

***The lived experiences of young men  
addressing their sexual health and  
negotiating their masculinities***

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**For Paul**

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# Contents

|                                                                        |           |
|------------------------------------------------------------------------|-----------|
| <b>Acknowledgements .....</b>                                          | <b>3</b>  |
| <b>Contents .....</b>                                                  | <b>4</b>  |
| <b>List of figures and tables.....</b>                                 | <b>8</b>  |
| <b>Abstract .....</b>                                                  | <b>9</b>  |
| <b>Glossary .....</b>                                                  | <b>10</b> |
| <b>Chapter One: Introduction and context .....</b>                     | <b>12</b> |
| 1.1 Introduction.....                                                  | 12        |
| 1.2 Layout of the thesis, and my reasons for undertaking this study... | 13        |
| 1.3 Defining sexual health .....                                       | 14        |
| 1.4 Sexuality.....                                                     | 17        |
| 1.5 Terminology.....                                                   | 18        |
| 1.6 Attitudes to sex.....                                              | 19        |
| 1.7 Historical attitudes to ‘venereal disease’ and sex.....            | 21        |
| 1:7.1 The Contagious Diseases Acts. 1864-1869.....                     | 22        |
| 1:7.2 The origins of family planning .....                             | 24        |
| 1:7.3 Prevention of ‘venereal disease’ .....                           | 25        |
| 1.8 Health care provision.....                                         | 26        |
| 1.9 Social interaction .....                                           | 27        |
| 1:10 Young men’s sexual health .....                                   | 31        |
| 1:11 Conclusions.....                                                  | 33        |
| <b>Chapter Two: Sexual health and Government policy .....</b>          | <b>35</b> |
| 2:1 Sexual health in the UK.....                                       | 35        |
| 2:1.1 Socio-economic class.....                                        | 39        |
| 2:1.2 Teenage pregnancy .....                                          | 41        |
| 2:2 Sexual health in Wales.....                                        | 42        |
| 2:3 Government policy in England and Wales.....                        | 42        |
| 2:4 Conclusions.....                                                   | 50        |
| <b>Chapter Three: Masculinities .....</b>                              | <b>52</b> |
| 3:1 Gender .....                                                       | 53        |
| 3:2 Masculinities.....                                                 | 55        |
| 3:2.1 Forms of masculinities.....                                      | 57        |
| 3:2.1.i Hegemonic masculinities .....                                  | 57        |
| 3:2.1.ii Subordinate masculinities .....                               | 58        |
| 3:2.1.iii Complicit masculinities .....                                | 58        |
| 3:2.1.iv Marginalised masculinities .....                              | 59        |
| 3:2.1.v Negotiation of masculinities .....                             | 59        |
| 3:2.1.vi Defining masculinities.....                                   | 59        |
| 3:3 Masculinities in context.....                                      | 64        |
| 3:3.1 Social class .....                                               | 64        |
| 3:3.2 South Wales; the local environment .....                         | 65        |
| 3:3.2.i Employment in the South Wales valleys.....                     | 66        |
| 3:3.2. ii Gender roles.....                                            | 67        |
| 3:3.2. iii Migration and community development.....                    | 69        |
| 3:3.2. iv Masculinities in South Wales.....                            | 70        |
| 3:4 Effects of masculinities.....                                      | 70        |

|                                                                  |            |
|------------------------------------------------------------------|------------|
| 3:5 <i>Changing role of men</i> .....                            | 73         |
| 3:5.1 <i>Men in crisis?</i> .....                                | 76         |
| 3:6 <i>Conclusions</i> .....                                     | 78         |
| <b>Chapter Four: Methodology</b> .....                           | <b>80</b>  |
| 4:1 <i>Research design</i> .....                                 | 80         |
| 4:1.1 <i>Choice of methodology</i> .....                         | 82         |
| 4:1.2 <i>Choice of IPA</i> .....                                 | 87         |
| 4:2 <i>Reflexivity</i> .....                                     | 89         |
| 4:3 <i>Data collection</i> .....                                 | 91         |
| 4:4 <i>Difficulties with sampling</i> .....                      | 92         |
| 4:5 <i>Possible sampling methods:</i> .....                      | 94         |
| 4:5.1 <i>Volunteering</i> .....                                  | 94         |
| 4:5.2 <i>Convenience sampling</i> .....                          | 94         |
| 4:5.3 <i>Community partnership</i> .....                         | 95         |
| 4:5.4 <i>Snowball sampling</i> .....                             | 96         |
| 4:5.5 <i>Limitations</i> .....                                   | 97         |
| 4:6 <i>Decision regarding sampling for this study</i> .....      | 97         |
| 4:6.1 <i>Details of areas where recruitment took place</i> ..... | 100        |
| 4:6.2 <i>Methods of recruitment</i> .....                        | 100        |
| 4:7 <i>Data collection</i> .....                                 | 101        |
| 4:7.1 <i>Practical details of interviews</i> .....               | 102        |
| 4:8 <i>Ethical considerations</i> .....                          | 105        |
| 4:9 <i>Analysis</i> .....                                        | 107        |
| 4:10 <i>Evaluating the research</i> .....                        | 109        |
| 4:11 <i>Conclusions</i> .....                                    | 115        |
| <b>Chapter Five: The process of data analysis</b> .....          | <b>116</b> |
| 5.1 <i>Process of analysis</i> .....                             | 117        |
| 5.2 <i>Example of analysis</i> .....                             | 117        |
| 5.3 <i>Presentation of the findings</i> .....                    | 122        |
| <b>Chapter Six: Annotated findings</b> .....                     | <b>124</b> |
| 6:1 <i>Sexual health knowledge and attitudes</i> .....           | 126        |
| 6:1.1 <i>Disclosure when discussing sexual health</i> .....      | 127        |
| 6:1.2 <i>Knowledge and education</i> .....                       | 129        |
| 6:1.3 <i>Attitudes to sexual behaviour</i> .....                 | 142        |
| 6:1.3.i <i>Concerns about pregnancy</i> .....                    | 142        |
| 6:1.3.ii <i>Concerns about STI</i> .....                         | 144        |
| 6:1.3.iii <i>Qualifying/ managing risk</i> .....                 | 145        |
| 6:2 <i>Feelings about masculinities</i> .....                    | 152        |
| 6:2.1 <i>Emotions</i> .....                                      | 153        |
| 6:2.2 <i>Injuries</i> .....                                      | 157        |
| 6:2.3 <i>Sexual attitudes</i> .....                              | 160        |
| 6:2.4 <i>Responsibility</i> .....                                | 163        |
| 6:2.4.i <i>Abdication of responsibility</i> .....                | 163        |
| 6:2.4.ii <i>Excuses for not being responsible</i> .....          | 168        |
| 6:2.4.iii <i>Taking control</i> .....                            | 171        |
| 6:2.4.iv <i>Trust</i> .....                                      | 174        |
| 6:2.4.v <i>Blame</i> .....                                       | 179        |
| 6:2.4.vi <i>Vulnerability</i> .....                              | 182        |
| 6:2.5 <i>Comparisons</i> .....                                   | 183        |
| 6:3 <i>Communication</i> .....                                   | 192        |
| 6:3.1 <i>Discussing STI</i> .....                                | 192        |

|                                                                                                                                                 |            |
|-------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 6:3.2 Girlfriend's complaints .....                                                                                                             | 200        |
| <b>6:4 Feelings about health care .....</b>                                                                                                     | <b>202</b> |
| 6:4.1 General health care experiences .....                                                                                                     | 203        |
| 6:4.2 Experience of sexual health services .....                                                                                                | 207        |
| <b>6:5 Feelings about working.....</b>                                                                                                          | <b>215</b> |
| <b>6:6 Keeping fit .....</b>                                                                                                                    | <b>219</b> |
| <b>6:7 Conclusions.....</b>                                                                                                                     | <b>224</b> |
| <b>Chapter Seven: Further discussion based on findings and conclusions.....</b>                                                                 | <b>226</b> |
| 7:1 <i>Further discussion based on findings.</i> .....                                                                                          | 227        |
| 7:1.1 Sexual health knowledge .....                                                                                                             | 228        |
| 7:1.2 'The hidden moral code' .....                                                                                                             | 228        |
| 7:1.3 Male dominance in sex and decision making responsibility .....                                                                            | 235        |
| 7:1.4 Masculinities .....                                                                                                                       | 239        |
| 7:1.5 Summary of findings.....                                                                                                                  | 252        |
| 7:1.5.i Sexual health knowledge .....                                                                                                           | 252        |
| 7:1.5.ii Dominance over women.....                                                                                                              | 252        |
| 7:1.5.iii Blame, roles and responsibilities .....                                                                                               | 252        |
| 7:1.5.iv Conflicts of ideals .....                                                                                                              | 253        |
| 7:1.5.v Conclusion.....                                                                                                                         | 253        |
| <b>7:2 Concluding remarks .....</b>                                                                                                             | <b>254</b> |
| 7:2.1 Evaluating the research.....                                                                                                              | 254        |
| 7:2.2 Limitations.....                                                                                                                          | 255        |
| 7:2.2.i Researcher bias in sample selection .....                                                                                               | 255        |
| 7:2.2.ii Joint interview of Owain and Gwyn.....                                                                                                 | 256        |
| 7:2.2.iii Researcher inexperience.....                                                                                                          | 256        |
| 7:2.2.iv Control of gatekeepers .....                                                                                                           | 256        |
| 7:2.2.v Sample size and homogeneity .....                                                                                                       | 257        |
| 7:2.2.vi Speculation about young women's role .....                                                                                             | 257        |
| 7:2.2.vii Limitations of the research method .....                                                                                              | 258        |
| 7:2.3 Recommendations .....                                                                                                                     | 259        |
| 7:2.3.i Sexual health knowledge .....                                                                                                           | 259        |
| 7:2.3.ii Dominance over women.....                                                                                                              | 260        |
| 7:2.3.iii Blame, roles and responsibilities .....                                                                                               | 260        |
| 7:2.3.iv Conflicts of ideals .....                                                                                                              | 261        |
| 7:2.4 Contribution to knowledge .....                                                                                                           | 261        |
| <b>References.....</b>                                                                                                                          | <b>263</b> |
| <b>Appendix One.....</b>                                                                                                                        | <b>284</b> |
| <i>Coding Structure – to show audit trail by giving evidence of the development of a coding structure.</i> .....                                | 284        |
| Final coding .....                                                                                                                              | 284        |
| Original coding.....                                                                                                                            | 286        |
| Development of Coding.....                                                                                                                      | 288        |
| <b>Appendix Two .....</b>                                                                                                                       | <b>290</b> |
| <i>Research diary – to show audit trail by giving evidence of the researcher's journey through the research.</i> .....                          | 290        |
| <b>Appendix Three.....</b>                                                                                                                      | <b>298</b> |
| <i>Reflections on research process – to show audit trail by giving evidence of decision making and some experiences of the researcher</i> ..... | 298        |

|                                                                           |            |
|---------------------------------------------------------------------------|------------|
| 1. Reflections - sampling .....                                           | 298        |
| 2. Reflections - first data collection interview .....                    | 300        |
| <b>Appendix Four.....</b>                                                 | <b>302</b> |
| <i>Suggested Topic Guide</i> .....                                        | 302        |
| <b>Appendix Five .....</b>                                                | <b>304</b> |
| <i>Summary of participants</i> .....                                      | 304        |
| Rhys .....                                                                | 304        |
| Gareth.....                                                               | 304        |
| Huw .....                                                                 | 304        |
| David .....                                                               | 305        |
| Aneurin .....                                                             | 305        |
| Owain and Gwyn.....                                                       | 305        |
| <b>Appendix Six .....</b>                                                 | <b>307</b> |
| <i>Posters and leaflets: materials used to recruit participants</i> ..... | 307        |
| <b>Appendix Seven .....</b>                                               | <b>310</b> |
| <i>Screen shot of NVivo in use</i> .....                                  | 310        |
| <b>Appendix Eight.....</b>                                                | <b>311</b> |
| <i>Risk assessments</i> .....                                             | 311        |
| <b>Appendix Nine.....</b>                                                 | <b>313</b> |
| <i>Pictures used in interviews</i> .....                                  | 313        |
| <b>Appendix Ten .....</b>                                                 | <b>314</b> |
| <i>Information sheet</i> .....                                            | 314        |
| <b>Appendix Eleven .....</b>                                              | <b>316</b> |
| <i>Consent form</i> .....                                                 | 316        |
| <b>Appendix Twelve.....</b>                                               | <b>317</b> |
| <i>Confirmation of research registration</i> .....                        | 317        |
| <b>Appendix Thirteen .....</b>                                            | <b>320</b> |
| <i>Model for reflective practice (Johns and Freshwater, 1998)</i> .....   | 320        |

## List of figures and tables

|                     |                                                                                                                 |            |
|---------------------|-----------------------------------------------------------------------------------------------------------------|------------|
| <b>Figure one</b>   | Graph to show HIV diagnosis by exposure category                                                                | <b>36</b>  |
| <b>Table one</b>    | Table to show New HIV diagnosis, AIDS diagnosis and AIDS deaths in the United Kingdom 1996 (and earlier) – 2005 | <b>37</b>  |
| <b>Figure two</b>   | Graph to show new incidences (diagnoses) of various sexually transmitted infection 2000-2004                    | <b>39</b>  |
| <b>Table two</b>    | Table to show characteristics described as hegemonic by various authors.                                        | <b>61</b>  |
| <b>Table three</b>  | Table to show an overview of the three different schools of phenomenology,                                      | <b>84</b>  |
| <b>Table four</b>   | Table to show measures used to evaluate this study                                                              | <b>112</b> |
| <b>Figure three</b> | Illustration of codes to show the process of data analysis                                                      | <b>119</b> |
| <b>Table five</b>   | Table to show summary of participants                                                                           | <b>125</b> |
| <b>Figure four</b>  | Diagram to show sub-themes in ‘sexual health knowledge and attitudes’                                           | <b>126</b> |
| <b>Figure five</b>  | Diagram to show sub-themes in ‘feelings about masculinities’                                                    | <b>152</b> |
| <b>Figure six</b>   | Diagram to show sub-themes in ‘discussing STI’                                                                  | <b>192</b> |
| <b>Figure seven</b> | Diagram to show sub-themes in ‘feelings about health care’                                                      | <b>202</b> |
| <b>Figure eight</b> | Diagram to show sub-themes in ‘feelings about working’.                                                         | <b>215</b> |
| <b>Figure nine</b>  | Diagram to show sub-themes in ‘keeping fit’                                                                     | <b>219</b> |
| <b>Figure ten</b>   | Pictorial representation of issues discussed in this chapter.                                                   | <b>227</b> |
| <b>Table six</b>    | Table comparing some ideals of masculinities identified in literature with those of participants                | <b>250</b> |

## **Abstract**

This thesis examines the lived experiences of young men, addressing their sexual health using Interpretative Phenomenological Analysis (IPA).

It is known that young men do not access sexual health services in the same numbers as young women (Pearson, 2003a) and their masculinities are posited as a contributory factor to this. IPA was used to analyse data, collected using semi-structured interviews. Participants were young men, aged 16-20 years (n=7), recruited through local authority leisure centres; convenience sampling was used. Six semi-structured interviews were used as two participants were interviewed jointly. Interviews were conducted exclusively by the researcher, a young woman. The study aimed:

- To discover young men's lived experiences of addressing, or failing to address, their sexual health.
- To discover young men's experiences of negotiating masculinities, relating to their sexual health.

Young men were found to have little knowledge of sexual health and sexually transmitted infections and asserted their wishes about sex over their partners. Women were characterised as the source of sexually transmitted infections and the young men sought to 'protect' themselves from their partners. However, contraception was seen as the preserve of women, despite unplanned pregnancy being a great concern for the young men.

Young men's ideals of masculinities often did not correspond to their personal ideals; in order to preserve their masculinities, the young men explained the compromises they made. In this way, they negotiated their masculinities with themselves and society.

The study has contributed new knowledge and understanding about young men's negotiation of their masculinities when considering their sexual health. A contribution to knowledge about methodology of interviewing young men has also been made, as the researcher was a young woman who was successful in eliciting rich data about a sensitive subject from young men.

## Glossary

|                   |                                                                                                                                                                                                                                                                                                                |
|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AIDS              | Acquired Immune Deficiency Syndrome. The name given to the disease which occurs when a person, infected with HIV, starts to develop certain opportunistic infections or has particularly ineffective immune system (Adler, 1999).                                                                              |
| Chlamydia         | Bacterial sexually transmitted infection, often presenting no symptoms in women and sometimes asymptomatic in men although a mild discharge is often present. Can lead to infertility in women if left untreated and to more complicated infections if untreated for men (Adler, 1999)                         |
| Epidemic          | A widespread occurrence of an infectious disease in a community at a particular time (Pearsall, 2001)                                                                                                                                                                                                          |
| Genital Herpes    | Viral infection causing ulceration of the genitals. Outbreaks can be treated but, once infected, a person cannot ever be sure that no further outbreaks will occur, much the same as herpes which causes 'cold sores'.                                                                                         |
| Genital Warts     | Warts which develop on the genital area, caused by a virus. Warts may be present internally on a female and therefore her partner may not realise that she is infected. The warts are caused by Human Papilloma Virus (HPV) a strain of which is contributory to women developing cervical cancer.             |
| Gonorrhoea        | Bacterial sexually transmitted infection, sometimes asymptomatic in women, but men often present with pain on urination and discharge. Untreated complications may occur in both sexes (Adler, 1999).                                                                                                          |
| Hepatitis A, B, C | Viral infection which affects the liver. Categorized into different types; A, B and C are the most frequently discussed. Vaccines are available. Hepatitis A is spread through the faecal oral route; the other infections are spread through contact with bodily fluids (for example, blood, mucous, saliva). |
| HIV               | Human Immunodeficiency Virus. The infection attacks the host's immune system preventing common infections from being repelled. No cure or vaccine is available for this infection, although treatment may delay the onset of opportunistic disease (Adler, 1999).                                              |

|            |                                                                                                                                                                                                                                                                                                                                                  |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Incidence  | The rate at which new cases occur in a population, during a specified period (Coggon <i>et al.</i> , 1997). This is often given as the number of new cases followed by the size of the population and then the time period. For example, 10 new cases in a population of 1,000 in a year (10/1,000/year)                                         |
| Pandemic   | A disease epidemic occurs when there are more cases of that disease than normal. A pandemic is a worldwide epidemic of a disease (WHO, 2009).                                                                                                                                                                                                    |
| Partner    | This term is used to refer to a sexual partner not a girlfriend or any other form of relationship.                                                                                                                                                                                                                                               |
| Prevalence | Is the proportion of a population that are cases at a point in time (Coggon <i>et al.</i> , 1997). Prevalence is an unsuitable measure for acute conditions.                                                                                                                                                                                     |
| STI        | Sexually transmitted infections                                                                                                                                                                                                                                                                                                                  |
| Syphilis   | Infection which may be acquired sexually or congenitally and also sometimes through skin to skin contact with an infected person at a particular stage of the disease. Can be treated with antibiotics but, left untreated, may be the cause of serious health problems. When acquired congenitally the infection may lead to birth deformities. |

# Chapter One: Introduction and context

## 1.1 Introduction

This thesis presents a study on young men's experiences of addressing their sexual health. The aims of the study were:

- To discover young men's lived experiences of addressing, or failing to address, their sexual health.
- To discover young men's experiences of negotiating masculinities, relating to their sexual health.

Government policy has acknowledged the poor state of sexual health in England and Wales (Welsh Assembly Government Committee for Health and Social Services, 1999; Department of Health, 2001; Her Majesty's Government, 2005) but has not given an explanation. Sexual health services are not used equally by men and women (Pearson, 2003a). Although male rates of attendance at family planning clinics have risen, females still utilise these services in higher numbers, perhaps because there remains a gender imbalance in contraceptive responsibility (Ringheim, 1999)<sup>1</sup>. The only service that attracts equal attendance from both sexes is Genito-Urinary medicine (G.U.M.) and it could be suggested that this is because attendees are often symptomatic (Pearson, 2003a). It is because of this discrepancy and the importance of young men's participation, both in preventing unintended teenage pregnancy (Teenage Pregnancy Unit, 2000) and the spread of STI, that this study was undertaken.

This introductory chapter aims to put the study into context; it neither seeks to provide an exhaustive account of the history of sexuality nor does it discuss at length sociological theories relating to sexuality. First the layout of this thesis is explained, then my personal reasons for undertaking the study are given and sexual health is defined. Sexuality is discussed, followed by consideration of attitudes to sex, terminology and sexuality. Historical attitudes to 'venereal disease' and sex are considered and health care provision discussed. Important issues which illuminate historical attitudes are discussed, as these provide the

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<sup>1</sup> Pearson (2003a) notes a problem with data collection about attendees. When a heterosexual couple attend a family planning clinic, only the individual prescribed the main method of contraception is recorded; a couple attending for the oral contraceptive pill will therefore be recorded as a female attendance.

basis of attitudes today. Sex and sexuality must be understood in their historical context (Weeks, 1989) and this chapter aims to provide a little of this context. Sexual health and sexual ill health are closely related to, and are a part of, social interactions; these interactions will be discussed. Research surrounding sexual health decision making and communication will be examined in order that the outcomes of these interactions can be better understood. Finally, the position of young men in relation to sexual health and sexual health provision is discussed.

### **1:2 Layout of the thesis, and my reasons for undertaking this study.**

When I started writing my thesis my intention was to include the majority of literature and discussion with the analysis. This is in line with strategies detailed by Smith and Osborn (2003) and has been used in the presentation of both phenomenological and interpretative phenomenological research (de Visser and Smith, 2006). The layout finally decided upon is based on a suggestion by Dunleavy (2003) that has been tailored to my research and thus provides an original thesis design. Two chapters provide introductory information; chapter one includes information about sexual health and chapter two discusses the current state of sexual health in the UK and government policy relating to sexual health. Chapter three is a literature review and discussion about masculinities, as these are a factor in young men's sexual health. Chapter four discusses methodology and chapter five details the process of data analysis using IPA. Chapter six provides annotated findings and chapter seven draws together this analysis, providing discussion and conclusions. Chapters four, five and six form the core of this thesis (Dunleavy, 2003).

My interest in sexual health was generated by the lack of sexual health education I received as a school child and my inability to discuss such issues with my parents or any other adult as a teenager. Before starting my training as a nurse, I was aware that I was most interested in contraception and sexual health; I now work as a contraception and sexual health nurse. As such, I was interested in service provision and its acceptability to potential users, as well as their experiences of sexual health and sexual ill-health. I designed this study in line with recommendations for further research detailed in *The National Strategy for Sexual Health and HIV* (Department of Health, 2001)<sup>2</sup>. This strategy

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<sup>2</sup> This strategy, and its research recommendations, are discussed in section 2.3, page 43.

identifies the need to research the reasons young men do not access sexual health services; this study aims to discover the lived experiences of young men doing this.

This study focuses on what could be regarded as a taboo topic, given that sexual health services, genito-urinary medicine services and their users remain somewhat stigmatised. Undertaking research on a subject that would, earlier in my life, have been impossible to discuss, has enabled me to challenge some of these difficulties for myself and reflect on my discomfort. This study focuses on young men and young men's experiences and feelings about addressing their sexual health because this area has been highlighted as requiring research (Department of Health, 2001). Masculinities have been identified as a possible factor in these issues (Holland *et al.*, 2004); as a young woman, I will never have personal experience of masculinities and therefore am ideally placed to examine their influences. The chosen method of research allows a discovery of the experiences of young men, whilst acknowledging my exclusion from this group and my life experiences.

### **1:3 Defining sexual health**

The World Health Organisation<sup>3</sup> (WHO) states that sexual health is more than an absence of disease and defines sexual health as:

*'A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (World Health Organisation, 2002).*

In explaining sexual health in this way, The World Health Organisation closely links sexual rights with human rights, giving sexual well-being an holistic perspective. This definition has not been used in policy writing in England,

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<sup>3</sup> The World Health Organisation was formed in 1948 and is part of the United Nations (UN). It was agreed, following the Second World War that there ought to be a body responsible for directing and coordinating health. WHO counts the eradication of small pox in its achievements and is working towards the eradication of polio and better health opportunities for all. WHO has employees in many countries throughout the world and the successful eradication of small pox is evidence of their influence. The WHO is primarily funded by voluntary contributions, only 28% of their funding comes from compulsory donations from member states (World Health Organisation, 2007). Although priorities are decided by the whole council, that comprises representatives from a wide range of both developed and developing countries, funding and its sources will impact on priorities.

Wales or the USA. This may be due to its overarching nature; it is difficult to legislate to ensure that individuals' sexual rights are respected, because sexual interactions are personal and often private. Even if legislation were extant, its enforcement would be impossible.

The WHO definition of sexual health is ubiquitous (Selby, 2000; Keighley, 2002). It is comprehensive, leaving little space for expansion. The fact that the definition is provided by an overarching body, such as the WHO, may dissuade others from offering alternative definitions. This consistency provides a positive place to begin discussion about sexual health and services relating to it. It would be beneficial to promote debate about the definition of sexual health amongst health care professionals and policy writers; the discussion process may engender a greater understanding of the definition reached and better prepare professionals to provide services and policies that embrace an holistic attitude to sexual health.

The World Association for Sexual Health<sup>4</sup> (WAS) also offers discussion about sexual rights, but does not compress this to a concise definition of sexual health. An individual able to exercise these rights would be sexually healthy according to the WHO (2002) definition previously discussed. These rights are:

1. *The right to sexual freedom.*
2. *The right to sexual autonomy, sexual integrity, and safety of the sexual body.*
3. *The right to sexual privacy.*
4. *The right to sexual equity.*
5. *The right to sexual pleasure.*
6. *The right to emotional sexual expression.*
7. *The right to sexually associate freely.*
8. *The right to make free and responsible reproductive choices.*
9. *The right to sexual information based upon scientific inquiry.*
10. *The right to comprehensive sexuality education.*
11. *The right to sexual health care.* (WAS, 1999)

These rights, whilst excellent for the individual, do not mention responsibilities, namely, the need to assert rights without causing harm or distress to another person. At present, many of these rights can only be achieved by an individual's assertiveness, which may be difficult for some. For example, those with mental

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<sup>4</sup> The WAS was formed in 1978 and was initially called the World Association of Sexology. It aimed to work with associations of sexology across the world to promote sexual health for all. WAS comprises of representation from many organisations who work in sexology or sexual health.

health problems or learning disabilities and sex workers may have difficulty knowing their rights, needs and wishes and being able to assert them. Even young people may not have the negotiation skills necessary to properly assert their own rights. Young men may also find themselves in this situation, as pressures to emphasise their masculinities may make assertion of their sexual needs or desires difficult. If their sexual wishes conflict with their ideas of masculinity, it may be impossible for them to fully achieve their sexual rights. Society affects individuals' ability or willingness to express their rights by labelling people and expecting them to behave in certain ways (Hewitt, 1997). In contrast, the definition offered by the WHO (2002) emphasises the need to maintain the rights of everyone.

The greatest problems with both the WHO definition and the WAS declaration of rights are their idealism and their failure to suggest any methods or strategies for achieving these almost impossible goals. Some people do not experience sexual pleasure for physical or psychological reasons; even the provision of psychosexual counselling and physical treatment may not be able to rectify this. The WHO definition has not been used by governments in determining sexual health policy, as previously discussed. This may be because its use would highlight the inconsistency between the definition and the experience of sexual health for the majority of the population; showing the shortfalls of government policy. I believe this indicates a requirement for a definition of sexual health that can be adopted by governments for the provision of sexual health services. This definition would not be overarching, but would be achievable and would provide the best sexual health possible, encouraging people to communicate and assert their wishes, needs and rights.

Government policies and services have not addressed issues raised by the WHO definition. Policies in England and Wales have continued to focus on sexual ill health and its consequences, instead of promoting the wider issues of sexual health. This focus is understandable, as sexual ill health has considerable consequences, including the long term effects of STI and high numbers of unintended conceptions and abortions. These outcomes have economic effects that must be considered by Government. They are far reaching and include more than merely the cost of treatment, for example, lost work time, emergency admissions for acute pelvic inflammatory disease, abortions due to unplanned pregnancy and in vitro fertilisation for women

rendered infertile due to infection (Welsh Assembly Government, 2009). There are also less visible, but equally long term, consequences of poor sexual health. For example, negative attitudes to sexual ill health could affect service uptake and thus have an effect upon sexually transmitted infection (STI) occurrences.

### **1:4 Sexuality**

There are complex relationships between sexualities and society; Davenport-Hines (1990) suggests that perceptions of sexualities and sexual acts derive from the society in which they happen. Individuals view their own sexuality and those of others through the magnifying glass of society; in this way, sexualities are a social construct. Sexuality is not only part of an individual's being, but part of society's being; sexualities are not only affected by societal changes, but influenced and moulded by them. It is partly because of this that their discussion has become taboo; sexualities are feared because of their potential effect on society, and this has led to their regulation by society. The natural association between sexualities and the family, which is seen as the bedrock of society and economically an important structure (Vogel, 2003), could be seen as a reason for this.

In this thesis sexuality has been taken to mean sexual feelings and behaviour, which is based on a dictionary definition of sexuality (Pearsall, 2001). Yet the term sexuality has been used in diverse ways and this definition does not fully describe the concept. Foucault (1978) described sexuality as an historical construct and Weeks (1989) describes sexuality as created by social interactions. Davenport-Hines (1990) wrote about sex and sexuality, failing to examine them as concepts but positing that sexualities are constructed by the societies in which they exist. Ashcraft (2006) also wrote about sexuality without properly defining it as a concept, although sexuality is described as playing a central role in young people's relationships and, importantly, in their structuring of power and gender.

Epstein and Johnson (1998) and Fine (1992) also found that young people had unequal gender relations and that sexuality and gender were part of this. Without a clear understanding of the concept under consideration, discussion becomes blurred and incomprehensible. Sexuality is more than the capacity for sexual feelings; the term is also commonly used to refer to sexual preferences or identities. Averett *et al.* (2008) describe female sexuality as scripted and

state that healthy adolescent female sexuality is used to refer to either young women having no sex, or having sex in an expected manner. This description in itself suggests that 'sexuality' is referring to more than merely sexual feelings and yet a definition is never offered. A disparity between the worlds of young women's and young men's sexuality is also identified; young men are expected to have sexual feelings and express them, however, young women doing so presents a challenge (Averett *et al.*, 2008).

Moore and Rosenthal (1993) explain that sexuality can be confusing and complex. This is because of the taboo nature of sex and sexuality in our society; it has become a source of confusion, the discussion of which is censored. Perhaps the best description of the complex nature of sexuality comes from Weeks (1989: 12), who described sex as a '*supreme secret*' which underlies our being and also serves to define us; because of this, sex and sexuality become important in all areas of life, from health to social status. Sexuality, therefore, is a hidden factor in our own definition of ourselves; unless we seek explicitly to make our sexuality overt, its influence is not obvious to those around us. Therefore, the consideration of the history of sexuality, sexual health services and the discussion of sex and sexuality becomes an exploration of a subject which people have sought to obscure, perhaps discovering aspects of an individual's self definition which had not previously been identified or made explicit. This, combined with the taboo nature of sex itself, have led to the labelling of the subject of this study as 'sensitive' (Lee, 1993).

### **1:5 Terminology**

Terminology used often reveals hidden prejudices and presumptions. The term 'venereal' implies that women are at fault and confers blame, as the term was derived from the name given to a part of the female anatomy. Thus, even in discussion of infections, women were implicitly blamed. 'Sexually transmitted disease' is also a term used to refer to the same infections, but this has also been seen as stigmatizing label because of its reference to disease (Jones, 1994). 'Venereal disease' was the preferred term for referring to all infections of the genito-urinary system but is no longer used in this country; however, venereology is still the term of preference used in some places to describe what is called, in Britain, genito-urinary medicine. There have been periods of history

in which women were explicitly blamed for the transmission of STI; this was even upheld in legislation.<sup>5</sup>

The term sexually transmitted infections (STI) is used here, as it is considered the term which carries the least stigma. When referring to the periods in history in which 'venereal disease' was used I will use this term.

Even though STI is considered a term with no stigma, it continues to be a taboo subject. Since not all infections in this category are always transmitted sexually, it would perhaps be more helpful to use a term that reflected the site of the infection. Discussing the mode of transmission apportions blame or judgement about the moral behaviour of the infected individual. An example of this is candidiasis (thrush), a problem which is suffered by many women and, whilst it can be sexually transmitted, is not always; it can be caused simply by a change in flora. Hepatitis and HIV can be transmitted sexually but can also be transmitted through the sharing of needles; or trans-placentally, in the case of HIV. Labelling these infections may cause certain groups of the population to be reluctant to seek help or treatment for them.

### **1:6 Attitudes to sex**

Current attitudes to sex are varied; whilst discussion about sexual intercourse is limited, the idea of sex is used to advertise products. However, condoms are advertised infrequently and health promotion relating to sexual health is not common. Sexuality and related issues are often discussed in popular media; this discussion informs the opinions of many. Some issues surrounding sexuality have been accompanied by moral panic and outrage (Goode and Ben-Yehuda, 1994). For example, the reaction to HIV and AIDS in the 1980s and the consequent blame assigned to homosexuals (Allen, 2000; Mort, 2000), or public feelings about lone parents and teenage mothers living on government 'hand-outs' (Doughty, 2005). These issues illustrate the predominance and strength of feeling surrounding sexuality and sex in our society, and the perceived danger associated with its discussion.

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<sup>5</sup> This will be discussed in section 1:7.1, page 22.

Weeks (1989) draws parallels between the changes that have taken place economically in the last century, namely the move towards a consumer society, and social changes which have been labelled as 'permissive'. These social changes took the form of laws that focused not only on issues surrounding sexualities (for example, divorce, abortion and de-criminalising homosexuality), but also other issues which are considered moral debates (suicide and gambling). The discussion of these issues, which involved consideration of the nature of morality and how it ought to be regulated, was emotive; those encouraging change were labelled permissive. This is evidence of the complex nature of the discussion of sexualities within society but also of the important role they play; if they were insignificant they would not evoke discussion.

People's attitudes to sexual practices are highly individual and yet norms regarding practices throughout history are discernable, with attitudes to, and the importance of, sexuality varying greatly (Weeks, 1986). Sexuality and attitudes to it have always been complex, it would be misleading to suggest, as Moore and Rosenthal (1993) do, that the past was sexually simpler. Despite common attitudes, there have also been people who do not conform to society's norms, who have been labelled 'deviants'; societal status has influenced what was considered acceptable or normal behaviour. All of these factors give sexuality a complex history.

Moore and Rosenthal (1993) refer to an accepted historical double standard, girls were expected to be virtuous and chaste until their marriage and then become housewives and mothers; boys could sow wild oats and marry later. Although these attitudes are historically present, it would be simplistic to suggest that they were the only attitudes in the past, or that these attitudes do not currently occur. Consider common slang and name calling. A young woman who is perceived to have had sex with many men may be referred to as a 'slag' or a 'slapper'; a young man in a similar situation may advertise this fact and thus be 'a bit of a lad' or a 'stud'. These perceptions relate closely to the double standard discussed by Moore and Rosenthal (1993).

Sexuality and sex have been described as social constructions (Weeks, 1986; Weeks, 1989; Moore and Rosenthal, 1993). That is, their nature is not biological but dependent on society's determination of what is and is not acceptable (Searle, 1995). The expression of sexuality and terminology relating to sex has

therefore changed. An examination of these changes sheds light on current attitudes and behaviours.

Weeks (1986) describes the evolution of terminology relating to sex and gender; in the sixteenth century, sex predominantly referred to the differentiation of male and female, but its current dominant meaning is the act of sex. Weeks (1986) posits that this shows a change in the nature and understanding of sexuality. 'Sex' may now be used to refer to many things; it is used to categorize people (possessors of male or female genitalia) and is also used to describe behaviour (Weeks, 2010).

### ***1:7 Historical attitudes to 'venereal disease' and sex***

Different interpretations mean that we cannot generalise about the history of attitudes to sexuality and STI. To do so would be to ignore the diverse opinions of society both now and historically and would over simplify the issues involved. Because attitudes to some aspects of sexuality change, it cannot be assumed that all attitudes have altered. Understanding this allows an appreciation of the differing attitudes within a population and to aspects of sexuality. It can be seen that disease has historically been associated with blame and this attitude has been conveyed to the present. Sufferers of AIDS and HIV have been treated with similar contempt by society, suggesting that blame continues to be associated with certain diseases (Davenport-Hines, 1990; Allen, 2000; Gill, 2006).

The moral panic associated with the discovery of the HIV virus was by no means unprecedented. Blame placed on certain 'at risk groups' revealed society's attitudes to these groups and the nature of their behaviour. For example, those who contracted HIV through sharing needles would not have done so had they avoided drug taking. As drug taking is perceived to be morally bad, so those who contracted HIV in this way could only blame themselves; their immoral behaviour was the cause of their infection. This idea that morality is absolute and immoral behaviour will, of necessity, result in negative outcomes appears severe, but it is prevalent (Goode and Ben-Yehuda, 1994).

Blame was apportioned to sufferers of syphilis when outbreaks first began in Europe. Sufferers were identifiable both by its symptoms and by the side effects

of its treatment, mercury, (Evans, 1994; Hall, 1998; Pelling and Harrison, 2001) and were often ostracised (Oriol, 1994). Even hospitals shunned patients suffering from the 'pox'. It could be assumed that this was due to fear of the spread of infection but the same hospitals admitted sufferers of the plague (Allen, 2000). So perhaps this revulsion was due to the belief that sufferers had brought the infection on themselves. Thomas (1971) explains that in the seventeenth century illness and disease were seen as punishment for immorality or sin and, as such, were deserved. This being so, the remedy for physical ailments was prayer and repentance, and physicians were sometimes seen as ungodly as they relied on physical cures and not on divine intervention (Thomas, 1971). The clergy reinforced this idea by blaming immoral behaviour or people for misfortunes of the whole community (Thomas, 1971).

Attitudes to illegitimate pregnancy, a consequence of sex outside marriage, also illustrate moralising attitudes of society. In order to obtain charity and care for her illegitimate child at the foundling hospital in eighteenth century London, a woman had to evidence that she had been abandoned by the father of the child and had been '*of good repute before her fall*' (Hibbert, 1987: 396). She had to have been seduced, illustrating her lack of immoral behaviour and her sexual passivity (Evans, 2005).

### **1:7.1 The Contagious Diseases Acts. 1864-1869**

These Acts have been chosen for consideration as they promoted much controversy and are evidence of government intervention in the sphere of sexuality. A Royal Commission, formed to investigate the health of the army following the Crimean War, found that 'venereal disease' was a problem (Hall, 2000; London Metropolitan University, 2006).

The first Contagious Diseases Act (1864) sought to control prostitutes in garrison towns; subsequent Acts (1866 and 1869) extended the geographical areas covered by the original provisions. These Acts worked by allowing the forcible examination of prostitutes to ensure that they were not infected with a 'venereal disease'; implicit in this is the thought that women were responsible for the spread of these infections. It was considered inappropriate to request members of the Army or Navy to submit to compulsory examination, as this would be detrimental to their self esteem and would be embarrassing (Mort,

2000). Police personnel and doctors were required to inform a justice of the peace of any woman they suspected to be a prostitute. The woman could then be forcibly examined and taken to a hospital where she might be detained for as long as three months. During this time, moral and religious education was given, presumably to encourage women to abandon prostitution. If a woman disobeyed hospital rules, or left before being medically discharged, she could be imprisoned for up to two months as a penalty (Mort, 2000). Even after discharge from initial detention, women could be regularly inspected to ensure they had not developed symptoms of 'venereal disease'. This must have been embarrassing for women and had social repercussions.

When apprehended, women were expected to sign a paper consenting to examination; this counted as an admission of prostitution and thus the women were morally tainted (Hibbert, 1987). If the woman refused to sign and thus admit her prostitution she could be detained until she did. This act provoked people to accuse women of prostitution so that their reputations might be permanently damaged. Once accused, there was little that a woman could do to dissociate herself from a crime that was described by contemporaries as 'the social evil' (Weeks, 1989). Prostitutes during the nineteenth century were thought to be the source of STI that were believed to originate inside them as punishment for their sexual promiscuity (Hall, 1998). It is important to note that the men using the prostitutes were not considered equally culpable (Hall, 1998). Weeks (1989) also points out the unfairness of the Acts and the double standard they upheld.

Mort (2000) discusses the social ideas behind the introduction of these Acts. The Acts were justified by comparing the detention of women with 'venereal disease' to government intervention in cases of small pox or typhus. This is referred to as the sanitary principle, used to justify more medical and moral involvement in regulating 'venereal diseases'.

There was opposition to the Contagious Diseases Acts (Hibbert, 1987 ; London Metropolitan University, 2006). This came from early feminists, such as Josephine Butler. Weeks (1989) described radicalism as working men rising up against the exploitation of working class women. The other important factor was the non-conformist Christian revival that was against the double standard and promoted chastity and social purity for both sexes (Mort, 2000).

The Contagious Diseases Acts were detrimental for women and their repeal could be attributed, in part, to feminism. The Acts were suspended in 1883 and finally repealed in 1886, although other measures remained to control prostitution to some extent. Weeks (1989) argues that this Act clearly differentiated boundaries between acceptable and unacceptable behaviour, creating an underclass of prostitutes.

### **1:7.2 The origins of family planning**

Family planning or birth control services were originally linked to the perceived need to check the increase in population and encourage working class people to have fewer children. Linked to Malthusian<sup>6</sup> ideas and eugenics<sup>7</sup>, concern was raised about the fitness of the population, especially the large numbers who were found to be unfit for service in the Boer War (Weeks, 1989). The concern was that the working classes had many more children than the upper classes and this would lead to the majority of the population being unserviceable citizens (Hall, 2000). Britain, at this time, was a strong imperial power with an empire stretching across the globe; if the population in Britain was really deteriorating then its status as an imperial power would be threatened.

Weeks (1989) discusses two schools of thought that suggested some solution to the problem, the first was maternalism – that women's primary role was as a mother and the improvement of mothering skills would lead to the improvement of the population as a whole. The Government also began to legislate to improve the health of children, for example, with provision of free school meals for those who needed them. The second set of ideas seeking to improve the human race was eugenics; this had been founded on the ideas Darwin and Galton and was widely discussed. Eugenics suggested that the human race needed to be improved, social reform alone could not achieve this. Eugenicists believed that the right people should be encouraged to reproduce in order to eliminate the biologically feeble and to improve the condition of the race as a

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<sup>6</sup> Malthus wrote about natural limitations of population growth and also suggested that moral restraint could be exercised in order to check population growth (1971: 271).

<sup>7</sup> There was increasingly concern that, although the population was increasing, the wrong sort of people were procreating, leading to a deterioration in the British race. It was thought that limiting the growth of the lower classes could control this (Hall, 1997; Rose, 1997). It is possible that this concern is currently evident; moralising about teenage parents and people unable to care for the children they produce displays similar feelings about eugenics. (although this would prove a controversial argument given the association of the word eugenics with the Nazi movement in Germany during the 1930s).

whole. The ideas of eugenics did not continue to be put forward forcefully after the First World War, although Marie Stopes was a eugenicist and her ideas can be seen in her approach to birth control.

Recognising the public demand for birth control and feeling there was a need herself, Marie Stopes opened the first clinic in London in 1921 (Berridge *et al.*, 2001). Without access to family planning, the maternal death rate had been high; women died in self induced abortions or were left to care for large families in poverty (Berridge *et al.*, 2001). Hall (1997) explains that people had trouble obtaining family planning advice; doctors were reluctant to discuss the subject and in some cases advised a couple to refrain from having any further children for the sake of the women's health, but failed to offer any advice about how this could be achieved. Weeks (1989) suggests that there are two reasons for providing birth control, individual freedom and social control, as was suggested necessary by eugenicists.

### **1:7.3 Prevention of 'venereal disease'**

Whilst examination of prostitutes in Britain was discontinued with the repeal of the Contagious Diseases Acts, prostitutes in areas where the Army was stationed abroad continued to be inspected. There was also a concerted effort to educate soldiers about personal hygiene, although it does not seem likely that detailed education was given about the spread of STI or preventative measures. Abstinence rather than prophylactic measures was seen as morally preferable, it was thought that the provision of prophylaxis might encourage immorality (Weeks, 1989). There was disparity between the treatment of soldiers and garrisons and the treatment of the remainder of the population.

In 1916 the final report of the Royal Commission on Venereal Diseases was given. Chaired by Lord Sydenham, this Commission had been started in 1913, but its importance had increased because of the increasing rates of 'venereal disease' amongst soldiers. The Commission revealed a high incidence of 'venereal disease'<sup>8</sup> and concluded that services should be provided free of charge to the whole population, under conditions that would not dissuade those who needed to from attending. Weeks (1989) argues that this also assuaged

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<sup>8</sup> Weeks (1989) considers their figures to have been overestimated.

the problem of encouraging immorality, providing free treatment would not encourage immoral behaviour in the same manner that prophylaxis might.

Providing a service acceptable to potential patients in order that they might attend is an idea ahead of its time. Compared to the harsh treatment of women occasioned by the Contagious Diseases Acts, progress appears great. It is possible that this relaxing of moral guidelines is not evidence of concern over the spread of 'venereal disease' but anxiety about the outcome of the First World War, as 'venereal disease' was seen as a potential obstacle to victory for Britain and her Allies.

### ***1:8 Health care provision***

The treatment of STI has developed in line with the development of other health care provision. The welfare state was not established in Britain until 1948 (Berridge, 2001). Before that time, health care provision was variable and could be divided into two distinct areas, charitable care for those who could not pay and other health care which required payment.

In Britain at present, sexual health services are available through the National Health Service (NHS). There is discussion about whether these services are appropriate or adequate, but there is consensus that the NHS should provide them (Department of Health, 2001; BBC, 2005). Genito-urinary medicine provides sexual health screens and medication for STI, condoms and counselling. Contraception and sexual health clinics provide contraception, condoms and some sexual health screens. Some of these services are also available from a General Practitioner, although this depends on the practice. Access to contraception and STI treatment is free in Britain; meaning that cost does not have to be a deciding factor in sexual practice. There are many other factors that may affect an individual's willingness or ability to access sexual health services, such as knowledge of services and how to access them, language, transport and privacy. Sexual health services are often provided at irregular times and buildings that host contraception and sexual health clinics are often not well marked, making access difficult for many.

### **1:9 Social interaction**

Discussion and consideration given to sexual interactions and their negotiation is important as relationships both affect and are affected by these interactions (Searle, 1995).

The changing status of women and sex in society has complicated the negotiation of sex. For example, in Victorian society a double standard existed, men were expected to enjoy sex, marry late and have sexual experience before their marriage. Women, certainly those of middle and upper classes, were expected to remain virgins until their marriage and certainly not expected to enjoy sex (Allen, 2000). Heath and Grigg (2002) explain this as a self fulfilling prophesy; pleasure for women was never sought and thus not achieved. The negotiation of enjoyable and equitable sexual interaction was not an issue in most circumstances. It could be argued that this led to sexual interaction being less complicated – pleasure is for a man and a woman does her duty not only in the bedroom but also elsewhere in her marriage. This could be equated with the status of women in society who were considered second class citizens and were not allowed to vote or own property (female suffrage was achieved to all women in Britain only from 1928). Women did not have the same rights to divorce as men until the Matrimonial causes Act (1923).

Modern expectations of sex are different; the change in attitudes and expectation has been described as a sexual revolution by several authors (Weeks, 1985; Heath, 2002) and was precipitated by changing social attitudes. The introduction of the contraceptive pill in Britain in 1961 is given as a reason for this change (Heath, 2002), but even without this development, the changing place of women in society and the workforce had begun a shift in attitudes.

The introduction of the Abortion Act in 1967 brought some change despite the fact that unsafe, illegal or 'backstreet abortions' had been available in the UK previously. The Abortion Act made abortion safer, easier to access and removed the need to pay. Adoption has always been available, but this does not allow women the same freedom as abortion, since illegitimate pregnancy remained socially unacceptable (Weeks, 1989). The combination of the availability of the contraceptive pill and the option to have an abortion if an unintended pregnancy did occur allowed women more sexual freedom and

changed their position in sexual encounters. Women could have more control over whether to become pregnant or to continue a pregnancy.

It must be noted that women needed to be able to access abortion. It is difficult to tell how easy this was, but abortion rates per 1,000 women have increased seven fold since 1968 (Office for National Statistics, 2007). It is possible to assume, therefore, that fewer women chose abortion when the Abortion Act was first passed. It is also important to note that, whilst women had a lot more choice about continuation of pregnancies, they did not always have choices about whether they want to have sex; rape in marriage was not a crime until 1994 and power balance in relationships sometimes means that women cannot assert their wishes not to have sex<sup>9</sup>.

This is not to say that the negotiation of contraception and pregnancy became easier for women, merely that they were, at least, presented with additional options and decisions to make. It is worth considering that contraception had been available to married women since at least 1921, when Marie Stopes opened her first clinic (Rose, 1993), providing contraception in the form of caps and diaphragms. These forms of contraception were not as easy to use, nor as independent of the male sexual partner, as the pill. This did not effect the same change in sexual attitudes as the pill and Abortion Act did, lending weight to the idea that the pill merely catalysed social changes that were already taking place.

The interaction between women and men regarding sex remains an issue even though options and control are available to both men and women. This suggests that the ability to negotiate for one's own desires in a sexual encounter is related to gender. Interactions and power in sexual relationships could also be related to other factors such as mental health or learning disability, poverty and age. Young people's attitudes have been investigated regarding safer sex and the transmission of AIDS (Holland *et al.*, 1991). The project sought to investigate the attitudes and practices of young people and their negotiation of safer sex, and used two groups from inner city areas, one from Manchester and one from London. Young women from both cities took part (n=148) but only forty-six young men participated. It is possible that attitudes, knowledge and

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<sup>9</sup> One of the findings of this study is that the participants (young men) created a discourse of dominance over women. Sex was viewed as a male centric activity and women's wishes were not given a place in the conversation of the young men. This finding is summarised in section 7:1.5.ii, page 252.

behaviour at this time would have been different in rural areas or small towns; this may remain the case now.

Some of the young women involved illustrated the difference between knowledge of sexual empowerment and desire for this, and actually being empowered. The line between the two was fine and some of the young women spoke of their frustration about not being empowered in a sexual situation. For example, one woman felt herself to be empowered and assertive, she sought pleasurable sexual experiences and spoke in a derogatory manner about young men who had not considered her pleasure important. This young woman had taken control of contraception by taking the pill but continued to find the negotiation of condom use impossible. She had been in a relationship for a number of weeks with a man whom she knew to be an injecting drug user, sharing needles, and felt annoyed that he refused to use condoms when they had sex. Her boyfriend told her that he did not like them and despite her desire for sexual empowerment she did not feel able to discuss the issue further, she felt that this would question trust and fidelity in the relationship (Holland *et al.*, 1991).

The lack of empowerment for women has continued to be a problem. Preventing the transmission of HIV in penetrative sex involves condom use and even if this is to be a female condom the male partner has to cooperate. Because of the difficulty this poses for many women worldwide, the use of some microbicides has been tried in order to prevent the spread of HIV in situations where women cannot ask or expect their male partner's cooperation (World Health Organisation, 2002). It is a potential problem for sex workers but is a great problem for women whose male partners use prostitutes, have sex with other women or men outside the relationship or engage in any form of risky behaviour.

Holland *et al.* (2004) describe the dominance of male sexuality and the importance of men's needs in a sexual encounter. This makes sexual empowerment difficult for a young woman to achieve. The perception of sex involving penetration and then orgasm for the man excludes the woman's pleasure from the experience. It is not only men who perceive sex in this way. Holland *et al.* (2004) described young women's feelings of duty to continue to have penetrative sex, when she became aware that a man had become

aroused. This idea, although common, negates a woman's right to refuse intercourse and gives men power. In order to gain power, young women reported choosing to have sex with younger men, as this made them the more experienced and possibly more dominant partner. Only one young woman described empowerment by describing safer sex as not necessarily involving penetration; she felt that both partners could get as much enjoyment and satisfaction from this.

The power differential between men and women was also described by Kelly *et al.* (2004) who found that Roma gypsy men had great sexual freedom before and during marriage but women were expected to remain virgins until marriage and subsequently remain faithful to their husbands. This study was undertaken in Bulgaria and Hungary and included Roma men (n=22) and Roma women (n=20). These authors describe an ethnographic method of sampling, a researcher attended places frequented by potential participants and watched in order that a sampling plan could be generated that would include a cross section of the community. The sample was purposive in order that it included participants of diverse ages but partners of those chosen were not purposely sought. Interviewing the sexual partners of those included might have led to interesting comparisons.

Communicating about contraception and prevention of STI is also an important factor in decision making. Communicating about condoms can pose particular problems as suggesting the use of a condom might be perceived as implying that a partner is likely to have STI. Coleman and Ingham (1999) undertook research with young people to discover their feelings about discussing condom use. The young people were concerned about initiating discussion about condoms as they felt this would suggest their partners were 'dirty', previously promiscuous or likely to be unfaithful in a relationship. Paradoxically, when the young people were asked how they would respond to a discussion about condoms being initiated by their partners they reacted positively.

It is possible that participants responded to this hypothetical situation with a socially desirable response (Kreuter *et al.*, 2008); perhaps their actual behaviour would not be as they described. There were 56 participants in the study and all were aged between 16 and 19 years. Participants were interviewed and thus responses given were more likely to be socially desirable than if a self reported

questionnaire had been used (Kreuter *et al.*, 2008). The study was undertaken in a small geographical area and this may have had an impact on the results. Teaching in schools with the same local education authority may have followed similar syllabuses and this may have led to many young people in the area having knowledge of STI and their prevention.

It would be interesting to discover if young people in a different geographical area would have the same personal positive attitudes to the introduction of a discussion of condoms use with a new partner. The young people in Coleman and Ingham's (1999) study were recruited in family planning clinics, youth groups and youth advisory centres. This might have yielded young people with better than average knowledge of STI and contraception and thus more positive attitudes to condom use. Schroder *et al.* (2009) used self reporting questionnaires and found that 'safer sex negotiations' had more of an effect on condom use than mood or alcohol consumption. This implies that young people with positive attitudes to condoms and their negotiation would use them, whether or not they had consumed alcohol.

### **1:10 Young men's sexual health**

Men have a role to play in the sexual health of both themselves and their partners. Traditionally, contraception has been seen as a woman's responsibility, perhaps because it is women who become pregnant. This causes a problem when considering the dominant role of young men in sexual encounters described by young women (Holland *et al.*, 1991). This dominance is related to accepted ideals of masculinities and femininities; assertiveness or aggressiveness does not fit with traditional ideals of femininities (Silva, 2008). Assertiveness and toughness is part of many men's ideals of masculinity (Pleck *et al.*, 1993; Holland *et al.*, 1993 ; Beynon, 2002; Haywood and Mac an Ghail, 2003); in asserting themselves sexually young men are asserting their masculinity and emphasising their status as 'proper men'. This could leave the negotiation of safer sex with the woman, but without allowing her power to negotiate and assert her wishes.

Contraception and sexual health have an effect on men as well as women; therefore, by allowing women to take control of contraception, young men are relinquishing control over an area of their lives which could have important

consequences. Historically, sex often led to pregnancies which could be detrimental to women's health as well as to the health of the children. Family planning clinics were provided by Marie Stopes as early as 1921 to provide contraception for married women (Rose, 1993). Stopes' ideas about sex and contraception met with opposition from the church. This is partly because the church viewed sex as solely for procreative purposes, contraception removing this purpose made sex sinful (Allen, 2000). These attitudes to contraception made it difficult for contraceptive services to be provided. Men were not included in Stopes' provision of contraception and the clinics were intended for women, but Stopes also dispensed written advice about sex which was sometimes provided to men (Rose, 1993).

Currently, men do not access sexual health services in the same numbers as women (Pearson, 2003a). Pearson (2003) conducted focus groups in order to discover whether young men needed sexual health services and what could be done to encourage them to use services. Young men (n=75) aged 13-21 took part in one of nine focus groups across the UK. It was found that young men felt that being open with groups of their friends about sexual health and problems relating to it was difficult for them; it was posited that this was due to feelings about masculinities. Young men also thought that services were designed and provided for women and that women were better able to take precautions sexually (Pearson, 2003b). However, because focus groups were used it is possible that the young men involved were limited in their disclosures and discussion because of their need to preserve their masculinities in front of their peers.

Masculinity and the pressure to behave in a proscribed manner can negatively affect young men (Barker, 2000; Holland *et al.*, 2004; Hyde *et al.*, 2005; de Visser and Smith, 2006). For example, a young man who wishes to give equal weight to the desires of his partner may experience psychological distress because this conflicts with his ideal of masculinity and implies that he is not a 'proper man'. Whilst the interaction between men and women in a sexual situation may be either controlled or heavily influenced by the desires and wishes of the man, his desires are, themselves, influenced by society's expectations of him and his ideas about masculinity (Haywood and Mac an Ghail, 2003). The dominance of men over women creates problems for men as well as women. Men are perceived both as having constructed a social system

that leads to their dominance and propagating this system to maintain power over women. Men can be controlled by this system as much as women can (Middleton, 1989; Haywood and Mac an Ghail, 2003). It is not the case that men should be perceived as victims of the social construction of masculinity and therefore not responsible for their actions, but there is pressure on men to conform to ideals and behaviour patterns.

Holland *et al.* (2004) describe 'the bastard syndrome', that is, thinking of a woman as an object to be conquered and not of her as a person. This technique was adopted by young men to enable them to negotiate sexual interaction with young women, as a method to lose virginity or a technique to decrease vulnerability. When loss of virginity was concerned, the rite of passage was important for the young man rather than the experience itself, the woman, or his feelings for her. Some young men described having been hurt or humiliated by women who terminated relationships with them, their adoption of these attitudes was to prevent further damage to themselves. The young men in the study described having sex with little feeling for the woman, penetrative sex being the important goal. This study was discussed earlier and involved fewer men (n=46) than women (n=148) which may have led to a failure to gain as full a picture of young men's attitudes.

To assume that all young men adopted these attitudes would be negatively stereotyping many. Not all the men involved in the study adopted this behaviour and it is always wrong to generalise from a small sample. It is clear that the young men assumed behaviours that were categorised as 'the bastard syndrome' to protect themselves or maintain their status.

### **1:11 Conclusions**

This chapter has discussed the context and background to this study, beginning with my reasons for undertaking it. This was done to explain my motivations and the reason for choosing to undertake research with young men.

The World Health Organisation has given an ubiquitous and overarching definition of sexual health; it is holistic making it difficult to legislate so that sexual health can be maintained. Maintaining sexual health, according to the WHO definition, would require individuals to assert their rights and wishes in

private interactions. Yet attitudes to sexual behaviour are not always positive and non-judgemental. The roots of these opinions can be found in history; terminology reflects attitudes to sexual behaviour and has changed as attitudes adjust. This chapter included reference to historic attitudes to illustrate these changes.

Understanding health care provision is essential when considering particular groups and their ability to access services. In order to understand young men and their sexual health I have discussed sexual health care provision as it is now. The NHS is a product of its history, it can be difficult to navigate around and services are not always easy to access. Sexual health services, especially, are provided at unusual times of day (to make access possible for those who work), in buildings and rooms borrowed from other services. It would not be uncommon to attend a Contraception and Sexual Health clinic held in the same rooms that held a baby clinic a few hours before; posters on the wall are often predominantly about breast feeding, weaning and childhood development. This lack of pertinent health promotion material is indicative of attitudes to sexual health. Information about current service provision was given so that young men's access of services could be explained. Young men's sexual health was discussed separately.

Social interaction was discussed in this chapter because it forms an important part of sexual interaction. The next chapter discusses sexual health in the United Kingdom and government policy.

## **Chapter Two: Sexual health and Government policy**

Government policy can have an effect on the spread of STI and sexual health. Although individuals' behaviour is not controlled by government; education and large scale media campaigns are. In this way governments can affect attitudes and opinions and influence behaviour. In the U.K. sexual health services are provided by the NHS, giving the government some control over service provision.

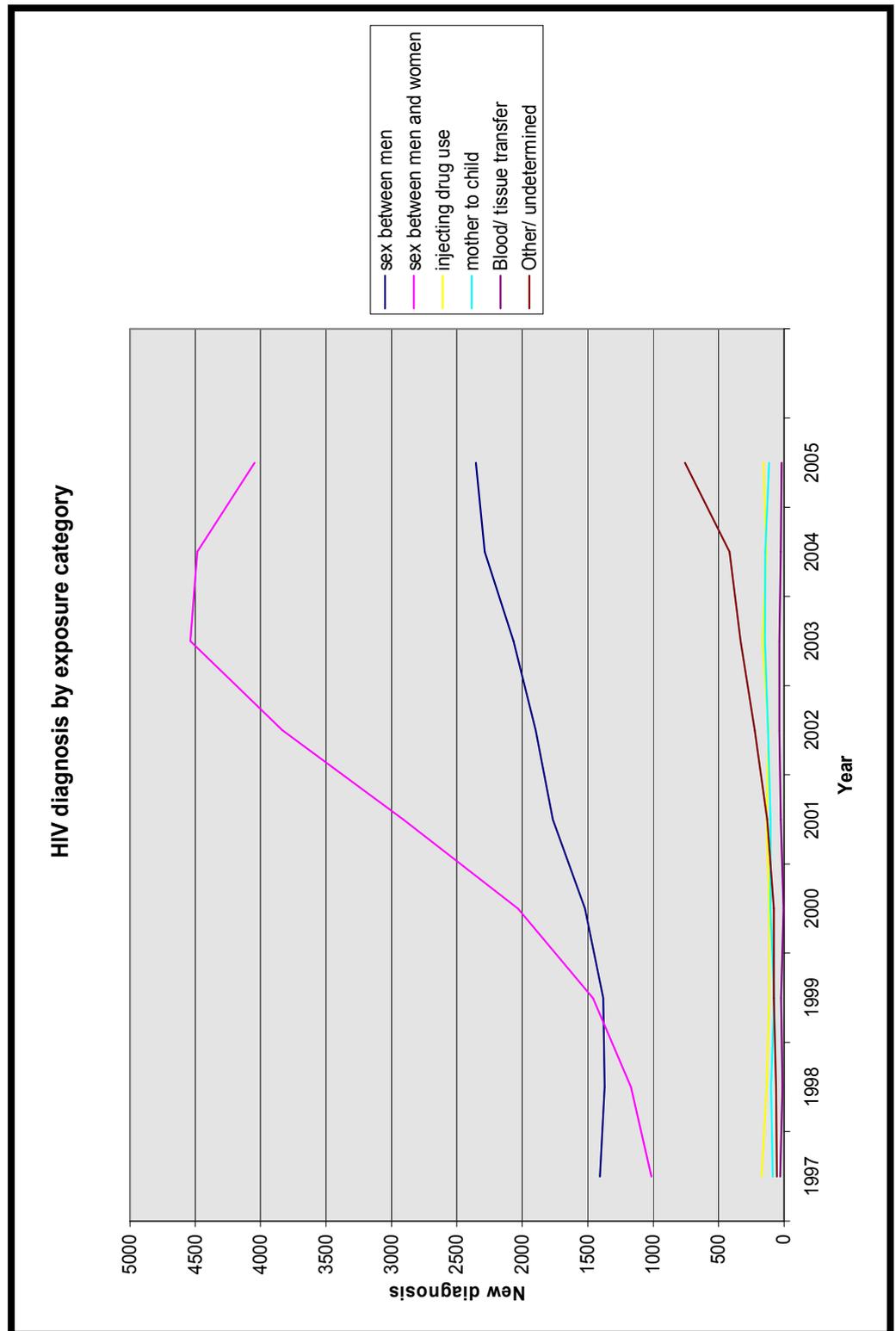
This chapter briefly discusses sexual health in the U.K. and also refers specifically to Wales as this is where this study took place.

