UNIVERSITY OF SOUTHAMPTON

YOUNG MEN'S SEXUAL BEHAVIOUR AND USE OF CONTRACEPTION

by Stephen Pearson

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ABSTRACT

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Previous research into young men's sexual behaviour, use of contraception and sexual health services is sparse. With sexual health campaigns promoting use of the condom (a male method of contraception), the need for more understanding of these topics is vital. This thesis uses data from 43, semi-structured, long interviews with men aged 16-29 from southern England. The interview schedule encouraged discussion of current sexual and contraceptive behaviour, and family, social and learning influences in childhood and teenage years. For data on impressions of, and best ways of promoting, sexual health services, 9 focus group discussions were held with men aged 13-21 around England.

Even though the interview respondents have similar demographic and social backgrounds, they exhibit diverse sexual and contraceptive experiences. Stereotypes of irresponsible, prestige-driven sexual behaviour generally are not borne out. The emergence of the Human Immunodeficiency Virus (HIV) dramatically changed the contraceptive environment, illustrated by the comparative experiences of the younger and older respondents. However, respondents of any age may not feel at risk of HIV infection. Good school education, non-sexual social interaction with young women and an emotionally 'warm' family environment are tentatively associated with contraceptive and communication outcomes. Problems with current sexual health promotion messages are highlighted.

Nationally, men are in the minority of sexual health service clients, and their sexual health needs are neglected. However, the 1990s have seen increased service uptake from young men. Services have the potential to increase their number of male clients by offering appropriate, male-friendly services and using well designed, tested and located methods of promotion.

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Data for this thesis were provided through two research projects - my gratitude to the funding bodies, and the research teams for allowing access:

a) 'Protocol Development for Comparative Studies on Social and Contextual Aspects of Heterosexual Conduct and the Risks of HIV Infection', funded by the European Commission, conducted by Roger Ingham, Emily Jaramazovic, Diane Stevens, Ine Vanwesenbeeck and Gertjan van Zessen.

b) 'Promoting Young People's Sexual Health Services', funded by the Brook Advisory Centres and Health Education Authority, conducted by Deborah Cornah, Ian Diamond, Marisa Hyde, Roger Ingham, Steve Pearson and Stephen Peckham.

The National Survey of Sexual Attitudes and Lifestyles provided valuable background information. My thanks to the principal investigators Julia Field, Anne Johnson, Jane Wadsworth and Kaye Wellings for allowing access, and The Data Archive for mounting the dataset.

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Final gratitude goes to the hundred or so young men who took time out of their days to provide personal, detailed information on their lives. I hope this thesis reflects the diversity and richness of their experiences.

CHAPTER ONE - INTRODUCTION

1.1 SEXUAL HEALTH

> I don't know, the people here, I mean during the day they (pause) English people are a bit different. During the day you see them and they're very polite you know umm, sex is sort of like a bit of a taboo, I think. During the night they drink, they get drunk, oh, they just copulate like rabbits, umm, I think. I don't know. I don't know how the English education system is so I don't know if you get a sexual education at school. Do you?
>
> *[167:56] Respondent brought up overseas, now living in England.*

The causes and consequences of sexual behaviour in Britain are issues of interest not only for this respondent, but leading policy makers of this country. As a pleasurable, personal and sensitive aspect of people's lives, sexuality always has attracted attention and interest. Inquisitiveness, however, is not a good enough reason to devote an entire thesis to the topic. Why does this thesis focus on sexual and contraceptive behaviour, and why are young men the research group of interest?

Answers to these questions are found by outlining some features of young people's sexual behaviour in Britain, and the role of young men. A useful starting point is provided by a 1974 World Health Organisation document (cited in Langfeldt & Porter, 1986) that identifies three basic elements of sexual health:

a) a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic

b) freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships

c) freedom from organic disorders, diseases and deficiencies that interfere with sexual response and reproductive functions.

Using these criteria, how sexually healthy are young people in Britain? Profiling all aspects of these three criteria is difficult, as some data are more readily available than others.

Starting with criterion a), Respondent 167's (quoted above) describes people getting "drunk" and "copulating like rabbits", suggesting some positive sexual response and *enjoyment* is taking place. More worrying for policy makers, however, is Britain's record on *control* of reproductive behaviour. In July, the Social Exclusion Unit (1999) published their report on teenage pregnancy for the British government. Prime Minster Tony Blair's forward to the report begins with the statement:

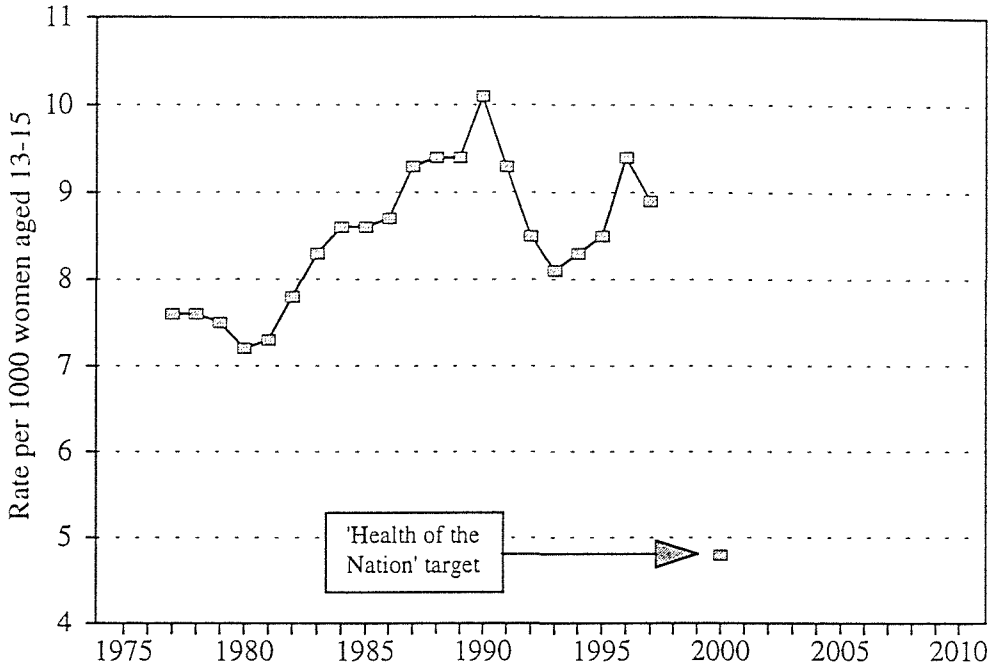
> "Britain has the worst record on teenage pregnancies in Europe. It is not a record in which we can take any pride. Every year some 90,000 teenagers in England become pregnant. They include nearly 8,000 who are under 16. Some of these teenagers, and some of their children, live happy and fulfilled lives. But far too many do not." (p.4)

The large proportion of conceptions terminated (50% of conceptions occurring to women aged under 16, 37% of conceptions occurring to women aged under 20 [Office for National Statistics, 1999b]) and attitudinal data (Allen *et al.*, 1998) suggest many teenage conceptions are unintended. Consequences associated with teenage motherhood including poor antenatal health, poor child and mother health, relationship breakdown and adverse educational, employment and relationship outcomes in adulthood (Social Exclusion Unit, 1999). Although very much a minority behaviour, the significant consequences of a teenage conception are evident. Since 1990, both British governments have set targets for reducing teenage conceptions, displayed in Figure 1.1. The *Health of the Nation* year 2000 target (Department of Health, 1993b) is unlikely to be reached, and whether the current Labour government's *Our Healthier Nation* year 2010 target (Department of Health, 1999b) has any more success remains to be seen.

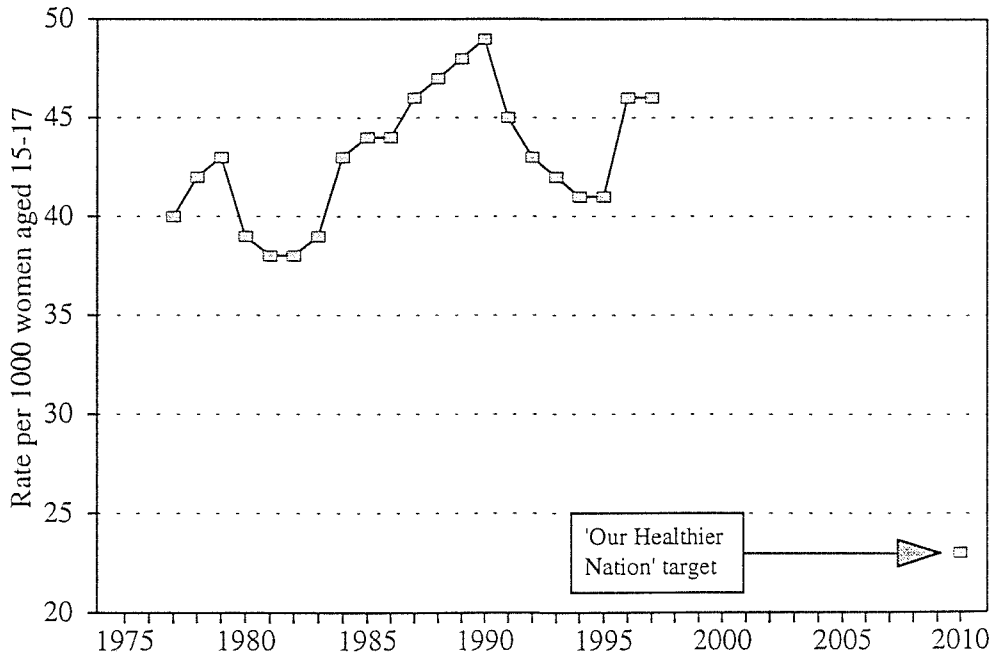
Criterion c), freedom from organic disorders and diseases, also warrants concern. Although harder to measure reliably, indicators of sexually transmitted infections suggest low, but notable, sexual ill health among British teenagers (Nicoll *et al.*, 1999). The number of new cases among people aged 16-19 increased substantially between 1995 and 1998 (Public Health Laboratory Service, 1999). Although of low prevalence among all young people, the immediate and subsequent (for example, associations with pelvic inflammatory disease, infertility and cervical cancer for women [Nicoll *et al.*, 1999]) health consequences of sexually transmitted infections suggest attention should be focused on promoting good sexual health.

Figure 1.1 - Conception Rates for Women Aged Under 16 and Under 18, England and Wales, 1977-97.

a) Women under age 16



b) Women under age 18



Notes: The 'Our Healthier Nation' target is a halvening of the April 1999 rate by 2010. As the April 1999 rate is unknown currently, the target displayed assumes the April 1999 rate will be around the 1997 rate of 46 per 1000.

Sources: Social Exclusion Unit. (1999). Teenage Pregnancy. London: The Stationery Office.

Department of Health. (1996a). Public Health Information Strategy. Overview on Sexual Health. Department of Health.

Lest the assumption be that some young people are unique in their sexual ill health, British people aged in their 20s and 30s exhibit similar indicators. One quarter of conceptions to women aged 20-24 are terminated, falling to below 20% for women aged in their late 20s and 30s (Office for National Statistics, 1999b). Of selected sexually transmitted infections seen at genitourinary medicine clinics[1], numbers are highest for men in the 25-34 age group (Public Health Laboratory Service, 1999a).

Many British people have healthy sexual lives, with control over their sexual and reproductive behaviour, pleasure, pride and fulfilment, free of disorder and disease. Others, however, do not. Can increased understanding of young men's sexual and contraceptive behaviour help people to have healthier sexual lives? The following sections consider the extent of previous research, rationale for research, and how this thesis intends to contribute to our understanding of this topic.

1.2 PREVIOUS RESEARCH

A striking point to emerge from reviewing the literature is a lack of research on men's as compared to women's sexual or contraceptive behaviour in Britain. Only four previous studies have concentrated solely on British heterosexual men:

a) Jean Morton Williams' (1976) exploratory study on attitudes towards contraception among men aged 18-45
b) Brenda Spencer's (1984) focus group discussions for the London Rubber Company on young men's attitudes towards sexuality and contraception
c) David Forman and Clair Chilvers' (1989) descriptive study of the sexual behaviour of men aged 15-49
d) Daniel Wight's (1993a, 1994abc; Wight & West, 1999) detailed investigation of the sexual and contraceptive behaviour of men aged 19 in Glasgow.

[1] Infectious syphilis, uncomplicated gonorrhoea, uncomplicated chlamydia, genital herpes and genital warts.

Useful findings have also resulted, however, from studies focusing on men *and* women (for example, Schofield, 1965, 1973; Farrell, 1978; Cooper *et al.*, 1992a; Wellings *et al.*, 1994; Holland *et al.*, 1998). Several reasons explain why more research has investigated female rather than male heterosexual and contraceptive behaviour. First, currently available contraceptive methods, and therefore contraceptive services, are directed primarily at the female user. Three main methods of contraception, the male condom, male sterilisation and withdrawal, work on the male reproductive physiology. The Family Planning Association's *Contraceptive Handbook* (Belfield, 1993) details at least fifteen methods aimed at the female reproductive physiology. As explored further in section 7.1, less than 10% of sexual health service clients in Britain are male.

Over the century, development of new or improved contraceptive technology has concentrated on female-orientated methods; the lack of funding for male methods has been criticised (Diller & Hembree, 1977; Chng, 1983), and estimated as accounting for only 8% of the world 'contraceptive budget'[2] (Spencer, 1988). Diller and Hembree (1977, p.1273) refer to a "vicious cycle of disinterest and relative stagnation in the scientific and commercial community", in which resources were directed towards female-orientated methods to the detriment of male-orientated methods. Since these authors wrote, however, the World Health Organisation has had success with an injectable hormonal contraceptive for men (Aribarg *et al.*, 1996), and clinical trials in America and Britain have tested an injectable or patch hormonal contraceptive in combination with an oral contraceptive (Waites, 1993; "Male pill breakthrough", 1999).

Why are most contraceptive methods aimed at the female user? It is debatable whether physiology makes fertility regulation easier in a woman than a man (Diller & Hembree, 1977; Nieschlag & Waites, 1996; Potts, 1996). However, the underlying aims of fertility regulation are different. From the 1920s onwards, pioneers of family planning stressed the need to improve women's health and free them from the burden of unwanted childbearing (International Planned Parenthood Federation, 1984). Undeniably, the fact that a woman (as opposed to a man) is affected most by an unintended conception helps to explain why contraceptive methods developed this century were oriented towards the female user. The emergence and high uptake of the pill in Britain in the 1960s transferred much of the

[2] Although what the world 'contraceptive budget' actually consists of is not stated by the author.

responsibility for family planning to the female user. As a result, the extent to which many men felt responsibility for contraception diminished. Meredith (1983, p.39) believes "what may have been lost to the post-pill generation of male youth is the awareness of consciousness of the subject of protection of pregnancy which accompanied traditional (condom) purchase and use".

Another factor cited to explain less research on men is different societal and cultural attitudes towards male and female behaviour. Men are perceived as less responsible and concerned about using contraception, and less likely to obtain and provide contraception than women. Societal and media stereotypical notions of single men employing 'love them and leave them' tactics, machismo, strong and unemotional men reinforce the belief that men are just not interested in contraception (Diller & Hembree, 1977). Even academic journals are not immune: consider this extract from a 1985 editorial in *The British Journal of Family Planning*:

> "The tragic thing is, [certain] attitudes among young men are all too frequent these days. Getting a girl pregnant, or giving her VD, or playing fast and loose with her emotions are all regarded as rather amusing activities ... In short, the 'Screw 'em and leave 'em' school of though among young men is causing a lot of trouble!" (Delvin, 1985, p.101)

Increased female labour force participation since the 1960s, coupled with the increasing importance of feminism and women's movements, meant that women were making substantial progress in social and personal development (Wellings, 1986). While an increasing amount of research on female sexuality complemented these social developments, research on masculinity and male sexuality was neglected. Research on masculinities in the 1970s and 1980s tended to be from a feminist perspective and essentially presents masculinity as problematic and a barrier to women's development.

Over the late 1980s and 1990s, however, more research on men's heterosexual and contraceptive behaviour has been undertaken. The emergence of HIV in the mid 1980s prompted research into condom use, and hence the role of male and female partners in heterosexual contraceptive use. More research is being undertaken into masculinities and men's sexualities (for example, Connell, 1995; Mac an Ghaill, 1996b). A growing body of research examines the contraceptive and sexual behaviour of men in Africa, Asia and South America (see Drennan, 1998).

1.3 RATIONALE

So, why is research needed on young men's sexual and contraceptive behaviour? Two main arguments are proposed. First, this thesis will support the concept that young men are a distinct group of contraceptive users, and have their own sexual and reproductive rights. Research is needed to inform health and public policy makers to recognise and support these rights. A useful definition of 'reproductive rights' is given by the Programme of Action approved by consensus at the International Conference on Population and Development (ICPD), held in Cairo, 1994. The document provides a holistic strategy for population and development around the world for the next 20 years. Early on, the document states:

> "[Reproductive] rights ... rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence." [United Nations, 1999, p.2]

A characteristic of this and other policy documents, however, is that more prominence is given to women's rather than men's reproductive rights. Given the inordinate power men in many cultures have over decision making around heterosexual behaviour and family planning (Gallen, 1986; Berger, 1996), this emphasis is justified. The two ICPD Actions concerning men's sexual and reproductive behaviour are reproduced in Table 1.1. The overall tone of the Programme suggests a disparity in how societies should view men's and women's behaviour. Basu (1996) argues that the document reinforces the view that women have *rights* to reproductive health, family planning and contraception, whereas men have *responsibilities* in these areas. Men are portrayed as mere partners to contraceptive users, or as barriers to women's reproductive health. Little merit is given to the reproductive *rights* of men, or the reproductive *responsibilities* of women.

A similar message is apparent in the British government commissioned report on teenage pregnancy (Social Exclusion Unit, 1999). While identifying a new focus on young men as *"half of the solution"* (p.8), the key actions for 'boys and young men' exclusively focus on raising awareness of the *responsibilities* of sexual behaviour and fatherhood.

Table 1.1 - Actions from the International Conference on Population and Development Programme of Action Concerning Men's Sexual and Reproductive Behaviour.

Section	Action
III. Gender equality, equity, and empowerment of women **D. Advocacy for gender equality and equity**	50. All leaders at all levels, as well as parents and educators, should promote positive male role models that facilitate boys to become gender-sensitive adults and enable men to support, promote and respect women's sexual and reproductive health and reproductive rights, recognising the inherent dignity of all human beings. Men should take responsibility for their own reproductive and sexual behaviour and health. Research should be undertaken on men's sexuality, their masculinity and their reproductive behaviour.
IV. Reproductive rights and reproductive health **A. Reproductive health, including family planning and sexual health**	52. Governments, in collaboration with civil society, including non-governmental organisations, donors and the United Nations system, should: (g) Promote men's understanding of the roles and responsibilities with regard to respecting the human rights of women; protecting women's health, including supporting their partners' access to sexual and reproductive health services; preventing unwanted pregnancy; reducing maternal mortality and morbidity; reducing transmission of sexually transmitted diseases, including HIV/AIDS; sharing household and child-rearing responsibilities; and promoting the elimination of harmful practices, such as female genital mutilation, and sexual and other gender-based violence, ensuring that girls and women are free from coercion and violence.

Source: United Nations. (1999). Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development. A/S-21/5/Add.1. New York: United Nations.

Why men have reproductive rights are discussed in an International Planned Parenthood Federation (1984) policy document. Six grounds are identified:

a) **biological grounds** - as reproduction requires male involvement, men have a right and responsibility to be involved throughout the process from contraception to child rearing.

b) **moral grounds** - men should be involved in contraceptive decisions due to their obligations to foresee the implications of a conception and birth.

c) **emotional and psychological grounds** - involvement in reproduction is a basic element in the development of men's emotional maturity and human qualities.

d) **sexual equality** - making joint decisions about contraception and respecting women's reproductive rights is an expression of sexual equality.

e) **economic grounds** - to promote the economic well-being of individuals, families, communities and society in general, by avoiding unintended births.

f) **health grounds** - to share with a partner any health burdens of using contraception.

The second main argument is hinted at in the Social Exclusion Unit's (1999) quotation that young men are half of the solution (or problem). Men play an important role in many contraceptive decisions in heterosexual activity. Asked why health professionals should involve men in contraceptive decision making, Robert Johnston, a New Jersey health professional, replied *"Men are already involved, and we have to understand how they're involved"* (Edwards, 1994, p.77). Societal perceptions that men are not interested in family planning have been weakened by research. Not only has the use of 'male' methods (that is, the condom and male sterilisation) increased among applicable age groups, but qualitative research reveals the significant extent of men's desired involvement in use of contraception (Morton-Williams, 1976; Cooper *et al.*, 1992; Mathie *et al.*, 1992; Wight 1994a).

Therefore, policies aiming to improve the sexual health of young people in Britain need to identify, acknowledge and respect the rights and responsibilities of young men. Stereotypes of young men's behaviour need to be examined, and challenged where necessary.

1.4 RESEARCH AIMS AND OBJECTIVES

The general aims of this thesis, therefore, are:

a) to increase understanding of British heterosexual young men's sexual and contraceptive behaviour

b) to provide policy-relevant information to enable British heterosexual young men and their partners to have healthier sexual lives.

The selection of specific research objectives was determined by three factors. First, what objectives are likely to provide the most useful and relevant information for the general aims of the research? Second, what research objectives are achievable given the context of a PhD thesis? The third factor relates to one of the primary data sources used in the thesis. As explained further in Chapter 2, this thesis contains secondary analysis of data collected in a separate research project, with its own research aims and objectives. What is considered in Chapter 2, therefore, is what thesis objectives are appropriate given the methodology, format and quality of the data collected in this separate research project.

The seven research objectives put forward are:

a) to examine the importance and meanings of the sources for heterosexual young men's learning about sex

b) to investigate heterosexual young men's socialisation patterns, including non-sexual interaction with young women

c) to explore and understand patterns and trends in the number and type of young men's heterosexual partnerships

d) to identify and understand ways in which young men adopt behaviour to protect themselves against risks in heterosexual activity

e) to identify possible associations between a young man's family influences, learning about sex, socialisation, and his heterosexual and contraceptive behaviour

f) to examine patterns and trends in heterosexual young men's use of sexual health services

g) to understand reasons behind use (and non-use) of sexual health services, and identify strategies to help increase levels of use.

1.5 THEORETICAL PERSPECTIVES

Previous research in the social sciences has provided different theoretical perspectives for studying and understanding young men's masculinity. Four of the more prominent approaches are discussed below, with a consideration of their roles in this thesis.

a) Social psychology

Sexual behaviour has received much attention in social psychology, with several prominent social cognition models formulated. Using attitudinal, normative and behavioural data collected through questionnaires, such models have been used to explain reported sexual and contraceptive behaviour. Prominent models include

i) Health Belief Model (Becker, 1974), in which factors determining the perception of risk of illness (susceptibility and severity of consequences) are compared to an evaluation of behaviour to counteract this risk. Cues to action may trigger a change in health behaviour. Examples of applications for contraceptive use include Herold (1983), Lowe and Radius (1987) and Wulfert (1993).

ii) Theory of Reasoned Action (Fishbein & Ajzen, 1975), and the Theory of Planned Behaviour (Ajzen, 1988), in which reported behaviour is best predicted by an individual's intentions. Intentions are formed through individual attitudes, subjective norms and perceptions of behavioural control, with each component affected by prior determinants. Examples of applications to contraceptive use include Ewald and Roberts (1985), Kashima and colleagues (1993), Morrison and colleagues (1994), and Reinecke and colleagues (1996).

iii) Self-efficacy theory (Bandura, 1977), referring to the degree of personal control a person feels they have over behavioural change. Self-efficacy can play a crucial role in making a decision to change health behaviour, and maintaining that adopted behaviour (Schwarzer & Fuchs, 1995). Examples of applications to contraceptive use include Rosenthal and colleagues (1991), Basen-Engquist and Parcel (1992), and Joffe and Radius (1993).

Some researchers argue that such an individual and rationalistic-based approach is inadequate to explain fully contraceptive behaviour (Davies & Weatherburn, 1991; Ingham *et al.*, 1992). Any sociosexual activity is between two people, and contraceptive use may be influenced by two sets of intentions, attitudes and any subsequent negotiation (Kent *et al.*, 1990; Browne & Minichiello, 1994). The couple may not have equal power in any negotiation (Holland *et al.*, 1998). Other important factors that may override a 'rational' decision include the physical arousal, desire and emotions involved in sexual activity, and intoxication (Ingham *et al.*, 1992; McEwan *et al.*, 1992). However, more sophisticated social cognition models can take account of some of these factors (for example, Kashima *et al.*, 1993).

A conventional application of one of these social psychological approaches is not an aim of this thesis. Much of the analysis in the thesis derives from secondary analysis of qualitative data; the theoretical approaches outlined above, however, require quantitative data. Nevertheless, the theories do provide structure for the discussion of sexual risk in section 6.3.

b) Symbolic interactionism

Symbolic interactionism (Blumer, 1969, p.5) is defined as "seeing meaning as social products, as creations that are formed in and through the defining activities of people as they interact". The three premises of Blumer's theory are

i) We act toward things based upon our subjective meanings towards them,
ii) these meanings arise out of social interaction,
iii) these meanings are modified through the interpretive process.

Applying this theory to sexual behaviour, Gagnon and Simon (1973) used the phrase 'sexual script' to refer to the learnt 'rules' of sexual behaviour. 'Rules' include what is appropriate sexual activity, the context, initiation and procedure of a sexual encounter, and who is an appropriate sexual partner. Sexual scripts are compiled prior to sociosexual activity based upon cultural messages on what is appropriate for someone of a certain age and gender. However, scripts may be reflected upon and modified with increasing sexual experience.

Examples of the use of sexual scripts for young people's sexual behaviour include Maticka-Tyndale (1991), and Gillmore and colleagues (1996). The concept of sexual scripts will be considered in Chapters 3 and 4 to see if they provide insight to the themes emerging from the data.

c) Discourse analysis

A useful framework for conceptualising differences in attitudes towards sexuality and relationships is discourse analysis. This approach, an aspect of symbolic interactionism, was applied to heterosexual relationships by Hollway (1984, p.227), who defines a discourse as "the meanings and incorporated values which attach to a person's practices and provide the powers through which he or she can position him or herself in relation to others". Hollway argues that people place them as either the subject or object of a discourse, but as discourses concerning sexuality are traditionally differentiated by gender, the taking up of these positions is not equally available to both sexes. Further work by other authors (Gilfoyle *et al.*, 1992; Miles, 1993; Wight, 1994a; Dallos & Dallos, 1997) has introduced and developed new discourses to accompany the three discourses constructed by Hollway (1984). Based upon their work on Australian young people, Moore and Rosenthal (1992, 1993) argue that the complexity and diversity of young people's sexual behaviour is not fully captured by concentrating solely on discourses. Nevertheless, the discourses identified by the above authors will be referred to in the discussion of interpersonal strategies and sexual partnerships in Chapters 4 and 5.

d) Feminist approaches

To quote from Holland and colleagues (1998, p.15); "feminist research is situated in a feminist theory and politics that identifies the gender relations of the UK in the twentieth century as hierarchical power relations, and judges that hierarchy to be unjust and unnecessary". The social construction of heterosexuality is argued to privilege men's role in heterosexual relationships, heterosexual activity and use of contraception. Equally, the rigid and restricting expression of male sexuality and masculinity causes difficulties for young men unwilling or unable to live up to those roles (Holland *et al.*, 1993). The most

comprehensive British study on young people's gendered relations from a feminist perspective is provided by the Women, Risk and AIDS and Men, Risk and AIDS Projects (Holland *et al.*; 1990, 1991ab, 1993, 1994, 1998).

Feminist perspectives provide some insight to the analysis of interpersonal strategies and sexual partnerships in Chapters 4 and 5 respectively. However, the topics of power and masculinity were not prioritised as crucial areas of investigation in the original semi-structured interview study, a main data source for this thesis.

1.6 THESIS STRUCTURE

The structure of the thesis reflects an attempt to present a coherent and consistent argument to address the above objectives. Chapter 2 discusses the methodology used in the two research projects, and the analytic approach used in this thesis. Analyses and findings are presented in Chapters 3 to 7. The research objectives suggest a sensible and chronological order for the thesis sections. For example, consideration of sexual partnerships precedes analysis of use of contraception, as contraceptive use cannot occur without sexual activity. Learning about sex is considered in Chapter 3, before discussion of socialisation patterns in Chapter 4, and sexual partnerships in Chapter 5. As will become apparent, however, there is temporal overlap in the scope of these chapters, for example, learning continues while sexual partnerships are experienced.

In addition to chronological ordering, the sections are ordered to progress from external to more individual factors. The external influences of sources of learning and socialisation, therefore, combine to provide a background to discussion of sexual partnerships. Chapter 6 then considers the use of contraception within these partnerships. The exception is the last findings Chapter, 7, that takes a wider perspective in considering young men's use of sexual health services. Finally, Chapter 8 draws together results from Chapters 3 to 7 to discuss the thesis' findings.

CHAPTER TWO - METHODS

2.1 INTRODUCTION

The research objectives listed in section 1.4 address a range of aspects of young men's sexual and contraceptive behaviour, and require drawing upon different sources of data. Two main sources are:

a) **Semi-structured interviews**. Research objectives a) to e) listed in section 1.4 will be addressed through secondary analysis of data collected by other authors (Ingham *et al.*, 1996) of semi-structured interviews with British young men.

b) **Focus groups**. Research objectives f) and g) listed in section 1.4 will be addressed through primary analysis of data collected by this author and colleagues (Pearson *et al.*, 1996) from focus group discussions with British young men.

Summaries of these two research projects are given in Table 2.1. Fuller descriptions of the research designs used in the two projects are available in Ingham and colleagues (1996) and Pearson and colleagues (1996). Rather than replicating the content of these two publications, this chapter focuses on:

a) whether secondary analysis of the semi-structured interview data is appropriate for the thesis objectives

b) whether primary analysis of the focus group data is appropriate for the thesis objectives

c) the main features of the two research designs

d) the analytical procedure for both sets of data

e) how the research designs may influence the reliability and validity of thesis findings.

Table 2.1 - Summaries of Two Research Projects.

