20 years		7	not stated	Y
20	Josephine	46	NZ/Euro	NZ	HSV	23 years		5 1	general practitioners gynaecologist	Y
21	Miranda	48	NZ/Euro	NZ	HSV	15 months		1	general practitioner	Y
22	Sophia	51	NZ/Euro	NZ	HSV	16 years 9 mo		approx 5	not stated	N
23	Leila	51	Euro/Maori	NZ	HSV	3 years		2 1 1	general practitioners sexual health doctor psychotherapist	Y
24	Jessica	56	NZ/Euro	NZ	HSV	2 years		2 1	general practitioners phone counsellor	Y
25	Katrina	61	Caucasian	USA	HSV	25+ years		not stated	not stated	Y

26	Jane	71	NZ/Euro	NZ	HPV	7.5 years		1 2 4	general practitioner gynaecologists counsellors	Y

Clinician participant details

No	Clinician's name	Ethnicity	Country of participation	Doctor	Nurse	Educator or counsellor/psychologist	Interview completed yes/no
1	Jessica	NZ/Euro	NZ		practice nurse		Y
2	Kate	NZ/Euro	NZ	sexual health doctor			Y
3	Annalise	NZ/Euro	NZ		sexual health nurse		Y
4	Edith	not stated	NZ		sexual health nurse		Y
5	Camilla	NZ/Euro	NZ	general practitioner sexual health physician			Y
6	Claire	Caucasian	Australian	sexual health doctor			Y
7	Helen	NZ/Euro	NZ		sexual health nurse	counsellor	Y
8	Karen	Chinese	NZ	sexual health doctor			Y
9	Jennifer	Euro/Chinese	NZ	sexual health doctor			N
10	Betty	Euro	NZ	sexual health doctor			Y

11	Sue	Euro	NZ			psychologist	Y
12	Margaret	NZ/Euro	NZ	general practitioner family planning doctor			Y

Appendix Three: Webpage

Catherine Cook [photo]

PhD Candidate

Master of Counselling (1st class honours)
Bachelor of Health Sciences (Nursing)
Diploma of Midwifery

Catherine's contact details:

P.O. Box 32305
Devonport
Auckland 0744
New Zealand

Phone: (mobile) +64 21 1513732

To receive information about participation, please email me:

Supervisor:

Dr Alison Jones
Professor
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Private Bag 92601
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Phone: 64 9 6238899 x88117
Email: a.jones@auckland.ac.nz

Welcome to my webpage and thank you for taking the time to consider participating in my international email-based research. The working title for my study is:

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

I have chosen to research a topic that is usually only spoken about in privacy. HSV and HPV are the most common viral STIs and have specific implications for women's sexual and reproductive health, and yet women diagnosed with these conditions often believe they are 'the only one.' Why it is that sex is a common, often explicit topic but sexual health isn't? Through my research I intend to make accessible to women and health professionals the resources women use (people, education material, and support) to make a difference to women's quality of life subsequent to a diagnosis of a condition usually considered to be private.

- Are you a woman living with HSV or HPV?
- Are you a health professional (nursing, medicine, health promotion, counselling) involved in clinical practice with women who have a diagnosis of HPV and/or HSV?
- Perhaps you meet both criteria – I discuss this situation in the Participation Information Sheet.
- If your answer is 'yes' to any of the above three options, you have the expertise I am seeking – please keep reading!

If you are a woman living with HSV or HPV, I am very keen to discuss with you your experiences of what it means for you to live with a sexual health condition that continues to be something of a

taboo subject. Although HIV, breast cancer and infertility are becoming more commonplace themes in the public eye; in movies, books, and magazines, you will have noticed that this visibility is not nearly so apparent for herpes and HPV.

If you are a health professional please consider that the experience you have is of great interest to me. Through my clinical work I know that the role of health professionals is particularly significant, given the few places people with HSV and HPV can speak with the assurance of privacy about their experiences. Most of the practitioners I have worked with who have a passion for women's health have learnt 'on the job' as sexual health does not feature highly in general curriculum. You may in the majority, as an experienced professional who has never published about the nuances of sexual health consultations and therefore other colleagues have limited access to your knowledge resource.