### ***2:1 Sexual health in the UK (England, Wales, Scotland, Northern Ireland)***

The prevalence of HIV has continued to rise in the United Kingdom along with increased rates of other STI (Health Protection Agency, 2006). The annual number of new diagnoses has increased from 2,707 in 1996 to 7,450 new diagnoses in 2005 (Health Protection Agency, 2006) although numbers are now stabilising (Health Protection Agency, 2006). Levels of HIV diagnosis amongst men who have sex with men (MSM) have risen steadily in the UK. Rates of heterosexually acquired HIV have increased greatly, although there has been a drop in diagnoses recently. It is thought that the majority of those diagnosed with HIV from heterosexual contact obtained their infection outside the UK, predominantly in Africa (Health Protection Agency, 2006).

Figure one shows that, whilst in 1997 the primary route of transmission of HIV was between men who had sex with men, sex between men and women is now the primary transmission route. Injecting drug use and mother to child transmission represent a comparatively small number of new diagnoses. The number of new diagnoses with an undetermined or other cause is also rising.

Figure one: HIV diagnosis by exposure category



Data from Health Protection Agency (2006)

Table one shows there has been an overall increase in the number of new HIV diagnoses in the UK since 1997; new diagnoses from 2003 to 2005 have been relatively stable. Despite this overall increase, AIDS diagnoses have dropped since 2003. This may be due to the increased efficacy of anti-retroviral treatment that can delay onset of AIDS.

**Table one: Table to show new HIV diagnosis, AIDS diagnosis and AIDS deaths in the United Kingdom 1996 (and earlier) – 2005 (Health Protection Agency, 2006)**

| <b>Year</b>             | <b>HIV Diagnosis</b> | <b>AIDS Diagnosis</b> | <b>Deaths</b> |
|-------------------------|----------------------|-----------------------|---------------|
| <b>1996 and earlier</b> | 32,819               | 14,615                | 12,093        |
| <b>1997</b>             | 2756                 | 1079                  | 749           |
| <b>1998</b>             | 2842                 | 794                   | 514           |
| <b>1999</b>             | 3137                 | 759                   | 472           |
| <b>2000</b>             | 3871                 | 832                   | 484           |
| <b>2001</b>             | 5064                 | 735                   | 477           |
| <b>2002</b>             | 6224                 | 884                   | 520           |
| <b>2003</b>             | 7283                 | 922                   | 570           |
| <b>2004</b>             | 7492                 | 854                   | 490           |
| <b>2005</b>             | 7450                 | 730                   | 503           |
| <b>Total</b>            | 78,938               | 22,204                | 16,872        |

Many STI are asymptomatic; It is difficult to know their prevalence in a population as many infected people will not be tested or receive any treatment. Rates of diagnosis of chlamydia have risen since 1996. In 2005 rates were highest in women aged 16-19 and men aged 20-24. The increase in diagnosis may be due, in part, to increased awareness of the risks of unprotected sexual activity and increased attendance at Genito-urinary medicine (G.U.M.) clinics for screening. The *National Strategy for Sexual Health and HIV* (Department of Health, 2001) suggested that awareness and knowledge of young people should be increased. It is impossible to know if increased attendance is the cause of increased diagnoses as information on health screens at G.U.M. clinics was not kept prior to 2002. Over the counter tests for chlamydia are also available at some pharmacies and a positive result may cause a person to attend a G.U.M. clinic for treatment. England also has a chlamydia screening programme that may identify the infection in people who would not otherwise have been

diagnosed (Department of Health, 2007). A screening programme has not been introduced in Wales.

There has been an overall decline in diagnosis of gonorrhoea, between 2002 and 2005. The number of men diagnosed was double the number of women diagnosed with the infection. This could be because men are more likely to have symptoms of infection. Incidence in men who have sex with men (MSM) has risen (Health Protection Agency, 2006). It is difficult to know why this might be, it could be because MSM are better informed than they previously were and therefore are attending for testing. This would have implications for other STI rates that do not show symptoms for example, HIV and hepatitis B and C.

The Health Protection Agency report, *A Complex Picture* (2006), describes the sexual ill health of the population of the United Kingdom. This report recognises the increase in incidence of STI since 1996 and identifies groups within the population who require specific interventions in order to improve their sexual health. The groups identified are men who have sex with men, black and minority ethnic populations, pregnant women, young people and injecting drug users. No recommendations are given about the type of intervention or service that would be suitable to address the sexual health of these groups. The Health Protection Agency report *Sexually Transmitted Infections in Young People in the United Kingdom* (2008) found that young people (aged 16-24) remained the group most likely to be diagnosed with an STI.

Some infections are rarely seen outside particular groups in the population, for example, in the UK Lymphogranuloma venereum (LGV) is predominantly seen in MSM although it is endemic in the population in other areas of the world (Africa, Asia and South America) (Health Protection Agency, 2006). Most of the MSM diagnosed with LGV had concurrent HIV infection; there were 344 cases of LGV within the UK before 2006 (Health Protection Agency, 2006).

In the UK general population there are high rates of genital chlamydia, herpes and warts in addition to the continued increase in prevalence of HIV (Health Protection Agency, 2006; Health Protection Agency, 2007).

Figure Two: New incidences (diagnoses) of various sexually transmitted infections 2000-2004 (Office for National Statistics 2006)

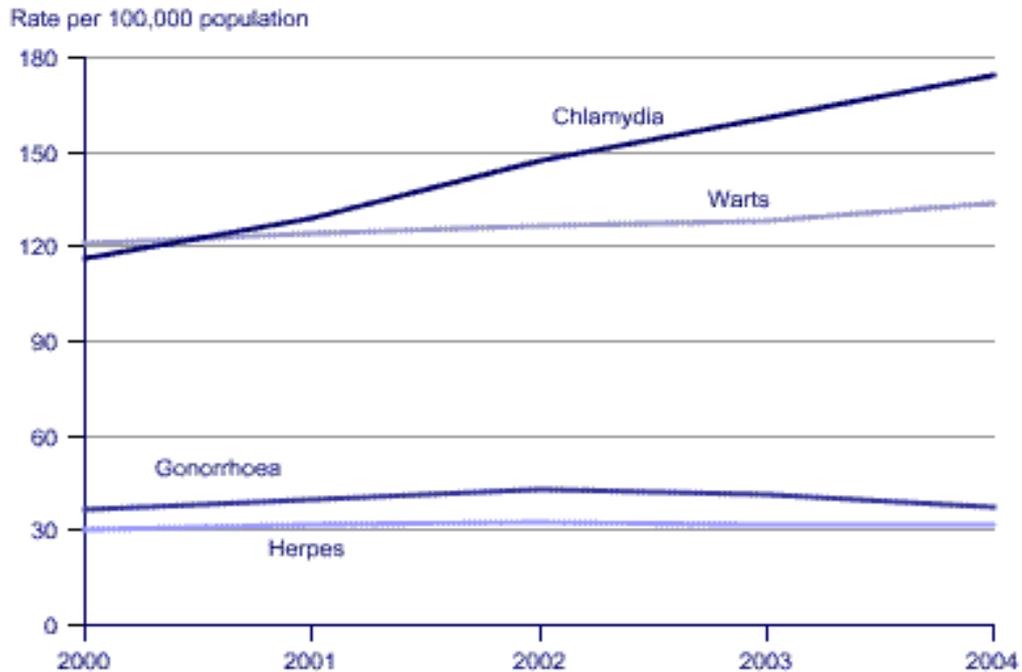


Figure two shows that the rates of chlamydia and warts have risen since 2000 in the UK; gonorrhoea and herpes rates have remained stable. It is possible that this difference is partly due to the symptoms shown by the infections: men often have symptoms of gonorrhoea and those infected usually have symptoms of herpes. Chlamydia often does not have any symptoms, meaning sufferers are unaware and therefore the infection is not treated. It is possible that the rising incidence of chlamydia shown has been caused by rising knowledge of the infection. This graph shows data regarding diagnoses of infections. Actual incidence in the population is higher than this, as many people may have infections such as chlamydia and be unaware.

### 2:1.1 Socio-economic class

Links have been made between socio-economic class and health outcomes (Black, 1992; Whitehead, 1992). Those in manual employment and their families experience worse health and lower life expectancy than those in professional occupations. Those in manual employment are less likely to access health care services; services provided to those with a lower income are often not equal to services provided for others (Whitehead, 1992). It has also

been suggested that there is a positive correlation between social background and sexual health outcomes. For example, those from a disadvantaged socio-economic background are more likely to become teenage parents (Botting *et al.*, 1998; Teenage Pregnancy Unit, 2004). Data about socio-economic background is not recorded in abortion statistics (Department of Health, 2007) and therefore links between socio-economic class, teenage abortion and teenage pregnancy cannot be drawn. Data about the socio-economic class of participants in this study was not recorded. Although they were asked about their occupation and the occupation of their parents they did not always answer directly.<sup>10</sup>

Whilst national information is not available to link incidence of STI with social class, some smaller studies have linked inconsistent condom use with employment status (Hope and MacArthur, 1998). This study was quantitative and found that men in manual employment were less likely than those from social class I and II (professional classes) to use condoms consistently. Although the sample size was 858, results are not generalisable to the whole population as men were recruited in 'gay' venues with the intention of accessing men who identified as homosexual. The study was undertaken in the West Midlands, so that the sample could include respondents from both rural and urban areas. Hope and MacArthur (1998) admit that sub-cultures and regional variations could mask the effects of class on safer sex practices. More generalisable results would be generated by recruiting a more heterogeneous sample from across the UK.

Conversely, Evans *et al.* (1997) found that men employed in non-manual jobs were less likely to use condoms regularly and more likely to have many partners. Participants for this study were accessed at a G.U.M. clinic, which biases the results. It is possible that the non-manually employed heterosexual men had attended the clinic because they were aware of their increased risk of contracting STI and wanted screening. Questionnaires were given to heterosexual men who attended a G.U.M. clinic (n=957). Attitudes amongst a population identifying as homosexual and a heterosexual population, accessed at a G.U.M. clinic, cannot easily be compared. The size of both studies means that conclusions cannot be drawn about the links between social class and STI or sexual health behaviour.

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<sup>10</sup> This is further discussed in section 3:3.1, page 64.

## **2:1.2 Teenage pregnancy**

Unintended pregnancy has recently been a focus of government policy. It is mentioned in *The Strategic Framework for Promoting Sexual Health in Wales* (Welsh Assembly Government Committee for Health and Social Services, 1999), *The National Strategy for Sexual Health and HIV* (Department of Health, 2001) and the Teenage Pregnancy Unit reports (Teenage Pregnancy Unit, 2000). The rate of teenage conception in the United Kingdom is the highest in Europe (Liao, 2003) and this can have a negative impact on the long term health and wellbeing of both the mother and child. Younger mothers are more likely to have pre-term babies and higher rates of infant mortality. Children born to younger mothers are less likely to have a father figure and more likely to live in poor quality housing (The National Assembly for Wales, 2000 ; Pevalin, 2003). Teenage parents are more likely to be dependent on benefits than other parents (The National Assembly for Wales, 2000). It has also been found that children of young mothers are more likely to have children themselves before they are 20 years old (Pevalin, 2003). Pevalin's study uses information from the British 1970 Cohort Study (BCS70) to compare outcomes for children at ages 5, 10 and 30. Teenage conception was found to have a negative effect on outcomes for the whole of a child's life. Outcomes for teenage parents and their children may be affected by the way that society is structured. Teenage mothers are more likely to be single or have less stable relationships which could affect the income of the household and have implications for child care. Teenage parents often have poorer quality housing which has health implications for both themselves and their children (Black, 1992). Poorer health outcomes not only affect the mother and child but a cycle is created, the children of teenage mothers are more likely to have children when they themselves are teenagers (Botting *et al.*, 1998). This cycle could be broken by ensuring education opportunities for teenage mothers, addressing deprivation and poor housing. Special education opportunities are provided for teenage mothers, for example, education centres with attached crèches and home schooling opportunities, but the success of these has been limited (Botting *et al.*, 1998; Teenage Pregnancy Unit, 2004).

There has also been concern about intended pregnancy in teenagers, which can result in similar outcomes to unintended pregnancy. Pregnancy is sometimes a positive choice for young women who feel that their other options are limited (Social Exclusion Unit, 1999). Addressing teenage pregnancy is difficult if it has

been a positive choice for young women especially when the underlying causes are poverty and social disadvantages. Giving young people hope and control of their situation and prospects may reduce the incidence of teenage pregnancy and affect other social problems positively. Diverse issues such as housing, education and family could all have an effect on the expectations of young people. An holistic approach to young people's well being should be encouraged (Welsh Assembly Government, 2008).

## **2:2 Sexual health in Wales**

The National Public Health Service for Wales has found that there has been an increase in incidence of many STI in Wales (National Public Health Service for Wales, 2005; National Public Health Service for Wales, 2009). Rates of chlamydia and gonorrhoea diagnosis are lower in Wales than in England (Welsh Assembly Government, 2009). It is also reported that prevalence of STI is not spread evenly throughout Wales. The genitourinary clinic in Cardiff diagnosed the highest number of cases of chlamydia, ano-genital herpes, gonorrhoea and HIV (National Public Health Service for Wales, 2005; National Public Health Service Communicable Disease Surveillance Centre, 2009). This could be for a variety of reasons, none of which are suggested by the report. For example, Cardiff has a higher population density than most of Wales (Office of National Statistics, 2001b). A larger percentage of the population in Cardiff belong to the high risk groups identified by the HEALTH PROTECTION AGENCY (Office of National Statistics, 2001b). Additionally, better service provision in Cardiff means that more people can easily attend for testing. It is possible that people travel into Cardiff in order to be tested somewhere that they are unlikely to be recognised by staff or other patients.

## **2:3 Government policy in England and Wales**

Government policy has aimed to reduce the incidence of STI and unintended pregnancies (Social Exclusion Unit, 1999; Department of Health, 2001), that is, to address the visible effects of negative sexual health. Policies that are target driven and address visible effects can be evaluated. The WHO definition<sup>11</sup> of sexual health promotes holistic well being and freedom to make decisions

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<sup>11</sup> See section 1:3, page 14, for this definition and discussion.

however, these would be difficult to measure targets and therefore would be unattractive. Sexual health as defined by the WHO requires individual assertion.

Sexual health policy sits within broader health care policy. Services should consider individual needs and preferences in order to be of a high quality (The Kings Fund, 2009). The Wanless report on health care in Wales identified a desire for greater public and patient involvement (NHS Wales, 2008). This would require individuals and communities to take some responsibility for their own health and health care planning. Whilst this is suitable when considering health care that can be easily discussed but sexual health is considered a taboo subject and provokes moral judgements in many people. Community involvement therefore poses problems. Individual responsibility should be emphasised since patients have a right to health care but should also exercise their own responsibility for maintaining their own health. The extent to which an individual is able to do this depends on their education and knowledge about the health topic in question. If people are not educated about sexual health they cannot be expected to take responsibility.

The *National Strategy for Sexual Health and HIV* (Department of Health, 2001) remains the policy for addressing sexual health in England. This strategy focuses on the provision of better prevention, better services and better commissioning of sexual health services.

#### *Better prevention*

The strategy states that the government will develop safe sex campaigns and

*'exploit the wide range of media available to provide safer sex information'*  
(Department of Health, 2001: 21)

Since 2001 there have been limited national information campaigns targeted at raising awareness of STI and their prevalence. There has not been a great increase in promotion of safer sex, although there have been a few television advertisements about chlamydia, gonorrhoea and condoms. Information is available on the internet for those looking for it and help lines are also available, these do not raise awareness in those who know little or who think that STI are not relevant to them. This policy can not yet be said to have failed, however some proposed actions have not yet been undertaken; media campaigns have

been limited and the incidence of STI has continued to rise or remained constant.

In the strategy specific attention is given to the reduction of new HIV infections and local provision of sexual health information. Local information is important as it is imperative that those concerned about having contracted STI can access information and services; inability to do so may lead to failure to seek treatment at all (Kinghorn, 2001). The *National Strategy for Sexual Health and HIV* identifies the importance of locally provided services in achieving targets (Department of Health, 2001). When compared to the government's other targets for health improvement, action on STI has been limited. For example, smoking reduction has occasioned television advertisements, posters, and a nationwide ban on smoking in places of work. Smoking cessation counselling and nicotine replacement therapy is provided free of charge, help lines are accessible and advertised, advice is available in pharmacies. In contrast condoms can still not be advertised on television. There have been few campaigns to increase knowledge in the population as a whole and STI continue to have negative connotations; indeed, the last large scale public health campaign was intended to inform the public about AIDS (Department of Health and Social Security and the Welsh Office, 1987).

Health promotion is a complex interaction that can lead to more than the sum of its parts (Naidoo and Wills, 1994). In the case of sexual health, effective health promotion would lead to a change in societal attitudes to sex and STI in the same way that smoking health promotion has begun to lead to a change in society's attitudes to smoking and increased the number of people seeking help to stop smoking (Stop Smoking Wales, 2009).

A widely used model of health promotion is that proposed by Tannahill (Downie *et al.*, 1990). This model consists of three facets of health promotion: health education, prevention and health protection and the way they overlap. Other models for health promotion are described by Naidoo and Wills (1994) although all models include reference to several key factors:

- Education – the importance of informing the public about their health options and allowing them to make decisions; some models emphasise self empowerment (Naidoo and Wills, 1994).

- Public policy – the importance of public policy reinforcing private decisions and health education. For example, the public were educated about the adverse health effects of smoking; the smoking ban reinforced this by legislating about where people could smoke.
- Services – the importance of providing services for the prevention and treatment of health problems. For example, immunizations and vaccinations or smoking cessation treatment.

Health promotion is an interaction between these factors that can lead to improved health outcomes for the population (Naidoo and Wills, 1994). The empowerment model of health promotion suggests that health promotion ought to be an interaction between public policy and health education (Tones, 2001). An emphasis is placed on health education because, by gaining knowledge, individuals are empowered to make informed choices. The model also demonstrates the ability of individual and community empowerment to influence public policy. This model is important because it acknowledges that individual interactions are an important part of health promotion (Tones, 2001). Health care professionals have a health promotion role in interactions they have with their patients, which is important when considering sexual health: opportunities for discussion should be taken. If sexual health education about is not effective, then an individual's behaviour is unlikely to be healthy. In order for government strategies to be effective, individuals must be empowered to take responsibility for their own sexual health. The community at large also ought to be empowered to lobby for healthy public policy; but because sexual health is a taboo subject it does not provoke overt community interest.

The effectiveness of health promotion interventions depends on their implementation and the strategies used; health promotion has had positive effects on health in many instances (Naidoo and Wills, 1994).

Another aim of the national strategy is to reduce the stigma of STI. Failure to publicise these issues leads to continued stigma and taboo which, in turn this could mean decreased attendance at services and reluctance to access information. The strategy also recognises high risk groups and the need to address their needs specifically.

### *Better services*

The main elements of sexual health services are identified in this strategy as contraceptive care and abortion, diagnosis and treatment of STI, prevention of STI and services to address psycho-sexual problems. There is no specific mention of sexual health education and no mention of how positive sexual health could be encouraged, for example, education about decision making and successful communication in a sexual situation. The focus of service provision appears to be to prevent sexual ill health and treat it when it occurs.

Government policy has recognised the necessity of addressing inequalities in sexual health identified by the Health Protection Agency (2006) and suggests that these barriers can be overcome by ensuring that staff have positive attitudes to service users in order to deliver positive and non-discriminatory care. The policy also suggests that developing services in collaboration with local service users and networking with other services provided in local communities would enable high risk groups (Health Protection Agency, 2006) to access services. There is no mention of the way in which service users will be consulted in order to maximise uptake. Members of some high risk groups may be difficult to access owing to the stigma attached to their behaviour (Lee, 1993).

Despite these potential problems, accessing members of high risk groups to discuss services and potential for improvements in provision is important. Problems may also arise where people do not identify themselves as members of a group. For example, a young man who injects steroids may not identify himself as an injecting drug user (Hampshire, 2002); he may equate 'drug user' with a stereotypical image within which he does not fit. Feeling that he is not a drug user he would not access services for drug users. Because this young man did not attend services or identify with members of a high risk group, it would become difficult to contact him to discuss sexual health service provision in relation to his increased risk of contracting some STI<sup>12</sup>.

Consultation strategies may well encourage further service access from members of populations who already have contact with services, but may fail to increase participation from those who do not.

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<sup>12</sup> Injecting drug users may contract an infection through needle sharing; as such the infection would not have been sexually acquired although it could still be transmitted sexually to others.

### *Better commissioning*

In recent policy documents (Wanless, 2002; Welsh Assembly Government, 2003) a focus is made on collaborative and partnership working. Commissioning should take place at a local level with the aim of provision matching local need. The strategy outlines the need for services to be open and easily accessible. Recent research throughout England has shown a perceived detachment between national strategy and local provision (Terrence Higgins Trust, 2007). This research asked sexual health clinicians (n=231) and primary care trusts (n=66) about changes in sexual health services. Two thirds of the clinicians who responded felt that sexual health was not sufficiently prioritised locally, citing factors such as insufficient funding (Terrence Higgins Trust, 2007).

The *National Strategy for Sexual Health and HIV* (Department of Health, 2001) also outlines the need for an evidence base and research to underpin practice. This is part of a wider emphasis in the NHS to provide evidence based health care (Chambers *et al.*, 2004) that can be standardised and cost effective. Evidence based care is dependent on rigorous research to inform clinical decisions; without this the evidence base would not be sound. Included in recommendations for future research is the need to gain a better understating of why young men do not access services. The research priorities identified in the strategy which directly relate to my study are to gain:

*'- better understanding of the sexual networks, health seeking behaviour and risk behaviour of targeted groups<sup>13</sup>.*

*-understanding of barriers preventing access to services, especially within targeted groups.*

*-a better understanding of why young men do not access services...'*

(Department of Health, 2001: 45)

The importance of researching young men's reluctance to address their sexual health and their reluctance to access services has been identified.

The *Strategic Framework for Promoting Sexual Health in Wales* (Welsh Assembly Government Committee for Health and Social Services, 1999) aimed

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<sup>13</sup> Young adults are identified as a targeted group (Department of Health, 2001).

to improve the sexual health of the population of Wales, to narrow sexual health inequalities and to promote and support fulfilling sexual relationships. Whilst it appears that the fulfilment of these aims could lead to a sexually healthy population<sup>14</sup> the framework elaborates that the final aim refers to education and information-giving for young people and making information accessible to others. Sex education may enhance the sexual health of young people and empower them to make positive decisions. A positive decision would be balanced and based on information and personal wishes of the young person; a coerced or uninformed decision would not be positive. This definition of positive decisions may not be shared by government or parents of young people concerned. It is possible that some parents seek to promote abstinence from sex as the only positive decision to be made; in some places governments also take this attitude (Abstinence Clearinghouse, 2007).

The framework points out that although media campaigns cannot equip people to cope with difficult interactions surrounding sexual encounters and practising safer sex, they can transmit single messages effectively. For example, media campaigns can increase service uptake, inform about service options or the possibility of emergency contraception (Welsh Assembly Government Committee for Health and Social Services, 1999). Given that the sexual health of the population of Wales is still poor in comparison with the rest of Europe I am surprised that the Welsh Assembly Government has not attempted any mass media campaigns in Wales recently (I have lived here for ten years and have not seen any). This may be contrasted with policies relating to smoking discussed above. The smoking ban is enforceable, whilst a ban on unsafe sex would not be. There is also a distinction between public behaviour (smoking) and private behaviour (sex).

Anti-smoking advertising and health promotion has begun to lead to a change in society's attitudes to smoking – it is this change in attitude which will lead ultimately to health improvement. A similar change in attitude relating to sexual health would greatly benefit the sexual health of the population but would not be easy to achieve given the private nature of sexual behaviour. An example of this change in attitude is evident in my practice as a nurse. Consultants are willing to introduce the topic of smoking in patients' consultation, even when

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<sup>14</sup> According to the WHO definition see section 1:3, page 15.

their complaints are not obviously caused by smoking. I have never observed consultants introduce the subject of sexual health in a consultation that did not take place in a G.U.M. clinic, even when the patient was presenting with anogenital warts. In this situation failure to introduce the subject of sexual health could be due to the consultant's lack of knowledge or discomfort about introducing an uncomfortable subject. This is anecdotal evidence of a reluctance to discuss a topic which is perceived to be taboo, even though it might adversely affect care. A societal change in attitude may begin to alter the taboo nature of the subject.

The community empowerment model of health promotion (Tones, 2001) suggests that communities can influence health policy. An emphasis is placed on dialogue and discussion in order to identify causes of poor health and address them. These methods would never be suitable whilst sexual health remains a taboo subject. Even when willingness to discuss the subject increases, blame is ascribed to certain behaviours and moral judgements are made (Allen, 2000).

During data collection for my study between September 2006 and September 2007, a lack of sexual health knowledge was recognised by most participants. Given that data collection took place six years after the publication of the *National Strategy for Sexual Health and HIV (2001)*, there would appear to have been gaps in the policy's plan for education and prevention techniques; after this time lapse it would be reasonable to expect some improvement in knowledge. It is possible that the young men in question had good sexual health education at school but had forgotten everything and so told me that they had received none. It seems unlikely that most of the participants would forget their education in the same way.

Although a new sexual health strategy for Wales has not been introduced the Welsh Assembly Government are currently consulting on a draft working paper (Welsh Assembly Government, 2009). The working paper identifies four points for action:

1. *Developing a culture to support sexual health and well being:* It is acknowledged that everybody has a right to sexual health information and services. Different people may require altered services and certain groups who are at higher risk may have particular requirements.

Services should be developed in partnership with those who use them so that individuals' needs can be met. Leadership and collaboration across Wales will produce the best results.

2. *Better prevention:* Improving sex education in schools and in the wider community. Although sex education is compulsory in all secondary schools it has been found to be of poor quality in many instances (Welsh Assembly Government, 2009). Improving access to information and contraception and providing information about the role of drugs and alcohol are also identified as important. Proposals to prevent unintended teenage pregnancy are also included as occurrence is higher in Wales than England. The need to improve access to HIV testing for high risk groups is accepted in order to prevent the spread of HIV and the importance of providing immunisations for other infections which may be transmitted sexually (hepatitis B and human papilloma virus).
3. *Delivering modern sexual health services:* Services are to be integrated (G.U.M. and family planning will become contraception and sexual health clinics). Nurses will see asymptomatic patients, reducing waiting times. Sexual health services will be provided in primary care settings (GPs) to increase accessibility and early access to abortion services will be improved.
4. *Strengthening health intelligence research.*

It is clear from the identification of these points that the nature of sex as a taboo subject should be addressed in order to change the culture around discussion of sex, improving education and service provision may lead to the prevention of sexual ill health.

## **2:4 Conclusions**

Sexual health has been recognised as an area which requires attention. It is important that service provision addresses the needs of the population so that those who require services can access them. This is especially important in the case of sexual health because some people are more at risk of contracting an STI. Services should be targeted so that these 'at risk' groups can address their sexual health. Researching the needs of these high risk groups would form an important part of developing successful and accessible services.

The identification of 'at risk' groups has informed my choice of research topic. Young people carry a high burden of sexual ill health (Health Protection Agency Centre for Infections, 2008) and participants 16 -20 years old were chosen to reflect this. My choice of young men as opposed to a mixture of men and women is discussed in the next chapter that considers masculinities.

## Chapter Three: Masculinities

Young men were chosen for this study because they have been found to access sexual health care services less frequently than young women (Pearson, 2003a) and because they have been identified as a group requiring specific sexual health service improvement (Teenage Pregnancy Unit, 2000).

This focus on young men caused me to question the differences between young men and young women, which are more than simply biological. I will argue that the disparity between young men and young women is created by their genders, which are socially constructed. There are few categorical statements that can be made about masculinities; thus discussion in literature is often abstract (Haywood and Mac and Ghail, 2003). However, it can be stated that masculinities exist although their form and expression may be diverse.

Whilst undertaking this study, I felt it important to consider my position as the researcher. I am a young woman and therefore my understanding of the masculinities of the young men involved required consideration. At the beginning of the research process I felt that encouraging young men to talk to me about their experiences of sexual health services would be difficult, if not impossible, my original plan involved the use of a male research assistant. However, it became evident that young men can be comfortable talking to women about such issues (Spencer *et al.*, 1988; Hutchinson *et al.*, 2002). As a young woman, I have been able to gain an understanding of the position of the young male participants and their masculinities; this may be partially because I could separate myself and my experiences from theirs. My understanding of masculinities has been influenced by my gender. Although I have never experienced being a man and cannot know how it feels to live with society's expectations of masculinities, I do know how it feels to attempt to conform to ideas of femininity and live with society's expectations of my behaviour.

Masculinities are a social construct, have changed throughout time and are dependent on social groups and stereotypes (Beynon, 2002; Haywood and Mac an Ghail, 2003). A definition is difficult if not impossible to reach, as masculinities can belong to members of either gender and can encompass a

wide range of behaviours. In grappling with possible definitions it could be assumed that every man aspires to a different ideal of masculinity and aims to achieve this ideal in an individual way, but Clatterbaugh (1998) argues that this cannot be the case as trends in behaviours seem to suggest some common factors. For example, men have been found to have higher rates of morbidity than women and are likely to die when they are younger than women in a similar situation<sup>15</sup> (Courtenay, 1998; Courtenay, 2000; Baker, 2001; Courtenay, 2002; Courtenay, 2003; Banks, 2004).

The discussion of these complexities may lead to a better understanding of masculinities and the pressures that men feel to conform to their ideals of masculinity. These pressures may have implications for health and therefore developing an understanding of them could facilitate the improvement of men's health. In the context of my study reluctance of young men to access sexual health services because of their ideals of masculinity could detrimentally affect their sexual health. Understanding the effects of young men's masculinity might enable strategies to be put in place in order to overcome some of the specific difficulties faced by young men.

Gender will be addressed first, followed by some definitions of masculinities which have been proposed. The different forms of masculinities will be discussed and problems with masculinities will also be considered. As it is feminism that has generated the discussion of masculinities, it is necessary that these problems be discussed with reference to feminism and changes in society. A section entitled masculinities in context (3.3) considers factors which may have affected the masculinities of participants in my study. Finally, the idea of 'men in crisis' will be taken into consideration.

### **3:1 Gender**

Gender differences are more than the difference between sexes; sex refers to biological differences whereas gender refers to social differences. Gender is about a lot more than biological function. Masculinities and femininities are expressions of gender and may be influenced by a number of other social factors for example, age, social class, personal beliefs and ideals. As

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<sup>15</sup> Health inequalities have been found across social strata (Black, 1982), therefore morbidity and mortality rates of men and women are only indicative of a disparity between genders when those from a similar social background are compared.

masculinities are affected by many factors, they have become a concept that is difficult to define and 'pin down'.

Gender and gender related behaviour is a social construct (Cornwall and Lindisfarne, 1994) but has too often been viewed two dimensionally as a categorical variable (Bufkin, 1999; Anderson and Umberson, 2001). Such a perspective not only disregards the myriad of behaviours and beliefs that could be gender related, but also complicates research of these behaviours and can cause difficulties for those who do not fit neatly into one or other of the prescribed gender categories. Gender is deeply entrenched into our thinking as a two dimensional variable; even authors who recognise this and seek to address the problem have mistakenly equated being un-masculine with being too feminine (Bufkin, 1999).

Gender could be more easily understood as a verb; something that an individual does (Courtenay, 2000). West and Zimmerman (1987) explain that not only is gender something that an individual does, but something that must be repeatedly done. Gender may therefore shift and change according to recent actions and ideals. The constant need to assert one's gender may create problems; for example, changes in behaviour or abilities following a major event may lead to a change in perception of personal gender potentially decreasing self esteem or changing interactions with other people. Gender forms part of our core concept of ourselves; asserting gender may provide a positive identity and a sense of belonging. For example, being a 'proper man' may enhance an individual's self esteem.

MacInnes (1998) posits that stereotypes and supposed behavioural differences between men and women help individuals to explain the world around them and the differences between the sexes. Thus gender not only affects an individual's self concept, but also the way in which others perceive and categorise the individual. However, categories and stereotypes can have a detrimental effect on individuals when they are imposed. Masculinities have, in the same way, been developed by society, both by the male and female sex, and have been predominantly used to categorise men.

### **3:2 Masculinities**

The discussion of masculinities as a subject in itself is a recent one. Historically the nature of men was not considered because men have been considered the norm. It was the advent of feminism, campaigns for women to be paid equally and receive the same opportunities as men, which invoked a discussion about the nature of men and masculinities (Whitehead, 2002). Feminism has affected and perhaps altered the status of men, such that they have been described as being 'in crisis' (MacInnes, 1998). This 'crisis' will be discussed later<sup>16</sup>. It could not be said that feminism was the only factor promoting the changes in discussion of masculinity. Societal changes have given cause to question the nature of gender and behaviours that have previously been linked to it. For example, Beynon (2002) suggests that the increased fluidity in gender roles for men and women, (the rise of 'laddettes'<sup>17</sup> and of men who are as interested in their appearance as their female counterparts) gives cause to consider the nature of masculinity as well as femininity. How far the rise of feminism has affected gender role changes is difficult to state. Undoubtedly factors such as increased consumerism have an effect on behaviours; for example, an increase in men who are concerned about their appearance could be partly attributed to increased advertising, changing role models, the rise of celebrity culture or an increase in disposable income. These factors have affected femininity too, but are not attributable to feminism. Therefore, a combination of many factors therefore has led to discourse about the nature of masculinity and how far it influences behaviour.

Absolute definitions of masculinity cannot be given as they are a social construct, changing according to time and place (Cornwall and Lindisfarne, 1994). Adopting a reductionist approach to defining masculinities would not facilitate understanding as it would exclude many men and their expressions of masculinities. Providing a definition of masculinities also causes contention in literature, so it is necessary to consider the meaning of the word 'masculinity'. The Oxford dictionary of English (Pearsall, 2001: 1137) defines masculine as;

*'having qualities or appearance traditionally associated with men'.*

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<sup>16</sup> See section 3:5.1, page 76.

<sup>17</sup> This term was coined in mainstream media to describe girls who behaved as 'lads' would previously have been expected to, it was notably applied to describe Zoe Ball who drank pints and talked about sport and practical jokes on her radio show.

This definition is less than complete; who determines which qualities or appearances are associated with men? Would 'traditionally' in this context mean within a particular society or group? If in our society men are traditionally tough and strong, does this mean that all men who are not, are not masculine?

This definition fails to isolate the essential features of masculinity; it assumes that traditional attitudes should be imposed in order to determine who is, and who is not, masculine. Mead (1968) found, in a study of three different societies, that 'traditional' gender roles are not homogenous. Even within our own society there are many different types of man. This definition suggests that some of them are masculine and others are not.

Clatterbaugh (1998) reasons that a definition of masculinity should be developed from behaviours as they exist, not from stereotypes or ideas about how a man should behave. It is clear that definitions of behaviours should be developed from the behaviours themselves, but when examining social stereotypes of masculinities this does not appear to have happened. Ideas about family roles, expressing emotions and types of job are endemic in our society, however 'open-minded' we intend to be. Clatterbaugh (1998: 32) defines masculinity as:

*'a masculine person is one who exemplifies those characteristics that have been shown to differentiate the sexes. A particular masculinity is the set of differentiating characteristics of a particular group of individuals determined by sex and some other set of ascriptive characteristics'*

Clatterbaugh (1998) suggests that this definition can be applied to many different types or groups of men. For example, Clatterbaugh suggests that using the term 'differentiating characteristics' allows for these behaviours or ideas to be linked to cultural or socioeconomic factors. This definition recognises the diversity of masculinities or those who may express them. The definition does not allow for women to express masculinities, even in the roles as described above. The behaviour must belong originally to members of the male sex to be defined as masculine, yet Clatterbaugh (1998) also highlights the problems with assuming that behaviours belong singularly to one sex or another. Clatterbaugh (1998) suggests that joining men with masculinities is deceptive and serves to complicate and compound the difficulties in describing masculinities.

Halberstam (1998) argues that masculinity can belong to members of both sexes. As femininity has been attributed to men in the past, for example, a man expressing a 'feminine side' or the stereotypes assigned to some homosexual men, it would be positive to acknowledge women's masculinities. These masculinities have been excluded from discussion as a method to propagate the status of men as masculine and powerful (Halberstam, 1998). The power of men necessitates the lower status of women and thus the exclusion of the possibility of female masculinity has helped to sustain patriarchy and all it entails. Although not offering a definition, Halberstam (1998) appears to be referring to a broad concept of masculinity in which power, wealth, privilege and status are important factors. This is not true of masculinities, as it would exclude men who express or seek to express some form masculinity and yet have little power, wealth or status in their society.

The idea of masculinities' association with power is also suggested by Cornwall and Lindisfarne (1994), although these authors do not limit the power gained to men. These masculinities, which result in power, are termed 'hegemonic masculinities' and their dominance necessitates the subordination of other forms of masculinity. Hegemonic masculinities describe successful ways of being a man in a particular society at a given time (Beynon, 2002).

### **3:2.1 Forms of masculinities**

Connell (2005) considers there to be many different types of masculinity; whilst masculinity is linked to class, sexuality, race and a host of other social factors, it is not defined by them. For example, within a working class population a range of masculinities may be expressed. Whilst Connell (2005) asserts that hegemonic masculinities are not static, types of masculinities are identified.

#### *3:2.1.i Hegemonic masculinities*

Hegemonic ideals have domination or leadership within a society (Haralambos and Holborn, 2000). Hegemonic masculinities are forms of masculinities that claim and maintain a leading or dominant position. For hegemonic masculinities to remain dominant, other forms of masculinities must be kept subordinate. Beynon (2002) suggests that this is achieved through the ridicule of these subordinate masculinities. Dominant forms of masculinities can be affected and influenced by the subordinate forms (Connell and Messerschmidt, 2005) and the

ideal of hegemonic masculinities is constantly changing; although in our society it often involves the subordination of women (Haralambos and Holborn, 2000). As a result, hegemonic masculinities have often been linked to patriarchy, which is a societal system in which men are dominant over women and children. The ideals of hegemonic masculinity have evolved in the presence of patriarchy, causing these two ideals to have become symbiotic in our society.

A group in society cannot gain and maintain power without the assent of the remainder of society, so hegemonic masculinities have remained dominant with the collusion of society (Gerzon, 1982). Patriarchal society was maintained in a similar way; women, being half the population, could not be kept subordinate without the consent of at least some women.

Since hegemonic masculinities are constantly changing; a particular form of masculinity is only hegemonic in a given time and place (Connell, 2005). Hegemonic masculinity does not express what men are, but rather what they might like to be; it exerts a pressure for men to conform (Connell, 1987). Hegemonic masculinities constitute an ideal; they are aspirations of behaviour. Even men who do not wish to conform to hegemonic masculinity may feel pressure or be aware that they have chosen to be excluded.

### *3:2.1.ii Subordinate masculinities*

Masculinities that are oppressed or ridiculed. Connell (2005) gives the example of homosexual masculinities and behaviours considered effeminate. These are ridiculed with name calling and insults.

### *3:2.1.iii Complicit masculinities*

By adopting complicit masculinities men are enabled to benefit from the power and status of hegemonic masculinities without their disadvantageous side effects<sup>18</sup>. Connell (2005) explains that these masculinities show men making compromises with those around them instead of overtly dominating others; yet the men expressing these masculinities gain from the general status of men in patriarchal society. By negotiating their assertion of this status with those around them, they are able to preserve successful relationships whilst continuing to reap the benefits of being masculine. It is this negotiation which

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<sup>18</sup> Seeking help might be seen as an unmasculine activity leading to men failing to seek health care or counselling. The failure to do so would lead to poorer health outcomes and this could be seen as a disadvantageous side effect of expressing hegemonic masculinities.

caused Connell (2005: 79) to describe these masculinities as '*carefully crafted*'. The support of men expressing complicit masculinities upholds the hegemonic ideal, but the support of women for an hegemonic ideal is also necessary to maintain its status.

#### *3:2.1.iv Marginalised masculinities*

Those which belong to particular groups in society and are affected by other social factors, for example, masculinities which belong to a particular race or social class. These masculinities have been shaped by the experiences of the social group as a whole and are unlike subordinated masculinities as a consequence of their overt link with other social factors. These masculinities can be contrasted with the hegemonic masculinities of the dominant group. An example would be young men who are unable to gain employment owing to a lack of educational achievement and whose parents have never worked, who might express a marginalised masculinity. Within their social sphere it could be a dominant form of masculinity but could be contrasted with hegemonic masculinities across a larger population.

#### *3:2.1.v Negotiation of masculinities*

Societal changes have affected gender relations. The growing influence of feminism and changing class relations has caused some men to renegotiate their masculinities and their gender related behaviour in order to maintain their authority and power (Heath, 2003). An example of this negotiation is given by Anderson (2002) who describes homosexual men in sport. Whilst homosexuality is not a part of typical hegemonic masculinities these men maintained their hegemony by proving themselves good sportsmen and meeting other dictates of hegemonic masculinities. In this way, they negotiated their masculinities, taking aspects that were acceptable to them but ignoring those aspects which were not, in this case heterosexuality.

#### *3:2.1.vi Defining masculinities*

A definition of all hegemonic masculinities would be impossible; Beynon (2002) discusses the idea of masculinities being culturally and historically shaped. Therefore, hegemonic masculinities change and evolve according to time and place. I will not make the mistake of reducing this complex issue to defined categories and yet, Holland *et al.* (2004) describe hegemonic masculinities in our society as referring to those of a white middle class male. Some explanation

must, therefore, be given of the values or ideals that may form part of this masculinity.

Early research on masculinities identified major threads described as masculinity as being avoidance of femininity, toughness and standing alone (or not requiring help) (Thompson and Pleck, 1986; Thompson *et al.*, 1992; Pleck *et al.*, 1993; Pleck *et al.*, 1994; Sinn, 1997; Sonenstein *et al.*, 1998). Craib (1987) identifies the man as strong, aggressive, rational, independent and successful. Tannen (1995) describes differences in the conversational styles of men and women. Men are described as seeking to avoid putting themselves in the 'one-down' position during their interactions with others. This characteristic is probably not typical of all men but Tannen (1995) implies that it is a typical trait of dominant western masculinities, or hegemonic masculinities.

These ideals are part of what constructs hegemonic masculinities in our society. MacInnes (1998) describes requesting groups of students to write a list of attributes that constitute masculinity. The list often contained mention of the attributes mentioned above, but the students often stated that these lists were stereotypical. Therefore, even though hegemonic masculinity is recognised, it is identified as being an ideal that few achieve.

**Table two: Table to show characteristics described as hegemonic by various authors, this list is by no means exhaustive but demonstrates some ideals**

| <b>Characteristic</b>                                  | <b>Author</b>                                                                 |
|--------------------------------------------------------|-------------------------------------------------------------------------------|
| Seeking dominance in conversation                      | Tannen (1995)                                                                 |
| Assertiveness                                          | Thompson, (1986) Thompson, (1992)<br>Pleck, (1993) Tannen (1995)              |
| Strong Oak (self reliance)                             | Connell (2005)                                                                |
| Reluctance to seek help                                | Good and Wood (1995)                                                          |
| Toughness                                              | Thompson (1992) Pleck (1994)                                                  |
| Ignoring feelings (private emotion)                    | Seidler (1992) Gordon (1995)<br>Courtenay (2000) O'Brien <i>et al.</i> (2007) |
| Able to exercise power over women in sexual encounters | Holland <i>et al.</i> (1991; 1993: 2000; 2004) Kelly <i>et al.</i> (2004)     |
| Avoidance of the feminine                              | Pleck (1981) Thompson, (1986)<br>Bendelow (1993) Pleck (1994)                 |
| Control                                                | Pleck (1981)                                                                  |
| Independence                                           | David and Brannon (1976)                                                      |

It is understood that this table represents a simplification of a complex concept and yet I felt it important to offer some tangible traits that might be considered hegemonic in our society.

MacInnes (1998) suggests that it is impossible to confine masculinities to a precise and objective definition but acknowledges that the concept conjures common perceptions even though these perceptions are often recognised as stereotypes. He also questions whether masculinities should belong solely to males and therefore questions the link between sex and gender. The possibility of masculinities belonging also to females raises questions about femininities belonging to males. Aversion to this idea stems from the opposite nature of a stereotypically masculine man and stereotypical ideas of femininity. By adopting femininities, men may be seen as ceding power and influence; MacInnes (1998) questions why anyone would choose femininities, if masculinities are purely a social construct. He further argues that if gender (masculinities and femininities) is purely a social construct, then individuals of both sexes would have access to the most powerful expression of gender, which is masculinity. Yet patriarchal

society has meant that people of the male sex gained power in preference to females, and not always that the masculines gained power over the feminines. A biological difference between the sexes is suggested as the reason men continue to benefit from patriarchal society but there are problems with blaming biological differences; both the extent and effect of socialisation and biological differences are impossible to know.

Many authors discuss masculinities, and even research them, without ever seeking to 'pin down' the nature of masculinities (O'Donnell and Sharpe, 2000). O'Donnell and Sharpe (2000) conducted a study of 15 and 16 year old men with questionnaires (n=262) and interviews (n=44) to gain some understanding of how boys become 'masculine'. They used a sample from several schools, including white, Afro-Caribbean and Asian young men. The study found that young men constructed their masculinities in relation to their class and ethnicity, and the divide between the areas of the young men's lives. Boys expressed different attitudes according to where they were and were more likely to adopt racist or sexist attitudes in an unsupervised environment, for example, with their peers.

O'Donnell and Sharpe (2000) identify this as a problem because it is likely to be these attitudes, adopted when unsupervised, which will influence the attitudes of the young man as an adult. This does not give information about all masculinities but rather about the nature of the masculinities espoused in the environment in which the young men were living. It creates a picture of uncertainty and ambiguity, and of young men feeling they should behave in different ways for different audiences. Some understanding can be gained of the experiences and feelings of men without defining masculinities; indeed, an inability to define masculinities may lead to a better understanding of the experiences of men themselves.

The importance of discovering the lived experiences of men is outlined by Haywood and Mac an Ghail (2003); although these authors do not offer a definition of masculinities, they explain the subjective nature of masculinities and their dependence on social surroundings. Attempts to quantify masculinities have previously been made (Thompson and Pleck, 1986; Thompson *et al.*, 1992; Pleck *et al.*, 1993), yet this appears to over simplify the inherent issues. Haywood and Mac an Ghail (2003) point out that these quantifications can lead

to men being labelled as either insufficiently or overtly masculine. These terms in themselves create stereotypes and expectations of men and their behaviour. Men may find attempting to achieve an ideal of behaviour created by social expectations problematic and women may become disadvantaged by men attempting to achieve this idealised behaviour. Moving away from such stereotypes would benefit both men and women.

When seeking to define masculinities, it is essential to remember that there are a range of practices that are considered masculine by a range of people. For example, a homosexual man, a 'stay at home' father and a wealthy business executive may all hold different beliefs about what it means to be masculine and express these masculinities in different ways. These expressions of masculinities do not lend themselves easily to a simple definition as they are so diverse.

If a definition could be offered, it should be more complex and comprehensive in order to explain the nature of masculinities. The definition must encompass the different expressions of masculinity that are shown by different men, and sometimes women. A definition of this nature would enable a better understanding of behaviours linked to masculinities. Whilst masculinity is difficult to define, vague ideas about what constitutes western masculinity are endemic.

Beynon (2002) asks how masculinities can be researched without having first been identified but also points out that further research of the lived experiences of men is necessary in order to better understand masculinities. My study seeks to explore the lived experiences of men in relation to seeking sexual health care. Even though a precise and definitive definition of masculinities cannot be offered, this research seeks to explore this concept in relation to participants' feelings about addressing, or failing to address, their sexual health<sup>19</sup>.

An attempt at a definition of masculinities should be offered. It is important to state that this has been kept unspecific in order to encompass the full range of masculinities expressed by members of either sex. Masculinities are behaviours

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<sup>19</sup> Some of the findings related to the masculinities of participants; indeed, '*feelings about masculinities*' formed a superordinate theme. These findings can be found in section 6:2, page 152 and further discussion about *masculinities* in section 7:1.4, page 239. This study confirmed that masculinities are a complex issue, negotiated by men with themselves and those around them.

adopted to express a male gender identity. They can be expressed by members of either sex in diverse ways. Some masculinities are hegemonic; the nature of these is dependent on time and place and is therefore continually shifting. Adopting hegemonic masculinities may be perceived to be beneficial to individuals.

The construction of masculinities occurs in various ways and this construction is as important as the masculinities themselves. Who decides which expressions of masculinities will hold most power or be hegemonic? And how do men compromise between their achievements and their ideals, or the ideals that would allow them most power? Masculinities are shaped by communities and organisations. Their nature as a social construct allows them to shift and change. Schrock and Padavic (2007) suggest that masculinities are constructed through interactions with cooperation and competition.

### ***3:3 Masculinities in context***

Connell (2005) explains that, in order to understand masculinities on an everyday as well as a scientific level; their practical expressions must be considered. Realities for young men in South Wales were therefore important to my study, as these realities affected and informed the gendered behaviour of the young men who participated. I have therefore attempted to describe the setting of the study in order to explain the possible backgrounds of the young men involved. Whilst not a key focus of this study<sup>20</sup>, social class is intricately linked to masculinities; both can give a sense of identity and help to define an individual's place in their world.

#### **3:3.1 Social class**

An in depth discussion of social class is beyond the scope of this thesis; however, in order to gain an understanding of masculinities, their interaction with social class must also be considered (Connell, 2005). Whilst recognised as important, social class is difficult to define or measure (Mackintosh and Mooney, 2004).

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<sup>20</sup> See page 65 for discussion of participants' social class and the reasons that I did not feel that it could properly be identified.

Ideas of social class have largely been based on income and employment. Marx considered that class was rooted in the organisation of production; two major classes existed, the 'bourgeoisie' (owners and employers) and the 'proletariat' (paid labourers or employees) (Mackintosh and Mooney, 2004), although variation was identified within these groups (Giddens, 1997). Weber also based his ideas of class on economic considerations but added theories about status (Mackintosh and Mooney, 2004: Giddens, 1997). Status and income are often linked, for example, a doctor or lawyer would be accorded both high status and high income but anomalies exist. Giddens (1997) gives the example of genteel poverty, upper class people who continue to be accorded high status despite impoverished circumstances, or the low status conferred on those who are perceived to be beneath the higher classes despite their wealth ('new money').

It is these discrepancies which highlight the problems with linking social class to income or employment. Social class affects identity and behaviour; it is not only related to income or employment but to other factors, for example, environment and parents' attitudes. I felt it would be impossible, therefore, to identify the participants' social class. Even with details of their incomes, I could not have quantified their attitudes and aspirations. Where it is known, I have given details of the employment status of participants and their parents<sup>21</sup>, in order to elucidate their social class or background. As the local social environment will also have affected participants, this is also considered.

### **3:3.2 South Wales; the local environment**

It is necessary to consider the geographical area where the research took place because environment could be a factor in the participants' social class; however, concerns about confidentiality mean that this is only referred to generally<sup>22</sup>. I felt that too much geographical information could lead to the identification of the leisure centres used and therefore possible identification of participants<sup>23</sup>. Wales has developed differently from other parts of the United Kingdom and its social history and development has shaped attitudes and behaviours.

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<sup>21</sup> See Table five, page 125, and appendix five, page 304.

<sup>22</sup> A short description of the geographical areas of the leisure centres is given in section 4:6.1, page 100.

<sup>23</sup> This might appear overly careful, but I have been guided by my practice as a nurse which requires exemplary standards of confidentiality (NMC, 2002).

### *3:3.2.i Employment in the South Wales valleys*

Communities of the valleys have been influenced by their manner of development and their history (Weeks, 2007). The coal fields have played a significant part in this development. The presence of coal furthered industrialisation and transport infrastructure was developed to support this (Evans, 2000). The dramatic economic growth which took place before and during the First World War provided employment for many (Evans, 2000). However, the twentieth century has seen a long decline in the coal industry, culminating in notorious strikes and subsequent pit closures of the 1980s (Evans, 2000; Smith, 1999; Weeks, 2007).

In the year 1983/4 more than twenty thousand people were employed in Welsh mines, making coal mines an important source of employment (Evans, 2000). This figure had dropped to just three hundred and eighty four employed in 1996; similar declines happened concurrently in both manufacturing and the steel industry (Black, 2000; Evans, 2000). This drop in manual employment opportunities left many without work, and related industries and services also suffered (Black, 2000). Unemployment has had an affect on the community as a whole; social problems resulted, including depression and family breakdown as well as poverty linked to poor health. More recently, there have been a high number of incapacity benefit claimants in Wales (BBC, 2005; Fothergill and Wilson, 2007; Rhys, 2009), both as a result of industrial injury and the mental health problems ensuing from the decline of the industrial sector.

New employment opportunities do exist, although the service sector has grown most (Black, 2000; Evans, 2000). Jobs in this area require a different skill set and often do not involve any manual labour. This change in the types of available employment means that men can earn a wage without performing manual labour and that women could participate equally in the labour market.

The South Wales valleys have changed greatly during the twentieth century due to the decline in heavy industry. Towns and villages used to have close communities and employment prospects; employment brought associated benefits, just as the lack of employment has caused far reaching consequences.

### 3:3.2. ii Gender roles

History has created traditional norms for gendered behaviour in the area; men as breadwinners, labouring to support their families, and women remaining at home to care for children and the home<sup>24</sup>. Employment provided by industrialisation was for men, who were seen as the breadwinners (O'Leary, 2004). This led to clearly differentiated roles existing within the family; women were not expected to work outside the home, but to look after their husband and children (Weeks, 2007). When less employment became available in the mines due to decreased demand (for example, in the interwar period), coal miners were left with a comparatively paltry income (Thompson, 2006) meaning they were unable to fulfil the 'breadwinner' role expected of them. This may have had a damaging affect on the identity of these men, as well as on the well being of their families.

Manual labour may have been important for men to assert their masculinities. Colliers were required to be physically strong but could earn a comparatively high wage (Thompson, 2006). Physical strength and the ability to be the breadwinner therefore became intertwined. This may still have an affect on attitudes of young men in these communities today; both the ability to earn a wage and physical fitness are important. When physical strength is not required to earn a wage, the necessity of achieving a certain body shape (that of a strong man) may remain compelling (Haywood and Mac an Ghail, 2003). Where the ability to assert their capability and masculinities by successfully performing manual labour and being breadwinners has been removed, men must find other ways to assert their identities and gender.

Women and feminine identities have also evolved with a legacy of the industrial history of the area. The majority of employment available was in heavy industry, leaving women to manage the household (Charles, 1994; Pilcher, 1994). Pilcher (1994) found that, whilst some young women talked of 'sharing' housework with a man, many discussed being 'helped' by a man, suggesting that theirs was the final responsibility<sup>25</sup>. Rees (1994) suggests that this may be a particular problem in Wales owing to the industrialised past which has left the

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<sup>24</sup> See section 3:5.1, page 76 for discussion of 'men in crisis'. It has been argued that these changes in employment opportunities have precipitated a crisis of masculinity.

<sup>25</sup> Pilcher (1994) talked to families of women (mother, daughter, adult granddaughter) who lived in Wales. Mannheim's theories about the effects of socio-historical circumstances on individual's development and world views were used to explain the findings.

'new man' uncommon<sup>26</sup>. In the past, men earned a family wage and women cared for the domestic sphere (Beddoe, 1986); at present both men and women work in many cases, but the responsibility for domesticity and child care remains rooted with women.

Women's role as mother has, at worst, excluded them from paid work or at least disadvantaged them. Rees (1994) explains that the roles of mother and employee conflict. A mother is seen as unreliable and not able to concentrate but a married man with a family is perceived as being committed and hard working. Even when women do work, the gender pay gap is larger in Wales than in England, meaning that they earn less than men (Black, 2000; Williamson, 2008). This leaves women working doubly hard (in employment and domestically) and gaining fewer benefits, namely remuneration and relaxation time.

Charles (1994) posits that the stereotypical image of a 'Welsh mam' was far from being the dominant norm, but was used as a method to control women's behaviour and exclude them from paid employment. This image is of the mother as a hardworking matriarch, caring for the family and domestic sphere; the toil and powerlessness involved in this role are concealed. A mother, although not economically active herself, would be given the earnings of her husband with which to manage the household. This was not a blessing, as managing a household is a burden (Beddoe, 1986). The idea of a 'Welsh mam' as a dominant force within the domestic sphere is questioned by Beddoe (1986) who argues that women had little control over their own bodies and endured repeated pregnancies and consequent difficulties.

Relationships between men and women, and socialisation of children, are complex interactions. It could not be said that these gender norms are ubiquitous either historically or currently. I draw attention to the history of employment and gender role norms merely because these norms might have affected the environment surrounding participants in my study.

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<sup>26</sup> This is impossible to prove. It should be stated that Wales is not homogenous and a variety of masculinities are enacted by the men living here.

### *3:3.2. iii Migration and community development*

Wales has been influenced by its industrial history. People migrated to take the opportunity of (relatively) well paid work in the coal mines (Smith, 1999). New towns in the valleys emerged where none had previously existed; the population of existing villages also increased. Marsh (2008) writes of the changes in a Welsh valley town which increased in size from a village to a market town with the coming, first of the iron smelting industries and later coal mining.

South Wales is comprised of different communities and is not homogenous, (participants recruited in leisure centre one did not live in the South Wales valleys) but there are some social factors which distinguish South Wales from England. Betts (1994) states that age of first marriage is younger in Wales than in England<sup>27</sup> and divorce rates are lower. These differences influence the expectations of young people and also society's expectations of them.

South Wales also has other factors which differentiate it from England, making the experience of young people different. Wales has a strong history of non-conformist religion that has been declining in parallel with heavy industry (Evans, 2000). Chapel was previously a centre of community, in which people worked and lived in close proximity. Evans (2000) explains that fragmentation of communities has led to a decline in Welsh non-conformity. Whilst the effects of this strong history might not be felt directly by the younger generations (Evans, 2000), young people may be affected by the attitudes of their parents.

Rugby (Union) is popular and small towns often have their own rugby team. Black (2000) posits that the decline in the coal mining industry is mirrored by a decline in Welsh National rugby; this sentiment would not prove popular, but it could be argued that local rugby teams owed a lot to the close community created by coal mining and its related industries. In close knit communities people worked together, worshipped together and participated in recreational activities together (Hopkins, 1980). This strong community evolved from necessity and has been influenced by geography<sup>28</sup>.

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<sup>27</sup> Recent data on marriage age amalgamates English and Welsh data so comparisons cannot easily be made (Office for National Statistics, 2009).

<sup>28</sup> The valleys of south Wales are often linear developments with houses spreading up the hillsides. Although some towns are larger the town in which leisure centre two was situated was a typical linear development town with one main road.

### 3:3.2. iv Masculinities in South Wales

Masculinities in South Wales have been shaped by their environment. Because heavy industry has been dominant in the area men have, historically, been more economically active. Women have been dependent on their male relatives (O'Leary, 2004). This has cemented a patriarchal norm<sup>29</sup>, in which men performed manual labour to support their family. This norm was further developed by the exclusion of women from men's recreational pursuits namely rugby, male voice choirs and the working men's institute (O'Leary, 2004). This exclusion has left Welsh women '*culturally invisible*', further constructing the historical dominance of men (Beddoe, 1986: 225). Indeed, Beddoe (1986) argues that the dominant image of Wales is 'macho'. This image is contrasted with a changing economy in which heavy industry no longer provides an opportunity for men to support their families by performing manual labour. The young men who participated in my study were growing up in communities which have been described as '*senescent and declining communities*' (Evans 2000: 231).

The strong sense of community is still present (Smith, 1980; Weeks, 2007). I was struck particularly at leisure centre two by the community surrounding the leisure centre. Everyone was known and had a history, I spoke to many people who did not participate and they talked of relations or friends who also attended the centre.

### **3:4 Effects of masculinities**

Whilst it is difficult to properly define masculinities it is no less important to consider their possible effects, especially as this research aims to discover young men's lived experiences of negotiating their masculinities relating to their sexual health.

This discussion will focus on some of the aspects of hegemonic masculinities which have been identified above. These aspects do not constitute all masculinities; not all men aspire to these ideals, but ignoring the existence of these ideals and their effects would not facilitate an understanding of the possible problems with them. The discussion of many different types or forms of

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<sup>29</sup> Patriarchy can be linked to hegemonic masculinities in our society. Many ideals of hegemonic masculinities lend themselves to control and dominance. This was discussed in section 3:2.1.1, page 57.

masculinities and their possible effects may simply 'muddy the waters' of an already ill-defined area and lead to further confusion. Therefore, hegemonic masculinities as they are understood in our society are used in this consideration. Some authors do not differentiate between masculinities and hegemonic masculinities (Thompson and Pleck, 1986; Thompson *et al.*, 1992; Pleck *et al.*, 1993; Sinn, 1997), they simply imply that they are synonymous. This disregards the possible effects of other forms or ideals of masculinity. I have used the term hegemonic masculinities to refer to a particular ideal of masculinity which in our society, at this time, may be considered hegemonic. I have done this for a degree of convenience, but it must be remembered that hegemonic masculinities are only such in a particular time and place.