Project title	Researchers	Commissioning body	Current author's involvement	Data collected	Data used in the thesis
Protocol Development for Comparative Studies on Social and Contextual Aspects of Heterosexual Conduct and the Risks of HIV Infection	Roger Ingham[1] Emily Jaramazovic[1] Diane Stevens[1] Ine Vanwesenbeeck[2] Gertjan van Zessen[2]	European Commission, Biomedical Concerted Action	None, apart from analysis in this thesis	167 semi-structured interviews with young people in Britain and the Netherlands	43 interviews with British young men
Promoting Young People's Sexual Health Services	Deborah Cornah[1] Ian Diamond[1] Marisa Hyde[1] Roger Ingham[1] Stephen Pearson[1] Stephen Peckham[1]	Brook Advisory Centres and Health Education Authority	Full, co-involvement in design, fieldwork, analysis and writing	18 single-sex focus groups with young people in Britain	9 focus groups with British young men

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2.2 SEMI-STRUCTURED INTERVIEWS

2.2.1 Introduction

The semi-structured, in-depth interview is a common instrument in qualitative research. With sufficient rapport, flexibility and time, a large amount of detailed information can be collected. The interview schedule lists core questions representing the research topics of interest, giving the interview some structure. However, the respondent is able and encouraged to respond in any manner they want, and introduce new topics of importance or interest to themselves. McCracken (1988) highlights the effectiveness and productiveness of this instrument; without taking up too much of the respondent's time, the researcher can enter the life world of the respondent.

The semi-structured interviews used in this thesis were part of a research project, conducted by Roger Ingham and colleagues (1996), aiming to produce a research protocol to investigate the social and contextual aspects of heterosexual behaviour, and the risk of HIV infection. A protocol with standard methods, sampling, and analyses would enable cross-national comparisons across the domain of the funding body, the European Commission. The protocol was developed and tested on respondents in Britain and the Netherlands; thus, 167 long, semi-structured interviews were conducted with young men and women in the two countries.

Analysing the content of the interviews was *not* a primary aim of Ingham and colleagues' research. Attention focused on constructing, testing and detailing an appropriate research design to be used by subsequent researchers. The lack of time and resources available for content analysis was felt to be a drawback, given the rich and valuable information in the interviews. Early on in the timetable of this thesis, therefore, Roger Ingham approached this author to discuss whether some of the interviews could be utilised to address the thesis research objectives. After discussion, it was decided that a secondary analysis of the data from the interviews with British young men would be rewarding.

Unlike with quantitative data, secondary analysis of qualitative data is rare in the social sciences (Thorne, 1990). Some researchers question the feasibility of conducting secondary analysis, given the importance of the original researchers' 'self' (identity, values and so on)

in the collection and interpretation of qualitative data (Denscombe, 1998). Heaton (1998) suggests four key issues that should be considered before secondary analysis proceeds, these are considered separately below in relation to this thesis.

a) **Compatibility of the data with secondary analysis.** How well do the characteristics and quality of the original data match the research objectives of this thesis? Because the data collection preceded the formulation of this thesis' research objectives, flexibility existed in formulating the objectives to reflect the nature, and draw upon the strengths, of the data. First, the original data include a subset of 43 interviews with British young men, matching the population of interest for this thesis. Second, the current research objectives are appropriately addressed through the use of semi-structured interviews as a research instrument. Sexuality is a sensitive and personal topic about which people may be reluctant, embarrassed or lack a suitable language to discuss (Catania *et al.*, 1990; Spencer *et al.*, 1988; Wight & West, 1999). The presence and skills of the interviewer enable the credibility, importance and confidentiality of the research to be emphasised. In combination with the rapport developed by a skilled interviewer, an honest and full reporting of a respondent's sexual and contraceptive behaviour should be forthcoming.

Similarly, the context of an interview facilitates a full and clear reporting of a person's experiences. Sufficient time is available to discuss a range of topics, particularly important given the need for information not only on recent sexual behaviour, but also possible antecedent factors in childhood and teenage years. The interviewer is present to ask follow-up, probing questions to encourage the respondent to expand and elucidate responses, or to rephrase and clarify questions on the interview schedule.

However, an interview is a peculiar social event (McCracken, 1988), and its context should be considered in relation to the reliability and validity of reporting. Interviewer skills and personal characteristics (such as age, gender, appearance) can influence how respondents report themselves. Certain attitudes and behaviours may be approved or disapproved in a culture, causing some respondents to report themselves falsely, thus presenting a positive image to the interviewer (Catania *et al.*, 1990). Respondents' abilities to report, understand and explain their behaviours

(including recalling past events) will vary whatever the interviewer's role. Finally, as Leonard (1980, p.71) states, a respondent is making a "reconstruction of the past from the point of view of the present". There is no guarantee that past events occurred as reported. An interviewer merely hears a respondent's views and recollections of events, reported within the context of the interview.

Limitations of secondary analysis are apparent in some sections of the thesis. The problem of missing data arises in describing the respondents' sexual partnerships and contraceptive use in sections 5.2.2 and 6.1 respectively. One reason for these missing data is that the original research design and interview schedule did not prioritise these topics to the extent necessary for this thesis' objectives. This source of error is acknowledged and discussed in the aforementioned sections.

b) **Position of the secondary analyst.** What is the relationship of the secondary analyst (this author) to the research team (Ingham *et al.*, 1996), and how does this affect access to, and understanding of, the data? While not being a member of the original research team, this author was given permission to access the audio recordings, anonymised transcripts and interview notes of the 43 interviews with British young men. Written information on the research design was also made available. The primary researcher for the British part of the study (Ingham) is a colleague at the University of Southampton and agreed to be an Advisor to this thesis, making himself available for consultation. The three interviewers for the British interviews were known by this author and also available for consultation.

c) **Reporting of original and secondary data analysis.** Are the original study design, methods and data quality issues described to accompany the secondary analysis? The rest of section 2.2 addresses this issue.

d) **Ethical issues.** Does secondary analysis honour the consent obtained in the original study? The original research team acknowledged that other researchers may be granted access to the data, and therefore worded the consent form accordingly. The

anonymity of the respondents was preserved in the transcripts. However, any field notes which would reveal their identities were withheld from this author.

2.2.2 Recruitment

Much qualitative research uses a purposive sampling scheme, that is, selecting members of the target population who are likely to provide the most valuable data addressing the research objectives. Clearly, respondents should have some familiarity with the research topics, but they need not necessarily be representative of the population from which they are selected. As McCracken (1988, p.17) explains:

> "The purpose of the qualitative interview is not to discover how many, and what kinds of, people share a common characteristic. It is to gain access to the cultural categories and assumptions according to which one culture construes the world. How many and what kinds of people hold these categories and assumptions is not, in fact, the compelling issue. It is the categories and assumptions, not those who hold them, that matter."

The research aims of Ingham and colleagues' (1996) study concern young people's heterosexual conduct and HIV prevention behaviour. To achieve these aims, both men and women were targeted, the age range for selection was set at 16-29, and participants were required to report recent experience of sexual conduct, namely **at least two** new sexual partners in the previous year. The researchers also aimed to ensure the final sample included respondents from across the age range, and with different consistencies of condom use (always used, sometimes, never) in their sexual partnerships over the past year. Thus, the study used purposive sampling stratified by gender, age and condom use.

British interviews were conducted in Southampton and its surroundings, and London and its surroundings. A variety of recruitment methods aimed to produce heterogeneity in the final sample. Methods included print advertisements and features (local and national newspapers, magazines), mentions on television and radio programmes, teletext, email and Internet pages, posters at universities, stands at health fairs and flyers at parties and raves. Once a person expressed interest, they were provided with a pack including information on the aims and purpose of the study, how they would be involved, and a screening questionnaire. Upon returning a completed questionnaire and meeting the selection criteria, participants were

contacted to arrange an interview. Interviewing took place in the second half of 1995 and the first half of 1996. Eighty-six British young people aged 16-29 were interviewed, of whom forty-three were male.

Why would a person choose to participate in the research? For example, this respondent, discussing his school sex education, cites his general interest in sex as a motivating factor:

> *(So did you think that [sex education] was relevant to you, or not really?)* Not really, I didn't care because ... I was interested 'cause I've always had an interest in sex, it's been one of my favourite topics. This is why I agreed to do this [interview], umm, I love talking about it, so I've always been interested. [162:21]

Participation bias is often present in social science research; even Alfred Kinsey and colleagues (1948, 1953) acknowledged their participants may have been more extroverted, self-assured and sexually uninhibited (Catania *et al.*, 1990). Participation in sexual behaviour research may be motivated by the desire to receive payment, interest in assisting science, or feelings of guilt, concern or proud about one's sexual history (Catania *et al.*, 1990; Ingham *et al.*, 1996). Although some respondents in the current study reveal why they were motivated to participate, for others the reasons remain unknown. Similarly, based upon information provided though recruitment, participants will approach the research session with their own preconceptions. Whether upheld or not, expectations can include likely questions to be asked, the research procedure, and culturally 'desirable' or 'expected' responses. For example, the following respondent perceives his first substantive statement of the interview as what the interviewer probably 'wants to hear':

> *(Tell me a bit about your family background, what life was like at home when you were a child?)* Right. Looking at it from your point of view, that you probably want to hear, umm, my father wasn't that much of a father figure because he was very ill when I was younger. [156:01]

2.2.3 Profile of respondents

As stated previously, it is not expected or necessary that the sample be representative of all British young men. However, sexual attitudes, norms and behaviour vary between groups in a population, for example, by age, social class, ethnicity, lifestyle and subculture. Before the

respondent's experiences can be described and understood, their background and current characteristics need to be profiled.

Table 2.2 displays information on the demographic and sexual behaviour characteristics of the 43 respondents. This table is not meant to enable exact comparisons of the respondents to the reference groups shown in the last column. The two sets of data were collected using different methods, phrasing of questions, definitions, and so on. However, the tables aid a general profiling of respondents. The interview respondents are mostly in their early twenties, with a median age of 22 years. Forty of the forty-three respondents belong to the white ethnic group. In terms of occupation and social class, the sample largely consists of young men in full-time education, and with parents from professional and managerial social classes. This bias probably reflects the recruitment scheme discussed in the previous section. Since the British research was based at the University of Southampton, it attracted young people from the University and local colleges.

The last three rows of Table 2.2 display simple indicators of reported sexual behaviour. As a reminder, a selection criterion for the study was having at least two sexual partners (self-defined) in the last year[1]. Note that only one quarter of men of the same age from the NSSAL report this level of sexual activity. The respondents' reported number of lifetime partners also is much higher than for an equivalent group from the NSSAL. Clearly, the respondents originate from the more sexually active portion of this age group.

2.2.4 Procedure

Interviews took place at the site of the research project (University of Southampton) or at the respondent's home. For the latter, appropriate safety protocols were used by members of the research team. Care was taken to ensure the interviews took place in a quiet, private room with no-one except the respondent and interviewer present or within earshot. Three

[1] Although note that Table 2.2 shows four respondents (9%) reporting only *one* sexual partner in the last year. This apparent contradiction is because first, one respondent's definition of a sexual partner included someone with whom he had only oral sex. Second, three respondents reported two partners in the last year; however, it emerged in the interview that one of these partners occurred just over a year ago.

Table 2.2 - Profile of Interview Respondents' Demographic and Sexual Behaviour Characteristics.

Characteristic	Interview respondents	Reference group[1,2,3,4]
Age (years)		
16-19	23%	*none*
20-24	40%	
25-29	37%	
Median	22 years	
Occupation		
Full-time education	74%	34%
Work, non-manual	12%	⎫51%
Work, manual	5%	⎭
Looking for work	9%	11%
Other		3%
Socio-economic status of parent[5]		
Professional	⎫63%	7%
Managerial	⎭	23%
Intermediate	14%	18%
Skilled manual	16%	32%
Semi-skilled manual		15%
Unskilled manual	7%	5%
Ethnicity		
White	93%	92%
Black-Caribbean	2%	1%
Asian-Indian	2%	2%
Other	2%	4%
Sexual intercourse before age 16?		
Yes	37%	28%
No	63%	72%
Number of sexual partners, last year		
0		18%
1	9%	58%
2	37%	13%
3-4	26%	8%
≥5	28%	3%
Median	3 partners	1 partner
Number of sexual partners, lifetime		
≤1		27%
2	5%	10%
3-4	16%	21%
5-9	35%	20%
≥10	44%	22%
Median	8 partners	3 partners
Sample size	*43*	*varies*

Table 2.2 cont.

Notes: [1] - Reference group for occupation is men aged 16-25 in the Labour Force Survey, winter 1995/96 (Office for National Statistics, 1996a, Table 40). Occupations are based upon International Labour Office definitions. The persons in full-time education include persons in full-time education but undertaking some part-time work or economically inactive.

[2] - Reference group for socio-economic status of parent is persons aged 45-64 in the General Household Survey, 1995 (Office for National Statistics, 1997b, Table 4.26). The age range is chosen to approximate the interview respondents' parents' age at interview. Sample size is 5,526.

[3] - Reference group for ethnicity is men aged 15-29 from the England and Wales Census, 1991, adjusted for under-enumeration (Simpson, 1996, Table 3.1a).

[4] - Reference group for sexual behaviour is men aged 16-29 from the NSSAL (Wellings *et al.*, 1994, unpublished raw data). Sample size is 3,055. The NSSAL defines a 'sexual partner' as a person with whom the respondent had vaginal, anal or oral heterosex, whereas the interview study excludes oral sex. The age distribution of the interview respondents is younger than that of NSSAL men aged 16-29. To allow comparisons, therefore, the age-specific partnership counts of the NSSAL have been weighted to reflect the age distribution of the interview respondents.

[5] - For the interview respondents, status is taken as highest reached during the parents' lifetimes. If there is a difference between parents, the status is based upon the highest.

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interviewers were used; all were female, social science postgraduates and aged in their 20s or 30s. All had experience of conducting social science interviews, and had been fully briefed and trained on the requirements of the research.

How might the interviewers' characteristics influence the reliability and validity of findings? Clearly, the personal identity, presentation and behaviour of an interviewer can affect responses. However, the literature does not agree on whether interviewer and respondent characteristics should be matched or contrasted (Catania *et al.*, 1990; Fielding, 1995; Ingham *et al.*, 1996; Denscombe, 1998). In the current study, a male respondent may be embarrassed or unwilling to report his sexual behaviour to a female interviewer. Alternatively, he may relish the opportunity to boast and impress her. Given the format of male-to-male discussions on sexuality described later on in the thesis, some respondents may talk more openly and freely to a female than a male interviewer. Respondents may also give fuller and clearer reporting to a female interviewer in an attempt to explain male cultures and perspectives on life. Evidence of all these reactions is apparent across the interviews. However, this does not support using interviewers of a specific gender, and

predicting before the interview which respondents will provide more reliable or valid data to a male or a female interviewer is not possible.

The full interview schedule is included in Appendix 1. Its construction was based upon a review of relevant literature and theoretical frameworks for the study of heterosexual conduct and HIV prevention behaviour. The schedule was piloted and refined before the main stage of fieldwork.

At the beginning of the interview, the respondent is introduced to the aims and funding body for the study, the anonymity and confidentiality of responses, and the format of the interview. The interview schedule is organised into eight successive blocks. The first block collected simple demographic information, recorded in a template by the interviewer. As well as providing useful information on the respondent's characteristics, asking simple questions helps the respondent to feel more relaxed and comfortable. The next seven blocks are organised as a chronological progression through the respondent's family, social and sexual life. Each block contains core questions, suggested additional questions and prompts, and possible topics for expansion. The flexibility of the instrument allows the interviewer to use their own ordering, follow-up and supplementary questions. However, the core questions of each block cover topics of importance to the research objectives, and all core questions were therefore asked in all interviews. The eight blocks in the schedule are:

Block One	Pre-interview schedule - demographic, parental, relationship and general characteristics
Block Two	Childhood and family environment, and communication about sex
Block Three	Social context of secondary school period, including school sex education
Block Four	Social life since secondary school, including current well-being
Block Five	First sexual experiences, including first-ever intercourse
Block Six	Sexual and contraceptive behaviour over partnership history, including solosex activities
Block Seven	Sexual and contraceptive behaviour in the previous year, including most recent partner, and HIV prevention behaviour
Block Eight	Future plans and aspirations, including those relating to sexual behaviour

Most interviews lasted between two and three hours. A list of contact numbers for sexual health advice and information was provided routinely in case the interview raised any topics of concern to the respondent. Finally, a payment of £10 was provided.

2.2.5 Analysis

Having considered different texts addressing approaches to qualitative data analysis (for example, Dey, 1993; Denzin, 1994; Miles & Huberman, 1994), analysis of the data followed a four-stage process, based upon Marshall and Rossman (1994);

a) data formatting
b) data organising
c) generating categories, themes and patterns
d) testing emerging hypotheses against the data.

a) Data formatting

All interviews were recorded using a stereo microphone and high quality recording equipment. Additional information collated for each session included:

i) Block One template
ii) Block Six sketched timeline of sexual partnerships (optional)
iii) post-interview report, completed by the interviewer.

Recordings were then transcribed by a professional agency specialising in audio typing. Transcribing was done near verbatim, with important speech utterances (for example, pauses, sighs, laughter) and contextual comments (for example, mimes, hand signals) included. The transcribing agency then returned each transcript in computer text file format to the research team for checking, who then anonymised the text by censoring any names, locations and so on. The text files were backed up, and paper hard copies printed.

b) Data organising

The need for organising the data became apparent when faced with the output from the interviews. Once formatted, the transcripts total around 2,500 A4 pages of text. As in much qualitative research, the perils of 'data overload' (Miles & Huberman, 1994) are apparent. It is difficult, for example, to handle, sort, read and digest the text relating to one category across all the respondents' transcripts at any one time. Techniques are needed to sort, simplify, and summarise the data to aid the identification of categories and themes. A number of tools were used to achieve this:

i) **Code database.** An extremely useful tool for the interviews is the code database, that is, a quantitative representation of the content of each respondent's interview. After thematic analysis and selected case studies, the original research team (Ingham *et al.*, 1996) defined around 500 nominal, ordinal and continuous variables of relevance to the original research objectives. The data dictionary listing and defining these variables (Ingham *et al.*, 1995) is 150 A4 pages: some examples of variables used in this analysis are included in Appendix 2. Each transcript was then coded according to this scheme by the original interviewers, with checks to ensure coding was sufficiently consistent between different coders. The database was formatted as an SPSS datafile. The database and accompanying data dictionary were made available to this author, and used (and expanded upon with new variables being defined and coded) in the identification of categories, themes and patterns, described in the next section.

ii) **Sexual partnership database.** As discussed further in section 5.1, good reporting of the respondents' sexual partnership histories enabled a detailed description of the patterns and types of their partnerships. To facilitate this, an SPSS datafile was created by this author to catalogue all the respondents' partnerships involving penetrative intercourse. Around twenty variables were defined, for example, respondent number, age of respondent at the start of the partnership, steady or casual partnership, duration of partnership, and so on. Values were then assigned for the 665 partnerships reported by the 43 respondents over their lifetimes.

iii) **Summary sheets.** Figure 2.1 displays the template key used to create a summary sheet outlining important events in each respondent's life. The horizontal axis represents age of the respondent, and the vertical axis consists of four strata. Symbols and text in the lowest stratum relate to the respondent's sexual and contraceptive experiences. The next three stratas are available for information on the respondent's social life, education and work, and any other important life events reported. Once completed, each summary presents a succinct representation of a respondent's life up to interview, and facilitates an understanding of the context in which behaviour occurs at any point in time.

The principals of simplification and summarisation behind these three tools were used also in understanding contraceptive behaviour. Given the importance of this topic, detailed summary sheets were completed for each respondent, describing the context, method(s) and justifications for use of contraception in each of his sexual partnerships.

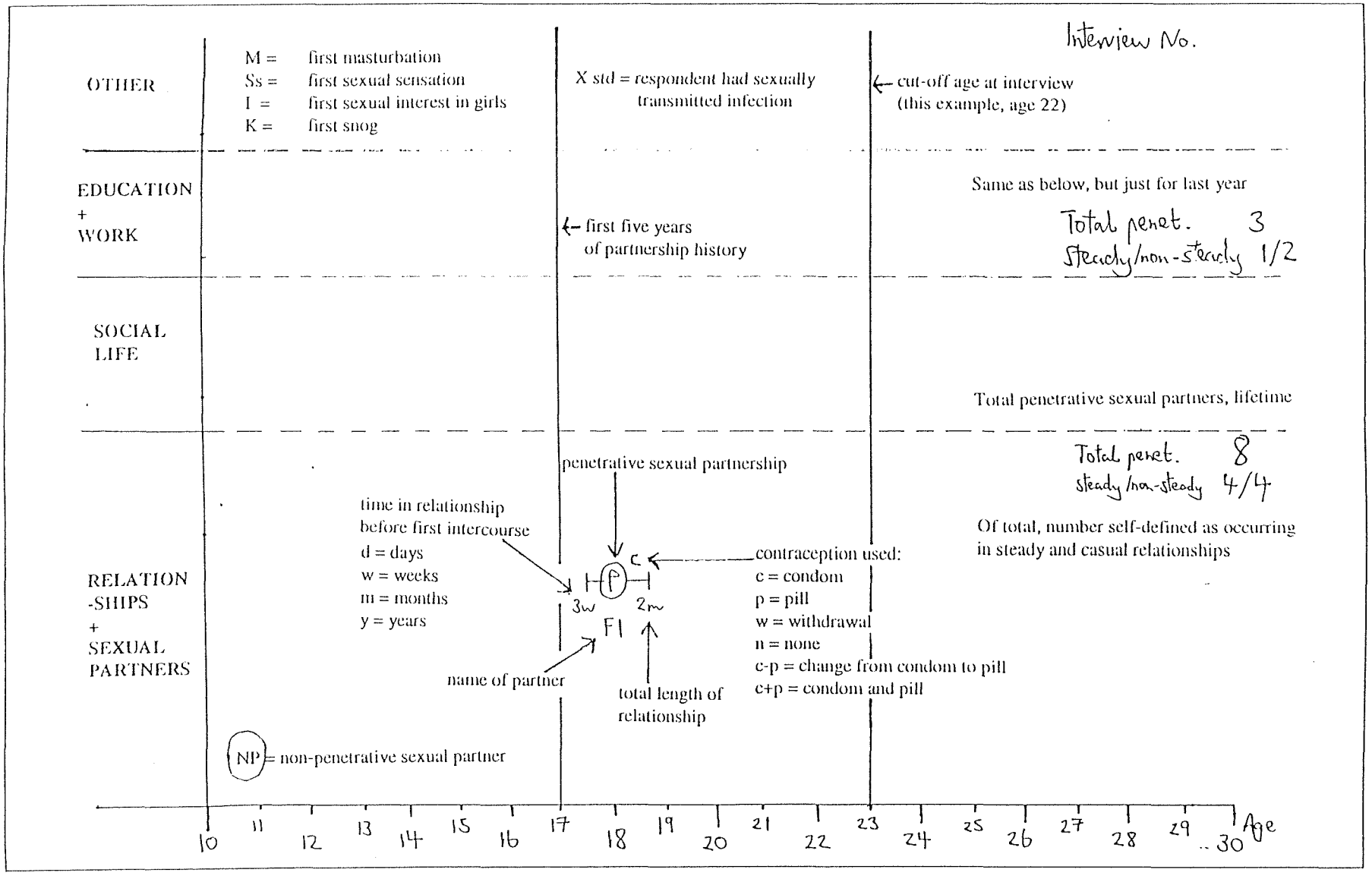
c) Generating categories, themes and patterns

The identification and definition of categories, and the examination of relationships between categories, underpins much of the analysis procedure. As Love (1994, p.1) writes;

> "A central question throughout these analyses was, "What is a theme?" How I was to recognize, invent, construct, deconstruct, reconstruct, and textualise themes?"

A common technique in qualitative data analysis is the use of computer software to handle, code and retrieve data (Fielding, 1993; Kelle, 1995). After constructing a codebook, segments of transcript are assigned a code by the researcher, and the computer searches for and retrieves all segments identified by that code. If the researcher has coded all transcripts accurately and reliably, this is an effective method for extracting all text relating to one theme or category. However, this approach was rejected for this analysis for two reasons. First, the existence of the code database and this author's increasing familiarity with the structure and content of the transcripts meant that text relating to a theme could be located easily. Second, constructing a codebook and coding 2,500 pages of text was felt to be unfeasible given the thesis timetable.

Figure 2.1 - Key for Template for Interview Respondent Summary Sheets.



Therefore, this analysis rests upon a systematic reading of text relating to each category or theme across all 43 transcripts, aided by the data organisation tools listed above. A typical procedure for each research objective listed in section 1.4 is outlined below. Although outlined sequentially, the stages of the analytical process are intertwined, as new information emerging from the transcripts suggests new themes of interest, new variables and so on.

First, the relevant published literature around each objective was reviewed - these reviews are included in the appropriate Chapter sections. The literature of previous research suggested certain initial lines of enquiry to investigate in the transcripts. Second, the code database was consulted for defined variables relating to the initial lines of enquiry. Simple descriptions and cross-tabulations of these variables were produced to get a feel for the range of responses across the sample, and patterns by other variables of interest such as age, social class and so on. Graphs, matrices and tables were also constructed to represent selected variables. This second stage also suggested an ordering for the systematic reading of transcripts. For example, investigating the quality of school sex education, the descriptives of relevant variables from the database enable respondents to be grouped into relevant categories (for example, 'received very effective education', 'received average/mixed education', 'received poor education', 'received no education'). Each of these groups' transcripts are then read in order, to help identify communalities in their experiences.

The third stage is the systematic reading of the transcripts. The adherence of the interviewers to the main structure of the interview schedule, the familiarity of this author with the transcripts through multiple readings, and this author's perseverance ensured all text from a transcript relating to the line of enquiry was identified. Each transcript reading was accompanied by 'cut and pasting' or summarisation of the relevant text. This was done either electronically on the computer screen, or by hand. This enabled the identification, construction and description of themes, based upon relevant data from all the transcripts.

This stage of the analysis process also includes identifying relationships in the data, for example, why do certain respondents share certain attitudes or behaviours? Research objective e) in section 1.4, for example, aims to identify any associations between an interview respondent's social and family background, and his subsequent sexual and contraceptive behaviour. In some cases, respondents explicitly self-identified such an

association, and these are often illustrated in the text. However, the analysis also needs to identify respondents unwilling to express, or unaware themselves of, an association. The SPSS code database enables cross-tabulations of two variables at a time, which can be conducted easily for a large number and range of possible predictor and outcome variables. Results of the cross-tabulations reveal associations between two variables. In cases where this association is statistically significant (Chi-squared test, $\propto$=0.05), and the association in consistent for a number of associated predictor variables, this is highlighted in the text. For example, section 4.5.2 identifies an association between early social interaction with young women, and subsequent use of the 'Friendship' interpersonal strategy. This association was identified through evidence of statistical associations in cross-tabulations of several predictor variables ('number of close female friends aged 12-16', 'gender composition of social group aged 12-16', 'Mixed or same sex secondary school' and so on) versus the outcome variable of use of the 'Friendship' strategy. The presence of this association then prompted re-examination of the transcripts to construct a plausible hypothesis for such an association.

d) Testing emerging hypotheses against the data.

This leads to the final stage of analysis, testing hypotheses. Various authors have suggested ways of increasing the validity and reliability of findings (Miles & Huberman, 1984; Kirk & Miller, 1986; Hammersley, 1993), including:

i) **Weighting** the data - are all pieces of evidence equally valid or reliable? Some respondents may have better recall, clearer and more considered explanations for their behaviour, and the context of the interview may influence the quality of reporting. Can the weight of evidence for a hypothesis be considered?

ii) **Plausibility** - does a hypothesis seem to make sense conceptually? Can logical and sensible mechanisms for an association be identified? For example, might liberal and egalitarian messages about sex originating from parents reflect in a young man's attitudes and behaviour in his relationships with heterosexual partners?

iii) **Confounding variables** - might an apparent relationship between two aspects of a respondent's behaviour merely reflect their association with a third, confounding factor?

iv) **Extreme cases** - a closer examination of respondents with experiences at an extremity of a theme provides a robust testing of a hypothesis.

v) **Alternative explanations** - if a hypothesis still seems to have some merit after tests i) to iv), would an alternative explanation equally represent the findings from the data?

All five tests were used when constructing, reflecting on and reconstructing hypotheses emerging from the data.

2.3 FOCUS GROUPS

2.3.1 Introduction

Thesis objectives f) and g) (see section 1.4) are addressed through primary analysis of focus group data collected by this author and colleagues (Pearson *et al.*, 1996). The project, summarised in Table 2.1, aimed to provide sexual health purchasers and providers with information to help promote their services to young people, thus increasing their appropriateness, accessibility and use. The three objectives were:

a) to investigate how young people make decisions about using sexual health services
b) to identify how young people form impressions about services
c) to identify what young people view as the most appropriate methods, media and locations for promoting services.

Eighteen single-sex focus groups were conducted around Britain, including nine groups with young men. Findings from this project have been published in Cornah and colleagues (1996) and Pearson and colleagues (1996).

A focus group is a discussion involving a group of respondents, focussed around the research topic (Morgan, 1988). Rather than just being an interview held concurrently with many respondents, emphasis is placed on how the group interacts in the discussion (Kitzinger, 1994). Agreement, disagreement, challenges and interjections can force respondents to clarify, justify, re-examine and sometimes retract their stated views. As respondents are reporting to the group and the researchers, valuable information on group norms and cultural beliefs can be obtained.

The group context is appropriate for obtaining information on young men's impressions of sexual health services. In a similar way to a semi-structured interview, the flexibility and intensiveness of the focus group allows respondents to provide detailed information in their own language and frame of reference, and to identify topics and themes of importance and interest to themselves, similarly dismissing unimportant or uninteresting issues. The numerical advantage of respondents over researchers facilitates a more open and 'natural' discussion. The focus group supports expression of views, ignorances and prejudices that may not seem strange when they discover other respondents hold similar feelings. As discussed further in section 7.4.1, 'word of mouth' is a crucial route through which impressions of sexual health services are shared between young people. Images, impressions and stereotypes of services should, therefore, emerge through a group discussion. Finally, the group environment and potential for small group work are ideal for respondents to brainstorm ideas for promoting services.

However, weaknesses of focus groups should be acknowledged. First, the group interaction requires a skilled moderator to keep the discussion flowing, ensure the relevant topics are introduced and enable all respondents to participate. A focus group can contain dominant and submissive, loud and quiet, articulate and inarticulate, interested and uninterested respondents. The moderator's verbal and nonverbal skills are crucial in ensuring all respondents feel able to express openly their views. Second, respondents are reporting to the researchers *and* the other respondents present. Therefore, some respondents may feel pressure to report socially desirable, prestigious or humorous responses, but not their 'true' feelings. This issue is present in other research instruments, but is prominent in a group discussion. Equally, some respondents may be unwilling to report personal or sensitive information in front of the group. For example, respondents who have experience of using a

sexual health service (valuable information for the research) may not want to share this personal information with the group.