A background to my research interest:

My interest in women's sexual health began in the early 90's when I was involved in the nursing care of women who had advanced cervical cancer. From these experiences I decided I wanted to be involved in primary health care. I qualified and worked as a midwife and subsequently worked for a period of time in the area of sexual health. The move from midwifery to sexual health was a stark contrast: from the climate of celebration and acknowledgement of women's bodies with flowers, cards, (often graphic) photos and newspaper announcements to a climate of privacy and secrecy.

I noticed a change professionally as well. On finding out I was a midwife, people loved to speak to me at length, telling me about birthing experiences, chatting in places we could be easily overheard. However, my sexual health work disclosure was for the most part a conversation stopper, or people might have a very discreet conversation with me. I discovered quickly that sexual health is still not an everyday topic despite most adults being sexually active.

Since 1996 I have been developing a specialist interest in women's sexual health. I am on the Professional Advisory Board of the New Zealand Viral Sexually Transmitted Infections Foundation (www.herpes.org.nz and www.hpv.org.nz) I work as a telephone and email nurse counsellor for this organisation and I am also the email nurse counsellor for the International Herpes Alliance www.herpesalliance.org. I also work as a counsellor at The University of Auckland Health Services. In order to advance my work in the area of women's sexual health, it is time for me to make the transition from an accumulation of anecdotal experience to research that has the potential to contribute to women's wellbeing.

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 00 61 9 3737 599 extn. 87830.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS
COMMITTEE on 20/6/07 FOR 3 years on 20/6/10 Reference Number 2007/192

Appendix Four: Research Advertisement

Announcement – Participate in women’s health research!

PhD candidate seeks research participants for email interviews

Are you a woman living with HSV or HPV? Are you a health professional involved in clinical practice with women who have a diagnosis of HPV and/or HSV?

Are you interested in contributing the knowledge you have gained from your experiences to my research?

Through my research I intend to make accessible to women and health professionals the resources women use (people, education material, and support) to make a difference to women’s quality of life subsequent to a diagnosis.

If you are interested in finding out more about my background and the research project, please visit my website for more information:

www.education.auckland.ac.nz/about/schools/sps/catherine.cfm

Contact me by email for participant information: **research@nznet.gen.nz**

The research will entail email correspondence with me over a four to eight week period (depending on participants’ time and availability).

Catherine Cook
PhD candidate
Faculty of Education
The University of Auckland
Auckland New Zealand

Master of Counselling (1st class honours)
Bachelor of Health Sciences (Nursing)
Diploma of Midwifery

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS
COMMITTEE on 20/06/07 for 3 years on 20/06/10 Reference Number 2007/192

Appendix Five: Women's Participant Information Sheet

Project title:

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

To: women with HPV and/or HSV

This research project is undertaken by:
Catherine Cook
PhD Candidate
Faculty of Education
The University of Auckland

An invitation to participate:

I am seeking women 16 years or older who have the experience of being diagnosed by a health professional with HPV and/or HSV to participate in an international qualitative research project conducted with me through email over the course of approximately four to eight weeks. (The time frame will vary dependent on participants' availability to respond to approximately ten key questions and will take a maximum of 2-3 hours in total). I am only able to conduct the email interview in the English language.

Reason for the research:

As a woman living with HPV and/or HSV you will be well aware that the experience of these infections usually remains private; there are few, if any role models for living with these infections. Discussing sexual health publicly has not yet become commonplace, unlike the changes which have happened in recent years with other areas of women's sexual and reproductive health, such as breast cancer and infertility. Through my research I intend to make accessible to women and health professionals the resources women use (people, education material, and support) to make a difference to women's quality of life subsequent to a diagnosis.

Data security:

The security of the research data and a user-friendly process are dual priorities for me in conducting this research.