Some negative effects of hegemonic masculinity are discussed by Addis and Mahalik (2003) who consider the reluctance of men to seek medical help, which can lead to increased health problems. This is because some conditions worsen progressively, therefore early diagnosis and treatment results in better patient prognosis and recovery. Addis and Mahalik (2003) consider predominantly mental health issues and seeking help from psychologists, finding that men might be more likely to seek help if they perceived the problem to be 'normal', that is, suffered by other men. Asserting hegemonic masculinity could lead to many men failing to admit a problem that they all shared.

Brannon and David (1976) find that self reliance is an important part of masculinity and assertion of this, also referred to as being a 'sturdy oak', could lead to a failure to discuss problems with others. Addis and Mahalik (2003) also suggest that if the problem relates to a central part of an individual's being, then admitting it may pose increased problems. Therefore, men who feel that hegemonic masculinity is central to their self identity could have an increased problem with help seeking. For example, if a man believes that masculinity means being emotionally self-reliant, then he may find seeking help for a period of anxiety difficult; this is because seeking help contradicts the concept of self reliance. Addis and Mahalik (2003) posit that this problem could be overcome if help seeking could be seen as taking control and relying on oneself to find a solution to the problem. These authors have used what they refer to as traditional masculine roles to consider men's help seeking behaviours; these roles emphasise notions of self reliance, emotional control and power as being particularly masculine attributes. Doing so negates the effects that other

masculinities could have on help seeking. Not all men hold up these ideals as essential to their masculinities.

Bufkin (1999) considered crimes committed against particular groups in society<sup>30</sup> ('hate crimes') and possible reasons for these crimes having been committed. The crime considered was often violent and sometimes resulted in murder (Levin and McDevitt, 1993). Men are more often the perpetrators of these crimes than women. Bufkin (1999) suggests that this is because of they are seeking to assert their hegemonic masculinity. Connell and Messerschmidt (2005) consider this male violence, not as the result of hegemonic masculinity, but as an attempt to seek recognition as a possessor of this ideal. Bufkin (1999: 159) explains that:

*'the attacker becomes what the victim is not by attacking'*

Not all men must resort to violence in order to assert their hegemonic masculinities but often this type of crime is committed by young men, Bufkin (1999) suggests that there are no easy ways for men this age to assert masculinity; they are not yet men and yet definitely not children. A method of asserting masculinity and assuring social status is sought, and committing violent hate crimes is seen as a successful method of doing this for some young men. This could, therefore, be viewed as a negative effect of hegemonic masculinities. It does not follow that the existence of hegemonic masculinities leads to violence merely that, the existence of masculinities which engender power or status causes men to strive to assert these masculinities.

Men's health has, increasingly, been the focus of discussion and it has been thought the discrepancies in men's health may be due at least in part to masculinities. Men have been found to endure worse health than women; their life expectancy is less than women's and their disease outcomes are worse (Banks, 2004). Men in the US are more likely to suffer from chronic conditions and they have higher death rates in all leading causes of death (Courtenay, 2000). In Europe, health inequalities are also apparent. Men are more likely to die before the age of 75, and they have a higher death rate for all the leading

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<sup>30</sup> These crimes are referred to by Bufkin, (1999) as bias crimes, the term 'hate crime' is commonly used in the United Kingdom. This term is used to denote crimes which are committed because of the victim's race, gender, sexuality or other defining feature which is considered unacceptable to the criminal.

causes of death in younger age groups (Courtenay, 2000). Masculinities may be an important factor in these inequalities; however, only speculation is really possible as no empirical evidence can be offered for this. Employment is a factor which may lead to long term health problems. For example, working in a coal mine often led to breathing difficulties; however, women too have had to work in dangerous conditions or been employed in jobs that caused long term health problems. If the link between men and poorer health is that men have historically been seen as 'breadwinner' and thus forced to take dangerous employment in order to provide, then the poorer health now is a result of a problem with patriarchal society and masculinity.

It is impossible to generalise about all men; doing so would impose stereotypes that are not helpful when seeking to understand masculinities; however, men's health and expected health outcomes are different than those expected for women. Men are more likely to engage in risky health behaviours and less likely to participate in health promotion behaviours (Courtenay, 2000). Men's unwillingness to access health services is well documented (Griffiths, 1996; Lloyd, 2000; Addis *et al.*, 2003; Banks, 2004), as is the difference in the way that they communicate with partners and health care professionals (Moreau-Gruet *et al.*, 1996; Rosenthal and Peart, 1996; Elderkin-Thompson and Waitzkin, 1999; Evans *et al.*, 2004; Kiss, 2004). Differences in communication could worsen health by creating problems when discussing issues with health care professionals and also, in case of sexual health, problems in discussing safer sex issues with partners. Literature also shows differing support structures between men and women, which is discussed in relation to health outcomes or awareness (Moreau-Gruet *et al.*, 1996; Evans *et al.*, 2004). If health is expected to be worse for men than women, it is necessary for the reasons for this discrepancy to be investigated. Further research considering masculinities may enable these discrepancies to be better understood and understanding may foster improvements in health for men.

### **3:5 Changing role of men**

This section is included in order to introduce the subject of the changing role of men. Patriarchy was the previous norm in our society. Behaviour of society and the law supported the lesser status of women and the power and control of men. Not all men had the same power and control in their lives, but their power was

usually greater than women of a similar social standing. It is the change in the status of men or degeneration of historical ideas central to masculinity which has cultivated discourse about the 'crisis in masculinity' (Beynon, 2002). Therefore, I will first consider briefly the definition of patriarchy and consider the previous nature of masculinity in order to examine how this might have changed.

Patriarchy is defined by the Oxford Dictionary as:

*'a system of society or government in which men hold the power and women are largely excluded from it'* (Pearsall, 2001; 1360).

This would appear to be beneficial for men, but pressure to conform to accepted ideals and to maintain power could also be seen as a strain, which was unrecognised by the men themselves (Watson, 2000). Men, who have historically held power in western societies, have not chosen this status but rather it is forced upon them by stereotypes and expectations, making both men and women victims of patriarchy. Whitehead (2002) argues that, by taking on the role of victims of patriarchy, men seek to remove themselves from any blame in the propagation of a system so detrimental to women. However, doing so may directly conflict with ideas of hegemonic masculinity, making acknowledgement of this victim status unacceptable. It is important to note that men's power in a patriarchal society is couched in terms of their power over women, their dominant status in relation to women. The nature of hegemonic masculinities, which demand that men adopt an ideal of masculine behaviour and subsequently conform to it, serves to remove power from men (Whitehead, 2002). Men are therefore as disadvantaged by hegemonic masculinities as women.

Beynon (2002) discusses Imperial masculinities. Discipline and education sought to create young men fit for the British Empire. Beynon (2002) links the scouting movement to this and negative attitudes to male members of other races, who were portrayed as being inferior. Certain characteristics were promulgated as being masculine, for example, stoicism and moral courage (Mason, 1982). Baden-Powell (2004) was a notable proponent of these ideals stating that religion, fortitude and sobriety are all important attributes in boys. The book *Scouting for Boys* is filled with stories of bravery and chivalry in battle to illustrate the importance of qualities considered necessary. The scouting

movement itself begun as a result of a recognition that young men must be prepared for the important role they would need to take on, maintaining the large British Empire (Baden-Powell, 2004 [1908]).

There remain remnants of these ideals within modern ideals of hegemonic masculinities; Beynon (2002) suggests that these can be seen in sport and body building but I would also add that ideals of stoicism and courage are still important to men. This might be illustrated with taunts given such as 'crying like a girl', and perhaps the unwillingness of men to request help from medical professionals is also evidence of this ideal.

Patriarchy is no longer the officially accepted norm in British society, as defined by statute. Men and women are afforded equal rights to hold property and equality between the sexes is upheld in law (Equal Pay Act, 1970, Sex Discrimination Act, 1975). It does not follow that this leaves men and women equally regarded by society. Beynon (2002: 85) describes patriarchy as '*entrenched in rituals, routines and social practices*'. This being the case, more is needed to alter the status quo than changes in law. Whilst women and men in the same job can now expect to receive equal pay, average wages for women remain lower than those of men (Women and Equality Unit, 2006). This may well be because women are expected to take career breaks in order to have children and therefore either do not get promoted at the same rate as their male counterparts or take on low paid part-time work in order to manage child care. Equality must be owned and enacted by everyone in order to truly exist. Women who refuse to enforce equality in their own relationships and interactions continue their condition of inequality. It must be added that women cannot always be held personally accountable for a failure to assert their equality. Many women are not sufficiently empowered to assert their own rights, but some women choose to cede their rights and, in doing so, lose their equality.

It is the change in ideals and roles which is said to have provoked a crisis in masculinity. Men's status was previously defined by their power and control, loss of at least part of this has resulted in what has been termed by some authors a 'crisis'. During the last century a growth in feminism has encouraged consideration of masculinities and what it means to be a man. MacInnes (1998) explains that the discussion of gender and masculinities has begun amongst

men since they have lost power and status as a result of the decline in patriarchy.

### **3:5.1 Men in crisis?**

There has been increasing mention of a crisis of masculinity, though whether this 'crisis' is real for men or primarily a discourse in literature is debateable.

This idea has been posited in the literature because of the changing status and performance of men in society. There is no longer an 'ideal' family structure that everyone strives to achieve, roles both inside and outside the home are no longer clearly differentiated and individuals must define themselves. Previously typical ideals of masculinity are now commonly demonised. For example, a man who said that he thought a woman's place was in the home may be sharply put down now, but a hundred years ago this view may not have been questioned. Girls now achieve better A-level results than boys, and boys are more likely to be convicted of crimes such as grievous bodily harm (Heartfield, 2002).

There is not a similar discourse regarding a crisis in femininity. Popular literature mentions 'women who expect to have it all' and the danger of 'leaving it too late' to conceive children. Perhaps the increasing mention of such categories as 'yummy mummies'<sup>31</sup> is also evidence of the acceptance of women expecting to assume a number of roles successfully. If it is the case that the 'crisis in masculinity' has been provoked by the changing roles of women and men, one would expect at least some discourse about problems or a crisis faced by women. A literature search using terms 'femininity' and 'crisis' returned articles about the crisis in masculinity but no reference to women. This may be because women's roles are considered to be changing positively but men's roles are not. Discussion about the crisis of masculinity could be considered a response to feminism and associated societal changes.

Beynon (2002) suggests that men are experiencing a crisis, although this concept is difficult to pin down. Symptoms of this crisis could be said to be problems in society. Examples would include the change in men's role as bread winner; problems some men have with expressing their feelings and dealing with

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<sup>31</sup> This term is used particularly in magazines and tabloid newspapers to refer to mothers who continue to dress fashionably and have beauty treatments, look after their children, play the role of wife to their high earning husband and continue with their successful career as a model or actor.

physical or psychological problems; the change in the men's role in the family as more families break down; problems with crime committed by men, especially violent crime and the under achieving of boys at school (Beynon, 2002). It is difficult to determine whether these are symptoms or causes of this crisis. Beynon (2002) also notes the lack of clarity in the term 'crisis' – does this refer to a crisis of men or masculinity? Are men the victims or the cause? Do men feel that they are in crisis? Do they experience it in the same way as each other?

Whitehead (2002) proposes that this crisis is merely an attack against women and feminist issues; the idea of crisis creates victims of men. Whitehead (2002) suggests that this is an attractive idea for men who are in control of a large proportion of the world's resources; by becoming victims they can move away from their previous role as oppressor. This theory directly conflicts with ideas of masculinity expressed by other authors. Those men who exhibit dominant or hegemonic masculinities are unlikely to want to be perceived as victims of society or even of women; far from being beneficial to them, this would clash with their ideas about being a man and thus challenge their masculinities. Heartfield (2002) also argues that characterising men as 'in crisis' promotes a crisis in itself. By opposing the idea of crisis, men are espousing characteristics that have been described as problems in themselves. Assuming the role of the victim of a crisis may directly conflict with a man's ideal of masculinity and promote a personal crisis.

This crisis in masculinity is argued to have been affected by a change in the economy and labour force. Beynon (2002) argues that work and earning money is central to masculinity. The number of industrial jobs in Britain has reduced and the economy has changed, 'feminine jobs' are the most available and some men who are forced to do these jobs feel emasculated (Beynon, 2002). Haywood and Mac an Ghail (2003: 40) argue that masculinities at work are subjective and by no means homogenous, for example, not all men feel the same about who manages the money. Some men felt emasculated by allowing their wives to do this and others happily handed their wages over. The same authors suggest that their research shows a change in men defining their masculinity through manual work '*working with their bodies*' to men using their leisure time to '*work on their bodies*'. An example of this would be using a gym to change body shape (working with weights rather than undertaking cardiovascular exercise).

It has been suggested that the perceived crisis in masculinity does not exist (Heartfield, 2002); but instead there is a crisis of the working classes arising from changes in employment and class roles. It is true to say that there have been changes in society in the past hundred years. These changes have been named as causes for the crisis in masculinity, but could also be the cause of a crisis of the working class. For example, the depression in the 1930s meant that many men could not work to earn money for their families, but it also impacted on the working class as a whole. The link between the crisis in masculinity and the crisis in the working class is work and employment; therefore, contrary to the arguments of Heartfield (2002), they could both be described as in crisis for this reason. Beynon (2002) also argues that, whilst masculinity may be considered to be in crisis, this is nothing new. Crises of masculinity have been evident before, especially in times of social change, for example, demobilisation following the Second World War. The changing nature of hegemonic masculinities and the need to constantly reassert gender could lead to masculinities being described as in permanent crisis.

I do not consider that the 'crisis in masculinity' should be discussed without references to the changing roles of the remainder of society and the possible problems resulting from these changing roles. Whilst assuming the role of victim may not suit individual men due to a conflict with their ideals of masculinity, this does not apply to men collectively. Men and women are not yet equal in society. Promoting a discussion of a 'crisis of masculinity' without considering the problems experienced by others may advance inequalities.

### **3:6 Conclusions**

Masculinities are difficult to define absolutely and every man may express his masculinity in a variety of different ways. Despite defining and expressing their masculinities as they choose, men continue to be faced with hegemonic or dominant forms of masculinity which suggest that certain behaviours and ideals are more acceptable for men than others. Masculinities may belong to either men or women, but are most often expressed by men; they are influenced by time and place so that a man's social circumstance may have an effect on his masculinities. Those men who strive to express hegemonic forms of masculinity may have problems requesting help or expressing problems, and those men

who do not achieve or do not seek to achieve hegemonic masculinity are subjugated.

## Chapter Four: Methodology

This chapter discusses research paradigms available and reasons for the choice of a qualitative method. Possible methods of undertaking the research and the reasons for choosing Interpretative Phenomenological Analysis (IPA) are also discussed.

Difficulties were encountered recruiting a sample because this study considered a population who are hard to reach for research purposes and the subject of the research was a sensitive one, and these are examined. Definitions of terms are given and the limited literature in this area is discussed in order to give an insight into the problems.

The process of undertaking the study is discussed, as well as reasons for the choices that have been made. The methods used to analyse the data are considered and finally limitations of the methods chosen are examined and possible methods for assessing the quality of the study are also reviewed; because the method chosen for analysis focuses on the role of the researcher, reflexivity is included throughout the chapter.

The aims of this study were:

- To discover young men's lived experiences of addressing, or failing to address, their sexual health.
- To discover young men's experiences of negotiating masculinities relating to their sexual health.

### ***4:1 Research design***

Research methodologies are split, broadly, into two groups; quantitative and qualitative research. Quantitative research has long been a dominant methodology in many scientific, or quasi scientific disciplines, including nursing. Quantitative research is positivistic, only data that can be confirmed by senses and tested objectively can be identified as knowledge (Bryman, 2004). Quantitative research is concerned with generating empirical data that can be

tested and used to prove a hypothesis. Many studies related to the subject of masculine ideologies were quantitative. Examples include Sinn's study (1997), that assessed masculine ideologies as a measure to predict attitudes in men compared to other models by asking a sample to complete questionnaires; another study assessed attitudes towards male roles in adolescent men (Pleck, 1994). This study measured participants' agreement with statements about the male role.

Conversely, qualitative research emphasises the importance of the social world. An understanding or description of this is gained through interaction with its participants – for example, in the form of interviews or through observation (Bryman, 2004). Qualitative research is becoming more widely used (Benton, 2000); it offers valuable insights into the social world in which we live and people's interpretations of this world that could not be provided using only 'objective' data (Porter, 2000). Nursing is a discipline that involves person to person interaction. Quantitative methods would not capture the essences of these interactions, which cannot be quantified. Increasingly, nurse researchers have sought to investigate the lived experiences of their participants in order to capture information which cannot be obtained by quantitative research. The need to build a body of nursing knowledge is probably also contributory to the growth of qualitative nursing research undertaken. Other disciplines have also increasingly embraced qualitative methodologies (Smith, 2004). It is important that qualitative research is not viewed merely as an incorporation of the factors absent from quantitative research; qualitative research is a methodology whose aims are distinctly different from those of quantitative research.

Qualitative research seeks to explore the world by gaining an understanding of the experiences and feelings of those within it (Power, 2002), making a qualitative methodology particularly appropriate to discover the experiences of young men. Although a quantitative method could have measured their experience it would reduce that experience to numbers; in this way the research would not have uncovered any of the wealth of information that participants may offer. Quantitative research in this area would be suitable for measuring to what extent known factors prevented young men accessing sexual health services but would be unable to meet the research aims of this study; a qualitative method was, therefore, most suitable.

Participants were able to have some control over data collection because of the method chosen. In qualitative studies participants are able to engage with issues and subjects that are important to them and they do not merely have to provide information requested by the researcher. This was particularly important in this study because it was exploratory; allowing participants to explain and explore their feelings and experiences was imperative. No qualitative literature has been found that examines the reasons for young men failing to attend sexual health services. By using a qualitative method, a gap in the literature may be addressed and understanding of this phenomenon might be enhanced.

#### ***4:1.1 Choice of methodology***

A number of possible methods within the qualitative paradigm were considered. These are briefly discussed here and reasons given for the choice of Interpretative Phenomenological Analysis (IPA).

Ethnography involves the researcher becoming part of the culture under investigation, observing behaviour, interactions between people, and listening to conversations (Bryman, 2004). Ethnography is a suitable method for investigating or examining a culture. For example, ethnography has been used to study gang culture (Cintrón, 1998) and nursing culture (Street, 1992). Literature suggests that young men do not attend health services readily (Banks, 2004) so becoming immersed in this culture could prove difficult. An observational method may only provide insights and interpretations from the researcher's perspective and in this case it is important to fully understand and interpret the perspective of the participants. Data generated, although interesting, would not have met the aims of this study and would have taken a prohibitively long time to generate. This could also be an inappropriate method: for example, observation, a commonly used means of data collection in ethnography, would be intrusive given the subject under consideration.

Another method considered was grounded theory, which was developed in order to enable a researcher to generate a theory grounded in qualitative data (Willig, 2001; Charmaz, 2003). This method seeks to develop a theory by collecting data until 'saturation' has been reached (Bryman, 2004). It is a method suitable for the study of subjects about which little is known and involves generating a theory to explain a phenomenon; this method of research is undertaken

systematically and involves collecting data, analysing it and then returning to the data until data saturation is reached (Benton, 2000). Strauss (1990) explains that analysis and data collection are tightly interwoven and thus must be undertaken simultaneously. Multiple methods of data collection are useful in generating theories about paradigms and analysis is used to guide future data collection (Strauss and Corbin, 1990). Constant comparative analysis is employed in grounded theory (Bryman, 2004); data generated is used to inform the schedule of subsequent interviews, in order that comparison can be achieved. This constant comparison might lead to interviews becoming too unwieldy, putting young men off and preventing the acquisition of rich data about their lived experiences. Whilst a study using grounded theory could produce useful data, a theory would be difficult to produce because of potential problems with sampling and saturation.

Due to the sensitive nature of this study many data collection methods would not be suitable. This is, in part, due to the in-depth nature of interviews required to meet the research aim. Before undertaking the study, I felt that there would be a great range of opinions and feelings in young men and it would, therefore, be difficult to reach the saturation of data required to formulate a theory (Benton, 2000). Opinions and feelings about such a sensitive subject may differ widely over even a small group of similar young men. For example, young men who live in a similar area and enjoy the same activities in their free time may still have different attitudes and feelings about sex and may never have discussed with each other out of embarrassment. I felt that an exploratory study would be most suitable to address my research aims.

Discourse analysis has also been used in previous studies to understand interactions between patients and health service providers. This is a method that analyses the language used in interactions, either in spoken or written form, in order to better understand meanings of an occurrence (Morgan, 1999). It would not be suitable for this study as its principal interest is the language used in the interaction and how this sheds light on the experiences of those involved, not the lived experiences of the participants in the research (Traynor, 2003). In this study the participants are the key to understanding the phenomenon; they are experts in their feelings and it is their gender and behaviour that influences the phenomenon. Discourse analysis does not link the language used to the underlying thoughts and ideas (Smith *et al.*, 1999).

There has been discussion in nursing literature about possible methods of undertaking phenomenological nursing research (Paley, 1997; Paley, 1998; Paley, 2005). Spiegelberg (1982) suggests that there are so many styles of phenomenology that every researcher or philosopher could approach it differently. There are, however, common themes between some authors on the subject. Dowling (2007) suggests that phenomenological writers can be loosely divided into three schools of thought:

| School           | Descriptive phenomenology                                 | Hermeneutic phenomenology                                            | Dutch School                                    |
|------------------|-----------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------|
| Authors          | Husserl                                                   | Heidegger<br>Gadamer                                                 | van Manen                                       |
| Important points | Bracketing necessary; focus on description of phenomenon. | Bracketing not necessary; focus on interpretation of the phenomenon. | Described as a combination of the other schools |

Table three: Table to show an overview of the three different schools of phenomenology, adapted from Dowling (2004).

It is important to note that phenomenological thinking cannot be so clearly divided, as researchers have not stuck rigidly to one method or another but employed varying methods and styles of reporting (Cohen and Omery, 1994).

The philosophical background to a study must be considered because it is this background which explains the standpoint of the researcher and the approach that was taken to the data. The term phenomenology was first used by philosophers such as Kant and Hegel (Dowling, 2007). Husserl is regarded as the originator of the phenomenological movement. There are now many different traditions of phenomenology. I have sought to give an overview of some of these in order to explain the choice of method for my study.

Husserl considered that no phenomenon can be observed except through someone's consciousness (Giorgi and Giorgi, 2003). Orleans (2004) explains that phenomenology does not generate theories that can subsequently be empirically tested but describes to its readers the processes by which phenomena become part of the world in which we live. Paley (2004) suggests

that phenomenological research in nursing has tended to follow an Husserlian tradition. Paley (1997) argues that nurses have not correctly interpreted Husserl's work and the phenomenology they employ is merely a shadow of Husserl's ideas. It is possible that part of this misunderstanding originates from the translation and explanation given by the translators<sup>32</sup>. Paley (1997) explains that Husserl suggested that everything we know in relation to being should be put aside or bracketed, in order to gain an understanding of the essence (eidos) of phenomena. This is almost impossible and would remove any prospect of the researcher explaining results since no frame of reference would remain. It has been suggested that preconceptions of a phenomenon should be identified and then 'bracketed', in order to remove previous conceptions and biases, thus rendering one presuppositionless (Koch, 1995; Rose *et al.*, 1995; Walters, 1995). Removing previous biases could prove difficult, even with extensive reflective consideration, individuals have experienced many things that affect their preconceptions and removing them all could be impossible.

Heidegger developed the methods of Husserl, also concentrating on human lived experiences. Heidegger focused on an interpretation of these experiences but Husserl considered a clean, true, mathematically pure description most important. Heidegger referred to his method as hermeneutic phenomenology because of this emphasis on interpretation. Phenomenology without interpretation would provide a description of the experiences; it has therefore been argued that, without interpretation, phenomenology can be superficial (Todres and Wheeler, 2001). Annells (1996) suggests that when using hermeneutic phenomenology it is impossible for the researcher to undertake phenomenological reduction. Dowling (2004) also explains that Heidegger considered the elimination of presuppositions impossible. Others have suggested that Heidegger's methods were a revision of those of Husserl rather than a rejection (Racher and Robinson, 2002). Annells (1996) asserts that the tradition of hermeneutic research has, like Husserl's methods, been misinterpreted by nurse researchers.

Gadamer further developed the ideas of Heidegger. Dowling (2007) explains Gadamer's two central positions as

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<sup>32</sup> Although I have had to rely on translations in order to gain an understanding of the work of Husserl and Heidegger I have attempted to minimise the translation problem by reading many different authors and focussing on authors who used the original texts as references.

- Prejudgement – our preconceptions and previous experiences are tools that make understanding possible.
- Universality – both the researcher and the participants are connected by a human consciousness which ensures that understanding is possible.

Understanding is seen as possible only through historical awareness and therefore always carries prejudices (Fleming *et al.*, 2003). These cannot be eliminated because without them no understanding would be gained. A suitable method for undertaking research with Gadamer's philosophy is suggested by Fleming *et al.* (2003). Gadamer also considered that in order to reach an understanding, a dialogue must take place; this is not necessarily a conversation although it could be. The term dialogue refers to the researcher listening and being open to the opinion of another (Fleming *et al.*, 2003). Dowling (2007) explains this dialogue as an interactive process between the researcher and the participant, feedback and further discussion is important.

Phenomenology was first developed as a philosophy not as a method of undertaking research. Some authors have developed a form of phenomenology that provides both a philosophy and a guide for undertaking research using this philosophy. Psychologists from the Duquesne school in Pittsburgh developed an approach slightly different from those suggested previously, notably Giorgi, van Kaam and Colaizzi. Dowling (2004) explains their approach in three steps:

- Descriptions of experiences are divided into smaller sections or units.
- The researcher uses these and transforms them to create meanings, expressing them as phenomenological and psychological concepts.
- These transformations can then be combined to give a description of the experience.

These transformations have several aims: to generalise so that findings are not so situation specific; to explicitly express what is implicit in the data; to label or explain meanings (Giorgi and Giorgi, 2003). Giorgi and Giorgi (2003) draw on the thinking of Husserl to inform their position of 'bracketing', refusing to allow influences of presuppositions on the data. Colaizzi employed similar methods of data analysis but emphasised the importance of using an appropriate method of data collection for the research in question (Omery, 1983).

It is possible to see that phenomenological methods and thinking do not exist in isolation but co-exist with each other. Thinking is informed by that of other

authors and there is much overlap between them. Figure five appears to over simplify this, but some understanding must be gained of the differences between the methods, whilst appreciating their overlaps.

Rose *et al.* (1995) suggest that phenomenology is a suitable research method to employ in nursing. Nurses must have an understanding of phenomena affecting patients in order to care for them in a person centred way (Rose *et al.*, 1995). Without an understanding of feelings, emotions and experiences the nurse would merely be treating the patient's condition and not the patient. Oiler (1982) also considers phenomenology to be a suitable research method for use in nursing. This is because both nursing and phenomenology consider personal experiences of patients or participants to be important. Rose *et al.* (1995) describe phenomenology as a suitable method of research for nursing as it requires many of the same skills that nursing does; nurses must be able to listen empathetically to patients, to empower them to make decisions and offer advice and information where appropriate. The idea of qualitative research as useful for the participants involved is suggested by Hutchinson *et al.* (2002). By employing these nursing skills, an encounter which was both informative for the researcher and empowering for the participant could be achieved.

#### **4:1.2 Choice of IPA**

This study will use phenomenology with a method of data analysis known as Interpretative Phenomenological Analysis (IPA). This method was proposed by Smith (Smith, 1996; Smith *et al.*, 1999) and discovers lived experiences of participants, using a process of analysis into which the researcher enters (Reid *et al.*, 2005). This approach seeks to discover the participant's perceptions and experiences of their world, though the lack of objective reality in this is acknowledged (Smith, 2003). Larkin *et al.* (2006) explain that IPA has been developed with the use of Heidegger's thinking. Individuals are an important part of a world and this world is also an important part of the individual. Thus analysis is a result of the relationship between the researcher, subject matter and participant. Smith (2004) describes the process of analysis using IPA as a double hermeneutic; the researcher is attempting to make sense of the participant making sense of their world. I chose to use IPA because this method acknowledges the researcher's role in interpreting the data. My presuppositions and beliefs will be examined and incorporated. This method accepts my

influence on the findings. I considered this was particularly important because I am a young woman and thus have preconceptions and ideas about what it means to be a young man that are not based on experience. Failure to recognise the researcher's beliefs and ideas could lead to their effect being ignored.

IPA recognises the impossibility of completely putting one's beliefs and preconceptions aside and accepts that the analysis of participants' lived experiences by a researcher will be shaped by the researcher's own interpretation of the experiences as well as the effect of the participant's interaction with the researcher (Willig, 2001). Smith (2004) describes IPA as an epistemological position and a method of undertaking data analysis. As an epistemological position, IPA fits with other phenomenology, having been derived in part from Heidegger (the interpretative) and in part from Husserl (the idiographic). Ricoeur (1981) suggests that belonging to the world is an interpretative experience in itself, all understanding being affected by interpretation. I felt that a method must be chosen for the study which would embrace my impact on the data; acknowledging that the interpretation is a result of me, my belonging to the world and my resulting interpretations of the participants' lived experiences.

Unanticipated topics may emerge during analysis using IPA, which takes place on several levels. A basic level is analysis of what is said; deeper levels of analysis can involve consideration of, for example, words or tenses used and an interpretation of their meaning (Smith, 2004). In some ways this is similar to the methods suggested by the Duquesne school, in that analysis seeks to make that which is implicit in the data, explicit (Giorgi and Giorgi, 2003). However, IPA focuses on interpretation rather than description.

Smith (2004) describes IPA as being idiographic, inductive and interrogative. Using a small sample group not only allows a detailed and in depth analysis of participants experiences but also can help to facilitate a deeper understanding of experiences that may be shared by others and yet could not be examined on a large scale owing to their complexity. Smith (2004) describes this as 'essence' and links the idiographic component of IPA to Husserl's phenomenology. IPA is inductive because the analysis is led by the data, allowing unexpected subjects and themes to emerge. In order for analysis to be properly inductive, I ensured

that the transcripts were read suspiciously as described by Ricoeur (1981), in order to expose concealed meanings (Ruthellen, 2004). The interrogative aspect of IPA is the in-depth analysis of the data that allows themes to emerge on different levels. IPA uses the subjects discussed and language used, for example, tenses, to illuminate the experiences of the participant. Analysis could be described as comprising many layers (Smith, 2004). This deep analysis was part of the reason for my choice of IPA. I anticipated some problems recruiting a sample and therefore wanted to gather the most information possible from the sample recruited.

As a young woman investigating the experiences of young men, it was important to select a method and philosophy of data analysis that embraced this instead of negating it. I also recognised that my presence in the interview may affect the interaction, which is accepted by IPA. I did not feel that I would ever be able to truly put aside all preconceptions and prejudices. Smith *et al.* (1999) describe the researcher's own perceptions and ideas as essential in order to make sense of the participant's personal world in an analytical way. The researcher's own experiences form part of the analysis. This affects the way in which the participant's world can be viewed. By making the researcher explicitly part of the process in this manner, differences in experiences and possible biases are exposed instead of being concealed.

#### **4:2 Reflexivity**

Despite recognising that my own position was important as the researcher I considered that it was crucial for me to examine my preconceptions and beliefs in order that I would be better able to understand them. I have based my reflections loosely on a tool proposed by Johns (Johns and Freshwater, 1998)<sup>33</sup>. I did not follow this rigidly, as the tool relates more to practical situations and experiences. I wanted my reflection to expose who I am and factors that may have influenced the interaction I had with the participants. The tool involves considering:

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<sup>33</sup> See Appendix thirteen, page 320, for a copy of this reflective tool.

- aesthetics of a situation - how and why I responded in the way I did.
- personal - how I felt.
- ethics - the difference or similarities between personal actions and beliefs.
- reflexivity - how a similar situation could be better addressed in the future.

I feel that my gender and background is an important part of who I am. I am a young woman. When I began undertaking this study I was relatively close in age to potential participants. I chose to curtail the upper age limit of the participants in order that I would be a little older than everyone I was interviewing. It is unusual for age to be a factor when undertaking research in this way; many researchers are younger or a similar in age to participants and it does not become a problem. I wanted to provide distance for the participants in order that they would feel more comfortable and willing to discuss potentially sensitive subject areas. Hutchinson *et al.* (2002) found that two thirds of the young men participating in their study were happier to be interviewed by a person of the same age or a little older than them. I felt that being a little older would mean that the participants viewed me as a person outside their peer group and thus might find it easier to talk to me.

It had been suggested to me that being female could prove a problem when asking young men to discuss sensitive subjects with me. Hutchinson *et al.* (2002) found that only a third of their participants stated that they would prefer a man to interview them and Spencer *et al.* (1988) found that men were more comfortable disclosing to women. After one of my interviews I found myself talking to one of the participants because I bumped into him at the leisure centre where I had first met him. He initiated a conversation in which he offered to persuade other young men who used the centre to participate, I gratefully declined this offer but was interested that he said he had found it much easier talking to me because I was a woman. He said he would not have volunteered if a man had been conducting the interviews. In my experience the young men were open and willing to discuss sensitive issues. It is impossible to know if these young men would have talked in the same way to another man; the comments above suggest that they might not have done. I have included some further reflections in the appendices.

### **4:3 Data collection**

Data collection when using IPA may be through semi-structured interviews, diaries, focus groups and unfocused (or unstructured) interviews. Because of the sensitive nature of the subject, focus groups may not have led to the generation of rich data about masculinities. Young men may be unwilling to discuss sexual health matters with other young men present. Focus groups have been used successfully for the discussion of sensitive subjects with young people (Hyde *et al.*, 2005); however, although Hyde *et al.* (2005) had success, a greater number of participants was used (n=124), recruited through schools and colleges. I did not want to recruit through schools because I felt that a large number of young men in the area where my study took place would be excluded having left school. Recruiting enough participants to use focus groups would be difficult without using educational establishments.

Diaries were considered but deemed unsuitable because encouraging young men to continue to keep a diary over a protracted period might have been difficult. I suspected there would be a lack of compliance amongst the young men.

Interviewing can be used to generate data for IPA. Semi-structured interviews encourage the participant to discuss issues important to them whilst allowing important areas to be introduced by the researcher through the use of prompts. IPA treats participants as experts in their own experiences and listens to them telling their story (Reid *et al.*, 2005), making semi-structured interviews an ideal method of collecting data for analysis in this way (Smith *et al.*, 1999). This interview structure enables the researcher and participant to work together to uncover the participant's experiences (Smith *et al.*, 1999; Reid *et al.*, 2005). Semi-structured interviewing allows the researcher to lead but gives freedom to the participant who is able to take part in directing the interview. This allows the participant power over the interview and the subjects that will be discussed (Lee, 1993).

Because this method of data analysis is detailed, using a large number of participants may lead only to the identification of shared experiences with the result that individual feelings, beliefs and incidents may be lost. In order to

facilitate a detailed and individual analysis of transcripts the number of participants in this study was small (n= 7). This is a suitable number of participants for analysis using IPA (Larkin *et al.*, 2006). Smith and Osborn (2003) find that using too many participants can create an overwhelming amount of data that would lead to only a general analysis, whereas IPA is committed to '*Painstaking analysis of cases*' (Smith and Osborn, 2003: 54). This small sample was never expected to lead to generalisable findings but through in depth analysis I hoped to discover the lived experiences of a small group of young men.

#### **4:4 Difficulties with sampling**

It would have been inappropriate to recruit the sample for this study from a health care setting because the study sought to discover the experiences of young men who did not readily access health care. Indeed, there is no sampling frame that would enable access to a selection of young men from every social background that was suitable for use in this study. I therefore deemed the population to be 'hard to reach' for research purposes and considered sampling strategies with this in mind. Knowing that the subject of the study was potentially sensitive also affected which sampling methods would be suitable.

A hard to reach population is described by Faugier and Sargeant (1997) as a population which shares characteristics that may be considered threatening to its members. This definition is imprecise, it confuses the terms 'hard to reach' and research on 'sensitive subjects'. Terminology should not be confused. A 'hard to reach' population is a population which is difficult to sample or access for the research being undertaken, for example, any population that does not have a straight forward sampling frame such as people of a particular age or gender with nothing else in common. These people would be 'hard to reach' simply because it would be difficult to approach them and invite them to participate. Literature often couples 'hard to reach' populations with hidden populations (Faugier and Sargeant, 1997; Benoit, 2005,). A 'hidden population' is usually 'hard to reach' but a 'hard to reach' population is not necessarily 'hidden'.

A 'hidden' population is one that has no defined limits (Faugier and Sargeant, 1997). For example, there is no reliable source to establish the exact size of the

population and membership of the population may depend on personal perceptions (Hampshire, 2002). A 'hidden' population is, therefore, difficult to sample as the researcher can only estimate its size and location; the researcher may also not be aware of existing subgroups within the population. This type of population is also referred to as a 'low visibility' population by Biernacki and Waldorf (1981). For example, prostitutes or illegal drug users would constitute a 'hidden population' as there is no information about the size of the population. Labels also depend on personal perceptions.

Lee (1993) concludes that all research that creates a considerable risk to those involved in it should be considered as sensitive. Such risks may result from the behaviour under investigation, a taboo surrounding the subject of the research or the possibility that the research may have implications for future care or political consequences. Such research could have consequences for the participant alone or a wider social group (Sieber, 1992). For example, a carer may consider research about respite care to be sensitive; as they may fear the withdrawal of care or that the patient would be provided with a lower quality of care if they are critical of the service. The carer could also be concerned about the possibility of this care being withdrawn if it were found to ineffective or if people are not happy with it. These fears and concerns may be completely unfounded but would never-the-less affect the willingness of the carer to participate in research.

The more sensitive the subject under research the more difficult sampling becomes (Lee, 1993) which is why there is need for a greater body of literature discussing issues involved in sampling hard to reach populations for research on sensitive subjects. A subject not considered sensitive by the researcher may contain hidden taboos or difficulties for potential participants, however, research deemed sensitive by the researcher may not appear so to potential participants. It is therefore important that such research is approached considerately by the researcher.

The issues of sensitivity, hidden taboos and hard to reach populations are closely linked and are often difficult to separate. For example, in relation to research on intravenous drug users, the behaviour is sensitive because it is socially stereotyped and illegal. It may be hard to reach potential participants because they undertake this behaviour discreetly; they are also a hidden

population because we cannot know the exact number of people who use intravenous drugs.

As sampling a 'hidden' population for research on a sensitive subject presents difficulties, results will not be generalisable across the population. This is also true of sampling with a 'hard to reach' population; because of the difficulties generating a sample, the researcher cannot always ensure that all sub-groups are represented. In the case of this study I am aware that not every young man likes to attend gyms and keep fit; some young men like to play computer games, but there was no way to access these young men.

#### ***4:5 Possible sampling methods:***

##### **4:5.1 Volunteering**

Pomeroy (1963), writing at a time when non random sampling was not the norm, observed that the most successful method of sampling in research about human sexual behaviour was to allow potential participants to volunteer. Simply giving potential participants information about the study, thereby allowing them to volunteer, can create its own problems. For example, the sensitive nature of the research could discourage participants from volunteering or attract a certain group of people, whilst excluding others. A further difficulty lies in making potential participants aware of the research. When considering hard to reach and hidden populations, provision information about the study may be particularly problematic. For example, posters advertising research may be chosen as a method to give potential participants the opportunity to volunteer, but there may be no suitable place to display posters when sampling hidden or hard to reach populations. When research is about a sensitive subject, potential participants may be reluctant to be seen looking at posters or may be offended by them.

##### **4:5.2 Convenience sampling**

This method involves recruiting participants who are convenient to the researcher (Bryman, 2004). Some other sampling strategies fall into this category including community partnership and snowball sampling. The strategy could be as simple as standing on a street and stopping people as they pass.

Great caution must be exercised in interpreting data from convenience sampling. Like volunteering sampling, there is a self selection problem to acknowledge; however, in many research studies this method is the only appropriate one to access a sample, therefore these problems must be acknowledged but cannot be circumvented.

#### **4:5.3 Community partnership**

This refers to a partnership between researcher and a community organisation, particularly where services are being provided to potential research participants. For example, Benoit *et al.* (2005) accessed participants for their study in partnership with a community organisation which provided services for prostitutes. Some of the problems of conducting research with sex workers in Canada are discussed by these authors, who describe the population as 'hidden' because there is no way of knowing its exact size. The subject is particularly sensitive because sex work is stigmatised, so ex-sex workers were trained as research assistants to conduct interviews and participants were recruited in collaboration with a community project.

It was hoped that the use of research assistants with experience of working in the sex trade would help participants feel more comfortable. This strategy may have resulted in data being misconstrued, if the research assistant assumed understanding and then failed to encourage discussion of ambiguous topics or words. This strategy may have also prevented participants from discussing subjects that they assumed to be taboo to others working in the sex trade. The ability to question participants' experience is essential and a critical analysis of the researcher's own suppositions is essential (Kvale, 1996). Benoit *et al.* (2005) do not explain how they ensured that the research assistants were able to achieve this.

Owen (2001) discussed the problems of conducting focus groups with vulnerable clients, who were accessed through a pre-existing community care service. Whilst she does not offer a definition of vulnerable in relation to the research, it is explained that the participants in this study had '*serious and enduring mental health problems*' (Owen, 2001; 653). By seeking the assistance of service providers Owen (2001) was able to gain access to a hard to reach sample. Employees of the service acted as gatekeepers and only recommended those groups of women they felt suitable for participation. This is

a problem when collaborating with local services and has been encountered in research in other areas; potential participants are often 'screened' for suitability by those asked to recommend them (Martin and Dean, 1993). Using pre-selected participants in this manner may mean that sub-groups of the population are not represented and may also affect the information that participants are willing to provide. For example, participants may worry that their care would be affected if they gave negative information about their care givers.

Working with service users to design and develop research can overcome these problems and empower the service users. Research has successfully been undertaken involving mental health service users at every stage of the research process to discover their views of medication (Northway and Wheeler, 2005).

#### **4:5.4 Snowball sampling**

In snowball sampling, contacts are made within a population of interest and individuals are invited to participate in research. Participants are then asked if they know of any other members of the population who may be willing to participate. Bryman (2004) explains that snowball sampling is suitable when conducting research with a hidden or hard to reach population. Behaviour among a group of people who have nominated each other may be similar and individuals may have influenced each other's behaviour.

This method was notably used by Becker (1963) in a study of marijuana use. Becker (1963) describes the population under consideration as 'deviant'. It was also hidden and hard to reach, having no known size or sampling frame. Having worked in a population who used this drug (as a dance musician), the author invited colleagues to participate and subsequently asked them to recommend other potential participants. Becker (1963) also asked research colleagues involved in studies with similar populations to recommend potential participants. Although a large number of participants in the study were musicians, there were participants from other employment backgrounds. Recruiting first from a population the author knew well could cause problems; meanings may have been assumed and ideas not fully explored. Becker does not explain how these issues were overcome in the interviews. The author conducted the research in order to test an hypothesis, however, testing this hypothesis on the population which also contributed to its formation may not produce valid and reliable findings.

Snowball sampling has also been successfully used by Brooks (1998) to discover men's views on hormonal contraceptives for men. Men (n=250) were accessed through their fitness club and, if willing to participate, were asked if they knew others who might be willing to take part. The population sampled in this study were not hidden, as the population of men in Britain is known. However, owing to the sensitive nature and subject of the research, they became a hard to reach population. This study was quantitative in design and although the sample obtained could not be considered representative of the whole population, the sampling method addresses some of the difficulties of obtaining a sample population for research on a sensitive subject.

#### **4:5.5 Limitations**

Ensuring that limitations of a sampling strategy are acknowledged is essential. When undertaking research with hidden populations the sample generated cannot be random, as there is no definitive information on the size or nature of the population. It is therefore suggested that a tentative map of the population is formed (Blanken *et al.*, 1992; Faugier and Sargeant, 1997); this can be done in discussion with others who may have knowledge of the group, for example, networking with those who provide a service to the hidden population in the area, talking to potential participants and using any pertinent information such as census data. One advantage of this strategy is that a researcher may become aware of a subgroup that had not previously been considered.

#### **4:6 Decision regarding sampling for this study**

Despite its drawbacks a convenience method was chosen for this study; if an opportunity had arisen to use snowball sampling, it would have been considered an appropriate tool for gathering further participants. An attempt to encourage volunteering was also made; posters and leaflets were placed in leisure centres where young men were to be recruited. Although all the young men later spoken to had seen the posters and read the leaflets, none of them were interested enough to call or email the researcher to find out more. Speculation as to the reasons for this include the possibility that young men were too embarrassed to take down a phone number in front of their friends or did not feel that they wanted to commit themselves to taking part.

The sample was purposive; only men between the ages of 16 and 20 were invited to take part. Men of this age have been selected as they have a high incidence of STI (Lavery *et al.*, 2006; Health Protection Agency Centre for Infections, 2008) and teenage pregnancy is high in Wales (Social Exclusion Unit, 1999). Young men have also been found to have the least knowledge about sexual health (Carver *et al.*, 1990; BBC, 2001; Blake, 2004).

The study only considered the experiences of heterosexual young men. This is because knowledge and attitudes around sex and sexually transmitted prevention strategies could be different in homosexual men, who have been targeted specifically by sexual health services and health promotion in the past (Department of Health and Social Security and the Welsh Office, 1987). Weeks (1976) points out that books on homosexuality now abound; considerable research about sexual behaviour amongst men who have sex with men has been carried out (Connell *et al.*, 1991; Martin and Dean, 1993; Flowers *et al.*, 1998; Hope and MacArthur, 1998; Flowers, 2001; Walker, 2001; Flowers *et al.*, 2002; Hart *et al.*, 2002; Davidovich *et al.*, 2004; Ross *et al.*, 2004; Kitzinger and Peel, 2005; Moralee, 2005; Whittier *et al.*, 2005; Bakker *et al.*, 2006; Steven *et al.*, 2006; Health Protection Agency, 2008a).

Because of this substantial body of research, only heterosexual men were considered in this study. As the study was small I considered that it would be best to limit the potential sample in this way in order that the participants would be in some way comparable. I judged that the experiences of young homosexual men might be so different that this would lead to a profusion of themes and information which could not be formed into any interpretation of the lived experiences of the participants involved<sup>34</sup>. I also thought that there were gaps in knowledge about the lived experience of heterosexual young men which had not been previously addressed. I decided that all men who met the criteria and volunteered would be interviewed, but only transcripts from those who did not identify themselves as homosexual<sup>35</sup> would be included in the analysis. This

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<sup>34</sup> This certainly involved conjecture as there was no way to know what participants would say or do during the interview and literature cannot foretell this. I made this decision because I felt that there was the potential to contribute better to knowledge by considering heterosexual young men as there are substantial gaps which required filling.

<sup>35</sup> If a participant disclosed a sexual experience with another man but did not define themselves as homosexual, their interview would have been included in the analysis.

situation did not arise, as none of the young men who took part identified themselves as homosexual, either before the interview or during it.

Recruiting the sample from schools and colleges was considered but this would have excluded a large group of the population who leave school at 16. Young men who stayed at school for longer may have received sexual health input at school, even if this only consisted of posters or a nurse available at the school. I wanted to consider those young men who had less opportunity to obtain information than this. Youth groups were also considered but the County Borough in the area provides sexual health nurses who attend youth groups and are able to provide contraception, advice and referrals to other health care professionals. This service is well used in the area and therefore recruiting from youth groups would have been inappropriate, because young men attending the groups may have been better informed. Accessing young men in pubs and clubs was also considered as a possible method of collecting a sample. However, because of researcher safety and the possible problems of arranging subsequent meetings with young men who had been drinking it was decided that this would be unsuitable.

A university was also considered as a location for accessing participants. Advertisements would have been placed and maybe lecturers asked to invite students to participate. As not everyone attends university and those who do are possibly better educated and equipped to negotiate the health care system than the majority of the population, it was decided that this would exclude many young men's experiences. Finally, it was decided to recruit participants from local leisure centres. Whilst it may seem that use of gyms and leisure centres is associated with healthy behaviour, this is not always the case. Baker *et al.* (2006) have shown that male gym users in a similar geographical area to this study are often users of anabolic steroids which is a damaging behaviour associated with ideas of masculinity (Haywood and Mac an Ghail, 2003). Local leisure centres provide a gym, usually a swimming pool and also fitness classes and instruction. They are often more affordable than private gyms and therefore are attended by a cross section of the community<sup>36</sup>.

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<sup>36</sup> No references are provided about the attendance of the local authority leisure centres or the facilities they offer as this might compromise the anonymity of participants, by allowing the geographical area in which the study took place to be made known.

#### 4:6.1 Details of areas where recruitment took place

The sample was recruited from three local authority leisure centres that are situated in three varied geographical areas:

- **Leisure centre number one** is in easy commutable distance of a large city and near good transport links.
- **Leisure centre number two** is in a small Welsh valley town. The town comprises a linear development and has few facilities, although there are some shops and pubs as well as the leisure centre. The participants did not feel that the nearest large towns and cities were far away, indeed, one of them commuted daily, although it often took more than an hour as the roads are not large and thus susceptible to traffic problems.
- **Leisure centre number three** is in a town with good transport links to larger towns and cities and also to the motorway, although it is the furthest away from the motorway. The town has many shops and supermarkets. The participants from this town did not regularly go to the nearest city but stayed in the local area.

#### 4:6.2 Methods of recruitment

Posters and leaflets were placed around the leisure centre and I attended regularly, sitting outside the gym<sup>37</sup>. This provided me with the opportunity of making personal contact with young men and inviting them to take part in the study. At the first meeting an information sheet was given out and discussed and a convenient time to meet again was arranged. At this meeting I told potential participants that I would give them a small gift voucher in order to thank them for their time.

At the next meeting, at least a week later, the consent form for the research was discussed and signed and any questions answered. A time for the interview to take place was then arranged with the young man. This 'cooling off' period is in line with Central Office for Research Ethics Committee<sup>38</sup> (COREC) guidelines, who recommend a two week 'cooling off' period (COREC, 2005). I met the participants after one week to look at the consent form and explain it, in order that questions they wished to ask could be answered.

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<sup>37</sup> Copies of leaflets and posters used can be found in appendix six, page 307.

<sup>38</sup> When the research was planned COREC guidelines were followed. This organisation no longer exists and has been replaced by the National Research Ethics Service (NRES) <http://www.nres.npsa.nhs.uk/>.

This method of recruiting participants was designed to enable young men, who could not be easily accessed in another way, to be offered the opportunity to take part in the study. Sitting at the leisure centre created problems for me and, although posters and leaflets were displayed, no young men contacted me as a result of having seen these. In order to recruit young men to the study it was necessary for me to approach them and introduce myself. I found it difficult to judge the age of the young men arriving. This appeared tactless especially as most young men had seen the posters and therefore knew the age of young men I wanted to talk to. I felt awkward approaching young men and when their age was not within the range required for the study I felt that I had insulted them<sup>39</sup>. I sought to overcome this difficulty by introducing myself to all the young men who attended the gym whilst I was there. This offered me the opportunity to introduce myself to people attending the gym so that they knew who I was and why I was there. I hoped that doing this would enable me to talk to all the young men who attended and would mean that they did not feel uncomfortable when I was there.

This method of recruitment was successful; but difficult. Two hundred information sheets were distributed, seventeen young men agreed to consent, nine young men consented and seven young men took part. Potential participants were given opportunities to decline, some did not come to the second meeting when the consent form would have been signed and others did not turn up for the interview, having signed the form.

#### ***4:7 Data collection***

This study consisted of semi-structured interviews with young men (n=7). These were carried out by the researcher. I had intended to conduct between six and eight semi-structured interviews with young men but I had trouble recruiting participants. At leisure centre three I had three interested young men. The first did not arrive for his interview and the second and third attended together. They insisted on being interviewed simultaneously and, owing to the difficulties experienced recruiting participants, I acquiesced. The interview with two participants (Owain and Gwyn) generated rich data and allowed interplay between young men to be observed.

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<sup>39</sup> There were very few young men attending the gym who were below sixteen years old, although there were a few. When I approached young men who were much older than 20 I felt that I had insulted them by suggesting that they looked young and immature.

I discussed the study with a young man and arranged to meet him the following week in order to sign the consent form. Interview times were arranged with the young man the second time he met me. I also asked the participants if they wanted to provide their mobile phone number and I gave them the number of my mobile phone<sup>40</sup>. I asked the participants if they wanted to receive a text message before the arranged time to remind them. They all agreed to this, meaning that most of the participants arrived for their interviews (although many were quite late). This text also reminded the participant that they could withdraw from the interview if they wished without giving a reason. This was included, so that the participants did not feel pressured by receiving the text message, although they had previously agreed to be contacted in this manner. Thus I met each young man three times: once to introduce the study, once a week later to sign the consent form and arrange the interview and then the following week for the interview.

This method of recruitment allowed the young men to withdraw their consent easily. Two hundred information sheets were distributed; some were given to young men and others left in the leisure centres. A total of seventeen young men agreed to a second meeting; only nine attended for their second meeting to sign the consent form and of these, seven attended for the arranged interview.

#### **4:7.1 Practical details of interviews**

Interviews took place at the leisure centre; this allowed the participants to feel more comfortable as they were in familiar surroundings (Hutchinson, 2002). It also provided safety for the researcher, as help could have been requested from staff if required. Each leisure centre had different facilities, meaning that the rooms in which the interviews took place were different.

- **Leisure centre one** – the interviews took place in a small room near the gym. The room had a table and two chairs and it was easy to manage recording equipment. Staff in the gym and the interview room had a small glass window in the door. I sat in the chair nearest the door so that any one passing could only see me if they looked through the window. The room was uncomfortably hot, perhaps due to its size. This

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<sup>40</sup> I had a mobile phone dedicated to the research project, in order to overcome any safety issues associated with distributing my personal number.

rarely appeared to matter to the participants who were dressed in gym attire. I could arrange to use this room at any time suitable for the participant. I asked the participant for two or three times and dates that would be suitable and then negotiated with gym staff to find an appropriate time. I ensured that the participant waited outside so that the gym staff did not know with whom I was arranging an interview.

- **Leisure centre two** – facilities were more difficult at this leisure centre; there was no small room but I was offered the opportunity to use an office behind the reception desk. The problem with this was that the office was in use until 5.30pm so interviews could only be arranged after this time. This prevented some potential participants from taking part. The room was an office, so there were sometimes interruptions; after every interruption I asked the participant if they were happy to continue. I tried to arrange interviews at times I knew the leisure centre would be quiet to protect the anonymity of my participants. At this leisure centre, I found that the clients knew the reception staff and told them themselves why they were there and what I was doing.
- **Leisure centre three** – there was no problem arranging space to conduct an interview at this leisure centre. I was offered an upstairs office but, as the participants could only attend in the evening, the manager did not feel that this was suitable and therefore provided a downstairs office. We were not disturbed during the interview and the room was a comfortable size to accommodate participants and recording equipment. It was at this leisure centre that a joint interview was undertaken, at the insistence of the participants.

At the beginning of the interview, I reintroduced the consent form. I reminded the participants that they may withdraw at any time or refuse to answer any questions that they wished.

IPA requires in depth analysis of data. The words and tenses used by participants are important; I therefore wanted to record the interviews and then transcribe them. I requested the participants consent to do this on the consent form but I also asked them again at the start of the interview. I gave the participants ownership of the recorder, placing it near them on the table and showing them how to stop recording if they wished to. At the start of one of the

interviews I was having some problems with the recorder and the participant was able to help me. In some circumstances this would appear unprofessional; in this instance, helping me gave the participant ownership of the encounter and control over the interview situation. When I pointed out that he could stop the recording at any time he joked that he would be better able to do this than me. This is evidence both of his ownership of the situation, some degree of comfort and a developing rapport.

Gadamer (1975) described a conversation as a process of two people opening themselves to the other person in order to understand their point of view. A research interview, however, begins from an unequal point, the researcher is attempting to discover the experiences of the participant but the participant may have little interest in the researcher's experiences. This creates an asymmetry of power (Kvale, 1996) in which the researcher becomes the most powerful. I wanted to redress this asymmetry and give power within the interview back to the participants; in part I felt this would enable them to best describe their lived experiences but also because I felt that participants ought to have ownership and power when discussing potentially sensitive subjects. I had anticipated some problems developing rapport. Berk and Adams (1970) point out that when a researcher does not know what to expect encouraging a participant to talk about a sensitive subject can be impossible.

As a young woman I was aware that I could never know what it feels like to be a young man and therefore I did not know what to expect. I was also aware of my position as a novice researcher, which can also pose problems for rapport development (Berk and Adams, 1970). Consequently, before commencing data collection I had requested and was given interview training by experienced researchers. I also allowed participants control of the tape recorder and attempted to tell them a little about myself in order to help address this problem. This was done carefully because I did not feel it would be appropriate to discuss my sexual history with participants; a truly equal discourse would have involved this (Gadamer, 1975). I started the interview with discussion about general subjects and general health; this developed a conversation and rapport but also allowed me to reflect some superficial personal information, for example, what I do for a living or my experiences at university.<sup>41</sup>

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<sup>41</sup> An outline of the interview structure which I used as a guide can be seen in appendix four, page 302.

I asked the participant at the start of the interview if they were comfortable and if they wanted a glass of water. I told them that I expected the interview to last about 45 minutes and asked if that was alright with them. The interview consisted of discussion about the participant, their life, their general health and then sexual health and sexual health help seeking (see appendices for interview prompts). During the interview I showed participants some pictures of symptoms of STI to promote discussion.

At the end of the interview I asked if there was anything they wanted to add or if they had any questions. Two participants wanted to ask further questions about STI, and one participant wanted to tell me about his sexual history and previous partners. One participant started to talk again after I had turned off the tape recorder; he wanted to talk about drug use in the leisure centre where we were having the interview and the young men who used drugs. Bryman (2004) warns that this can happen and suggests that the tape recorder is left recording for the entirety of the time the participant is with the researcher. Given the sensitive nature of the disclosures by the participant in this instance, he might have asked to turn the tape recorder off anyway or refrained from discussing the issue.

#### **4:8 Ethical considerations**

There are many ethical considerations generated by discussing a subject so sensitive with young people. Only participants deemed to be capable of giving valid consent for participation in the study were invited to take part. The study was explained and discussed with them to ensure that they understood it before they were asked to consent. The interview style was explained, as was the aim of the research. This ensured that the participants understood the aim and purpose of the study before agreeing to participate. It is important that potential participants understand what is involved in being part of a study before they give their consent (RCN, 2004). Young men approached were under no obligation to participate and were informed that they could withdraw from the study at any stage if they so desired. They were told they could refuse to answer any question without giving a reason or leave at any time they wished. Hutchinson *et al.* (2002) suggest that participants are reminded of this during the interview to aid their comfort; this was done as discussed earlier. I also felt that it was important to explain to the participants why I was collecting this information. I

told them I was a student and talked a little about why the research was important, usually when I first introduced them to the study.

Participants' anonymity has been ensured; names were not mentioned in the transcription but substituted for pseudonyms and the area of recruitment has not been named. When attending a new leisure centre I was also careful not to mention to staff the previous sites at which I had recruited participants in order to protect anonymity of previous participants. University lone working procedures were followed at all times to ensure my safety and the safety of the participants. I only undertook interviews when others were present in the building, I ensured that my location was known along with an expected time of return and I always carried a mobile phone. Following the interview the participants were provided with information about local sexual health services and telephone counselling services, as the interview covered potentially difficult subject areas, such as STI and contraceptive use. This promoted the idea of the research interview being beneficial to the participant as suggested by Hutchinson *et al.* (2002).

If the participant had disclosed experiences such as abuse these would have been discussed. It was unlikely that the participant would disclose anything due to the short term nature of the participant/ researcher relationship. Potential disclosure could have been addressed by discussing things raised by the participant. If a disclosure had been made that had not previously been confided to anyone, it would have been important to allow the participant control. By discussing the situation with the researcher the participant could have been encouraged to report problems to a professional themselves. It may have been that they needed information about how to do this, which could have been provided. Dealing with disclosure in this way allows control to remain with the participant whilst ensuring that abuse is not allowed to continue.

The Nursing and Midwifery Code of Conduct states that confidentiality must only be broken:

*'if disclosure can be justified in the public interest (usually where disclosure is essential to protect the patient or client or someone else from the risk of significant harm)'*

*'if disclosure is required by law or by order of a court'* (Nursing and Midwifery Council, 2002).

Therefore, disclosure would be made only if abuse were ongoing or if the young person were under protection of the local authority (Welsh Assembly Government, 2004). At the beginning of the interview the participants were told about this and no participants made any disclosure which required me to break their confidentiality.

Ethical issues are raised by informing the participants that there will be some compensation for their time, namely that potential participants should not feel pressurised or compelled to take part. I overcame this by not telling the young men the value of the gift they would be given. I chose to tell the young men before the interview that they would get a voucher for practical reasons. I wanted them to have something useful; by telling them, I could ask from where they would like their voucher.

Most of the young men requested vouchers from high street clothing shops. I would not have instinctively chosen vouchers from these shops, so I was glad that I had asked. This probably reflects my preconceptions about what the young men would wear and be interested in. I had expected them to request vouchers for shops where DVDs and video games could be bought. Asking for vouchers from the clothing shops that were requested reflects an interest in fashion and appearance that I had not expected. This reveals some of my prejudgements or preconceptions about masculinities. I had not realised that I did not expect young men to be interested in their clothes but this was the case. Before commencing the study, I had thought appearance was an important part of masculinity; recruiting in gyms reflected this belief as exercise can change appearance.

#### **4:9 Analysis**

The data collected were analysed with the use of IPA (Smith, 1996, 1999). This method also takes into account the researcher's own perspectives, which help in the analysis and interpretation of the data (Smith *et al.*, 1999). It is a sincere method in that the preconceptions of the researcher are laid bare through

reflection. This is more honest than imagining that all preconceptions can be laid aside for the duration of the research. Whilst undertaking the research, I became aware of personal opinions and suppositions that I had neither examined nor challenged previously. As this only became apparent during the research or analysis process it would have been impossible for me to lay them aside before beginning.

Interviews were transcribed verbatim by the researcher and subsequently read through numerous times. This was done in order to become immersed in the data, as described by Ritchie and Spencer (2002) who find that in qualitative research the researcher should familiarise themselves with the data in order to gain an overview. Comments on the text were subsequently added as suggested by Smith *et al.* (1999). These comments, when grouped together, allowed the researcher to formulate themes<sup>42</sup> (Smith *et al.*, 1999). Having identified themes they were grouped and clustered. So, analysis began with a list of themes or subject heading relating to a particular piece of text or a group of pieces of text. This list was subsequently ordered into overarching themes and sub-themes. Emerging themes were discussed with a third party experienced in this method of data analysis in order to ensure that consistent results were obtained (Reid *et al.*, 2005). Reid *et al.* (2005: 22) describe the process of analysis in IPA as '*Organising, integrating and interpreting*'. Doing this allowed the researcher to use the participants' experiences to address the research aims. Because interviews were transcribed verbatim, sections of coded text contained the participants' own words, allowing a direct link between the analyzed data and the participants' lived experiences. The results therefore contain verbatim text including repeated words, local constructions and grammatical errors.