2.3.2 Recruitment

The objectives of the focus group study suggest a target population who are likely to provide valuable data. First, the research aimed to gather views from users *and* non-users of sexual health services. Second, the age limits for participation aimed to reflect current or potential users of services. Nationally, two-thirds of Brook Advisory Centres' clients are aged 16-24 (Brook Advisory Centres, 1999). However, the age distribution of clients varies by location, so age limits were left unspecified and left to the judgement of the recruiter. To ensure that all respondents felt able to talk freely and openly, single-sex groups were used.

Eight sites around England (Birmingham, Camborne, Carlisle, Gosport, London, Manchester, Milton Keynes and the Wirral) were selected as sites for data collection to represent urban, semi-urban and rural locations. Due to the wide geographical dispersion of these sites and the research team's lack of local knowledge, participants were recruited by staff from the Brook Advisory Centre at each site. Recruiters were given clear guidance on the procedure for approaching potential participants, introducing the study, and inviting participants to take part. Various recruitment methods were used including direct contact through services, outreach work and school visits, posters and leaflets, and snowballing. An incentive payment of £10 was provided to respondents at the end of a group.

A total of 157 young people (82 women and 75 men) aged 13 to 21 took part in eighteen, single-sex focus groups at the eight sites during the first quarter of 1996.

2.3.3 Profile of respondents

At the end of each focus group the respondents were asked to complete privately[2] a short, anonymous questionnaire on their demographic characteristics, use of sexual health services, sexual experience and use of contraception. A copy of the questionnaire is included in Appendix 3. Seventy-four of the seventy-five respondents completed a questionnaire, a response rate of 99%.

Table 2.3 shows the respondents' characteristics. Ages range from 13 to 21 years, with a median of 17 years. Two-thirds of the respondents are in school or sixth form college. Compared with an equivalent group from the Labour Force Survey, the focus group respondents are *under*-representing men in work, and *over*-representing men looking for work.

According to whether experience of sexual intercourse is reported, the focus groups include both sexually experienced and inexperienced young men. There are more sexually experienced young men as compared with a similarly aged group from the NSSAL, and a larger proportion reporting sexual intercourse occurring before age 16. The distribution of reported number of sexual partners approximates the NSSAL, although note that 14 of the 67 respondents aged over 16 chose not to answer this question. Non-responders are slightly younger on average than responders. It is possible some non-responders reported they had experienced sex for the preceding question, but actually had not, and preferred not to answer the following question on number of sexual partners.

In summary, the respondents are mainly in their late teens and are currently either at school or college, or looking for work. A mix of reported sexually experienced and non-experienced, and, as shall be seen in Chapter 7, sexual health service users and non-users is useful for the objectives of the research.

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[2] Although the intention was for the questionnaires to be completed privately, this was not always achieved. The lack of space at some focus group locations, combined with respondents wishing to end the session quickly, may have influenced the reliability of questionnaire responses.

Table 2.3 - Profile of Focus Group Respondents' Demographic and Sexual Behaviour Characteristics.

Characteristic	Focus group respondents	Reference group[1,2]
Age (years)		
≤15	9%	*none*
16	28%	
17	30%	
≥18	30%	
Median	17 years	
Sample size	*74*	
Occupation		
Full-time education	66%	57%
Work, non-manual	4%	⎫ 32%
Work, manual	3%	⎭
Looking for work	22%	9%
Other	5%	2%
Sample size	*74*	.
Experience of sex?		
Yes	80%	64%
No	20%	36%
Not answered	*2*	.
Sample size	*65*[3]	*817*
Sex before age 16?		
Yes	50%	28%
No	50%	72%
Not answered	*3*	.
Sample size	*64*[3]	*817*
Number of sexual partners, lifetime		
0	25%	36%
1	26%	18%
2	9%	9%
3	13%	9%
≥4	26%	28%
Median	1 partner	1 partner
Not answered	*14*	.
Sample size	*53*[3]	*827*

Notes: [1] - Reference group for occupation is men aged 16-25 in the Labour Force Survey, winter 1995/96 (Office for National Statistics, 1996a, Table 40). Occupations are based upon International Labour Office definitions. The persons in full-time education include persons in full-time education but undertaking some part-time work or economically inactive.

[2] - Reference group for sexual behaviour is men aged 16-19 in the NSSAL (Wellings *et al.*, 1994). The NSSAL defines a 'sexual partner' as a person with whom the respondent had vaginal, anal or oral heterosex. The focus group questionnaire asks whether the respondent has had sex, and with how many people.

[3] - Excludes seven respondents aged under 16.

2.3.4 Procedure

Four of the nine focus groups took place in school or college classrooms, two in youth clubs, two in a Brook Advisory Centre[3], and one in a youth drop-in centre. Care was taken to ensure that any staff from these establishments who may have known the respondents were not present for the discussion. Each focus group consisted of the respondents, this author as moderator, and an observer. The moderator had been trained in qualitative research, and had experience of conducting focus groups. The observer was a member of the research team or a neutral person selected by the recruiter. It was the observer's responsibility to write notes summarising the content of the discussion and any important non-verbal interaction between respondents.

The focus group question route is included in Appendix 4. This was constructed after a review of the published literature on promoting sexual health services, as well as talking to health professionals working with young people. The question route was tested and revised based upon a pilot focus group conducted in Southampton. The moderator had flexibility to allow new and out-of-order topics to be introduced to improve the flow and quality of the discussion, but all important topics on the question route were introduced in each group. A summary of the structure of the question route is given below.

The first section is the introduction. The moderator explains the aims and importance of the research, sets the ground rules for the discussion (for example, respecting other respondents' views) and stresses the anonymity and confidentiality of the discussion. The second section aims to make respondents feel more comfortable by introducing an easy, non-contentious topic. Respondents are encouraged to discuss how and when they learnt about sex.

Having established a non-threatening atmosphere, the moderator then introduces the topics of importance to the research. First, respondents are presented with a number of hypothetical situations concerning sexual health, and are asked how they would advise a friend in those situations. The aim is to explore how young men make decisions around sexual health, and whether visiting a service is part of that decision. Next, the respondents are asked (first unprompted, and secondly prompted) what sexual health services they know

[3] Financial and time limitations prohibited using more neutral locations for these two groups.

of in the locality. As well as basic information on the nature of the service, their impressions of the services are sought.

After a break for drinks and biscuits, respondents are divided into small groups to think about ways of promoting a chosen local sexual health service. Groups are asked to report on the types and styles of promotional material they would use, where the material should be located and key messages and images. The final section of the question route gauges reactions to example promotional posters and photographs, listed in Appendix 5. Respondents are encouraged to highlight positive and negative aspects of the materials, as well as general issues around promotion and advertising.

At the end of the session, respondents are asked for brief feedback on the focus group, to complete the short questionnaire, and given payment. Most groups lasted between one and a half and two hours.

Overall, the focus groups ran successfully, although some reflections on this author's experiences of moderation may be useful for researchers undertaking similar work.

a) Some respondents incorrectly assumed I was directly employed by, and representing, Brook Advisory Centres. This may have subsequently affected their discussion of the quality and images of sexual health services. Information given at recruitment should be stress the independence of the researcher.

b) Researchers should remember that participating in a focus group does take up respondents' time, and may interfere with socialising and leisure activities usually taking place at that time. Some groups were organised to coincide with youth club nights or other regular meetings of young people. While this increases the likelihood that participants can take part in the research, they must also forfeit their usual activities at that time.

c) The difficulty of moderating larger groups (say, nine people or more) became apparent. Larger groups impede some respondents from participating in the discussion, who therefore may start to lose interest in the proceedings. Additionally,

the circumference of a large focus group impedes the moderator from maintaining eye contact with respondents closest to the moderator.

2.3.5 Analysis

The analysis of the focus group data followed a similar four-stage process used for the semi-structured interview data, outlined in section 2.2.5:

a) data formatting
b) data organising
c) generating categories, themes and patterns
d) testing emerging hypotheses against the data.

a) Data formatting

All focus groups were recorded using a stereo microphone and high quality recording equipment. Additional information collated for each session included:

i) short questionnaires completed by respondents
ii) observer's written notes
iii) rough material from group work on promotional methods
iv) post-group report, completed by the moderator and observer.

Recordings were then transcribed by a professional agency specialising in audio typing. Transcribing was done near verbatim, with important speech utterances (for example, pauses, sighs, laughter) and contextual comments (for example, mimes, hand signals) included. Individual respondents are *not* distinguished throughout a transcript. The size and liveliness of some groups made identification of individual speakers difficult, therefore increasing the potential financial cost of transcription. However, if the moderator or observer felt one respondent's role was noteworthy[4], this was recorded in the post-group

[4] For example, one respondent had superior knowledge of sexual health services because his mother was a family planning clinic nurse.

report. The transcribing agency then returned each transcript in computer text file format to the research team for checking, who then anonymised the text by censoring any names, locations and so on. The text files were backed up, and paper hard copies printed.

b) Data organising

The main organisation tool used was a comprehensive summary sheet completed for each focus group. The involvement of the whole research team (Pearson *et al.*, 1996) in data organisation facilitated complete coverage of the transcripts, and researchers' different interpretations to be identified and discussed. A sample of transcripts were read so that each member of the research team became familiar with the content and nature of the discussions. Following briefing meetings, templates were constructed to summarise the main themes in the research, with the choice of themes driven by the content of the discussions. The structure of the summary sheet was:

i) Decision making around sexual health

- Seriousness of dilemma?
- Who to consult?
- Obstacles to use of services?

ii) Key issues and themes around services

- How have respondents heard about services?
- What are the most important aspects of a service?
- What determines the popularity of a service?
- What image/reputation do services have?

iii) Methods of promotion

- What makes promotion work?
- Merits of different promotion methods?
- Where to promote?
- When to promote?

iv) Promotion design details

- Key messages to get across?
- Wording and style of promotion?
- Use of images?

Summary sheets were then completed for each transcript by at least two members of the research team independently.

c) Generating categories, themes and patterns

Similar to the analysis of the semi-structured interviews, a decision was made not to use computer software to aid the analysis. The relatively few numbers of focus groups, combined with the use of summary sheets, suggested an alternative approach would be more fruitful. In addition, several authors (Carey & Smith, 1990; Kitzinger, 1994; Catterall & Maclaran, 1997) express concerns that the coding and retrieval process of computing software is inappropriate for analysing the process and dynamics of focus groups.

Therefore, the analysis rests upon thorough readings of each transcript accompanied by the construction of interpretive notes, supported by the aforementioned summary sheets. While the summary sheets give an indication of the content across groups, reading completely through each transcript gives a better understanding of the process, development and dynamics of a group discussion. This enabled the identification, construction and description of themes, based upon relevant data from all the transcripts.

d) Testing emerging hypotheses against the data.

The same tests outlined in section 2.2.5 were used for the hypotheses emerging from the focus group data.

2.3.6 Use of quotations

Throughout the thesis, extracts from the interview and focus group transcripts have been included. Corden and Sainsbury (1996) note the inconsistent and often unexplained way quotations are used in qualitative research output. In this work, quotations are used to illustrate and illuminate the findings being discussed. A noted strength of qualitative research is allowing respondents to speak for themselves (Ely, 1991). It seems only fair for respondents to continue to speak for themselves in the research output. Care was taken to ensure quotations were selected without bias (for example, not selecting quotations from just the more articulate respondents), and were not used as the sole piece of evidence to justify findings.

Attempts are made to remind the reader of the context in which quotations are made. Many of the interview quotations include the interviewer's preceding question and any interjections during the respondent's speech. An interview is not merely a succession of statements from a respondent, but a form of conversation between two people; the respondent and the interviewer. Similarly, most quotations from focus groups include speech from two or more respondents and/or the moderator. This aims to reflect the group interaction present in the discussion, and the fact that the primary unit of analysis is the group, not individual respondents (Kitzinger, 1994).

Formatting guidelines for quotations are:

a) Any identifiable features (institutions, companies, places) have been replaced by analogous titles (for example, 'Truro' becomes 'Coastal Town') to preserve the anonymity of the respondent, but retain the context of the feature.

b) Person forename are often mentioned by respondents. To preserve anonymity, any forenames in quotations have been replaced with a forename randomly selected from pools of male and female forenames (excluding very uncommon ones) stated in *all* the interviews.

c) For the interviews, *'(text)'* refers to the interviewer's speech.

d) For the focus groups, *'(M: text)'* refers to the moderator's speech. 'R:' indicates a respondent, with each speaker's section starting on a new line.

e) '[text]' refers to text inserted to help understand the subject of a quotation.

f) '...' refers to an incomplete sentence.

g) '[123:45]' refers to the [interview/focus group number:page number] of the transcript the quotation is taken from. The interviews are numbered from 144 to 186; the focus groups M01 to M09.

2.4 OTHER SOURCES OF DATA

2.4.1 National Survey of Sexual Attitudes and Lifestyles

The National Survey of Sexual Attitudes and Lifestyles (NSSAL), funded by The Wellcome Trust, was conducted by Kaye Wellings and colleagues (1994). With fieldwork in 1990/91, this survey was the first to provide representative and detailed data on sexual behaviour in Britain. Around 19,000 interviews were conducted with men and women aged 16-59, using interviewer-completed and self-completion questionnaires. The NSSAL dataset (in an SPSS file) and accompanying codebook were obtained by this author from The Data Archive[5]. A few sections of the thesis use secondary analysis of the NSSAL data for descriptive and comparative purposes.

2.4.2 Client use of sexual health services.

Research objective f) listed in section 1.4 requires data on use of sexual health services. The Department of Health requires all National Health Service (NHS) Trusts to return data annually on clients attending their family planning clinic services. Information is available on the number, age, gender and contraceptive method use of clients. Similar data are available from Brook Advisory Centres (1999), NHS genitourinary medicine clinics (Department of Health, 1996c), and to a lesser extent, general practitioners (Department of Health, 1996b). All these sources are used in Chapter 7 to profile young men's use of sexual health services. Limitations of these data are evident, and highlighted in the relevant Chapter sections.

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[5] The Data Archive is a national resource centre disseminating data throughout the United Kingdom. It is funded by the Economic and Social Research Council (ESRC), the Joint Information Systems Committee (JISC) of the Higher Education Funding Councils, and the University of Essex.

CHAPTER 3 - LEARNING ABOUT SEX

3.1 INTRODUCTION

Learning about sex is a process that, although usually concentrated in the teenage years, extends throughout a person's life. This chapter considers the different sources of information that young men cite as important for learning about sex, the social and cultural context these sources operate in, and the types of images of sex these sources convey. Consideration of these issues provides a background for the discussion in Chapters 4 and 5 of young men's sexual behaviour and attitudes when they begin and progress through their sociosexual history.

Before considering the interview respondents' experiences, the NSSAL (Wellings *et al.*, 1994) can be consulted for questions about sources of knowledge on sexual matters. Some of this information is shown in Figure 3.1, differentiated by age group and sex of the respondent. For men in the youngest age groups (16-24), friends, school and television are the most frequently cited sources, as compared with friends, school and mothers for similarly aged women. The most striking trends over time (as indicated by responses by age group[1]) include the increasing importance of school and television, although the former source is more important for women than men. More recent birth cohorts are more likely to cite mothers as a source, although mothers are much more important for young women than young men. Less than 20% of men or women in any age group cite their father as a source for learning about sexual matters.

3.1.1 Data quality

Early on in the interviews, the respondents were encouraged to discuss their childhood and teenage years, how they learnt about sex, and whether they received any sex education at school. Similar to young men interviewed by Holland and colleagues (1993), some respondents have difficulty in recalling how they learnt about sex. Although acknowledging

[1] Although recall error may affect the reliability of responses from the oldest age groups.

Figure 3.1 - Percentage of Respondents Reporting Sources for Learning about Sexual Matters, by Age Group and Sex, NSSAL.

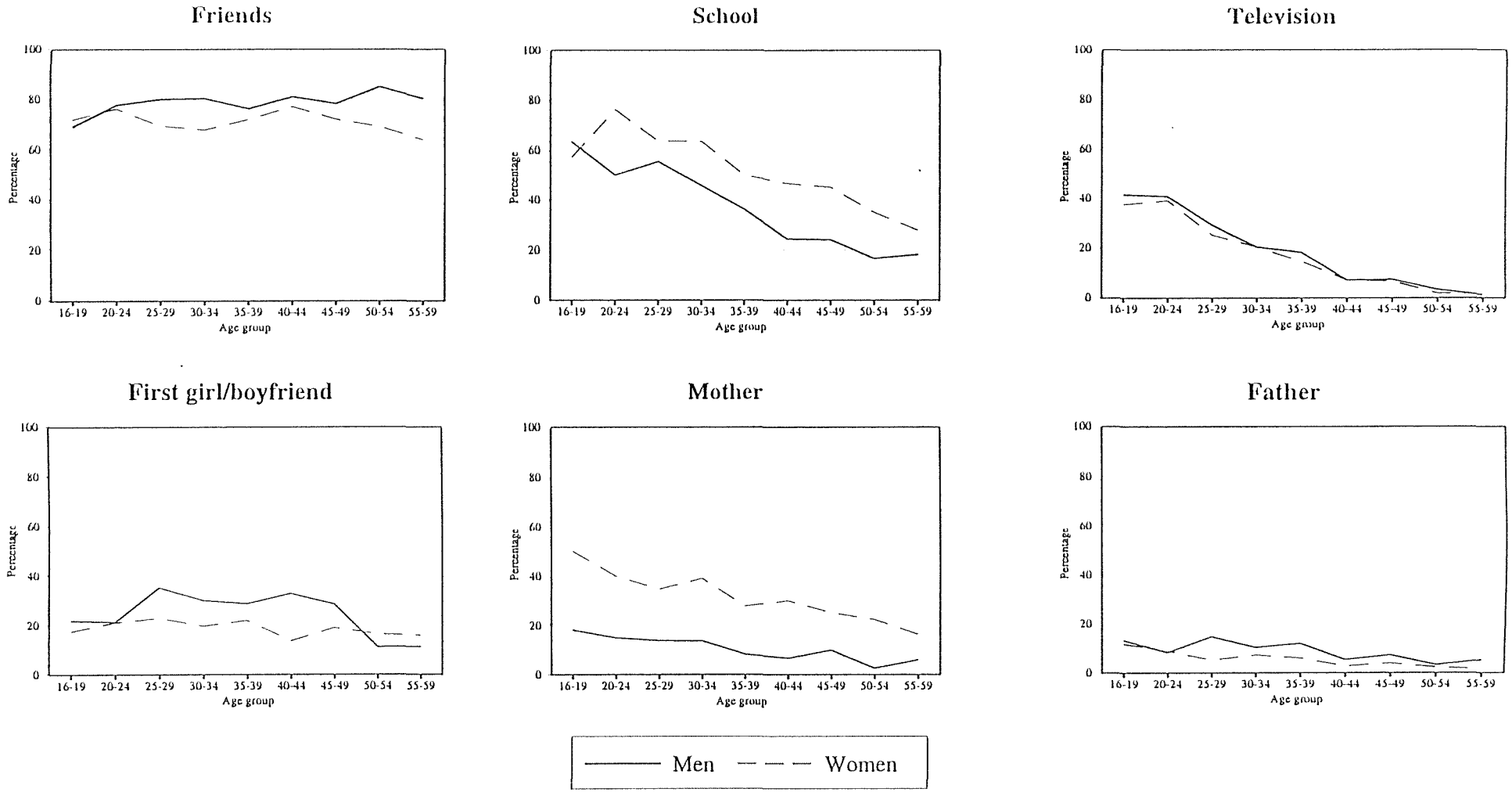
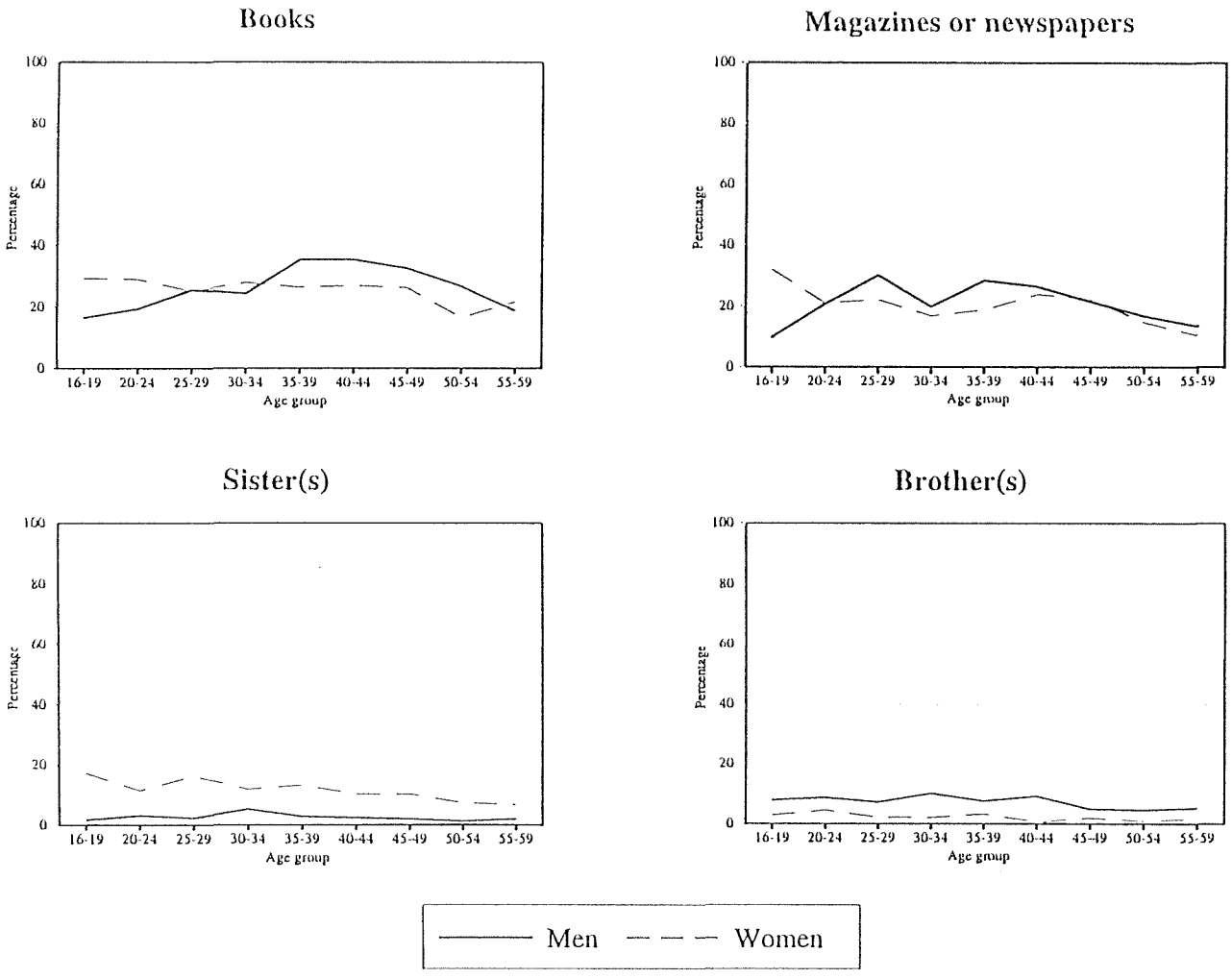


Figure 3.1 continued.



Sample sizes

Age group	Men	Women
16-19	*224*	*246*
20-24	*284*	*290*
25-29	*301*	*380*
30-34	*245*	*340*
35-39	*246*	*341*
40-44	*291*	*293*
45-49	*199*	*273*
50-54	*149*	*218*
55-59	*148*	*194*

The question was phrased "When you were growing up, in which of the ways listed on this card did you learn about sexual matters?". A number of letter-coded closed and open categories were listed on a card presented to respondents. Multiple responses were allowed. This Figure includes only the ten most frequently chosen categories.

Source: Wellings, K., Field, J., Johnson, A. M., & Wadsworth, J. (1994). The National Survey of Sexual Attitudes and Lifestyles [Unpublished raw data].

that they must have learnt about sex at some stage in their life (as they now possess knowledge), they have difficulty recalling any sources, as with this respondent:

> Umm, I really haven't got a clue at all where I first sort of came across the idea of sex, what it was about and how to do it. I really don't know how I found out, if you like. [151:05]

Two factors might explain this apparent recall problem. First, some respondents are being asked to recall events a long time prior to interview. The earliest learning (for example, asking parents basic questions about sex) occurred from age six upwards, which is around 15-20 years before the interview took place. With such a lengthy time, some uncertainty in recall is understandable.

A second factor is reluctance to admit to *not* knowing about sex at some time. This theme emerges in relation to several topics in this thesis, and has been identified by other authors (Belfield, 1988; Jewitt, 1995; Davidson, 1996). Particularly in the teenage years, some respondents report a conflict between their personal knowledge about sex, and how much knowledge they were expected to present to their peer group. As this respondent discusses, showing ignorance about sex could result in ridicule and mockery from your male peers:

> *(So in your childhood, what would you say was the main source of sexual information that you had?)* (pause) Oh, I don't know. Peers, I suppose. And we didn't really talk about it either, because everyone had to assume you kind of, you had to pretend you knew everything there was to know about it, you could never show your ignorance on the subject 'cause, people make, you know, you seem to be a fool. So you get snippets of information here and there, and you pretend not to be interested and like you knew that already. [178:11]

When a respondent is being asked in the interview how he learnt about sex, this need to appear knowledgable about sex may still be operating. For example, this respondent is defensive in his assertion that he was never ignorant about sex:

> *(So what would you say was the main source of sexual information in your childhood?)* Umm, I don't know, I just, suppose, you know, just what you read in the papers, looking at TV, and your mates really I suppose, you know. I mean, I don't think that I was ignorant, you know, about it. I never talked about it with my parents but I don't think I was ignorant really at all. [169:07]

A second issue on data quality is the representativeness of the cited sources of learning. Throughout the sample, exceptional and memorable episodes that contribute to learning

often are cited. Examples include a 'birds and the bees' talk from a parent, school sex education lessons and viewing pornographic films and magazines. In contrast to these memorable episodes, however, is evidence of important background, but not so event-specific, sources. In particular, mass media is not recalled as a source in reference to specific events or episodes, but is cited as a general source for learning about sex. Previous research (and data from the NSSAL in Figure 3.1) shows the increasing importance of the media as a source of information about sex (Abrams *et al.*, 1990; Currie, 1990; Talbot, 1995). This trend reflects the changing role of mass media in British society over this century (Strinati & Wagg, 1992). Television HIV/Aids awareness campaigns, documentaries and soap operas were identified by teenage men in Wessex as important sources of information about sex (Cooper *et al.*, 1992a). Non pornographic[2] magazines have also been cited as useful sources; as discussed further in section 7.4.2, magazines aimed at young women (for example, *Just 17*, *Sugar*) may also be read by young men (often the young woman's brother or boyfriend) (Cooper *et al.*, 1992a; Jewitt, 1995; Lynch, 1995).

3.1.2 Timing

> *(So when you were finding out about all this stuff in your secondary school was it relevant to you, or did you think you knew it all by then?)* No, you were always learning something new, I mean you're still learning now aren't you, let's face it. (laughing) [157:09]

As illustrated in the quotation, specifying a fixed time over which people learn about sex is too simplistic. The earliest recollections from respondents include parents answering a question similar to "Where do babies come from?", or early sexual experimentation between children, motivated by curiosity. As with the respondent quoted above, an upper age limit is undefinable, with the learning experience continuing throughout adulthood.

As discussed further in section 4.2, any group of similarly aged teenage men is likely to have different levels of interest in, and knowledge about, sex. One way to think about the timing of learning is in relation to when a young man believes he needs to know about sex. While several sources for learning about sex emerge essentially by chance, young men may

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[2] Pornographic magazines are considered in section 3.4.

actively seek out sources of information when they are becoming more interested in sex and beginning to have sexual experiences. For a young man not yet interested in sex, providing information at (what he perceives as) an inappropriately early age may result in him dismissing the information as irrelevant and of no concern:

> *(How old were you [when you received sex education at school]?)* Ah, probably about 14 or 15. 'Cause I felt very much like, well you know, that's not gonna, it's got nothing to do with me at this stage. It felt very much like knowledge that I was not part of. [178:15]

However, other respondents report that even if information is obtained too early, it can be remembered and is likely to be of use in later years. This respondent received school sex education before he was really interested in sex:

> *(And did you think [school sex education] was particularly relevant at that age?)* Umm, that was relevant to everyone except me umm probably, I just filed the information away for future use. That was probably pretty relevant to everyone who was actually in relationships at the time. [166:06]

3.1.3 Mix of sources

When looking across the sample, patterns in the mix of sources are present that generally reflect those reported in the NSSAL. Younger respondents are more likely to cite learning from school, parents, television and newspapers. Older respondents are more likely to cite pornography and their own personal experiences. However, at the individual level the mix and importance of sources vary. Not all sources are equally available to all young men, for example, one respondent who changed primary and secondary schools several times reports missing out on school sex education. Just under half the sample report no sex education at all from parents. Other respondents report a greater degree of control over their learning about sex. Having an inquisitive and curious nature can motivate a person to seek out information, as with this respondent:

> Yeah, I mean I'm always curious and read everything and had to find out sooner or later (laughing). The world couldn't hide it from me. [155:06]

A useful metaphor to describe the overall learning process, similar to the description given by the respondent quoted below, is that of constructing a jigsaw puzzle, with the completed picture being a representation of the 'reality' of sex:

> *(Right, so can you remember where you learnt about like how babies were made?)* I don't know. It was just something that we gradually picked up, I can't ever recall being told this is what happens. I think it just, you gathered your little bits all the way along and put two and two together. [180:10]

The pieces of the jigsaw originate from different sources at different times; some young men actively seek out pieces, whereas others find or are provided with pieces more by chance. Understanding the picture becomes easier as more pieces are obtained, and it also becomes easier to discard pieces that do not seem to fit into the overall picture (for example, falsifications picked up from friends). However, the jigsaw may never be complete, or present a consistent, understandable representation of sex, a problem this respondent discusses:

> My parents didn't give me any emotional or sexual support. All I got at school was the biology umm, you can't really get a real feel for the real world from reading men's magazines umm, so you're left out there and "What the fuck's going on here, then?" [174:18]

The next sections consider, in order of importance for the sample as a whole, selected sources for learning about sex: friends, school, pornography, and the family.