The researcher's handling of data:

- For the research period I will check my emails 5 days per week.
- I will download each email using Post Office Protocol Version 3 (POP3) compliant email software which will ensure the email — once downloaded to my PC — will be deleted from the email server.
- My email account will require username and password authentication. I will employ a password at least 6 characters long. The password will contain both alphabetic and numeric characters. The password will not be a dictionary word.
- From the downloaded email I will create a Word document which is 'cleaned' of any identifying email information and instead identified by a code.
- A hard copy of the coded email will be kept in a locked filing cabinet. A list of codes and email addresses will be stored separately in another locked filing cabinet for the duration of the study, as a back-up in the unlikely event that my PC 'crashes.' My response to the email will be similarly 'cleaned' and coded.
- As soon as I have sent a response and retained a coded copy I will delete the email from the inbox and outbox and from the deleted items folder. The space left after deleting emails

will be regularly recycled and de-fragmented to 'cover' electronic tracks of identifying information as well as possible.

- I will use an email address that is used only for the research project.
- I will use a personal computer (PC) that is not networked and is kept off-line apart from downloading and sending research communication. I will employ firewall software on my PC. This step will make 'hacking' difficult. I will keep my PC's antivirus and antispyware software up to date. My PC is a laptop that will be password protected and stored in a locked filing cabinet when not in use.

The participants' handling of data:

Steps you can take to increase the security of your email correspondence includes:

- Password protection — including the above steps for choosing a password.
- If using a PC-based email program (such as Microsoft Outlook) I advise you to follow the security steps I describe above. If you are unfamiliar with any of these security practices I am able to advise you how to put these systems in place.
- If you prefer to use a web-based email program, such as Hotmail or G-Mail, I am able to advise on how to set up and use a web-based email account. To ensure anonymity, the choice of web-based email should use a non-identifying email name that is not linked to your real name.
- I advise you not to use workplace email systems; employers in many countries are legally entitled to access any emails sent on workplace servers.

Participants are welcome to retain copies of all correspondence. At the completion of my PhD I will remove all the 'cleaned' correspondence from my PC. I will also destroy the hard copies of the correspondence.

The right to withdraw from the research:

You have the right to withdraw from the research at any time. If a period of a fortnight has lapsed between email replies I will email you to ask if you wish to continue participation.

Withdrawal of data:

You may withdraw your data from the research for a period of seven days after submitting an email reply. You are welcome to continue to participate if there is a portion of the correspondence you wish to withdraw. This option includes altering and resubmitting data.

Qualifications and age requirement:

This research is specifically aimed at women who have had a diagnosis of HPV and/or HSV and who are aged 16 years or older.

Confidentiality:

If the information you provide is reported/published, this will be done in a way that does not identify you as its source. Portions of what you write in your emails may be used in my PhD and articles for publication to demonstrate particular points. If you mention any other people or health services by name I will ensure that these names do not appear in anything I write in my PhD or for publication.

Identity: For the purposes of this research it is option as to whether or not you disclose your identity.

The possibility of psychological discomfort:

It is possible that participation in this research project may be psychologically discomforting. Please consider the following possibilities:

Given that it is common for people to keep private a diagnosis of HPV/HSV, for some participants there may have been few previous opportunities to discuss their experiences in-depth. It is possible therefore that some participants may experience a range of emotions through participation. The most likely emotions are the normal emotions of grief, including feelings of loss, sorrow and anger,

which are often transitory and may also be helped through the opportunity to 'talk' with me in the interview process.

In deciding to participate in this research, you may want to consider telling a trusted person about this decision: a partner, friend, family member or health professional. It is often useful to have a pre-arranged 'buddy' to turn to in case you want to share your experiences face-to-face, and in case the timing of my reply does not have the immediacy that would be most helpful.

If you are dealing with other health conditions, including mental health conditions, or work/family pressures that are currently in any way disruptive to your time and energy, you may want to give particularly careful consideration to the decision to participate.

You are welcome to raise any experiences of discomfort with me. You may indicate if you wish this discussion to be 'outside' of the research conversation. If you wish to have a face-to-face discussion or to have email correspondence with an appropriate health professional relating to any discomfort, then through my network of contact with health professionals internationally I will endeavour to link you with an appropriate person.