A computer software package, NVivo<sup>43</sup> was used in order to make data analysis more manageable. This software allows a transcript to be marked, so that small sections of text can be collected into themes. These themes can be moved around and arranged into superordinate themes and sub-themes and the

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<sup>42</sup> Throughout this thesis I have used two terms. Themes refer to collections of text created by analysis, because it was the term used by Smith *et al.* (1999); and codes because it is a term used by other qualitative researchers and describes the process of analysis better than the term themes.

<sup>43</sup> This software uses different language to refer to data analysis: themes are called nodes by the software and superordinate themes are referred to as 'tree nodes'. NVivo also allowed me to highlight small sections of text and add notes about what I was thinking during the analysis, that I later referred to when writing the results. It was these notes which were used to record in depth analysis about the text for example, tenses or particular language the participants used and how it related to their experiences.

software allows a diagram (or model) to be drawn to illustrate these. It must be noted that this software does not help in analysing the data but assists in ordering large amounts of information so that it can be accessed.

Analysis using IPA could be described as unpacking the data. This was done in layers. The first layers dealt with the content of the interview, the information and facts about what was said. 'Inner' layers considered the data more deeply; factors such as the tense that was chosen by the participant or perhaps sub-texts, alluded to but never explicitly stated. It is because of this that the researchers' role in analysing the data requires such careful consideration. The analysis consists of the researcher's interpretation of the participant's lived experiences. I chose to use an idiographic approach to data analysis similar to that described by Smith *et al.* (1999). An initial interview was chosen and analysed. The themes generated were then applied to subsequent interviews, ensuring that new themes were also recognised as they emerged.

#### **4:10 Evaluating the research**

Reliability and validity are used to assess the quality of quantitative studies (Carter and Porter, 2000). Assessments of reliability are used to determine whether results obtained are stable over time; that is, if the same sample were retested later would results have a high degree of correlation (Bryman, 2004). Reliability also considers consistency; if a number of questions are asked the results for all of them should be related (Bryman, 2004). Validity is concerned with assessing whether a study measures the concept which it set out to measure (Bryman, 2004).

Owing to its different nature, criteria for evaluating qualitative research must be different from those used in quantitative studies. If the same criteria for evaluation were used to assess studies that aimed to achieve such different things a truthful picture of the accuracy of the research could not be gained. I have chosen to consider two approaches for the assessment of qualitative research found in literature. Rose *et al.* (1995) were chosen because they examine phenomenology in nursing and Guba and Lincoln (1998) because their approach is individual and focussed on the nature of qualitative research.

Rose *et al.* (1995) consider the assessment of phenomenology within nursing and suggest credibility, consistency and congruence as suitable measures:

- Credibility – trustworthiness, bracketing (recognizing intentionality towards the phenomenon)
- Consistency – of methodology; philosophical underpinning must be understood in order to gain and understanding of the phenomenon. Method slurring is not appropriate as this clouds the philosophical basis.
- Congruence – of methodology with field of research. (Rose *et al.*, 1995)

Guba and Lincoln (1998) divide assessment criterion into two parts trustworthiness and authenticity.

**Trustworthiness** is comprised of four different measures; each is comparable to a measure used to assess quantitative research. Credibility and transferability measure equivalent qualities to validity in quantitative research (Guba and Lincoln, 1998). A qualitative research study could not be considered valid in the same way as a quantitative study because social situations and phenomena are subjective and thus could not necessarily be recreated. Credibility and transferability should be ensured, instead, by using techniques such as respondent validation, which is checking results or findings with participants and asking for feedback (Bryman, 2004). Working with another researcher when analysing the data can also be used (Bryman, 2004); this ensures that themes are agreed on by another person, to minimise bias and prejudice in the research. Gaining rich, descriptive data and undertaking a reflective diary to provide an audit trail also help to attain credibility (Bryman, 2004; Koch, 2004). These can all ensure that a detailed description of the participants' world can be generated. These 'trustworthiness' criteria judge qualitative research using similar measures to those used to evaluate quantitative studies. The approach of adapting these criteria has been taken by many authors (Rose *et al.*, 1995; Slevin and Sines, 1999). Whilst this can ensure greater credibility in a field dominated by positivist enquiry, it does not properly address the fact that qualitative research aims to discover different information from quantitative research.

For this reason, Guba and Lincoln (1998) used another criterion for assessing research, **authenticity**. This deals with the social background in which the research was carried out and considers whether the participants were

empowered by the research, with either an enhanced understanding of their situation or an ability to change their situation (Lowe and Hulatt, 2005). This set of criteria evaluates qualitative research on its own terms; it is an evaluation of a research method that involves the participant and researcher working together to gain an understanding of the participant's world. The fairness and ontological basis for the research is examined, as well as whether the research leads to an improved understanding of the participants' social constructions (Guba and Lincoln, 1998).

Ideally, constructivist research, which aims to study social constructions as opposed to positivistic data, would be judged using only criteria developed to evaluate it. To gain wider academic credibility, research needs to be seen to have been evaluated with approved criteria. A qualitative research study should therefore fulfil the measures of evaluation which are similar to those used to judge a quantitative study, but should also be able to have a wider effect on the area it examines.

I chose to use a number of methods to assure the quality of my study. Methodological slurring was avoided by conducting the analysis of data within the philosophical underpinning of Interpretative Phenomenological Analysis. This did not involve bracketing, but the consideration of my effect on the interview and analysis. In order to properly examine this effect, I kept a project journal and reflexive diary<sup>44</sup> throughout the research process. After every research interaction I considered my role, my behaviour and wrote a brief reflection using a reflective guideline (Johns, 1998). This enabled me to critically examine my practice, behaviour, attitudes and ideas in order that their effects could be laid open. It is not appropriate, when using IPA, to discuss themes emerging from the data with the participants themselves, because these themes are acknowledged as the researcher's interpretation of the participant's experiences. Respondent validation was not, therefore, used; however, I ensured credibility by discussing themes and coding with another person experienced in the use of IPA.

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<sup>44</sup> My research diary can be found in appendix two, page 290; reflection can be found in appendix three, page 298.

**Table four: Table to show measures used to evaluate this study**

| Measure used (Rose <i>et al.</i> , 1995) | Ensured by                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Credibility                              | <ul style="list-style-type: none"> <li>• Clear audit trail</li> <li>• Reflective journal</li> <li>• Reflective analysis of the interview / data collection process.</li> <li>• Acknowledgment of limitations of the study.</li> <li>• Checking coding structures and analysis with experienced researcher to ensure codes are grounded in data.</li> </ul> |
| Consistency                              | <ul style="list-style-type: none"> <li>• Clear methodological approach (no slurring).</li> <li>• Understanding of philosophical underpinnings of IPA and adherence to these.</li> </ul>                                                                                                                                                                    |
| Congruence                               | <ul style="list-style-type: none"> <li>• Study checked by Department of Care Sciences Research Programmes Committee (DRPC) to ensure experienced researchers agree method is appropriate to aims.</li> </ul>                                                                                                                                               |

Reflexivity is an important idea when compiling a qualitative research report. Northway (2000) discusses the importance of reflexivity in making a research report accessible and unambiguous. By laying open research decisions and completing a research diary an audit trail can be established; this allows the research to become convincing to the reader (Koch, 2004). An audit trail should allow research decisions to be examined; also the process of analysis and emotions of the researcher can be laid bare, to allow proper examination of the research process and conclusions reached (Koch, 2004).

Lee (1993) discusses how researcher bias can affect the outcome of research; researchers may blame factors on their previous suppositions. If research is undertaken reflexively, this effect can be minimised. Northway (2000) suggests that a researcher may be changed by research, just as research may be affected by the researcher. Exposing these changes allows the research to be properly assessed and makes decision making in the research clear to the reader. In the same way, by exposing their own preconceptions and beliefs, researchers may allow these to be examined. This further establishes an audit trail.

As a young woman, my preconceptions about the world of young men could enormously affect my ability to undertake research with them. It is of interest to note that many people working in family planning services are also female. This means that they also do not have direct experience of being a young man, and probably have preconceptions about the young men they work with, making this research particularly important. My knowledge of the world of young men has been largely gained from literature around the subject, generated from information from the men themselves; I do not have experience of the driving forces behind behaviours of young men, I come with limited preconceptions and no personal experience which allows me more wholly to take on my research participants' descriptions of the phenomena under examination and analyse it. McCracken (1988) suggests that an intimate personal experience of a culture under investigation can be detrimental to research; the fact that I have no personal experience of this phenomenon could be helpful in gaining insight.

My role as interviewer; a young woman requesting intimate detail or personal information from young men, must also be considered. Hutchinson *et al.* (2002) describe in-depth interviewing as an important method of discovering the intricacy of men's lives. The method enables participants to explore their feelings and express their experiences in a way that they might not otherwise do. Hutchinson *et al.* (2002) describes this process as both enlightening for the researcher and beneficial to the participants. Hutchinson *et al.* (2002) used both male and female research assistants in order to interview young men about procreative responsibility.

Although it may be assumed that men should not be interviewed by women, Hutchinson *et al.* (2002), in evaluation questions posed after their interviews,

found that a majority of men interviewed did not mind whether a man or woman interviewed them. They also did not express a preference for an interviewer of the same ethnic background. The young men in the Hutchinson *et al.* (2002) study also stated that they would prefer to be interviewed by a researcher the same age or a little older than themselves. Lee (1993) found, having considered many reviews of interviews, that the social characteristics of the researchers are much less important in determining perceived difficulty of the interview, than researcher expectations are. By using IPA, my study considered the fact that I was a young woman interviewing young men. The interviewer and interviewee construct the interview, thus every interview was different.

Hutchinson *et al.* (2002) suggest that being non-judgemental and sensitive are of principal importance when interviewing young men, regardless of researcher age, ethnicity or sex (Lee, 1993). These authors also emphasised the beneficial and therapeutic effect of being involved in research reported by their participants. My own interest in qualitative research was developed by participating in a research study myself. Although the subject of this study was entirely different from my own research interests, it was a sensitive and emotive subject for me to discuss.

Before taking part in the research I would never have considered that the subject was one that I needed to address. Participating in the study allowed me to resolve issues, and this has significantly changed the course of my career. Based on my own experiences I have no doubt that being involved in a study such as mine could be of benefit to the participants. Reflexivity denotes that reasons for undertaking research should be carefully examined (Northway, 2000). I am aware of my wish to effect change within the area of young men's sexual health. I do not feel that this is possible without properly understanding their perspective. It is easy to decide what sexual health services would be appropriate and provide them, but without understanding the world in which the client lives, services are unlikely to be effective.

There were issues surrounding the fact that this study covered a potentially difficult subject area, although Johnson and Delamater (1976) found that researchers expect some subjects to be more difficult for their participants than they are, this expectation affects outcomes more than does the participants' discomfort. Hutchinson *et al.* (2002) suggest that making the participant as

comfortable as possible could aid in building trust with the interviewer. These authors also suggest that the room for the interview is comfortable, private and that participants are regularly reminded that they can stop the interview at any time or refuse to answer any questions; their anonymity must also be assured. Lee (1993) suggests that an interviewee may be more forthcoming with information when they feel their confidentiality will be protected, and if they feel they will not see the interviewer again.

It is suggested that expectations of the researcher have a great effect on interview findings (Johnson and Delamater, 1976: Lee, 1993). These expectations have had a larger impact on research outcomes than the researcher's social characteristics (Lee, 1993). Johnson and Delamater (1976) studied the differences in participant's responses to questions when interview variations were taken into account. They found that interviewer gender, sexual experience, rapport and competence did not have a significant effect on participants' disclosure. The way that the subject is introduced to the interviewee is important. Explaining exactly what the researcher wants to discuss could limit the interview and lead the participant. In an interview where rich data are sought many things may be significant. In order for informed consent to be given the interviewee must have some knowledge of what he will be asked about (Lee, 1993). It is therefore important to find a balance between ensuring that the participant is informed and not constraining the interview.

#### ***4:11 Conclusions***

This chapter has discussed methodological issues about the study as well as methods used to undertake it. The rationale for the study design has been considered and explained as well as its strengths and weakness. The following chapter discusses data analysis in more detail, before results are considered in chapter six.

## Chapter Five: The process of data analysis

This chapter seeks to explain and justify the process of data analysis. It contains reflexive accounts about analysis, both to clarify the process, and the results. Because masculinities were a major emerging theme, I felt it important to consider my attitudes to these, as I have shaped both coding and analysis. Whilst IPA allows this and admits its effect, I felt that a credible audit trail would be established by providing detailed description about the process of analysis. Koch (1994) describes writing a field journal, to examine her experiences as a researcher and establish an audit trail. This chapter along with my journal in the appendices<sup>45</sup> links me to the data, analysis and results.

In order to properly explain the process of data analysis, I have used short excerpts of data to demonstrate analytical decisions made about them. This is in order that the reader may understand both the coding structure that has been applied, and the finer detail of analysis, required by IPA. Data analysis in IPA has been illustrated to me as an onion, as layers are peeled back, another is revealed underneath. I felt that more explanation of the analysis process was required to illustrate this.

A computer software programme, NVivo, was used to assist with data analysis. Transcripts were transferred into NVivo and the coding structure, that had been formulated on paper, was saved. This gave an opportunity to become further immersed in the data, and to examine the coding structure. Deeper analysis, thoughts about emerging themes, links between them and considerations of implications of coding were saved using 'annotations'<sup>46</sup>. These provided helpful *aide memoirs*, when writing data analysis. A research journal was also kept in NVivo. This provided an audit trail and gave an opportunity to scrutinise the researcher's journey. NVivo was also used to create 'models', illustrations of emerging themes and their arrangement. In these ways, NVivo assisted with organisation of large amounts of information, and has enabled easy access to particular sections of data. NVivo does not analyse qualitative data but helps to organise it, so that the researcher may more effectively do so.

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<sup>45</sup> See appendix two, page 290, for the research diary and appendix three, page 298, for reflections on the research process.

<sup>46</sup> See appendix seven, page 310, for an example of NVivo in use.

Pseudonyms are used to refer to participants in chapter six (findings) and seven (further discussion). These are Welsh names chosen at random from a baby names website and are not linked to the participants' names. A description of each participant is given in the appendices<sup>47</sup>. I asked all the participants if they would like to choose a pseudonym as part of our discussion about changing names and protecting their confidentiality; they all declined.

### **5.1 Process of analysis**

After repeated reading of the initial transcript (Rhys), comments and thoughts were added to the margins. These comments were then grouped into initial emerging themes. At this stage, ideas about coding were discussed with an experienced researcher. This gave an opportunity to ensure that coding was grounded firmly in the data, and the coding structure was comprehensible. Some of the themes emerging were expected, others were not. The coding structure was then moved into NVivo and annotations added. At this juncture a report was submitted for application to transfer from MPhil to PhD. This provided an opportunity to write a coherent summary of preliminary data analysis, and allowed ideas and thoughts to be developed. It was a useful and important part of learning to use IPA to analyse data.

Other transcripts were analysed using the same method, the themes generated in Rhys' transcript were used. New themes, that emerged, were added into the coding structure; annotations were used to record deeper analysis and links between themes and transcripts. When this was complete, the emerging themes were ordered, superordinate themes were identified and other themes fitted into them. There were some ideas that did not fit neatly; these were left outside the coding structure.

### **5.2 Example of analysis**

An example and explanation of analysis was thought appropriate; both to explain how analysis took place and to make explicit the researchers link with

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<sup>47</sup> See appendix six, page 307.

the data. In order to do this a passage, from the interview with Aneurin, has been chosen; its coding and analysis will be explained:

**Anna:**

Ok and do you feel that you know enough about sexually transmitted infections? Do you feel prepared?

**Aneurin:**

well umm no no I don't know I only know the basics not that I ummm I don't go around just sleeping with anyone like when I have just met them I don't go out and just...well you know I don't go in for one night stands

This first part of the passage was read and coding applied as follows:

|                                        |                                                |
|----------------------------------------|------------------------------------------------|
| <b>well umm no no I don't know</b>     | <i>admission of lack of knowledge</i>          |
| <b>I only know the basics not that</b> | <i>Inadequacy of education/ unsure of info</i> |
| <b>I ummm</b>                          |                                                |

These codes related directly to Aneurin's words, or the feeling behind them. He clearly admitted his lack of knowledge, saying that he did not feel he knew enough. He was unsure of information, leading to this code being applied. Whilst he did not directly refer to education and its inadequacy, this code had been generated in another interview and appeared to fit well with what Aneurin was saying. This is the first layer of coding. The second part of the section revealed more about what Aneurin thought and felt, and was coded as follows:

|                                               |                                      |
|-----------------------------------------------|--------------------------------------|
| <b>I don't go around just</b>                 |                                      |
| <b>sleeping with anyone like when I</b>       | <i>attitudes to sexual behaviour</i> |
| <b>have just met them I don't go out</b>      |                                      |
| <b>and just...well you know I don't go in</b> |                                      |
| <b>for one night stands</b>                   | <i>qualifying/ managing risk</i>     |

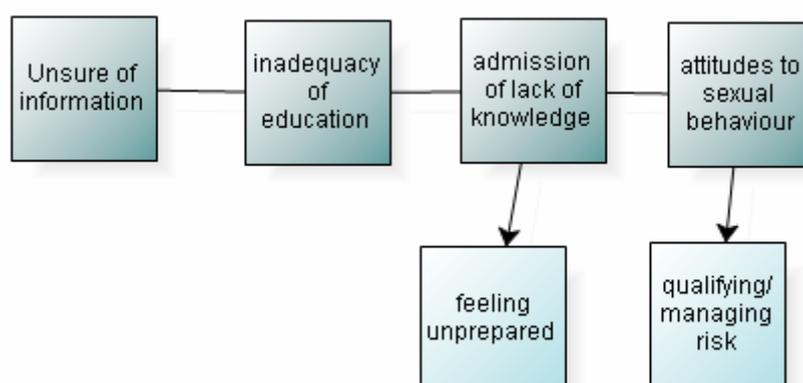
Aneurin was talking about sexual behaviour, his discourse demonstrated a negative attitude to one night stands, and the section was coded as '*attitudes to sexual behaviour*'. This is the second layer of coding. What Aneurin said was coded according to the way it revealed his thoughts.

There is a third level of coding that applies to the whole section. Aneurin was qualifying his risk or discussing how he manages his risk. He does not feel he

knows enough about STI but this is unimportant because he does not have one night stands. Therefore, the code '*qualifying/ managing risk*' was also applied.

There could be another level of coding, Aneurin uses the word '*I*' a lot; by doing so, he is creating a contrast between himself and others who engage in the behaviour discussed. Creating this juxtaposition allowed Aneurin separate himself from behaviour that he does not like, and also to assert his views; in this case that one night stands are risky behaviour. The relationship between the superordinate themes and their sub-themes could be referred to as another level of coding.

There are four levels of coding applied to this passage. Highlighting text and adding it into an NVivo 'node' could not adequately record this in depth analysis. I used a function of NVivo: annotations<sup>48</sup>, to add a footnote to a piece of text, for my reference when writing up the research. As all the codes applied to this passage related to sexual health, they belonged within the superordinate theme '*sexual health knowledge and attitudes*'. The themes were arranged like this within the superordinate theme:



**Figure three:**  
Illustration of codes to show the process of data analysis

*'Feeling unprepared'* is part of *'admission of lack of knowledge'* and *'qualifying/ managing risk'* is part of *'attitudes to sexual behaviour'*.

This is an example of the coding that took place, throughout the transcripts. A lot of detail was generated and depth of analysis is only discussed when I considered it important. In this way, I became influential; both in undertaking the analysis and in deciding what was important. In order to establish credibility,

<sup>48</sup> See illustration of this in appendix seven, page 310.

coding was discussed with an expert researcher. This ensured that codes were grounded in data (Rose *et al.*, 1995).

Rose *et al.* (1995) also suggest that credibility can be established by reflective analysis of the researchers' influence on the data collection process<sup>49</sup>. Reflective examination of the data analysis process was also considered important. Because of this, I have given some reflective examination of the data analysis process with direct reference to the coding structure in the passage above. A general analysis of my biases follows.

The codes applied to the section above were chosen by me, as the researcher. Not only their application to the section, but also the points that I considered of interest, are important. Aneurin firstly said:

**well umm no no I don't know**                      *admission of lack of knowledge*

I coded this as admitting lack of knowledge because I felt that perhaps an explicit admission of lack of knowledge could be seen as a threat to his masculinities. My coding also reflects my knowledge, that is greater in this area than that of the general population. There was, perhaps, a disparity between my expectation of knowledge and that belonging to the participant. A similar disparity would exist if I were to discuss car engines with a mechanic; they would consider me to be un-knowledgeable, and I would have no idea of the depth of my lack of knowledge. Thus, coding Aneurin's statement in this way reflects my position.

Coding in the next section also reflects my opinions and position. The code '*inadequacy of education*' had been generated in a previous interview, but was applied here. I feel that sexual health education ought to be provided in a manner that is accessible to all young people, in order that the information is useful to them. This thought became part of my coding, when Aneurin admitted that he did not have a lot of knowledge, I considered this to mean that he had not been taught satisfactorily and applied this code. I also felt that Aneurin was '*unsure of information*' although if asked, he might not have said this:

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<sup>49</sup> This was discussed in section 4:10, page 109. See table four, page 112, which details methods used to evaluate this study.

**I only know the basics not that**                      *Inadequacy of education/ unsure of info*  
**I ummm**

The last section described Aneurin's managing of sexual risk:

**I don't go around just**  
**sleeping with anyone like when I**                      *attitudes to sexual behaviour*  
**have just met them I don't go out**  
**and just...well you know I don't go in**  
**for one night stands**                                      *qualifying/ managing risk*

My coding of this reflects my sexual health knowledge; namely, I understand the prevalence of STI, and the ease with which an unintended pregnancy can happen. When contrasted to Aneurin's lack of knowledge, I see a false strategy for preventing infection and pregnancy. One of Aneurin's peer group may feel that his strategy would be effective; if I had little knowledge in this field, I might not have coded this section in the same way. To return to the car mechanic, if I, who knows nothing of the way an engine works, found a method to maintain the speed of the car despite it being broken, I would do this. A car mechanic may perceive the futility of my attempts, because he understands the facts.

I felt that coding about masculinities was of particular importance for reflection, because none of the participants mentioned them directly. Their talk is interpreted as referring to masculinities and, as such, it refers to what my ideas of masculinities are. Coding about masculinities reflects my expectations of masculinities. I have no personal experience of masculinities, but see them being enacted around me every day. Whilst I feel that this has enabled an examination of factors that may be due to masculinities, the participants probably would not have attributed their behaviour to their gender. This analysis is wholly in line with the ethos of IPA. The process of data analysis is a double hermeneutic; the researcher trying to make sense of the participants, making sense of their life experiences. In writing about masculinities, I am trying to make sense of the participants' discourse, about their experiences.

Masculinities are discussed in chapter three: it is from academic literature that I have gained my opinions about masculinities and their enactment. I live in a world, where I see those around me negotiating their gender; I feel that this

cannot go without mention. I consider the way I choose to negotiate my gender has an affect on how I feel about others around me, negotiating theirs. I have always felt that as a woman I did not need to be treated any differently from the men around me. I enact this in every day life in many ways; I refused to change my name on marriage, and will not take on traditional responsibilities in my home merely because they are traditional.

This is a negotiation; I must interact with others every day and the roles and responsibilities that I perform are dependant on those around me. For example, I may refuse to cook because it is traditionally a woman's role but if no one else is available to cook, does that mean my family do not eat? How do I feel about my refusal, meaning that my family only eats fish and chips? I must balance my gender enactment, with necessity and other priorities<sup>50</sup>. Participants faced similar dilemmas; this is the origin of my referral to negotiation of masculinities.

My experiences reflect how I view masculinities; I questioned the data to discover the attitudes of the participants to young women. I was also likely to focus analysis on those comments that upset or riled me; namely, those which viewed women negatively. Considering the data without feeling would be an ideal, my feelings are part of me, as the researcher, and therefore part of the data analysis.

### **5.3 Presentation of the findings**

Chapter six contains annotated data analysis. It has been divided into parts; each one is a superordinate theme. At the start of each part of the chapter an illustration of the theme is given, so that its sub-themes can be clearly identified. As some of these sub-themes are relatively small and closely interlinked, they have not all been separately discussed, they have been woven together to present a coherent argument. Larger superordinate themes such as '*feelings about masculinities*' contain separate analysis of individual sub-themes. Some superordinate themes are large, containing a lot of coding; others are relatively small.

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<sup>50</sup> <sup>50</sup>It should be noted that I do not refuse to cook and my family eat a healthy and balanced diet which is prepared by both my husband and me.

In order to ensure that the description of analysis is firmly rooted in data, quotes and sections of the transcripts have been given. These are always lifted from the transcript, and are in the participant's own words. It is clear when this has been done; each quote is indented and labelled with the participant's name<sup>51</sup>.

Smith (2004) explains that the write up of an IPA study should allow the reader to gain an understanding of the themes and feelings that the participants share; but also of the individual participants, their experiences and their perceptions of them. In order to better understand the individual participants, table five provides some information them, a profile of each is available in the appendices<sup>52</sup>.

Discussion about themes has been included in chapter six (annotated findings), but is drawn together in chapter seven (further discussion and conclusions); where arguments are formed and discussed.

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<sup>51</sup> All names used in the analysis have been changed to preserve participants' anonymity and confidentiality, place names have also been changed so that there is no chance that participants can be identified.

<sup>52</sup> See appendix five, page 304.

## Chapter Six: Annotated findings

This chapter contains a presentation of the findings of this study. Analysis identified six superordinate themes, each are considered in separate parts of this chapter. These parts are further split into sections, which consider separate themes. The findings are annotated, thus discussion and referral to relevant research literature is included. The analysis is drawn together in chapter seven (further discussion based on findings).

Each superordinate theme is presented with a diagram of coding, so that the structure can be clearly seen. Each code has not been considered separately because too much repetition would have ensued, larger codes are examined individually but smaller codes are not. Similarly, minor codes of little relevance have been excluded. Individual themes are not discussed in a particular order; when themes are linked they are considered consecutively.

Extracts from transcripts have been used to illustrate coding and analysis. These are always in the participants' own words; as they were transcribed. Quotes can be clearly identified as they are labelled with the participants' name<sup>53</sup>. Table five<sup>54</sup> gives some details about the participants.

Grammatical errors have not been changed; all quotes are written verbatim, including pauses. Some codes were named using a participant's quote; these are also given verbatim and grammatical errors have not been corrected.

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<sup>53</sup> A brief description of each of the participants is given in the appendix five, page 306. The participants' names have all been changed and pseudonyms given in order to preserve the confidentiality and anonymity of participants.

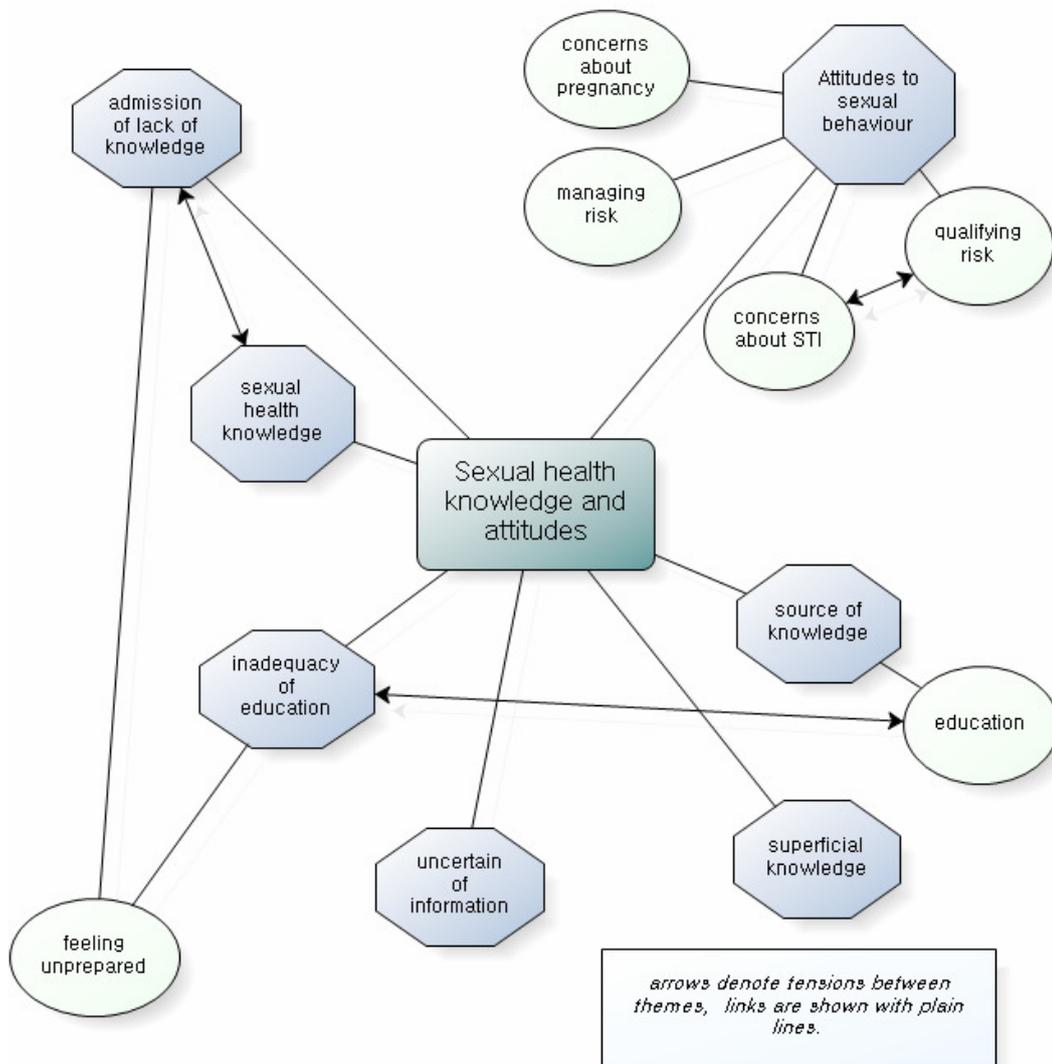
<sup>54</sup> Page 125

**Table five: Table to show summary of participants; they were interviewed in the order of the table.**

|                                            | <b>Rhys</b>                                                                                   | <b>Huw</b>                                                                                                                                                            | <b>Gareth</b>                                                 | <b>David</b>                                                     | <b>Aneurin</b>                                                | <b>Owain</b>                                                            | <b>Gwyn</b>                                                                                 |
|--------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <b>Age</b>                                 | 20                                                                                            | 18                                                                                                                                                                    | 17                                                            | 20                                                               | 19                                                            | 16                                                                      | 16                                                                                          |
| <b>Lives with</b>                          | Parents                                                                                       | Parents                                                                                                                                                               | Parents                                                       | Parents                                                          | Parents                                                       | Parents                                                                 | Parents                                                                                     |
| <b>Employment</b>                          | Off work due to knee injury<br>Usually works in manual employment installing security systems | At college, studying art and design                                                                                                                                   | At college doing A-levels (English lit economics and history) | Reading for a degree in nutrition and Health science             | Training to be a welsh teacher                                | At sixth form college doing A-levels (chemistry, biology and computing) | College, studying plumbing, spends one day a week working as part of his course             |
| <b>Parents employment</b>                  | Mother – nurse<br>Father – manual employment                                                  | Father– recently retired from employment with oil company in Saudi Arabia (no information about whether this was manual)<br>Mother – works part time as a hairdresser | Parents both employed but evasive about what they did         | Father- civil servant<br>Mother- Lifeguard at leisure centre     | Father- retired<br>Mother- receptionist at the leisure centre | Father- civil servant<br>Mother- dinner lady                            | Parents own property development company father is a builder and mother does administration |
| <b>Siblings</b>                            | One older sister lives with her husband separately                                            | One older sister lives with husband separately                                                                                                                        | Two older sisters both at university                          | One brother has left home                                        | One sister much older, his niece is similar in age to him     | Younger brother and sister, both live with parents                      | Two older sisters both live at home                                                         |
| <b>Interview Details</b>                   | Leisure centre one                                                                            | Leisure centre one                                                                                                                                                    | Leisure centre one                                            | Leisure centre two                                               | Leisure centre two                                            | Leisure centre three -with Gwyn.                                        | Leisure centre three -with Owain                                                            |
| <b>Relationship/ sexual partners</b>       | Girlfriend for one year, one previous sexual relationship                                     | Girlfriend for two months                                                                                                                                             | No Girlfriend                                                 | Girlfriend long term relationship but exact length not discussed | No girlfriend                                                 | No girlfriend                                                           | No girlfriend                                                                               |
| <b>Interaction with other participants</b> | Did not know any others                                                                       | Friends with Gareth                                                                                                                                                   | Friends with Huw                                              | Friends with Aneurin                                             | Friends with David                                            | Interviewed with Gwyn, they were friends                                | Interviewed with Owain, they were friends                                                   |
| <b>Employed in the leisure centre</b>      | No but was friends with gym staff                                                             | No                                                                                                                                                                    | No                                                            | Yes                                                              | Yes                                                           | No                                                                      | No                                                                                          |
| <b>Gym attendance</b>                      | Three times a week, sometimes more                                                            | Up to five times a week. Also used gym at school.                                                                                                                     | Up to five times a week. Also used gym at school              | Worked out during or after work. Worked nearly full time         | Worked out during or after work. Worked nearly full time      | Three times a week                                                      | Three times a week                                                                          |

## 6:1 Sexual health knowledge and attitudes

Figure four: Diagram to show sub-themes in 'sexual health knowledge and attitudes'



This superordinate theme was called 'sexual health knowledge and attitudes'. Initially, it would have been simply called 'sexual health knowledge' but I considered that the young men's attitudes to sexual behaviour were strongly linked to their knowledge. The young men's concerns were informed by their levels of knowledge, especially their methods of managing risk. Sub-themes have not all been discussed individually but the section divided into three parts. The first part considers the participants' attitudes to discussing their sexual health and their behaviour during the interview. The second discusses all the sub-themes about knowledge and education; the third examines participants' attitudes to sexual behaviour.

### **6:1.1 Disclosure when discussing sexual health**

Although this was not an identified theme, I considered it important to include analysis about the willingness of participants to discuss sexual health issues. I noticed that in some interviews, the section involving discussion of sexual health was monosyllabic to begin with, or was shorter. These factors could not be allowed to pass without mention; reluctance to discuss these issues with me may be a reflection of participants' feelings about talking about sex and sexual health with others.

Few participants made direct reference to their sexual experiences. It is possible that some of the participants were not sexually active, although they did not state this. It would perhaps have had consequences for their masculinities and sense of self to admit to a woman, interviewing them about sexual health, that they had never had sex.

Participants talked about their sexual health knowledge and experience when questioned, but were often not very forthcoming. Laughter and euphemisms were used and this appeared to indicate embarrassment. For example, Rhys said on many occasions during the interview that he was happy to talk about sexual health. However, the second half of the interview with Rhys, in which sexual health was discussed, was noticeably shorter and answers were more often monosyllabic in comparison with the first half of the interview, during which his general health was discussed. This suggested some level of discomfort or embarrassment. David appeared quite happy to discuss sexual health but laughed and seemed embarrassed when he disclosed the fact that his mother had provided him with a bag of condoms:

No I well [silence] this is going to sound quite embarrassing I can remember when I was sixteen my mother came up to me and she had a bag full of condoms [laughs]

*(David)*

David's silence and subsequent laughter support his statement that this was an uncomfortable disclosure. His statement of embarrassment also highlights his feelings about discussing the subject; by introducing a topic with an affirmation

of his embarrassment, he was negated its importance to him. Without this admission of embarrassment, he may have felt that the mention of the incident was inappropriate and vulgar; by stating embarrassment he distanced himself from these attitudes.

Aneurin answered the questions that were asked but did seem slightly uncomfortable; again, the section of the interview in which sexual health was discussed was relatively monosyllabic. Aneurin was the only participant who stated that he had previously attended a Genito-urinary medicine (G.U.M.) clinic. This only became apparent at the end of the interview, indicating his reluctance to discuss his attendance. He qualified the statement quickly by saying:

Well I didn't, hadn't done anything...like I just wanted to get a check-up and make sure everything was ok so I went...

*(Aneurin)*

This need to explain his reason for attending suggested some degree of embarrassment.

Gareth appeared embarrassed, his answers were shorter and he appeared slightly reluctant to discuss sexual health. Huw was more curious than the other young men; he asked a lot of questions about STI, some of these suggested that he might be worried about having one:

...can you get genital warts but not have them straight away but just get them a couple of years later from sex you had like two years ago?

*(Huw)*

When asked if he was worried for a reason, he quickly denied it and added that the pictures had caused his concern. Huw's questions may also have been a method of deflecting conversation from his personal situation and distancing himself from a subject that he found embarrassing.

Owain and Gwyn appeared to be comfortable talking about sexual health issues, but the interview did not contain many personal disclosures. Owain and Gwyn talked more than the other younger participants; perhaps the presence of a friend increased their comfort.

Most of the participants relaxed throughout the duration of the interview. Despite answers about sexual health being initially monosyllabic; by the end of the interview, some of the participants wanted to ask questions or add other information that they felt might be useful.

### **6:1.2 Knowledge and education**

Most of the participants admitted a lack of knowledge about sexual health and sexual health services. During the interview the participants were asked if they knew anything about STI.

Rhys was keen to make it clear that he knew little about STI. His first comment, when asked if he knew anything about them, was:

I know like names but I don't really know a lot about it

*(Rhys)*

Rhys separated knowing the names of STI from other knowledge, which he felt he lacked. He referred to STI as though there was only one, using 'it' rather than 'them'. Later, when asked which infections he could name he was only able to give the name of one STI, Acquired Immune deficiency syndrome (AIDS). He did not mention HIV or give a clear description of how AIDS could be contracted. His knowledge about this infection was limited to an awareness of its existence. This fits with the literature that suggests that young people have unrealistic perceptions of the spread of HIV/AIDS and are more likely to take precautions against unintended pregnancy than against contracting AIDS (Grimley *et al.*, 1993).

Several authors have found that many young people who use condoms, only apply them after initial penetration and continue penetration after condom removal (de Visser and Smith, 2000; Hatherall *et al.*, 2007). This suggests that these young people are using condoms solely to protect against unintended pregnancy. Grimley *et al.* (1993) proposes that this is because young people may have seen contemporaries dealing with the results of unintended pregnancies, but have not had experience of the consequences of HIV. This makes AIDS an unreal and unclear risk; leading to young people failing to

recognise AIDS as a possible outcome of risky behaviour, for example, unprotected sex or ineffective use of a condom.

The initially identified spread of HIV has instigated this problem. The virus began to be spread amongst discrete groups: homosexual men, intravenous drug users and prostitutes; leaving a perception that only those belonging to those groups can contract the virus. This stereotyping of HIV infected persons also affects attitudes to those who do contract the virus, blame is ascribed. When HIV first began spreading in the UK, a public health campaign was launched to educate the population; its message was 'AIDS, don't die of ignorance' and it was shown to improve knowledge about how HIV could be transmitted (Department of Health and Social Security and the Welsh Office, 1987). The campaign did not improve negative attitudes to sufferers of HIV.

Negative attitudes have been identified by Pötsönen *et al.* (1999) who found that AIDS knowledge was good amongst young people, but their behaviour did not reflect this knowledge. The young people in their study did not feel that HIV transmission was relevant to them or their behaviour. Although Pötsönen *et al.* (1999) used a large sample (n= 1183), all respondents were resident in Finland meaning generalisability of the study is limited; attitudes and behaviours may be different in Finland from the United Kingdom.

Rhys did not feel that HIV was a real risk to him: he was too young to have been informed by the public health campaign of the 1980s (Department of Health and Social Security and the Welsh Office, 1987). This lack of knowledge could significantly influence his perceptions of sexual health behaviour and his willingness to access sexual health services.

Aneurin gave a longer list of STI, but said at the end of it, that his knowledge was probably lacking:

Well like chlamydia, umm HIV and AIDS obviously, syphilis and umm gonorrhoea and warts and herpes I don't know there are probably a lot more

(Aneurin)

Like Rhys, he did not give any information about specifics such as transmission or symptoms. Aneurin was also similar to Rhys in his attitude to HIV and AIDS.

Aneurin considered HIV to be an obvious infection to mention; although his risk of contracting it is not as great as his risk of contracting another STI (Health Protection Agency, 2007). In contrast to Rhys, Aneurin knew the names of many other infections. Aneurin's assumption that there are probably many more STI than he can name, shows that he feels his knowledge in this area is lacking. The lack of information given may also indicate a lack of knowledge, knowing the names of STI does not provide knowledge to deal with the possibility of contracting an infection.

Other participants did not have enough knowledge to name infections, but instantly negated any knowledge that they did have. Huw's first comment was:

I know that they are easy to catch these days ummm I don't really know much  
(Huw)

His comments about the ease with which an infection can be contracted, appear to compare the present situation with that of another era. The implication is, they are easier to catch now than they were previously suggesting he may have been warned about this, by someone from an older generation<sup>55</sup>. Huw denied having spoken to any members of his family about STI; he said the information he had gained, came from friends. Acknowledging that an STI can be transmitted easily does not mean that Huw was prepared to protect himself from contracting one.

He also said that he does not know a lot about STI; despite saying that they are easily transmittable he did not give clear information about how they could be transmitted. In response to a direct question about methods of transmission he said:

ummm through sex without a condom...is that it?  
(Huw)

He had a little more knowledge than he had originally admitted, but was still unsure about its veracity.

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<sup>55</sup> This idea was also referred to by Gareth when talking about how he had learnt about sexually transmitted infections. He discussed travel information and said that the advert stated that '*these are the times of holiday infections*'. Gareth's discussion of '*these times*' contrasts with a previous time as though STI were not a problem before. See section 6:1.2, page 140.

David's response when asked about STI was:

for something that's used a lot I don't really know a lot about it

(David)

David had heard about STI enough to feel that it was a frequently discussed subject, but when asked specifically where he had heard about STI, David said sex education at school eight years before. He did not mention seeing any advertising campaigns or information like some other participants did. It is possible that David did not notice advertising because he did not want to. Because consistency is required between behaviour and belief (Festinger, 1957) people may alter their beliefs, in order that their behaviour may remain constant (Peretti-Watel *et al.*, 2007). David may have failed to notice information because he did not want to reassess his sexual behaviour.

Peretti-Watel *et al.* (2007) found that smokers developed patterns of belief that allowed them to challenge anti-smoking messages; they changed their beliefs and not their behaviours. Although the study was large (n=2,533) it took place in France where smoking attitudes and prevalence may be different from the United Kingdom. More important are the differences between smoking and sexual risk-taking behaviours; smokers involved in the study were well-informed about the risks of smoking (Peretti-Watel *et al.*, 2007) but used belief changes to release themselves from these risks, sexual risk takers may not be as well informed. Indeed, in his quote above David stated that he was not well informed, if he took sexual risks these may be justified in a different way because David had little information. In a study examining young women's sexual risk taking (n=209) Ethier *et al.* (2003) found that young women were likely to underestimate their risk of contracting an STI. Given that risk taking can be part of asserting hegemonic masculinities (Thompson and Pleck, 1986) this may be even more so for young men.

Gareth, who was a little more willing to talk than some other participants, said:

I know that they are not very nice to have... I don't know that from personal experience...

(Gareth)

His first thought about STI was negative. He did not think first about names of infections, as other participants had, but about the personal negative effect an STI would have. Gareth was keen to add that he had never had any experience of this. He accepted the negative manner in which STI are viewed and was also aware of the blame that remains attached to STI. This negative attitude to those with STI could discourage help seeking behaviour and partner notification if an infection is identified.

Lichtenstein (2003) found that stigma associated with STI was likely to cause a delay in seeking medical attention, with an associated risk of increased morbidity. Focus groups were used to discover what the stigma related barriers were to obtaining treatment or screening for an STI, excluding HIV. The study took place in a small town and city in the American south; staff and patients from a public health clinic and students from a higher education establishment were invited to take part. There were three focus groups in each geographical area; each one consisted of a separate group: staff, patients or students. The study was relatively small (n= 42). The results of the study are not transferable, because the participants were mostly unemployed African-Americans. There is a high incidence of STI in the American south coupled with a mistrust of health care provision resulting from the Tuskegee<sup>56</sup> experiment (Lichtenstein, 2003).

Similar stigma exists in other social groups and therefore similar effects of stigma may be seen in other places. Allen (2000) explains that stigma has long been associated with STI; the infections themselves were seen as punishment from God for immoral behaviour and therefore sufferers could be blamed for their own affliction. It is tempting to think that these attitudes no longer exist in our society but stigma associated with the identification of AIDS and those who contracted HIV, have shown that this is not the case (Allen, 2000).

Gareth was the only participant to talk without having been asked about the method of transmission of STI. He added this to an admission of his lack of knowledge:

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<sup>56</sup> This experiment is a notorious example of lack of research and medical ethics. It studied the long term effects of untreated syphilis on African American males in the American south and has precipitated a mistrust of health care provision amongst African Americans, especially men (Thomas and Quinn, 1991).

I know how they are transmitted obviously the name kind of gives it away but umm there's not much I do know....

(Gareth)

The assumption that the mode of transmission is obvious was peculiar to Gareth. His assumption is also evidence of either a lack of knowledge or an unwillingness to discuss details at the beginning of the interview. His use of the word '*obvious*' is indicative of reticence to discuss sensitive issues in detail. STI can be transmitted through vaginal sex but also through intimate contact, oral and anal sex. It is possible that Gareth knew this but he did not say explicitly. Given that another participant referred to vaginal sex as:

proper sex

(Rhys)

It is possible that this was also the case for Gareth. This raises a concerning issue; a perception that infections could only be transmitted through vaginal intercourse may lead to failure to take precautions to prevent the spread of infection, when other practices are being engaged in. Prinstein *et al.* (2003) found that young people were more likely to engage in oral sex with multiple partners, than vaginal sex and were less likely to use any form of STI prevention.

Owain and Gwyn were the only participants who did not admit to a lack of knowledge when asked about STI. This may have been because there were two of them present in the interview<sup>57</sup> and they were reluctant to admit to a lack of knowledge or to being unprepared. When asked about STI, they responded by laughing:

**Gwyn**

Yeah [laughs] yeah I know about them...

**Owain**

[laughs]

(Owain and Gwyn)

---

<sup>57</sup> Owain and Gwyn were interviewed jointly at their insistence. The disadvantages of this are discussed in section 7:2.2.ii, page 256.

Gwyn was sure that he knew about infections but did not disclose any information. Both Owain and Gwyn started to talk more throughout the interview; therefore, I felt that this initial response was due to their discomfort at the introduction of a sensitive subject. Other participants had become comfortable talking to me by this point, but I felt that rapport took longer to be established with Owain and Gwyn. This might have been due to their personalities but could have been due to the joint interview.

The participants were asked where they had gained their sexual health knowledge. Rhys said that he had gained the bulk of his sexual health knowledge:

through school really

*(Rhys)*

But went on to explain that his sex education lessons had been provided on a fortnightly basis and that he felt that this was insufficient. He also felt that the lessons:

wasn't like really good educational wise

*(Rhys)*

It is evident that Rhys had expectations of education that his sex education lessons did not meet. Given that Rhys' experience of education was predominantly based on his schooling, his perceptions of his sex education must have been judged on its failure to reach the same standards as his other lessons. He also commented that:

they didn't go into great detail it was like more or less like read out of a book

*(Rhys)*

Rhys suggests that there was something missing from his sex education at school. He acknowledges that the detail given was not sufficient and he criticises the teaching methods used.

This may suggest that the teacher had a lack of knowledge regarding sexual health or was uncomfortable discussing the subject. It would be preferable to

invite a nurse who may be more knowledgeable and comfortable with the subject to teach these lessons.

During the interview, I did not feel that I could question Rhys at length about what he would have liked from his sex education; I was concerned that doing so may have impeded his willingness to talk openly. Thus, information about Rhys' preferences was not gained.

Rhys' opinion of sex education at school coincides with the results of a study undertaken by Measor *et al.* (2000) who studied pupils' opinions and experiences of sex education in five comprehensive schools in the U.K. This study was triangulated, using both quantitative and qualitative methods to gain an insight into pupils' experiences of sex education. Measor *et al.* (2000) found that pupils thought sex education was insufficient and information provided during lessons was not adequately comprehensive but did not investigate the style of teaching. Rhys' comment suggests that he was unhappy, not only with the content and quantity of the lessons but also with the quality of teaching given. Woodcock *et al.*'s (1992) findings support Rhys' view; young people were dissatisfied with both the content of lessons and teaching methods used. However, in Woodcock *et al.*'s (1992) study, young people complained about having been shown videos that were not interesting or informative. Rhys' experience differed from this; the content of the lessons provided for him was insufficient, but Rhys did not have much knowledge before the lessons were delivered.

Rhys said:

and like what people do say to you, you know like AIDS and you know  
(Rhys)

Rhys felt that there must be somewhere else that he gained some knowledge about sexual health, but he could not put his finger on it. This suggests that he felt he knew more than he was taught at school. Rhys did refer to this when, later in the interview, he was asked if he had had any other sources of knowledge. He commented:

Eastenders when Martin Fowler was on there and he had AIDS it being passed on and that and ummm

(Rhys)

Rhys felt that he had gained sexual health knowledge from a television soap opera, this may have been the knowledge that he referred to earlier in the interview.

David's feelings about sex education were similar to those of Rhys, although his first comment did not mention school at all, he said:

Just through people talking with y'know...

(David)

He was either reluctant to disclose the sources from which he had gained information or he was unsure of them himself. David mentioned that he had talked to friends about STI but that it had happened in a group of them; he noted that this made the interaction:

more of a joke instead of some serious issue

(David)

David's tone in this section appears to suggest that he was disappointed about this in some way, this was communicated by his contrast of the joke that the conversation becomes, with what he would like it to be, a serious issue. He conveys this, by using the word 'some' to place an emphasis on the end of the sentence.

David did mention the sex education he received at school, but he was as negative about it as Rhys had been:

we had like sexual education classes in school but that was like a while ago and that was that was when you are like twelve years old, eight years ago

(David)

David's mention of his age when he was given sex education is interesting. His comment suggests that he felt information had been given but this had not been followed up later, leading him to forget facts. This is contrary to the findings of

Woodcock *et al.* (1992) who discovered that young people felt they were given too little information, too late. David appeared to feel that he was given insufficient information, too early.

David's feelings about the quality of the education he received were similar to those of Rhys, although David specifically mentioned the content of the lessons:

Ummm [silence]...they put you on the right track I think if you are interes...if you want to listen to what they tell you to have safe sex

(David)

He did not feel that he had been provided with sufficient information, but did feel that the basics had been provided. This is consistent with the findings of Measor *et al.* (2000).

David also evaluated his sex education by stating that he did not really remember its content:

it obviously haven't stuck in my mind well and in terms of disease and so forth I like I just practise safe sex and that's y'know...<sup>58</sup>

(David)

This could be seen as a reflection of the teaching methods used, the quality of teaching was inadequate, as suggested by Rhys. David did not remember his sex education lessons, yet he was confident he practised safe sex. If he was not properly informed, his assessment of safe sex might not have been accurate. For example, he could be using a condom but doing so incorrectly and thus not protecting himself from STI transmission.

Conversely, Aneurin did not mention at first having learnt about sexual health issues at school. He said that his information had come from:

the TV and posters

there are adverts and posters and flyers and things...

(Aneurin)

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<sup>58</sup> David appeared to be considering further comment here but unfortunately the interview was interrupted, by someone who came into the room.

In my experience there are few advertisements, posters or information leaflets that give information about sexual health to the general public. It is possible that Aneurin did not remember exactly where the majority of his knowledge had come from; he had learnt about STI during a course at school:

I did umm sports science and I well in one of the modules was about all disease and stuff and so we had to learn about them for the exam

*(Aneurin)*

The differences between Aneurin's experiences and those of Rhys are marked. Aneurin had chosen to undertake a course that involved him learning about STI, he had, therefore, taken responsibility for his learning. Rhys' experience was of education provided to all pupils.

Owain and Gwyn had differing experiences of learning about sexual health; Owain was clear about where he had gained information:

I went on a course in the summer...it was with the police and they did things like sexual infections and drugs and alcohol and first aid...and so I learnt some things there

*(Owain)*

Attending this course had been Owain's choice; he had learned what he knew about sexual health there, and had found it interesting.

Gwyn did not appear as interested and could not state exactly where he had gained his knowledge:

[shrugs] just picked it up really you know as you go along

*(Gwyn)*

Gwyn did later mention another possible source of information but he had not remembered this initially:

**Gwyn**

Well when I started college there was a nurse came in for half a day and then she talked to us about it and asked us if we wanted to be tested...

**Anna**

Ok... so she gave you information?

**Gwyn**

Yeah she did and then she is there every week now on a Monday morning if we need to talk to her

**Anna**

Ok that's handy

**Gwyn**

Yeah it is...I have never needed to though...

(Gwyn)

It is possible that this lesson had been the source of Gwyn's knowledge, but he did not remember. In this passage, Gwyn asserts his knowledge, whilst distancing himself from ever needing to use it. He says '*I have never needed to though*'; this was, perhaps, because of how he felt about discussing sexual health issues. He said clearly that he would not discuss sexual health with his friends at college, as they would laugh at him. This might be indicative of Gwyn's insecurity or an assertion of his masculinities; by others knowing that he needs help; he fails to assert his toughness and self reliance. The lesson might have been ineffective because the young men present were unwilling to cooperate, meaning that it was an inadequate source of knowledge. Measor *et al.* (2000) found that sex education lessons were likely to be disrupted by the boys present, whether it was a mixed sex or male only group. The boys were particularly likely to be disruptive if a health care professional delivered the lesson. It is, therefore, possible that the teaching provided to Gwyn did not supply all his sexual health knowledge.

Gareth also did not mention his sex education lessons at school but talked about another source of information:

I was looking at brochure for the holiday we are going on and there's an advert for the NHS it's got little islands ummm... [silence] it said that these are the times of holiday infections and you should use a condom, that's about it

(Gareth)

Before this, Gareth had been able to give a list of the names of some STI, suggesting that he did have some knowledge; he said he had gained this from the health promotion leaflet mentioned above.

Huw mentioned another source of information:

ummm...through the radio as always adverts, always warning you of...about it these days...through friends..

(Huw)

No other participant had mentioned radio advertisements in this way, Huw used the word '*always*' several times. He suggested that, not only are radio advertisements always the way to find out about sexual health, but also that these advertisements are '*always warning*'. His choice of language implied a fatigue with being warned. He stopped himself, or did not elaborate about what it was he was being warned. He paused, and then simply referred to the subject as '*it*'. This indicates that either the warnings had not been effective, or Huw's feeling of fatigue surrounding the subject meant that he did not remember the information given.

Most of the participants spoke about different sources of sexual health knowledge. Sex education at school was mentioned, but not generally thought useful. None of the participants were in compulsory education, although many of them had opted to continue their studies. Their impressions of sexual health education were based on their memories of it. It could be argued that the young men did not remember the information they were given or the quality of the education they received, but it is their memories and lasting knowledge which have influenced their long term behaviour.

The two participants who thought that their sources of knowledge were most useful were those who had chosen, in some way, to learn about the subject. Aneurin had needed to, because it was in the syllabus of a course he had chosen to do, and Owain had chosen to attend an extra curricular activity during a summer holiday. Several participants were unsure of exactly where their knowledge had come from.

### **6:1.3 Attitudes to sexual behaviour**

Some of the participants discussed their attitudes to sexual health behaviour and their attitudes to sexual behaviour. There are three themes included in this sub-theme:

- Concerns about pregnancy
- Concerns about STI.
- Qualifying/ managing risk (these were originally two themes but were merged together because their content was not sufficiently distinct to justify two themes.)

These will be discussed separately but the content of each theme overlaps and complements the others. They all build a picture of the young men's attitude to sexual behaviour. The themes about the young men's concerns have been placed here, because their concerns affect their sexual health behaviour and their attitude to this behaviour. Their perceptions of risk also influence their perceptions of the behaviour of others around them. Tensions were identified between the way that the young men qualified their sexual risk taking and their concerns about contracting an STI.

When conducting the interview I had been worried that I would introduce a new fear of STI to the participants and their expressed concerns would not be genuine, but what they thought I wanted to hear. Because of this I discussed concerns about sex before discussing the pictures that I took with me<sup>59</sup>. I introduced this subject in the context of an hypothetical situation; this enabled me to ask the participants if they knew where sexual health advice and help was available, as well as discussing their concerns.

#### *6:1.3.i Concerns about pregnancy*

Pregnancy was a concern for many of the participants and was the reason expressed for taking contraceptive precautions. When asked what he was most worried about Aneurin said:

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<sup>59</sup>Appendix nine, page 313, gives some examples of these pictures.

getting pregnant would be *really* bad

(Aneurin)

David also expressed concern about pregnancy and discussed the fact that his mother had had a son when she was seventeen. He expressed his mother's fears about this by stating that she:

[didn't want him to] Make the same mistakes that she did

(David)

When Gwyn and Owain were asked what worried them most, Gwyn quickly interjected:

Well...about babies

(Gwyn)

Owain later added:

Well...having a baby well that would be worrying

(Owain)

The primary concern of these young men was finding out their partner had become pregnant. Concerns about pregnancy were found to be a factor in determining condom use amongst a group of students (n=103) in Australia. Students were asked to complete a condom use diary; many of them reported late application of a condom<sup>60</sup> (de Visser and Smith, 2000). This suggests that the condom was seen primarily as a method to prevent pregnancy and not to prevent the transmission of STI. Participants may have been predominantly concerned about pregnancy because of its visibility around them. Teenage pregnancy has been a focus of media interest and Government strategy (Social Exclusion Unit, 1999); whilst STI have not been as evident in the media. This may be because it is possible to deal with the repercussions of an STI without discussion with others, but pregnancy is more difficult to conceal. Because of this, young men may have gained a distorted perception of possible risks.

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<sup>60</sup> Condoms are an effective method of preventing pregnancy and STI transmission when applied according to instructions before penetration or genital contact. Application after initial penetration could lead to unplanned pregnancy and also transmission of STI.

Heterosexual young people's knowledge and beliefs about STI have been studied (de Visser, 2005). It was found that, whilst the young people thought that unplanned pregnancy and STI contraction were equally likely, they were more concerned about pregnancy. This study took place in Australia. Single sex focus groups were used to collect qualitative data from 53 participants. Although attitudes may be similar amongst young people in Australia and the United Kingdom there may be important differences, thus results are not generalisable. Information provided to young people in Australia may be different from that in the United Kingdom and young people's knowledge would, therefore, differ. Also, participants in de Visser's study were accessed through advertisements on a university campus and through a free newspaper, perhaps giving access to a particular sub-set of the population<sup>61</sup>. Whilst it is easy to assume that perceptions of risks are indicative of priorities, the young men may have determined their risks based on what they perceived the possibilities were, without adequate information to assess them properly.

#### *6:1.3.ii Concerns about STI*

The participants did not state that they were worried about STI but their comments about choosing sexual partners revealed their feelings about sexual risk and how their behaviour relates to this risk. Their attitudes to the risk also reflected their attitudes to women and to sexual behaviour in general.

Only three participants spoke directly about concerns of contracting an STI. Huw's comments about his concerns were in response to being shown some pictures of the physical symptoms STI. He was prompted to ask questions about warts; the picture of these horrified him. He said:

....can you get genital warts but not have them straight away but just get them a couple of years later from sex you had like two years ago?

*(Huw)*

His comments show concern about his past behaviour, although when I questioned him further, and asked him if he wanted to talk about anything else he denied having any personal concerns. He followed quickly by asking:

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<sup>61</sup> De visser (2005) clearly states that the University used for accessing a sample comprised an socio-economically diverse group of students. However, they were all young people able to access university education. A free newspaper was also used but this would preclude young people who could not read well from becoming aware of the study. This sampling problem is impossible to counteract as any method of accessing a sample precludes certain members of a population from taking part.

what are the chances of getting one of those diseases?

(Huw)

Huw's concern was in contrast to the lack of comment the pictures provoked from other participants.

When asked about STI, Owain and Gwyn denied even considering them:

**Gwyn**

[shrugs] don't think about it

**Owain**

Well no..

**Gwyn**

...it is not something that you really have to think about....

(Owain and Gwyn)

Gwyn's use of the word '*have*' suggests that he does not consider STI his problem, as well as not considering them a pertinent issue. Most of the participants talked about managing their risks of contracting an STI, instead of merely expressing concern.

#### *6:1.3.iii Qualifying/ managing risk*

Risk was qualified by some of the participants by considering who their partner would be. Aneurin explained this:

I don't go around just sleeping with anyone like when I have just met them I don't go out and just...well you know I don't go in for one night stands

(Aneurin)

Aneurin made this comment when asked if he had enough knowledge about STI. Aneurin considered that, not having sex with people he had just met, would protect him from contracting an STI; he also counted this as knowledge about sexual health. He felt prepared to avoid STI, because he knew that '*one night stands*' could lead to him contracting an infection.

At this point, Aneurin did not mention sex with new partners, sexual practices or the possibility that partners may not be monogamous. This emphasises

Aneurin's view of the man in control of sexual interaction and the woman as a passive partner, thus revealing his beliefs about masculinities and acceptable power balances within heterosexual relationships. Holland *et al.* (2004) also posit that these power balances exist and are maintained by both young men and young women. It appeared that Aneurin felt that his risk was managed if he avoided sex with people he did not know well. This was clear when he was asked if he knew how to avoid getting an infection:

well you can use a condom and you can be careful...

(Aneurin)

I asked him what he meant by careful; he gave choice of partners as a measure of this. In his thinking there are two separate methods of avoiding contracting an STI; condoms is the first, careful choice of partners the second. Choice of partners alone is an ineffective measure to avoid contracting an STI. It is not clear from his comments whether Aneurin used both methods simultaneously, or relied only on condoms if he felt he was in a risky situation. Aneurin discussed choice of partners further:

Well who you umm have sex with... it's not that if you go out and meet someone and ummm have sex then umm you don't know what will happen but umm well it's not that if you know someone for like six weeks first it won't but it's less likely...y'know if you just sleep with someone then it might be that she umm just slept with someone else you know and then...you can catch something from her.