3.2 FRIENDS

3.2.1 Context for learning

Friends, almost exclusively male, are the source respondents cite most frequently for learning about sex. This finding replicates both the NSSAL data in Figure 3.1 and many other studies (Schofield, 1965; Farrell, 1978; Spencer, 1984; Currie, 1990; Cooper *et al.*, 1992a; Holland *et al.*, 1993; Talbot, 1995). One way of conceptualising this source is as a large, common resource pool of information about sex, into which young men can theoretically input or extract information at any time. Information originates from any of the other sources discussed in this chapter, and is transferred (through discussion) into the

common pool by young men who have obtained the information. Respondents identify certain members of the peer group who are key conduits in this flow of information. These young men may be more knowledgable about sex (for example, older members or 'early' sexual developers), or just the more conspicuous and vocal members. The respondent below identifies television as a source of information, and conduits into the resource pool:

> It's around you, the TV, umm, people seem to know, my friends. Someone of my friends, always seemed to know before the rest of us, and passed it on and we picked ... I suppose we knew ... you picked up what half of it was about and some of it you didn't, but you always saw it on TV or something like that. [155:06]

The extent to which this common pool of information is available to a young man varies, and depends on the types and members of social groups he has access to, and their amount of sexual knowledge. As considered further in section 4.3.1, one important social group is a young man's friendship group, that is, closer friends with whom he socialises often. Besides sharing attitudes and behaviour, members of friendship groups can have similar levels of sexual knowledge and experience. For example, this respondent describes his friendship group as the *"intellectual group"* or the *"university clique"*, and feels he was a *"late developer"* [168:07,9] sexually. Sharing these characteristics with his close friends influenced the extent to which sex was talked about:

> *(Did you discuss sex with friends at school?)* No. We were so esoteric or whatever. Like, we wouldn't, we were so clean cut, young typical middle class kids, it didn't really come into the equation. Like, we discussed politics or ... but girls never really came into it 'cause I think we were all pretty much at the same level. [168:12]

Much discussion of sex is reported to occur within friendship groups. Two other social groupings provide a context for learning about sex from friends. First is a one-to-one discussion with a close, trusted friend. This format is most associated with discussion of serious topics, for example, issues around a current relationship. Second is a discussion involving not only a young man's friendship group, but acquaintances and members of the wider peer group. This larger group loses its homogeneity in the participants' levels of sexual knowledge and experience; therefore, a young man can learn about sex from other group members with more sexual knowledge or experience. This respondent's curiosity about sex increased after hearing older members of his gang discussing aspects of sex and using terminology he did not fully understand:

> There was all these people sort of like, going around. They've obviously heard their big brothers and sisters talking about it, or hung around in gangs and stuff you know, so you've got the older members of the gangs telling you all about it and laughing and stuff, and I felt a bit left out. So I found out all these different names that they were talking about and looked them up. [157:06]

Reflecting the gender composition of young men's social groups, much discussion of sex occurs between young men. However, some respondents also cite discussion with young women as a source of learning. This may be through discussion in a mixed-gender social group, or through one-to-one discussion with a close, trusted female friend. An example of this latter context is a young man's girlfriend, who can act as a source for learning about sex, particularly if the relationship involves sexual activity.

3.2.2 Topics of discussion

The previous section outlined the context in which learning about sex from friends takes place, but what topics are being discussed? How do the topics compare to content from other sources such as schools and parents? A questionnaire-based survey considered these questions (Turtle *et al.*, 1997); responses from Year 11 school pupils are shown in Table 3.1. The Table shows topics that young men report having discussed seriously at least once with friends; personal relationships with girlfriends, sexual intercourse, pregnancy, contraception and safer sex are most frequently reported. Note that whatever topic, or with friends or parents, young women are more likely than young men to report discussion. Faced with just the evidence in Table 3.1, it is tempting to infer that discussion of sex between young men is quite serious and sincere. Based upon the current interviews, however, the context and format for much discussion of these topics do not support this premise. Three prominent topics of discussion are identified; mechanics, gossip and banter.

a) Mechanics

This category, labelled the 'mechanics'[3] of sex by several respondents, refers to discussion of the physical aspects of sex, including male and female anatomies, reproduction, and

[3] Men's use of machine-based metaphors to describe physical aspects of their body and health has been noted by other authors (Watson, 1993; Watson *et al.*, 1996).

Table 3.1 - Percentage of Year 11 Pupils Reporting Having Discussed Sexual Topics Seriously at Least Once with Friends or with Parents, by Sex.

Topic	With friends		With parents	
	Young men	Young women	Young men	Young women
Personal relationships with boy/girlfriends	76	92	41	58
Sexual intercourse	66	84	34	47
Getting pregnant or getting a girl pregnant	52	83	31	55
Safer sex	50	79	38	52
Contraceptives	50	83	34	52
HIV (the AIDS virus)	42	69	36	49
Sexual development/puberty	42	66	30	54
Other sexually transmitted diseases	33	60	25	39
Menstruation/periods	15	86	7	82
Base (100%)	*855*	*1001*	*855*	*1001*

Source: Turtle, J., Jones, A., & Hickman, M. (1997). Young People and Health: The Health Behaviour of School-Aged Children. A Report on the 1995 Survey. London: Health Education Authority, Tables 12f, 12g.

sexual activities (particularly penetrative intercourse). This mode of talk is common in the childhood and early teenage years, when members of the friendship or peer group have had little sexual experience. Also described as 'playground' talk, some respondents remember having doubts on the truthfulness of some information being shared, with an associated need to use commonsense to filter out the conceivable truths from the more implausible statements. This filtering takes place either at the time the information is received, or retrospectively later in the young man's sexual development. Although Tolson (1987, p.38) states that the discussion of sex between young men is "a self-sustaining network of boasting, half-truths and fabrication, in which it is impossibly to distinguish reality from fiction", evidence from the respondents shows that some young men can make such distinctions.

Discussing the mechanics of sex is also reported to occur later on in a respondent's sexual partnership history on, for example, the relative merits of different sexual activities, or more exotic sexual activities.

b) Gossip

Gossip is a very common topic of discussion, starting when peers begin to have their first sociosexual experiences, and continuing with great vigour thereafter. Discussion includes issues of who is in a relationship with whom, who 'got off' with whom[4], and what level of sexual activity is involved. Besides sharing real (or supposed) details on fellow peers' sexual experiences, discussion often turns to one or more of the participant's sexual activity. The veracity of these reports was often questioned (either spoken or unspoken):

> *(And they would be fairly open and talk about things they'd done with girlfriends?)* Yeah, they would be but, I mean, half the time a lot of it sounded very dubious and always ... *(You think it was made up?)* Not, not made up, but umm, expanded on. (laughing) You know what I mean? [160:26]

How truthfully and completely the respondents feel their peers reported on their sexual activity depends on the audience present for the discussion. If the audience consists of a young man's close and trusted friends, then more accurate reporting of sexual activity may be forthcoming, but perhaps in less detail (due to the speaker's modesty and his desire to preserve confidentiality). In addition, as the members of a friendship group often socialise together, the speaker's friends may have a good idea whether the reported sexual activity actually took place.

When the audience consists more of a young man's wider peer group, however, embellished or falsified reporting of sexual activity is likely. This is due to the social pressure some young men are under to present a certain image to their peer group; one aspect of this image is to be heterosexually active. The respondent quoted below believes that boasting of sexual activity helps to present this desired image:

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[4] The phrase 'getting off' with someone is open to interpretation. Young people talking to Hirst (1994b) explained it as meaning a couple pairing off, kissing and groping, and possibly mutual masturbation and intercourse.

> *(And did you discuss sex with your friends?)* Yeah. *(In what way?)* (laughing) All ways, all ways you know. I was fascinated to listen to their accounts and their sexual experiences, they described them in detail. I mean, at that age I think much was exaggerated, but you know still a little bit of the, that's what makes a cool dude, you know? [167:15]

Candid accounts of sexual activity aim to impress not only male peers, but also any female peers in earshot or who hear from secondhand sources:

> But I saw that the girls sometimes seemed to be a bit superior and that, and when the lads were having their sort of childish humour you could see that the girls just weren't interested. It was always aimed at the girls, of course, 'cause it was always the lads trying to impress the girls and saying this and all that crap. [155:11]

However, one female peer unlikely to be impressed by such gossip is the young woman with whom the sexual activity took (or, indeed, did not take) place. If she finds out the young man has been discussing her, this is likely to be viewed as an act of betrayal and breach of confidentiality, or just unfounded gossip, causing great upset.

When talking about sex with male friends, one of the most awkward topics is virginity. As discussed in section 5.5, many male peer groups attach considerable social stigma to being a virgin. This respondent recalls the topic as one of his most memorable discussions about sex with friends:

> *(Did you talk about sex with your friends at all at secondary school?)* I can't remember talking about sex until ... one thing that does stick in my head was a conversation I had in the fifth form common room. There were five of us, and somebody asked the question, "Hands up who's still a virgin?" I mean, that's the only thing I can remember actually, and from then on in, yes, there was talk about girls and what have you. [151:10]

Respondents who were still virgins when this topic arose in conversation identify several coping strategies:

i) Lying, by reporting they have lost their virginity.

ii) Saying nothing; this, however, is felt to suggest implicitly that the (non)speaker is a virgin.

iii) Saying nothing, but here hoping to give the impression that they have lost their virginity, but do not need to boast about it.

iv) Being honest and stating they are a virgin. This, however, requires the audience to be close friends, or the young man to have considerable respect and social standing in his peer group.

The chosen strategy depends on the audience for the discussion, how honest and truthful a young man wants to be, and how important it is for a young man to preserve his social status in front of the audience and his peers.

c) Banter

Banter describes different modes of talk about sex, all containing (or intended to contain) an element of humour. This includes jokes, stories, innuendoes, teasing and insults (for example, questioning a peer's sexuality or virginity status), as described by this respondent:

> *(What sort of things did you talk about?)* Umm, everything I suppose. Yeah, I mean, who is going out with who and how far they'd got, umm, oh, and just like loads of dirty jokes and, umm, sort of sexually based insults and stuff like that. I can't remember anything specific. [185:10]

Much discussion of sex between male friends, even including mechanics and gossip, is reported to occur in a humorous context. However, as this respondent argues, an apparent lack of seriousness should not be viewed negatively:

> Yeah, it's only the really close friends and me girlfriend obviously that we talk about sex with, and even then, I mean, it's always in a very jocular manner 'cause I don't see why I should be serious about sex, you know? [157:14]

Humour helps to overcome the social embarrassment associated with sex. Other respondents report that if they had tried to talk seriously about sex in a group context, peers would ridicule them for showing lack of knowledge about sex. Underpinning much banter talk between male peers are elements of competitiveness and one-upmanship. Particularly within certain friendship groups (for example, the 'Lads' group discussed in Chapter 4), the use of insults and teasing are taken as part of ordinary socialising between young men:

> The normal male to male interaction would be, unless something terrible happened, somebody's parents died or house burnt down, you'd be constantly nasty to them. But that was not taken in a bad light, that was just a normal way of interacting. So if

somebody said something to you and you went "F. off", it was quite acceptable. [182:11]

The importance of banter in British young men's friendship and peer groups has been reported in several other studies (Morton-Williams, 1976; Wood, 1984; Holland *et al.*, 1993; Wight, 1994c; Talbot, 1995). Based upon observation and interview research in the school environment, this interaction is argued to play a role in defining a young man's sexual identity. Verbal sparring, sexual storytelling, comic displays, homophobic teasing and insults serve to create and police what are acceptable forms of masculinities. Within the hierarchy of the male peer group, they help to identify who does and does not belong, and enhance and depreciate reputations (Edley & Wetherell, 1997; Epstein, 1997; Kehily & Nayak, 1997).

3.3 SCHOOL

3.3.1 Previous research

The extent and quality of school sex education have been studied quite extensively elsewhere (Lee, 1983; Allen, 1987; Massey, 1991; Woodcock *et al.*, 1992a; Mellanby *et al.*, 1996); therefore this section only discusses the topic briefly, with particular emphasis on young men's experiences. Under the 1993 Education Act and the Department for Education's (1994) Circular, all maintained secondary[5] schools must provide sex education. It must be provided in a context that encourages the pupils to regard moral considerations and the value of family life. No obligations on the purpose and content of sex education are specified, apart from the need to include education on HIV/Aids and other sexually transmitted infections.

A major theme to emerge from previous research is that although the quantity and quality of sex education received currently still vary considerably, it is more extensive and of a higher quality than in previous decades. In Schofield's 1965 study of 15-19 year olds, 53% of the

[5] The provision of sex education in maintained primary schools is left to the discretion of the governing bodies. Although new guidelines are to be issued following the Social Exclusion Unit's (1999) report on teenage pregnancy, the only requirement appears to be that primary schools ensure pupils know about puberty and how a baby is born.

men reported they had not received any sex education at school (as compared to only 14% of the women). Compare this figure to a more recent study; around 90% of Year 11 pupils in a 1995 survey reported the topics of sexual development/ puberty, sexual intercourse, safer sex and contraception had been discussed in school (Turtle *et al.*, 1997).

Many studies have reported that young men feel that school sex education is more oriented towards young women, who therefore receive more useful and relevant learning (Cossey & Chambers, 1984; Currie, 1990; Holland *et al.*, 1993; Talbot, 1995; Dines *et al.*, 1996). Human reproduction, gestation, birth and contraception are common topics in school sex education. However, these topics focus around the female physiology, and are topics that women are perceived to have more interest in as they are at risk of conception (Woodcock *et al.*, 1992a; Sex Education Forum, 1997).

One aspect of this bias towards young women is young men's lack of learning about menstruation. For example, young women can receive a talk on menstruation from a teacher (or representative of a feminine hygiene company) from which young men are excluded (Jewitt, 1995). Dines and colleagues (1996, p.16) quote a respondent who recalls him and his fellow male pupils *"were sent out to play football while the girls had a talk"*. Young men recognise menstruation is of more importance to young women at that age (Cooper *et al.*, 1992a) and that a mixed-sex session would inhibit young women from asking questions. However, a total exclusion reinforces the notion of menstruation as a taboo and mysterious aspect of women's lives, an issue raised by respondents in the current study.

3.3.2 Respondents' experiences

The school sex education received by respondents varied in timing, amount, and the perceived quality. Some respondents had education on male and female anatomies and reproduction in the last years of middle school. In secondary school, sex was most likely to be covered in science or biology lessons (before or as part of 'O' Level/GCSE), typically including the topics of reproduction and contraception, and sexually transmitted infections. In addition, lessons on personal and social education, religious education, general studies, and form time may have involved discussion of sex, relationships and morals.

Sexual information was usually given in a factual and neutral way, with few respondents perceiving their school attached moral or value-laden messages. Others report the moral values generally associated with their school also reflected in the school's teaching on sex. For example, a school with a strong religious foundation provides certain messages on contraception, morals, relationships or abortion. The respondent quoted below reports the location and traditionalism of his school, combined with the period he attended, limited his sex education:

> *(What about anything about contraception or anything like that?)* No. There's a sad lack of that stuff in our school, umm, partly because, I mean the school as I said was quite traditional, also it was 'Irish City' and also it was, you know, 1985. I think people were less liberated about those things then than they are now. [185:10]

Views on the usefulness and relevance of school sex education are affected by, among other factors, the quality of the education and the timing of provision. Across the sample, the younger respondents and those who attended a mixed sex secondary school are more likely to report better quality school sex education. A common theme is respondents feeling they already knew the information provided in school sex education, which therefore reduced the lessons' relevance. Other respondents report that although they learnt the mechanics of sex from other sources, school education augmented the picture by providing more reliable and detailed information:

> *(So was the sex education that you received at school relevant to you at that time?)* Umm, was sex relevant at that time. Umm, I suppose so. I mean, I think I knew most of what I needed to know then, but it certainly helped in joining it, it gave me much better knowledge of what happens. [154:08]

The timing of teaching of sex, personal relationships and morals generated some discussion. Previous research presents contrasting evidence on whether young men do (Jewitt, 1995; Lenderyou & Ray, 1997) or do not (Woodcock *et al.*, 1992a; Talbot, 1995) want to learn about these topics in school. The respondents acknowledge that the exclusion of these topics is a deficiency in sex education programmes, but that the practical details of teaching raised some problems. The respondent in this extract believes the early to middle teenage years are inappropriate for learning about these issues:

> *(At school then, what sort of ideals were there about sex? Was it just purely the mechanics or did they talk about other things?)* They tried to have these discussions about the morals and things, but they were only when we were about 13, 14, so I don't think anyone was really involved enough to know what was going on. I think

> they were trying to instil an idea into you of being morally proper and things. [149:05]

An example of the difficulties of learning these topics is provided by a young man interviewed by Talbot (1995, p.72) who took part in a mixed-sex classroom exercise on emotions and feelings:

> "I remember it was called 'My Rainbow of Emotions'. I thought it was really sad. We had to write our feelings on a huge rainbow stuck on the blackboard and I was thinking "God, I'll die if she asks me.""

Besides the timing of lessons, the skills, personality and attitude of the teacher are crucial factors in determining the quality of learning. Positive teacher attributes include appearing not to be embarrassed, to be in control and have the respect of the class, and to ensure the lesson is interesting. To help achieve the latter point, the respondents identify teaching methods including videos, displaying and allowing pupils to handle contraceptives (particularly the demonstration and practice of using a condom) and the ability for pupils to ask questions anonymously[6]. Interesting and amusing moments are cited as memorable aspects of school sex education:

> Just somebody asking a really silly question that ... I can actually remember one of the questions. *(Yeah?)* Yeah, someone asked, "What happens if you need to go to the toilet, you know, while you're having sex?" And it just seemed funny at the time, you know? [159:19]

Similar to discussion of sex between young men, an observer viewing school sex education lessons might question whether the male pupils take the subject seriously. Many respondents recall their sex education lessons included giggling, joking and general 'messing about', mostly by male as opposed to female pupils. Why do some young men behave in this manner? First, disruptive behaviour acts to mask a young man's embarrassment about sex, as this respondent discusses:

> *(D'you think [the sex education] was right then at your stage of development, for your age, d'you think it fitted in with what you needed to know?)* Yeah. I mean, it wasn't something by then that I was giggling about. They say that you should be told off for giggling but I don't think that young people giggle so much 'cause they think

---

[6] One popular method of achieving this is for all pupils to write a question on a slip of paper privately, that are then collected, shuffled, read out and answered by the teacher.

> it's rude, I think they giggle more that they get embarrassed and it's a way of hiding ... [160:12]

This embarrassment is compounded by the strange and inappropriate context of the classroom environment for discussing sex. With joking, teasing, and gossiping, discussion of sex usually takes place with male friends in the playground or out of school. This context contrasts with the sombre and studious environment of a school classroom, with the topic being raised by perhaps the *last* person a young man would expect (or want) to discuss sex with - his teacher.

A second factor is the pressure young men are under to appear knowledgeable about sex. As this respondent explains, disruptive behaviour in lessons does not necessarily imply that the perpetrators already know about sex:

> But most of the boys just laughed it off I think. Those that knew about [sex] laughed 'cause they knew, and those that didn't laughed it off 'cause they didn't want to show that they didn't know. [186:11]

This ability for a young man to learn about sex without having to reveal his level of knowledge on the subject is a definite advantage of school sex education:

> That was the first and only time I remember being taught about sex. It was really too late by then because everybody was just creased up and stuff, yeah, because most of us knew. And if anyone didn't know I suppose, well fine ... I suppose in that sense it was a good time because if somebody didn't know about it they could laugh with the rest and learn at the same time. [180:16]

3.4 PORNOGRAPHY

Pornography played an important role in many respondents learning about sex. For simplicity, the term 'pornography' is used, although this refers to a range of material, some of which is not traditionally assigned the label of 'pornography'. From a user's perspective, the common theme behind these materials is images, text or audio content that is (or at least, aims to be) sexually arousing. Formats of pornography the respondents identify include:

a) Magazines - softcore or hardcore.

b) Books - including fiction with some sexual content, (for example, *The Cement Garden* (McEwan, 1978), erotic literature (for example, *My Secret Garden* (Friday, 1976)) and sex manuals (for example, *The Joy of Sex* (Comfort, 1986)).

c) Films - seen on video or television (terrestrial, satellite or cable channels). Respondents distinguish softcore and hardcore films, with the latter seen on video.

d) Internet.

e) Phone sex lines.

Some of these formats are fairly easy to obtain (for example, television), whereas the consumption of others is legally restricted. To help overcome restrictions, respondents describe a large illicit market in pornographic magazines (and to a lesser extent, videos) existing in the early and middle teenage years, with much buying, selling, bartering and borrowing occurring. Other sources for obtaining pornographic magazines include finding discarded ones, and surreptitiously borrowing magazines from other men (often a young man's father or older brother).

Pornography is cited as a source for learning about sex by around two thirds of the 43 respondents. Although Holland and colleagues (1993) cite the importance of pornography for young men, other studies generally do not support this idea (Farrell, 1978; Spencer, 1984; Wellings *et al.*, 1994; Talbot, 1995). This apparent contradiction might be explained by two factors; first, the different research methods used. Studies using structured questionnaires may not include a pornography category, as in the NSSAL[7]. A second factor is reluctance to admit use of pornography to researchers. In British society, pornography traditionally has been viewed as indecent and immoral material (Ferris, 1993; Thompson, 1994). The face-to-face context of an interview may be thought of as inappropriate for honest reporting of use of 'improper' material. However, the trust and rapport built up over the interview, with the open and unembarrassed discussion of other sexual matters, are likely to facilitate discussion of pornography.

[7] Although respondents could select categories labeled 'magazines and newspapers' or 'television' to refer to pornography.

The respondents' recollections of using pornography suggest an appropriate sexual 'script' (Gagnon & Simon, 1973) has been learnt. First, respondents are unwilling to assign importance to this source. An underlying theme is that use of pornography was not taken seriously, more 'for a joke':

> I think my brother had [pornographic magazines]. I found them in his cupboard when I was quite young, about 12, 13. I think that was quite an eye opener, and they were going round school and I'd be looking at them at the back of maths lessons or something. But I think it's more, it wasn't a serious like "Wow! God, look at that, take it home", it was just more of a laugh and people joking around and big fat ugly women in it and things. [149:23]

This lack of importance is reported particularly in reference to pornography viewed in a group situation (for example, watching a video). Again, this may be explained by the need for young men to present a certain image to their peers. If a young man admits that he takes pornography seriously or it helps him to learn about sex, this may be interpreted by his peers as admitting that he is unable to have 'real' sex, that is, heterosexual activity. This may be more of an issue when more of the peer group are having sexual experiences themselves.

A second, more private function is that viewing pornography has a stimulating and arousing effect, even if the respondents were unsure why at the time. Consequently, pornography was often used by respondents during the teenage years (and later) as a stimulus when masturbating, discussed further in section 4.2.1.

The third aspect is how pornography is forbidden material young men should not have access to unless they are adults. This perception is reinforced by the clandestine methods used by adult men to store pornography (for example, hidden on the top shelf of cupboards, in garages), and reactions from adults when a respondent was discovered with pornography. This young man describes his mother's reaction when she found him with magazines:

> When I was about ten we had this gang, there was me, Shawn and this guy called Joel and his dad had a pile of pornographic magazines in his garage about three feet high, I took some home with me, not knowing that I wasn't allowed to have them at the time and of course mum went ballistic and said "Where did you get them?" "Oh, Joel's dad". She went round, rant, rant to him - just didn't approve of that at all. *(Did she tell you off for having them, or was she just shocked that you had them?)* She said "No, you shouldn't have them, you're not allowed till you're over 18", and she pointed it out, "Look it says '18' on the thing and you're not allowed to have them", so it was his dad that was wrong for letting me have them. [174:10]

The manner in which adults dealt with and reacted to pornography built up mystique, which in part increased respondents' curiosity and desire to view the material. This desire, however, was often accompanied by feelings of guilt and shame when viewing the 'forbidden' material. Other negative emotions include shock and disgust at the sexual explicitness of hardcore pornography. Equally, some respondents express concerns of the images of women and sexuality presented in pornography. The respondent quoted below was caught (with friends) reading pornographic magazines at boarding school, and given a talk by his house master on how the magazines do not give an accurate representation of sex. The respondent then discusses how he equates pornographic magazines with a more liberal view of sexuality:

> Porno mags, for me they're just sort of definitely the more liberal side of sex, you know. I mean, you can have sex and you can make love I suppose, do you know what I mean? *(Yeah.)* I mean, most porno mags are sort of having sex, you know, not making love sort of thing. It's like the Playboy Channel and the Adult Channel, do you know what I mean? [153:09]

Besides pleasurable feelings, pornography is cited as providing useful information on the female body (particularly the genital area), and the physical practicalities of sexual activity, information that is less forthcoming from other sources. In the words of this respondent, pornography helped to 'clue him up' on the reality of sex:

> *(Videos, did you get to see any videos then or ...?)* Yeah, when we were about sixteen we broke into my mate's dad's cupboard where he had every 'Debbie does Dallas', yeah. I think by the time we were sixteen we were all pretty clued up. [179:14]

What does previous research suggest about the content of, and effects of viewing, pornography? Although some feminist research suggests causal links between pornography and harm towards women (for example, Dworkin, 1981; Russell, 1993), there is still debate on whether use of pornography causes detrimental effects on men's attitudes and behaviour towards women (Donnerstein *et al.*, 1987; Fukui & Westmore 1994; Frable *et al.*, 1997). Content analysis of pornographic material (usually American magazines and films) suggests the presence of themes of violence, male dominance over women and gender stereotyping (Frable *et al.*, 1997). However, Thompson (1994) suggests these themes are not as prevalent in British softcore pornographic magazines, the type respondents probably had most access to in their teenage years. The increasing importance of video and computer-based

pornography should not be underestimated. Merchant (1994) sent a questionnaire to all British primary and secondary schools asking whether the teachers are aware or had found computer-based pornography circulating in school. Of those who replied, 13% of mixed-sex secondary schools and 31% of all-boys secondary schools reported affirmatively. The low response rate (27%), however, undermines the reliability of these estimates. The range of images and text available through computer-based pornography is likely to include more sexual explicitness, themes of violence and dominance over women as compared to British softcore magazines.

3.5 FAMILY

3.5.1 Context

Generally, parents are not identified as a useful or important source of learning about sex. Respondents from studies in the 1960s and 1970s and more recent retrospective studies of older men infrequently cite parents as an important source of information on sex, with the majority reporting no discussion of the topic at all (Schofield, 1965; Spencer, 1984; Cooper *et al.*, 1992a; Holland *et al.*, 1993). However, the NSSAL data shown in Figure 3.1 suggest that parents are more important for recent birth cohorts, although more so for women than men.

An example of a more recent cohort is provided by the Year 11 pupils who responded to a questionnaire for Turtle and colleagues (1997); results are shown in Table 3.1. Around one third of the young men report having discussed various sexual topics at least once with their parents. Contrastingly, a different study asked parents if they had (or planned to) discuss sexual topics with their children (Health Education Authority, 1995). Sixty-nine percent of parents reported they had discussed sexual matters with their children, with an additional twenty-five percent saying they would do when the time is right. Although different designs were used in the two research studies, the difference in parents' and children's perspectives on the same issue is striking.

Turning to the respondents' experiences - for simplicity, the term 'parents' is used; however, a respondent's 'parents' may be one, two or more adults at any one time, and change may

occur through separation, divorce, or death. In addition, while some respondents perceive their parents as a homogenous unit sharing similar attitudes about sex, other respondents identify conflicting and/or changing attitudes. Respondents in this latter group either explicitly received opposing messages about sex from their parents, or implicitly felt their parents held differing views.

The importance of parents for learning about sex is low across the sample. Just under half of respondents report they received no sex education at all from their parents. Running throughout the respondents' recollections is an underlying feeling of embarrassment associated with sex, either from the respondent, his parents, or both parties. This embarrassment manifests itself at moments when the subject of sex arose and the respondent and his parents were present. Examples include attempts at sex education initiated by either party, exposure to sexual themes on television, and a respondent's reluctance to discuss a girlfriend with his parents. Very few of the respondents report they felt comfortable discussing any aspect of sex with their parents, even when the respondents were adults themselves. The respondent quoted below expresses his distaste when thinking about his family and sex:

> I think all the knowledge, all the feelings that I had around sex ... because I guess it was never talked about and it was never discussed, I felt ... I guess everyone does ... a great deal of revulsion thinking about my family's connection with sex, which seems totally distinct. My family and sex just don't mix. [178:10]

Some respondents explain this dissociation as a reluctance to accept that their parents are (or, at least, were) sexually active. Such an idea entails some discomfort for this young man:

> *(What do you think [your mother's] ideals are about sex? I mean, does she think sex before marriage is wrong or ...?)* Oh, blimey, I can't imagine. *(She's never ever ...)* I can't imagine my parents having sex let alone anything else, you know. [161:14]

However, other respondents are less troubled by their parent's sexuality, particularly if they had more exposure to evidence of it. Living with a divorced or separated parent and seeing them having different sexual partnerships is reported to foster a more open and honest atmosphere in the family about sex.

The other main factor cited to explain embarrassment around sex is cultural, religious or moral attitudes and beliefs held by parents. These convictions may prohibit discussion of sex within the family, or foster a parent's unwillingness to accept that current young people have different sexual attitudes and values:

> But it's funny because my mum is so open, but there is a little bit of her to do with sex that doesn't seem to be, umm, that probably turns a blind eye to what I do. I'm sure she knows exactly what I do, but probably just says, "Oh, that's what that generation does and it's not what I do". [185:05]

For the respondents who do report receiving some sex education from their parents, which party initiated the education? Sometimes, both parties play a role; for example, a young man's simple question about sex may unwittingly expand into a full and detailed talk from a parent. Other prompts parents used to initiate discussion include the verification (or refutation) of something a respondent had heard or read, and a respondent's enquiry about an object he had seen (for example, a tampon or condom). Those few respondents who initiated their sex education from parents did so because they felt if they had waited for their parents to raise the subject, it would have been too late.

Contrasting joint or son-led provision, however, is the unprompted and unexpected parent-led provision. A common format is a basic lecture on sex - the proverbial 'birds and the bees' talk. For those respondents who received very little sex education from their parents, this talk played a memorable and important role. Elements of ritual are attached to its delivery; first, respondents felt their parents felt obliged to give the talk, even if they obviously appeared uncomfortable doing so. Second, the talk is planned and a departure from the parent's usual behaviour. This respondent had a talk from his father whom he previously described as a *"hands-off"* parent:

> *(So did [your father] initiate that and say "Look son, I want to sit down and ..."?)* I must say it was quite staged, my mother took the two other kids out for the day, I was left behind, I thought "Oh, I'm left behind". And I was sat down ... *(And what was said?)* Quite a lot actually, I was quite embarrassed really. Just told me all about everything. *(Yeah? Contraception?)* Contraception, pornography, sexual behaviour, prostitution ... *(Really?)* The works yeah, I had the full business. [179:06]

3.5.2 Timing and provider

Two situations are evident when considering the timing of sex education provided by parents. First are parents who provide information before their son is felt to need it. Basic information on puberty and reproduction at an early age, perhaps complemented by information on contraception may be provided in the middle teenage years. Some respondents who received this approach thought it effective, while others felt the amount of information provided by parents was less than that already obtained from other sources.