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Appendix Six: Health Professionals' Participant Information Sheet

Project title:

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

To: Health Professionals

This research project is undertaken by:
Catherine Cook
PhD Candidate
Faculty of Education
The University of Auckland

An invitation to participate:

I am seeking health professionals (medical, nursing, health educators and counsellors) to participate in an international qualitative research project conducted with me through email correspondence over the course of approximately four to eight weeks. (The time frame will vary dependent on participants' availability to respond to approximately ten key questions and will take a maximum of 2-3 hours in total). I invite health professionals to participate who are currently involved in clinical practice (or who have recent relevant experience) and whose client group includes women who have a diagnosis of genital human papilloma virus (HPV) and/or genital herpes simplex virus (HSV). I am only able to conduct the email interview in the English language.

Reason for the research:

Health professionals working in the area of sexual health will be well aware that there is often a considerable disparity between the medical and social implications of a sexual health diagnosis. I have chosen to research the effects of the diagnosis of two viral infections that are endemic amongst sexually active adults and which have specific implications for women's sexual and reproductive health. Through my research I intend to make accessible to other health professionals the strategies experienced health professionals' utilise in their educative role to facilitate women's quality of life subsequent to a diagnosis.

Data security:

The security of the research data and a user-friendly process are dual priorities for me in conducting this research.

The researcher's handling of data:

- For the research period I will check my emails 5 days per week.
- I will download each email using Post Office Protocol Version 3 (POP3) compliant email software which will ensure the email — once downloaded to my PC — will be deleted from the email server.
- My email account will require username and password authentication. I will employ a password at least 6 characters long. The password will contain both alphabetic and numeric characters. The password will not be a dictionary word.
- From the downloaded email I will create a Word document which is 'cleaned' of any identifying email information and instead identified by a code.
- A hard copy of the coded email will be kept in a locked filing cabinet. A list of codes and email addresses will be stored separately in another locked filing cabinet for the duration of the study, as a back-up in the unlikely event that my PC 'crashes.' My response to the email will be similarly 'cleaned' and coded.
- As soon as I have sent a response and retained a coded copy I will delete the email from the inbox and outbox and from the deleted items folder. The space left after deleting emails

will be regularly recycled and de-fragmented to 'cover' electronic tracks of identifying information as well as possible.

- I will use an email address that is used only for the research project.
- I will use a personal computer (PC) that is not networked and is kept off-line apart from downloading and sending research communication. I will employ firewall software on my PC. This step will make 'hacking' difficult. I will keep my PC's antivirus and antispyware software up to date. My PC is a laptop that will be password protected and stored in a locked filing cabinet when not in use.

The participants' handling of data:

Steps you can take to increase the security of your email correspondence include:

- Password protection — including the above steps for choosing a password.
- If using a PC-based email program (such as Microsoft Outlook) I advise you to follow the security steps I describe above. If you are unfamiliar with any of these security practices I am able to advise you how to put these systems in place.
- If you prefer to use a web-based email program, such as Hotmail or G-Mail, I am able to give advice about how to set up and use a web-based email account. To ensure anonymity, the choice of web-based email should use a non-identifying email name that is not linked to your real name.
- I advise you not to use workplace email systems; employers in many countries are legally entitled to access any emails sent on workplace servers.

Participants are welcome to retain copies of all correspondence. At the completion of my PhD I will remove all the 'cleaned' correspondence from my PC. I will also destroy the hard copies of the correspondence.

Clarification about the privacy of your workplace:

Many participants will be employed within organisations and may have multiple employers. Participants are likely to draw from a breadth of clinical experience including practice that occurred prior to current workplaces. My research does not investigate specific workplace practices within organisations and there will be no reference to specific employers or organisations. I am interested in the individual points of view of health professionals developed through clinical practice, not a workplace critique. I will request broad categories of workplaces for statistical purposes only. Therefore, permission from employers is not required in order to participate. It is appropriate for people to participate outside of work hours.