(Aneurin)

Even though it is clear that Aneurin was aware that sex with people he has known for some time could be a risk, he negates this by saying that it would be less likely. Aneurin alluded to his attitudes to STI in his final comments. He placed the blame for the transmission of an STI firmly on a woman and her past behaviour. The words that he used emphasise this point. He stated that he could catch something from a girl he did not know, he placed some blame on this fictional woman by stating that she might be likely to transmit an infection because she had recently '*slept with someone else*'. In this he was making a judgement about women's sexual behaviour and what he deemed to be acceptable. Aneurin did not suggest that, if he had many partners, he could be

passing an infection on to them, but blamed a woman as the original source of the infection.

This idea has been historically common and led to the introduction of measures such as the Contagious Diseases Acts in the 19<sup>th</sup> century<sup>62</sup>. Historically, sickness has also been linked with immorality (Allen, 2000). By adding comments about women's sexual behaviour, Aneurin was implying that he considered this behaviour to be immoral and thus, linked with the infection that might accompany it. This can be contrasted with the way Aneurin viewed his behaviour. Frequent partner changes for him were discussed as risky; it is his own health not an absolute moral which he considered.

Aneurin's beliefs about immoral behaviour and blame were elucidated by the following comment:

Well I didn't...hadn't done anything....like I just wanted to get a check up and make sure everything was ok so I went....

*(Aneurin)*

Aneurin said this to explain his visit to a genitourinary medicine clinic. His denial of having '*done anything*' was suggestive of his trying to remove any blame from himself. He did not explain what he had not done. He might have been referring to a particular sexual practice, a particular partner, or many partners. Aneurin was the most knowledgeable of the participants and, therefore, I considered that he must have had some cause for attending the clinic, or feeling that he needed to. He did not take any responsibility or allude to his potential role in transmitting an STI to his partner.

The idea that women were the agents of STI was also expressed by other participants. Huw, when asked if STI were a worry for him, said:

umm...well not really cos I would make sure I used protection if it was with like a girl I wasn't sure about

*(Huw)*

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<sup>62</sup>These Acts have been discussed in section 1:7.1, page 22.

This comment placed the source of infection solely in women, and made value judgments about which women were likely to pose a problem. Huw did not mention that he could have transmitted an infection in this circumstance. It had been established earlier in the interview that *'protection'* was used to denote condoms; this was a common euphemism amongst participants. I asked Huw if he carried condoms with him in case they were needed but he said:

ummm sometimes...

(Huw)

This implied that, either Huw was lying about using condoms for casual or unplanned sex, or that he had never been in this situation. Huw used the verb *'would'* insinuating that, if he has casual or unplanned sex in the future he will use a condom but this was not consistent with his level of preparation; he did not carry condoms with him all the time<sup>63</sup>.

This divide between what young people plan to do and what actually happens, is documented in the literature. A study of young people who pledged abstinence found that those who had promised virginity until marriage had similar rates of STI as those who had not made a pledge (Brückner and Bearman, 2005). This study involved testing samples from young people (aged 18-24) for three bacterial STI (n= 11,471) and collating these results with information already collected about the young people's abstinence pledge status. The study took place in three parts, enabling a long term consideration of the effect of abstinence pledges. Those young people who had made a pledge were less likely to be aware if they had become infected with an STI and were less likely to use a condom at their sexual debut, than those young people who had not made a pledge. The young people who had pledged were also likely to contract an STI through sexual behaviours other than vaginal penetrative intercourse. This may have been because the young people who made an abstinence pledge failed to prepare themselves for sexual interaction, but continued to place themselves in situations in which this was likely to happen.

This study took place in the USA and is not wholly generalisable to the United Kingdom as the demographic of the population is different in the USA. African

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<sup>63</sup> It is possible that Huw had never been in this situation because he had never had sex, he may have been reluctant to admit this in the interview.

American or Hispanic young people have higher STI rates in the USA (Brückner and Bearman, 2005). Also, abstinence pledging is not common in the UK. The study shows that young people do not always behave as they expect to. Huw was unprepared for unplanned or casual sex but this does not mean that he will never find himself in this situation.

Huw said quite clearly that he did not expect to find himself in a situation where he had casual or unplanned sex and made a moral judgement by adding that this is not something he would do:

say like I met someone at a party, not that I would

*(Huw)*

It appears that Huw did not feel that his values and morals were compatible with one night stands or casual sex.

Gwyn was also clear that he considered sex with a certain type of partner to be more risky; lending weight to the idea that women are the culpable party in the spread of STI. When asked if STI were something that caused him concern he commented:

...and if she...well if you went with someone who has a reputation well then you would be worried really

*(Gwyn)*

Gwyn suggested that he would only need to worry about contracting an STI if he had sex with a woman who had gained a reputation. This assumption blames women, as agents of infection, but also reveals the continuation of a different expectation of men and women's sexual behaviour. Men may behave as they wish sexually, but women would be considered promiscuous if they had many partners and may be called names such as 'slut'. This derogatory term is in sharp contrast to society's opinions of young men who engage in similar behaviour; they may be referred to as a 'stud' or 'one of the boys' (Lees, 1986; Moore and Rosenthal, 1992; Moore and Rosenthal, 1993). Measor *et al.* (2000) and Willis (1977) found that young men divided girls into two categories, the girls deemed promiscuous or 'slags' were acceptable as casual sexual partners but would not be considered as suitable people with whom to have a relationship.

Gwyn said:

Yeah yeah like if the girl has a reputation you would want to use protection even if she was on the pill....you would just say to her you want to make sure like....but if she doesn't or like its her first time or something and she is on the pill well you don't have to worry....

*(Gwyn)*

He did not mention how he would judge the reputation that a girl had, how would he know if it were merely a rumour, or would he take precautions with anyone he had heard something about? This comment also reinforced Gwyn's priorities of concern. His primary concern was pregnancy. He said if his partner was taking the pill, he would then assess whether STI protection was necessary.

I would also like to use this quote to discuss Gwyn's feelings about sex. His concerns surround his choice of partner and whether he deemed her to be risky. He never mentioned any emotional aspect of sex or whether this was a factor in choice of partner. This is demonstrated by his quote above, he did not consider the feelings of the girl in telling her he wants to use a condom as well as her being on the pill. He said this with apparent disregard for the feelings of his potential partner.

The young men's concerns and methods of risk management reveal not only their attitudes to sex but also their attitudes to their partners. Young women were seen as the cause of STI. The young men did not explain how their masculinities were negotiated in this situation, although they appeared to be asserting an hegemonic style of masculinity rather than a complicit masculinity<sup>64</sup>. A negotiation of some form must have occurred with a female partner in order to initiate a sexual experience with her. This led me to believe that the young men were using the interview to assert their dominance in an exaggerated manner.

There are clearly tensions between the participants' concerns and their methods of managing their risk. It did not appear that the participants were using risk taking to demonstrate their masculinities, because they assessed their risk and managed it accordingly (if not effectively). Their risk management strategies are

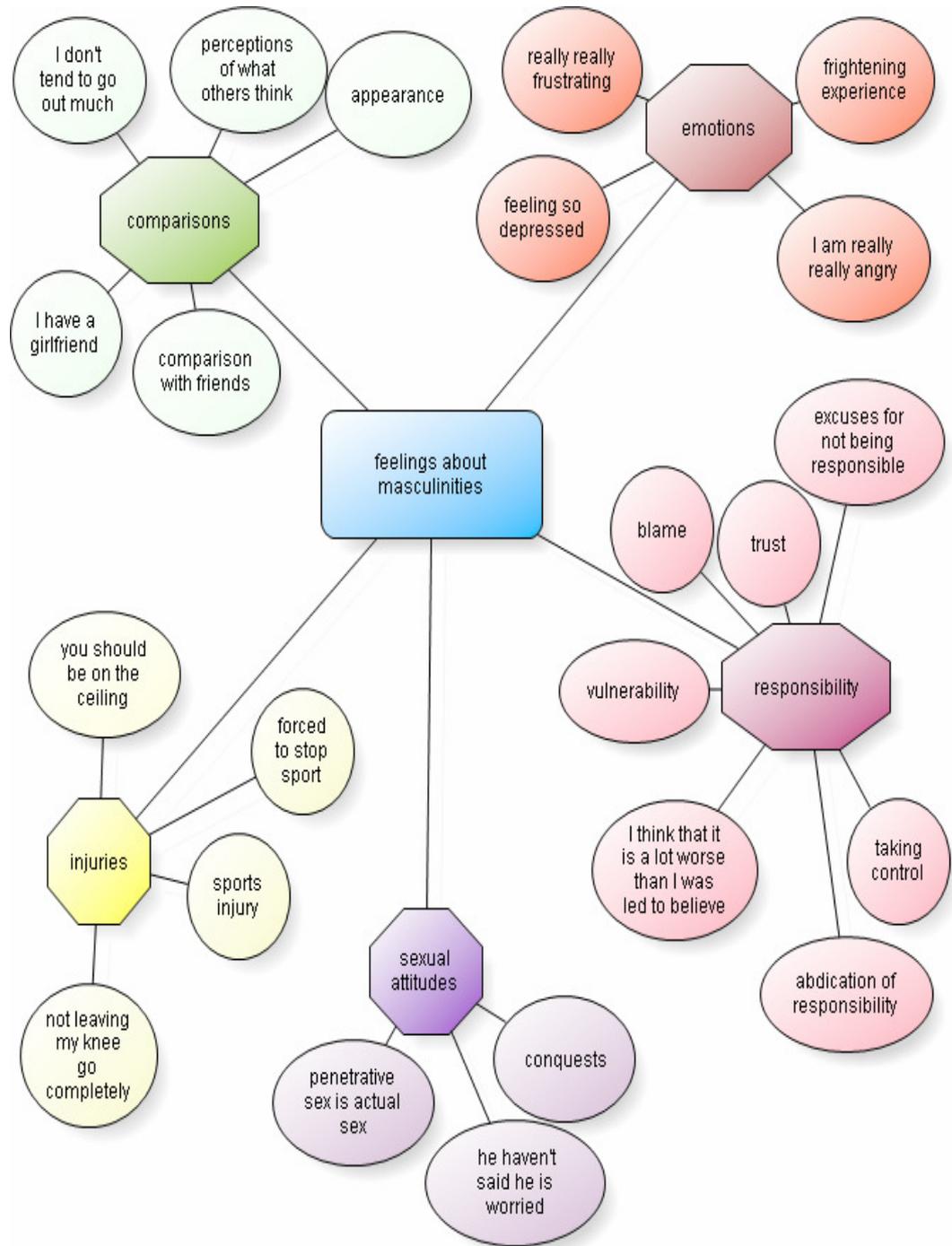
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<sup>64</sup> See section 3:2.1.i, page 57 and 3:2.1.iii, page 58.

indicative of their lack of knowledge, rather than their wish to assert masculinities. Lack of knowledge cannot entirely explain this phenomenon as, merely providing information about STI is not sufficient to change behaviour (de Visser, 2005). It is possible that participants had adjusted their beliefs (Peretti-Watel *et al.*, 2007) in order that they did not need to accurately assess their risk and change their behaviour. De Visser (2005) suggests that young people talked about STI as something that happens to others, thus they were able to distance themselves from risk of contracting an STI.

## 6:2 Feelings about masculinities

Figure five: Diagram to show sub-themes in 'feelings about masculinities'.<sup>65</sup>



<sup>65</sup> Some themes were named using verbatim text from an individual transcript. NVivo refers to this as coding 'In vivo'. This was done where the participants' words captured the essence of the theme. This is the reason that the names of some themes contain poor grammar and repeated words.

This is a major superordinate theme, as the figure suggests. Whilst masculinities have been discussed in chapter three, it is important to emphasise the nature of this theme. I have interpreted the lived experiences of the participants and, as such, this is my interpretation of their feelings about masculinities. Participants would probably not identify any of these themes as their discussion of masculinities. I have coded participants' statements into those that I perceive as expressions of their masculinities, or epitomising their ideals about masculinities. This makes my perceptions and beliefs about masculinities central to this analysis.

Themes within this superordinate theme have been grouped into sub-themes in order to make their interpretation more comprehensible. The links and overlaps are great and thus referral is sometimes made concurrently to several sub-themes. When writing up the analysis of this superordinate theme I began to wonder if this interlinking was evidence of a weakness in my analysis, that maybe there was a lack of coherence in the coding structure. On further reflection, I concluded that this consistency and constancy within the superordinate theme provided a framework into which sub-themes fitted.

### **6:2.1 Emotions**

None of the participants discussed their emotions as openly as Rhys; therefore much of this theme has been derived from Rhys' interview. Rhys was not talking in the context of sexual health but was discussing a football injury and the impact that it was having on his life.

Rhys admitted to feeling depressed:

I have been feeling so depressed

*(Rhys)*

Rhys was not reticent about admitting his recent depression. Depression remains a taboo illness in our society and there are many barriers to seeking help for it (Wilson *et al.*, 2007). Reluctance to admit a mental health problem and embarrassment are reasons for failing to seek help (Saunders *et al.*, 2006) for depressive illness . However, help seeking before the illness becomes

severe can lead to improved outcomes and lessened incidence of other mental health problems (Wilson *et al.*, 2007). Moskos *et al.* (2007) posit that young men may find it more difficult to seek help for mental health problems than young women and consequently are more likely to die from suicide.

Rhys' willingness to admit this experience may be because of to what he attributes it. Rhys was clear that the depression had been caused by the injury and his having been forced to be away from work. These ideas tie into another theme within this superordinate theme<sup>66</sup>, Rhys blamed circumstances and other people for his situation in order to make suffering with depression more acceptable to him. Hewitt (1997) points out that, where a socially devalued identity exists, a person may focus on the way that this negative identity does not define them. Depression appeared to be considered a negative identity for Rhys; by blaming this depression on his situation and those he perceived as having caused it, Rhys could remove this negative identity from himself.

This can be seen in Rhys' explanation of the beginning of his depression:

that is when I started to feel depressed, I haven't had a tidy nights' sleep in five months

*(Rhys)*

Rhys was referring to his treatment by the National Health Service (NHS) which he felt had contributed to his having been in pain for a prolonged period of time. Rhys blamed others for his treatment and traced the start of his depression to this situation which he perceived as being out of his control. Rhys linked his failure to sleep properly, with his depression.

Ogden (2007) discusses attribution theory, the manner in which people attribute responsibility for the causes of illness. These attributions are closely linked to control and determine whether an individual perceives control (Kelley, 1971). An individual who attributes responsibility for a health problem internally may react differently from one who does not. Ogden (2007) also differentiates between attributions for the problem and the solution, Rhys did not ever attribute his illness to himself or his behaviour but believed that the NHS was responsible

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66 See section 6:2.4.v, page 180-181 for further discussion of Rhys' feelings about his illness.

for restoring him to perfect health. Doing this removed any responsibility for his depression from himself, thus allowing him to admit to the problem. Rhys was linking his pain with his failure to sleep and blaming his pain on his poor treatment by the NHS. In this way the negative connotations of suffering with depression were eliminated in Rhys' thinking.

Literature suggests that expression of emotions conflicts with western hegemonic masculinities. Haywood and Mac an Ghail (1994) consider emotional toughness to be a central feature of western hegemonic masculinity. Beynon (2002) explains that modern men face a conflict between repressing their emotions and being tough, and the idea of 'the new man' who is comfortable with the expression of his feelings.

Blaming his depression on external factors made admitting it acceptable to Rhys. Collinson and Hearn (1994) found that men in industrial settings took control of their masculinities and adopted behaviours that asserted these, even though they had little real power in their workplace. Rhys adopted a strategy of blame so that he could remain in control of his masculinities and his identity.

Rhys also describes other emotions, but in a similar manner to his disclosure of depression. He admitted to his situation being:

really really frustrating

*(Rhys)*

Rhys was admitting to feeling negative emotions, but remained unwilling to take responsibility for these. His emotions were blamed on his situation which was blamed on others' failure to resolve it. This represents a contradiction in his masculinities. Rhys wanted to feel appear self-reliant and in control. Yet in explaining his situation he blamed others; demonstrating his lack of control.

This was particularly evident in the following statement:

I can't sleep 'til like two o'clock in the morning cos as soon as I lay down it's like constant toothache. And whatever painkillers I take there is just nothing shifts it and I am really really getting angry about it and I just...um...I don't think enough was done...to rectify what had happened.

(Rhys)

Rhys explained that he was becoming angry because of the pain. By doing this he removed the responsibility for feeling emotions, such as anger, from himself. Rhys did not take any responsibility for the original injury, that was the result of a poor tackle whilst playing football. His football accident became merely, '*what happened*'; Rhys did not claim it as an accident or blame the other player in the tackle. He moved his injury from the real into the abstract. By doing this, he allowed blame or responsibility to pass from him or others at the point of injury, onto the health care providers who ought to have given better care.

Rhys sought to assert his masculinity in his expression of emotions by not taking responsibility for them. In so doing, he allowed others to take control of his situation. Connell (2005) describes a similar situation in which a young man's sporting prowess, the method he used to construct his masculinity, also undermined the hegemonic masculinity he had constructed. His sport necessitated that he could not drink or fight and his training schedule left little time for women; meaning that his constructed masculinity relied solely on his sport. In the same way, the process by which Rhys seeks to assert his masculinity (admitting emotions but not accepting responsibility for them) is also the process that undermines his masculinity, because he relinquishes control over himself.

This is evidence of a complex negotiation for Rhys; admitting his emotions undermines his masculinities and yet blaming them on others requires him to admit a lack of control. Rhys is undertaking this negotiation, not with others in his life, but with me the interviewer; showing that assertion of masculinities was important to him within the interview.

The only other participant who discussed his emotions was David; in a different context from Rhys' admissions, although there are similarities. David was involved in a fight in a town centre when he was out in the evening with his friends. He described this as a frightening experience and thus it was coded

with emotions. This is David's account of what happened to him; he later showed me his wound and admitted to having been 'knocked out':

I...umm...was out in xxx about six weeks ago and it was well someone was fighting with a bouncer about ten metres away and I was watching and I was just in the line of another bouncer and the other bouncer threw me and they split my head open

(David)

He began the account with some reticence or hesitation, as though he was trying to find words to best explain what happened. He immediately distanced himself from the situation saying '*I was watching*' and stating that he was standing '*ten metres away*'. In a similar manner to Rhys, David asserted his masculinity by emphasising his powerlessness when resisting the attack of two bouncers. His assertion that there were two bouncers involved meant that he could not be expected to triumph in an attack; therefore his injuries were not an affront or challenge to his masculinities.

This emphasis of powerlessness also undermined David's masculinities. Being attacked and injured could be seen as demonstrating weakness. I was not convinced by David's account of events, it is possible that he became involved in the fight voluntarily but did not admit this to me, not wanting to affect my opinions of him. His account given to a group of young men, or in another situation, may have been different. Assuming this was the case; David had weighed the importance of asserting his masculinity and given his account in a manner that he deemed most appropriate to his audience.

These participants used the interview in different ways. Rhys asserted his masculinities and undertook a complex negotiation in his discussion of emotions to do this. David weighed possible outcomes and did not assert his masculinities in an attempt to affect my opinion of him. Both participants were using the interview to assert their identities.

### **6:2.2 Injuries**

This subject arose within a discussion about general health and health care seeking. I had included this in the interview schedule in order that participants' views about seeking health care might be revealed. Both Rhys and David had

suffered sports injuries. Whilst only these two participants contributed to this theme, I considered its inclusion important as identity, self and therefore masculinities were closely tied to sports injuries for these young men. Indeed, Connell (2005) identifies physical performance both in sport and manual labour as a method of constructing masculinities. If masculinities are constructed in this manner then they become vulnerable when physical performance is threatened through injury, illness or loss of ability to continue with similar manual employment.<sup>67</sup> Therefore, injuries could be seen as important for the young men discussed here.

Rhys had suffered greatly as a result of his injury because it affected many areas of his life. He was unable to work and was awaiting an operation to repair the damage to his knee. His dialogue about the injury related mostly to his feelings about his treatment and the care he had received. Rhys' injury appeared to have many meanings for him, not only a loss of ability to participate in a sport he loved, but also loss of income and therefore status.

Status may be linked to employment as ability to earn a wage or be the breadwinner has been seen as masculine (Connell, 2005). Therefore an inability to do so may be perceived as un-masculine and thus confer a drop in status. This link between earning and status is particularly apparent in South Wales owing to its industrial past.<sup>68</sup>

Conversely, David mentioned his sports injury in passing; it had taken place many years previously although it had affected his ability to continue with sports:

Ummm well it was just through cricket when I was younger

*(David)*

David minimised the seriousness of his injury. The word '*just*' is used to do this; it allowed David to convey a feeling that the injury had been an un concerning incident in his life, it was not something that bothered him. He also added that the injury had occurred when he was younger, conveying a similar sentiment.

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<sup>67</sup> The loss of heavy industry could have contributed to changes in construction of masculinity for many men. Suddenly not only their ability to provide money was compromised but also their means of asserting their physical capabilities which could challenge their position in the home (Beynon, 2002).

<sup>68</sup> See section 3:3.2.i, page 66, for discussion of employment in South Wales.

Despite this, David admitted to me that this injury had meant he had stopped playing cricket:

I had to stop playing about three years ago because of my back, I was having back problems

(David)

David's use of the words '*had to*' demonstrated a feeling of his having been forced to stop sports. He did not say clearly whether the pain of his back injury prevented him from continuing or whether the possibility of further damage occurring was the deciding factor. This may have relevance to his feelings about masculinities. The link between masculinities and sports is identified by many authors. Beynon (2002) recognises the association between sport and character development in Victorian Britain. Whilst this idea is not prevalent in society today, similarities can be drawn. Sporting and physical prowess has been seen, historically, as a method of asserting masculinities and developing traits considered essential for a man (Beynon, 2002) and sport is now used to define and assert masculinities (Connell, 2005). Physical prowess and success in organised sports allows men to compete and succeed amongst other men, thus asserting their dominance. It also excludes women from competition<sup>69</sup> (Connell, 2005).

As such, lack of success at sports may be seen as a challenge to masculinities. Connell (2005) describes gender as being vulnerable when physical prowess cannot be achieved. In order to continue to assert masculinities different strategies may be adopted. By rejecting an hegemonic ideal it can be made inconsequential. Another option would have been to assert the same hegemonic ideal in another manner, for example, emphasising sexual prowess (Connell, 2005).

By drawing attention to his being forced to stop sports, David is removing a challenge to his masculinities. Placing blame on a situation out of his control enabled him to admit that he was not a successful cricket player without

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<sup>69</sup> Women are excluded in organised sport even when a separate event is provided for them. For example, women and men would not play together on the same football team. The differences in women's' physical capabilities are given as justification of this. However, it could be seen as removing competition from men and allowing them to assert their masculinities amongst each other. The changes in society in the last 60 years have meant that there are few arenas in which men do not have to compete with women (e.g. for a job or academic success).

admitting what he perceived to be a lack of masculinity. David still attended the gym and was quick to assert that he was still able to participate in other sports:

I play sport...I play football

*(David)*

He added that he played football but this was not the central assertion of his statement. This supports the idea that David felt that success at sports enabled him to assert his masculinities.

Rhys also talked about his injury and the fact that it caused him to stop participating in sport. He commented that he had stopped playing football emphasising this:

only because of an injury

*(Rhys)*

Rhys is removed responsibility from himself for not continuing to participate in sport. Rhys continued to attend the gym regularly, although he could no longer play football; he may have been attempting to assert his masculinities by doing this in the manner suggested by Connell (2005). Rhys did not reject the idea of hegemonic masculinities and the importance of physical prowess in asserting them; he merely found another way to assert his physical capabilities. Because masculinity must be constantly asserted and reaffirmed a change in circumstances could precipitate a change in opinions of masculinity or ideals of masculinity (Haywood and Mac an Ghail, 2003).

Rhys' change in circumstances had not altered his ideals; although a permanent change might. Rhys continued to negotiate his masculinities in discussion of his situation in order to maintain his original ideals and show that he achieved them.

### **6:2.3 Sexual attitudes**

This theme is relatively small, not because these issues were not discussed but primarily because many issues about sexual attitudes better accompanied other

quotes in another theme: attitudes to sexual behaviour<sup>70</sup>. This section is, therefore, comprised of ideas linked to sexual attitudes that I felt particularly reflected attitudes to masculinities.

Rhys, despite having denied discussing sexual health with any of his friends, mentioned that one of them had recently attended a G.U.M. clinic. I asked Rhys why his friend had gone and he replied:

well the number of people he had slept with

*(Rhys)*

This comment shed light on the constructions of masculinities of both Rhys and his friend. Rhys felt that it was unacceptable to discuss sexual health issues, but he had discussed numbers of sexual partners with his friends. It was considered more appropriate to discuss sex in this manner than to talk about other issues surrounding it. Sexual experience in young men is considered not only acceptable but desirable (Lichtenstein, 2003; Lichtenstein, 2004) and thus is a rewarding subject of communication for young men to discuss with their peers. Rhys also alluded to conversations with other friends about their sexual partners in the context of attending G.U.M. clinics:

I know like a few of my friends have gone to clinics because of the amount of people they have slept with

*(Rhys)*

Discussing attendance at a G.U.M clinic could be framed positively if the reason for attendance was because of a large number of partners. This assertion of sexual prowess, or experience, took precedence over any reticence to seek help that may have been present in a different situation. This was further supported by another comment made by Rhys about his friend. I asked Rhys if they had discussed the reasons for attendance at a G.U.M. clinic and if his friend was concerned, Rhys replied:

he haven't said he is worried

*(Rhys)*

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<sup>70</sup> See section 6:1.3, page 142.

This supports the idea that help seeking because of sexual experience was acceptable to the young man but help seeking because of a medical problem may not have been. Rumours abound amongst young men about methods of testing for STI, and may be enough to discourage a young man from attending a G.U.M. clinic without sufficient reason. It is therefore possible, that Rhys' friend had reasons for his attendance that were not discussed.

Rhys talked about sex in a male orientated manner. He described penetrative sex as:

actual having sex

(Rhys)

Rhys perceived sex to mean male penetration of the vagina concluding with male orgasm. Holland *et al.* (2004) found that young men referred to 'sex' as sexual intercourse in this way. This idea asserts men's needs and desires whilst negating those of women, thus making sexual intercourse a male centred activity and a method of asserting masculinities over women. Men's desires are perceived as paramount and their power used to assert these over their female partners. Holland *et al.* (2004) found that women were often complicit in this assertion of power and described young women's dilemma. Challenging this male assertion of power may undermine their own femininity but failing to challenge it could lead to unintended pregnancies and STI, as women do not have the dominance to assert their wishes about condom use.

I felt that Rhys' description of penetrative sex as '*actual sex*' was an assertion of a form of hegemonic masculinities; it asserted his dominance over women in a sexual relationship. When having a similar discussion with a partner, Rhys might have undertaken a negotiation of his masculinities, adopting a complicit masculinity<sup>71</sup> instead of the dominant tone he used in the interview.

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<sup>71</sup> See section 3.2.1.iii, page 58.

## **6:2.4 Responsibility**

The theme of responsibility is comprised of many sub-themes, these are each discussed separately. This is because their size and clear delineation lent itself best to separate discussion.

### *6:2.4.i Abdication of responsibility*

Many of the participants discussed their chosen methods of contraception. This gave information about their relationships and their perceptions of personal responsibility. I considered this to be linked closely to the participants' feelings about masculinities because the way that women were referred to, reflected the participants' ideas about being a man. The young men spoke more freely about contraception than about STI prevention; it seemed that it was deemed a more acceptable subject.

When asked about his chosen methods of contraception Aneurin explained that he felt condoms were best. In some ways this shows an acceptance of responsibility, as condoms are largely controlled by the male partner. When asked where he would obtain condoms, Aneurin's answer showed an abdication of his responsibility:

I suppose if you were with a girl and she was...ummm...going to the family planning clinic then... ummm...she could get them.

*(Aneurin)*

Aneurin's addition of the words '*suppose*' and several '*ummm*'s suggest that he was either unsure of his answer, or of the acceptability of his answer to me. Aneurin said that he was not in a relationship at the time of his interview; he avoided saying where he obtained condoms when he was not in a relationship. There could be several reasons for this; he might not use them regularly or he might buy them from a vending machine or shop but be too embarrassed to admit that. Aneurin was the only participant who told me he had attended a G.U.M. clinic. It is possible that his wish to be screened originated in a failure to use condoms. Aneurin felt that, if he were in a relationship, then the woman could assume responsibility for obtaining condoms. This shows a dichotomy in Aneurin's thinking, condoms are seen as controlled by men and therefore are an attractive contraceptive; but Aneurin did not appear to take control for providing condoms, thus relinquishing his control over the contraceptive.

Holland *et al.* (2004) found that masculinities and femininities played an important role in condom use for young people. The choice to use condoms is not merely a choice about safe sex and prevention of unintended pregnancies but is constrained by social conventions and norms. Women are inhibited by societal norms and male dominance. This may impair their ability to introduce the subject of safer sex and condom use, but men may be relying on the woman raise the subject (Holland *et al.*, 2004). Aneurin's expectation was that a woman could be responsible for obtaining condoms; it is possible that he would also rely on the woman to negotiate condom use with him. Norms of femininity do not promote assertiveness or sexual preparedness (Silva, 2008), making it difficult for a young woman to both assert a wish to use a condom and conform simultaneously with society's expectations of her femininity.

Aneurin's reliance on a woman to obtain condoms in this situation may also be due to a lack of local service provision, meaning that he cannot obtain condoms free of charge. He might have been offered condoms when he attended the G.U.M. clinic, but most local primary care services do not offer young men the opportunity to access condoms free of charge. Whilst a condom card scheme<sup>72</sup> does operate in the area where Aneurin lives, it is advertised primarily to younger men and Aneurin was unaware of its existence. General practitioners do not distribute condoms and the cost of purchasing them can be great.

Other participants also demonstrated an abdication of responsibility in contraceptive use. I asked David about use of contraception, condoms and whether his girlfriend used any hormonal contraception:

she does yes....because how can I put this now... [silence]...condoms ain't one hundred percent and we did have one encounter where it didn't work to the effect...that...but...uhhh...so yeah she is very careful now

(David)

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<sup>72</sup>This scheme enables young people to obtain condoms free of charge from a variety of sources. Young people are educated about condom use and given a card. Each card enables the young person to be given condoms on ten separate occasions. When condoms are given the card is stamped, when complete the young person must have their condom use knowledge checked by a health care professional. When they have a card the young person can obtain condoms from youth clubs, pharmacies, youth workers, counsellors and sexual health care workers (nurses). In order to protect anonymity and confidentiality of participants I have given no more specific details of this scheme.

David's talk about this issue demonstrated his embarrassment; he never says specifically what happened and hesitated in mentioning the subject of problems with condom use. His use of pronouns was particularly enlightening, when considering his opinions about responsibility for contraception. Initially, David stated that '*she does*', (he was referring to her taking an hormonal contraceptive), this revealed an attitude that this area was the responsibility of his partner, further added to by his final comment that '*she is very careful now*'.

Contradictorily, when discussing the incident in which he felt a condom to have been ineffective he said '*we did*' suggesting some responsibility on his part. David contrasted contraception used during sex (condoms) which had shared responsibility and contraception separated from sex (contraceptive pill) which was the responsibility of only the woman<sup>73</sup>. The idea of contraception being the responsibility of his partner was further explicated by David when he was asked if he knew where to obtain contraception, or contraceptive advice. David said:

the girlfriend goes to family planning

(David)

This statement clearly distanced him from involvement in contraception and contraceptive decisions. His language did not suggest that he accompanied his girlfriend or even that he felt he ought to. His language also appeared to objectify his girlfriend, by referring to her by saying '*the girlfriend*' instead of saying my girlfriend.

Rhys' language when asked about contraception displayed a similar lack of assumption of responsibility. Rhys said:

she's on the pill

(Rhys)

Again the use of the pronoun '*she*' cemented the idea that this form of contraception is entirely the woman's responsibility. It is easy to see where these ideas in society have originated; reliable and long acting reversible forms

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<sup>73</sup> I wanted to discover whether this feeling would have extrapolated to female controlled barrier methods or other contraceptive methods in which David had to participate but I was unable to elicit any further information.

of contraception are available only to women. This leaves women bearing contraceptive responsibility.

Ekstrand *et al.* (2007) also found that young men perceived hormonal contraception to be the responsibility of women. Six focus groups were conducted with young men aged 17 (n=40) and it was found that whilst young men viewed adolescent pregnancy as a catastrophe, they believed young women to have greater responsibility for hormonal contraception and trusted their partners unquestioningly. This study was undertaken in Sweden and young people's perceptions might have influenced by different social attitudes or sex education.

Holland *et al.* (2004) suggest that young men maintain control of contraception in relationships where condoms are no longer deemed necessary by seeing themselves as instrumental in the decision. Weld and Gould (1992) suggest that contraception is a complicated area for men. They want their partner to prevent unplanned pregnancy, without the freedom to have sex with somebody else. If young men think they have suggested the pill, they maintain control over its use. This is quite different from the attitudes expressed by the young men in my study who, it appeared, were quite willing to abdicate all responsibility for contraception when their girlfriend started taking hormonal contraception; they did not appear to have been part of the decision making process. By abdicating responsibility, participants were demonstrating their lack of control over a situation and thus their lack of self efficacy. Self efficacy is the ability to have mastery and control over one's situation (Longmore *et al.*, 2003).

Rhys did not take any responsibility or admit having influenced whether or not his girlfriend took the pill; in fact he stated that:

her mother put her on it, when she was seventeen I think.... that was before I ..just before I started seeing her

(Rhys)

Rhys did not only allow his girlfriend all the contraceptive responsibility, but he admitted to me that he had no part in the instigation of this; he not only abdicated his responsibility, but passed it to his girlfriend's mother. It is not uncommon for young women to be encouraged to start taking hormonal

contraception by their mothers (Holland *et al.*, 2004). I have no way of knowing about the familial structure of Rhys' girlfriend's family. Rhys' language suggests some coercion on the part of her mother, using the phrase '*put her on it*' when referring to starting the '*pill*'. It is possible that this is the impression that Rhys had been given and not a true account of the situation.

Rhys informed me that he had been his girlfriend's first partner, yet it had been deemed necessary for her to take a contraceptive, even before she started having a sexual relationship with Rhys. Rhys might have been misinformed about his girlfriend's sexual past, or might have chosen to believe that she had been a virgin at the start of their relationship.

Rhys further abdicated responsibility for contraception when he discussed his feelings about his girlfriend taking the pill:

it is comforting to know that she is on the pill

(Rhys)

Rhys described the contraceptive decisions of his girlfriend as providing him with comfort. He did not take any responsibility for gaining this '*comforting*' knowledge himself. Rhys was not only asserting his lack of perceived responsibility for contraception and his girlfriend's duty to ensure that contraception is reliable, but also his ideals of masculinity. He clearly differentiated femininity and feminine duties, from masculine ones. Conventional femininity may lead women to feel under pressure to take a passive role in sex and submit to their partner's wishes about sexual practices and condom use (Pearson, 2006); making them less able to assert their wishes or contraceptive choices. Rhys' feelings about the responsibility of his girlfriend were further emphasised when he discussed male contraception. I asked him whose responsibility he felt contraception was; he explained that he had discussed male hormonal contraception with his girlfriend recently because they had read a newspaper article about its possible availability. Rhys did not feel that it would be a suitable method for him and said:

I am too forgetful to take it, I am useless with things like that

(Rhys)

Here, Rhys delineated his responsibilities from those of his girlfriend. He implied that, if he were good at remembering to take pills, then he could assume this responsibility. The inference is, because Rhys feels he is not good at taking pills, the responsibility should revert to its natural owner, the woman. Being the natural possessor of the responsibility for contraception, Rhys' girlfriend did not have the option of being forgetful or wishing to opt out in the same way as Rhys did. Rhys appeared to be demonstrating a form of complicit masculinities<sup>74</sup>. He has discussed contraception with his girlfriend and undergone some negotiation but his underlying ideals continue to be hegemonic; the woman remains responsible for contraceptive concerns and Rhys need not take responsibility as he would not be effective in this feminine role.

The responsibility of women for contraception is probably due to women's responsibility for child bearing and traditional child rearing. Early family planning services focused on providing services to married women (Rose, 1993; Rose, 1997) in order that they could control their fertility.

In different ways, three of the participants, Aneurin, David and Rhys all abdicated responsibility for contraception and placed this responsibility on the women, with whom they were having sex. This was the case even for Aneurin, who was not in a relationship at the time of our interview. Responsibility for obtaining condoms was also given to an hypothetical woman.

#### *6:2.4.ii Excuses for not being responsible*

Several of the participants made excuses for not assuming any responsibility for contraception.

When asked whether he had ever attended a family planning clinic David said:

ahh...no I haven't...she has never...she has never complained about it that I should well...it sounds wrong really....she didn't complain about it and she never felt uncomfortable there and like I think her and a few friends used to go anyway so

*(David)*

David was reticent to admit that he has never accompanied his girlfriend. He appeared to feel guilty about this, as he then made excuses for not having done

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<sup>74</sup> See section 3:2.1.iii, page 58, where a description of complicit masculinities is given.

so, and finally justified himself by explaining that his girlfriend felt better without him there anyway. His statement gave his girlfriend responsibility, not only for obtaining contraception, but also for informing him if she wanted him to play any part in this.

Huw also gave excuses for his failure to be responsible. When asked why his girlfriend took responsibility for contraception Huw said:

ummm...that's probably just because it's easier there's nothing invented for men...you know like a pill or anything or I don't think so anyway

(Huw)

Huw's admission that it was easier for his girlfriend to take responsibility could be interpreted in several ways. He might have been referring to local health care provision, which he perceived as easier for women to access, or to his perception that it was easier for his girlfriend to take responsibility in a similar manner to Rhys<sup>75</sup>. Huw also stated that contraception is unavailable for men. He had previously mentioned condoms but was referring to hormonal contraceptives in this instance. If Huw felt that the lack of availability of hormonal contraceptives meant that there were no contraceptive options available for him, it would be easy for him to excuse himself from any responsibility for contraception. It is difficult to differentiate whether Huw felt that he could not take any responsibility, or if he would not. Taking responsibility would not have to involve being the partner to use a long acting contraceptive; it could include participating in contraceptive choices and obtaining advice. As Huw had failed to do this and made excuses about it, it could be assumed that he did not feel it necessary to take part in obtaining or deciding about contraception. This is an example of a negotiation of his masculinity, Huw was willing to discuss reasons he had not taken a lead in contraception '*just because ...there's nothing invented for men*'. Hegemonic masculinities idealise subordination of women and dominance, reasons for taking control would not need discussion. Huw appeared to feel awkward about his failure to participate and thus was demonstrating a negotiation of masculinities. He was not really willing to participate but he was willing to find a good reason why he could not.

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<sup>75</sup> See section 6:2.4.i page 164 where Rhys' attitudes to contraception are discussed.

Huw, like David and Rhys, had not accompanied his girlfriend to a family planning clinic. When questioned about this he said:

uhh...last time she went on her own but well she is a twin she is so she goes with her sister.

*(Huw)*

It appeared, from his statement, that going with his girlfriend had not really occurred to him. He excused himself by explaining that she is a twin; his explanation makes it sound as though he views his girlfriend's relationship with her twin sister as special and unique, but also implies his exclusion from this. The structure of his sentence suggests that he felt that theirs was a relationship with which he would never be able to compete. By stating first that she is a twin and then saying his girlfriend attends with her twin sister, Huw suggested that this was an inevitable consequence of being a twin<sup>76</sup>, thus supporting it as an excuse for his non-attendance. His excuse was undermined by his initial statement, that his girlfriend went on her own the last time she attended the clinic.

Rhys identified his lack of responsibility by saying:

if men had to have babies and...all that...

*(Rhys)*

By making this statement, Rhys not only acknowledged his failure to take responsibility for contraception, but also admitted an attitude that suggested he felt there was no reason for him to want to take control of contraception. His choice of language suggested that pregnancy was not a choice for women but an obligation; he used the words '*had to*' to suggest this. Rhys implied that, if this obligation were his, he would feel differently about assuming responsibility for contraception.

Historically, in marriage at least, men have been expected to take control of contraception and birth control (Fisher, 2006). There is a contrast between historic attitudes, where the man remained in control, and attitudes of

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<sup>76</sup> A sentence structure of this type would not be used when referring to friends or even a sister, it suggests a special and inevitable relationship with which nobody else can or should interfere.

participants in my study, who expected their female partners to take control. Fisher (2006) found that women felt birth control was a burden and so were happy to relinquish control to their husbands. Rhys, Huw and David also characterised birth control as a burden and they expected their female partners to take responsibility for it. Fisher (2006) explains that female sexual identities (naïve and passive) were an important factor in allowing their husbands control. Women's sexual identities remain important in determining their ability to negotiate contraception and STI prevention.<sup>77</sup>

#### *6:2.4.iii Taking control*

This sub-theme demonstrated participants taking control in various areas of their lives. There was an interesting dichotomy between the idea of taking control and abdication of responsibility; participants who discussed taking control, abdicated responsibilities in other areas. In their talk, they felt that they would take control, but when they discussed situations, they had often not.

David discussed taking control of his appearance and health by coming to the gym:

you know coming to the gym and looking after your body but you know in terms of health but then there is the other aspect of you know trying to look better...vain you know but there you go

*(David)*

David was taking control in an area particularly pertinent to his masculinities. Haywood and Mac an Ghail (2003) identify men's bodies as important in the assertion of their masculinities, as bodies are used in manual labour to earn a wage.<sup>78</sup> In this way, not only the body, but its appearance asserts masculinities, a muscular body that would be capable of manual labour asserts a man's ability to work and therefore to provide.

Rhys thought about paying for private health care in order to take control of his recovery:

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<sup>77</sup> See section 7:1.3 page 255 for further discussion of male dominance in sex and femininities. See also page 173 where male control is discussed.

<sup>78</sup> This may be particularly pertinent in the geographical area of this research see section 3:3.2.ii, page 67.

I was thinking about going private

(Rhys)

Rhys was considering taking control of his situation (he did not actually pay for private health care). I judged this to be an example of Rhys asserting his self reliance.

David demonstrated his wish to take control over gaining information if he thought that he had an STI:

I would probably go on the internet first because you would probably spend about five hours up the surgery with us waiting to see the doctor.

(David)

Looking for information himself on the internet would not involve any input from others. David's reasons for doing this are clear; he felt that the health service would be an inconvenient method of gaining information. Using the internet would also provide some anonymity. David would not need to make any personal disclosures. This was an hypothetical situation: it is possible that David would be less willing to take control if he felt he had a serious health problem.

His problem with attending the surgery was the service that was offered there and the length of time it would take to be seen by a doctor. His response was first, that he would go to the doctor '*straight away*' and then he considered further, adding his reservations. These unconsidered initial answers should not be taken as a reflection of what David would actually do if he found himself needing sexual health care, but it reflected his feelings about what he should do. David equated seeking information on the internet with visiting the doctor. He implied that he would seek information on the internet to determine whether it was necessary to attend the doctor.

David considered that the information on the internet would enable him to decide his likelihood of needing medical treatment. This is concerning because STI often do not have symptoms (Adler, 1999; Clutterbuck, 2004) and the internet is not always a reliable source of information. David mentioned neither, how he would seek information on the internet nor, how he would use this information to

determine whether health care was required. Gray *et al.* (2005) studied adolescents' use of the internet to find health information. One hundred and fifty seven adolescents from the US and UK participated in one of 26 single gender focus groups. It was found that the internet was viewed as an attractive source of health information and sometimes preferable to talking to a health care professional. Young people pointed out that if their complaint were serious the internet might not be a suitable source of information; seeking professional help would be more desirable. They also stated that the impersonal nature of health information seeking on the internet was attractive when researching sensitive subjects like sexual health (Gray *et al.*, 2005).

Several of the participants discussed taking control in relation to contraception and the prevention of the spread of STI. This was in contrast to their discussion of their behaviour. It appears that, whilst participants felt it appropriate that they take control or responsibility for contraception, they actually left the control and responsibility to their partners. It is possible that this was because participants were influenced by what they thought I wanted to hear. The way in which individuals present themselves is affected by their intended audience (Goffman, 1971).

In contrast to his discussion considered above<sup>79</sup>, when asked whose responsibility contraception was David said:

both

(David)

Despite having expressed a view that hormonal contraception was the responsibility of his girlfriend, he felt that it should also be his responsibility.

A contrast was also perceptible in Huw's discussion of responsibility. He had made excuses for not assuming responsibility for contraception, and for not accompanying his girlfriend to the family planning clinic; but when asked directly he admitted that he felt he ought to take some responsibility to prevent the transmission of STI:

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<sup>79</sup> See section 6:2.4.i page 163.

you should still wear a condom just in case of infections

(Huw)

Despite the fact that Huw admits liability in the prevention of the spread of STI, he did not feel the same about contraception<sup>80</sup>. This is evidence of pregnancy, child-bearing and therefore contraception being seen as women's problem. Infections that could have affected Huw directly were perceived differently by him. He felt that he ought to take control to prevent himself from contracting one.

Both Owain and Gwyn felt that they had some responsibility for contraception and the prevention of the spread of STI. When asked whose responsibility contraception was Gwyn said:

It's both

(Gwyn)

But Owain said:

Well boys mainly but if the girl brings something that is well....

(Owain)

It is clear from this comment that Owain was not referring to hormonal contraception but condoms; his reference to bringing something, makes this clear. His use of the word '*mainly*' suggests that Owain has a paternalistic attitude to contraception provision. The impression created is of a man taking responsibility and a woman doing things to help him, suggesting male control.

#### 6:2.4.iv Trust

This sub-theme includes references to both contraception but also to other issues evoked in discussion about failure to trust others, namely, Rhys' experience of the health service. Lack of ability to trust is also discussed in this sub-theme. These were previously separate themes that were merged together.

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<sup>80</sup> This has been discussed fully in section 6:2.4.ii, page 168.

When discussing contraception and STI, both Owain and Gwyn were keen to admit to taking some responsibility; unlike other participants<sup>81</sup>. The responsibility they assumed was not mentioned in the context of preventing an unintended pregnancy, but to prevent them contracting any infections. In this way, their assumption of responsibility was selfish; they both expressed a lack of trust in their partners.

Gwyn mentioned contraception when we discussed STI

she can have protection but I prefer to take care of it myself

(Gwyn)

In saying this, Gwyn admits that even if his partner was using contraception he did not trust her sufficiently to leave this responsibility entirely to her. All the other participants used the term '*protection*' to refer specifically to condoms; here Gwyn appears to be referring to other methods of contraception as well. Gwyn's use of language clarified his opinions about contraception; he negated the efficacy of a girl taking responsibility by saying '*I prefer to take care of it*'. Gwyn was taking a solipsistic approach by stating that it was his health that concerned him most, not that of his partner. When questioned further about this Gwyn said:

if you take care of it yourself you are more sure about it [laughs]

(Gwyn)

Gwyn was sure that he should be taking responsibility for his own health and did not appear willing to trust his partners at all. A similar phenomenon was discovered by Holland *et al.* (2004) when discussing sexuality with young men and women. Young men were more likely to insist on condom use to ensure that they did not contract an STI; young women often did not feel they had sufficient control to do the same. This is attributed to femininity and masculinities. Femininity requires trust and openness in adult relationships and is, in part, defined by this but masculinities are not. Therefore, young men can assert their wishes to use condoms even if this implies an assumption that their partner cannot be trusted.

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<sup>81</sup> See section 6:2.4.i, page 163.

Owain's feelings about condom use were similar to Gwyn's:

Well I would still like to have protection just like then you...know it is safer...but then if she is on the pill and you trust her like it might be ok, you might not get an infection

(Owain)

Owain asserted that his preference would be to take control of condom<sup>82</sup> use in order to prevent any unintended consequences of sex. He referred specifically to his lack of trust of his female partners by drawing a clear distinction between those he would trust and those he would not. He also said that, even sex with a woman he trusted may lead to him contracting an infection. This implied that he never completely trust his partners.

The comments of Owain and Gwyn about contraception reflect a lack of trust in their partners and a degree of self-reliance. Owain felt that it would be better to ensure he was in control than to rely on a partner. His language conveyed an interesting sentiment; he said '*I would still like to have*', suggesting that using a condom for him was an ideal not a given. This implied that either, he has found himself in a situation without a condom when he would have liked one, or he anticipated this happening. This language also suggested that there may be a dichotomy between his ideals of masculinity and his perception of his actual masculinity. For example, perhaps his ideal is that he would be in control in a sexual situation and insist on using a condom that he provided, but in reality he did not always carry condoms, meaning that his ideal of being in control may not be achievable.

Owain also displayed a lack of trust in his partner's decision making. When talking about condom use he said:

if she says no or she doesn't want to then I just would anyway....

(Owain)

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<sup>82</sup> The use of the word protection was taken to mean condoms in this instance because of its context. Earlier in the interview I had clarified what Owain meant by this, he said condoms were being referred to so I took this to be the case for the remainder of the interview.

Owain was well informed and felt that he could assert his wishes regarding condom use, in a manner that would be successful. This statement supports the idea of the masculine as dominant and feminine as subordinate and further emphasises the lack of power that women may have in a discussion about contraception or safer sex. Owain's decision was good, but if he had been equally assertive about wishing to have sex without a condom would his wishes have been similarly unquestionable? Holland *et al.* (2004) explain that men can introduce the subject of condom use without fear of undermining their masculinity, but young women risk damaging their femininity if they carry condoms, introduce them in communication, or insist on their use. Owain clearly felt that his decision to use condoms should override any potential partners' decision that they are unnecessary. This was in contrast to the abdication of responsibility displayed by some participants when considering contraception<sup>83</sup>. A clear divide appears between female controlled methods; perceived by participants to be for the prevention of pregnancy, and condoms; that are controlled by the men and are discussed as being to prevent the spread of STI.

Gwyn also alluded to the idea of trust in a partner determining whether he would contract an STI, although he was more explicit than Owain had been:

Yeah yeah like if the girl has a reputation you would want to use protection even if she was on the pill....you would just say to her you want to make sure like....but if she doesn't or like its her first time or something and she is on the pill well you don't have to worry....  
(Gwyn)

Gwyn linked a girl's previous partners with the likelihood of his getting an infection, although he did not state that he would discuss this with this sexual partner. He would rely on gossip or notoriety, which is not a trustworthy source of information. It is notable that, Gwyn used reputation to determine whether condoms ought to be used, but did not refer to it influencing his willingness to have sex with a girl. This might suggest that sexual conquests were important to Gwyn, namely, it was more important to have sex than to consider with whom he had sex.

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<sup>83</sup> See section 6:2.4.i, page 163.

Rhys' trust in his current relationship<sup>84</sup> was contrasted with a different attitude in a previous sexual experience. He did not discuss it at length but did say:

that was with protection and that was on my behalf

*(Rhys)*

Rhys was referring to using a condom, that he had provided. This suggested a different attitude to contraception and STI prevention in differing contexts, but also different levels of trust. The level of trust in a partner not only depended on the nature of the relationship, but also denoted the willingness of participants to take responsibilities for contraception and STI prevention.

One of the participants discussed trust in service provision; Aneurin was the only participant who had visited a G.U.M. clinic. When asked what he would like from a sexual health service he said:

Well I would like them to get to know me as a person so that I wasn't just a person with a disease I would like them to talk to me and stuff like that I suppose...they should be friendly...

*(Aneurin)*

Whilst none of the other participants spoke so explicitly about sexual health services, their opinions of general health services were expressed differently. Rhys had had problems with the health care he had received; he felt he had been misdiagnosed. Rhys was upset about feeling the service was inadequate and blamed it for the situation in which he found himself. This contrasted with Aneurin's expectations. Aneurin did not mention waiting times, location of clinics or accessibility but interaction with staff was an important thing for him. This did not feature in discussion of health services for any of the other participants. Aneurin's feelings about sexual health services were coded in the theme of trust because his trust in health care provision was implied in the fact that it did not need to be mentioned. Aneurin trusted that health services would be adequate but felt that he might not be well treated by staff, otherwise he would not have considered it worth mentioning.

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<sup>84</sup> Discussed in section 6:2.4.i pages 166-167.

Trust was mentioned specifically by several of the participants; I have also interpreted some of their statements as referring to trust, usually trust of their sexual partners. Trust has been categorised with masculinities because I saw the young men's ability and willingness to trust others as a reflection of their feelings about masculinities. An unwillingness to trust could be seen as a need to be self-reliant and dominant; to take personal control.

#### *6:2.4.v Blame*

This sub-theme is about participants' blaming others for their situation. It is closely linked to the sub-theme '*excuses for not being responsible*' (6.2.4.ii) but quotes coded in '*blame*' were those in which participants appeared to accept no responsibility or where they directly held others responsible. This was part of the participants' feelings about masculinities, because it expressed self-reliance and assertiveness. Blaming others asserts one's own independence but also means that negative personal situations are not personal failures. Blaming others negates the need to accept culpability or question one's own identity.

Rhys is a good example of this; he blamed others for his football accident and the length of time that treatment had taken. When he was in pain he did not need to question his masculinities, because he could blame others and therefore preserve his identity.

David discussed a fight in which he was hurt and needed health care. He did not feel that the incident was his responsibility. The fight happened on a night out and David explained his lack of blame by saying:

yeah I had only been out about two hours I mean they can't really say I was drunk because I had only had two drinks, like two or three drinks

*(David)*

For David being in a fight, and consequently in trouble with the police, was synonymous with inebriation. He felt that, as he was not drunk at the time of the fight, he was not accountable. He did not make excuses for his lack of responsibility, although he was unsure about the amount he had drunk and on reflection, changed his estimation of his alcohol consumption. David also did not refer to the type of drinks he drunk; double measures of spirits contain more alcohol than singles and may still be referred to as one drink.

David also qualified his willingness to blame others for the situation by mentioning his personal identity and contrasting it with someone who would be responsible for a fight:

yeah and I am not a trouble maker...make sure you put that in [laughs]

(David)

David distanced himself from blame by saying this but also referred to the fact that the conversation was being recorded. He felt that the recording should present a correct depiction of him.

Rhys was the participant who best depicted this sub-theme because of his feelings about his injury. Rhys' injury was a threat to his identity and masculinities because it meant that he was unable to work, earn money or play football. It had also led to depression that Rhys appeared reluctant to admit so he was quick to blame on the injury.<sup>85</sup>

Rhys did not take personal blame for having been injured but blamed the health service for his constant pain and their failure to improve his condition. He felt that the length of time it had taken to diagnose his problem meant that he might have caused further damage:

I put myself at more of an health risk by walking round on it doing more damage

(Rhys)

Although this could be seen as Rhys accepting some blame as he said '*I put myself*'; this was not the case. He was complaining about health care and the length of time that it had taken for him to get a diagnosis.

Rhys felt that the injury was not his responsibility and nor was his pain<sup>86</sup>. Rhys' conversation suggested that he allowed things to happen to him. This did not appear to pose a threat to his identity. This contrasted with Rhys' behaviour. Whilst his conversation suggested that he relied on what he was told, he regularly attended the gym, in order to maintain his general fitness. This self

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<sup>85</sup> See section 6:2.1, 153.

<sup>86</sup> Rhys' quote about his pain are given on page 153-156 section 6:2.1

management of his fitness levels shows Rhys taking control and refusing to relinquish his responsibility or blame others. The difference between Rhys' conversation and behaviour is difficult to explain; his feelings appeared to be revealed in his conversation. If these feelings of blame and lack of responsibility had challenged Rhys' identity or masculinities he may not have been so willing to discuss them with me. When talking about depression he was quick to justify himself and the reason he suffered from it. This contrast has led me to conclude that blaming others for his injury and its treatment did not pose a threat to Rhys' identity.

Not only did Rhys blame others for their lack of ability to help, he also did not consider it to be worth asking health care providers for help; believing his past experience proved that he would not receive any:

but...it's nothing that anyone can really do for you like

*(Rhys)*

This showed not only a degree of blame but also Rhys' self reliance and his desire to deal with his situation without help. Rhys blamed others for failing to help him and yet saw little point in asking for help. He wished to be self reliant but also expected help from others. When the support he received was not as he expected; he blamed others.

Rhys said of his injury:

I think that it's a lot worse than what I am led to believe

*(Rhys)*

Rhys contrasted his determination of the extent of his injury with that of the health care professional's by saying '*I think*'. By saying this he was comparing his own belief about the nature of his injury with what he has been told. Doing this shows not only self-reliance but also a lack of trust. Rhys' comparison also led me to consider his self belief. He felt he was as good a judge of his injury as the health care professionals looking after him were. This is notable, not because health care professionals are always correct in their diagnosis but because he was not trusting and unquestioning. Rhys compared what he was told about his injury with his own assessment.

Rhys also suggested that the health care providers had '*led him to believe*' that his injury was not as bad as he had thought. Rhys did not merely feel that the health service was not trustworthy, but also that he had been deliberately misled. The contrast between what Rhys felt about his injury, the fact that it had taken so long for him to be diagnosed, and his feeling that he had been deliberately misled caused Rhys to feel disempowered and vulnerable. These feelings were reflected throughout Rhys' interview, but never explicitly stated. I believe that Rhys discussed his situation at length in order to justify it and thus explain the cause of his feeling powerless, that threatened his masculinities.

Rhys alluded to this feeling of powerlessness when discussing his health care and its failings. He made comments like:

because somebody didn't say right this boy has had an accident

*(Rhys)*

In this statement, Rhys, clearly put blame on his health care by using the word '*because*' leading the listener to believe that the cause of Rhys' problem was a failure of health care providers to deal properly with him; not the accident itself. This blame caused Rhys to feel powerless, because he attributed his problems to others and therefore removed his ability to address them. Rhys referred to '*somebody*' and not a particular person, he could not find someone else to blame wholly for his situation and so blames the whole health care system.

#### *6:2.4.vi Vulnerability*

This sub-theme relates to participants' feelings of vulnerability related to their personal responsibility. Some of the quotes coded appear unrelated to responsibility but, when undertaking analysis, I considered that the feelings of vulnerability expressed, reflected a lack of personal responsibility, or vulnerability had been a motivation for participants to take responsibility.

I believe that participants' feelings of vulnerability reveal some of their opinions of their masculinities. Vulnerability could be considered contradictory to hegemonic masculinities; being vulnerable is contrary to self reliance and toughness. Openly expressing vulnerability may have been a demonstration of

participants' feeling that occasions of vulnerability were not a challenge to their masculinities. Conversely, participants may not have felt that vulnerability and masculinity were disparate.

Several of David's comments were coded in vulnerability. David discussed an injury that he had had when he was a teenager, within his discourse about healthcare:

I was having problems with my back and my hamstrings that you shouldn't have when you are so young

(David)

David's use of the word '*shouldn't*' to describe his injury suggested vulnerability or a failing of some kind. In using this word he compared himself with an ideal and found that he did not match it. If the injury, or his failure to match up to his perceived ideal, were a threat to his masculinities or his identity it is unlikely he would have discussed them. Other participants used a different method to discuss issues that appeared to threaten them. For example, Rhys was quick to explain the reason he suffered with depression and why it was not his fault; in order to mitigate the threat to his identity<sup>87</sup>.

David discussed two injuries; the first involved bouncers but the second had happened when he was beaten up in a night club lavatory. His dialogue suggests feelings of vulnerability but David took control of the situation by reporting the incident to the police.

### **6:2.5 Comparisons**

This sub-theme considers the comparisons participants made between themselves and others. The participants did not always make these consciously, but the comparisons were implicit in their discourse. Comparisons were part of masculinities because they formed an important part of personal identity. The participants constructed their masculinities and personal identities in a social context (Hewitt, 1997) and therefore their opinions of social comparisons and the way they saw themselves were significant.

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<sup>87</sup> See section 6:2.1, page 153.

Appearance was identified as important by several of the participants. Body image is a social construct and is therefore dependent on social values and norms (Cash *et al.*, 2004). Images of muscular men are increasingly portrayed in media and advertising (Grogan and Richards, 2002). As body image is partly a comparison with others, these ideals may effect young men (Mishkind *et al.*, 1987). Beynon (2002) suggests that a muscular body signifies self control and self empowerment for many young men. Thus, controlling one's appearance would represent much more than merely looking attractive or muscular; it would symbolise self reliance and toughness.

When asked why he attended the gym regularly Gareth replied:

I dunno some of it is to improve self consciousness I suppose like ummm how you feel about yourself (Gareth)

Gareth identified self esteem as an important reason for attending the gym, explaining '*how you feel about yourself*'. Gareth did not explain if this improved self image would be due to a difference in appearance or to enhanced feelings resulting from exercise. Gareth does not use a tense that refers directly to himself, but uses '*you*' and '*yourself*' instead. This conveyed no personal feelings and therefore did not mean that Gareth needed to disclose anything that he might consider sensitive. To extenuate this, Gareth could have been expressing his belief that his personal identity did not need to be enhanced by his level of fitness or his appearance. Gareth was dichotomous, he felt that he did not need to rely on visiting the gym to assert his personal identity; yet he did regularly attend the gym.

Huw also referred to appearance as a reason for attendance at the gym. When asked why he went regularly he said:

well at first it was just to get into shape and then it just turns into you get in the habit of it and then you just get carried away really... (Huw)

Huw split his reasons for attending into three parts: '*to get into shape*', '*habit*' and '*getting carried away*'. Huw's first reason could be clearly linked to masculinity and appearance although he did not clearly mention his body image. Getting into shape suggests fitness and a strive to achieve an ideal body shape,

requiring self control (Beynon, 2002). Huw's next reason is more difficult to link to masculinity, but perhaps once an ideal body shape has been achieved, to allow it to slip would be perceived as a failure or a lack of self-control.

Finally, to '*get carried away*' suggested more than merely maintaining the body shape that has been achieved, Huw's use of language suggested an over-reliance on attending the gym or a dependence on maintaining or improving his physical appearance. His motivations were affected by his habit of attending the gym regularly. Perhaps attending regularly caused him to compare himself to the other young men, and alter his ideal, or become more competitive and ambitious about his body shape. Haywood and Mac an Ghail (1994) assert that not only must masculinity be constantly achieved, but males wish to emphasise their masculinity in social circumstances out of their control by asserting their power. Huw's feelings about attending the gym could be explained like this; not only did he need to achieve a satisfactory body shape but he had to maintain it to assert his masculinities. His comparisons with others behaving in a similar fashion led him to strive to improve his body image, to maintain his masculinities in relation to others. He had no control over the behaviour or appearance of the other men around him, but compared himself to them, and then strived to appear superior.