A second approach is displayed by parents who provide information more through necessity because they believe their son has become sexually active, or is about to enter a social environment in which he may become sexually active. Just before going on holiday (without parents) or to a party or festival, some respondents recall their parents telling them to 'be careful' and use contraception. Parental acceptance that a young man is, or may soon become, sexually active is described by this respondent as transcending the traditional parent-child relationship:

> I guess there were little kind of statements now and again [from my parents], "I hope you're using condoms" kind of thing, but much more of an adult to an adult rather than parents to child fashion. [178:11]

Regardless of the timing, do mothers or fathers take separate roles in the respondents' learning? Some studies suggest young men are more likely to talk with their mothers than their fathers about sex (Farrell, 1978; Rudat & Speed, 1992; Turtle *et al.*, 1997). The Sex Education Forum (1997) suggests that a mother is the parent expected to provide sex education, but is likely to know less about men's sexual development than women's.

Parental involvement in providing sex education to the respondents is displayed in Table 3.2. Not only are the parents' respective input shown, but also the association between these two factors. What types of respondents are more likely to receive 'nil', 'limited' or 'medium to full' parental involvement? An age pattern is apparent, with younger respondents more likely to receive fuller education. Another demographic factor is birth order, with first borns more likely to receive fuller education that those born second or higher in the birth order.

Table 3.2 - Mothers' and Fathers' Involvement in Providing Sex Education to Respondents.

Father's involvement		Mother's involvement: Nil – Not provided at all	Nil – Mother not present	Nil – Provided only by father	Limited	Medium to full	*Total*
Nil	Not provided at all	☺☺☺☺☺ ☺☺☺☺☺ ☺☺☺☺☺ ☺					*16*
	Father not present	☺☺☺			☺☺		*5*
	Provided only by mother				☺☺☺	☺☺☺☺	*7*
Limited				☺☺☺	☺☺☺	☺☺☺	*9*
Medium to full				☺☺☺☺☺			*5*
Total		*19*	*0*	*8*	*8*	*7*	*42*

Notes

☺ - one respondent

Shaded cells indicate impossible combinations.

'Father' and 'mother' refer to the biological or step parents who were most important in the respondent's childhood.

'Nil' indicates no sex education provided.

'Limited' indicates parent gave brief and vague 'birds and the bees' talk; or answered one or two questions when asked; or subtly provided book.

'Medium to full' indicates parent gave more detailed and specific 'birds and the bees' talk; and/or fully answered questions when asked; and/or discussed sex freely.

A third factor relates to the emotional warmth and parental regime in the family. Respondents were asked how warmhearted, approachable and loving their mother and father respectively were towards them, as well as the general emotional atmosphere in the family environment. Taken together, these variables are labelled emotional 'warmth' in the text. Parental regime refers to the attitude and style of upbringing from the respondent's mother and father. Different categories of responses include 'repressive', 'restrictive', 'mixed/ambivalent' and supportive.

Parents reported as emotionally 'warm' and adopting a supportive regime with the respondent are more likely to provide medium to full parental involvement. Conversely, emotionally 'cold' parents operating a more restrictive parental regime are associated with nil, or limited provision.

Excluding the 16 cases in which parents provided no sex education, most respondents report one parent as primarily responsible for education. Few of the respondents' descriptions suggest that the task was shared equally between parents. Three factors determine which parent took a lead. First, an element of chance is involved; for example, which parent happened to be present when the respondent asked about sex. Second are factors relating to the warmth of the relationship between a respondent and a parent. The warmer and closer the relationship, the more likely the respondent is to report discussion of sex with that parent.

Third are cases in which a respondent feels that his mother and father decided one of them should take responsibility for providing sex education. This is a common situation for respondents who had limited sex education from parents, for example, the basic 'birds and the bees' talk. Although obviously appearing uncomfortable, the parent was seen as fulfilling their parental duty to tell their son about sex.

3.5.3 Messages

Besides factual information, the respondents were also asked whether they received any other messages about sex from their parents. These messages may be stated explicitly, implicitly picked up from parents' statements on related subjects or from reactions to the

respondent's behaviour. Three categories are discussed below: messages relating to the sexual behaviour of the respondent, sexual relationships, and appropriate locations for sexual activity.

a) Sexual behaviour

Variation exists in the extent to which respondents feel their parents wanted to influence their sexual behaviour. At one end of the spectrum are what might be termed laissez-faire parents, that is, parents who wanted their son to learn about sex as he grew older, primarily through personal experience. Moving along the spectrum are respondents who picked up parental messages on whether sexual activity is generally a 'good' or 'bad' thing. The respondent quoted below spent time living separately with his divorced father and his divorced mother, and picked up messages based upon both parents' sexual behaviour:

> *(And were there any implicit messages about sex, like it should be reserved for marriage or anything like that?)* Well that's the thing, the implicit message was that you should do it as often as you could, 'cause I mean, when I went to stay with my mum, she also had boyfriends. I still think that sex only in marriage is the minority or a thing that weird people do, like just the fact that I was brought up in these two households where partners were not exactly swopped, but not infrequent. [168:07]

The most common message from parents was that a respondent should 'be careful', that is, avoid risks in his sexual behaviour. This message usually is explicitly stated, and is common from parents providing limited sex education. What 'being careful' means either is left unstated (due to embarrassment or a belief that the young man understands the meaning of the statement) or accompanied by a statement that the respondent should always use a condom when having sex, citing the risks of pregnancy and/or infections (particularly HIV/Aids).

b) Relationships

These parental messages focus on the types of relationships appropriate for their son's sexual activity. Most messages suggest restrictions rather than freedom, namely that sex should only occur in a long-term, steady relationship or marriage. Usually implicitly picked up by the respondent, these messages are explained with reference to traditional and

moralistic attitudes held by parents. The respondent quoted below lived most of his teenage years in a country he describes as having a *"macho culture"*, and received contrasting messages on the type of relationship his parents thought was appropriate for sexual activity:

> I used to, this was when I was a year older, say 18, come back with girls that stayed the night and that's it, and my mother got really upset. She said that I wasn't supposed to do that, that I was a disgrace, her house was not a whore house and things like that. I couldn't understand what she was going on about. And my dad was quite happy, you know, he said "Do what you want son". [167:08]

c) Locations

This third, unexpected group of messages reflect whether a young man is allowed to sleep with a sexual partner in the parental home. These episodes are one of the few times some respondents explicitly received any message about sex from their parents. Conflict is inherent; for possibly the first time a young man's parents consciously and visibly have to acknowledge that their son is sexually active.

Parental responses to this situation range from allowing the partner to sleep with the respondent, to the other extreme of not allowing the partner to sleep with the respondent and commenting that the respondent should not be sexually active anyway. Another response between these extremes is prohibiting the respondent from sleeping with his partner, but implicitly or explicitly passing on a message of general acceptance that the respondent is sexually active, as in this example:

> *(Were there any rules about sex that were set?)* My mum said "If you're going to do it you're going to do it, but don't do it in my house." [154:06]

If a respondent's parents did prohibit his partner from sleeping with him, the reason for this refusal may be left unspecified. The parents might be suggesting whether they feel the young man should be sexually active, whether the respondent should be sexually active with that particular partner, or whether having sex in the family home is appropriate. This respondent believes his parents adopted an 'out of sight, out of mind' attitude to his sexual behaviour:

> And I think, [my parents] work on ignorance is bliss, if [me and my partner] slept in the same room then it's fairly obvious that what we're doing, if we sleep apart then they're just quite happy to ignore it. [150:12]

3.5.4 Siblings

Before leaving the family as a source of learning, the role of siblings is considered briefly. Most of the sample had brother(s) and/or sister(s) available to them at some time during childhood and their teenage years, be they biological or step siblings. Around one quarter of these respondents report siblings as a source of learning about sex.

Two factors influence whether a respondent discussed sex with a sibling: the closeness of their relationship, and the sibling's relative birth order. First, respondents who report a better relationship with a sibling (that is, they felt close, got on well and were comfortable talking to each other) are more likely to report learning about sex from them. The gender of a sibling is rarely reported as an important factor[8].

Second, some respondents feel that an *older* brother or sister is likely to have more experience and knowledge about sex, and is therefore a good source to approach for information. One facet of this experience is that older siblings help to define and test the parental limits of acceptable behaviour around sex and relationships. If a young man is aware of conflict between an older sibling and his parents over sex, he may cite that sibling as a source for learning, or feel more able to talk to the sibling about sex. The respondent quoted below had a good, close relationship with his sister, and feels he learnt from her confrontations with their parents:

> *(Did [your father] talk about contraception at all?)* Umm, not then. My mother did later. I only picked it up as my sister was going on, 'cause she always hit the barriers first - then by the time I came through it was all sort of, you know, set down in concrete. She'd fought all the battles and I went sort of straight through. [150:10]

[8] Although data from the NSSAL in Figure 3.1 suggest otherwise, with men more likely to cite brothers than sisters as sources for learning.

3.6 SUMMARY

a) More recent cohorts of young men report better quality learning about sex, with school and the media playing important roles. Older respondents cite pornography and personal experience as useful sources.

b) Friends, however, are the most important source overall. Young men who socialise at the fringes and have a smaller social crowd available to them may have less opportunity to learn from the 'educators' of a male peer group, that is, the sexually knowledgable members. Banter, gossip and mechanics are common modes of discussion; all contain messages about appropriate gender roles and behaviour for young men.

c) Conflict can exist between how much sexual knowledge a young man feels he is expected to present in the public domain, and his actual level of knowledge. This makes it difficult to acknowledge that he may need to learn about sex, and concealment and bravado may be used when discussing sex.

d) Therefore, passive learning sources (in which levels of knowledge do not have to be revealed) are popular. Media, certain discussions with friends and peers, and school sex education also examples of safe, passive sources. However, teaching of issues around sex, relationships and morals requires the use of participatory techniques, which may result in more guarded and defensive responses.

e) Overall, the quality of learning from parents is low. Younger respondents, first borns and respondents reporting emotionally warm and supportive parents are more likely to report better quality learning. Apart from factual education, parental messages on 'being careful', appropriate sexual partnerships and a young man's sexual activity in the parental home are common messages received from parents.

CHAPTER 4 - SOCIAL CONTEXT

4.1 INTRODUCTION

This chapter discusses the setting within which young men begin and experience the early stage of their sexual partnership history. The aim is to understand the personal, social and cultural context in which 'asexual' boys make a transition to 'sexual' young men. Accompanying the physical and emotional changes of puberty, a young man's sexuality develops and manifests itself in different spheres. First is the realm of autoerotic behaviour (pleasuring one's own body): an important outlet for sexual interest. Second is the sphere of sexuality involving other people, particularly heterosexual interest. Translating sociosexual interest into sexual experiences, however, requires interpersonal strategies and social contact with potential partners. The chapter, therefore, provides a link between the acquired information and message about sex considered in Chapter 3 and the sexual partnerships considered in Chapter 5.

Throughout the chapter, reference will be made to the six categories in Table 4.1, reflecting young men's social and sexual interaction with young women. The categories reflect several dimensions of a young man's interaction with his female peers, including his social, romantic and sexual interest, socialisation patterns and interpersonal strategies. While some categories reflect the values and meanings embedded in the heterosexual discourses discussed in section 4.5, they also represent the reality of a respondent's social contact with young women. For example, while some respondents subscribed to a romantic discourse during their early and middle teenage years, their limited social contact with young women meant that this discourse was rarely able to be put into practice.

4.2 SEXUAL INTEREST AND DEVELOPMENT

Two contrasting spheres in which a young man becomes more aware of his developing sexuality are identified. First is autoerotic sexual development, represented by experiences including sexual sensations, erections, wet dreams[1] and masturbation. Second is any sexual

[1] A 'wet dream' refers to ejaculation occurring during sleep.

Table 4.1 - Respondents Grouped According to their Social and Sexual Interaction with Young Women.

Group	Summary	Young women viewed primarily as	Level of sexual interest in young women	Level of discomfort interacting with young women	Typical characteristics
'Uninterested'	Low level of interest in young women - other social activities more interesting.	Potential friends	Low	Low/medium	• Mostly male friendship group • Subset very active in sports or leisure pursuits
'Shy boys'	Little social contact with young women.	"Different species" [168:18]	Low	High	• Early on in sexual development • Primarily male leisure pursuits • Attending single sex secondary school • Late sexual developers
'Girls talk'	Prefer company of young women to young men.	Mostly potential friends	Low	Low	• Dislike 'laddish' behaviour of male peers • Bullied and teased by male peers • Low self-esteem, concerns about body image
'From a distance'	Interested in young women, but limited social contact.	Potential friends or sexual partners	Medium	Medium/high	• Attending single sex secondary school • Living in rural, isolated location • Low self-esteem, concerns about body image • Late sexual developers
'Friendship'	Sexual partnership based on friendship and romance.	Potential friends or sexual partners	Medium/high	Low	• Attending mixed sex secondary school • Socialise in mixed-gender social groups • Early sexual developers
'Lads'	Young women to be 'chatted up' and 'got off' with.	Potential sexual partners	High	Low	• High status in peer group • Early sexual developers

interest in members of the opposite and same sex. What meanings do these events hold for young men, and how are they associated with the timing and context of their sociosexual attitudes and behaviour?

4.2.1 Autoerotic

The process of puberty involves changes in an individual's appearance, body sexualisation, hormone concentrations (with effect on mood and libido) and growth rates (Moore & Rosenthal, 1993). How do the respondents understand these changes, and how are they associated with outward expressions and interest in sexual behaviour? The respondents were asked to recall the age at which they first experienced various sexual events. Figure 4.1 shows the cumulative percentage of respondents reporting age at first sexual sensation, masturbation, sexual interest in women, snog[2], heavy petting[3] and penetrative intercourse. For the whole sample, ages 11 to 17 are when these first experiences are concentrated.

Two of these indicators can be used to represent autoerotic development: first sexual sensation and masturbation. The question on age at first sexual sensation generated a range of interpretations. Many respondents recall when they first cognitively linked a visual or physical stimulus with an associated physical response of sexual arousal. Examples of reported stimuli are:

a) physical stimulation, for example, rubbing genitals against the floor, climbing a rope or swinging on a swing
b) kissing, touching or being in close physical proximity to someone
c) viewing a film or television programme with sexual content or featuring an attractive person
d) seeing an attractive person in reality.

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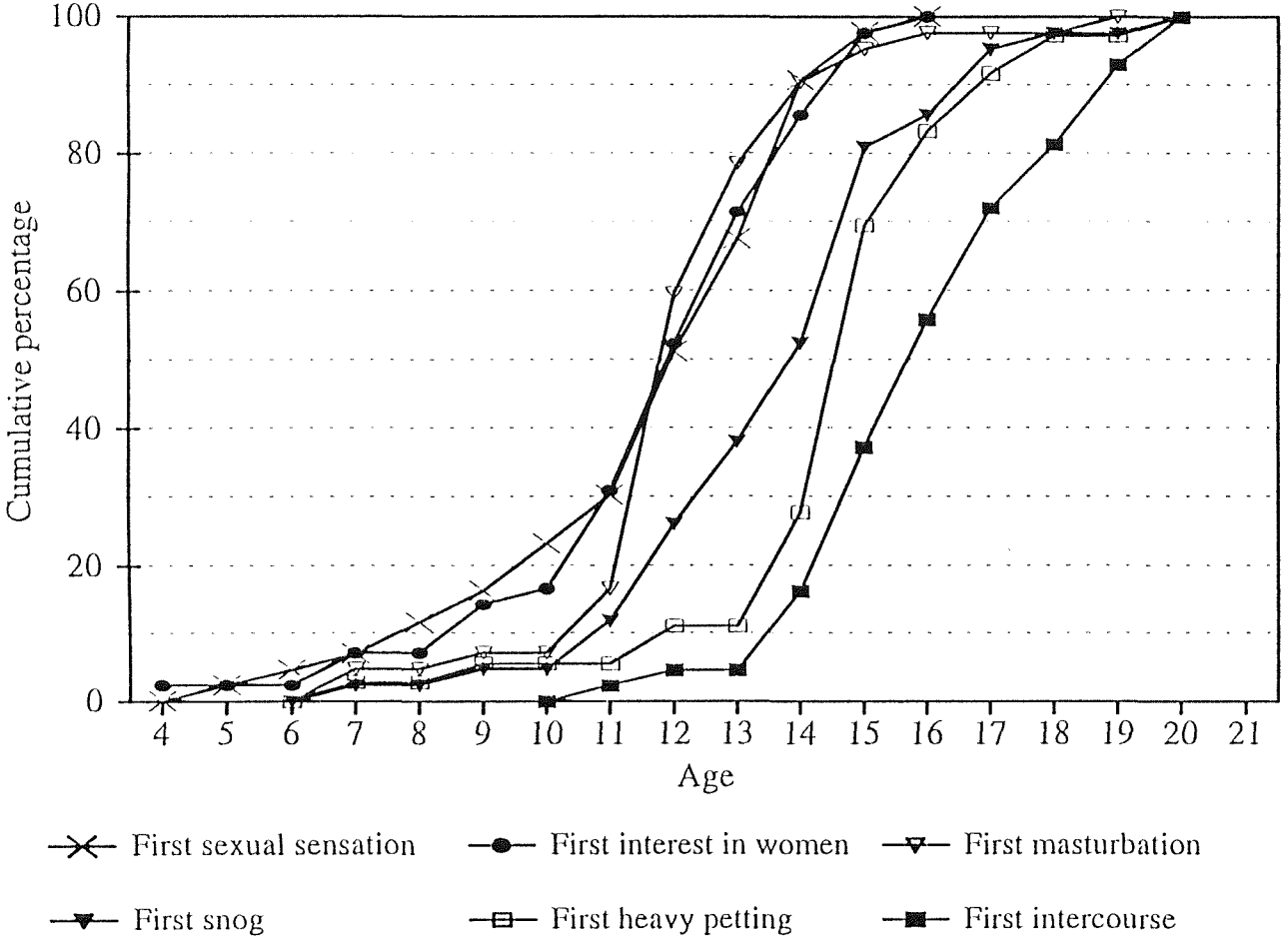
[2] 'Snog' refers to consensual kissing with sexual meaning as opposed to, for example, a friendly peck on the cheek.

[3] 'Heavy petting' refers to consensual touching of a partner's genital region underneath clothing.

Figure 4.1 - Cumulative Percentage of Respondents Reporting Indicators of Sexual Development, by Age.



Indicator	Sample size	Median
Sexual sensation	43	12 years
Interest in women	42	12 years
Masturbation	42	12 years
Snog	42	14 years
Heavy petting	36	15 years
Intercourse	43	16 years

'Sexual sensation' is self-defined by the respondents; see the text for their interpretations.

'Interest in women' refers to the first time a respondent became interested in young women as potential sexual partners. See the text for discussion of this indicator.

'Snog' refers to consensual kissing with sexual meaning, as opposed to, for example, a friendly peck on the cheek.

'Heavy petting' refers to consensual touching of a partner's genital region underneath clothing.

'Intercourse' refers to anal or vaginal penetrative intercourse.

The related feeling of sexual arousal may include having an erection. As discussed in the quotation, although erections may have occurred before in a young man's life, he may not have understood their sexual meaning:

> *(When do you first remember feeling any form of sexual arousal?)* (pause) I don't know, umm, I think it was kind of, I would get erections but I wouldn't know why, and that probably happened since I was born. Umm, I think probably I connected it with my own feelings when I was about 12 or 13. [185:17]

The uncontrollable occurrence of erections may be embarrassing and a source of worry for young men during this period of their life (Moore & Rosenthal, 1993; Talbot, 1995).

The reported age at first masturbation ranges among respondents from 7 to 19 years, with a median of 12 years. Some respondents recall that self-stimulation of the genitals was a common behaviour throughout childhood, and therefore do not identify a specific event as the occurrence of first masturbation. However, other respondents dismiss childhood masturbation as just *"fiddling with yourself"* [163:29], and define the start of 'real' masturbation as either:

a) when first orgasm occurs during masturbation, or
b) when first ejaculation occurs during masturbation.

Of these two events, first ejaculation from masturbation (also termed 'semenarche' or 'spermarche' [Adegoke, 1993; Stein & Reiser, 1994]) is the more important event. This respondent feels his first ejaculation was, similar to his first penetrative intercourse, a decisive event in his sexual development:

> *(And how did you feel about sex after that first time?)* Umm, I felt it was like another leap in my growing up if you like, perhaps the same way I felt after that time on 'Holiday Lake' when I first masturbated. It was maybe the next graduation up, if you like ... it was something that was going to happen to me. [151:22]

Semenarche is a memorable event for other respondents, although few assign it the pivotal status given by the respondent quoted above. A range of feelings accompany semenarche; pleasurable physical sensations of masturbating and orgasm can combine with curiosity, bewilderment and even apprehension. The strength of these latter feelings depends on a young man's prior knowledge of masturbation. Chapter 3 identified sources for learning

about sex; information about masturbation was sketchy or nonexistent for many respondents. For example, this respondent describes his surprise at semenarche:

> Umm, the first time I didn't really know what was going on umm, I hadn't really had it explained to me beforehand. I was like sort of sat in the bath and, "What the hell's going on here!", sort of thing. [172:40]

A few respondents were told about masturbation from parents or through school sex education. Other respondents had discussed masturbation with close friends or had heard male members of their peer group talking. Equally, masturbation occurred for some respondents in twosomes or larger male groups (for example, a gang or in a boarding school dormitory). For most of the sample, however, masturbation (and, for that matter, wet dreams) was a solitary and taboo behaviour not discussed with friends:

> I just can't remember anybody ever saying anything to me about [masturbation], no one ever talks about, guys don't talk about it. Some of them do, you know, it's just a big joke, but within the circles I was in nobody ever mentioned the word. *(Really?)* Yeah. God knows how I found out about it. [155:29]

An inability to discuss masturbation and wet dreams can cause concern about whether these autoerotic activities are 'normal'; that is, whether a young man's male[4] peers also masturbate or have wet dreams. Feelings of guilt and shame may result if the young man believes masturbation to be an obscene and immoral activity. Respondents with a strong moral or religious upbringing (for example, Catholicism) are more likely to report these feelings:

> *(What did you think about masturbation?)* I thought it was wrong, it was dirty and that sort of thing, disgusting. *(From the religion?)* Yeah. *(So had you been taught that that was wrong and dirty and disgusting?)* Yeah. From the priest. *(Did that stop you doing it?)* Umm ... it made me feel guilty. *(Right.)* Umm, dirty and that sort of thing afterwards, but it wasn't a regular thing. *(So how often would you be doing it?)* I suppose once every couple of months really, it was very rare. [164:41]

Another aspect of guilt is believing that masturbation is being used as a substitute for having 'real' sex, that is, heterosexual activity, a view also reported by Wight's (1994c) young men.

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[4] The topic of female masturbation arose in several interviews. A common theme is how the respondents could not imagine that their female peers were interested in or masturbated to the same extent as young men.

Fewer meanings are associated with wet dreams as they are perceived as uncontrollable events. Therefore, a young man need not feel responsible or guilty when they do occur. However, respondents still recall concerns and embarrassment that their parents would discover semen stains on bed sheets or clothing.

4.2.2 Sociosexual

Accompanying autoerotic development, all respondents were becoming more sexually aware of, and interested in, other people. Some respondents feel their sociosexual interest emerged out of a 'vacuum'; peers who previously had been viewed with disinterest or merely as friends suddenly emerged in a new, exciting and strange context. Similar to first sexual sensation, respondents recall events catalysing their sociosexual interest. In this example, a Valentine's Day party signified the onset of interest in young women:

> *(So what was the context of this Valentine's party, what did you do afterwards?)* It just went from there, I think. We started seeing the girls, started calling them up and spending time on the phone, wanting to be with them. I think it was the time we realised that they were, there's something about girls we actually liked - "Hang on, there's something here." [149:13]

Note that the respondent describes this transition not as a personal event, but one shared with his male friends. As discussed further in section 4.3, peers' attitudes and behaviour can influence a young man's heterosexual behaviour, not only by prompting and reinforcing sexual interest, but through a desire to emulate peer behaviour. This respondent's realisation that his peers had contrasting sociosexual activities to his more solitary hobbies prompted him to change his behaviour:

> The only loneliness I can remember was when I was about 14 or 15 or something and I suddenly realised all the other kids were out playing with each other, playing with the girls that I was interested in, and there I was stuck in my room obsessed with - by then it was Dungeons and Dragons - and that suddenly struck me and I thought "You sad fuck." (both laughing) And that was quite, that was a very lonely experience. [178:07]

Although given equal importance by the interviewers, most discussion on this topic was on heterosexual as opposed to homosexual interest. Around one fifth of the respondents report homosexual interest at some time in their teenage years. For some, this interest is reported

to have been transient and reflecting increasing interest in all aspects of sexuality. Other respondents' interest was accompanied by homosexual activity, either then or later in their sexual history. Compared with heterosexuality, however, it was much harder for respondents to openly acknowledge or discuss homosexual interest. Disapproval and condemnation of homosexuality from male peers resulted in homosexual activity being concealed from friends and peers, and dismissed as meaningless behaviour.

What form does emerging sociosexual interest take? Note from the previous two quotations that sexual interest is not necessarily associated with an immediate and strong desire to experience high-intimacy sexual activity. Some respondents *did* link sociosexual interest with a desire to experience specific sexual activities, as for this respondent:

> But I mean, I saw my first hard core porn film when I was probably about 16, which did turn me on. That's when I thought "I'd like to do that, that, that and that". You know, I had longings but not ... I didn't care. [162:46]

Other respondents report their developing sociosexual interest encompassed feelings around the emotional and social aspects of interpersonal relationships. These include the desire to share social and leisure activities with young women and the social prestige of having a girlfriend. Sexual activity may develop from these activities, but it is not the primary meaning of the interest. Non-sexual aspects of heterosocial interest are particularly important for the 'Shy boy' and 'From a distance' groups of respondents who had limited social contact with young women in their childhood and early teenage years. Young men who seldom socialise with young women may be curious and interested to find out more about their personalities, interests and lifestyles, as this respondent discusses in relation to the biological basis of his school sex education:

> *(How did you feel about girls at [age 14/15]?)* Umm, I suppose I was interested. *(What in though?)* Getting to know them. Sort of, like in the [sex education] lessons we were just talking about general like bodily things. I was interested in how they thought and you know, the other differences, like how they thought about say football for example, or certain TV programmes. I don't know, anything just to see what the main differences were other than physical. [164:17]

The association between the reported timing of the start of a respondent's autoerotic behaviour, sociosexual interest, and sexual activity varies. For some, many of these events occurred around the same time:

> *(So when did it first happen that you actually had an orgasm?)* Masturbating with a result? *(Yeah.)* I suppose when I was about 12. All those things seemed to sort of happen at the same time; people started talking about sex, you start kissing girls, you start masturbating with sort of things happening. [179:22]

A clustering of events is apparent in the lives of other respondents, with a comparatively short time during which they became aware of their own sexuality, developed sociosexual interest, and experienced sexual activity with other people. Figure 4.1 suggests a sequential pattern of experiencing sexual activities with greater levels of intimacy over time. Following age at first sexual interest, half the respondents experienced their first snog, heavy petting and intercourse within one, two and three years respectively[5].

A period of varying duration, therefore, occurs between the onset of sociosexual interest, and a young man's experience of sociosexual activity. Any sexual interest may be identified and acknowledged, but not considered a great priority for that period of his life. This reasoning can be accompanied by an acceptance that although sexual activity is unlikely to occur now (through lack of opportunity or personal confidence to initiate and experience sexual partnerships), it is likely to occur in a few years time. Alternatively, some respondents used masturbation as a more accessible and simpler outlet for sexual interest:

> I mean, I knew that's what girls were for, sort of thing, but they seemed like a different species ... it didn't occur to me to want to go further. I mean, because I did have lots of porn at that stage, so I think that was what kept me happy. I just really was able to wank off at these magazines instead of bothering myself about actually of thinking of going out and finding anyone. [168:18]

4.3 PEERS

Of all the influences on a young person's sexuality, the role of peers receives much attention. Young people are often represented in media and social science research as vulnerable and controlled by peer group pressures (Warwick & Aggleton, 1990). First is a description of the social groups respondents had access to during their teenage years. Second, it shall be seen how the structure of, and norms expressed within these groups

[5] Sexual interest is reported to precede (or occur in the same year as) these three sexual activities for all respondents apart from two whose first snog occurred before their first sexual interest.

influenced the respondents' interest, and interpersonal strategies used, in heterosexual interaction.

4.3.1 Structure

Studies of social networks identify a range of relationships acting, including best friends, friendship groups, cliques, acquaintances and the larger social crowd (Coleman & Hendry, 1990; Hendry *et al.*, 1993; Urberg *et al.*, 1995). The respondents were asked to describe the different social groups they socialised in during their teenage years. Their social networks are differentiated by the number, type and size of social groups, their cohesion and stability, and member characteristics (especially gender and age). Peers can be classified according to the degree of friendship and familiarity to a respondent. Using these criteria, four prominent social groups are:

a) **Close friends** - usually only a handful of members with the closest personal relationship with a respondent
b) **Friendship group** - a primary group for social and leisure activities consisting of close friends and other individuals
c) **Acquaintances** - a more casual relationship with a respondent, with occasional conversation and socialising
d) **Peer group** - people known of and seen around, but less social interaction.

Besides the friendship and familiarity of the interpersonal relationship, respondents identify groups of peers according to their shared characteristics. Groups can form around common backgrounds, social and leisure interests, appearances and behaviour. Labels used by respondents to identify social groups or cliques among their male peers include:

a) Lads [154:11]
b) Smokers [180:12]
c) Sports [170:07]
d) Boffins [148:17]
e) Bookworms [147:24]

Similar[6] social groupings have been reported in other studies of British young men, particularly the 'lads' clique (Willis, 1977; Connell, 1989; Edley & Wetherell, 1997; Kehily & Nayak, 1997). Groups can be placed in a hierarchy within the social structure of the peer group, differentiated by factors of power, prestige and popularity (Michell, 1997). This hierarchy has been found to be strongest in the middle to late teenage years (Connell, 1989); Phillips (1993) suggests the masculine 'pecking order' is established in the first two years of secondary school.