The right to withdraw from the research:

You have the right to withdraw from the research at any time. If a period of a fortnight has lapsed between email replies I will email you to ask if you wish to continue participation.

Withdrawal of data:

You may withdraw your data from the research for a period of seven days after submitting an email reply. You are welcome to continue to participate if there is a portion of the correspondence you wish to withdraw. This option includes altering and resubmitting data.

Qualifications and age requirement:

This research is specifically aimed at health professionals with specific sexual health experience and therefore precludes any participants younger than 16 years of age.

Confidentiality:

If the information you provide is reported/published, this will be done in a way that does not identify you as its source. Portions of verbatim may be used in my PhD and articles for publication to demonstrate particular teaching points. I anticipate that when you use clinical examples, these examples will have generic themes that will not lead to any possible identification of individual

clients. . If you mention any other health professionals or health services by name I will ensure that these names do not appear in my PhD or anything I write for publication.

Identity: For the purposes of this research it is option as to whether or not you disclose your identity.

The possibility of psychological discomfort:

It is possible that participation in this research project may be psychologically discomforting. Please consider the following possibilities: Participation may lead health professionals to recall experiences from their professional life that are disquieting in some way. Participation may lead health professionals to reflect upon their personal experiences living with a viral sexually transmitted infection. I will not ask you about any personal experiences in relation to sexual health. However, as a health professional, you are welcome to discuss the possible inter-relationship between professional and personal experience.

You are welcome to raise any experiences of discomfort with me. You may indicate if you wish this discussion to be 'outside' of the research dialogue. If you wish to have a face-to-face discussion or to have email correspondence with an appropriate health professional relating to any discomfort, through my network of contact with health professionals internationally I will endeavour to link you with an appropriate person.

Contact details:

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Appendix Seven: Consent form for women with HPV and/or HSV

All forms will be stored in a locked filing cabinet for six years on the premises of The University of Auckland in compliance with the research regulations of The University of Auckland Human Participants Ethics Committee.

This research project is undertaken by:
Catherine Cook
PhD Candidate
Faculty of Education
The University of Auckland

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

I agree to take part in this research. I have read the Participant Information Sheet and I understand the reason for the research and the interview method. I have chosen to participate and I meet the participation criteria. I have had the opportunity to ask questions by email and have had the questions answered to my satisfaction prior to returning this form. I understand that my participation is voluntary.

I understand that Catherine will conduct the interview with me through email correspondence over the course of approximately four to eight weeks. I will respond to approximately ten key questions. The interview process will take a maximum of 2-3 hours in total.

I understand the steps outlined in the Participant Information Sheet that Catherine will take to ensure the security of email data.

I understand that I have the right to withdraw from the research at any time. If a period of a fortnight has lapsed between email replies, Catherine will email me to ask if I wish to continue participation.

I understand that I may withdraw my data from the research for a period of seven days after submitting an email reply. I understand that I am welcome to continue to participate if there is a portion of the correspondence I wish to withdraw. This option includes altering and resubmitting data within the seven day period.

I understand that this research is specifically aimed at women who have had a diagnosis of HPV and/or HSV and who are aged 16 years or older and I agree that I fit this category.

I understand that if the information I provide is reported/published, this will be done in a way that does not identify me as its source. Portions of what I write in my emails may be used in Catherine's PhD and articles for publication to demonstrate particular points.

If I mention any other people or health services by name I understand that Catherine will ensure that these names and any identifying details do not appear in anything she writes in her PhD or for publication.

I understand that it is possible that participation in this research project may be psychologically discomfoting. I agree that I have considered the points outlined in the Participation Information Sheet.

I understand that, given that for this research is open to international participation, the process of obtaining a signature for consent by post or facsimile (fax) would incur an expense that would be difficult for the Catherine to reimburse. Reimbursement would also involve identity disclosure which I understand is optional for this research. Therefore, email confirmation will be considered adequate for participation.

I agree to email confirmation to Catherine of the following points:
The Informed Consent Form has been read.
There has been the opportunity to ask questions and I agree to take part in the research.