Huw also commented that:

you get a bit like not obsessive but...you feel bad if you don't go so you end up just going like every day... (Huw)

Huw recognised that he relied on his visits to the gym but denied being obsessive; perhaps he would have perceived this as losing control and thus a failure of masculinities. His choice of the word '*obsessive*' suggests that he recognised that his visits to the gym could appear as such, although he maintained this was not the case. His reason for going '*you feel bad if you don't go*' did suggest some reliance on attending regularly. I consider obsess to mean that one is preoccupied or has their mind filled.

If maintaining body image is seen as an enactment of masculinities then Huw was not choosing to assert his masculinities but was influenced to continue or maintain them, by the situation around him. Huw used his choice of words to

describe his feeling that he 'had' to maintain his appearance and masculinities; he had not exercised a personal choice to do this but was swept along by society; which influenced his behaviour. Masculinities can, therefore, be negative for both men and women. Watson (2000) also found that men used representations of men's bodies in order to evaluate other men's health. For example, a picture of a muscular man is seen as healthy and other men are compared against it. This point of comparison is unrealistic.

Similar ideas relating to women's body shape have received much media attention (Women's Hour, 2007) and there has been great criticism of the fashion industry for promoting female body shapes that are unhealthy and might lead women to use drastic measures to achieve them. Women do compare their bodies throughout their life with society's expectations of what they ought to be (Justine *et al.*, 2008), and it is possible that men behave in similar ways. However, unrealistic images of men's bodies have not received similar media attention. This could be because the ideal of a man's body is seen as healthy, because it is muscular and physically fit.

The female body ideal as promoted by media and celebrity culture is very thin. This body shape cannot be achieved by most people without a severely calorie controlled diet and is not synonymous with health. Therefore, women can justify their failure to conform by citing their desire to remain healthy and campaigning against the ideal. Men cannot do this so easily; to fail to conform would be an admission that they could not achieve the necessary levels of fitness or strength.

David referred to this idea in his conversation about reasons for attending the gym:

It was the professor from down there somewhere, they done a study on steroid use in the valleys and it was crazy but the reason why it was so high was because they just want to go out look big in their tops and but that's but I don't want to well I am not into that kind of training (David)

David saw himself as different from the young men involved in the study on steroid use<sup>88</sup>, he used the term 'they' to distance himself from other young men

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<sup>88</sup> Baker *et al.*'s (2006) study was conducted in similar geographical areas to those used in this study. David is referring to Baker *et al.* (2006) which was reported on Welsh television at the time of its publication. I did not

who used steroids. He also gave some explanation for his failure to achieve the same body shape as *'they'* do, namely, by describing them as *'crazy'* and referring disdainfully to their desire to *'look good'*.

David also mentioned appearance in his reasons for attending the gym:

As vain as it sounds, it does sound vain. No obviously it is the aspect of you know coming to the gym and looking after your body but you know in terms of health but then there is the other aspect of you know trying to look better...vain you know but there you go. (David)

This passage shows tensions in David. He gave two clear reasons for attending the gym, his appearance and health. Appearance can be seen as the main reason because it is discussed first; although David was quick to dismiss its importance to him by saying *'as vain as it sounds, it does sound vain'*. David felt that vanity was not an appropriate reason for him to attend the gym and, therefore, offered his second reason; of improving health. By repeatedly mentioning vanity, he tried to imply that its affect is trivial. There was a conflict for David, he wanted to achieve a masculine body image without using steroids but he did not want to appear as though body image mattered most to him. This was an example of David enacting masculinities. Whilst achieving a masculine body shape was valuable, he perceived striving after appearances to be unmasculine, and therefore attempted to belittle its significance in discussion.

David was keen to mention his body shape, suggesting that he was proud of it. He said:

I am not small<sup>89</sup>, well when I go other places I am not...but compared to the boys who come here. You can tell who has been taking them they just want to look good in their tops an' that (David)

It is clear that David constantly compared himself to others. He said he was not small, a favourable comparison. He then mentioned that he was smaller than other young men who attended this leisure centre, but David also made this a

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feel that it was necessary to remove David's reference to this study because Baker *et al.* (2006) used different gyms and leisure centres over a wide geographical area from which to collect their participants, therefore David's identity cannot be determined from reference to Baker *et al.* (2006).

<sup>89</sup> This refers directly to muscle size, David was talking about other men 'bulking up' in order to improve their appearance.

favourable comparison, by distancing himself from steroid use. This allowed David to explain his shape and its comparisons with other young men, whilst continuing to assert his masculinities. He achieved his shape with hard work and without drugs; emphasising his self-reliance.

Many of the young men compared themselves with their friends and appeared to use this to measure themselves or their status. Aneurin commented that he enjoyed similar leisure activities to those of his friends:

Well they like socialising too....

*(Aneurin)*

He was referring to drinking. Rocco (2000) points out that drinking has, historically, been seen as the domain of men and described drinking to excess as a symbol of masculinity. Conversely, Rhys emphasised his differences from his friends saying:

a lot of them do go out I would rather stay in to be honest with you

*(Rhys)*

He also made it clear that he was different from his friends saying:

a few of my friends do tend to go out more or less every weekend

*(Rhys)*

I found this hard to explain but Rhys was keen to point out that he was in a relationship. He said:

I have a girlfriend

*(Rhys)*

This may be more of an assertion of his masculinities than drinking would be; leaving him happy to admit that 'going out' is not a priority for him. Rhys was even willing to admit that he rarely went out drinking:

I don't tend to go out much of a weekend....it's very rare its like someone's birthday or something

*(Rhys)*

Rhys' assertion of masculinities can be considered as a scale, the most desirable attributes are at the top. If these cannot be achieved, then lower goals must be, in order to maintain masculinities. This is a form of negotiation, Rhys was undertaking with himself and those around him. In this case the scale would appear like this:

1. Having a girlfriend<sup>90</sup>
2. Drinking
3. Socialising (going out in the evening to pubs/ clubs)

As Rhys had a girlfriend, he did not need to undertake behaviours further down the scale in order to assert his masculinities. David also made a comment which suggested a similar idea:

I don't tend to go out every weekend. I am interested in training and sport...if I do go out its every six weeks *(David)*

David explained his failure to go out drinking every weekend by mentioning another interest. For David, physical training made up for not drinking regularly. This comment could be explained as David saying that the two pastimes are incongruous; to succeed in sport, one ought not to consume large amounts of alcohol. I have rejected this explanation for two reasons, firstly, David did say that he drank a lot but on limited occasions (every six weeks) and secondly the culture in the area where the study took place links sport closely with alcohol consumption. David's scale of assertion of masculinities may appear like this:

1. Drinking regularly
2. Interest in sport and training
3. Drinking sometimes<sup>91</sup>

His failure to accomplish goals at the top of the scale led him to stress his achievement of lower goals.

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<sup>90</sup> This might have an unspoken link to regularity of sex.

<sup>91</sup> It may appear that a need to drink regularly excludes the possibility of drinking sometimes being an acceptable assertion of masculinities. However, I felt that David used his occasional drinking to assert his masculinities. He did not feel that it was as important as sport but he did emphasise his ability to drink.

These scales could be seen as an endorsement of hegemonic masculinities and an attempt by participants to explain their failure to achieve these ideals in a given situation. De Visser and Smith (2006) also found that a participant in their research was able to explain a failure to conform to hegemonic masculinities in a similar way. The young man explained health related behaviours which did not conform to an ideal of hegemonic masculinities but used his language to assert that he could achieve these ideals if he so desired. Participants were negotiating their masculinities with those around them; instead of conforming to all aspects of hegemonic masculinities they chose characteristics which suited their lifestyle. This is a form of the complicit masculinities described by Connell (2005)<sup>92</sup>.

Perceptions of what others thought appeared important to participants. There was a dual need to assert masculinities for themselves and to demonstrate to those around them. David said of his lack of sexual health knowledge:

I feel silly not knowing

*(David)*

David did admit a lack of knowledge but felt awkward about it; this reflected David's masculinities because of the dynamic of the interview situation. By saying this David admitted that he knew less than me, a young woman, about sexual health. I wondered if he would have felt differently about admitting a lack of knowledge to another man or an older woman.

Rhys also considered the opinions of others to be important. When asked where he had gained his sexual health knowledge he said that a television soap had been a source for him but before admitting this commented:

I think I will be really sad<sup>93</sup>

*(Rhys)*

Rhys might have considered watching Eastenders to be unmasculine or it might be that he felt it was an unmasculine source of information. Fiske (1987)

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<sup>92</sup> These were discussed in section 3:2.1.iii, page 58.

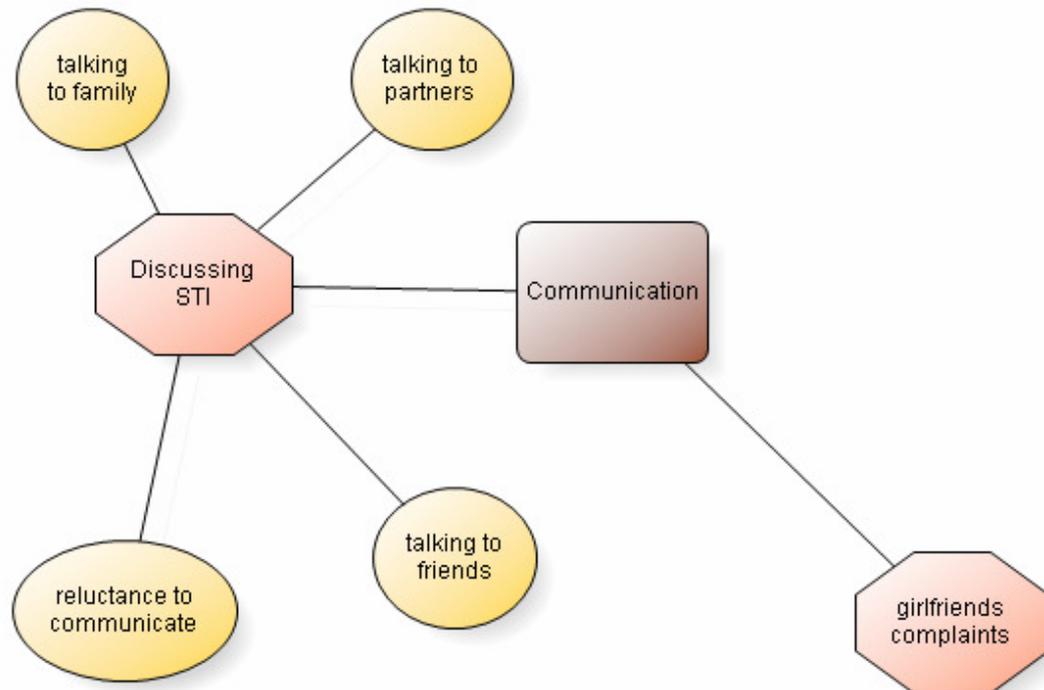
<sup>93</sup> The word 'sad' is used as slang to mean pitiable or geeky as opposed to the usual meaning. In this instance Rhys was using the slang term.

suggests that soaps are feminine narratives because they have multiple characters and plots with no defined endings. The feminine aspect of soaps might have led to Rhys' reticence. This comment may also shed light on the dynamics of his relationship; he may feel reticent to admit that he gives in to his girlfriend's television choices. Whatever his reasons, Rhys considered what others thought of him to be important and tried to excuse things that he thought others would not consider appropriate.

'Feelings about masculinities' was the largest superordinate theme. It is clear that many types of behaviour can be interpreted as gender related. It appeared that the way that the young men reacted to situations was affected by their masculinities.

## 6:3 Communication

Figure six: Diagram to show sub-themes in 'communication'



Participants discussed their willingness to communicate about sexual health and STI; these are considered within this theme. These issues might have influenced their willingness to attend sexual health services or affected their behaviour. Ability to communicate about contraception and prevention of STI is an important part of preventing unintended pregnancy and transmission of STI.

### 6:3.1 Discussing STI

This theme has been split, to express the relationships that the young men had and their feelings about discussing their sexual health with others. The young men expressed both positive and negative attitudes to discussing their sexual health with certain people. Participants felt that both the situation and the nature of the discussion were important; some of the participants felt they would not talk to friends in certain situations but would talk to friends in others. A section '*reluctance to communicate*' was used to group experiences or feelings of the participants who were reluctant to discuss sexual health issues with certain people.

Many of the participants expressed a reluctance to communicate with their partner or with others about sexual health issues.

Aneurin explained that he would not talk about sexual health issues with his friends:

Well my friends not much cos it's not really something that you talk about but well I would talk to my sister about it

(Aneurin)

He did not state that he had never spoken to his friends about sexual health issues, he used the term '*not much*' implying that he sometimes might have done. This attitude was in stark contrast to his opinions of talking to his family. Aneurin explained that he would be quite happy talking to his sister about sexual health issues. Aneurin's mother was working in the leisure centre at the time of our interview; I had no idea that this was the case and would have scheduled the interview differently, or held it in a different venue, had I known. Aneurin was not at all concerned about this; although his mother was aware of the purpose of the interview. When I asked if he would like to alter the interview arrangements he said:

No no it's fine we are quite open like... I don't mind

(Aneurin)

I was surprised that Aneurin would be happy to talk to his family and not to his friends. I would have discussed most things with close friends and been unwilling to discuss similar subjects with family. This disparity is probably due to more than merely a gender difference, family background and attitudes would influence this greatly.

In researching sex education programmes, Measor *et al.* (2000) noted that boys teased and joked when sex was introduced as a subject. Connell (1987) suggested that this may be due to the need to assert masculinities, establishing hierarchies being an important method of asserting masculinity. Therefore, this joking behaviour may be undertaken as a method of asserting masculinities. With this in mind, Aneurin may have felt that discussing sexual health with

another male friend provided a platform for his friend to assert a dominant masculinity; especially if Aneurin had been asking for help. This idea provides an insight into Aneurin's '*not much*' comment. Brief mention of sexual health issues with his friends provides a joke, and therefore an opportunity to assert his masculinities; a more in-depth discussion would present a challenge to his masculinities. This would also provide some explanation of the reason that young women may be less reticent to discuss sexual health with their friends; they do not have the same gender stereotype to assert. It would also go some way to explain Aneurin's willingness to discuss sexual health issues with his sister. In that relationship there is no need for him to assert his masculinities, as his sister poses no threat to them.

Aneurin also stated that sexual health was '*not something you talk about*'. This is a difficult concept to unravel. He did not mean it was an absolutely taboo subject, because he felt he could talk to his sister about it. I, therefore, concluded that he meant this solely in the context of his friendships with other males.

David also spoke about the difficulties of discussing sexual health issues with other young men, particularly in a group:

but when you say, like, in front of a group of boys it is something that's a lot, I know it sounds silly but you...you laugh (David)

This may also be as a result of attempting to assert masculinities amongst the group, as suggested by Connell (1987). Measor *et al.* (2000) found that this behaviour was common in sex education lessons with boys present and Kehily and Nayak (1997) suggest that this joking is a deliberate performance of masculinity. Those young men who used the best insults gained a higher status in the group, and thus asserted their masculinities.

David compared talking to a group with how he imagined talking to a close friend would be. He suggested that he might feel more comfortable talking to one of his friends if they were alone, stating that he thought it would be treated as a more serious issue than it would if he talked with a group:

say I think if you spoke one on one with your close friends I think a close friend not friends I think it's more of a serious it's more on a serious level (David)

This may support the idea of young men creating hierarchies in order to assert their masculinities (Connell, 1987; Kehily and Nayak, 1997; Measor *et al.*, 2000). Perhaps when only two young men, who are close friends, interact, the need to assert masculinities diminishes.

Owain and Gwyn were interviewed together giving the opportunity to observe some interaction between them. When discussing contraception and STI prevention, and amidst much laughter, Gwyn said to Owain:

No you pleb....pill doesn't stop that, just getting pregnant (Gwyn)

This statement shows the joking nature that talking about contraception and STI evoked. The participants insulted each other and their lack of knowledge. Their willingness to communicate about sexual health issues was set within a need to assert their masculinities; Gwyn was affirming his superior knowledge and therefore his masculinity. It is possible that my presence made this necessary. Lyman (1987) suggests that sexist jokes and joking relationships amongst men may be a method used to negotiate the roles between men and women. Measor *et al.* (2000) found a similar effect: young men asserted their masculinities over girls and each other in a classroom situation.

David was willing to admit that he would discuss sexual health with his brother:

Yeah I'd have no problems speaking to my brother (David)

This comfort may have been for the same reason as his comfort talking to just one close friend, or may have been due to his relationship with his brother. Perhaps there was no need to compete to assert masculinities with his brother because he felt accepted and the hierarchy was already established.

David did mention having spoken to a friend about sexual health issues saying:

I can't remember what he called it but he had some kind of rash after some kind of sexual encounter with this girl  
(David)

Not only does this statement prove that talking to friends was sometimes appropriate for David, it shows his attitude to STI and culpability. The words that David uses to describe the person at fault '*this girl*' ascribe blame. It is his choice of language which does this; had David said 'a girl' he would have sounded less accusatory. His friend is perceived as the innocent party.

Huw and Gwyn did not draw a distinction between comfort talking to close friends and comfort talking in a group, but rather specified certain friends that they would be more comfortable to talk to. Huw said that he might talk to certain people but still expressed reluctance to discuss the subject with anybody:

mates I would well I don't know certain mates I would ummm... I would probably just keep it to myself mostly.  
(Huw)

Huw went on to explain that this was because he would be embarrassed:

I would probably just feel embarrassed or I wouldn't want people just to know that I got a sexual infection  
(Huw)

Gwyn expressed different reasons for his choice of confidantes:

Well yeah....I would talk to the boys at work...I don't have to see them everyday  
(Gwyn)

The important factor for him was the infrequency of his meeting with the people he worked with. This appears different from the feeling expressed by David, who felt that having a close friendship with someone would be a factor in his willingness to discuss sexual health with them. This might be because Gwyn expected a certain amount of discomfort or challenge to his masculinities; by allowing this to take place in a situation he was hardly ever in, he minimised his discomfort.

Owain did not feel that he would ever be comfortable talking about sexual health with his friends. He said:

Well I wouldn't talk to the boys I hang around with

*(Owain)*

I asked him why he felt like this and if there might be anyone else he would be willing to talk to about sexual health. His answer suggested, unlike other participants that the problem was the sensitive subject and not the specific person he was talking to about it:

Well you know it wouldn't be good to talk about it, I wouldn't like it...[pause]

*(Owain)*

Rhys also denied having ever spoken to anyone else about the subject of sexual health:

I've never really spoke to anyone else about it

*(Rhys)*

He did not say that he never would and later in the interview he admitted that he knew one of his friends had attended a G.U.M. clinic. This knowledge reflects some discussion of the subject.

Gareth did not talk about reluctance to discuss sexual health issues with friends, but did mention that the last time he had sex with a girl there was neither communication about prevention of pregnancy and the spread of STI, nor was a condom used:

no it wasn't because it was awkward or anything it just never really entered the head

*(Gareth)*

Gareth admitted that communication had not happened but denied that this was because the subject was awkward. He simply felt that the idea of communicating about it had never occurred to him. Gareth described the subject as not having '*entered*' his head. This word suggests that he expected somebody else to introduce it. By failing to use the word '*I*' he removed the

responsibility for the introduction of the subject from himself. This is important in the light of findings by Holland *et al.* (2004). Sexual interactions were found to be male orientated; young women often had little control with which to initiate discussion about condom use, or insist on certain practices (for example, not having penetrative sex). Both young women and men are controlled by male dominance and ideas of masculinities. Gareth's partner may not have had the communication skills necessary to address the issue, doing so may have challenged her ideas of femininity and thus been unacceptable to her.

Conversely David said of talking to partners about contraception:

No not a lot but you talk about it cos it is a possibility

(David)

David was accepting some responsibility for discussion of sexual health but his language distanced him from the situation. The use of the pronoun 'I' would leave no doubt as to his intentions to discuss issues but David used 'you'<sup>94</sup>. This pronoun distanced David himself from admitting what he would discuss; instead he referred to what he assumed anyone would do in a similar situation.

Despite having said that he had not spoken with a partner about sexual health and contraception, Gareth said:

I would feel quite comfortable talking about it like I wouldn't mind

(Gareth)

Gareth talked about hypothetical situations differently from situations he had actually experienced. Gareth felt that he would not mind discussing issues with a partner, but when the situation arose it did not '*enter the head*'. There was a disparity between what Gareth expected of himself and his behaviour.

Gareth also talked about preparing to have sex with a girl. This is interesting when considering the contrast between his expectations and his experiences of his past behaviour:

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<sup>94</sup> Instead of the more formal pronoun 'one' (Pearsall, 2001).

umm [silence] umm I suppose if I was going to start sexual relations with a girl then I might...I would obviously have to buy condoms and stuff so I would probably just pop down to ASDA and buy some but if I didn't know what ones to get...cos there is quite a selection, they are quite confusing...I might ask (Gareth)

Gareth amalgamated ideas about what he felt he ought to do (buy condoms and use them) and what he would like to be able to do (ask for help so that he gets the right type). He was clear that, before starting to have sex, he would buy condoms, but when he had previously found himself in a similar situation, this was not the case. By saying '*I would obviously*' Gareth asserted that he would be in control of the situation and it would be his responsibility, as the man, to buy condoms. There is no suggestion that a woman might do this or that another form of STI prevention could be suitable. Gareth's discourse suggested that he would be taking control, which would remove control from the woman in what is already a male orientated experience<sup>95</sup>.

Gwyn also asserted his control in a sexual situation by saying:

No no I would just take protection of my own

(Gwyn)

Whilst it is encouraging to envisage young men taking responsibility for their own health and using condoms, all the participants who discussed this, implied that they took control. By taking control of their own health they were also asserting their wishes on the young women who were their partners; in many ways this was not positive. Young men are in a 'catch 22' situation, if they leave decision making and contraceptive action to their partner, they are relinquishing responsibility and if they take control they become over assertive. Complex communication skills are required in order to negotiate contraceptive use and sexual activity with a female partner. Doing so is an example of a complicit masculinity, men negotiating with others around them, not simply asserting their dominance. It is possible that the participants were unable to explain how this happened to me, in the interview, but were able to undertake these negotiations at some level.

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<sup>95</sup> Sex is described as a male orientated situation by Holland *et al.* (2004) who emphasise the lack of power young women often have to assert their wishes as being assertive directly challenges their femininity.

Owain was clear that talking about contraception and STI were taboo, saying he would '*never*' talk about them, except just before the situation arose. I felt that this hinted at embarrassment, perhaps not of condoms but the whole situation. It is possible that he was concerned that introducing the subject would expose him to misinterpreting situations; his potential partner might not have interpreted the circumstances in the same way.

When asked who he would talk to if he thought he had an STI, Huw said:

well if I had a girlfriend at the time obviously her if I got it off her..

(Huw)

This comment has been coded and discussed in communication because I felt that it shed light on the nature of the potential communication when an STI was discovered. Huw's use of '*obviously*' leaves no doubt as to his certainty about discussing it, but his comments suggest that he would blame his partner for the transmission of an STI. This would influence the nature of the communication between them. There is clear reference to getting STI from a partner and Huw appears to assume that transmission would be easily traceable. The notion of blame is inherent in his discourse.

### **6:3.2 Girlfriend's complaints**

The last section of coding in this section does not refer to communication about sex or contraception but was included because it illuminated Rhys' relationship and, I felt, his masculinities. When talking about how his illness had affected him he said:

Obviously you've got your girlfriend then saying like you know stop having a go at me an' all that.

(Rhys)

Rhys was talking about how being in pain made him change. This comment reflected his relationship, which must have been open and honest for his girlfriend to be able to chastise him for his behaviour. The comment also revealed the power balance in the relationship, balanced between them both, as his girlfriend was able to admonish Rhys' behaviour. Given that this was the case it is interesting to note that Rhys' girlfriend was expected, by Rhys, to take

responsibility for contraception<sup>96</sup>. Even in an equally balanced relationship, it was expected that contraception was not the business of a man and should be left to the woman.

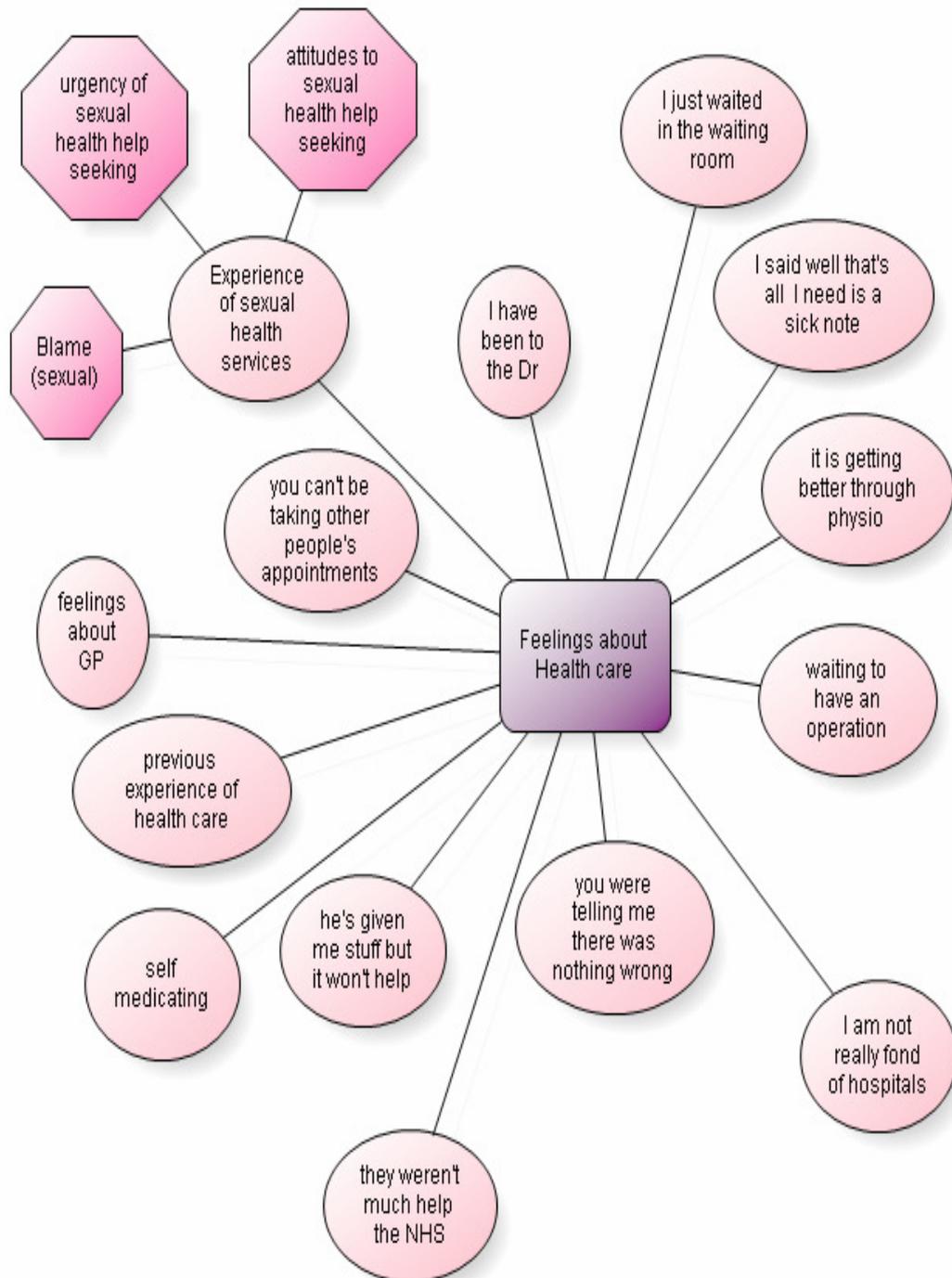
There was not consensus amongst participants about discussing sexual health issues, although some of them admitted they were willing to discuss certain things with certain people. This is not surprising as personal relationships and personalities are different. A strong undertone of control was evident in some the participants' discourse about managing their sexual health.

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<sup>96</sup> See section 6:2.4.i page 166-167

## 6:4 Feelings about health care

Figure seven: Diagram to show sub-themes in 'feelings about health care'



This superordinate theme did not relate directly to sexual health care, but to the participants' general experiences of accessing health services. Participants were asked how they felt about going to the doctor in the first half of the interview. This was included to provide a link between more general questions at the start of the interview, and the questions that might have been considered sensitive, in the second half of the interview. When designing the interview structure, I considered that it would be important to talk to the participants about their preconceptions and opinions of health care, as these might influence their willingness to access sexual health care. I had not expected this to be an emerging theme but it was dominant in the discourse of some participants.

Sub-themes that relate to health care generally are first considered followed by discussion of the sub-themes that concern sexual health care.

#### **6:4.1 General health care experiences**

Rhys was dominant in coding about general health care because he sought care following a football injury. Other participants did mention past experiences of health care. Aneurin said:

Well when I was younger I ummm well I had to go to the doctors but I haven't been for...years. *(Aneurin)*

Aneurin was happy to admit that he had accessed health services but he drew a distinction between his current self and his younger self. He had been to the doctor, but had not needed to go for years. This implied that, whilst Aneurin thought it acceptable for a boy to go to the doctor, a man should not<sup>97</sup>. Gareth appeared to make a similar observation; there was a difference in accessing a doctor when he was a boy:

I didn't find it that difficult to talk to him I suppose cos I suppose the problem I didn't have wasn't that serious- it was just general illness and I was quite young so... *(Gareth)*

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<sup>97</sup> Whilst it may seem that this quote belonged in the superordinate theme 'feelings about masculinities' I have coded it here because reference to masculinities is only evident on deeper analysis. Masculinities are all pervasive; their emergence within other superordinate themes is evidence of this.

Gareth felt that talking to the doctor was unproblematic for two reasons, his problem was not difficult to discuss, and he was a boy. It follows then that he would have found it much harder to discuss a subject that could be perceived as sensitive; therefore, accessing sexual health services may be difficult for him. When asked about sexual health services in the area Gareth quickly said he would use his G.P.:

yeah that would be where I wouldn't feel bad about going there I feel quite confident that he wouldn't break the law by telling anyone so...I'd just do that...

*(Gareth)*

Gareth's earlier statement suggested that his primary concern about talking to his G.P. would be discussing a sensitive issue. This statement intimates that confidentiality would be a primary concern. Gwyn also appeared to contrast previous visits to a doctor with his current good health by saying:

Well ummm I don't go to the doctor I haven't been for years, I had a lump on my neck in year three and I went to have it removed but not since then...they didn't know what it was...

*(Gwyn)*

Gwyn said he has not attended a doctor for a long time (meaning that he was a boy when he last went). He mentioned the problem, for which he sought health care, in order to emphasise its seriousness. Saying that the doctor did not know the cause of the problem affirms this, but also hints at Gwyn's negative feelings about the doctor and their ability to help.

David said simply:

I don't mind going to the doctors at all

*(David)*

But when asked about going to the doctor Owain said:

No no my health is good....I don't have asthma or anything....

*(Owain)*

Owain saw attendance at the doctor as an admission of poor health and thus perhaps an admission of weakness or failure to be masculine (Connell, 2000;

Whitehead, 2002). Owain chose a particular illness and asserted that it was not something from which he suffered. He compared his own health with that of others and asserted that he was healthier and therefore more masculine. Owain must have had experience of asthma amongst those around him in order to use it as a contrast.

Rhys' opinions of health services, but especially his G.P., were negative. He felt that he had been let down by the health service and had not received the care that he was owed<sup>98</sup>. This was evident in a few of Rhys' statements about the G.P. he said:

the G.P. didn't like...I asked him questions like you know

(Rhys)

Rhys felt that the G.P. did not have time for him to ask questions. Rhys also felt that he should not have needed to ask questions; information should have been given to him. Rhys' pause shows that this was his meaning. The G.P. did not volunteer information; therefore, Rhys was forced to ask questions. This is important because some patients would feel empowered by asking questions, but Rhys did not. Interactions between doctors and patients take place within a wider context (Bensing *et al.*, 2003); Rhys may have felt disempowered by the lack of time given to his consultation and therefore unable to ask questions.

Rhys also did not trust his doctor to give helpful treatment to him. He said:

he's given me stuff but it won't help

(Rhys)

This could be interpreted as a lack of trust in his own G.P.

Rhys looked for solutions to be provided to his problem. He had sought help from his G.P. but did not feel that anything would help, there is a note of defeat in his language and his statement '*it won't help*' gives the impression that he has not even tried the medication prescribed. Rhys appeared to have a sense of entitlement, not only to health care, but to health care that solved his health

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<sup>98</sup> This has been discussed in other themes and repetition was not considered necessary. See section 6:2.1, page 154.

problems. Even excellent health care can be unsuccessful in solving all illnesses; Rhys never acknowledged that his problems might not have a solution that could be provided by better health care.

Rhys took a passive approach to his health care and relied on the doctor developing the relationship and giving information. Shaw *et al.* (2009) found that many patients were unable to understand and utilise health information. It is possible that Rhys was given information in an ineffective way that he did not understand and thus could not use. Shaw *et al.* (2009) studied patients in a cardiology inpatient unit (n= 321) and found that patient/ doctor trust was an important factor for their participants. These authors argued that health care professionals ought to improve their communication skills to facilitate better patient understanding of healthcare information. The behaviour and understanding of these patients may have been affected by their inpatient status and their condition, therefore results are not generalisable. Rhys concentrated on a medical model of illness, focusing on diagnosis and cure (Reed and Watson, 1994) without considering other factors that may affect his condition. This focus affected his interaction with health care professionals and also his expectations of care.

Rhys had a high expectation of health care and his own entitlement to it. His experiences disappointed him. He said of the NHS:

I do think that they haven't done enough for people

*(Rhys)*

Rhys' criticism was general. He did not explain what he thought ought to be different or improved, merely that not enough was done. He felt this, despite his reluctance to assert his needs; Rhys felt that health care ought to be provided without the need to request it. He also said of the NHS:

it's like always laxydaisy (sic)

*(Rhys)*

This was a much clearer criticism and suggested that he felt that health care was inadequate because of lackadaisical attitude of staff. This was implied in

much of Rhys discussion of health care and would impact his future willingness to request help or access health care services. Rhys commented:

they weren't much help the NHS as per usual

*(Rhys)*

This put Rhys' experience in context; he felt that not being helped by the NHS was usual. This comment was incongruous because Rhys felt that he ought to have received better care. He consistently measured the care provided against what he felt it ought to have been, yet his comment suggested that he did not anticipate the NHS meeting his expectations anyway.

#### **6:4.2 Experience of sexual health services**

Only one participant acknowledged previously attending a sexual health service as a patient but several participants had accompanied their girlfriends to a contraception and sexual health clinic.

Aneurin had attended a G.U.M. clinic and said of the experience:

It was alright...it was ok

*(Aneurin)*

This contrasted with the expectations of all the other participants who had not attended a clinic themselves. David said:

I know friends of friends that have gone and doesn't seem well what they say doesn't seem like a very pleasant experience...some of the things that they have done

*(David)*

David had been told about what happened at a clinic by friends of friends. Despite David's negative perceptions, the nature of the discussion should be considered. As David referred to friends of friends we must assume that he had not had a private conversation about their experiences, but that it had been discussed more generally in a group; David had referred to this type of discussion as encouraging a joke and laughter<sup>99</sup>. David's impressions therefore

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<sup>99</sup> See section 6:1.2, page 137 where this quote is discussed. It is also discussed in section 7:1.4, page 243.

may have been formed on inaccurate information. The other young men talking to him may have been exaggerating, in order to assert their masculinities. For example, if a young man asserted that the tests done at a G.U.M. clinic were horrendous, but he had tolerated them, he would assert his own toughness despite the fact that he had needed to seek health care, which may challenge his masculinities<sup>100</sup>. This is speculation, but would partly explain David's negative attitudes. David and Aneurin were friends; either Aneurin had never mentioned his more positive experience to David, or Aneurin had described the experience differently to his friends.

Whilst he denied ever having attended a G.U.M. clinic, Gwyn was clear that sexual health was a subject of discussion:

well when the boys are having a laugh they say this happened to you and that happened to you so they all know what they have been up to ....

(Gwyn)

Gwyn used this as a reason for not wanting to talk to his friends if he had a problem, but it shows that others in the group had discussed their experiences. Gwyn's assertions that he would not discuss attending a clinic with his friends suggested that he would be embarrassed about the need to seek health care for this issue. The subject was used as '*having a laugh*' and not referred to seriously. Measor *et al.* (2000) noted that jokes in sex education lessons were made by boys and posited that this was because the boys were striving to achieve a high-status position within the group. This could be explained as an assertion of masculinities, indeed Haywood and Mac an Ghail (2003) explained joking behaviour, especially that which was derogatory to women, as a method of working class men asserting their masculinities. Telling his friends that he needed sexual health care may have altered Gwyn's status within his group of friends.

Rhys also referred to some embarrassment about sexual health care seeking. Whilst he had never attended on his own behalf he had accompanied his girlfriend to get contraceptives. He described the experience as:

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<sup>100</sup> This would be an example of a scale of masculinity as discussed in section 6:2.5, page 189.

bit embarrassing at first going up there

(Rhys)

Rhys' reference to '*at first*' suggested that he has been more than once and his expectations of embarrassment had never been fulfilled. When probed as to the reasons for his feelings, Rhys said:

I hope people don't think I am coming here to have like myself checked

(Rhys)

Rhys' concern was not because he was attending with his girlfriend but because others may think he was attending for himself. As Rhys was not reticent about talking about accessing health care, his potential embarrassment appears to relate to the nature of the health care. Rhys went to a contraceptive and family planning clinic where men are rarely treated and certainly not tested for STI. His comment reveals his lack of knowledge about sexual health care and the lack of knowledge that he expected of his friends. He further elaborated, saying that others would:

obviously know what you are going in there for and what have you

(Rhys)

Rhys considered that others would find reasons for attendance at sexual health care '*obvious*'; he felt that attending would let others know that he required help with a particular type of health problem. This denotes some shame or blame around sexual health and STI, as Rhys did not want others to know. Gareth also referred to the potential of being embarrassed about attending sexual health services:

I would probably feel quite embarrassed actually and umm it would definitely lower your self confidence easily not umm I am not sure cos...I am not sure...it would be annoying it certainly wouldn't be pleasant telling the doctor about it but if you had to do it you would have to do it so...

(Gareth)

Gareth tied his potential embarrassment about attending a sexual health service to his feelings about who he was. He said it would '*lower your self confidence*'. Gareth felt that attending a sexual health service would challenge his status as a

man or cause him to think negatively about himself. If other young men felt similarly, this would have implications for their willingness to seek sexual health care and leave them in a difficult position, namely, that to seek sexual health care would challenge their masculinities but to feel that there was something amiss with their sexual health would pose an equal challenge.

Gareth was not consistent in his feelings about help seeking and said of the prospect of talking to his doctor:

I wouldn't feel bad about going there I feel quite confident that he wouldn't break the law by telling anyone so...I'd just do that...

(Gareth)

When considering the situation hypothetically Gareth thought that his G.P. would be easy to access. His concern that his confidentiality would be breached was a major consideration. When talking about how he would feel accessing health services Gareth had not mentioned a concern about confidentiality but had thought about how he would feel about himself.

David's attitude to STI and health care seeking was summarised in his comment:

And if you did manage to get one, you could go to see the doctor like they could give you some medication like or something

(David)

David felt that it was not easy to contract a sexually infection. He used the word '*manage*' as though it would be difficult; this also implied that there was an element of blame in contracting an STI. He insinuated it would be difficult to get an STI; one would need to be behaving irresponsibly or doing something ill-advised. David also felt that seeking health care in this situation would be easy. He said '*you could just go and see the doctor*' implying that this would be straightforward. This does not tally with the feelings he expressed about his doctor's surgery and the difficulty of getting an appointment<sup>101</sup>: David also assumed that all STI were easily treatable with medication. Even without

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<sup>101</sup> David also commented on accessing sexual health services and looking for information on the internet. This was coded both in 'feelings about healthcare' and 'masculinities- taking control'. It has been discussed in the latter, see section 6:2.4.iii, page 172.

considering HIV, for which there is no cure, other STI cannot easily be treated. For example, whilst medication can be given to control an outbreak of genital herpes, once infected a person may continue to have outbreaks for the rest of their life (Clutterbuck, 2004). This statement reveals David's lack of sexual health knowledge and his attitudes to STI, these attitudes may affect his behaviour and his willingness to seek health care.

Huw said he did not know a lot about seeking sexual health care but commented that his girlfriend had attended:

the women's clinic...it's like that special little clinic for the women.

(Huw)

It is clear that Huw perceived a clear divide between health care available to him and that provided for women. Referring to a contraception and sexual health clinic (CASH) as the '*women's clinic*' and '*special*' implies that Huw felt women were given better sexual health care than men. Huw's use of the word '*little*' may also illuminate his feelings about this clinic and women in general, giving his statement a condescending tone.

Apart from Aneurin, who had attended a G.U.M. clinic, Gwyn was the only participant who had talked to a health care professional about sexual health issues. This was because a nurse attended his college every week, gave sexual health education and was available to see the students. Gwyn said:

she is there every week now on a Monday morning if we need to talk to her

(Gwyn)

Gwyn had never used this service and commented that he would not want his friends at college to know if he had any cause to seek sexual health services.

The blame associated with STI and certain forms of sexual behaviour was alluded to by some participants. Comments coded in this theme related directly to sexual health services and blame<sup>102</sup>.

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<sup>102</sup> These comments were coded as blame (sexual) to differentiate them from another code entitled blame (section 6:2.4.v, page 179). When the participants discussed blame in relation to their female partner and the responsibility of their female partner it was felt more appropriate to code in '*feelings about masculinities – blame*'. Items coded here are those that relate specifically to the behaviour of the participants.

Aneurin explained his visit to a G.U.M. clinic by saying:

Well...I hadn't done anything...like I just wanted to get a check up and made sure everything was ok so I went... (Aneurin)

Aneurin felt the need to explain his visit. A visit to another form of health care might require little or no explanation, in a similar context. Aneurin drew a distinction between himself and others attending the clinic by saying '*I hadn't done anything*'. Aneurin felt that going to a G.U.M. clinic was an indicator of unacceptable behaviour and he was quick to point out that he had not behaved in this way. Aneurin would not have wanted a check-up if he did not suspect that he might require it. He had not accessed other health care often and, therefore, probably would not have attended a G.U.M. clinic unless he thought it necessary. The sub-text of blame is clear in this passage, Aneurin felt that people who had behaved in a certain manner ought to attend G.U.M. clinics for check-ups but he did not place himself in this category. The association of blame and STI is long standing. Women have been described as transmitters of infection and men as passive sufferers with particular censure reserved for prostitutes and homosexuals (Hall, 2001). Aneurin reflects these attitudes in his assertions that he did not need to attend a G.U.M. clinic.

David also alluded to blame associated with sexual behaviour, when he was asked about his knowledge of STI. He replied that he did not know a lot but:

When some one tells me something is bad I am quite scared of things...like...I don't do it then (David)

David was abdicating responsibility for his sexual decision making. Despite not having a lot of information, he felt being told that STI existed was enough to affect his behaviour. The subtext of blame is also apparent; he used the word '*bad*' in reference to certain behaviours. David made a judgement about the types of behaviours that would put one at risk of STI.

Whilst the idea of blame associated with STI has been longstanding, and may dissuade people from engaging in sexually 'risky' behaviours, it perpetuates a negative myth about sexuality and sexual behaviour that may prove a barrier to

sexual health help seeking. It may also cause a reluctance to inform partners of a diagnosis of an STI and thus impair treatment causing the infection to spread further. In a study, to discover preferences in relation to partner notification (n=2544); Apoola *et al.* (2007) found that people were more likely to report positively about a partner notification method if they were the partner being notified than if they were the index<sup>103</sup> patient. This also carries an undertone of blame associated with STI. If people feel that they are the cause then they feel negatively about others being informed, however those who are informed are merely satisfied to have been warned of their exposure.

Some of the participants referred to the urgency with which health care would need to be sought if they had concerns about their sexual health. When asked if he would seek advice were he concerned David said:

Well yeah straight away

(David)

David was initially unsure about what he would do and said he would first access the internet<sup>104</sup>. Even though David recognised that he would be concerned, he tempered this with other concerns about the length of time it would take to be seen at the surgery. He neither knew about G.U.M. clinics, nor knew how to access them.

Huw's comments about sexual health help seeking directly related to his feelings. When shown a picture of a penis infected with genital warts he commented:

I'd kill myself if I had that... well no I wouldn't actually kill myself...I just well I dunno I would see what the doctor says about getting treated straight away. (Huw)

When asked about where he would access help Huw said:

well I would find out where to go first

(Huw)

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<sup>103</sup> This term is used to refer to the initial patient who has been diagnosed with an STI. Contacts of the index patient are traced in order to prevent further spread of infection Clutterbuck (2004).

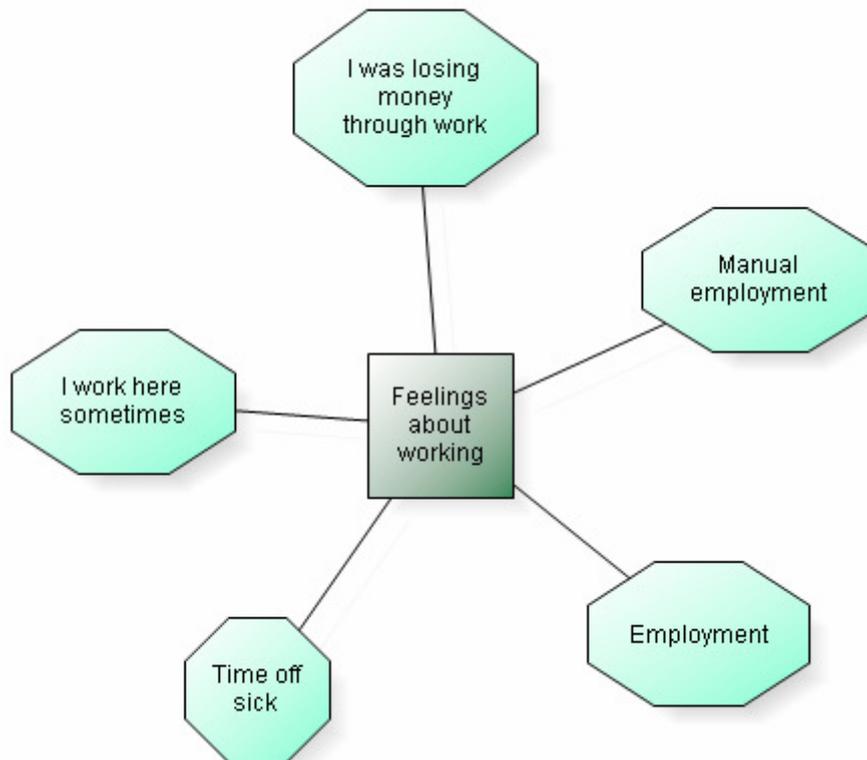
<sup>104</sup> This was discussed in section 6:2.4.iii 171.

Huw's progression through a series of emotions is evident in his response. His initial horror is emotive; he felt that life would not be worth living if his penis were so physically affected. Connell (2005) points out that the penis is closely linked to masculinities, therefore, the threat of physical deformation of his penis may have threatened Huw's masculinities. Huw then tempered his initial emotion by asserting his ability to deal with a problem like this '*I just well I dunno I would see what the doctor says*'. Despite the fact that some participants seem to have associated seeking health care with a failure of masculinities, in this context Huw was taking control by asserting that he would ask for help. This was because the alternative, a deformed penis, would have posed a greater threat to his masculinities than asking for help would have done. Huw realised that seeking help would have been difficult or in some way challenging. He tempered his initial claim that he would immediately seek health care by saying '*I would find out where to go first*'. In this way Huw's feelings can be seen wavering between different factors that affect his masculinities. The first is concern about his penis, then taking control by seeking health care and finally realising that this health care seeking may pose a threat to his masculinities and moderating his enthusiasm to do so. This is an example of Huw negotiating his masculinities: he altered his responses according to which factors concerned him most.

Feelings about accessing health care were important to many of the participants even though there were a few, more dominant voices. It is likely that negative experiences of health care would have a negative effect on the participants' willingness to seek sexual health care. It appeared that accessing health care was tied to masculinities; asking for help did not always occur easily for participants and many wanted to explain or excuse their reasons for having done so. Participants associated seeking sexual health care with blame.

## 6:5 Feelings about working

Figure eight: Diagram to show sub-themes in 'feelings about working'



This theme was not large but contained coding that was considered important and discrete from other themes. During the first section of the interview employment was discussed, partly as a means to develop rapport and encourage conversation. However, it transpired that work was an important issue for some of the participants. Work and employment has been closely linked to masculinities (Haywood and Mac an Ghail, 2003). Historically, men have taken a role as the breadwinner and women's jobs have been seen as supplementary. Consequently, work and men have become equivalent. Society is now changing, but attitudes and long held beliefs take longer to alter. Participants may have based many of their feelings about families, working and breadwinning on the behaviour of their parents.

Whilst the participants were asked about employment and the employment of their parents I considered that this could not be used to accurately ascertain their social class. Information about social class would have proved interesting

as masculinities are socially constructed they are affected by other social factors.<sup>105</sup>

Both Aneurin and David were working whilst undertaking a university degree. They were not concerned about talking about their work but were quick to add their concurrent status as students. Aneurin said:

I work here sometimes and I am at university. I am training to be a teacher...  
(Aneurin)

Aneurin was not ashamed of undertaking manual employment (in the leisure centre) but by adding '*sometimes*' and quickly mentioning his degree he implied that working full time in the leisure centre would not be suitable for him. Not only would Aneurin earn more when employed as a teacher but he would have a different status, as a professionally qualified person. Beynon (2002) examines the assertion of masculinities through employment and describes working class men asserting their masculinities through drinking, sport and 'having a laf'; middle class men used control to achieve a similar thing. By training to be a teacher, Aneurin was investing in his future, but also taking control. Gaining a professional qualification would give Aneurin more scope to be employed in a role in which he had control.

David said:

I am a fitness instructor part time...ummm...cos I am doing a full time degree in nutrition and health science  
(David)

In a similar manner to Aneurin, David felt he must qualify his part time work, and justify his reason for doing it. David stated that his work in the leisure centre was '*part time*', contrasting it to his full time degree. This contrast elucidates David's priorities. His degree takes most time and is his primary concern; his work must fit around it. David also attributed his employment to his degree, by saying he worked as a fitness instructor because he was doing a degree. This statement could be explained in two different ways. He might have been saying his work as an instructor helped him with his degree (as the subjects are linked), or he might have been explaining his employment because he felt it was

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<sup>105</sup> This has been discussed in section 3:3.1, page 64 and 3:3.2, page 65.

unbefitting for him. The true explanation of David's feelings might be a combination of both factors; but they both inform about David's attitude to manual employment. David felt that manual employment was not a good enough, long term, option for him, and needed to offer an explanation for doing it.

It is difficult to interpret how Gwyn felt about his employment and training, but his behaviour was revealing. I asked what he was studying at college and he said:

Well plumbing [laughs]

*(Gwyn)*

Whilst Gwyn did not qualify his answer, as both Aneurin and David had done, he laughed. Gwyn had no explanation to offer for undertaking manual training and employment; he laughed instead. Owain, who was interviewed alongside Gwyn, was still at college and said:

Well I am doing A-levels chemistry, biology and computing. They are hard subjects but I hope to go to university to do micro-biology or forensic science or something like that...

*(Owain)*

It is possible that Gwyn felt uncomfortable about the contrast between himself and his friend and laughed because of this.

These participants' responses led me to believe that education and professional employment were important to them, and provided a means to assert their masculinities, by allowing them control and the ability to gain power in the future. Rhys was an exception; his feelings were complex and his motivations difficult to extrapolate. Rhys said he worked in:

home security with xxx I was with them for four years

*(Rhys)*

And described the job:

well at work we are up and down ladders

*(Rhys)*

Rhys' job was manual and required him to be fit; he installed burglar alarms. When he spoke about his work, he did not feel he needed to make excuses for it, as other participants did. Perhaps his inability to work at the time of interview, affected his feelings. Rhys talked about not being well enough to work, saying:

five months now I have been out of work now

*(Rhys)*

And:

I was losing money through work

*(Rhys)*

It is impossible to determine Rhys' feelings about manual employment but, it is clear that, being unable to work left him feeling emasculated and powerless. Rhys felt that the responsibility for much of this lay with the health service; he did not accept any personal responsibility<sup>106</sup>. MacInnes (1998) states that the younger generation do not subscribe to the idea of the male breadwinner and the female homemaker, but Rhys was upset about his failure to earn money. Rhys' feelings about working were eclipsed by his injury, and his feelings about himself resulting from his time off work. Gheradi (1995) described emasculation as a result of unemployment, because work constitutes masculinity but masculinities are too complex to be constituted by only one factor. Being unable to work challenged Rhys' masculinities; he utilised coping strategies to mitigate the effects of this<sup>107</sup>. This has also been described by Campbell (1993), who found that employment provided an opportunity to assert different masculinities.

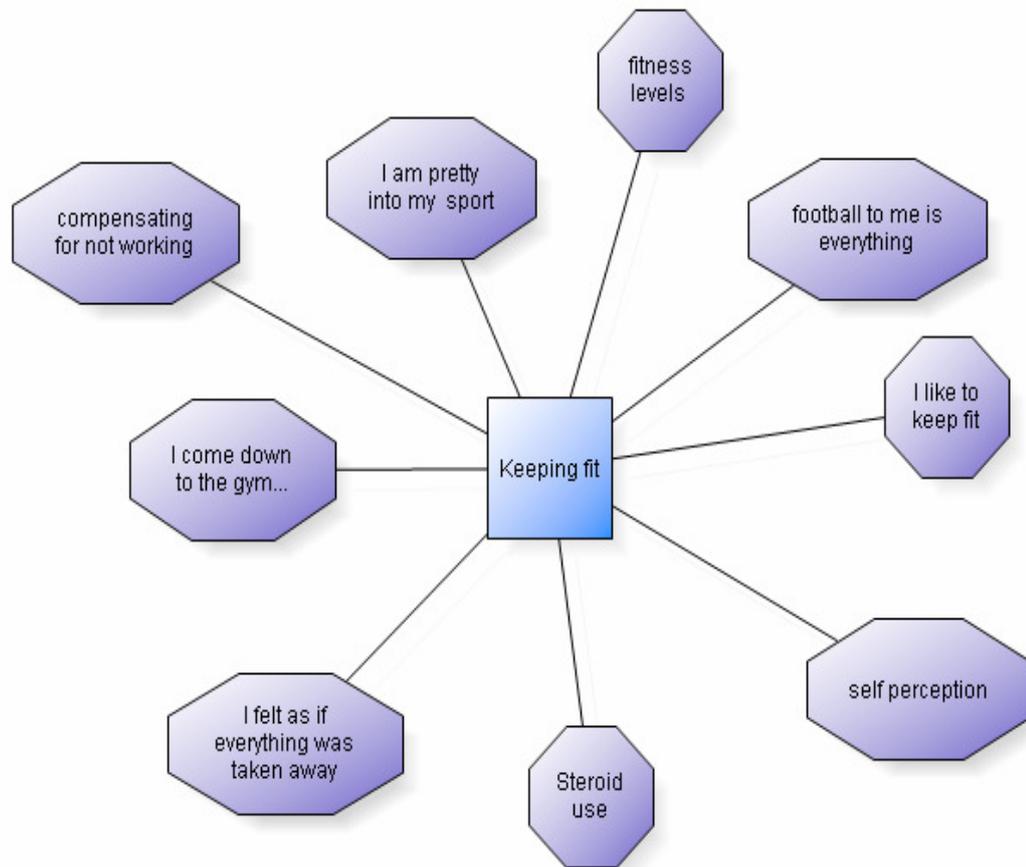
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<sup>106</sup> This was discussed in section 6:2.4.v, 179.

<sup>107</sup> This is discussed further in the next section (6:6, page 219) because Rhys' coping strategy was keeping fit and attending the gym regularly.

## 6:6 Keeping fit

Figure nine: Diagram to show sub-themes in 'keeping fit'



This theme was important because the venue of interviews made a natural opening for discussion of fitness and related behaviour. In the course of some conversations, participants were asked how often they attended the gym. The venue was chosen primarily for convenience<sup>108</sup> but the opportunities to discuss health related behaviour, made possible because of it, were informative. It is clear, that the young men who participated in the study were particularly interested in their personal fitness. This would not be the case for a wider sample, but is nevertheless an important factor for these young men.

Rhys appeared to use the gym and his fitness as a compensation for his inability to work. He felt emasculated; keeping fit gave him back some control. He said he attended the gym:

<sup>108</sup> Sampling is considered in section 4:5 page 94 with discussion of decisions in section 4:6, page 97.

often, since I have been out of work

(Rhys)

Rhys contrasted his current state '*out of work*', with his previous state, by saying that now he comes to the gym often. On a basic level, Rhys had more time during the day because he was not at work, but this is too simple an explanation to be complete. If this were the only reason, he would not necessarily have chosen a physical pastime, for example, he might have spent more time playing computer games or reading. His choice of pastime is evidence that attending the gym gave Rhys something that work would usually provide. It allowed him to use his body for a purpose, and thus assert its usefulness. When asked if his friends also attended the gym regularly, Rhys said:

they are not in and out of the gym all the time

(Rhys)

Rhys drew a comparison between himself and his friends<sup>109</sup>. They could work and therefore did not go to the gym so often; Rhys could not work, but compensated for this by attending the gym regularly. Haywood and Mac an Ghail (2003) found that changing patterns of employment, from manual work to service sector employment, had caused men to alter their approach to their bodies. In manual employment, fitness is necessary to earn a wage. Many men now work in other sectors; their physical fitness is not a requirement. Men have changed from '*working with the body to working on the body*' (Haywood and Mac an Ghail, 2003: 40). They compensate for their failure to use their body to earn a wage, by striving to achieve a physical appearance that asserts the usefulness of their body. Rhys was attempting to assert his masculinities, and the usefulness of his body, by working to improve his fitness and appearance.

Huw also compared himself favourably to his friends. He said that they did not attend the gym as regularly as him, but added that his friends went sometimes:

not that regularly, they do though quite a lot of them do go to the gym.

(Huw)

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<sup>109</sup> This quote was also coded in 'feelings about masculinities'- 'comparisons' section 6:2.5, page 183 however it was felt that discussion should take place within the superordinate theme 'keeping fit' because it shows Rhys' need to assert the usefulness of his body in comparison with that of his friends.

Huw is taking a dominant stance over his friends; but his addition that his friends also like to go to the gym, reveals a lack of self-confidence. Huw was reassuring himself that attending the gym is a common pursuit, and he is not unusual in doing so. He was asserting his masculinities by conforming with other males around him, emphasising his place within an accepted masculinity (Connell, 2005).

Rhys further asserted the use of his body, by describing how he was 'helping' a friend to get fitter. Rhys drew a parallel with his friend by saying:

I come down to the gym with one of the boys

*(Rhys)*

There is a sense of camaraderie within this statement; Rhys then said of his friend:

he is trying to get himself fit

*(Rhys)*

Rhys distanced himself from his friend by referring only to his friend and not to himself; Rhys said '*he*' and not '*we*'. Rhys' use of the term '*trying*' evokes an image of a struggle, or attempt to achieve fitness. Rhys had distanced himself from this, so he implied that he did not need to struggle to achieve fitness, thus asserting the superior usefulness of his body. This was in contrast to Rhys' injury, but as a direct result of it. Rhys was asserting the value of his body despite its injury.

Some participants talked, without hesitation, about their failure to achieve physical goals. On close examination of their discourse, they used alternative methods to assert masculinities and physical prowess. For example, David said:

Umm I used to [play cricket] I had to stop playing about three years ago because of my back I was having back problems

*(David)*

David was clear that he was, now, unable to play cricket; which might have been perceived as a failure. He used the interview to assert his capabilities in other physical areas mitigating the effect of this failure on his masculinities. He said:

Training is my life pretty much, and football

*(David)*

By asserting this, he emphasises his physical capabilities in other areas. Gareth did a similar thing; he talked about his fitness level failing because of his increased alcohol consumption:

I am drinking a lot more so I suppose that is having a bit of a bad effect on me ummm

*(Gareth)*

This is an example of Gareth negotiating his masculinities; both drinking alcohol and fitness are important for him. His priorities are fluid and can alter, provided his behaviour continues to assert his masculinities. For example, Gareth was not as physically capable because he was drinking too much. Failure of physical capability would have a different meaning if its cause were less desirable for Gareth.

Sport and fitness appeared to be important to many of the participants. It is possible that this was because of what success at these occupations represented to the young men. Rhys said:

Football, to me, is everything

*(Rhys)*

Stating that football was worth '*everything*' sounded disproportionate, but success on the football pitch may have asserted Rhys' masculinity and improved his self-worth. Rhys had been unable to play football; this could have caused him to over evaluate its importance. The importance of football to Rhys was further emphasised when he said, of not being able to play:

I felt as if everything was taken away

*(Rhys)*

The statement not only asserts that football was important, but suggests that it formed part of Rhys' identity. There is an undertone of blame in this statement; Rhys referred to everything being '*taken*'. This implied situations, or another person, were responsible for his inability to play football.<sup>110</sup>

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<sup>110</sup> This idea has been discussed further within the theme 'feelings about masculinities' – 'blame' section 6:2.4.v, page 179.

## **6:7 Conclusions**

This chapter has discussed the in-depth analysis of the data.

Participants were reluctant to discuss sexual health with me, although they had said that they would happily do so. Some of them also referred to some lack of discussion with their partners, despite saying that they would discuss condom use before the situation arose. They were reluctant to talk to others about STI and sexual health. Although some participants said they would speak to family members, none of them actually had. They did not discuss talking to partners before finding themselves in a situation that they needed to, and some of them felt that this conversation was not necessary.

Most participants admitted that they felt they had a lack of knowledge about sexual health, and were disparaging about the sex education they received at school. They cited other sources of information. Participants talked about the stigma of STI, and thought that this might cause reluctance to seek help. They also related this stigma, to blame. Participants deflected blame from themselves by passing it to others. For example, Rhys did not take any responsibility for his injuries but blamed the health service for their lack of ability to cure him. Participants also blamed their partners for STI; if they did contract an infection, their partner would be blamed. Participants did not state this explicitly, but referred to their risk management procedures. These involved not having sex with girls who had a reputation and not doing anything '*bad*'.