Although many respondents identify a similar hierarchy in the early and middle teenage years, others would dispute that they easily fitted into one of these social 'pigeonholes'. Some recognised a social hierarchy existed in their peer group, but recall they did not belong to one particular group (for example, due to mixing in none, or many separate groups). Other respondents report occupying the 'middle ground' within the hierarchy and their friendship had no distinctive features. An example is given by this respondent who discusses how he initially tried to emulate the 'Lads' behaviour, but later rejected it:

> There was always the 'lad' thing which was what I thought to be the really boys' thing, the really rascal thing, if you like, and I didn't like that. I always thought that was crap. I saw it as really separating the boys from the girls. In turn, the girls had their own things and they were always sort of giggly girlie thing, I could always see all this. Then you always get boys and girls who are not into either of those and they're always just kind of easy going, and that's the people I related more to. [155:11]

Using the suggested criteria of power, prestige and popularity, the young men at the top of the hierarchy are often the 'Lads' group described in Table 4.1. Respondents who attended private secondary schools cite members of the school rugby or football team as leaders of the hierarchy, with the pinnacle occupied by sports captains, head boys or prefects[7]. Towards the bottom of the hierarchy are the more academically inclined 'swots' or 'bookworms', and the less sporty or physically developed young men.

Generally, close friends and friendship group members are of similar age and the same gender. Only 11 of the 43 respondents (26%) report one or more close female friends in

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[6] Although the names of the groups vary.

[7] Tolson (1987) argues that an outcome of traditional middle class education is an installation of the concept of hierarchy in masculinities.

their adolescence (12-16 years), as compared with 39 of the 43 respondents (91%) reporting one or more close male friends. Young women are more likely to be acquaintances or members of the wider social crowd. Exceptions to this pattern include the social advantages of having close female friends, highlighted in section 4.5.2. Access to social groups consisting of older 'young' people also is cited as advantageous. Older social groups facilitate earlier access to adult social environments and activities, with perhaps more liberal heterosexual norms and attitudes present.

From the middle teenage years onwards, most respondents report increased socialising in groups consisting of both genders. Transitions in social and leisure activities (outlined in section 4.4.2) provide greater opportunities for heterosocial interaction. One format for this interaction is an amalgamation of a friendship group of young men and friendship group of young women. This is an useful social group; while supported by the familiar and comfortable surroundings of his own friendship group, a young man has the opportunity to socialise with young women. If he has romantic or sexual interest in a female peer, the amalgamated group enables them to meet and talk without the formality and pressure felt to accompany an one-to-one social 'date'. Mixed-gender groups, therefore, provide a forum for a young man to initiate relationships. This follows a pattern suggested by British authors (Leonard 1980; Wight, 1994c), and Dunphy's (1972) work on Australian adolescents; the fusion of male and female friendship groups is followed by disintegration into smaller, mixed groups and the pairing off of couples.

The amalgamated group is an example of a social environment facilitating a young man's heterosexual socialising. Examples are given of two other social relationships having the same effect. If a male member of a young man's friendship group has a girlfriend, she may become involved in more of the friendship group's social activities. Consequently, her female friends may accompany her, forming a mixed gender social group. Here, the couple acts as a link between the two separate groups, assisting heterosexual interaction. A second example of this bridging effect is given by respondents whose sisters facilitated their socialising with young women; namely, their sister's female friends.

4.3.2 Influence

How might the structure, characteristics and norms of a young man's social networks have an influence his sociosexual behaviour? Previous research has highlighted peer influence on many aspects of adolescents' behaviour and attitudes. Peers provide different roles and functions for a person, including social identity, reputation, conformity (versus individuality), support and friendship (Brown *et al.*, 1986). It is argued that during some adolescents' social development, peers displace parents as major sources for forming beliefs and attitudes around sexual behaviour (Lloyd, 1985; Hendry *et al.*, 1993). Peer influence can reflect group norms and act as a model for appropriate sexual behaviour, policed through comments on an individual's actions (Moore & Rosenthal, 1993).

Peer influence is strong in early as opposed to later adolescence (Brown *et al.*, 1986; Hendry *et al.*, 1993). During the early and middle teenage years, a young man has less control over the membership and structure of his peer group which is usually focused around the members of his school year group. With becoming older, changes in education, employment and social activities (outlined in the next section) allow more freedom in choosing friends and acquaintances. Hendry and colleagues' (1993) research in Scotland suggests that same-sex peer influence is stronger for young men than young women. Young women were more likely to report spending time with their best friend and mixed-sex groups, whereas young men were more strongly associated with mixing in same-sex groups. Young men were also more likely than young women to view conformity in behaviour and appearance as important factors in a person's popularity.

Peer influence is apparent in many of the respondent's discussions of their teenage years. This influence usually acted to suggest the respondent should express the same level of interest and match the heterosexual behaviour of his male peers. Why 'peer pressure' can have such a strong influence is articulated in this quotation:

> *(Why do you think that [sex] was important?)* I have no idea, but everybody else said they did that so ... it's not important in itself, it's important as that's seen as an experience that you should have had, and if you haven't you're not part of the normal, you're an outsider, you're a different ... you're far away from everybody else - somebody who doesn't understand. [182:14]

Peer influence can be explicitly or implicity communicated within a peer group. Derisive comments on a respondent's heterosexual experiences and sexuality (derogatory statuses being a virgin and being homosexual) are common examples of explicit pressure. As discussed in section 3.2.2, an outcome of young men's group discussions on sex is what Holland and colleagues (1993, p.17) refer to as keeping a young man on the "straight and narrow path towards heterosexual masculinities".

A young man's perception that members of his peer group are more sexually experienced or active than he (whether or not they actually are) acts more implicitly. This source can be as influential as explicit pressure:

> *(So when you said you were quite interested in girls but you just didn't do anything about it, were you interested in sex?)* No, I think I was interested in them because it seemed that girls were having boyfriends and boys having girlfriends, but I wasn't and like "Why wasn't I good at this?" [186:13]

It is also useful to distinguish between influence originating from members of a young man's wider peer group and his friendship group. For some respondents, this distinction is irrelevant; others, however, report that peer pressure is more likely to originate (and be communicated explicitly) from the wider peer group as opposed to closer friends. As discussed in section 3.2.1, members of friendship groups can have similar levels of sexual experience. Therefore, pressure to match the group's level of sexual experience is less as members are already close to this norm. Equally, as members of a friendship group have closer and friendlier relationships and occupy a similar stratum within the peer group hierarchy, they are less likely to want to gain relative prestige or popularity by pressuring a young man.

Although most reported examples of peer influence are to express more heterosexual interest, to have more girlfriends and to have more heterosexual activity, influence (both explicit and implicit) can also operate in the opposite direction. The respondent in this quotation reports he did not feel under pressure to be sexually active because of the apparent low level of sexual activity of his school peers:

> I mean, there were only about four or five couples dating in the school, ever, you know out of like 1500 kids, so it was just never considered. I mean, you hear one or two guys say that they'd got laid at like 15 or 16, but there was never that feeling in the school that you had to date or you had to have sex. [165:10]

4.4 SOCIALISING

> I mean it was hard for me 'cause umm, like being at an all boys' school and that you know, and not really knowing that many girls, when I was young, you know. I still used to get embarrassed when they were around and that, and people at school used to call me like frigid and all that. I showed them. (laughing) [161:26]

Three factors make it useful to consider socialisation patterns to provide the context for the sexual partnerships discussed in Chapter 5. First, a large proportion of the reported sexual partners were known as friends or acquaintances, with social interaction occurring through social, leisure, employment or education activities. Second, the pattern and extent of a young man's non-sexual social contact with young women may influence his heterosexual attitudes and behaviour. Third, there are clear transitions in opportunities for, and patterns of, socialising over the teenage years and into the early 20s. These often are cited to explain changes in respondents' success in experiencing sexual partnerships.

4.4.1 Social opportunities

Socialising is influenced by various personal and external factors, including an individual's confidence and interest in socialising, personal independence, income, mobility and the availability and accessibility of social facilities. In the early and middle teenage years, when a young man typically is living in the parental home and attending school, some of these factors are out of his locus of control. Based upon the respondents' recollections of this period of their lives, three circumstances had a prominent influence on their opportunities for socialising and therefore meeting young women.

The first is living in an **urban or rural area**. Living in a rural location typically places restrictions on personal mobility. This is especially important during the teenage years when a person is more reliant on parents or public transport for access to (and more important, from) social facilities in the day and evening. Respondents who resided in rural locations emphasise the improvements in their social life from learning to drive a car or ride a motorbike from age 17 upwards. Less personal mobility combines with a geographically dispersed population: for example, a young man's school friends may live in the same town as the school, whereas he lives in a more distant, rural location. Some respondents feel

these factors restricted their social activity in adolescence, an issue identified in other studies of rural youth (Johnson, 1986; Chance, 1988; Fabes & Banks, 1991). As shown in Table 4.1, rural residency is a typical characteristic of respondents placed in the 'From a distance' group, indicating interest in young women, but lack of opportunities for socialising with them. Table 4.2 gives some examples of movement over time between the groups described in Table 4.1; the examples of two respondents entering and leaving the 'From a distance' group relate to rural residency. A few respondents identify restrictions of residence as *the* fundamental factor delaying the start of their heterosexual experiences. Ford and Bowie's (1989) comparison of urban and rural levels of heterosexual activity did find lower levels (and a later onset) of sexual activity among rural young people in Somerset as compared with their urban/semi-urban counterparts[8].

An alternative scenario, however, is an accelerated sociosexual development based on closer interaction with fewer peers. One respondent describes his early sexual activity and first-ever intercourse with a young woman in a rural location occurred due to *"mutual desperation"* [179:23] as no peers their age lived locally. Although the phrase is used with an element of humour, a lack of peers and social facilities locally could influence the establishment of closer and more intense heterosocial relationships.

The second factor stresses the importance of the **school environment** in a young person's life. School is not only a place of formal learning, but a location for individuals to socialise with their peer group on a daily basis. A growing area of research examines associations between gender and education. One theme emerging is how the attitudes and behaviour of young men in school help them to construct their social identity and masculinity (Mac an Ghaill, 1996a).

The sample can be divided according to whether the respondent attended a mixed or single-sex secondary school. Attending a single-sex school is identified as restricting a young man's ability to meet and socialise with young women. This limitation coincides with the important period of the middle teenage years, when young men are becoming romantically or sexually interested in young women. Most respondents who attended a single-sex secondary school are identified as belonging (at least, in their early association with young

[8] However, results are not presented separately for males and females.

Table 4.2 - Examples of Transitions between Social Groups Outlined in Table 4.1.

		FROM					
		'Uninterested'	**'Shy boys'**	**'Girls talk'**	**'From a distance'**	**'Friendship'**	**'Lads'**
T O	**'Uninterested'**					Lost heterosexual interest during "turbulent" period of life [169:36]	Lost personal confidence and went through sexually "barren" period [152:35]
	'Shy boys'						
	'Girls talk'						
	'From a distance'						Social contact with women decreased when working in a rural location [174:14]
	'Friendship'		Leisure activities changed from male pursuits to more gender-mixed [184:16]	Gained confidence and respect of peers as his sporting skills improved [172:08]			Entered intense, romantic relationship [156:12]
	'Lads'	School work more important than women, then got into rave culture [157:12]	Older friend provided intensive course on how to chat up women [167:25]		Personal mobility increased when he bought a car and moved out of the parental home [179:15]	Observed male peers who were "bastards" having more girlfriends [146:38]	

women) to the 'Shy boys' and 'From a distance' groups in Tables 4.1 and 4.2. This limitation was particularly salient for this respondent as he contrasted his experiences with those of his male friends attending a mixed-sex school:

> *(What did you think or feel about the opposite sex when you were, say like, 13, 14, 15?)* Ahh, I suppose that was the stage when all my friends who went to a mixed school were, like, starting to meet girls, talking about kissing girls and snogging girls. And being at an all boys' school, I knew girls, but I didn't really ... I suppose I was a late starter. [160:24]

Although strong, this influence is not absolute and may be weakened if, for example, a young man takes part in mixed-sex social activities outside school. In addition, some respondents who attended a single-sex school acknowledge their school encouraged pupils to socialise with young women (usually attending a 'sister' school) through shared lessons, extracurricular activities or social events. The intense social pressure associated with these latter termly or annual discos, balls or other events is vividly recalled. A sudden influx of young women into the previously all-male school environment is described by one respondent as creating a *"cattle market"* [153:25], with a young man under pressure from school friends to 'get off' with one (or preferably more) of the young women present.

Conversely, attending a mixed-sex secondary school allowed more opportunities for socialising with young women. The 'Girls talk', 'Friendship' and 'Lads' groups are associated with respondents attending mixed-sex schools.

The third highlighted factor allows opportunities for socialising outside of any restrictions of residence or school through **leisure activities**. Similar to the gender exclusivity of all-boys schools, some popular leisure activities pursued by respondents in their teenage years primarily appeal (or participation is restricted) to young men. Activities include sports (for example, football, rugby and cricket), organisations (for example, Scouts and Boys' Brigade) and pastimes (for example, computing and role-playing games). This respondent describes how the combination of his school and leisure activities affected his opportunities to meet young women:

> It was very strange when I grew up because, umm, I was in a single sex school. *(Yeah.)* And I was in the Boys' Brigade which is a single sex organisation. *(Yeah.)* And that basically took up most of my spare time, and so up until I was about 17 like, girls were just something you dreamt about. (both laughing) [171:07]

Conversely, respondents who took part in leisure activities involving both sexes (for example, music bands, groups and orchestras, drama and Young Enterprise) report greater opportunities for socialising with young women.

4.4.2 Transitions

Of the different representations of young people in the social sciences, one suggests portraying adolescence as a period of transition, with development influenced by internal (emotional and physiological), and external (parents, peers, societal and cultural) factors (Hendry *et al.*, 1993). One aspect of this transition is changes in a young person's personal circumstances, influencing their opportunities for heterosocial interaction. Generally, the respondent's social opportunities increased and diversified from the middle teenage years onwards due to changes in personal circumstances. Four prominent aspects of these changes identified by respondents are:

a) **Changing social environments**, or what Hendry and colleagues (1993) describe as a transition from casual, peer-orientated groups to socialising in commercial leisure facilities. For young men in British society, gaining access to pubs and nightclubs is especially important (Leonard, 1980). As well as being ubiquitous and easily accessible, pubs and nightclubs have the prestige of being adult social environments, with both sexes[9] meeting and interacting on neutral territory. The availability of alcohol provides *"Dutch courage"* [176:18] to ease interaction with the opposite sex. Although English licensing laws require a person to be aged 18 before they can buy alcohol in a pub, many respondents report being served in pubs before this age. This was easier for young men whose physical appearance made them look older than their actual age.

   Another aspect of changing social environments is increased freedom to take holidays without parents. Trips to holiday locations or travels overseas include exposure to new environments with increased social opportunities and the potential

[9] Although Leonard (1980) notes that solo or same-sex small group access is more socially acceptable for men than for women.

to experience more sexual partnerships. An increase in people's sexual activity on holiday has been noted elsewhere (Ford, 1991) and is reported by some respondents in this study, particularly those who travel widely and report the highest number of sexual partnerships.

b) Gaining more **personal freedom and independence** to engage in social activities, including relaxation of conduct rules from parents or guardians. Turtle and colleagues' (1997) comparison of 11 to 15 year-olds found generally increasing time spent going out with friends[10], and the timing of any parental-imposed curfew becoming later with age. This factor also includes increased personal mobility associated with being able to drive from age 17 onwards, or mixing in social groups in which somebody has a vehicle and can drive.

c) **Leaving the parental home.** Thirty-eight of the forty-three respondents (88%) had left their parental home by the time of interview, to attend further or higher education or to live in a separate or shared residence. Such a transition in living arrangements (sometimes involving a change in location) is cited by some respondents as an important milestone, signifying the beginning of a new and more liberating social life. Having left a small, rural community to attend higher education, this respondents discusses this theme:

> Well [my social life] changed, it was not so much in the things I did, more in the people I was with because when I left the school, I chose to come here. It's very far away and nobody I knew had come here. It's a totally fresh start, I don't know anybody and that's just what I wanted because I was getting very bored with things at home. It was such a closed community, so tight, I felt I had no freedom there. [155:12]

In addition to greater social opportunities, living in a residence with fewer restrictions on whether sexual partners can stay overnight (as discussed in section 3.5.3, a source of conflict between parents and children) is an advantage for having sexual partnerships. However, leaving the parental home can restrict a person's social life. Having to pay for accommodation expenses (from a low income of early employment) imposes restriction on social and leisure activities. Equally, a move to

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[10] Although a drop between 13 and 15 year olds is explained as associated with duties of homework and exam preparation for 15 year olds.

a distant location severs a person's former social network and requires the construction of a new one.

d) **Starting employment or attending further or higher education.** As discussed above, this change can involve leaving the parental home, and a move to a new social environment. Starting work can also provide rapid access to a more adult social environment through socialising with co-workers. This exposes a young man to the group norms and behaviour of an older age group, and facilitates access to adult social establishments. Co-workers may include both sexes, or socialise in mixed-sex groups, offering opportunities for social interaction with women.

Some respondents who attended further or higher education[11] report an associated increase in their heterosexual activity, particularly in the first year of a course. Characteristics of this period combine to produce a social environment with the potential to support a high level of sexual activity. New and plentiful social and leisure activities can coincide with meeting people with more liberal and permissive norms around sexual behaviour. Other characteristics include (typically) living in a hall of residence with single occupancy rooms and a large pool of potential sexual partners. Lear (1995) identifies the first two years at (in this case, an Australian) university as a period of sexual experimentation reflecting this new-found freedom.

4.5 INTERPERSONAL STRATEGIES

The previous section outlined the context within which young men meet and socialise with their peers, particularly young women. For sexual activity to occur, however, a couple's relationship needs to develop beyond friendship or acquaintanceship. This section considers the interpersonal strategies respondents use to try to further relationships to experience sexual activity, and the ease with which they interact with potential sexual partners. This process is influenced by individual and contextual factors pertaining to both members of the

[11] See section 2.2.2 for how the recruitment scheme resulted in many respondents who had attended higher or further education.

couple, and the interaction and any negotiation between the couple. Of course, the interviews allow the consideration of the respondents' strategies only, not their partners'.

4.5.1 Types

The respondents' interpersonal strategies are directed at achieving one or more goals, with the achievement of one perceived to increase the chance of a successive goal occurring. One goal is to increase the level of friendship with a young woman, a second is to enter a romantic relationship, while a third is to experience different types of sexual activity. Indirect goals include the social admiration and prestige from being seen socialising with young women.

Although interpersonal strategies may be available, it would be misleading to suggest that a strategy was used by respondents for *all* the sexual partnerships discussed in Chapter 5. A number of these partnerships are reported as unplanned, unexpected, and controlled by the partner. This includes controlling the initiation and speed of the progression from acquaintanceship or friendship to a sexual relationship. This is a common scenario for some respondents in the earliest phase of their partnership history - reporting themselves as less confident in romantic or sexual interaction, their sexual partner's confidence and experience 'drive' the sexual encounter. Factors associated with lack of confidence are discussed in the next section.

Two main interpersonal strategies are identified, best labelled according to the 'Friendship' and 'Lads' groups described in Table 4.1. Respectively, these strategies approximate the 'romantic' and 'male sexual drive' discourses constructed by Hollway (1984) and introduced in section 1.5.

The choice of strategy will be influence by cultural and social messages received on what is appropriate for a person's age and gender (Moore & Rosenthal, 1993). These two strategies are potentially available to all young men, but not equally taken up. Section 4.5.2 considers why respondents report being more comfortable using a particular strategy. As discussed further in section 5.6.3, some respondents change strategy over their partnership history. In Table 4.2, for example, Respondent 146 describes how he initially chose the 'Friendship'

approach, but after observing his male peers' greater degree of success, followed their example and switched to the 'Lads' strategy.

a) Friendship

The two strategies can be differentiated by, among other factors, the degree of 'emotional distance' (Holland *et al.*, 1993) a young man places between himself and his potential partner. This strategy, labelled 'Friendship', is based upon first establishing a close degree of friendship with a young woman. While being an acceptable achievement in itself for some respondents, others feel that a relationship based upon close friendship will develop into a romantic or sexual relationship, a process one respondent terms as *"trying to worm your way into their affections"* [149:14]. Close friendship develops through the couple talking, spending time together (especially in an amalgamated social group) and sharing leisure activities. Consider this respondent's strategy which, based upon the assumption of being friends with people irrespective of their gender, uses more intensive interaction for a person he is attracted to:

> *(How did you behave when you were with girls then, I mean did you just treat them as if they were boys?)* I didn't really treat them any differently. *(Right.)* Unless you liked them, of course. *(Unless you liked them?)* Yeah, and then you'd try and impress them, I suppose we did. *(And how did you try and impress them?)* Get to know them, be their friend, help them, that's what I tried to do. I was never the big hunk, I always tried to impress them some other way. [174:19]

The 'Friendship' strategy has the advantage of enlarging a young man's friendship group. It also can involve less risk of rejection from a potential partner as the young man can delay making his romantic or sexual intentions clear until he is more confident the young woman reciprocates these feelings. However, rejection still occurs; some respondents report frustration that important relationships based upon friendship seldom become more serious. Although rejections also occur using the 'Lads' strategy, the closer emotional attachment formed with the potential partner makes rejection perhaps harder to bear. The embarrassment of rejection may result in the loss of the couple's prior friendship. This respondent discusses aspects of these concerns:

> I generally tend to put girls I like on pedestals and generally not worship them but ... because I get to know them so well first and then when they sort of reject an advance from me, just say they want to be my friend, it gets to you after a while, you know? Two or three times that can happen and you think, "What am I supposed to be -

everyone's best friend for the rest of my life?", you know. "Cheers, thanks a lot", you know. [174:33]

b) Lads

The second 'Lads' approach is aimed at rapid achievement of sexual activity. Here, female peers are primarily viewed as potential sexual partners, with any emotional relationship that may develop less important. First, the strategy includes frequenting more conducive social environments (for example, parties, pubs, discos and nightclubs) with the reputations and 'atmospheres' in which flirting, chatting up, and other forms of interaction prior to sexual activity are more likely and acceptable. Second, a young man can classify his female peers according to the likelihood of achieving sexual activity. Information on her sexual reputation (number of partnerships, permissiveness), culture, area of residence, and so on gives an indication of the social, romantic or contextual 'prerequisites' necessary before she is likely to agree to sexual activity. A typical scenario is then for the young man to approach the potential partner and, using his seductive skills, try to *"pull"* [172:44] and *"score"* [168:37] with her. In contrast to the 'Friendship' strategy, this process may have to occur over a shorter period, for example, a few hours at a pub or nightclub:

> *(What's normally led to sex, how has it come about generally?)* Umm, it's always been at the end of an evening, an evening out and a good couple of hours hard chatting up I should think. Usually alcohol as well. [149:19]

Holland and colleagues (1993) suggest that 'Lads' is the dominant discourse present in young men's sexuality. As discussed earlier, 'Lads' occupied a visible and prestigious position within social hierarchies in the teenage years for some respondents. As discussed in section 3.2.1, the leaders and vocal members of a peer group also act as a source of learning for less sexually knowledgable young men. Therefore, the 'Lads' strategy may be viewed as the appropriate norm for sociosexual attitudes and behaviour, and something the respondents should aim to emulate.

4.5.2 Determinants of success

The respondents' sexual partnership histories discussed in Chapter 5 give an indication of the success of their interpersonal strategies. The 'Lads' strategy is associated with a high frequency of reported partnerships, and an earlier initiation. Referring to Figure 4.1, respondents following the 'Lads' strategy report earlier experiences of first sexual interest, snog, heavy petting and intercourse than other respondents. As an added bonus, the 'Lads' cite the excitement and challenge of being the 'hunter' in this predatory strategy, perhaps its greatest attraction (Wight 1994c). So, the 'Lads' start early, report more partnerships, and report the thrill of the chase involved. Respondents following the 'Friendship' strategy are more likely to report themselves as early sexual developers, but do not exhibit earlier initiation of sexual experiences as compared to the other respondents. The other noteworthy feature of the 'Friendship' respondents' sexual histories is a preference for steady partnerships, and a low frequency of casual partnerships.

Beyond simple outcome measures of the types and numbers of reported partnerships, however, are the ease and confidence with which respondents socially, romantically and sexually interact with young women. The sample report contrasting emotions associated with early heterosexual interaction; excitement and enjoyment of novel experiences may accompany feelings of shyness, nervousness and uncomfortableness. The strength of these emotions is not fixed over time; for example, a common reported development is fewer feelings of discomfort or nervousness as respondents became more confident, and a decrease in the novelty aspect as social interaction with young women occurs more often. Table 4.2 gives examples of Respondents 184, 167 and 172 whose increasing confidence and skills improved their success in interacting with young women.

Different levels of comfort are associated with the nature and context of interaction. Some respondents report feeling at ease interacting with young women as friends, and therefore felt comfortable if a friendship developed into a romantic or sexual relationship. Respondents in Table 4.1 identified as belonging to the 'Girls talk' group are comfortable interacting with young women as friends, but have difficulties taking a relationship any further. Young men in this category report dissatisfaction or difficulties in interacting with male peers (for example, they are bullied or dislike the macho culture of masculinity), and therefore prefer the more sensitive and caring company of female friends.

As suggested earlier, a demanding aspect of heterosexual interaction is the initiation of verbal or nonverbal signals suggesting romantic or sexual interest in a potential partner. Here a young man may feel most vulnerable; by making his feelings clear, he risks embarrassment or humiliation if the young woman rejects his advances. Holland and colleagues (1993) suggest the reason young men find this task difficult is that it exposes their vulnerability and dependence on women, two attributes incompatible with heterosexual masculinities. To compound this difficulty, a common sexual 'script' (Gagnon & Simon, 1973) emerges from the data; respondents believing the man is expected to take the lead in the development of a heterosexual encounter. This includes the initial social contact and pursuit, initiating and controlling the progression through non-penetrative activities prior to intercourse. Respondents do not explicitly identify which sources this script is learnt from, but the gender roles suggested match common representations of masculinity through media sources (Connell, 1995). While some respondents appear comfortable with the demands of this role, others express more unease and prefer heterosexual encounters in which the woman has equal or greater control. Thus, this sexual script is challenged or refined as respondents gain more sociosexual experience.

Evidence from the interviews suggests that influences in childhood and teenage years are associated with a) which interpersonal strategy is adopted, and b) how comfortable a young man feels when interacting with young women in the early stages of his sexual career. As this respondent discusses, one influence is the extent and context of a young man's social interaction with women prior to having any romantic or sexual interest:

> I remember thinking, when I first met and had contact with girls, how difficult it was, how we hadn't been taught how to deal with women and how, in my case, I'd probably put women on a pedestal, umm, because I didn't really see them as being the same as me [but] as being other people, if you know what I mean. I don't think that lasted for a long time but, yeah, subconsciously I probably did that. [185:06]

The interview schedule encouraged discussion of a respondent's social interaction during childhood, age 16 onwards and at time of interview. Information was obtained on the number of close male and female friends, the predominant gender composition of friendship groups and how the respondent recalled his position to other peers (social 'insider', 'outsider', 'hanger-on' etc.). Respondents who report *more* social interaction with women both within and outside the family context exhibit fewer difficulties interacting with young women, and are more likely to use the 'Friendship' as opposed to the 'Lads' strategy.

Within the family context, the role of female relatives is cited as important. This young man describes how familial influences affected his attitudes towards young women:

> I never go out on the pull. I've not been brought up to treat women like that, you know, like they're objects of ... you know, little notches that you put on your bed. I was always brought up to have a lot of respect for women, particularly 'cause of my sisters, so I never go out on the pull, and it surprises me really when women come up to me or they want to come home with me 'cause it is out of the blue. [165:31]

The nature of a young man's relationship with female relatives may help to familiarise him with the company of women, and promote attitudes around gender equality. However, this association may also reflect the general atmosphere in the family. Respondents exhibiting the 'Lads' behaviour are more likely to report an emotionally 'cold' family, with a restrictive parental regime. Conversely, the 'Friendship' strategy and more comfortable social interaction with young women are associated with emotionally 'warmer' families. Interestingly, respondents in the 'Friendship' group cite good relationships with their fathers, reporting them as physically available and emotionally 'warm'.

Another family effect may act through siblings, with some respondents' birth order associated with their interaction with young women. Respondents who are second or higher in the birth order are more likely to report feeling comfortable interacting with young women and following the 'Friendship' strategy, as compared with those who are first in the birth order[12]. As discussed in section 3.5.4, having an sibling can give a young man opportunities to interact with the older sibling's friends, and learn from the sibling's experiences of socialising and relationships.

Outside the family, early interaction with young women through friendship or social activities can help a young man feel more familiar and comfortable with the company of young women. Thus, he may feel more at ease when he develops romantic or sexual interest. A more gradual introduction to young women over time is less of a social 'shock' than the abruptness of exposure some respondents experienced. Referring to Table 4.1, respondents in the 'Shy boys' group had limited early social contact with young women due to, for example, attending a single sex secondary school or having male leisure pursuits. Difficulties then emerged when these respondents were expected to be comfortable in the

[12] This association still holds when excluding respondents who are an only child.

company of young women, attract them, and form and maintain emotional and sexual relationships. Consider this quotation from a respondent who reports problems interacting with young women for most of his teenage years:

> It's almost a bit sad really looking back on it, you know, just go up and speak to [young women] for Christ's sake you know, but I wouldn't do that then. I'd worry about it for weeks before I'd go and speak to somebody. [174:19]

Another source for learning about sex and relationships, school, played different roles for the 'Lads' and 'Friendship' groups. The latter group report better quality school sex education; however, this may just reflect the younger age profile of the 'Friendship' respondents, as younger respondents report receiving better sex education.

The success and choice of an interpersonal strategy will also be determined by individual factors, especially self-esteem and social confidence. One aspect of the 'Lads' strategy, for example, is that a young man needs a high degree of self-confidence and appropriate interpersonal skills to implement the strategy successfully. Respondent 167 in Table 4.2 moved from a 'Shy boy' to a 'Lad' thanks to the tuition of an older male friend:

> I was very shy, I used to flush. I knew this bloke who was 20 and we used to go out with him and he used to say "Go and chat that woman up", I'd say "Why?", you know, and he'd say, "'Cause you like her very much", and he made me chat up so many women in one night. He did that for about a month or two and after that I just lost all my shyness, you know. 'Cause you'd walk up to a woman, I was very young, I didn't know what to say. I'd say an inappropriate thing sometimes, I'd get blown out, but he taught me to get right back onto the horse and ... I mean he was a bit of a womaniser and he'd had loads of experience with women. I just saw him as a teacher. [167:25]

However, other respondents report they would have preferred to use the predatory 'Lads' strategy, but lacked appropriate social skills. Not only is a young man being judged on his performance by the observations of his peers, but again the fear of humiliation from a young woman's rejection is present.