Contact details:

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Supervisor:

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COMMITTEE on 20/6/07 FOR 3 years on 20/6/10 Reference Number 2007/192

Appendix Eight: Consent form for health professionals

All forms will be stored in a locked filing cabinet for six years on the premises of The University of Auckland in compliance with the research regulations of The University of Auckland Human Participants Ethics Committee.

This research project is undertaken by:
Catherine Cook
PhD Candidate
Faculty of Education
The University of Auckland

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

I agree to take part in this research. I have read the Participant Information Sheet and I understand the reason for the research and the interview method. I have chosen to participate and I meet the participation criteria. I have had the opportunity to ask questions by email and have had the questions answered to my satisfaction prior to returning this form. I understand that my participation is voluntary.

I understand the steps outlined in the Participant Information Sheet that Catherine will take to ensure the security of email data.

I understand that I am advised to take the steps outlined in the Participant Information Sheet to increase the security of my email correspondence.

I understand that Catherine's research does not investigate specific workplace practices within organisations and that there will be no reference to specific employers or organisations.

I understand that I have the right to withdraw completely from the research at any time. If a period of a fortnight has lapsed between email replies, Catherine will email me to ask if I wish to continue participation.

I understand that I may withdraw my data from the research for a period of seven days after submitting an email reply.

I understand that I am welcome to continue to participate if there is a portion of the correspondence I wish to withdraw. This option includes altering and resubmitting data within the seven day period.

I understand that this research is specifically aimed at health professionals with specific sexual health/women's health experience and therefore precludes any participants younger than 16 years of age.

I understand that if the information I provide is reported/published, this will be done in a way that does not identify me as its source. Portions of what I write in my emails may be used in Catherine's PhD and articles for publication to demonstrate particular points.

If I mention any other people or health services by name I understand that Catherine will ensure that these names and any identifying details do not appear in anything she writes in her PhD or for publication.

I understand that it is possible that participation in this research project may be psychologically discomfoting. I agree that I have considered the points outlined in the Participation Information Sheet.

I understand that, given that for this research is open to international participation, the process of obtaining a signature for consent by post or facsimile (fax) would incur an expense that would be difficult for the Catherine to reimburse. Reimbursement would also involve identity disclosure which I understand is optional for this research. Therefore, an electronic signature will be considered adequate for participation.

I agree to email confirmation to Catherine of the following points:

The Informed Consent Form has been read.

There has been the opportunity to ask questions and I agree to take part in the research.

Contact details:

Catherine Cook

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Appendix Nine: Research questions for women with HSV or HPV

Project title:

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

Please provide the following information for statistical purposes only:

- Gender
- Age
- Ethnicity
- Country of residence at time of participation
- Time since diagnosis (in years or months)
- The number and role of health professionals (doctors, nurses, counsellors, other) you have consulted in relation to the diagnosis (public/private, general or specialist in women's/sexual health)
- Household annual earnings a)NZ\$20,000-40,000 b)NZ\$41,000-NZ\$ 60,000 c)NZ\$ 61,000-80,000 d)NZ\$81,000-100,000+ (if you choose to provide the category in the currency you are familiar with, please include the currency).
- Household annual earnings a)US\$20,000-40,000 b)US\$41,000-US\$ 60,000 c)US\$ 61,000-80,000 d)US\$81,000-100,000+ (if you choose to provide the category in the currency you are familiar with, please include the currency).

Questions about the relationship with health professionals and the consultation experience:

Can you tell me about when and how you came to find out about this diagnosis?

What do you recall about the initial process of consulting a health professional?

What have you experienced in any subsequent follow up with health professionals?

How similar or different is the consultation process compared to experiences consulting health professionals about other conditions?

What questions, if any, are difficult to ask health professionals? Why? Are there any topics you would find it helpful for a health professional to initiate in a conversation related to HSV that would ease the way for you?

Based on your experiences, what is the 'prescription' you would like to give health professionals about an ideal consultation process in relation to women with HSV or HPV?