Participants discussed their concerns about sex and its risks. Pregnancy was primary, but this concern did not lead to action. Participants continued to abdicate responsibility for contraception, expecting their female partner to assume it. This was deemed acceptable, because child bearing is not a man's responsibility. It was interesting that participants were willing to relinquish all control of this issue, that they described as most concerning. The balance of contraceptive responsibility was asserted by Rhys, who insinuated he might take more control if men were responsible for child bearing. Despite considering contraceptive responsibility to belong to their partners; participants did not talk to them about it. This created a situation in which the young men were in control, responsible for asserting their wishes over those of their female partners but

relinquished all responsibility. This, combined with the notion that only penetrative sex was proper sex, meant that sex was seen as a male or phallogocentric activity.

STI were a secondary concern but were not described as something that required consideration.

Appearance was important to participants, and was a factor in their attending the gym, although they only admitted this reluctantly. Comparisons of body shape and fitness levels were made with others. These suggested a comparison of masculinities.

I interpreted a variety of behaviours as the young men asserting their masculinities. They appeared to negotiate their masculinities with themselves and those around them, excusing their 'failure' to perform the most masculine behaviours with descriptions of other behaviours. I used a scale of assertion of masculinities to explain this concept.

The following chapter aims to draw this analysis together into major themes and discuss the findings. Some further interpretations will be offered and the themes integrated.

## **Chapter Seven: Further discussion based on findings and conclusions.**

This chapter is split into two parts: discussion of findings and concluding remarks. The aim of the discussion in this chapter is to tie together the themes that emerged in Chapter six. The previous chapter was presented with direct reference to the coding structure but this chapter integrates and synthesises themes. Some important ideas were present within many codes; this further discussion gives an opportunity to 'stand back' and observe the data as a whole.

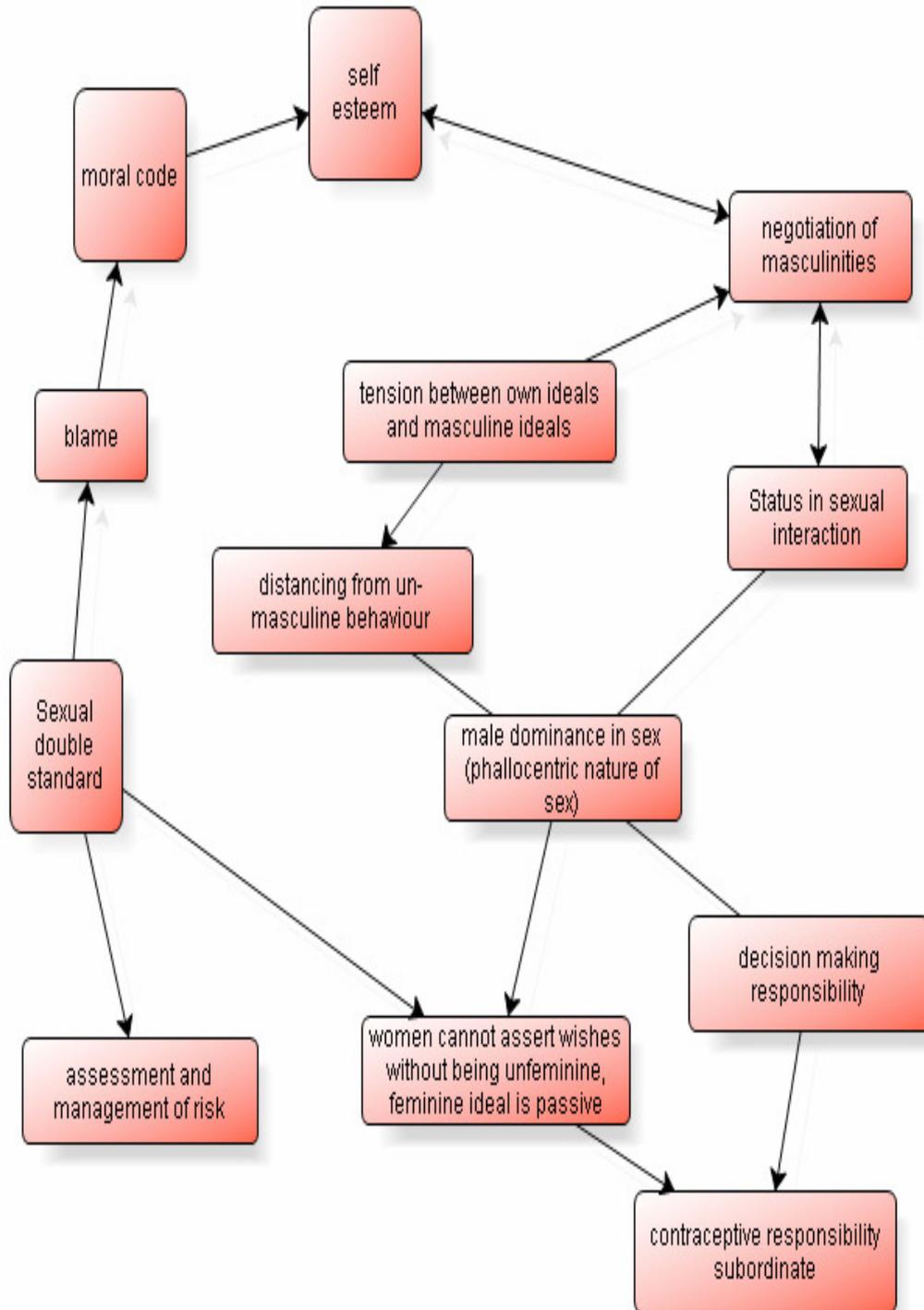
The discussion in this chapter has been divided into three sections. The first section deals with the 'Sexual health knowledge' of participants. The two subsequent sections, 'The hidden moral code' and 'Masculinities' discuss themes illustrated in figure ten. Figure ten is not a model or a theory but is a pictorial representation of important themes discussed in the chapter and the links between these themes.

Where reference to the data is appropriate it has been given; when direct quotes in participants' own words have been used in this chapter they are integrated into the text but given in italics. This has been done in order to more easily compare views and opinions of participants. Where appropriate, reference has been made to codes that were discussed in the previous chapter.

The final part of the chapter is concluding remarks. Here the research is evaluated and its limitations are discussed. Appropriate recommendations are also given followed by an explanation of the contribution to knowledge made by this thesis.

### 7:1 Further discussion based on findings.

Figure ten: Pictorial representation of issues discussed in this chapter (this is not a model or theory.)



### 7:1.1 Sexual health knowledge

Participants involved in the study had little sexual health knowledge and many of them recognised this. For example, Rhys said *'I know like names but I don't really know a lot about it'* (Rhys) and Aneurin said *'I don't know, I only know the basics'* (Aneurin). On a superficial level this raises the possibility that sex education had not been effective for these young men as they feel unprepared to deal with STI. It also suggests that health promotion has not been implemented effectively as the participants were not empowered to make informed decisions about their health.

### 7:1.2 'The hidden moral code'

Participants attributed blame to some forms of sexual behaviour but not others. Comments made by the participants suggested that they ascribed blame to certain forms of behaviour and associated these behaviours with STI. I surmised that to do this they must have determined a personal code about what was acceptable sexual behaviour and what was not. I have termed this code *'the hidden moral code'*, as it was neither overt, nor referred to. Its existence was acknowledged implicitly in the comments of participants, when discussing sexual behaviour. This idea is not derived from a literal analysis of the participants discourse but from a deeper consideration of the data; it forms one of the inner layers of data analysis<sup>111</sup>.

This 'hidden moral code' was alluded to by some participants, Aneurin said *'I hadn't done anything'* (Aneurin) and also said *'I don't go around just sleeping with anyone like when I have just met them I don't go out and just...well you know I don't go in for one night stands'* (Aneurin). David alluded to this idea when he said of certain forms of sexual behaviour *'when some one tells me something is bad, I am quite scared of things'* (David). Huw also considered some forms of sexual behaviour to be riskier than others, and his language conveys an idea of blame associated with these behaviours *'like say... like... I met someone at a party, not that I would, but like if I met someone at a party*

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<sup>111</sup> The process of data analysis was discussed in chapter five; an example of the layers of coding is given in section 5:2, page 117.

*then and anything happened I would make sure like if I had never met the girl before (Huw).*

These statements suggest that the participants considered some forms of behaviour acceptable and others not. Aneurin believed his risk of contracting an STI to be low because he did not have sex with women he did not know well or '*one night stands*'. Aneurin was explaining his personal moral code as well as explaining how he managed the risk of contracting an STI. David was also explaining his personal moral code. He felt that he had been told that there were bad things one could do that would lead to contracting an STI. By avoiding these behaviours he was both managing his risk of contracting an STI and making his moral code clear. Huw felt that, by not having sex with women he had just met, he would minimise his risk of contracting an STI. Embedded in his language are hints at his own moral code. His comment '*not that I would*' suggests that he would consider this to be unacceptable behaviour. The participants may have been labelling certain behaviour as unacceptable because they wanted to portray themselves in the interview in a certain manner. This is a potential limitation of the method of data collection. An ethnographic study design might be an alternative way to attempt to discover participants' perceptions of acceptable behaviour and would be able to consider the group culture of young men.

The link between behaviour that was considered morally unacceptable by participants and behaviour that they perceived as leading to contracting an STI, makes obvious their opinions of those who contract STI. There is an assumption that those who have an STI are morally accountable because their behaviour must have caused them to be infected. This idea is harmful to participants and those around them. Their belief that behaviour management protects them from contracting an STI causes them not to use another form of risk management (condoms). This belief may also cause participants to be reluctant to access sexual health services because they feel blame is attached to seeking sexual health care.

The way that the participants talked during the interview revealed something of their sense of self. They used the subject of the interview to assert their self esteem. For example, when discussing knowledge about STI David felt that he should know more about them and was embarrassed that he did not: '*for*

*something that is used a lot I don't know a lot about them'* (David). But Gareth distanced himself from knowledge: *'I know that they are not very nice to have, I don't know that from personal experience'* (Gareth). Aneurin also distanced himself from knowledge by saying: *'I only know the basics'* (Aneurin) and Huw admitted limited knowledge: *'I know that they are easy to catch these days'* (Huw). These differing responses reveal not only participant's knowledge about STI but also their attitudes to this knowledge, and whether they felt it was sufficient. The participants who distanced themselves from knowledge revealed their opinions about STI. They felt blame is associated with contracting an STI, and thus were quick to assert that they had never had an STI or did not need to worry about getting one. Self esteem may be based on many factors; Mruk (2006) points out that a sense of virtue or moral worth may be one of these. Participants felt that not having an STI or being at risk of an STI demonstrated a form of virtue and this enhanced their self esteem. In this way, the participants were using the subject of the interview to assert themselves.

Blame has long been associated with STI. Victorians considered that venereal disease was the consequence of vice and promiscuity (Hall, 2000). Disease was attributed to prostitutes and women, as reservoirs of disease and men as victims who were merely enacting their biological needs (Mason, 1994). Blame was attached to syphilis; perceived as punishment from God for debauchery (Allen, 2000). AIDS has been viewed similarly in more recent times.

Allen (2000) argues that it is those in power who have perpetuated the idea of infection as manifestation of God's punishment and, thus blame those suffering for their malady. Indeed, this is a convenient way to separate sections of the community and blame them for their situation. This has happened in the case of HIV and AIDS (Yankauer, 1994), that was seen as a disease only affecting drug users and homosexuals. This attitude is not helpful because it causes a lack of empathy and an unrealistic assessment of risk for the rest of the population. These attitudes also increase stigma and may lead to sufferers failing to be tested or diagnosed, thus perpetuating the spread of the infection. Huw felt that an STI carried stigma and consequently would have hesitated to discuss it with anyone: *'I would probably just feel embarrassed or I wouldn't want people just to know that I got a sexual infection'* (Huw). This stigma may have led him to fail to seek sexual health care.

The idea that some people were more at risk of STI was also alluded to by Gwyn who said: *'like if the girl has a reputation you would want to use protection even if she was on the pill....'* (Gwyn). Choosing who he had sex with was part of Gwyn's risk management strategy. He further elaborated saying: *'you would just say to her you want to make sure like....but if she doesn't or like its her first time or something and she is on the pill well you don't have to worry....'* (Gwyn). Gwyn's assessment of risk is clear; if the girl has a reputation he would use a condom but if the girl does not have a reputation, or is a virgin, there is no need. This labels some women as potential vectors of infection (Yankauer, 1994). Gwyn did not refer to refraining from sex with partners whom he considered to be risky; he merely suggested he would ensure that he used a condom. This method of risk management is not effective.

The blame Gwyn associated with certain forms of sexual behaviour and STI is implicit in his statement. Gwyn implies a perception of dirtiness associated with girls who have a reputation because he suggests he would always use a condom in this situation, but perhaps would not in other situations. This also indicates that Gwyn considered women to be the source of STI. It is also interesting to consider how Gwyn would know the sexual history of a potential partner. Rumours and reputations are not necessarily an accurate representation of a person's sexual behaviour and may have been propagated maliciously. Gwyn was saying that he made judgements about other people according to their societal status and popularity.

This form of judgement has long been present. For example, when the Contagious Diseases Acts were passed a woman was not deemed to be a prostitute because she was caught prostituting herself, but because she was reported as a prostitute (Weeks, 1989). This meant that reports could be made maliciously, and because of the terms of the act there was little that could be done by the woman to refute them. Gwyn was giving women sexual labels that would become hard for them to refute or change. In addition to this, Gwyn was communicating preconceptions about the source of STI and the reason for their spread, namely, that women were culpable. Even recently, women have been perceived to be silent reservoirs of disease because they suffered no symptoms of gonorrhoea but their sexual partners did. Barlow (1979) described women's lack of symptoms of gonorrhoea as a primary reason for the continuation of its endemic levels within a population and also stated that:

*'the women's contribution to the infected population is potentially much greater than the man's' (Barlow, 1979: 36)*

By contrasting women with men, Barlow (1979) implies that women are the blameworthy party. These attitudes have continued and are currently present, although not often stated explicitly.

Huw, however, did express this sentiment explicitly when discussing who he would talk to if he discovered he had an STI: *'well if I had a girlfriend at the time, obviously her if I got it off her.'* (Huw). Blame would fall without question on his hypothetical girlfriend. This blame was also implicit in David's statement about a friend of his: *'he had some kind of rash after some kind of sexual encounter with this girl'* (David). The girl is described as the source of the rash and David's friend as the innocent party.

The idea of blame was also revealed by Lichtenstein (2003) who found that women were categorised as 'good' or 'bad' depending on their behaviour. Staff (n=6) and patients (n=6) at a public health clinic were recruited to take part in focus groups. Students (n=7) were also recruited from a local school. Two geographical areas were used, rural and urban. Factors which labelled a woman as bad were different for the staff and the other groups. Staff at the clinic categorised good women as those who were embarrassed about attending, in long term relationship and those who regularly had health checks. Patients and students drew a different moral boundary and found that 'good' women had only one man at a time and knew the names of their children's fathers (Lichtenstein, 2003). Both groups in this study were making moral judgements and categorising others according to their own moral codes. Men were not categorised in a similar fashion, upholding the idea of a 'double standard'.

Gwyn referred to the way he would address a situation when he wanted to use a condom (because the girl had a reputation) but his potential partner was taking the pill *'you would just say to her you want to make sure like'* (Gwyn). By making this comment Gwyn acknowledged the potential hurt of suggesting that a partner might have an STI, further signifying the blame that he attaches to STI.

His comment is not sufficiently sensitive or ambiguous to minimise the risk of upsetting his partner.

A sexual double standard has been described by Holland *et al.* (2004). Sexual promiscuity, which asserts a young man's masculinities, would cause a young woman to be labelled as a 'slag' and to gain a bad reputation. The negative reputations that are gained by women as a consequence of their behaviour are regulated and propagated by both women and men. A woman who carries condoms demonstrates that she is sexually aware and prepared, and thus contravenes ideas of traditional femininity. A man who carries condoms would merely be perceived as prepared. This stereotype is not forced on women, but perpetuated by them, as well as by men. In this way women participate in maintaining male dominance over sexual interactions.

Gwyn appeared to believe that one only needed to be concerned about STI in certain circumstances: *'It depends though doesn't it...if you have got anything to worry about'* (Gwyn). This statement linked blame and STI. Only those who practised certain behaviours or had sex with certain people should be concerned about STI. The logical progression of this thought is that those who have contracted an STI are in some way culpable. Apart from explaining how he categorised sexual partners (determining whether the girl had a reputation) Gwyn did not mention any other forms of behaviour that he considered risky. Huw also considered that his risk of contracting an STI were greater in some situations. He said: *I would make sure I used protection if it was with like a girl I wasn't sure about* (Huw). Huw felt that women were the source of infections; it was his choice of partner which would cause him to consider whether he ought to use a condom.

Holland *et al.* (2004) found that young people abandoned condoms as a mark of trust in a long term relationship. Huw and Gwyn described condom use as a mark of lack of trust in a partner. Rhys commented that: *'I know like a few of my friends have gone to clinics because of the amount of people they have slept with'* (Rhys). This comment links STI not only to whom one has had sex with but how many people; thus blame was also associated with promiscuity. Shafi *et al.* (2004) found that condom use at sexual debut was an indicator of subsequent condom use. Their study used data from the national longitudinal study of adolescent health (n=4024) to model the association between condom use at

sexual debut and condom use at most recent sex. As this study took place in the United States of America, results are not generalisable or directly comparable to the UK. It is interesting that Shafi *et al.* (2004) found that condom use was more reliant on habit forming. Participants in my study suggested that a decision to use a condom was based on a complex set of judgments, including an assessment of the 'riskiness' of the potential sexual partner. Stone *et al.* (2006) also found that condom using decisions were based on complex factors when condom use in oral sex was investigated. Condom use did not differ between respondents who knew that fellatio could pose a risk of STI transmission and those who did not. The most common reason that men gave for not using a condom in this situation was that fellatio felt better without and they had not considered it (Stone *et al.*, 2006). In this way the male respondents did not appear to consider their own health or that of their partner (performing fellatio constitutes more of an STI transmission risk than receiving fellatio).

Implicit in participants' discourse is their denial and lack of responsibility, combined with their belief that they will not suffer adverse effects of their behaviour. Sexual risk taking behaviour in young people has been researched (Santelli *et al.*, 2009) using previously collected data from a representative sample of young people in the United States of America. The sample was large (n= 125,000) and it was found that even young people who did not take non sexual risks often took sexual risks. This implies that the young people believed that the risks of engaging in risky sexual behaviour were not relevant to them, or even that young people did not recognise the risk inherent in certain sexual behaviours.

Several authors have linked risk taking behaviour with condom non-use (Orr and Langefield, 1993; Sonenstein, 1998; Crosby, 2004) implying that those who take risks are likely to take a variety of risks. Risk taking behaviour could be an assertion of masculinities, as taking risks demonstrates two key factors of dominant masculinities, namely, toughness and self reliance. It could be argued that young people did not fully understand the possible risks involved in unprotected sex. Participants' discourse suggested that they understood that risks were apparent and attempted to control them, although ineffective measures were often used (for example, using condoms only with girls who had a reputation).

Participants felt that blame was associated with certain forms of sexual behaviour, namely promiscuity or having sex with 'risky' partners. Women were perceived as culpable in the spread of STI, and men as needing to protect themselves from potentially dangerous partners or behaviours (promiscuity). None of the participants mentioned particular sexual practices as more risky than others. This may have demonstrated a lack of sexual knowledge or experience but may simply have been due to embarrassment.

### **7:1.3 Male dominance in sex and decision making responsibility**

Participants used their risk assessments and assertion of their choices about condom use to assert their masculinities. In the tone of their statements they emphasise their status within a sexual interaction and assert their control. For example, Huw's statement: *'I would make sure I used protection if it was with like a girl I wasn't sure about'* (Huw) puts emphasis on Huw's decision making and his ability to control the interaction. Gareth also accentuated his role in decision making when he said: *'umm I suppose if I was going to start sexual relations with a girl then I might...I would obviously have to buy condoms and stuff'* (Gareth). From this statement it appears that the 'girl' is expected to take a passive role in deciding to have sex and managing condom use. Gareth asserts that buying condoms would be his responsibility. Gwyn also asserted his role in control of condom use saying: *'I just like to know... if you take care of it yourself you are more sure about it'* (Gwyn), which implied not only a passive role for the female partner but that possibly she could not be trusted to provide and use a condom.

Owain asserted that even if a sexual partner were reluctant to use condoms he would feel able to insist: *'well you might just before y'know say well do you have a condom or I am just going to put a condom on....if she says no or she doesn't want to then I just would anyway....'* (Owain). Owain's statement draws attention to his expectation of a female sexual partner as passive in a sexual interaction. As well as expressing his expectations of female partners Owain's statement was, itself, an assertion of masculinities. It appears to reflect more about what he expects, or considers important, than what would actually happen. He was using his statement to assert his masculinities, but his statement itself appeared bolstered with bravado. The statement is therefore also evidence of Owain

asserting his masculinities within the interview, for the interviewer (me) and Gwyn (who was interviewed with him). It is also interesting to consider how likely the scenario was, that the man wants to use a condom and the woman refuses. I also questioned Owain's hypothetical partner's ability to challenge his use of a condom. If Owain expected his partner to be passive then it is unlikely she would have the control or power to assert that she did not want to use a condom.

Young women may not have the same opportunities for control of condom use that young men have, not least because of the physical nature of condoms. They are put onto the erect male penis and thus the male partner must be complicit in their use. Although traditional gender roles have been challenged in some areas of society, power remains with men and women continue to be subordinate. Masculinities are a method used to maintain this power and continue male dominance (Connell, 2005). Condom use and power over it is an expression of masculinities. The erect penis symbolises the dominant male and male power (Middleton, 1989). When he has control over a condom (and consequently his penis) he remains dominant. If a woman were to insist on condom use she would assume power over the man's penis but also his masculinities. Because of this, whatever the feelings of young men about equality and women's choices, to allow their partners these choices would be to challenge their own masculinities.

Despite their wishes or intentions, young people followed gender norms and thus are created as gendered entities. Regardless of their opinions about roles and ideals, in practice their behaviour propagated their gendered state. This is described by Holland *et al.* (2004: 49) as the privileging of male sexual pleasure and power within heterosexual interaction, making femininity an 'unsafe gender'. Gendered behaviour is often adopted despite not benefiting the individual. Levant *et al.* (2007) point out that gender role strain may be the result of people having been socialised into traditional and inflexible gender roles. Levant *et al.* (2007) undertook an examination of the femininity ideology scale using a convenience sample (n=407) of undergraduates in the USA. This scale has a five factor structure: stereotypical images and activities, dependency/deference, purity, care taking and emotionality. These factors are all considered to be ideals of traditional femininity.

To become the dominant partner in a sexual interaction would oppose these ideals and challenge a young women's femininity. If a woman carried a condom she would contradict her femininities by asserting her independence (not dependant), asserting her wishes (not deferential), and demonstrating that she was impure (prepared for sexual interaction). It seems that carrying a condom would be straightforward, but if it challenges femininities on so many levels it could disadvantage a young woman more than taking a chance without a condom would<sup>112</sup>. The young men in this study negotiated their masculinities and young women do a similar thing. The discourse of young men in this study certainly suggested that young women were left in a dangerous position.<sup>113</sup>

Huw, Gareth and Gwyn were doing more than merely asserting their wish to use condoms. They were emphasising their power within a heterosexual interaction and thus stressing the lack of power for women. They were also emphasising their needs and wishes as being of primary importance, regardless of the wishes of their partner. It did not appear that the participants in the study would recognise this interpretation of their feelings. In fact, their justifications suggested that they felt they had few options but to assert their wishes, suggesting that young men might be as disadvantaged by masculinities as young women. This accentuates the lack of power that their partners would have in a sexual interaction but also the supposed roles and responsibilities of each partner. Men's responsibility is condom use and women have no agency to assert their wishes over men. To challenge a man's authority over condom use would be to challenge his dominance over his penis and therefore his masculinities, which might not be conducive to the continuation of sex. This would also mean the woman challenging her status within a heterosexual relationship which would demonstrate her failure to be a feminine woman (Levant *et al.*, 2007); historically, women who have done this have met with conflict, for example, the violent treatment of suffragists discussed by Hall (2000).

These struggles for power, and the 'unsafe' nature of femininities which ensues all take place in the context of sex. This is a personal and potentially embarrassing situation for young people (Tucker *et al.*, 2007) who are coping

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<sup>112</sup> If failing to conform to traditional gender roles results in gender role conflict as suggested by Levant *et al.* (2007) then depression, low self esteem and anxiety could be the result.

<sup>113</sup> The young men sought to protect themselves from their sexual partners and expected their partners to take on a feminine role. This role did not leave space for young women to assert their wishes over the young men.

with their changing bodies (resulting from puberty) and social status (from child to adult). The introduction of discussion of condom use, gender roles and a challenge of power may be more than is possible. If young women cannot challenge male power in a situation not considered embarrassing then it may be impossible to do so in a situation such as sex.

Drawing young men's attention to this power discrepancy may allow them to personally address it. Lamb (1997) suggests that sex education ought to provide teaching about cultural sexual norms and the role of gender in sex. Halstead and Waite (2001) also suggest that teaching young people to reflect critically on their attitudes about sex and gender ought to form an important part of sex education. Indeed they posit that it is this dimension which makes sex education truly education and not merely a transmission of information. In a small study (n=35) of primary school children, Halstead and Waite (2001) found that boys and girls developed their sexual identity differently and boys were more likely to link violence to sex. In itself this emphasises the need to provide sex education that encourages young people to examine their beliefs and values. Bleakley *et al.* (2009) also emphasise the need to educate young people about sexual values.

The perceived control of condom use was contrasted starkly with the manner in which participants abdicated responsibility for contraception. David said of his partner: *'she is very careful now (David)* and Gwyn said: *'if she was on the pill then you don't need to worry about that...'(Gwyn)*. Many of the participants did not attend the family planning clinic with their girlfriends but required the reassurance of their partner taking a long acting contraceptive. Their use of language emphasised the nature of control of the woman in preventing conception. Rhys even commented that he was reassured to know that his girlfriend was in control of this: *'it is comforting to know that she is on the pill' (Rhys)*, contrasting this with his own ability to manage (hypothetical) long acting contraception: *'I am too forgetful to take it, I am useless with things like that' (Rhys)*. Rhys explained his reluctance to accept responsibility by stating that it might be different *'if men had to have babies'* (Rhys), but because women become pregnant they are responsible for contraception. Contraception and the protection from STI were created as a gendered behaviour. Men could take responsibility for condom use but women were ultimately responsible for

contraception. This was explicitly stated by one of the participants, Gareth who said '*I know that a man uses a condom and a woman uses the pill*' (Gareth).

The incongruity of participants' attitudes was further increased when they explained their concerns about unprotected sex that focused primarily on unintended pregnancy. Aneurin said: '*getting pregnant would be really bad*' (Aneurin), Huw said: '*I was a bit worried in case like she got pregnant...*' (Huw), and Owain said: '*Well...having a baby well that would be worrying*' (Owain). Young people's greater concern about unintended pregnancy and their consequent poor use of condoms has been documented (Warner *et al.*, 1998; de Visser and Smith, 2000; de Visser, 2005)<sup>114</sup>.

In conclusion, participants felt that they were in control of condom use and could assert their wishes over a potential partner if necessary. Participants were more concerned about unintended pregnancy than STI, but allowed their partner to take responsibility for contraception. In this way a clear line was drawn, between contraception, that was women's responsibility because they could become pregnant and STI prevention, that was men's responsibility because they must protect themselves from women, the perceived source of infection.

#### **7:1.4 Masculinities**

Whilst 'feelings about masculinities' was made a superordinate theme, masculinities were ubiquitous within the participants' discourse. Participants mentioned feelings related to their masculinities within all the superordinate themes. As such, this was an important emerging issue that warrants discussion outside the coding structure.

Masculinities are difficult to define as men express their gender individually. Every man may express his ideals of gender in a different manner and even men's ideals of gender may be individual. This means that coding about masculinities was heavily biased by my opinions and feelings about what constituted masculinities. The data showed participants clearly attempting to assert their opinions and ideas and to justify their situations.

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<sup>114</sup> See section 6.1.3.i, page 142 and 6.1.3.ii, page 144.

Participants used their gender to assert themselves. Their roles in sexual interaction were indicative of this, as was the way they discussed these roles. Participants talked about responsibility for contraception and decision making regarding this, which made clear their opinions about women and their own roles in sex. The differences between male and female bodies are important in the formation of these opinions and beliefs. The male penis protrudes and inserts into the woman, symbolising dominance both in sexual situations and generally. Even the act and focus of sex itself is male dominated. Rhys defined it as penetrative sex when he talked about: '*actual having sex*' (Rhys). This gave focus to male penetration and orgasm. This male dominance can have an effect on sexual interaction: a woman expressing her sexual desires (especially those about safe sex) may directly threaten a man's power. So, when considering contraception a woman's preference may be unacceptable to a man both because of the preference itself and its having been asserted.

Another effect of this male dominance is the focus on penetrative sex and its associated risks. Other sexual practices would carry less risk of pregnancy, if not of transmission of STI; however, because of male dominance over sex other practices are not considered as possibilities. Holland *et al.* (2004) found that many women defined sex only as penetrative intercourse, thus focusing on the man; this is an example of female collusion in male power.

Sex is often a private arena and therefore young men and women may behave differently from their public façade. I had expected to see less male dominance in this private arena<sup>115</sup> but participants described their power negotiations differently. In the private sphere, they could assert their masculinities and power over their partner without societal admonishment. In the public sphere, the young men had to consider women as emancipated and allow them to make decisions. The young women appeared to have colluded in this negotiation of power by taking on responsibilities which were placed with them (Contraception Education Service, 1998) without challenging the authority of their partner.

This power was demonstrated in different ways by participants, for example, Gareth, Huw and Owain spoke of enforcing their decision to use condoms: 'I

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<sup>115</sup> I had expected a private arena to constitute an opportunity for young men to negotiate their masculinities and compromise with their female partner. This would provide an example of the complicit masculinities discussed by Connell (2005) see section 3:2.1.iii, page 58.

would obviously have to buy condoms and stuff' (Gareth) 'I would make sure I used protection' (Huw) '...if she says no or she doesn't want to then I just would anyway...' (Owain), but other participants spoke of their expectations of their partner to provide contraception<sup>116</sup>.

Assertiveness is not an accepted part of femininities (Silva, 2008) and therefore for a woman to assert her wishes directly challenges her femininity, whilst a man would be reinforcing his masculinities when asserting his wishes. Despite this lack of ability to assert preferences and the male centric nature of sex, participants in the study still expected their female partners to take contraceptive responsibility. When talking about condoms Aneurin said: *'if you were with a girl and she was going to family planning then she could get them'* (Aneurin). The responsibility placed on the young women is emphasised by the way that the participants use the word *'she'*. It is impossible to determine how the participants' partners felt about their level of responsibility from the discourse of participants. However, the balance of responsibility suggests that the young women either took responsibility because they felt they had to or because they chose to. Rhys commented that he *'was too forgetful'* (Rhys) to be trusted with taking any sort of hormonal contraceptive which further suggested that he felt that contraception was not his responsibility and he was not interested in taking more responsibility. Buysse and van Oost (1997) also found that young women were expected to care more about safer sex, although young men in their study found it easier to introduce the subject of condom use during sexual interaction; for young women, condom use was seen as a process of negotiation.

A woman may describe herself as forgetful but long acting contraceptives have been developed in order to counteract this problem (Guillebaud, 2004). Participants saw sex as constituting penetration; contraception was seen not only as the preserve of women, but also as their responsibility. This meant that for the participants sex was an activity which focused on them and their needs rather than the complex balance of needs of both partners. In this way the participants demonstrated their power in the private arena of sex.

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<sup>116</sup> The potential affect of the interview on the participants' discourse, should be remembered. Their reported potential behaviour may have been affected by their wish to appear in a certain way in front of me, the interviewer.

This has implications both for relationships and for contraceptive decision making. Women may not be able to assert themselves because of constraints of their gender and men may not feel a need to discover their partners' feelings or wishes because they view sex as a phallogentric activity.

Participants perceived sex to be their domain; they created it as a phallogentric activity for their pleasure. The idea of sex as a male centric activity also appeared to be linked to their ideas of masculinities; their partners became passive recipients but incongruously were expected to take control of contraceptive decision making. This situation left the participants' partners in a difficult position. To express femininity they must accept a passive role, but their ability to control contraception was limited by this, so they had to choose female controlled methods which did not require male input. Female controlled methods of contraception often do not provide protection against STI, meaning that to protect herself from STI, a woman would need to adopt behaviour that directly challenged her male partner's ideas of masculinities.

The participants attempted to use the interview to assert their masculinities and their status. They asserted their self-esteem by emphasising their moral code and their adherence to it. The assertion of masculinities could be seen particularly in the interview with Owain and Gwyn because they were interviewed together. When talking about STI there was a lot more laughter than was present with other participants: '*yeah [laughs] I know about them*' (Gwyn). This was a form of bravado; the interview constituted a public arena and the young men's discourse did not allow for their female partners to make decisions. This might not have been a true reflection of the way contraceptive decision making happened; it provides more information about the way the young men perceived their negotiations with their partner.

Gwyn's need to do this reveals more about what he felt. Blake (2004) suggests that young men may use this form of bravado to cover their lack of knowledge, embarrassment or lack of confidence. Measor *et al.* (2000), when researching sex education and adolescent sexuality, found that young men directed their jokes at others, namely girls, teachers and also other boys. By doing this the young men were asserting their own masculinities and their superiority to the targets of their jokes.

Gwyn was employing the same tactic as the young men studied by Measor *et al.* (2000) attempting to assert himself over Owain and also the interviewer (me). This was seen even more clearly when Gwyn insulted Owain for his lack of knowledge *'No you pleb....pill doesn't stop that'* (Gwyn). Connell (1987) posits that masculinities can be effectively asserted with harassment, especially when this takes the form of sexual harassment. In this way Gwyn was asserting his masculinities over Owain in the interview. Gwyn was also asserting his dominance by distancing himself from lack of knowledge. His ideal of masculinities appeared to demand power and therefore knowledge; by asserting that he had superior knowledge Gwyn was asserting his superior masculinities. Interestingly Owain's response was to laugh along with the joke. This could also be interpreted as an assertion of masculinities. Owain remained impervious to pressure and kept his cool. Lyman (1987) suggests that this is a method of a man asserting his masculinities even when a joke is made his expense.

David mentioned that this situation arose when talking to friends about sexual health saying that it became: *'more of a joke instead of some serious issue'* (David). Discussions about sex between David and his friends were also then a method of asserting masculinities over the other members of the group.

David also asserted his masculinities when discussing sex education. His declaration that he practised safe sex (despite not remembering his sex education lessons) was designed to assert his confidence, knowledge and power in a sexual situation: *'it obviously haven't stuck in my mind well and in terms of disease and so forth, I like I just practise safe sex and that's y'know'* (David). The difference in assertion of masculinities through knowledge acquisition can be seen by contrasting Owain and Gwyn's experiences of learning about sexual health. Owain had chosen to attend a summer school. Whether he had known that sexual health would be included is not clear: *'It was with the police and they did things like sexual infections and drugs and alcohol and first aid...and so I learnt some things there'* (Owain). This assertion of choice in learning asserts his masculinities by conveying a sense of personal control, dominance and power. Gwyn's statement about the same subject was also used to assert his masculinities but in a different way. Gwyn said *'[shrugs] just picked it up really you know as you go along'* (Gwyn).

Whilst this statement at first appears to convey passivity and a lack of interest it is actually insinuating that Gwyn was sexually dominant and masculine because he did not need to educate himself about such matters. This sort of knowledge was inherent in him. All the other participants had admitted a lack of sexual health knowledge. Owain and Gwyn were the only participants not to do this. I wondered if Gwyn had unwittingly used this assertion because he was interviewed alongside Owain. When contrasted with a friend who had not only superior knowledge but had also gained this knowledge himself, Gwyn felt he had to assert his own masculinity. By suggesting he did not need to seek knowledge, he was asserting himself over Owain who had sought knowledge.

This contrast between Gwyn and Owain's knowledge acquisition and their comments about it show their differing ideals about the negotiation of their masculinities. They both used sexual health knowledge acquisition to assert their masculinities and it appears that the element of masculinities that they asserted was similar (dominance) but they chose conflicting methods of doing so. On first analyzing such statements it would be easy to assume that the young men had adopted contrasting ideals of masculinities and thus their assertion was necessarily different. The ideals of masculinities asserted were similar but it was the methods chosen to assert these ideals that were disparate.

Young men negotiate the assertion of their ideals of masculinities in many different ways. The same ideals may be asserted in incongruent manners. Because of this the method or manner of assertion of masculinities does not necessarily inform an observer about the ideal being asserted. Discourse or behaviour must be more closely examined to reveal underlying ideals. Participants' ideals and the manner in which they were asserted were therefore entirely separate.

Participants excused themselves if they felt that they had not achieved an ideal. I have explained this with reference to scales of goals for assertion of masculinities<sup>117</sup>. Participants identified the most desirable behaviours and either performed them or gave an excuse for not doing so. For example, David gave sport as an excuse for not drinking heavily regularly; both behaviours were desirable but drinking heavily must have been more so because David felt he

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<sup>117</sup> See section 6:2.5, page 183.

must give an excuse for not behaving in this way: *'I don't tend to go out every weekend. I am interested in training and sport...if I do go out it's every six weeks'* (David).

Other factors must have intervened to persuade David to prioritise sport and training over a more socially desirable behaviour. Perhaps he felt that his appearance or health (and thus his masculinities) would benefit. He may have been influenced by health promotion advice or information that he had learned at university<sup>118</sup>. If this is the case it shows David considering long term implications of his actions as well as more immediate concerns. His masculinities may have been temporarily enhanced by demonstrating that he could drink heavily regularly but the long term repercussions would be more harmful to his masculinities. Therefore, choosing a less desirable behaviour now may have led to better long term outcomes for David; he would be fitter and more attractive.

David also used a similar technique when discussing anabolic steroid use. He admitted that a perfect body was desirable but excused his failure to achieve this by categorising those who used anabolic steroids as *'crazy'*. This language was used to distance David from the use of steroids and the body image resulting from their use, but also from the young men who used them. Despite resulting in an ideally masculine body shape, steroid use was labelled as an unhealthy masculinity. Grogan and Richards (2002) found that young men characterised body builders as unattractive as it was felt that bodybuilding was associated with an unmasculine obsession with appearance. Interestingly, the same authors found that young men described muscularity as an ideal, but contrasted this to the extreme muscularity of bodybuilders that was seen as unmasculine.

Huw commented that his initial reason for attending the gym had been his appearance: *'well at first it was just to get into shape and then it just turns into you get in the habit of it and then you just get carried away really...'*(Huw), and did not feel ashamed to admit that this had been important to him. Grogan and Richards (2002) sought to explore young men's ideas about body image and body shape and used focus groups consisting of four young men each to do so.

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<sup>118</sup> David was studying for a degree in nutrition, which included learning about diets for exercise and healthy eating.

A range of ages were used (8 year olds, 13 year olds 16 year olds and 19-25 year olds) but each focus group consisted of homogenous ages. The study found that young men considered body image to be important, muscular and toned bodies were desirable and this ideal body shape was associated with power and self confidence. However, the young men in Grogan and Richards' (2002) study did not view exercise as masculine appropriate behaviour and felt that attempting to use exercise to achieve a body ideal was trivial and did not justify the time that would be spent. Huw felt that body shape was important and exercise was an acceptable means of achieving an ideal body shape.

Masculinities have been described as a social construct (Beynon, 2002; Connell, 2005); that is, they are constructed by society and do not exist outside their social context. Whilst participants expressed their feelings about ideals of masculinities, they also alluded to their lack of choice in these ideals. Whilst the participants' ideals of masculinities favoured toughness, independence and self reliance, these ideals themselves were not independently generated. Therefore, by expressing these ideals, participants were demonstrating their lack of independence and self reliance. In expressing masculinities, participants were emphasising their failure to fully adopt the behaviours they sought to endorse.

Literature suggests that men are likely to suffer worse health than women (Courtenay, 2000; Courtenay, 2003), and are more likely to engage in risky health behaviours (Addis, 2003). It is thought that masculinities contribute to this. Men do not have the power to choose their masculinities because of the nature of hegemonic masculinities. Asserting an alternative implies a failure to achieve an ideal. Even in achieving an ideal, a man is admitting a failure to assert his own opinion about what masculinities ought to be. Men are disadvantaged by the adoption of hegemonic masculinities and yet they cannot choose alternatives; to do so would be to further disadvantage themselves. The adoption of a subordinate masculinity would lessen a man's potential for power or dominance in his interactions. A man may either choose hegemonic masculinities, which suggest that he cannot assert his own opinion about his ideals of masculinities, or choose his own ideals, which if differing would constitute a subordinate variant of masculinities and thus also disadvantage him. This dichotomy was negotiated by participants. They attempted to explain and justify their behaviours when they felt they differed from masculine ideals.

There was often a tension between the ideals that the young men sought to endorse and their own opinions and ideals. The participants gave clues about their underlying feelings which were not stated, but would not have been compatible with their ideals of masculinities. This indicated the lack of choice young men have in their expression of gender. For example, those participants who had a girlfriend expressed dichotomous ideas about supporting her and who ought to be in control of contraception. Rhys felt awkward attending the clinic but overcame this in order to support his girlfriend although he took a passive role: *'Ummm it was a bit embarrassing at first going up there to be honest with you but no it was alright I just waited in the waiting room I did when she went in and she was being weighed and had her blood pressure taken umm and she just come back out then and we just went'* (Rhys).

Huw felt that as his girlfriend had a twin he was not required to attend: *'uhh...last time she went on her own but well she is a twin she is so she goes with her sister'* (Huw), and David hinted at a feeling of guilt about not ever having accompanied his girlfriend: *'she has never...she has never complained about it that I should well...it sounds wrong really...she didn't complain about it and she never felt uncomfortable there and like I think her and a few friends used to go anyway so...'* (David). The participants felt that supporting their girlfriends attending the family planning clinic was not masculine or appropriate for them as contraception is the preserve of women, yet they also wanted to support their girlfriend. In order to resolve this conflict they either attended with their girlfriend but took a passive role (Rhys) or they provided excuses about the reason that they did not need to attend with their girlfriend (David and Huw).

This shows the contrast between what the young men felt was expected of them by society (masculinities) and their own beliefs and feelings. When these conflicted, the young men did not contest society's ideals but attempted to satisfy both society's and their own ideals. Participants felt that society's ideals of masculinities were important and they adopted them as their own; when these ideals conflicted with other ideals they attempted to appease both.

This tension demonstrates the young men's dependence on society's ideals and their lack of self reliance. I wondered whether the participants' age affected how willing they were to assert personal ideals. Because all the participants were young men, it is impossible to determine whether they will mature and become

more self assured. There was an age range amongst the participants (16 -20 years old) and they all demonstrated that there were tensions between their personal ideals and ideals they felt were required of them to assert their masculinities.

McVittie and Willock (2006) found that older men (>65 years old) discussed health in a similar manner. The men were subject to uncontrollable external forces which were inconsistent with their ideas of masculinity. Barker (2000) found that young men may assess the impact of masculinities and make considered decisions about their behaviour. Indeed, it was found that constructing an identity different from those around them was part of failing to adopt traditional masculine norms of behaviour. Participants in my study did not assert different identities but struggled with the tensions between their own ideals of masculinities and their other ideals; they wanted to conform.

Whilst participants could choose how to express or assert their ideals of masculinities, the ideals themselves were already decided for them. Beynon (2002) states that hegemonic masculinities are determined through consensual negotiation or through power and dominance. Participants demonstrated both their endorsement of hegemonic masculinities and also their need to achieve them in their behaviour. The tensions between their personal feelings (for example, to support their girlfriend) and their masculinities, reveal their support for hegemonic masculinities. Participants negotiated these tensions in an attempt to effectively assert their masculinities.

The negotiation of masculinities has been discussed (O'Brien *et al.*, 2007; Schrock and Padavic, 2007). O'Brien *et al.* (2007) found that men constantly negotiated their masculinities as their own situations changed. The researchers used men's experiences of illness to examine these negotiations of masculinities. Fifteen focus groups (n=59) and interviews (n=9) were used to discover men's experience of prostate cancer, coronary heart disease and depression. These illnesses were chosen to discover if mental illness presented different challenges to masculinities from physical illness.

Men sometimes denied depressive conditions in order to preserve their masculinities (O'Brien *et al.*, 2007). Whilst Rhys did not hide his depression: '*I have been feeling so depressed*' (Rhys), he excused it by blaming it on others,

thus negotiating his masculinities in a similar manner. A similar technique was employed by women dealing with the stigma of STI, who transferred blame and deflected stigma in order that they did not have to accept it themselves (Nack, 2000).

Schrock and Padavic (2007) found that men constructed and negotiated their masculinities through cooperation and competition. Rhys was doing this; expressing depression would challenge his masculinities (O'Brien *et al.*, 2007) but instead of denying it to assert his masculinities (Bendelow, 1993; Gordon, 1995) he negotiated his masculinities. By attributing blame to others, he did not need to accept blame for himself. This process of negotiation allowed participants to continue to express their ideal of masculinity without matching up to it all the time.

As can be seen from the table below in some instances participants' behaviour endorsed ideals which could be described as hegemonic<sup>119</sup> but in others participants' behaviour was contrary to ideals. In some instances excuses were given for this.

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<sup>119</sup> See table two, page 61.

Table six: Table comparing some ideals of masculinities identified in literature with those of participants

| <b>Hegemonic masculinities (as identified in chapter three: Table two, page 61)</b> | <b>Participants personal ideals (main proponents of the ideals given in brackets)</b>                                                                                                                                   |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Seeking dominance in conversation                                                   | Using the interview to assert self esteem over other participants (Gwyn).<br>Using interview to assert self esteem by distancing oneself from need for knowledge thus asserting moral worth (Huw, Gareth, Aneurin Huw). |
| Assertiveness                                                                       | Insisting on condom use (Owain, Gwyn, Gareth, Huw).                                                                                                                                                                     |
| Self reliance                                                                       | Taking responsibility for STI prevention (Owain, Gwyn, Huw, Gareth).<br>Blame others for personal situation (Rhys, David).                                                                                              |
| Toughness                                                                           | Excuses made for failure to defend oneself (David).<br>Explanations for injuries (Rhys).                                                                                                                                |
| Ignoring feelings or emotions                                                       | Admitting depression but excusing it due to cause (Rhys).                                                                                                                                                               |
| Able to exercise power over women in sexual encounters                              | Insisting on condom use (Owain, Gwyn, Gareth, Huw).                                                                                                                                                                     |
| Avoidance of the feminine                                                           | Felt compelled to accompany girlfriend to family planning clinic or excuse themselves for not having done so (Rhys, Huw, David).                                                                                        |
| Control                                                                             | Relinquishing responsibility for contraception (Rhys, David)                                                                                                                                                            |
| Independence                                                                        | All participants lived with family. Many chose to continue to do so (Rhys, David, Aneurin). This lack of independence was linked to age. Relied on girlfriend to provide contraception (Rhys, David).                   |

Participants could have chosen other forms of masculinities <sup>120</sup> but doing so would have compromised their power and dominance, since it is hegemonic masculinities which give them this. Participants appeared to choose hegemonic masculinities, although in some instances there was evidence that complicit masculinities were used.

Whilst it could be argued that women are disadvantaged by masculinities (Whitehead, 2002), men are equally so. Adopting hegemonic masculinities may result in a perception of power and dominance but men have little choice over the ideals they must adopt to gain this power. When these ideals clash with their personal ideals, young men seemed to either pretend their personal ideals were not important or compromise them in some way.

Participants, who all appeared to choose hegemonic masculinities, negotiated these in order to lessen the difference between personal ideals and their ideals of masculinities, but also to explain their failure to achieve the best or ideal assertion of masculinities. For example, David felt that drinking heavily would effectively assert his hegemonic masculinities, but he did not drink to excess. He used another method (sport and fitness) to assert his masculinities and explained his behaviour. David's need to explain his behaviour suggests that he considered it second best. In this way participants sought to maintain their assertion of hegemonic masculinities and defend their power and status. Participants did not appear willing to compromise with negotiation about condom use. I posited that this was because condoms are used on an erect penis which symbolises masculinities. Allowing any negotiation of this with their female partners would directly challenge their masculinities and thus be unacceptable. Participants also distanced themselves from behaviour which they deemed unmasculine in order to better assert their masculinities (Kendall, 2000).

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<sup>120</sup> See section 3:2.1 page 57, for discussion of various types of masculinities.

### **7:1.5 Summary of findings**

This summary of findings has been divided into sections so that recommendations, given in section 7:2.3<sup>121</sup>, can be clearly linked to findings.

#### *7:1.5.i Sexual health knowledge*

Participants in the study had little sexual health knowledge and scant skills to negotiate their sexual health. They felt that their sexual health education had been inadequate and poorly delivered. Participants with more sexual health knowledge had acquired it from sources other than compulsory education.

#### *7:1.5.ii Dominance over women*

Participants created a discourse of dominance over women and felt that they needed to assert masculinities. They did this in public (amongst friends and in the interview) and also in private (with a partner). Sex was viewed as a male centric activity and an opportunity to assert masculinities. Whether participants demanded their partner took contraceptive control or they used condoms themselves, their discourse did not reflect their partner having made a choice. These masculinities were not asserted in a vacuum, but had real consequences for the sexual partners of participants and also other women in their lives. Femininities do not allow young women the same opportunities to assert themselves and therefore young men asserting themselves over women leads to women becoming subordinated. Sex was perceived as a male centric activity; therefore female partners were disadvantaged even before masculinities and male dominance were taken into account.

#### *7:1.5.iii Blame, roles and responsibilities*

The young men assumed definite roles and responsibilities (provision of condoms, protecting themselves from STI) and ascribed other roles to their female sexual partners (contraception). The young men's discourse did not suggest that the female partners had any agency in the determination of these roles, although this may have been bravado and assertion of masculinities on the part of the participants.

Participants characterised women as the source of STI and discussed their need to protect themselves from this source. Participants labelled and categorised the women they had sex with as a measure of determining their risk of contracting an STI from a partner. However, participants relinquished responsibility for contraception to their female partners, perceiving that this would only be their responsibility *'if men*

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<sup>121</sup> Page 259.

*had to have babies*'. The young men's dominance in the sexual situation would leave little space for women to challenge this idea.

#### *7:1.5.iv Conflicts of ideals*

Despite this dominance, participants expressed their need to assert hegemonic masculinities even when the ideals espoused by these conflicted with their own personal ideals. In expressing hegemonic masculinities, participants demonstrated a lack of the characteristics they sought to endorse. By explaining and justifying themselves, they confirmed their failure to be self-reliant or tough. The explanations themselves challenged their masculinities and power, although participants did not perceive this to be a problem.

There was sometimes a tension between the participants' ideals of masculinities and their behaviour. They struggled with the disparity between their personal ideals and society's ideals of masculinities, which they felt they must endorse. A negotiation took place in order that the participants could preserve their masculine status, whilst attempting to appease their personal ideals and beliefs; also so that participants could continue to associate with their ideal, although they admitted to not having met with it. Participants explained these differences in order that their masculinities would not be challenged. Young men negotiated their masculinities; by explaining their choice of behaviour and comparing it to their ideals they justified and explained their choices. Doing so emphasised the differences between their ideals and their achievements.

#### *7:1.5.v Conclusion*

This left a picture of young men enforcing their own decisions on their sexual partners and leaving their partners unable to assert themselves. However, participants were equally unable to assert their personal wishes because of their continual need to assert and negotiate their masculinities. Hegemonic masculinities, far from leaving the participants in a dominant and powerful position over women, left them unable to express their wishes and desires. They were, therefore, as equally subordinated as the women and other men, over whom they attempted to assert power.

## **7:2 Concluding remarks**

### **7:2.1 Evaluating the research**

The research was evaluated using a number of methods discussed in table four<sup>122</sup>. To ensure credibility (Rose, 1995) a reflective journal has been completed<sup>123</sup>. Whilst not comprehensive it details my journey through the research process. Reflective analysis of my effects on the interviews and analysis have been included throughout the thesis, as well as reflections on important events during the data collection process<sup>124</sup>. Themes and coding were discussed with a researcher experienced in the use of IPA. Consistency was provided by ensuring a clear methodological approach and adhering, both to the philosophical underpinnings of IPA and to a method consistent with its use. Before data collection began the study aims and proposed methods were checked with a research committee, to ensure congruence would be achieved.

This research aimed:

- To discover young men's lived experiences of addressing, or failing to address, their sexual health.
- To discover young men's experiences of negotiating their masculinities relating to their sexual health.

These aims have been met by recruiting a sample of healthy young men and discussing their experiences of addressing, or failing to address, their sexual health. Young men were not accessed through a health service provider; because I hoped to give young men, who failed to address their sexual health, an opportunity to take part. Undertaking qualitative research with young men allowed them to discuss their lived experiences and enabled their ideals of masculinities to be examined. Quantitative research would have been unsuitable to meet these aims.

Interpretative Phenomenological Analysis (Smith, 1996; Smith, 1999; Smith, 2003; Smith, 2004) was chosen as a research method. This was appropriate because it fitted with the aims of the study; semi-structured interviews, described as exemplary when using IPA (Smith, 2003), allowed participants to discuss their lived

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<sup>122</sup> See section 4:10, page 109.

<sup>123</sup> See appendix two, page 290.

<sup>124</sup> See appendix three, page 298.

experiences. This study was exploratory, as little previous research exists; this is also congruent with the method of IPA. Due to the in-depth analysis undertaken when using IPA, it is suitable for use with a small number of participants (Smith, 2003); if the sample size is too large then detailed analysis becomes unworkable. I had anticipated some difficulties in recruiting healthy young men to participate in this study on a sensitive subject; indeed recruitment took one year and less than 10% of young men approached took part<sup>125</sup>. Using IPA facilitated research with the small number of participants who were recruited.

IPA embraced my effect on the data; interpretations are the result of me, my experiences and my interactions with the participants, as well as the experiences of the participants themselves. IPA recognises that it is impossible to completely put one's own beliefs and preconceptions aside. This recognition made it a particularly appropriate research method; my experiences as a woman were acknowledged when considering the participants' experiences. Using IPA allowed the research aims to be met and, despite some limitations discussed below, it was the most appropriate method for this exploratory study.

### **7:2.2 Limitations**

All studies have limitations and a doctoral thesis aims to train the researcher for the future. The limitations of this study are:

#### *7:2.2.i Researcher bias in sample selection*

Difficulties accessing a sample meant that a convenience sample was the best option. I collected the sample alone which meant that I could choose which young men to approach. I chose not to approach young men who attended in large groups or anyone whom I felt was intimidating. Some young men were visibly uncomfortable about being approached by a woman they did not know, even before discussion of the research. These young men were therefore excluded from data collection, further limiting the sample.

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<sup>125</sup> Two hundred information sheets were distributed, seventeen young men agreed to consent, nine young men consented and seven young men took part. Potential participants were given opportunities to decline, some did not come to the second meeting when the consent form would have been signed and others did not turn up for the interview having signed the form. The process of recruitment was discussed in section 4:6.2, page 100.

#### *7:2.2.ii Joint interview of Owain and Gwyn.*

Owain and Gwyn were interviewed together; although this provided a depth and comparison to the data, I would have liked six individual interviews. Perhaps a follow up study could use focus groups to discover more about interactions between young men when discussing sexual health and negotiations of gender. Whilst this joint interview was not ideal, it was not felt that it posed a problem for the study as the initial five individual interviews provided rich data and much of the coding structure. Owain and Gwyn's interview added depth and further information.

#### *7:2.2.iii Researcher inexperience*

I am acutely aware that I am a novice researcher and therefore made mistakes (it is hoped more at the beginning than at the end of data collection). This can be viewed as a limitation of the study because an expert researcher may have gained more depth from the initial interviews. For example, my pictures of sexual health problems were not shown to Rhys. I forgot I had them because I was so concerned about whether the tape recorder was working. Whilst this is viewed as a limitation, this study forms the basis of my research training and therefore subsequent studies in which I take part will benefit from a more experienced researcher.

#### *7:2.2.iv Control of gatekeepers*

Another limitation of the study was access to young men and the control of gate keepers. Initially I would have liked to access young men through schools or colleges, but my attempts to arrange this were blocked: my letters to the local education authority were never answered and my telephone calls were not returned. Accessing young men through schools might have provided a wider sampling frame from which to gather participants. Gate keepers even controlled access to young men in the leisure centres; staff advised about when to attend and when not to, and whom to approach. Whilst I attempted to be impartial, this was often impossible, especially in the leisure centres where I was near to the staff when approaching young men (leisure centre two and three). I had also considering attempting to access young men through workplaces but I decided that the subject of the research could make participating uncomfortable for participants. I was interested to find that two of the participants did take part at their place of work and were not uncomfortable about it; knowing this might have affected my initial decision making.

#### *7:2.2.v Sample size and homogeneity*

Although this study was small, IPA seeks to examine individual cases in detail in order that the collective experience may be better understood (Smith, 2004). It is an ideal method for undertaking exploratory research into phenomena about which little is known (Smith and Osborn, 2003). IPA does not seek to provide information about the objective reality of a phenomenon, but seeks to explore the individual's perception of the phenomenon, thus investigating the lived experience of an individual or small group individuals (Smith *et al.*, 1999). Therefore, whilst the results of this study could not be said to explain the experiences of all young men, they reveal the experiences of the participants which expose issues that relate to other young men. The idiographic nature of the study should be emphasised; analysis has been grounded in the accounts given by the young men who participated. The themes generated relate directly to these accounts and to the individuals who participated.

Sample size could be perceived as a limitation. However, this sample was consistent with the use of IPA (Smith and Osborn, 2003). Although the sample was never intended to be representative, participants were relatively homogenous. Smith (2003) explains that IPA researchers aim to find a comparatively homogenous sample. Using an alternative research method might have enabled recruitment of a larger or more varied sample, but this would have been at the cost of the in-depth analysis made possible by the use of IPA.

The homogeneity of the sample itself could be considered as a limitation. If it had been possible to access young men in a different way then this would have been considered. It would have been interesting to access young men who had a wide range of interests as opposed to young men with similar interests (keeping fit). An ideal method of doing this would have been accessing young men through education or their workplace; providing a sample that would have been homogenous enough for use with IPA.

#### *7:2.2.vi Speculation about young women's role*

Data emerged about young women and their relationships with young men. Whilst I have speculated about the roles that young women play, I cannot know about their feelings because I did not talk to any. I view this as a limitation, because discovering young women's lived experiences of their relationships would expand young men's discourse and allow deeper analysis of young men's lived experiences by

comparison. When young men talked about their experiences I had no way of knowing whether their discourse was a true representation of the facts or bolstered by bravado. The result of this was that it became impossible to separate bravado and masculine behaviour within the young men's stories. Interpretations of masculine behaviour are simply my opinions; there is no way of comparing participants' reports with reality.

#### *7:2.2.vii Limitations of the research method*

IPA has its own limitations; these are also limitations of this study. IPA is concerned with lived experiences and participant's cognitions. These experiences are communicated and described to the researcher by participants, with language. Language could be said to construct reality as well as describe it. In remembering or describing an experience, a participant is constructing their version of events and choosing their words and detail to reflect this. This may be done consciously or unconsciously, but either constructs a new reality: the way the participant wishes the researcher to be presented with their lived experiences. I felt that this was particularly a problem in this study as one of the phenomena under consideration, masculinities, could lead the participants to construct a new reality in order to appear as they wished.

Language is described by Willig (2001: 63) as '*adding meanings which reside in the words themselves*'. IPA has not paid sufficient attention to this (Willig, 2001); without a participant being able to articulate their experience in some way it is not possible to use IPA to discover these experiences. An inarticulate participant will be unable to express themselves clearly, and may use words which do not properly reflect their feelings or experiences, not appreciating the nuances and subtleties of the language they use. It is evident from considering the abstracts of transcripts included in this thesis, that some of the participants were less articulate than others; incorrect use of words, repetition and verbal tics could have all served to mask the experiences that the participants were trying to express.

There are limitations inherent in research using interviews. Kvale (1996) explains that to transcribe interviews transforms them into something new. A question is raised about how far an interview can ever discover the lived experiences of a participant's world; there are a number of opportunities for transformation. The participant must be able to explain their life world using language. The researcher must record this for future analysis. The researcher must understand the explanation

given by the participant; there is opportunity for the researcher to entirely misunderstand terms used or for nuances to be lost in transcription. Added to this are the needs of the participants in the interview; for example, participants in this study used the interview as an arena for assertion of masculinities.

### **7:2.3 Recommendations**

It is usual to offer some policy or practice recommendations in conclusion of a thesis submitted for PhD; however I considered that this was not appropriate. It is noted by Smith (1999), that theorising about the general population cannot be undertaken as a result of research with a small number of participants. Smith (1999: 296) suggests that subsequent research is undertaken to elaborate on the results of his study on transition to motherhood, stating that his findings could not be considered a *'final statement on the matter'*. I do not consider that my study forms a final statement about young men's sexual health and their negotiations of masculinities. This study is the beginning of a discovery process about these phenomena and because of this I did not feel it was appropriate to offer policy or practice recommendations; it would be unwise to do so following an exploratory study.

However; my findings will inform my personal practice since this study has provided a research foundation. The way that young men discussed young women's responsibility for contraception and the blame they placed on their female sexual partners could influence my future conversations with young men in a clinical setting. For example, a health care professional discussing sexual health would not involve blame or discuss from whom an infection had been contracted. Instead, sexual contacts and sexual behaviour are discussed. The importance of this is highlighted when considering the blame loaded discussion of the participants in this study.

Instead of making policy or practice recommendations; linked to my findings, I have made further research recommendations which build on the findings of this exploratory study. These refer directly to the findings discussed in section 7:1.5<sup>126</sup>.

#### *7:2.3.i Sexual health knowledge*

As a result of the young men's experiences of sexual health education (or lack of it), further research would be beneficial in order to discover whether sex education was

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<sup>126</sup> Page 252.

inadequately preparing young men or if they did not retain information sufficiently to be able to use it. Whilst previous studies have developed sexual health education and trialled it with young men (Davidson, 2003), a longitudinal approach was not adopted. In order to discover whether young men were able to retain sexual health information they would need to be assessed after completion of a sex education programme and again some time later.

It would be interesting to discover more about whether sex education can provide skills which equip young people to navigate their gender ideals and discuss their sexual health. Without the ability to do so, young people will not be able to address their sexual health no matter how knowledgeable they are, as they will not have sufficient skills. An ideal sex education programme would provide both knowledge and skills.