Similarly, a young man's confidence to implement a strategy can be affected by his self-image. The social pressure young women feel under to present a certain body image has been well documented (MacSween, 1993; Turtle *et al.*, 1997). Some respondents in this study report similar pressure, although it is less of an issue for the whole sample. Besides social and cultural messages presented through, for example, the media, implicit or explicit

messages from peers provide feedback on a young man's self-image. Respondents who felt they were furthest from the ideal body image are more likely to recall anxiety on this issue. One of the most worrying concerns was whether young women would find a respondent with an 'inferior' body image physically attractive, thus affecting his confidence in making romantic or sexual advances. Physical attributes which respondents feel young women view positively include having a muscular, well-defined body (especially the chest and stomach) and looking old for a certain age. Conversely, negative physical attributes include being overweight, being underweight (and under height), and wearing glasses. The potential importance of this factor should not be underestimated; some respondents report the defining moment in their teenage social life (and subsequent sexual and relationship experiences) was when a change occurred in their appearance. At age 15, this respondent changed from wearing glasses to contact lenses:

> I never had much luck at the start because of my glasses, I suppose, I don't know, and my lack of confidence, my complete lack of confidence I suppose, that was a small factor. Umm, so nothing physically happened for me until I was about 15 and I suppose that it was a few months after I, you know, got fitted for [contact] lenses and I was much more confident about myself and that would have been the first time that I ever got off with someone. [185:18]

4.6 SUMMARY

a) The physical changes of puberty are as involving for young men as young women, but perhaps less open and acknowledged for young men. Important autoerotic developments include masturbation and semenarche, however these activities are rarely discussed seriously.

b) Hierarchies in male peer groups contain social groups with different characteristics and prestige, but not all young men easily fit into one group. The 'Lads' group often occupy the highest strata, and act as a prominent norm for heterosexual behaviour.

c) Peer 'pressure' is strong in the early and middle teenage years, and originates more from the wider peer group as opposed to closer friends. Peer influence usually centres around a young man's sexual reputation; that is, he should increase his level of heterosexual activity.

d) Rural residency, single-sex school and male leisure activities can restrict a young man's opportunities for socialising with young women. Over the teenage years, however, transitions in personal circumstances support more heterosocial interaction.

e) Two interpersonal strategies, the 'Lads' and 'Friendship' approach, are distinguished by the emotional closeness a young man places between himself and his partner. The choice of a strategy is influenced by factors including a young man's morals and attitudes, his social skills and confidence.

e) Respondents who had more contact with women through family and friends report less discomfort and are more likely to report using the 'Friendship' strategy. Socialisation without underlying sexual interest may prevent the 'shock' some respondents had when they suddenly wanted (or were expected) to romantically or sexually interact with young women.

CHAPTER 5 - SEXUAL PARTNERSHIPS

5.1 INTRODUCTION

The dynamics of any sexual activity are located within a personal relationship between the individuals involved. Gold and Berger (1983) argue that the situational variable most influencing contraceptive use is this relationship between sexual partners. It was not a primary aim of the interview research to collect detailed sexual partnership histories. During the interviews, however, the respondents did describe and discuss the number, timing and nature of most of the sexual partnerships they had experienced over their lifetime. Information of this type is valuable as a review of the literature suggests it is currently lacking for British young men. Wight's (1993a, 1994abc) analysis of Glaswegian 19 year old men is one of the most detailed studies of British young men's sexual partnerships. The NSSAL (Wellings *et al.*, 1994) provides data on the number of sexual partners differentiated by demographic characteristics, and some information on a respondent's sexual partners in the five years prior to interview.

As acknowledged by Wellings and colleagues (1994), collecting accurate data on the number, timing and types of sexual partnerships using a structured questionnaire is difficult. The long, semi-structured interviews also encountered some problems, but do provide a good representation of a respondent's 'partnership history'. This is defined as the time between the year of a respondent's first-ever sexual intercourse and the year of interview. For example, if a respondent experienced his first-ever intercourse at age 16, then the first year of his partnership history is his sixteenth year, the second his seventeenth year, and so on. Among the 43 respondents, the length of the partnership history ranges between 2 and 16 years, with a median of 8 years.

In the partnership database discussed in section 2.2.5, each partnership is assigned to a year of the respondent's life in which the partnership started; 85% of the reported partnerships can be reliably assigned to a year. As discussed later in section 5.2.2, however, some respondents have difficulty providing information on all their partnerships, in particular recalling at what age (or in which calendar year) the partnership started. If, for example, a respondent reports six partnerships over a three-year period but cannot recall further details on their timing, then two partnerships have been assigned to each year. Another problem

with the constructed partnership histories is the starting point. Consider the example of a respondent who experienced first-ever intercourse in the ninth month of his sixteenth year; the first year of his partnership history would therefore consist of only four months exposure. Unfortunately, information on the timing of partnerships is not specific enough to allow the partnership history to be based upon absolute rather than calendar years. It is recognised, therefore, that these factors may introduce slight error into the constructed partnership histories.

This chapter particularly focuses on the occurrence of first-ever intercourse and the early stages of a partnership history, here taken as the **first five years**. Given the social, family, education and employment transitions young people go through over the ages 16-29, it is useful to limit the period considered. Although this section concentrates on heterosexual partnerships, the few penetrative sexual partnerships with men have been included in the analysis. The chapter begins with a detailed discussion of the range of sexual partnerships reported by respondents, and constructs a typology of non-penetrative and penetrative partnerships. Section 5.3 then considers why young men prefer certain types of partnerships by discussing the various roles and meanings attached to sexual activity. Sections 5.4 to 5.6 consider the dynamics of sexual activity: first, over the duration of a partnership, and second, over a respondent's partnership history.

5.2 TYPOLOGY

5.2.1 Non-penetrative partnerships

Although the primary interest of Chapter 5 is the discussion of sexual partnerships involving vaginal or anal penetration, respondents were also encouraged to discuss any non-penetrative sexual partnerships. Care is taken, however, in defining a non-penetrative partnership as diverse levels of intimacy are involved in non-penetrative sexual activities. For current purposes, a non-penetrative partnership is defined as involving more intimacy than kissing or light caressing (that is, partnerships involving intimate caressing, heavy

petting, mutual masturbation or oral sex), but not including penetrative sexual activity[1]. Using this definition, the number of non-penetrative partnerships the respondents report over their lifetime ranges from 0 to 45, with a median of 5. A slight (but statistically insignificant) positive correlation exists between the reported number of non-penetrative and penetrative partnerships.

The reasons why non-penetrative partnerships occur are similar to the reasons cited for penetrative partnerships, considered in section 5.3. Given that heterosexual activity is socially constructed around vaginal penetration (Spencer *et al.*, 1988; Holland *et al.*, 1993), perhaps a more useful question is why non-penetrative as opposed to penetrative sexual activity occurs. Two situations can be distinguished; first, non-penetrative sexual activity is preferred by one or both members of the couple. This may be due to the pleasure involved (described by one respondent as *"sort of, sexual tension which is quite nice"* [183:49]) or the status of the couple's relationship. As discussed later in section 5.4.1, the period of a partnership leading up to first intercourse often includes non-penetrative sexual activity of increasing levels of intimacy. Some non-penetrative partnerships are in this continuum, that is, the couple's relationship has not developed to the extent that it is felt appropriate for intercourse to occur. This view may be equally held by both members of the couple, however, the respondents more commonly report that their partner impedes intercourse from occurring. This may be a typical situation prior to first-ever intercourse, as with this respondent's experiences at age 14:

> I had a few girlfriends, but nothing major at that age. *(So you kissed them?)* Yeah, kissing and maybe fondling. *(Through clothes or under clothes?)* Mainly through clothes but after a while it was under clothes, it never really went further than that at that age. *(And did you want to go further?)* Yeah, I did at that age, yeah. I was totally lusty and hormone overdrive and ... *(And why didn't you?)* Probably 'cause she wouldn't let me. [173:38]

Other reasons for preferring non-penetrative sexual activity include one member of the couple being in a relationship with another person (and not wanting to be unfaithful by

[1] Excluded from this definition are early experiences of sociosexual activity, commonly described as *"doctors and nurses"* [163:08] games. These mixed or same gender experiences usually occur in childhood between the ages of 5 and 12. While sometimes involving much physical intimacy, they are usually dismissed by respondents as motivated by curiosity rather than sexual interest.

having penetrative sexual activity[2]), avoiding the risk of conception, being too young (for example, aged under 16) and citing moral or religious beliefs concerning appropriate sexual behaviour.

The second situation refers to partnerships in which the couple's desire for penetrative intercourse is prohibited by the context of the sexual encounter. The location may be unsuitable (for example, a toilet cubicle), the young man (and/or his partner) may be too intoxicated, the young man may be unable to establish or maintain an erection, or the couple may not have any contraception available.

5.2.2 Penetrative partnerships - reporting

Figures 5.1, 5.2 and Table 5.1 display information on the penetrative sexual partnerships reported by the sample over their lifetime and in the first five years of their partnership histories. The number of penetrative partnerships reported by individual respondents ranges from 2 to 55, with a median of 8. The number of partnerships reported to have occurred in the first five years of a partnership history ranges from 1 to 43, with a median of 5. As a reminder, a criterion for selection in the study was at least two sexual partners in the past year, a number much higher than the average for men in this age group. Figure 5.1 displays the higher partnership counts of the sample as compared to the partnership counts of a similar age group from the NSSAL (Wellings *et al.*, 1994).

Aggregating the counts gives a total of 311 partnerships for the first five years of the respondents' partnership histories. This total, however, is influenced by extreme values; three respondents with the highest reported partnership counts account for around one third of the 311 partnerships. The total duration of a partnership ranges from zero days (that is, the partnership consists only of that sexual encounter, from here on termed 'one-night stand'[3]) to seven years. Similar to Wight's (1994a) Glaswegian 19 year old men, most of the sample's partnerships are of short duration; 51% are classifiable as one-night stands, and

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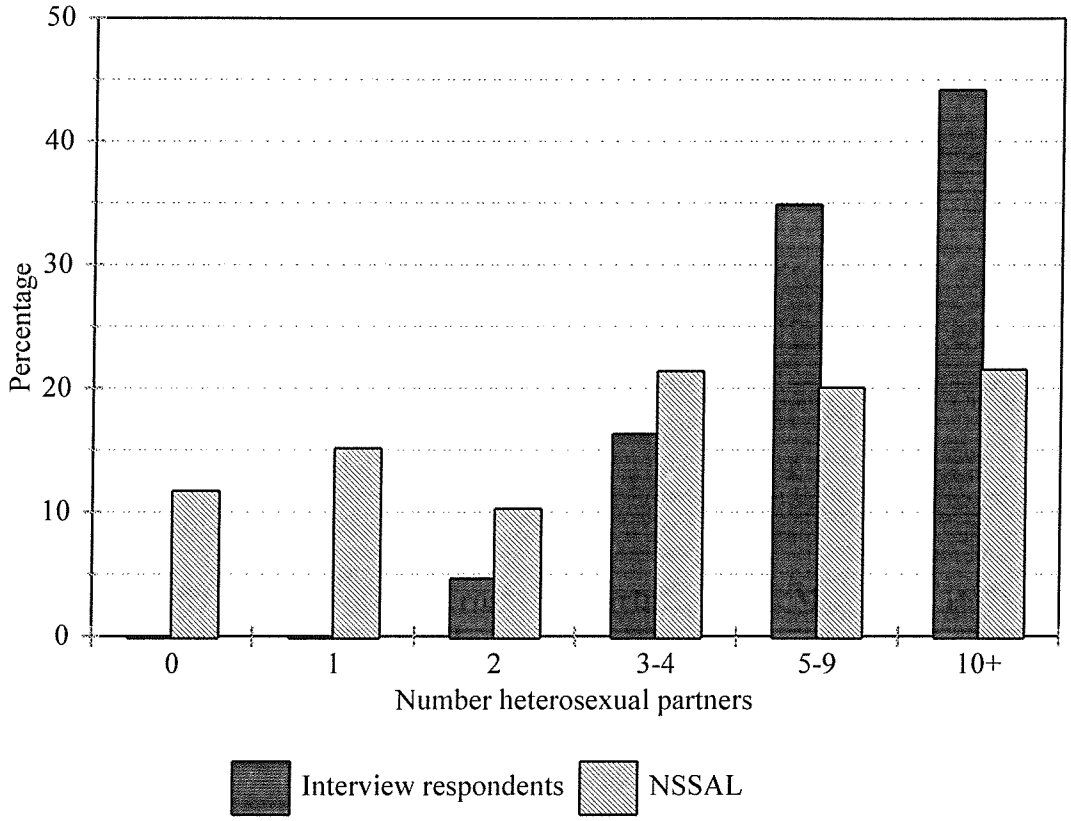
[2] The assumption being non-penetrative sexual activity is *not* an act of unfaithfulness.

[3] It is recognised this term is not strictly accurate; the sexual encounter may not take place overnight.

Figure 5.1 - Number of Reported Heterosexual Partners Ever, Men Aged 16-29, Interview Respondents and the NSSAL.



Notes: Interview respondents n=43, NSSAL n=3055.

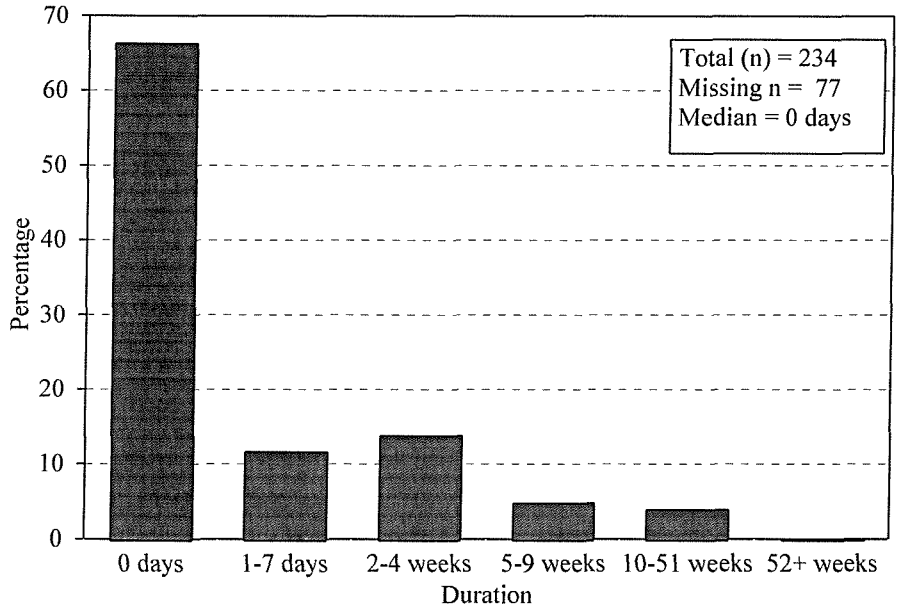
The age distribution of the interview respondents was somewhat younger than that of NSSAL men aged 16-29. To allow comparisons, therefore, the age-specific partnership counts of the NSSAL have been weighted to reflect the age distribution of the interview respondents.

Slightly different definitions were used in the two surveys. The NSSAL data refer to heterosexual partners with whom the respondent had vaginal, oral or anal sex. The interview respondents data refer to heterosexual partnerships in which the respondent had vaginal or anal sexual intercourse.

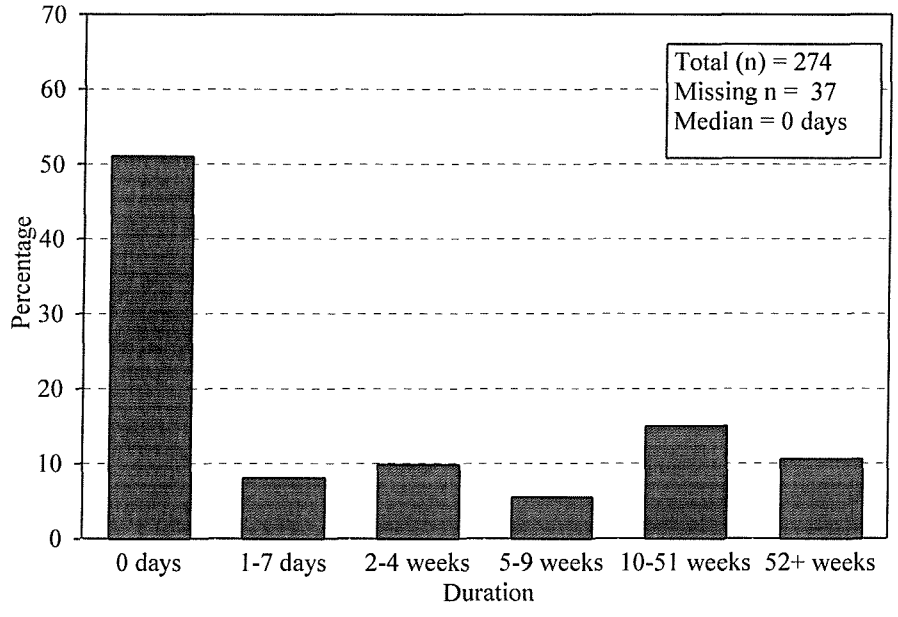
Source: NSSAL data - Wellings, K., Field, J., Johnson, A. M., & Wadsworth, J. (1994). The National Survey of Sexual Attitudes and Lifestyles. [Unpublished raw data].

Figure 5.2 - Durations of Respondents' Penetrative Sexual Partnerships in the First Five Years of their Partnership Histories.

a) Time to first intercourse



b) Total duration of partnership



Notes: Seven partnerships were still active at the time of interview. The total duration of these partnerships has been taken as time in the partnership prior to interview.

Table 5.1 - Summary Statistics of Respondents' Penetrative Sexual Partnerships.

	First five years of partnership history	Total partnership history
Total number	311 partnerships	665 partnerships
Number per respondent		
First quartile	3 partnerships	5 partnerships
Median	5 partnerships	8 partnerships
Third quartile	7 partnerships	24 partnerships
Sex of partner		
Female	99%	99%
Male	1%	1%
Total (n)	*311*	*665*
Self-defined status of relationship		
Casual	69%	76%
Steady	31%	25%
Total (n)	*311*	*654*

69% lasted less than or equal to one month. Similarly, in 66% of the partnerships with data available (see next paragraph) intercourse occurred on the first day of the partnership.

The manner in which the respondents report their partnerships should be noted. First is the issue of **missing data**. As indicated in Figure 5.2, 12% of the 311 partnerships are missing information on total duration, and 25% are missing time to first intercourse. These missing values undermine the reliability of the statistics given in the text above.

Three factors explain why some partnerships are missing data. First, it was not a primary aim of the interview schedule to collect this level of detail. Second, the limitation of time in an interview meant that information on all partnerships could not be collected; this is more of a problem for respondents reporting the highest partnership counts. Third, some respondents express difficulties recalling partnership details. Respondents who report the highest partnership counts, more casual partnerships and are older at interview are more likely to have recall problems. Some respondents who report the highest partnership counts estimate partner frequencies for periods of their life, with rounding and digit preference for multiples of five, as here:

> *(You put on your form about 25.)* But I think it's probably slightly less than that, or it might even be 25, but you see, the thing is I tried to count up the ones I had sex with and I knew there was loads that I couldn't remember, so I couldn't really tell you. *(Right.)* I can guarantee that I've had sex with 15 people. [153:29]

How missing data are biasing the statistics presented in Figure 5.2 is uncertain. Most of the missing partnerships are likely to be short-term and casual, so the data presented in graph b) of Figure 5.2 could be overestimating total partnership duration. However, some respondents describe casual, short-term partnerships for which they are unable to remember the total duration as 'one-night stands'. These partnerships are therefore entered as '0 days' duration, though they may have lasted slightly longer. This approximation would compensate some of the overestimation described above. It is suggested, therefore, that the data presented in Figure 5.2, particularly graph a), be interpreted with caution.

Second is the issue of **validity of reporting**, in particular under or over reporting of the number of partnerships. Whether men are more likely than women to over-report their level of sexual activity has been discussed by other authors (Smith 1992; Wadsworth *et al.*, 1996; Wight & West, 1999). For the main objectives of this chapter (see section 1.4), information on the true number of partnerships is of low importance. However, the summary statistics above and some analyses later in the Chapter use the reported number of partnerships. Ultimately, the sole use of one source of self-reported data prevents verification of the respondents' reporting, although certain indicators within the interviews can be examined. Respondents who report vague or suspiciously similar details to successive partnerships, or who are unable to recall details of partnerships reported to have occurred recently can be viewed with a greater degree of caution.

Of those respondents who report a high (say, more than 10) number of partnerships in the first five years of their history, only a few speak in bragging terms, which perhaps might be expected if they are over-reporting deliberately. However, equally apparent within this group are respondents who appear positive (but do not boast) about their high partnership count, others who report feeling ambivalent or neutral, and some who report feeling embarrassed or guilty when questioned on (and therefore reminded of) their high partnership count.

5.2.3 Penetrative partnerships - typology

Penetrative sexual encounters can occur in a range of relationship contexts. Given that the term 'relationship' implies a degree of emotional or romantic involvement between the two[4] members of the partnership absent in many of the respondents' sexual encounters, using the term 'partnership' is more appropriate. It should be remembered that only the respondent's perspective of the partnership is available. His partner may have had differing views on the status of the partnership; for example, this respondent reports one partner *"thought she was going out with me, but I wasn't going out with her"* [161:80]. Equally, the nature of a partnership is likely to change over its lifetime, an issue considered in section 5.4.

The different ways in which respondents perceive the status of a sexual partnership are highlighted by the range of terms used (independent of the interviewer's terminology). Examples include:

a) Steady [157:21], serious [173:45], stable [158:26], long-term [182:53]
b) Casual [185:19], short-term [184:43]
c) One-night stand [145:48], one-off [170:31]
d) Five-night stand [185:22]
e) Fling [164:51], flingette [177:48]
f) Affair [180:41], mini-affair [166:13]
g) Seeing each other [156:11]
h) On and off relationship [158:17]
i) Rebound relationship [172:29]
j) Pseudo or quasi relationship [181:12]

These terms reflect variations in the degree of emotional involvement assigned to a partnership, whether a partnership is monogamous, the nature and amount of time spent in a partnership, and prior knowledge of the partner, each of which are discussed separately.

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[4] Although the majority of the respondents' sexual partnerships involved two individuals, a handful involved three. Two of the threesome were in a relationship, with the other person a mutual friend.

a) Emotional involvement

The emotional context within which sexual activity takes place is a key determinant of the self-described nature of the couple's relationship. Spencer (1984) suggests all relationships can be sorted hierarchically by this variable. Two useful and generally understood terms are 'casual' and 'steady' relationships. If the respondent feels there is a low degree of emotional or romantic involvement between him and his partner, this is termed a **casual** partnership. Sixty nine percent of the 311 partnerships are defined by respondents as casual. All one-night stands are defined as casual, though at the time some respondents may have perceived them as the start of a steady partnership. If a respondent identifies the primary function of a partnership is sexual activity, then this is usually identified as casual. These partnerships are usually short-term, as for this respondent who was in a steady relationship with another person at the time of this partnership:

> And so Nicky and I disappeared off for a couple of nights and had sex. We were very careful not to fall in love. We were absolutely, "This is physical", yes, I mean, and as soon as we felt twinges of emotion coming into it we'd call a halt. [168:28]

However, longer (of up to four years) casual partnerships are also reported, in which contact between the couple is sporadic and primarily motivated by a desire for sexual activity.

Steady partnerships represent relationships in which a greater degree of emotional or romantic involvement exists between the couple. As suggested by Spencer (1984), one indicator of when a partnership has this status is when a couple report themselves to be 'going out', and recognise each other as boyfriend and girlfriend. Steady partnerships may also (although not necessarily) entail aspects of faithfulness, trust and companionship.

b) Monogamy

The notion of remaining faithful to a partner (that is, not having sexual activity with another person while in that partnership) is held to varying degrees by the respondents, although most of the partnerships are reported to be monogamous. Twelve of the forty-three respondents (28%) report at least one partnership occurring at a time when the respondent was in a sexual relationship with another person, accounting for 26 (8%) of the total 311 partnerships. The NSSAL (Wellings *et al.*, 1994) provides data on the prevalence of this

behaviour: 21% of men and 18% of women aged 16-24[5] report having a concurrent sexual partnership in the last five years, with a similar percentage calculated by Ford (1992a).

In a few cases, a respondent's concurrent partnership is undertaken with the reported knowledge and explicit (or implicit) approval of his steady partner, as in this example:

> Well, the thing with Becky was, I mean, when I was in this relationship with Becky it was intense, loving, caring, but also completely open. *(Right.)* She knew about all these people I'd slept with so, I mean I loved her and had sex with her and it was very involved, so I went off and just had one-night stands. *(Just for the physical side?)* Yeah, and she did the same, it wasn't all one side, she went off as well and had one-night stands as well. *(Did you tell each other?)* Yeah, that was the only rule, we had to tell each other immediately. [168:36]

However, most concurrent partnerships are reported to be undertaken illicitly, either due to a planned strategy, through the opportunity unexpectedly arising, or during the overlap period of one partnership ending and another beginning[6]. One method of maintaining this strategy is for concurrent partners to be residing in separate locations or, less common, socialising within separate social circles. Respondents who prefer and actively initiate concurrent partnerships typically boast of this strategy in the interview, whereas respondents whose concurrent partnerships occur through an unexpected opportunities report feeling guilt or regret. The act of unfaithfulness can be rationalised by a respondent if his steady partner is believed (or known) to have been unfaithful as well.

c) Time in partnership

As shown in Figure 5.3, generally casual partnerships last for a shorter time than steady partnerships, although some overlap exists. Taking the two extremes, one respondent reports several partnerships lasting three to four days that he defines as steady, whereas another respondent had a casual partnership lasting four years. This reflects Ford's (1992b) assertion that perceptions of what constitute a steady relationship vary widely among young people.

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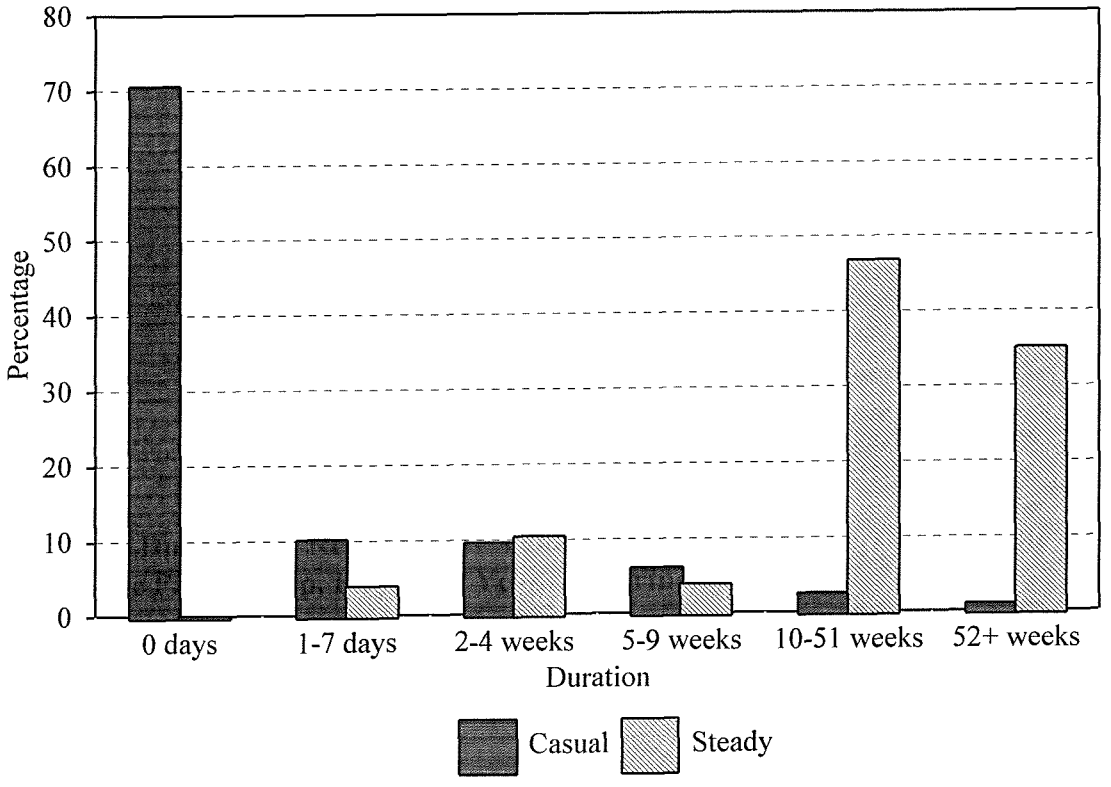
[5] The base figures for these percentages exclude those who report no sexual partners in the last five years.

[6] A person may use the commencement of a new partnership as a defining event to help conclude the previous partnership.

Figure 5.3 - Duration of Respondents' Penetrative Sexual Partnerships by Self-defined Status of the Partnership, First Five Years of Partnership History.



Notes:

	Median	n
Casual	0 days	197
Steady	6 months	77

Seven partnerships were still active at time of interview. The total duration of these partnerships has been taken as time in the partnership prior to interview.

Just considering the duration of a partnership, however, conceals variations in the consistency and intensity of time a couple spend together. Whilst the mode is for a partnership to be continuous, some partnerships involve sexual activity on a very intermittent basis. This may be due to choice (for example, the long duration, purely sexual partnerships described above), restrictions imposed by locations of residence (see below), or periods when the couple break up for weeks (or months), but consequently reactivate the partnership. Equally, variations are found in the intensity of time a couple spend together. For example, when the couple's relationship is being established during the early stage of a partnership, they may see each other infrequently at weekends or on intermittent social occasions, but have sexual activity when they do meet. If the relationship does not develop into a steady partnership, the respondent may report that he and his partner were only *"seeing each other"* [183:23].

In some partnerships, the couple reside at separate and sometimes distant locations (for example, one partner living in the family home and the other attending higher education), a situation one respondent terms a *"long distance relationship"* [172:31]. Although the couple are still going-out with each other, physical contact between the couple is limited to, for example, weekends and holiday periods.

d) Prior knowledge of partner

The extent to which respondents knew their partners before the start of a partnership varies considerably. Some partners are met for the first time on the first day of the partnership. At the other extreme, a partner can be known as a very close friend. Most of the respondents' partners were known as friends or acquaintances prior to the start of the sexual partnership. This reflects how new partners are often met in situations when a young man is socialising with members of his close or wider peer group.

Generally, prior knowledge of a partner is not felt to be an important factor in the status of the subsequent relationship. One exception is provided by some respondents who associate the term 'one-night stand' with a partnership in which the partner is a stranger before the sexual encounter. A partnership occurring with a close friend is reported as especially problematic, with the prior level of friendship liable to adversely affect the survival of the consequent sexual relationship. Similarly, a few of the respondents' partnerships are new

occurrences of sexual activity with a previous sexual partner. While these partnerships are new and distinct, the couple's previous relationship may be important when considering interaction in the sexual encounter.