How significant or unimportant is the consultation process with health professionals compared with the overall experience of living with the virus? (by this question I mean how big an impact have you found doctors and nurses to have on your overall experiences to date living with HSV/HPV).

What resources (people, education material, support), if any, have you found useful in living with and providing knowledge about the virus? Why have these particular resources helped?

Have health professionals ever initiated a conversation with you about the possible effects of living with the virus (physically and the emotional impact) on sexual relationships? (This question includes whether health professionals have raised the topic of any advice about telling/not telling a partner).

Questions about any differences brought about by the diagnosis:

What, if anything, have you experienced in your personal life (with yourself, sexual partner(s), family, and friends, work, and recreation) that for you is related to receiving this diagnosis?

Were there any factors around the period of time of the diagnosis that shaped the experience in some way? (for example, for many people, the context of relationship/s may shape the overall experience)

Are there any factors from earlier in your life that may have shaped the meaning of experience in some way? (This question is very broad and may relate to aspects that have made the diagnosis easier or harder – perhaps related to family, faith, sex education, cultural beliefs, and previous difficult/traumatic life events).

Prior to contracting the virus what experience, if any, did you have in talking with potential or current sexual partners about sexuality and sexual health?

In terms of talking to a partner about sexuality and sexual health, has anything changed since the diagnosis?

Has the meaning of your sexuality altered at all since you became aware of having a viral STI? (I use the term, sexuality, broadly to mean feelings of desire and desirability).

When you think of the virus, what image or words come to mind? Do you have your own word that you use for the virus?

The focus of my research is women's sexual health experiences. Do you think there are similarities/differences in the effects of the diagnosis for women as compared to men?

Appendix Ten: Research questions for health professionals

Project title:

Learning experience: Women, health professionals and the HPV (human papilloma virus) and HSV (herpes simplex virus)

Please provide the following information for statistical purposes only:

- Gender
- Age
- Ethnicity
- Country of residence at time of participation
- Health professional status/qualification
- Areas of clinical practice in relation to women's health from which you draw experience in relation to this research (public/private/primary or secondary health care facility, generalist or specific to women's and/or sexual health)

Questions about the role of health professionals/consultation experience:

Based on your clinical experience, how do you think health professionals influence women's experience of the diagnosis of HSV or HPV and its relevance to their lives?

When a woman has a diagnosis of HSV or HPV, how do you typically 'frame up' the way you talk about the implications of these diagnoses?

What resources (people, education material, support) have you found that are useful/not helpful to women living with a viral STI? (You may want to include a comment on anything you've noticed about the role of the Internet).

Based on your experiences, what key points you would give in teaching other health professionals about an effective consultation process in relation to women with HPV or HSV? (Just a handful of points that come to mind that you have found seem to make a useful difference to women's experiences – I'm not meaning for you to write up guidelines!).

Questions about women's experiences of the diagnosis and effects of living with HPV/HSV:

In your clinical experience, what proportion of women undergoes some process of adjustment subsequent to contracting HPV or HSV? What do you think are the main adjustments women have to make?

What range of responses do you notice from women who are diagnosed with HPV or HSV? How do women usually react to the diagnosis? What conversations have you had about the reaction to the diagnosis? Can you recall some?

Do many women experience the diagnosis as negative? What do they commonly say? What do you say?

Of the women who seem to take the diagnosis in their stride, relatively speaking, what do you think contributes to their ability to do that?

Does the response to the diagnosis change over time and if so, why? What factors contribute to the change?

Does the diagnosis tend to influence women's experiences of sexuality and sexual desire?

Does the diagnosis have much of an effect on women's subsequent decision-making in relation to sexual health, sexual relationships and pregnancy decisions? (Please include examples if any come to mind).

Do you notice a correlation between symptoms and distress? For example, do you notice that women who have a true primary episode (HSV) and/or frequent recurrences or who have problematic HPV sequelae have more difficulty with the diagnosis than women for whom the symptoms are less of a feature or is there no predictable pattern of response in this respect?

The focus of my research is women's sexual health. Do you notice any similarities/differences in the effects of the diagnosis for women as compared to men?

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