#### *7:2.3.ii Dominance over women*

Young men's discourse about dominance over women has implications for all areas of both young men and young women's lives. Further research would involve both men and women of two age ranges in order to begin to investigate whether this discourse of dominance changes as men learn to negotiate with their female partners and adopt more subtle complicit masculinities.

#### *7:2.3.iii Blame, roles and responsibilities*

Further research about roles and responsibilities in sexual interaction related to masculinities and femininities is required. A study design which included both young men and young women might enable the exploration of gendered behaviour in these situations and could examine its effects on young people. Holland *et al.* (2004) found that both young men and young women colluded to uphold male power. A further study investigating contraception and male and female responsibility would draw on these findings and develop them. Involving both members of a couple, interviewing them separately and together, would also enable some investigation of men's use of the interview to assert themselves. Other research has found that young men view hormonal contraception as the domain of women (Holland *et al.*, 2004; Ekstrand *et al.*, 2007) but I would like to investigate how this might be addressed within a couple. This might inform development of sex education programmes designed to provide skills and may provide health care workers with information enabling them to address negotiations of roles and responsibilities within individual consultations.

Blame and STI are linked and this study has explicated some of the ideas of blame held by the young male participants. I would like to undertake further research into young women's ideas of blame. This would tie in closely with roles and responsibilities and could inform sex education programmes and individual consultations. Tackling ideas of blame and '*hidden moral codes*' might enable people to seek sexual health care without fear of judgement.

#### *7:2.3.iv Conflicts of ideals*

The participants described conflicts between their ideals of masculinities and their personal ideals. Research to further investigate these conflicts could inform understanding of masculinities. It would be interesting to undertake this research with men of different age ranges so that it could be discovered whether problems with these complex negotiations were peculiar to young men or apparent throughout men's lives.

### **7:2.4 Contribution to knowledge**

This study has made several contributions to knowledge. The way that participants created dominance over their female partners and labelled them as the source of STI has not previously been observed. Young men's negotiation of masculinities in reference to their sexual health has also not been explicitly established, although gendered behaviour of young people in relation to heterosexual sexual activities has been examined (Holland *et al.*, 2004).

The link between condoms and masculinities and the clear differences between condoms and contraception in the young men's opinions has been identified and analysed. This has not previously been done, but is important when considering STI prevention and contraception methods acceptable to young men. The notions of responsibility and blame have also been identified as important factors.

No research of this type has been undertaken in South Wales. This is significant because types of employment available in the area have changed during the lifetime of the participants; South Wales previously relied on heavy industry and now many of these industries have changed, leaving many areas socially and economically deprived. This has affected the wider community as well as changing the experiences of young men enacting their masculinities, as masculinities are related

to time and place (O'Donnell and Sharpe, 2000). Three geographical areas were chosen. These are socio-economically different, meaning that the backgrounds of participants were varied. This combination of examining young men addressing their sexual health in the context of changing masculinities represents a new contribution to knowledge.

This study also has a methodological contribution to make. Young men have been interviewed about sensitive subjects by other men (Pearson 2003b) and also by older women (Hutchinson, 2002) but I have found no reference to interviews being carried out by a woman close in age to the young men being interviewed.

This thesis has explored young men's lived experiences of addressing their sexual health. Masculinities were found to be an important part of this, particularly the manner in which young men negotiated their masculinities with those around them and themselves. A young woman was able to conduct the interviews to collect data for this study. It is hoped that this exploratory study will allow further research in this area to take place in the future.

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# Appendices

## Appendix One

**Coding Structure – to show audit trail by giving evidence of the development of a coding structure.**

### Final coding

This list shows the final coding structure, superordinate themes given in bold type, this structure has been illustrated throughout the text with diagrams.

#### **Communication**

##### *Discussing STI*

*reluctance to communicate*

*talking to family*

*talking to friends*

*talking to partners*

##### *Girlfriend's complaints*

#### **Feelings about health care**

##### *Experience of sexual health services*

*Attitudes to sexual health help-seeking*

*Blame (sexual)*

*Urgency of sexual health help seeking*

##### *Feelings about GP*

*He's given me stuff but it won't help*

*I am not really fond of hospitals*

*I have been to the doctors*

*I just waited in the waiting room*

*I said well that's all I need is a sick note*

*it is getting better through physio*

*Previous experience of healthcare*

*Self medicating*

*They weren't much help the NHS as per usual*

*Waiting to have an operation*

*You can't be taking other peoples appointments*

*You were telling me there was nothing wrong with me*

#### **Feelings about masculinities**

##### *Comparisons*

*Appearance*

*Comparison with friends*

*I don't tend to go out much of a weekend*

*I have a girlfriend*

*Perceptions of what others think*

##### *Emotions*

*Frightening experience*

*I am really really angry*

*I have been feeling so depressed*

*really really frustrating*

##### *Sexual attitudes*

*he haven't said he is worried*

*'conquests'*

*'actual sex'*

### *Responsibility*

*Abdication of responsibility*

*Blame*

*Excuses for not being responsible for contraception*

*I think that it's a lot worse than what I am led to believe*

*Lack of trust*

*Taking control*

*Trust*

*Vulnerability*

### *Injuries*

*Forced to stop sport*

*Obviously not leaving my knee go completely*

*Sports injury*

*You would be on the ceiling by now*

### **Feelings about working**

*Employment*

*I was losing money through work*

*I work here sometimes*

*Manual employment*

*Time off sick*

### **Keeping fit**

*Compensating for not working*

*Fitness levels*

*Football to me is everything*

*I am pretty into my sport*

*I come down to the gym with one of the boys*

*I felt as if everything was like taken away*

*I like to keep fit*

*Self perception*

*Steroid use*

### **Leisure**

*Aspirations*

*Family*

*Happiness*

*Health*

*I like to go out socialising and umm I like sport*

*Leisure activities*

### **Sexual health knowledge and attitudes**

*Admission of lack of knowledge*

*Attitudes to sexual behaviour*

*Concerns about pregnancy*

*Concerns about STI*

*Qualifying managing risk*

*Inadequacy of education*

*Feeling unprepared*

*Sexual health knowledge*

*Source of knowledge*

*Education*

*Superficial knowledge*

*Unsure of information*

## Original coding

When coding started a complicated list of superordinate themes had not been developed. Original codes were generated from the first transcript to be analyzed (Rhys) and then applied to other transcripts. Subsequent transcripts also generated new themes and these were applied to the original transcript as appropriate.

This is a list of codes generated from Rhys' transcript before any organization had been applied. In the development of a coding structure the transcript was returned to in order to ensure that coding structure related closely to the data.

A coding structure was developed from Rhys' transcript and discussion of this was included in a report for transfer from MPhil to PhD. This coding structure was built on by adding codes from subsequent transcripts and reorganizing data.

Codes from Rhys' transcript before organisation:

*Feelings about GP*

*He's given me stuff but it won't help*

*I am not really fond of hospitals*

*I have been to the doctors*

*I just waited in the waiting room*

*I said well that's all I need is a sick note*

*it is getting better through physio*

*Previous experience of healthcare*

*Self medicating*

*They weren't much help the NHS as per usual*

*Waiting to have an operation*

*You can't be taking other peoples appointments*

*You were telling me there was nothing wrong with me*

*I don't tend to go out much of a weekend*

*I have a girlfriend*

*I still live at home*

*Perceptions of what others think*

*Reasons for attending gym*

*I've never really spoke to anyone else about it*

*Accidents*

*Forced to stop sport*

*Obviously not leaving my knee go completely*

*Only because of an injury*

*Sports injury*

*You shouldn't be walking*

*You would be on the ceiling by now*

*Abdication of responsibility*

*Blame*

*Direct challenge*

*Excuses for not being responsible for contraception*

*I think that it's a lot worse than what I am led to believe*

*If men had to have babies*

*Lack of trust*

*Taking advice*

*Taking control*

*Trust*

*Vulnerability*

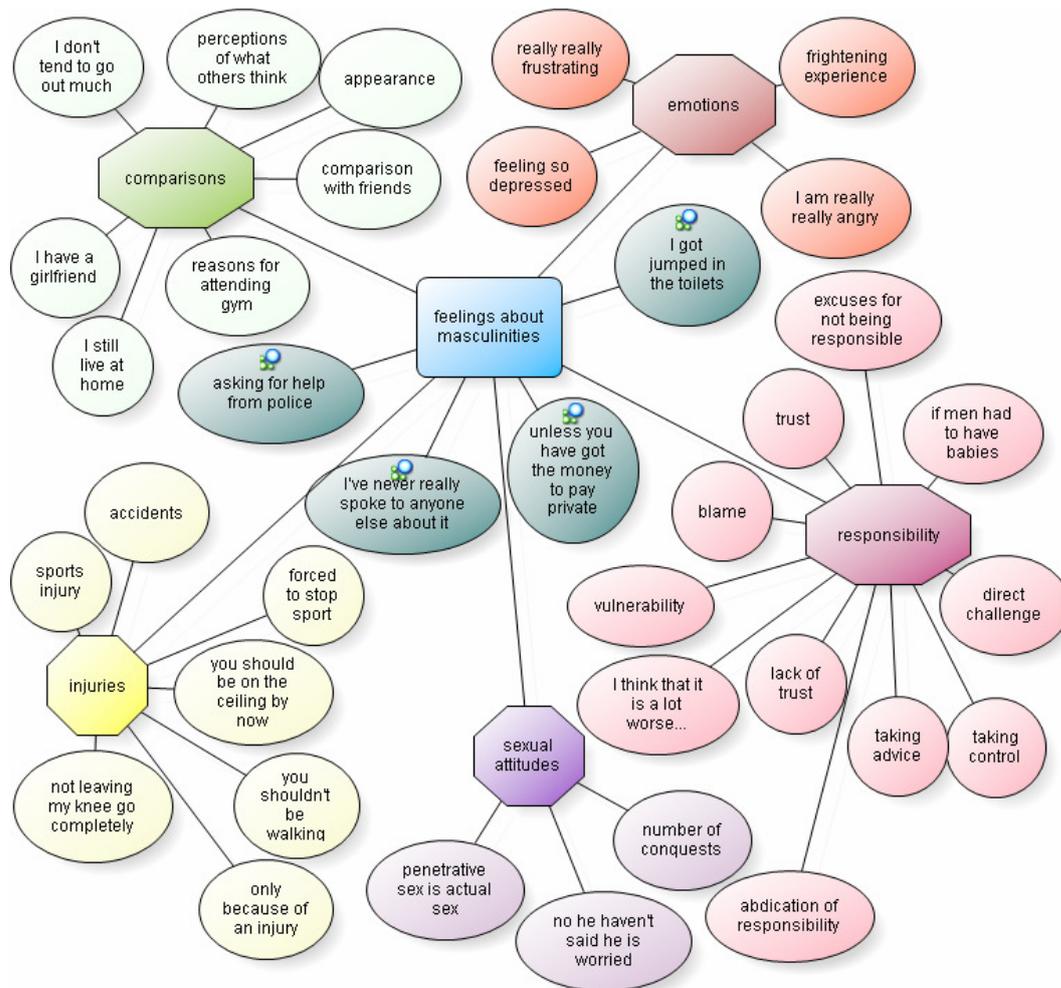
*Unless you have got the money to pay private*

*Employment*  
*I was losing money through work*  
*Manual employment*  
*Time off sick*  
*Compensating for not working*  
*Fitness levels*  
*Football to me is everything*  
*I am pretty into my sport*  
*I come down to the gym with one of the boys*  
*I felt as if everything was like taken away*  
*I like to keep fit*  
*Admission of lack of knowledge*  
*Feeling unprepared*  
*Source of knowledge*  
*Superficial knowledge*  
*Unsure of information*  
*Asserting knowledge*  
*Motive for help seeking*  
*Parents' employment*  
*Perceptions of STI*  
*Role of teacher*  
*Unprepared for sex*  
*We weren't told*

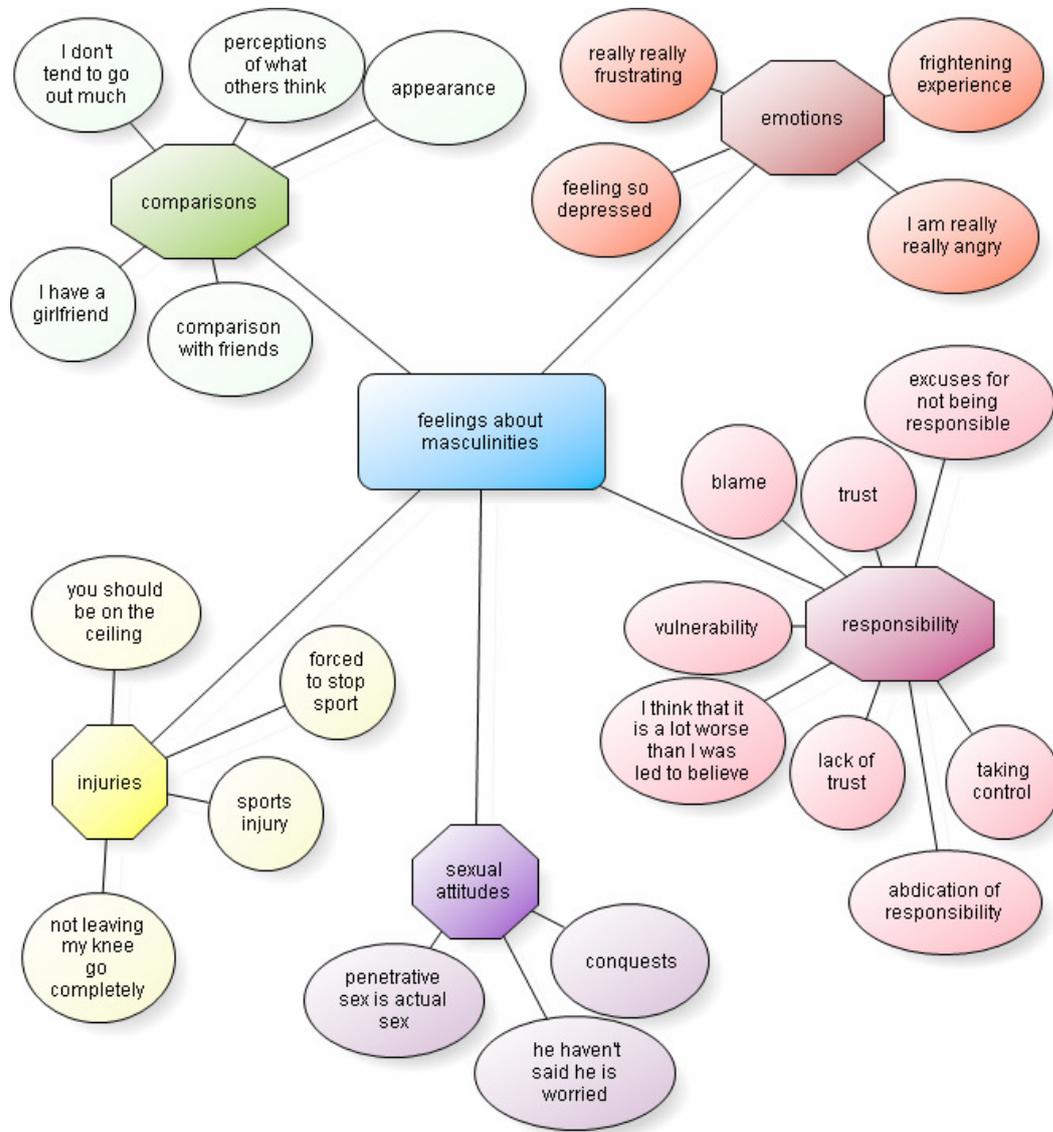
## Development of Coding

Even later in the analysis process the coding structure continued to be developed and clarified. This is illustrated below, the first diagram is the original coding structure for 'feelings about masculinities' the second shows how the theme has been streamlined in order to make it easier to explain and understand. Inconsequential codes were removed or merged into the wider coding structure.

### Original diagram (stage one):



**Diagram after further development (stage two):**



## Appendix Two

### ***Research diary – to show audit trail by giving evidence of the researcher's journey through the research.***

This diary is not exhaustive; I have often forgotten to write it, but it does demonstrate a journey through the research process. I only started to write it following a period of suspension due to illness, I had completed about eight months of study prior to this, which had involved writing a research proposal for submission to the Departmental research programmes committee and writing a submission to the faculty ethics committee.

#### *December 2005*

It is important to understand what I am feeling at every stage of the research process in order to be truly reflexive and create a credible audit trail. I have been thinking about my reasons for undertaking research, probably the most important is my wish to study and gain a higher qualification. This is perhaps not considered a suitable reason for beginning a research project yet I think that without admitting to myself that this is a driving force I am hardly being honest. Secondly, I remember the impact that participating in research had on my life. At the end of my nursing degree I was so sure that I did not want to nurse. I never had a vocational calling to lead me to nurse; I wanted a professional qualification with lots of scope for diversity of employment. I care deeply about people and wanted to effect change but I never felt a deep compulsion to be the person doing the caring. I think it is important to remind myself that I am driven and my self worth derives entirely from what I achieve, and my perceived status. When I started my degree I was so upset to find that there was contention over whether nurses are professionals and more so that they were not truly expected to behave as such. Nurse's autonomy is sometimes dubious and often non-existent; it is well to say that one is supposed to be autonomous but if all circumstances of employment prevent this, one is not. Because of my strong wish to be professional and autonomous I fully intended to leave nursing and never work as a qualified nurse (consequently when I did finish my degree I did something else entirely). During my training I went to study in Denmark for a while. I was pleasantly surprised by the difference in the way that nurses were perceived and treated and their ability to work as autonomous professionals. The research I was a participant in was about this experience and the effect that studying abroad has on nursing students. Talking to other students who had had similar experiences and had similar feelings was so beneficial to me. My friends regularly talked about their calling to the profession etc and did not understand what I was feeling but the students who had been abroad felt the same. Perhaps the most highlighting circumstance was the fact that another student noticed that nurses in other countries do not get bought chocolates. This is a rather strange custom in the UK when a patient is discharged they buy the nurses chocolates or biscuits. Whilst it is nice to be thanked, no other professional receives this attention and it almost implies that the nurses are doing the patients a favour and thus indicates that the patients feel they are less professional than the other people looking after them.

#### *March 2006*

Called youth info service in xxxxx. This is a service for young people 11-25. They can drop in for health advice, condoms, contraception, school issues etc. There are two nurses there and a doctor who pops in during the afternoon it is open from 11-3.30pm every Saturday. There is also a youth worker present. There is a bus which

goes round to schools. The bus goes around areas as there was not demand for info in family planning clinics. Saturday clinic was started after some research to ask young people what they wanted. The service is in Bridgend centre and has a good uptake.

Considering accessing young men for my study through local authority youth groups or communities first. Attempted to call communities first to discuss research no answer on xxxx will try again.

Have decided to change my strategy somewhat, this is because the youth groups offer some family planning services and condom card scheme therefore young people accessing youth groups also have easy access to these services. Services in xxxx are good too. Making this sampling strategy less appropriate. Considering local authority leisure centres as a possibility.

Called manager of local authority leisure services on xxxxx xxxxxx he asked some questions about the study and seemed to know what he was talking about. He would like a letter from me on headed note paper, detailing my methodology, that this research is part of my studies, that this is the best way of accessing young men for this study and a letter of introduction from Paul.

Sent letter as described above by recorded delivery, checked with tracking code to ensure that it arrived, it did.

Have not heard anything as yet re: sampling see above maybe will call next week so that they have had sufficient chance to read the information.

Sent email to Paula McIntyre to check that she received my ethics submission she is out of office.

Found article detailing research which is similar to my proposed study. This research involved asking young men in focus groups what they thought of sexual health services a brief mention is given in the article to masculinities, wondering whether to contact author of article to ask for info about other publications. Article published in journal of family planning and reproductive health by Pearson (2003), it says that this is only part of the research undertaken for a doctoral thesis sampling took place in sexual health services schools youth groups across the country.

*April 2006*

I have contacted Mr xxxx with a request to access young men through leisure centres; this seems possible as long as I have a CRB from within one year and ethics approval. I contacted Paula to check what had happened to my submission and it is going to be kept until the meeting on 3rd of May I will hear about it by post.

Below is a copy of the email from Mr xxxx detailing the conditions of my accessing a sample through the local authority leisure centres.

Anna,

Further to my discussions with Dr Wheeler on the above matter, I am happy for your research to be undertaken, via xxx Leisure Centre, on the basis that the following criteria is met.

1. Under no circumstances are you to state or suggest that you are acting as an employee or agent of xxxx County Borough Council. (written or verbal)
2. Under no circumstances are you to state or suggest that the research is being undertaken on behalf of xxxx Borough Council. (written or verbal)

3. A current Criminal Records Bureau clearance must be obtained and made available to me, which validates a period not exceeding 12 months from the date of your attendance at the centre.

4. The anonymity of all participants must be maintained at all times.

5. Evidence of ethical approval must be made available to me, which has met the criteria laid down either by the University of Glamorgan or the Health Service.

Your contact following the receipt of the information requested is the Manager at the xxx Leisure Centre, Mr xxx who can be contacted on xxx -if no response, hold for reception.

I await details of the information requested and wish you every success in your research.

Kind Regards

Xxxxx

I need to get in touch with the R and D committee at the trust to inform them of my research but I have been trying to email various people and the emails are repeatedly returned to me. This month also did a practise interview for Ray which was so interesting I think I need to practise!!

#### *May 2006*

Having sent of my CRB form I am waiting for a reply from them and then I will be able to get started, have sent a letter to Paula re: ethics committee meeting as I have not heard anything yet.

Xxxx wants me to register my research with the trust R and D committee I and everyone else I talk to cannot see why this is necessary. Xxxx sent me the email of someone on the committee and I have sent her an email to tell her who I am and explain that I am not hoping to do research with anyone in the trust or even in the area covered by the trust. I am waiting to hear something from her about this. It is frustrating because I have no idea why I need to register with the trust and I think that if I have to they will make a fuss about something and expect it to be changed but if I do change things I would have to get back to the school and change my proposal there. It all seems ridiculous to me, I do understand the importance of regulation in research and think that it is necessary to have proposals reviewed by those who are responsible for the subjects of the research but everyone seems to disagree. I am beginning to have nightmares about this.

#### *June 2006*

The month is just beginning and I am getting scared that I have not got enough done, although I have had some good news. Having emailed my proposal to the trust they said that they thought it was an interesting project and did not say a whole lot else I just sent them an email to say I would let them know about the findings in due course and they seemed happy enough about that. What a relief! Also I have just been given ethical approval which is good; I have contacted John Beynon to ask if he would act as an advisor, he has said that he is too busy at the moment.

#### *July 2006*

I am trying to get sorted out for commencement of data collection and attended some interview training.

The training was interesting and certainly got me thinking I was not pleased with how the practice interview went though. Xx pretended to be a young man and I was surprised at how difficult it was to talk and draw out interesting themes. There were several points that I would have liked to encourage him to talk about but drawing them out was impossibly hard I had not expected that. I must remember to mention words at the beginning of the interview and then that gives the participants

permission to use the words afterwards. There were themes on masculinity and opinions about women that would have been so interesting but I failed to encourage elaboration. A couple of times I stopped xxx short when he would have continued. I could remember to own and be comfortable with the silence and then the participant may be encouraged to fill it with further thoughts and experiences. Power balance is important in the interview but this is hard to make participants feel comfortable; I have to let some of myself through to develop rapport.

I have a meeting with xxxx from the leisure centre today which I hope will be useful. I have had some posters and leaflets printed to show him and ask him if I can put them up. I need to ask if I can go and sit in the leisure centre to promote human contact and invite people to participate in the research.

### *August 2006*

So far things have plodded on the same as usual. I have continued working on the article I would like to get published perhaps in Nurse researcher and also am writing an abstract possibly to present at the RCN sexual health conference next year. Apart from being a little absorbed in moving house and getting married both things which I should not be doing at the same time as research things are going alright. I have taken copies of my posters and leaflets to the xxxx leisure centre and have been once to access some participants.

This was hard I think that getting interested young men to participate will not be easy. I approached a few but they were coming and going from classes they are in a hurry to get there on time and at the end they want to leave to watch the football and shower etc. It is difficult to know what to do I did give out some in for leaflets and that was good, I was surprised I did not find them scattered at the bottom of the path when I left. I think that the pilot focus group is out really as I do not think I will be able to find enough participants to make it worth while I am just hoping that I will get enough for the interviews. After seeing Paul and Rachel yesterday they suggested that I actually go into the gym and chat to people who are not in such a hurry. I am going to the leisure centre today so I will have a chat to the assistant manager about this I need to wander around really also I think that I will start telling the young men that I will be paying them for their time with a store voucher and then ask them what they would like e.g. HMV etc and see if this encourages them to volunteer.

I have spoken with Julian Baker who conducted a study about drug use in gyms in south Wales he has provided me with details of some of the gyms that were used and I am currently trying to contact one of them which is located in xxx to ask if I might use them to access some participants.

I finally spoke to someone at this gym who felt that the subject of the research would be too uncomfortable and he did not want his paying customers to be discouraged from attending.

I have had three practise interviews so far and each has got a little better. The first one was difficult I did not give the participants enough time to answer I found the silences uncomfortable and filled them with further questions which was not good, the second was also not marvellous I find it hard not to adopt the role of educator, it is a difficult balance. On one hand one feels responsible in a way as these young men may feel that I am an adult and have come to tell them what they need to know if I do not correct their wrong beliefs then they may leave with the idea that they have been doing the right thing but my role in that situation is not as an educator it is not even as the powerful one as when I am a nurse. My role is to discover the experience of the young man that I am talking to and as such adopting the educator role and correcting etc could lead to a break down in communication or the building

of a wall between me and the participant. The third practice interview I did involved Paul being the participant this was really hard as he was trying to be difficult and it was difficult not to laugh I could see that the others were laughing and this made it even harder. Body language is important facial expressions it is important to appear non judgmental and un-shockable as the young man may be trying to shock me. Three things have been identified as important points:

change of role not as educator but as researcher  
ask open questions allowing silences  
be flexible with the interview schedule.

It is important that I know my topic guide really well before beginning as then I can move around between subjects with the participants and allow them to lead me to what they want to discuss whilst ensuring that the important points are still covered. Asking open questions allowing the participant to feel important and valued and allows them to tell their own story not what I want to hear from them.

#### *First Data collection interview 22/08/06*

I spent the whole of yesterday running around making sure that I had everything ready for today. I had to go and collect equipment make sure I had info re services and buy minidisks and batteries I found it quite stressful as I arranged the interview on Friday so I spent all weekend worrying about it. The interview was arranged for 4pm this afternoon and I arrived early and set up the participant was about an hour and a half late but that did not matter I was just so pleased that he came and that he agreed to take part. The interview itself was hard he has had some difficult things to deal with and has been off work for a long time he has been ill he talked about depression even though I felt that I had asked him to elaborate on his feelings about this he seemed reluctant. the interview only lasted about 30mins about which I was disappointed as I felt like I had not got enough information but I had run out of questions I wanted to ask some more about masculinity etc. I felt that I just took what he had to say and did not actually try to question what he was saying etc to gain an insight into what was going on with him. I think that I did alright with repeating things back and getting some more information but I really wanted it to be a little deeper. I always feel like quite a failure after such things as I have been thinking about everything else I should have asked or said all the way home. I am dreading listening to the tape as I feel that this will show up all the problems with the interview and everything I did wrong.

The participant was willing to discuss difficult issues but had little knowledge and I felt guilty because I had not told him more about STI etc and I forgot to get my pictures out which I had thought would be really good to show him.

#### *October 2006*

I am feeling incredibly disheartened because I do not feel that anything is happening I am also not feeling well and this makes me miserable. I have not achieved a lot since the last time I wrote this is for a number of reasons. I decide to apply to do a research project for Merthyr children and young people's partnership this was work intensive and I had a short amount of time I which to complete the work. They have short listed me and I have interviews I have been preparing for these interview, which means that I have not achieved much else. After the interviews I am hoping to start analysing the interview which I have already done I need to go back to the leisure centre in order to continue recruiting.

I will take them some new posters and leaflets

#### *November 2006*

The proposal submitted was not successful and I am pleased about it I think it would have been too much for me. They said that they needed to have it done in the time frame owing to their funding and that if they had had longer they would have chosen me (my proposal estimated taking longer than their time frame by three months). They were kind about it and told me some nice things which always helps.

I am not doing well at all at the moment. I feel as though I am really behind and really struggling I am never going to complete and I have just had enough. I find it really hard because I feel as though my career is suffering as a result of this and if I am not doing well at this then what am I achieving - I have to be going somewhere. I wanted to spend a bit of time getting the house at least to comfort level but I understand now why they say that you should not get married or move house or anything whilst you are trying to do a PhD. I have got some new posters printed and some leaflets which I will take into the leisure centre - I cannot arrange to do this until I have my off duty for this week which I will get tomorrow.

#### *October 2007*

It has been a whole year since I wrote here but I have been working in the meantime. I have transferred from MPhil to PhD and now the hard graft has started I have done 5 interviews and need one more probably.

I am considering giving up my studentship because I feel that the trust is not taking me at all seriously I had an email from xxx to day which implied that she had not listened when I said that the course (contraception and sexual health) might cost. I wrote back and said that whilst doing the course was not essential to my work in outpatients it could be considered essential to my work as a ShORT studentship student.

I have still not submitted anything for publication.

#### *Analysis*

I have analyzed the first interview the one with Rhys and now I am using the codes that I generated in that interview to code the others. I am also generating new codes appropriate to each new interview.

#### *Aneurin*

I am particularly interested in the way he qualifies his risks regarding getting a sexually transmitted infection, not having one night stands reduces the risk in his eyes. If you know the person you are having sex with they are less likely to give you an infection. This is interesting. Also towards the end of the interview he admitted to having attended a G.U.M. clinic. He explained that he had not done anything which is interesting as though there is some blame attached to STI and putting oneself at risk is dangerous he wanted to make sure that he was not placed in this category.

#### *January 2008*

I have completed data collection. I had arranged a final three interviews at the third leisure centre. The first participant was late and eventually I found out that he was not going to attend. I had a wait of two hours for the next one. When they arrived they insisted on doing the interview together I was so worried about failing to collect sufficient data that I acquiesced. This did provide some interesting interaction and the young men Owain and Gwyn still talked quite openly about their experiences of sexual health education and service provision. Their banter also provided some interesting insight into the interaction of young men discussing sexual health.

#### *April 2008*

I have continued with my analysis which is time consuming. The worst thing is not knowing if I am getting it right that is I am not sure that I am not making illogical jumps that should not be made. Paul's sudden death affected my feelings about analysis and completion. I had not realised how much I relied on knowing that he would be around to ask questions etc. It is strange because he had been off sick for some time I think that I had just kept in the back of my mind that it would be possible to ask him for help in the near future.

I analysed the first interview with Rhys and then applied nodes to subsequent interviews. New nodes also emerged and I have added them in for example, some participants discussed appearance and its relation to gym attendance I have added this to the tree node about masculinities because I feel that appearance is an important expression of gender.

I have created a new section in attitudes to health care specifically about sexual health care, it contains nodes that reflect the feelings of the young men around this subject, the urgency of health care seeking, previous experiences of seeking sexual health care and also nodes which express their concerns about sexual health (pregnancy and STI). These nodes did not fit obviously anywhere else but I did not want to leave them as free nodes because they fit so well into the subject of the study. I have put them here because I felt that it is these concerns which would prompt health seeking if it were to happen.

I have also added the node blame (sexual) to this tree because I feel that these feelings would have an impact on willingness to access health care.

I have added a new tree node called leisure. This is because there were a number of free nodes in which the young men discussed their feelings about leisure activities and it seemed that as such it was worth including as a tree

#### *January 2009*

Well yet again an extraordinarily long time has passed since I last wrote in my journal but this time I do have a good excuse, Tobias arrived in August and since then has somewhat commandeered my time. My studies were suspended though.

I am hoping not to go back to outpatients but am asking for flexible working in case I do have to. I have completed my sexual health course and am awaiting results. I am applying for lots of jobs.

Having just started again I see the importance of keeping a diary.

I am writing about blame which is a section of masculinities/ responsibilities. It has occurred to me that participants seemed quick to blame others for situations in which they found themselves for example, Rhys and his injury. I had coded this in masculinities because I felt that blaming someone else meant that young men did not need to question their identities or even necessarily assert them in other ways because what had happened had been done to them. Then I wondered how this felt I know that when something is done to me I feel powerless and this leads me to question my sense of self and independence however I also sometimes excuse myself from feelings because if I did not then the identity questions that the feeling raised would be too enormous to cope with. A simple example of this might be of course I have put on weight I have just had a baby, by saying this I do not need to question my self-control or eating habits but merely am able to blame a situation which was not my choice

I cannot remember why vulnerability was coded in responsibility (feelings about masculinities); even though I have read the content which was coded here I can still not make a mental link. I need to consider this further. I am struck by how useful it would have been if I had explained myself here!

Vulnerability is part of responsibility because either quotes expressed a lack of responsibility or participants had been motivated to take responsibility by their feelings of vulnerability.

David's quote about his injury links to Rhys talking about depression. Rhys was quick to explain why his depression was not his fault. Should the first quote in vulnerability also feature in lack of responsibility because David like Rhys did not take responsibility for the accident?

*This diary is not complete, in that I stopped writing it when I no longer found it necessary. Towards the end of my studentship, I was writing my thesis and working on it every day; consequently, there was not a need to remind myself what I had done. The process of writing up the thesis did not need to be documented in order to evidence an audit trail*

## Appendix Three

### ***Reflections on research process – to show audit trail by giving evidence of decision making and some experiences of the researcher***

#### **1. Reflections - sampling**

Whilst the population of young men is not hidden as its size is known, it is a hard to reach population for research on sensitive subjects. Owing to the aims of the study it was not considered appropriate to recruit participants from a health care or sexual health care setting; young men who have accessed health care may have different attitudes to those who have not. It is also thought that young men who access sexual health care are a minority group (Pearson, 2003a). Convenience sampling was chosen to recruit participants; volunteering and snowball sampling were also attempted but have been unsuccessful to date.

Because of the sensitive nature of the study, it would not be considerate to attempt to access young men through their place of work; potential participants could be dissuaded from volunteering owing to fear of disclosure. It may also challenge their ideas of masculinity, Whitehead (2002) posits the view that work is considered an opportunity to assert power and masculinity – participating in research on a sensitive subjects may directly conflict with this.

Schools were also considered but because not all young men in this age group attend education and because of the sensitive nature of the study it was not considered appropriate. Local authority youth groups were also considered unsuitable because sexual health advice is provided during some youth group sessions in the area in which the study took place. Accessing potential participants through these groups may therefore provide access to a sub-group of the population who are much better informed than others.

A sample has been obtained for this study by accessing young men who attend local authority leisure centres to use gym facilities. Leisure centre managers were approached to request access and ethical approval gained before commencement of data collection. Whilst it may seem that gym use is a healthy behaviour; studies in South Wales have shown that many young men who attend gyms also use anabolic steroids (Baker *et al.*, 2006). Because this is an unhealthy behaviour possibly associated with ideals of masculinity such as a desire to appear strong and tough (Haywood and Mac an Ghail 2003), accessing participants through gyms was apposite to the research aims.

Posters and leaflets were placed in the leisure centre to encourage volunteering. I talked to gym staff so that they would understand my presence as I sat outside the gym for long periods talking to all the young men attending. Having spoken to young men I asked if they might have any friends who would be interested in taking part. A small incentive in the form of a gift voucher was offered to thank participants for their time, participants were told about this before the interview. Young men were given several weeks to consider whether or not to take part in the study and thus needed to be approached more than once.

There were problems with accessing young men in this way. Firstly, I became aware whilst recruiting participants that my biases and opinions were having an affect on which young men were recruited. For example, I screened potential participants before approaching them, asking myself if they appeared to be 'in a hurry'. I felt uncomfortable approaching a young man if he was with a woman – due to the sensitive nature of the research, for the same reason a large group of young men were less likely to be approached by me. Only those young men physically approached became interested in the study, although they acknowledged having seen the posters. As a young woman; approaching young men could be interpreted in many different ways. It is difficult to gauge the age of a person and only young men between 16 and 20 were eligible for inclusion in the study, I often made mistakes judging the age of young men and I felt that this either excluded potential participants or appeared unnecessarily tactless. As I approached many young men it became easy to forget which had expressed interest, this meant that some young men who said they were not interested were approached on more than one occasion. I felt that this was insensitive and I have minimised the occurrence of this by keeping notes although this system is not infallible.

It is acknowledged that establishing rapport is an important part of conducting research (Berk and Adams, 1970); this can be difficult when a sensitive subject is being discussed. I talked to young men and gym staff so that I was able to establish rapport within the leisure centres and become known. In this way I hoped that information about the study would be passed by word of mouth in the gym. Gym staff were helpful in recruitment, they sometimes told customers who I was and introduced me to regular customers. I did feel a little uncomfortable about this, as though the gym staff were endorsing the study and therefore unwittingly pressurizing young men to participate. I was careful not to let this affect whether young men took part in the study by stressing that I was not an employee of the leisure centre and ensuring that all young men had at least two weeks to contemplate either alone or with others the information sheet and whether they would like to participate (Central Office for Research Ethics Committees 2006). I was also careful not to mention who had agreed to take part in the study as this would have breached participants' confidentiality. Most participants were recruited solely by having been approached by me; although young men offered to ask their friends to participate, a snowball strategy has not been successful to date. It is possible that this is due to the sensitive nature of the subject.

I am a young woman and was concerned that young men might be unwilling to discuss sensitive subjects with me. Whilst researcher profile is thought to be important by some authors (Deatrick and Faux, 1991; Kruegar, 1994); Hutchinson *et al.* (2002) suggest that the interview is constructed by both the interviewee and interviewer. Factors such as the interviewers experience and their ability to be non-judgemental are also important to the interview process. Establishing rapport with the potential participants was important in order that they felt comfortable with me. This was established before the interview took place; I met the young man on several occasions to discuss the study, gain written consent and arrange a time for the interview. Whilst my profile as a young female researcher may have affected their willingness to talk, all participants stated that they had felt comfortable during the interview. Some participants volunteered sensitive information which had not been requested, for example, about previous sexual partners. This is evidence that a non-judgemental approach and accepting attitude are more important than the researcher's gender.

This sampling strategy has limitations most notably that many young men do not access local authority leisure centres, only a sub-group of the population is available there. The research aims and phenomenological nature of the study do not require a large sample, a sample of 6-8 participants for use with IPA is recommended by Smith and Osborn (2003). As such this study does not seek to be representative of all young men. In order to gain a wider understanding of young men's experiences, participants have been recruited in three, different, geographical areas.

## **2. Reflections - first data collection interview**

Undertaken using Johns (1998) model for reflection.

### *Aesthetics*

I had arranged the first interview with a young man who I met at the leisure centre, he had read the information leaflet and I spoke to him again when he signed the consent form. We did this on a Friday (following his two week cooling off period) which gave me all weekend to worry about the interview which was planned for the following Tuesday. Having prepared everything that I needed I arrived in time and set up the room which I had booked. The young man was an hour late, during which time I was getting more and more concerned about my research and whether it would happen at all. After he had arrived we had a chat and he was happy to go on with the interview. He was willing to talk, answered all my questions and talked a lot, the interview lasted about 45minutes. I was pleased that my first interview went so well as I had had visions of sitting in silence – I even got the recording equipment working. The room in which I conducted the interview was small which was ok but it was unbearably hot.

However I found the interview difficult, the young man had had some negative experiences with the NHS and wanted to talk about them, we spent some time discussing this. I found it really hard because he had been off work for a long time and was struggling with chronic pain; he had been taking the same medications as I had taken when suffering with a similar chronic pain condition.

I felt that there were a lot of interesting issues that I should have been able to get this participant to talk about more; he did not talk about masculinity directly although I tried to ask some questions which could have allowed him to discuss how he felt about being a man. I felt disappointed when transcribing the tape as I keep thinking of questions which should have been inserted and wondering what the answers would be.

We talked about sexual health, I wanted to just listen to what he had to say and not quiz him. He had some interesting things to say and we talked about contraception, condoms, AIDS, sex education and girlfriends. I think I managed to listen and not try to educate or tell him things except when he asked a direct question. I hope that he felt comfortable doing this, it did not feel as though it was too awkward and he talked openly. I was disappointed because he really did not know much about STI and this would have provided a marvellous opportunity to look at my pictures and discuss them but I forgot about their existence until I got back out to my car.

### *Personal*

My first interview was inevitably difficult, a new skill or task takes time to master and practice enables one to become an expert. Although I had undertaken training I was aware that I was a novice researcher, even simple and practical things concerned me

for example, would the mini disk recorder cease to work suddenly? or all the spare batteries I had equipped myself with prove to be spent?

The participant arrived late which meant that I had been waiting for some time, getting more and more worried about the interview.

I found some of the initial discussion difficult for two reasons; firstly I had not been expecting to talk about this subject and thus had not prepared myself. Secondly I found it difficult to listen impartially to the participant whose experiences had been so similar to mine. I did not want to disclose information about myself and my situation both because I did not think it would be appropriate and because I found discussion of the subject upsetting.

The participant had difficult feelings about not being at work which I also found easy to identify with. I was away from work for a long period and I do not feel that I had ever properly dealt with my feelings surrounding this. It was also hard to assume the role of researcher when I wanted to suggest the things that had worked for me discuss what he felt and talk about what he could do next. I did not do this but it was not easy to listen impartially to what he had to say. I found it difficult. When I was given training in interview techniques I found that the most difficult thing was assuming an impartial role. As a qualified nurse I am often expected to not only listen to the problems of my patients empathetically but also provide helpful advice or possible solutions, even if this is merely referral to a doctor. The stark difference between this role and my role as a researcher was difficult for me to overcome.

### *Ethics*

I believe that a qualitative research interview should be a beneficial encounter for the participant as well as the researcher (Kvale 1996). With this in mind I felt that participants should be allowed to discuss what they felt was relevant and I should listen empathetically, I felt that I did listen in this way during this first interview. However, I almost felt that in order to make the interview as empowering as it could possibly be I should share my experiences and talk further with the participants about his feelings surrounding his chronic pain. With hindsight I am glad that I did not do this. The participant may have had a more beneficial and empowering experience by having been allowed to talk about his feelings without anyone giving him advice or information.

### *Reflexivity*

Subsequent interviews have raised different issues. Subjects discussed by the participants are as individual as the participants themselves. None of the other interviews covered subjects which I found as personally difficult.

I have learnt from my experience though, during subsequent interviews I have found it easier to employ empathetic listening techniques without offering advice and information. I feel that the interviews I have undertaken have provided the participants with a balance of information, which is provided at the end or through looking at pictures and empathetic, non-judgemental listening.

I have also changed the way I behave in my work as a staff nurse, I am now more inclined to listen to the patient for a lot longer before offering suggestions or advice. This allows the patient to identify what they would really like or what their problem really is.

## Appendix Four

### *Suggested Topic Guide*

- **Discuss consent and confidentiality are you happy to carry on?**
- **Discuss tape recorder are you happy for me to record?**
- Can you tell me about yourself?

*How old are you?*

*Can you tell me about where you live?*

*Can you tell me about any relationships with girls you have? Do you have any children?*

- What do people around here like to do in their spare time? Is that what you like to do?

*Can you tell me some more about that? Is there anything else you enjoy?*

*Can you tell me about coming to the gym?*

*Expand on this from the answer given, repeat words said, could you say some more about that?*

- Can you tell me about your general health?

*Have you ever had a problem with your health? Can you tell me about that? Could you tell me about any experiences that you have had of dealing with any health problems? (visits to the GP, pharmacist, talking to friends/family, hospital) How did it make you feel?*

- I would like to move on to discuss sexual health.

- Can you tell me what you know about sexually transmitted infections?

*Do you know any of the infections that you could get? Do you know if any of them have symptoms? How would you know if you had one? Do you know how they are transmitted? Do you know how you could stop yourself from getting one?*

- Can you tell me about how you found out what you know about sexually transmitted infections and contraception?

*E.g. talking to friends (do you think this is accurate/reliable? How do you feel about it?) Talking to family (how do you feel about this?) reading books or the internet or television (how do you feel about this? Was information easy to find? Do you think it*

*was reliable?) Do you feel that you know enough? How would you find out more if you wanted to?*

- Do you feel worried about getting a sexually transmitted infection?

*Does this change things that you do? Can you tell me some more about that? (e.g. use condoms, not have sex, with who?) Have you ever had a sexually transmitted infection? How did you feel about that?*

- What would you do if you thought you had had sex with someone who had an infection?

*Where can you go for help? How would you get there? How would you feel about going? Have you ever been to a G.U.M. clinic or other sexual health service? Can you tell me about what that was like for you?*

- Do you feel that there is help that is easy for you to use if you did have a problem with your sexual health?

*Could you tell me about what you find easy about it? What would make it easier or more suitable for you? if you found out that you did have a problem (give an example) what would you expect from a service (how would you expect to be treated, how near would it be, what would it be like, what would the people working there be like?) How have your experiences compared to this expectation? (or try imagine that there were a perfect service, what would the difference be between the perfect service and the service that you went to/ have heard about)*

**Is there anything else you would like to add/ talk about?**

**Have you got any questions?**

**How do you feel about what we have talked about/ what you said?**

Give participant information about service provision in the area; explain what the information is about.

Thank you very much for taking part

## **Appendix Five**

### ***Summary of participants***

#### **Rhys**

Rhys was the first of the participants to be interviewed and thus is considered first here. I met Rhys at leisure centre one.

Rhys was twenty years old and lived at home with his parents; he had an older sister who lived with her husband. Rhys had a girlfriend, who he had been having a relationship with for at least a year, prior to this he had had a sexual relationship with one girl (he volunteered this information).

Rhys attended the gym regularly as he was on long term sick leave following a football injury. His job was manual and involved installing home security systems; therefore he could not do it unless he was physically able.

Rhys had injured his knee playing football; he was upset about the treatment that he had received from the NHS for his knee injury and also about his inability to play football because of the injury. He was also not happy that he had lost his income, he no longer received sick pay.

Rhys talked for some time and was quite open and willing to discuss a variety of issues.

#### **Gareth**

I also met Gareth at leisure centre one. He was seventeen and was friends with Huw.

Gareth lived at home with his parents; he had two older sisters who had left home to go to university. Gareth hoped to go to university, to study law and international studies, the following year. He was still studying A-levels at a sixth form school.

Gareth did not attend the gym as often as Rhys did but he said that he went more often to the gym at his school.

Gareth was planning to go on a walking trip in Bolivia and wanted to be physically fit but stated that he had been regularly attending a gym before he decided to do this.

Gareth did not have a girlfriend.

#### **Huw**

Huw was friends with Gareth and I met him at leisure centre one. He was studying art and design at the same sixth form college as Gareth.

Huw lived at home with both his parents. He had an older sister who lived with her husband and children.

Huw had a girlfriend but it was a relatively new relationship (two months). He attended the gym about five times a week.

## **David**

David worked at leisure centre two in his spare time. He was twenty and studying at university for a degree in nutrition. I met David in the gym at the leisure centre when he was training, I did not realise that he was also employed there until the interview.

David lived at home with his parents and travelled to university (this represents a choice about where to live as he could have lived in university accommodation if he had wanted).

David had a girlfriend and sport was important to him. He enjoyed both watching and playing it.

David talked about a couple of incidents, in which he had been injured. At the student union at university, he had been assaulted in the lavatory by two unknown men. He had reported this to the police and had needed stitches on his face. He also mentioned a fight that he had become embroiled in on a night out in a city centre. He said that a bouncer had punched him and knocked him out, he showed me the scars. He said he had been sober and had been told by the police that, as his friend was involved in the fight, if he pressed charges against the bouncer then his friend would also be charged.

This was the first interview at leisure centre two and there were some problems with interruptions, the tape was stopped and the interview restarted at the end of the interruption. The interview was particularly rich and long in comparison to some others.

## **Aneurin**

Aneurin also worked at leisure centre two and was friends with David. Aneurin was at university studying to become a Welsh teacher.

He lived at home with his parents and travelled to university. I was concerned when, half way through the interview, he told me that his mother was a receptionist at the leisure centre and was working that evening. I was worried that this would cause him discomfort but he denied this. The interview actually took a long time, he appeared reluctant to talk and there were lots of silences. I do not think that this was due to discomfort but because he was a thoughtful and relatively shy young man. Despite saying that he knew hardly anything about sexual health, he knew more than any of the other participants had and gave a long list of infections and fairly accurate assessments of possible symptoms.

He did not have a girlfriend but disclosed that he had attended a G.U.M. clinic.

After his interview when I was at the leisure centre recruiting participants Aneurin stopped to talk to me and said that he had felt comfortable during the interview and it was much better talking about these things with a woman than with a man.

## **Owain and Gwyn**

This interview took place in leisure centre number three. The leisure centre is situated in a small town in an historically deprived area. Many young men and women attended the gym and leisure centre, it was always busy when I visited.

I had arranged to undertake three interviews with young men from this leisure centre. The first did not turn up at all. When I spoke to the second young man Owain to

finalise the details of his interview he explained that his friend had been having a driving lesson the previous day. Owain arrived for his interview with his friend, Gwyn, who had also agreed to take part in an interview but at a different time. They were both keen and insistent that they wanted to have the interview together. Because they had both previously agreed to take part and I had had so much difficulty recruiting young men at this leisure centre, I allowed them to attend together. Before the interview started we discussed the consent form again and the subject of the interview I told them that if they changed their minds about doing the interview together then we would stop straight away.

I was concerned that they would not talk as much if they were together but they both talked although not as much as some participants.

Owain was a sixteen year old who was at sixth form college doing A-levels, he hoped to attend university. He lived at home with his parents and two younger siblings, a brother and a sister.

Owain and Gwyn were friends and used to attend the same school but at the time of the interview Gwyn, who was also sixteen was studying at college. He was learning plumbing and spent one day a week working, as a form of day release. Gwyn lived at home with his parents and two older sisters.

Neither Owain nor Gwyn had a girlfriend and past sexual relationships were not discussed, I could not speculate about whether these young men had had previous sexual partners as there was an element of bravado in the interview which might have led to exaggeration.

## Appendix Six

*Posters and leaflets: materials used to recruit participants (sizes changed)*

Are you a man  
between 16 and  
20 years old?

I am doing some research about young men's health and I would like to talk to you.

To find out more please call Anna on: 07772  
704995

Email: [asydor@glam.ac.uk](mailto:asydor@glam.ac.uk)



This leaflet was produced so it filled both sides of an A4 sheet of paper. The size has been reduced and the font size changed.

**Young men's health**

Are you a young man between 16 and 20 years old?

I am doing some research and I would really like to talk to you about health issues

Taking part would involve having a chat with me about these issues

To find out more please call Anna on :  
0777 27 049 95



**Anna Marguerite Sydor**

School of Care Sciences  
University of Glamorgan  
Clifton Campus  
Phone: 07772 704995

**Are you a  
man between  
16 and 20  
years old?**

My name is Anna and I would like to ask you to take part in some research that I am doing about young men's health.

- The research is about young men's health.

## Interested?

- Do contact me and I will tell you some more about the research.
- Taking part would involve talking about health related issues with me.
- Nobody will be able to tell who took part in the research or what they said.
- When you have found out about the study and asked any questions you can decide if you would like to take part.



### **Anna Marguerite Sydor**

School of Care Sciences  
University of Glamorgan

Phone: 07772 704995

E-mail: [asydor@glam.ac.uk](mailto:asydor@glam.ac.uk)

# Appendix Seven

## Screen shot of NVivo in use

The screenshot displays the NVivo software interface. At the top, the menu bar includes File, Edit, View, Go, Project, Links, Code, Tools, Window, and Help. The main window is titled 'version 2.nvp - NVivo'. On the left, a 'Nodes' pane shows a tree structure with 'Tree Nodes' selected. The 'Tree Nodes' pane contains a table with the following data:

| Name                         | Sources | References | Created | Modified         |
|------------------------------|---------|------------|---------|------------------|
| communication                | 0       | 0          | 19/0    | 21/01/2008 11:10 |
| feelings about health care   | 0       | 0          | 19/0    | 24/10/2007 15:21 |
| feelings about masculinities | 0       | 0          | 19/0    | 19/02/2007 17:35 |
| feelings about working       | 0       | 0          | 19/0    | 21/01/2008 11:10 |

The main search results pane shows the following text:

**qualifying managing risk**  
 <Document\data\Interview\_Aneurin> - § 10 references coded [11.11% Coverage]  
 Reference 1 - 1.29% Coverage  
 I don't go around just sleeping with anyone like when I have just met them I don't go out and just...well you know I don't go in for one night stands  
 Reference 2 - 1.51% Coverage  
 Oh yeah well one of them is engaged but yeah they are all older than me I hang out with a group of older boys they are like five years older than me and I...they don't do that  
 Reference 3 - 0.45% Coverage

The 'Annotations' pane shows the following content:

1 Aneurin uses the word "I" a lot here. Creates a distinction between himself and others and further distances himself from behavior he finds unacceptable.  
 2 many of the young men in this study have talked about protection when they are referring to condoms

The bottom status bar shows '10 Items | Sources: 5 | References: 35' and a 'start' button.

## Appendix Eight

### *Risk assessments*

UNIVERSITY OF GLAMORGAN

#### PRIFYSGOL MORGANNWG RISK ASSESSMENT

| Department                               | SoCS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Location/Room<br>No | Cis Lab |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------|
| Brief Summary of Work Activity           | <b>Visit to leisure centre to recruit participants for semi structured interviews</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |         |
| List Significant Hazards                 | <b>Visit will be made alone, Hazards involved are those associated with this. E.g. whereabouts of the researcher must be known in case of untoward event.</b>                                                                                                                                                                                                                                                                                                                                                  |                     |         |
| List Who might be exposed to the Hazards | <b>Anna Sydor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |         |
| List Existing Control Measures           | <b>Ensure that whereabouts of researcher are known.</b><br><b>Attend with mobile phone.</b><br><b>Time of meeting arranged for a time when the leisure centre is likely to be busy.</b><br><b>Make sure duty manager aware of presence of researcher.</b><br><b>Sign visitors book</b><br><b>Agree 'call in time' with third party who knows researchers whereabouts and will investigate if 'phone call has not been received by such time.</b><br><b>Supervisor to be made aware of all intended visits.</b> |                     |         |
| Residual Risk - High, Medium or Low      | <b>LOW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |         |

**Are risks adequately controlled? YES**

**If NO list additional controls/action required below to eliminate risk or reduce so that it is LOW and who is responsible for implementation**

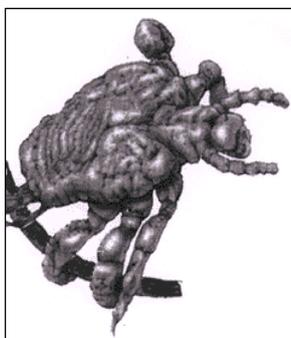
| Additional Control Measures | Action to be taken<br>by | Implementation<br>Date |
|-----------------------------|--------------------------|------------------------|
|                             |                          |                        |

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## Appendix Nine

*Pictures used in interviews*<sup>127</sup>

### Sexually Transmitted Infections



<sup>127</sup> These pictures were used during the interview; they were not shown to participants in this format but were larger. None of the pictures were labelled in order to provoke discussion about the causes of the problems.

## Appendix Ten

### *Information sheet*

This information sheet was formatted so that it filled two A4 sides, these were printed on one sheet of paper so that the information did not appear daunting.

### Information Sheet

**A study of young men's experiences of addressing their sexual health and the effects their masculinities have on this.**



*My name is Anna, I would like to invite you to take part in a research study. It is important to understand why I am doing this research and what it involves before you decide whether you would like to take part*

### **What is it about?**

- *I would like to find out what young men think of going to talk to someone about their sexual health (This could be a doctor or a nurse at a clinic or surgery).*
- *I would like to know about whether you would go to talk to someone about it, where you would feel comfortable and who you would trust?*
- *I would like to know what you think about the sexual health services that are available?*

### **Who can take part?**

*I am asking you to take part in the research because you are a young man between 16 and 20 years old.*

### ***Is it up to me?***

- It is up to you to decide whether or not to take part.
- You can keep this information sheet and think about it.
- If you would like to ask any questions you can contact me.
  
- If you decide you would like to take part, you will be asked to sign a consent form to say you are happy to participate.
- You are still free to leave the study at any time without giving a reason.
- If you do decide to take part you can refuse to answer any questions you don't want to without saying why.

### ***What will happen if I take part?***

- If you decide to take part, the research will mean coming to an 'interview'. This is a conversation which is recorded on tape. It will last about an hour.
- It would happen at a time and place which was convenient for you.
- When we have finished talking I will transcribe the tape and then destroy it.
- Your confidentiality and anonymity will be protected, this means that I will change all the names and not mention places when I write up the results.

If you would like to ask any questions you can contact me:

Anna Sydor

Tel: 07772 704995

Email: [asydor@glam.ac.uk](mailto:asydor@glam.ac.uk)

# Appendix Eleven

## *Consent form*

### **Young men's experiences of addressing their sexual health**

Name of Researcher: Anna Sydor

**Please initial box**

1. I confirm that I have read and understood the information sheet for the above study.
  
2. I have had time to decide whether I want to take part and I have had my questions answered.
  
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
  
4. I can refuse to answer any questions without giving a reason.
  
5. I agree to take part in the above study.
  
6. I agree for the interview to be tape recorded and I understand that this tape will be transcribed and subsequently destroyed. The transcription will protect my anonymity (all names and places will be left out).

Name:

Signed

date:

Researcher:

Signed

date

This form will be stored separately from interview transcripts so that anonymity is completely assured.

Anna Sydor

Tel 07772704995 Email: [asydor@glam.ac.uk](mailto:asydor@glam.ac.uk)

# Appendix Twelve

## Confirmation of research registration

University of Glamorgan

Prifysgol Morgannwg

Research Unit Uned Ymchwil

School of Care Sciences Ysgol Gwyddorau Gofal



11<sup>th</sup> February 2005

Ms Anna M Sydor  
C/O SOCS Research Unit

Dear Ms Sydor,

*Registration for MPhil/PhD at the University of Glamorgan – Title of Research A  
Phenomenological study of Young men’s experience of addressing their sexual  
health and the effects their masculine ideologies have on this*

I am writing to confirm that at its meeting on the 11 February 2005, the School of Care Sciences’ Departmental Research Programmes Committee (DRPC) approved your registration for the award of MPhil/PhD.

Please note that this registration takes effect from the 11 October 2004..

Your supervision team was approved as:

Dr Sandy Kirkman  
Dr Paul Wheeler  
Dr Roiyah Saltus

If you have any queries about the Committee’s decision, please do not hesitate to contact me.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Karen Roberts'.

Karen Roberts  
Research Administrator & DRPC Secretary

cc: Dr Sandy Kirkman, Director of Studies  
Dr Paul Wheeler, 2<sup>nd</sup> Supervisor  
Dr Roiyah Saltus  
Prof. D Cohen, Lead Reviewer – DRPC



Head of School/Pennaeth yr Ysgol Professor Donna M Mead  
University of Glamorgan/Prifysgol Morgannwg Pontypridd CF37 1DL UK/DU  
Tel/Ffôn 01443 483158/483092 Fax/Ffacs 01443 483140

www.glam.ac.uk

Vice-Chancellor/Is-Ganghellor - Sir/Syr Adrian Webb

University of Glamorgan

Prifysgol Morgannwg

School of Care Sciences  
Ysgol Gwyddorau Gofal



A. Sydor  
C/O School of Care Sciences  
University of Glamorgan  
Pontypridd  
CF37 1DL

6<sup>th</sup> June 2006

PMC/SG

Dear Anna,

I am pleased to confirm the School Ethics Committee has now approved your project  
*'A Phenomenological Study of Young Men's Experiences of Addressing their Sexual Health and the Effects their Masculine Ideologies has on this.'*

Yours Sincerely,

Paula McIntyre  
Head of Administration  
Faculty of Health, Sport and Science



Head of School/Pennaeth yr Ysgol Professor/Yr Athro Donna M Mead  
University of Glamorgan/Prifysgol Morgannwg Pontypridd CF37 1DL UK/DU  
Tel/Ffôn 01443 483105 Fax/Ffacs 01443 483095



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Vice-Chancellor/Is-Ganghellor - Professor/Yr Athro David Halton

University of Glamorgan

Prifysgol Morgannwg

Faculty of Health, Sport and Science  
Cyfadran Iechyd, Chwaraeon a Gwyddoniaeth



20 April 2007

Anna Sydor  
16 Pen y Fai Road  
Aberkenfig  
Bridgend  
CF32 9AA

Dear Anna

**Re: Application for Transfer from MPhil to PhD**  
**'A phenomenological study of young men's experience of addressing their sexual health and the effect their masculinities have on this'**

I am pleased to inform you that at its meeting held on the 18<sup>th</sup> April 2007, the Faculty of Health, Sport and Science Research Programmes Committee approved your application to transfer to PhD.

Your transfer will take effect from the 3 April 2007.

If you require any further information please do not hesitate to contact me.

Yours sincerely,

**Karen Roberts**  
Secretary – FRPC

cc: Dr Paul Wheeler, Dr Roiyah Saltus, Dr Sandy Kirkman



Dean of Faculty/Deon y Cyfadran Professor/Yr Athro Donna M Mead  
University of Glamorgan/Prifysgol Morgannwg Pontypridd CF37 1DL UK/DU  
Tel/Ffôn 01443 483094 Fax/Ffacs 01443 483118



Vice-Chancellor/Is-Ganbhellor - Professor/Yr Athro David Balton

## **Appendix Thirteen**

### ***Model for reflective practice (Johns and Freshwater, 1998).***

#### **Description**

Write a description of the experience.

What are the key issues within this description that I need to pay attention to?

#### **Aesthetics**

What was I trying to achieve?

Why did I act as I did?

What are the consequences of my actions?

- For the patient and family
- For myself
- For people I work with

How did I feel about this experience when it was happening?

How did the patient feel about it?

How do I know how the patient felt about it?

#### **Personal**

What internal factors influenced my decision-making and actions?

What external factors influenced my decision-making and actions?

What sources of knowledge did or should have influenced my decision making and actions?

Ethics

Could I have dealt better with the situation?

What other choices did I have?

What would be the consequences of these other choices?

#### **Ethics**

Could I have dealt better with the situation?

What other choices did I have?

What would be the consequences of these other choices?

## **Reflexivity**

How can I make sense of this experience in light of past experience and future practice?

How do I **NOW** feel about this experience?

Have I taken effective action to support myself and others as a result of this experience?

How has this experience changed my way of knowing in practice?