5.3 ROLE OF SEX

The one feature shared by all the sexual partnerships discussed in this Chapter is that sexual activity has occurred - but why does it occur? Moore and Rosenthal (1993) point to a lack of research which asks young people their motives for having sex. An exception to this is research on first-ever intercourse (see Schofield, 1965; Ingham *et al.*, 1991; Wellings *et al.*, 1994), but the particular and symbolic nature of this event (see section 5.5) makes it difficult to generalise findings to sexual activity later in a partnership history.

This section discusses why young men have sexual activity, and why they have sexual activity within the types of partnerships described in the previous section. The answers to these two questions clearly are linked, but allow more understanding of why young men prefer certain types of sexual partnerships. The use of the word 'preference', however, implies a degree of planning and rationalisation that is absent from some partnership histories. A preference for sexual activity to occur in a specific type of relationship can be nullified by the context of the sexual encounter or the partner's role. Consider the contrasting situations outlined in the two quotations below: the first respondent had an unexpected steady partnership, while the second had an unexpected casual partnership:

a) Going out with Diane was a bit of a shock because I still wasn't looking for a relationship, but since I started seeing her we've got on really well and now I'm keen on having a long relationship again with her. [170:36]

b) *(How did you feel about that [partnership]?)* Not very good. Didn't ... it was just a bit, a bit rejected. I don't know, a bit used I suppose as well. *(Mmm.)* Just, I was a bit upset, you know, that maybe it was just sex that she wanted and that was it. [159:57]

The meanings attached to sexual activity by respondents are varied, and more than one meaning can be associated with the same sexual encounter. This respondent presents two contrasting meanings of sex that apply to two distinct types of partnerships:

> Like, for me, sex is, umm, has two very different roles, for me. Like, sex can be the ultimate culmination of emotion and love for another person in a steady relationship, which is wonderful, but also sex can also be bloody good light entertainment with somebody you don't know. [168:35]

One indicator of how respondents express the meanings of sexual activity is through language. For example, sexual intercourse is labelled[7] as either 'having sex' or 'making love', with the terms used according to the type of sexual partnership or the nature of the sexual encounter. 'Having sex' can signify sexual activity in a casual partnership or a more physically-oriented, shorter duration sexual encounter, whereas 'making love' can signify sexual activity in a steady partnership or a more emotional, longer lasting sexual encounter.

The respondents' discussions suggest four themes on meanings of sexual activity; physical pleasure, emotions, companionship, and indicator of sexual prowess, discussed separately below. Referring back to section 4.5, respondents subscribing to a 'Friendship' strategy stress the importance of the first three factors, whereas respondents using the 'Lads' strategy are more likely to cite the first and last factors.

One of the most important factors for having sex is **physical pleasure**; the enjoyment, satisfaction and sheer fun that sexual activity can involve. This is usually reported around the respondent's own pleasure, but is also referenced to bringing pleasure to a partner, or both in combination. Some respondents feel that sexual activity is more enjoyable, relaxed and varied (non-penetrative activities, oral sex, role-playing and so on) with a partner they trust and feel comfortable with; qualities associated with a steady partnership. Other respondents, however, report the same benefits from sexual activity in casual partnerships because of *less* emotional involvement.

Second are any **emotional** meanings. Sexual activity can express the strength and nature of the couple's relationship. This can be an expression of romantic affection or love[8], trust and emotional commitment to a partner, as the following respondent notes:

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[7] It is acknowledged that a respondent's language in the interview may not reflect his language used outside of this context.

[8] See Moore and Rosenthal (1992) for Australian young people's interpretations of romantic love within a sexual relationship.

(Why do you think it's important to save a sexual expression for someone special, because that seems to be what you're saying is quite important to you?) Yeah, because the women that I've known, it's been special to them, that's the case, and because if it's important to them, it's automatically important to me. There's not very much that someone can give to someone they love, and sex seems to be one of the few things that we can give that is special and important. I guess it's those two reasons. [184:48]

The intimate nature of sexual activity is felt by some respondents to produce an emotional bond between a couple that is unattainable through non-sexual activities. An example of this intimacy is the close physical contact, and personal and open conversation that can occur in the period immediately after sexual activity. A young man's preferred degree of emotional involvement, therefore, can influence his preference for certain types of sexual partnerships. Respondents who desire steady partnerships at some period in their life stress the importance of intimacy, love and trust in a sexual relationship. Conversely, respondents who do not want a high degree of emotional involvement in certain periods of their life express a preference for casual partnerships. These two quotations discuss aspects of these themes:

a) My mother, I mean even though she's Roman Catholic and she said you know, "Don't go jumping into bed with everyone that comes along", she always used to tell me "Why buy a book when you can join the library?", so I'm not looking for a serious commitment at the moment. I suppose I'm trying to avoid it, to a certain extent. [154:31]

b) I think [one-night stands] more emotionally destroy ... I don't think they make you feel good about yourself at the end of the day, or they don't make me feel good about myself. Umm, I was pretty horrified when I wrote all those girls' names down and found out there was 30 like, you know. I thought that was far too much and I regret having had that many partners. That's too much. [175:61]

Similarly, a desire for **companionship** is associated with preferences for type of sexual partnership. Steady partnerships are characterised by high levels of companionship; for example, having someone to spend time with, go out socially, share leisure activities and so on. However, if a young man desires more freedom in his social life and is concerned about retaining his personal independence, he may prefer casual partnerships.

Fourth, casual sexual partnerships, particularly one-night stands, are preferred by some respondents as measurable **indicators of sexual prowess**, or, as one respondent describes, *"another notch on the bedpost"* [172:44]. This is important at a time (or within a social

group) when the reporting of a high number of sexual partnerships raises a young man's prestige and social standing. Another reported advantage of many short-term, casual partnerships is they enable a young man to have sexual activity with a wider variety of people.

Taking these meanings into account, are there any factors associated with preferences for steady as opposed to casual partnerships? Respondents experiencing more steady than casual partnerships are more likely to have attended a single-sex secondary school, and report an emotionally 'warm' family environment. The reverse of both these factors is true for respondents experiencing more casual partnerships. School and parents (particularly the mother) are fairly good sources of learning for respondents experiencing more steady partnerships, whereas casual partnership respondents cite poor school sex education, poor parental education, but good learning from television, newspapers and magazines. Finally, respondents experiencing more steady partnerships are the early sexual developers of the sample, with little delay in their first sexual experiences outlined in Figure 4.1. Casual partnership respondents, conversely, report and exhibit more of a delay between first sexual interest and any sociosexual experiences.

5.4 PARTNERSHIP DEVELOPMENT

Once a sexual partnership has ended and is being discussed retrospectively, an individual can more easily describe, evaluate and classify that partnership. However, a partnership is not a static experience; its status and meanings for the participants change over its existence. One indication of this process of change is provided by the 22 of 43 (51%) respondents who report being in a sexual partnership at the time of interview. Some partnerships had just begun and the respondents are unsure whether the partnerships are casual, steady or will even continue, while other respondents' partnership are nearly finished or possibly inactive, therefore also being uncertain about their status. The brief discussion below considers partnership development in two stages; the period prior to first intercourse, and the total duration of the partnership.

5.4.1 Before first intercourse

Figure 5.2 shows the duration of a partnership before first intercourse ranges from 0 days to 7 months, with most of short duration. The time before first intercourse is specified as the time the couple have been going-out in a relationship, as opposed to other indicators such as time as acquaintances, time 'seeing' each other socially, and so on. However, this is not a clear-cut definition and is interpreted differently by individuals during the early period of a partnership when the couple may be uncertain or hold different views on the status of their relationship[9]. Equally, as discussed in section 5.2.3, just using the time leading up to first intercourse conceals variations in the intensity of time a couple spend together.

The actual time before first intercourse may not reflect a respondent's preferred period. He may wish intercourse had occurred earlier in the partnership, but this did not happen because his partner did not yet want to have intercourse, a suitable location was unavailable, contraception was unavailable, or the woman was having her menstrual period. Equally, first intercourse may occur earlier in the partnership than preferred, as often happens to this respondent:

> In a perfect world I'd like to know somebody and court them, do you know what I mean, and know them for a while at least. (laughing) *(And what kind of while?)* Ideally, maybe a couple of months or something like that. It would be nice to go out maybe once or twice, innocently like, and sort of go to the pictures and kiss goodnight, and then eventually sleep with them. But it never does work like that. I think your animal instincts take over, don't they, laced with a quantity of alcohol or whatever, and before you know where you are, you're waking up together. [175:62]

Partnerships that have a long (say, more than two weeks) time leading up to first intercourse fall into two groups; first are those in which intercourse is 'prevented' due to factors identified above. Second are partnerships in which the respondent (and/or his partner) believed that sexual intercourse is a reflection of a close, interpersonal emotional relationship, and therefore the couple's relationship should develop to an appropriate stage before intercourse occurs. Young men who predominantly experience partnerships with these meanings may also believe that intercourse on the first night of a partnership is inappropriate. Over the period leading up to intercourse, however, the couple may progress

[9] See Leonard (1980) for more discussion of this point.

through more intimate non-penetrative sexual activity: for example, snogging, mild and more intimate heavy petting.

5.4.2 Duration of partnership

After intercourse has occurred, then there is the period before the partnerships ends. The respondents' discussions of the total duration of a partnership centre around which of two categories the partnership can be retrospectively assigned to: partnerships that are considered to have reached their 'natural' conclusion, and partnerships that end sooner or later than the respondent would have preferred. The former category includes one-night stands in which the sexual encounter is accepted as a one-off, or the couple do not socially see each other again. This category also includes longer duration partnerships in which the respondent does not want the partnership to develop into a more committed relationship. A casual partnership is ended, therefore, before it becomes too serious. Changes in personal circumstances (such as employment, education) and changes in feelings towards the partner are also cited as reasons for a partnership ending.

The second category is partnerships that respondents retrospectively consider to have ended too soon or too late, usually the former. This includes short term partnerships considered as failed beginnings of longer-term, steady partnerships. Lasting between a few weeks and a few months, these partnerships abruptly end or, as one respondent terms it, *"fizzle out"* [160:44]. This premature ending may be explained by respondents due to the couple's mismatched expectations on the emotional and sexual characteristics of the partnership. For example, the requirements for companionship and socialising associated with a steady partnership are too demanding for this respondent's lifestyle:

> *(And what about your feelings about relationships, I mean you said that you don't want one at all?)* No, I don't. I'm not seriously considering giving this one up, umm, I like being in a relationship. Before I'm in a relationship I want to be in a relationship, 'cause it seems like everyone else is in a relationship, but when I'm in one and I've been in it for say a month, I do get bored and they start [saying], "Oh you've got to see me", and you know, "Can you see me this night?" At the moment the problem is my sports getting in the way of us seeing each other. [173:71]

Another common explanation for a failed partnership is that the respondent places too high expectations upon his partner, or he falls in love with a partner too easily. Once he realises his partner does not match these expectations, or does not reciprocate his feelings, the partnership soon ends. Some respondents concede that they held this attitude for periods of their life when they were searching for a 'perfect' partner or "soul mate" [177:25]. An underlying aspiration of this nature is used by this respondent to explain his experience of many, short-term partnerships:

> I think as well over the last years it has been a case of wanting really to meet someone as well, there's been that. That effort and trying ... it's almost like going through people to try and find somebody to connect with. *(Somebody to click with, yeah?)* Yeah. So there's that element as well. I don't think I've been like a real 'shagger' type normally, but I don't know, I don't think so. [169:48]

5.5 FIRST-EVER INTERCOURSE

5.5.1 Introduction

> I don't know if I wanted to have sex with her really. Part of me did, because I was the boy and I wanted to lose my virginity and get it over with and generally be able to not lie in the pub when you're talking to your mates about when you lost your virginity and all that sort of thing, you know that real male need to lose it. And then there was a part of me that thought "Well, no, I don't know if I really want to." *(Because of her ...?)* Because I didn't know if it ... I don't know. Maybe I had some value there that said "No, I don't know her that well, is she the right person?" But I did it anyway. [174:44]

One of the most important occasions in a young man's sexual development is the loss of his virginity. This is true in two respects; first, from a practical perspective, it marks his first experience of sexual intercourse. Second, and more important, it has a symbolic meaning as an essential rite of passage a boy must pass through before he becomes a man (Holland *et al.*, 1993; Wight, 1994c). Pressure to lose virginity originates mainly from male peers but has also been cited from older brothers and fathers (Holland *et al.*, 1993; Kent & Davies, 1993).

Most respondents clearly distinguish the sexual encounter in which they lost their virginity, usually the first occurrence of penetrative intercourse. However, some respondents discount previous sexual encounters in which the penis was only half-inserted or withdrawn after a

short time (for example, due to the partner's physical discomfort). One respondent does not view his first penetrative intercourse as when he lost his virginity because it occurred with male friends as opposed to a woman.

As shown in Figure 4.1, the reported age at first-ever intercourse ranges between 11 and 20 years, with a median of 16 years. Sixteen of the forty-three respondents (37%) report first-ever intercourse occurring before age 16. Half the respondents report their partner was the same age (in years), and 19% a younger partner. Figure 5.4 displays the total duration and time in partnership before first-ever intercourse. Just under half the sample report first-ever intercourse occurred on the first day of the partnership. The U-shaped distribution of graph b) suggests two settings in which first-ever intercourse occurs; within an ongoing relationship or on the first-night of a partnership. The social and contextual characteristics of these settings are discussed separately below.

5.5.2 First-ever intercourse within a steady partnership

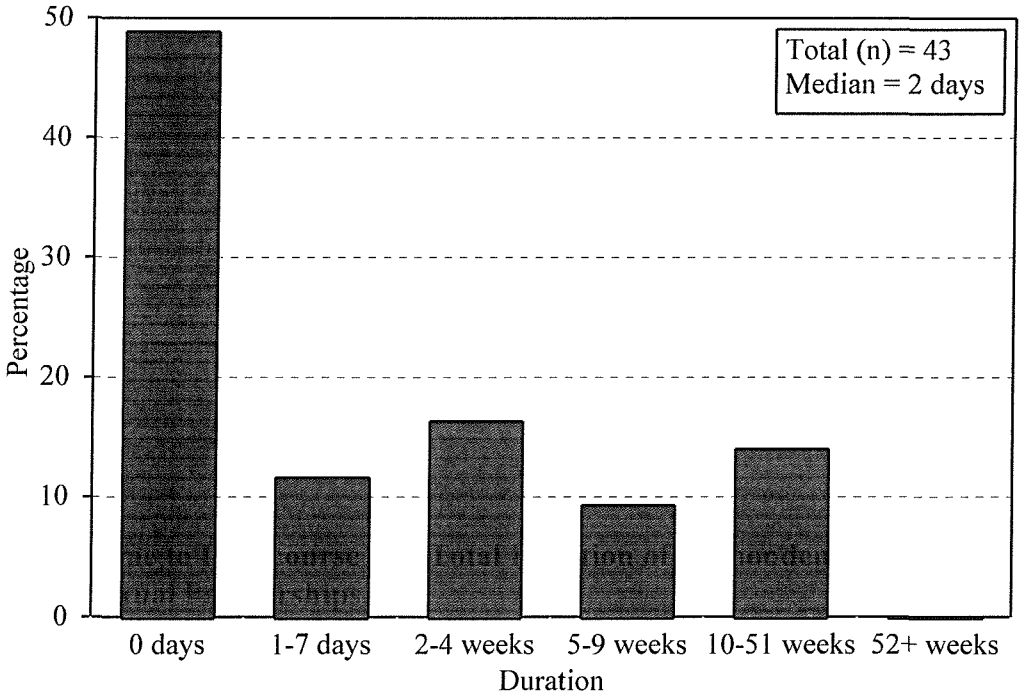
This category (including 22 of the 43 respondents, or 51%) encompasses first-ever intercourse occurring within the context of a steady relationship in which the couple recognise they are going-out with each other. Most couples were going-out both before and after the occurrence of first intercourse, although a few respondents report first-ever intercourse occurred at the end of the partnership[10]. In addition, a few respondents describe an intermittent relationship with their partner leading up to first intercourse.

Of the continuous relationships, the time the couple had been going-out together before intercourse ranges between one week and seven months, with a median of four weeks. While some respondents report that intercourse 'just happened', this group had a greater degree of expectation and planning that intercourse would occur either on that day or in the immediate future. Similarly, the encounter was more mutually organised, in that one partner did not take greater control over initiating and controlling the pace of sexual activity.

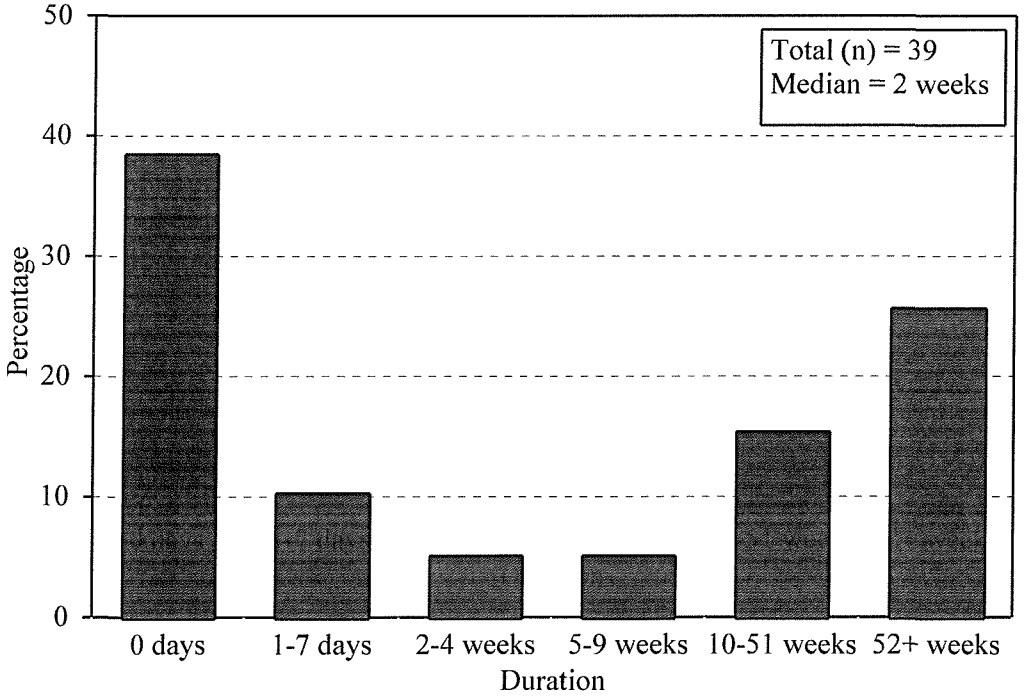
[10] However, first intercourse is not thought to have caused the partnership to end, rather the partnership had reached its 'natural' conclusion.

Figure 5.4 - Time to Intercourse and Total Duration of Respondents' First-Ever Penetrative Sexual Partnerships.

a) Time to intercourse



b) Total duration of partnership



Previous research suggests gender differences in responses to questions on factors leading to first-ever intercourse. Common responses[11] from men include 'sexual desire' (Schofield, 1965; mentioned by 46%), physical aspects (Ingham *et al.*, 1991: mentioned by 57%), 'curiosity about what it would be like' (Wellings *et al.*, 1994: chosen by 27%), and peer pressure (Ingham *et al.*, 1991: mentioned by 43%). The most popular responses from women are on the theme of being 'in love', or citing the couple's emotional relationship.

In discussing why intercourse occurred, respondents in this group cite similar reasons to those reported by men in the 'first-night' category discussed in the next section. These include a general desire to prove oneself sexually, and the wish to lose the social stigma of being a virgin. However, respondents in this group are less likely to report intercourse was motivated by opportunity (although having a suitable time and location are still important), but more associated with the couple's developing emotional and romantic relationship. Being in a relationship, in love or viewing intercourse as part of the natural progression of a relationship are common explanations.

Does this group of respondents share any characteristics? As compared to respondents experiencing first-ever intercourse on the first night of a partnership, these respondents are more likely to report gradual social dealings with young women, and use of the 'Friendship' strategy. Their sexual interest in young women developed comparatively early, but then there was a longer period of time until first heavy petting and intercourse.

5.5.3 First-ever intercourse on the first night of the partnership

This category includes respondents who report their first-ever intercourse occurred on the first day of the sexual partnership. The vast majority of these partnerships also ended on that day, that is, a one-night stand[12], with the remaining developing into a steady partnership. Also included are respondents who had first-ever intercourse with a prostitute (2 of 43). As it is the first day of the partnership, the degree of planning and expectation that intercourse

[11] Different research instruments are used to collect this information. Two important aspects are whether responses are prompted, and whether multiple responses are allowed.

[12] Although for a few respondents, sexual activity occurred with the same partner at a later date in a new, distinct partnership.

would occur was fairly low[13]. A few respondents actively set up a situation in which they hoped intercourse was likely, but most report that intercourse occurred because the opportunity unexpectedly arose. Through nonverbal and verbal signals, a respondent became aware of his partner's desire to have intercourse, and the couple were in a suitable environment (for example, at a party) and had enough time (for example, when parents are out of the house) for intercourse. Two-thirds of the respondents in this group report their partner initiated the sexual encounter (as opposed to respondent-based or mutual initiation): a higher proportion than in the steady partnership category.

Opportunistic factors act in combination with a respondent's underlying aspiration of experiencing intercourse. Desire may be referenced to the physical attraction and lust felt towards the partner, curiosity about the experience of sexual activity, losing the stigma of being a virgin, and to prove oneself as a sexual person. This respondent recalls his mixed feelings immediately before the event:

> *(And why did it happen do you think?)* I couldn't honestly say, it happened when she asked me to sleep with her. It happened for me because I was like too scared to say no, to be honest about it. I didn't really know what it was all about. I was interested in it 'cause, yeah, at that age a few boys at school were boasting all about it and, well, it's something that I don't know about so there was general interest. She was a very, very attractive girl and if I was going to have sex with someone it would have been quite happily her, so I thought "Why not?" [172:20]

5.5.4 Emotional meanings

> I was more scared than anything 'cause it's, I don't know, it is scary, you know. You've never done it before and you don't know what's going to happen. It was a mix of excitement you know, adrenalin rush and the excitement and like fear, I suppose. [152:21]

In the period immediately before and during first-ever intercourse, the respondents recall a range of emotions, mostly positive. These include excitement that sexual intercourse was (for some, it seemed, finally) to occur, pleasure from the arousing physical sensations, combined with nervousness and trepidation about the encounter. One source of nervousness relates to the physical practicalities of sexual intercourse, and whether the respondent's

[13] Except for the two respondents who sought out a prostitute.

performance would be satisfactory. As discussed in Chapter 3, young men's understandings of the physical act of sexual intercourse originate from different sources; in particular, friends, pornography and school sex education. While these sources can provide information on the female physiology (as one respondent describes it, *"where her bits were meant to be, exactly"* [165:20]), respondents still recall concerns on whether they would get things wrong. Concerns like these are associated with general worries around performance in sexual activity, discussed in the next section. Respondents whose first-ever intercourse occurred in a steady partnership are less likely to report concerns about physical performance. This may be due to more trust and communication built up between the couple, and opportunities to improve sexual competence through non-penetrative sexual activity earlier in the partnership.

Most respondents report that, in retrospect, first-ever intercourse was an overall positive experience, with only one fifth expressing any form of immediate or subsequent regret. Two positive emotions commonly expressed are excitement of the new sexual experience, and relief of finally losing virginity. Respondents in the steady partnership category also recall feeling emotionally closer to their partner.

Respondents who express regret do so in relation to the risk they may have exposed themselves and their partners to (by not using a condom or any contraception) or because intercourse occurred too early in the partnership or with the wrong person. Another reported feeling is that the physical act of intercourse did not match expectations, and was therefore disappointing. This assessment partly is being made in retrospect once first-ever intercourse has been compared with subsequent sexual activity. A common complaint was the short time between penetration and the respondent's orgasm. Any feelings of disappointment are compounded by the great expectations placed upon the event. Given the symbolic importance in some male peer groups of losing virginity, young men exposed to such influence may approach the event with expectations of immediate and fantastic transformations in their personality and lifestyle. When this does not usually occur, feeling disappointed is inevitable.

5.6 PARTNERSHIP HISTORY

5.6.1 Patterns

Some authors have attempted to describe a typical sexual partnership history in which individuals progress through sequential stages of partnership types. Generally, a current British partnership history is characterised by a transition from more, short-term partnerships to fewer, long-term partnerships (Wellings *et al.*, 1994; Wight, 1994a). Leonard (1980), in her work on premarital dating among Swansea married couples in the 1970s, suggests young men have a period of casual dating starting at ages 13/14, reaching a peak in courting[14] at ages 18/19. The applicability of these statements can be examined with data on relationship status and number of sexual partners by age. The NSSAL shows the percentage of men reporting two or more sexual partners in the last year is greater for the 16-24 age group than any other (Wellings *et al.*, 1994). Even accounting for generational changes, the 16-24 age group still reports the highest number of partners, and numbers decrease with age within this age group, a finding reported elsewhere (Bowie & Ford, 1989; Bury, 1991). As individuals progress through their 20s and 30s, they are more likely to enter longer-term, monogamous relationships such as marriage and cohabitation.

A term often used to describe patterns in young people's sexual partnerships is 'serial monogamy'. Bury (1984, p.34) writes "this so-called 'serial monogamy' has characterised teenage relationships for the last 20 years and shows little signs of change". The term 'serial monogamy' implies two aspects; first, partnerships occur one after the other with no overlap, and second, that neither of the couple has a concurrent partnership. Another interpretation of the term is that generally, the partnerships are stable and not short-term, lasting at least several months. The general applicability of serially monogamous partnerships among young people has been confirmed by some research (Farrell, 1978; Ford, 1992a; Wellings *et al.*, 1994).

Section 5.6 considers whether the patterns outlined above are present in the respondents' sexual partnership histories. Of particular interest are changes in the type (steady, casual,

[14] The author acknowledges the difficulties in defining relationship status. 'Courting' refers to a "relationship when both parties acknowledge some commitment to each other" (p.108).

concurrent) and number of partnerships over time. These measures are interrelated, however, as casual partnerships typically are shorter than steady partnerships (Figure 5.3), and therefore higher casual partnership counts are possible over the same time period.

Table 5.2 presents descriptive statistics on each respondent's sexual partnerships reported for the first five years of his history. The data have been kept at the individual level to illustrate the diversity in experiences. It is difficult to find two respondents who have the same number, type and duration of partnerships. The Table still conceals variations in the duration (the median only representing the level, not the spread) and timing of partnerships. Moving down the Table indicates an increasing average number of partnerships per year; the higher the number, the more casual (as opposed to steady) and shorter duration partnerships are reported. Propensity to report concurrent partnerships seems spread through the Table.

Clearly, some respondents report one type of partnership more than other types. In this sense, some respondents can be classified as experiencing mostly short-term casual partnerships, or serially monogamous longer-term steady partnerships, or concurrent casual partnerships. This classification, however, conceals diversity within individual histories.

Looking at Table 5.2, few respondents exclusively report only *one* type of partnership; as with this respondent, most report a mixture (to varying degrees):

> *(Can you see any patterns in your time line?*[15]*)* Oh, I doubt it. Well it's just, yeah it's just relationships, separated by little islands of promiscuity isn't it really, by the look of it. [182:52]

Many respondents report one or more partnerships that do not match their underlying pattern. For respondents who experience mostly steady partnerships, the occurrence of an opportunistic, casual sexual encounter is an example of an atypical partnership. Usually lasting only one night, these partnerships are reported and excused referring to contextual factors such as being intoxicated or highly aroused. Conversely, young men who experience predominantly casual partnerships may have this pattern interrupted by an unexpected steady partnership with strong romantic and emotional feelings present.

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[15] Time lines were sketched in some interviews to clarify a partnership history.

Table 5.2 - Information on Each Respondent's Penetrative Sexual Partnerships in the First Five Years of His Partnership History.

Age at interview	Median duration [1,2]	Percentage concurrent	Percentage self-defined as		Total number	Average number per year[3]
			Casual	Steady		
28	0 days	0	100	0	1	0.2
26	4 years	0	0	100	1	0.2
18	7 weeks	0	50	50	2	0.4
22	.	0	0	100	2	0.4
26	4 months	0	0	100	2	0.4
28	2 years	0	50	50	2	0.4
26	.	0	67	33	3	0.6
18	1.5 weeks	0	100	0	2	0.7
22	3 days	25	25	75	4	0.8
26	4 months	25	25	75	4	0.8
21	.	0	50	50	2	1.0
19	6 months	33	33	67	3	1.0
20	15.5 weeks	20	60	40	5	1.0
23	2 weeks	0	60	40	5	1.0
23	10 months	20	40	60	5	1.0
23	2 months	0	20	80	5	1.0
25	2 years	20	60	40	5	1.0
27	2 months	0	60	40	5	1.0
23	3 months	33	33	67	6	1.2
27	0 days	0	0	100	6	1.2
29	1 month	17	83	17	6	1.2
27	2 days	17	67	33	6	1.2
19	4 months	0	75	25	4	1.3
20	3 months	0	43	57	7	1.4
25	2 weeks	57	71	29	7	1.4
24	2 months	0	71	29	7	1.4
21	1 month	0	57	43	7	1.4

Table 5.2 cont.

Age at interview	Median duration [1,2]	Percentage concurrent	Percentage self-defined as		Total number	Average number per year[3]
			Casual	Steady		
19	3 days	0	67	33	3	**1.5**
29	2 months	0	88	13	8	**1.6**
18	.	0	40	60	5	**1.7**
18	3 months	0	40	60	5	**1.7**
19	.	0	60	40	5	**1.7**
20	3 months	0	43	57	7	**1.8**
19	2 months	0	50	50	8	**2.0**
20	0 days	0	82	18	11	**2.2**
21	.	0	100	0	11	**2.2**
28	1.5 weeks	0	75	25	12	**2.4**
16	6 weeks	0	60	40	5	**2.5**
22	0 days	57	71	29	14	**2.8**
22	0 days	0	89	11	9	**3.0**
27	0 days	0	94	6	18	**3.6**
25	0 days	12	82	18	33	**6.6**
20	0 days	0	79	21	43	**8.6**
All	*0 days*	*8*	*69*	*31*	*311*	*1.7*

Notes: Each row represents one respondent.

[1] - Blank cell indicates that more than 30% of the respondent's partnerships are missing data on total duration.

[2] - Seven partnerships were still active at the time of interview. The total duration of these partnerships has been taken as the time in the partnership prior to interview.

[3] - This column has been calculated as 12 respondents have not experienced five or more years of their partnership history. The previous column of total number of partnerships, therefore, does not allow a valid comparison of partnership numbers.

5.6.2 Partnership numbers

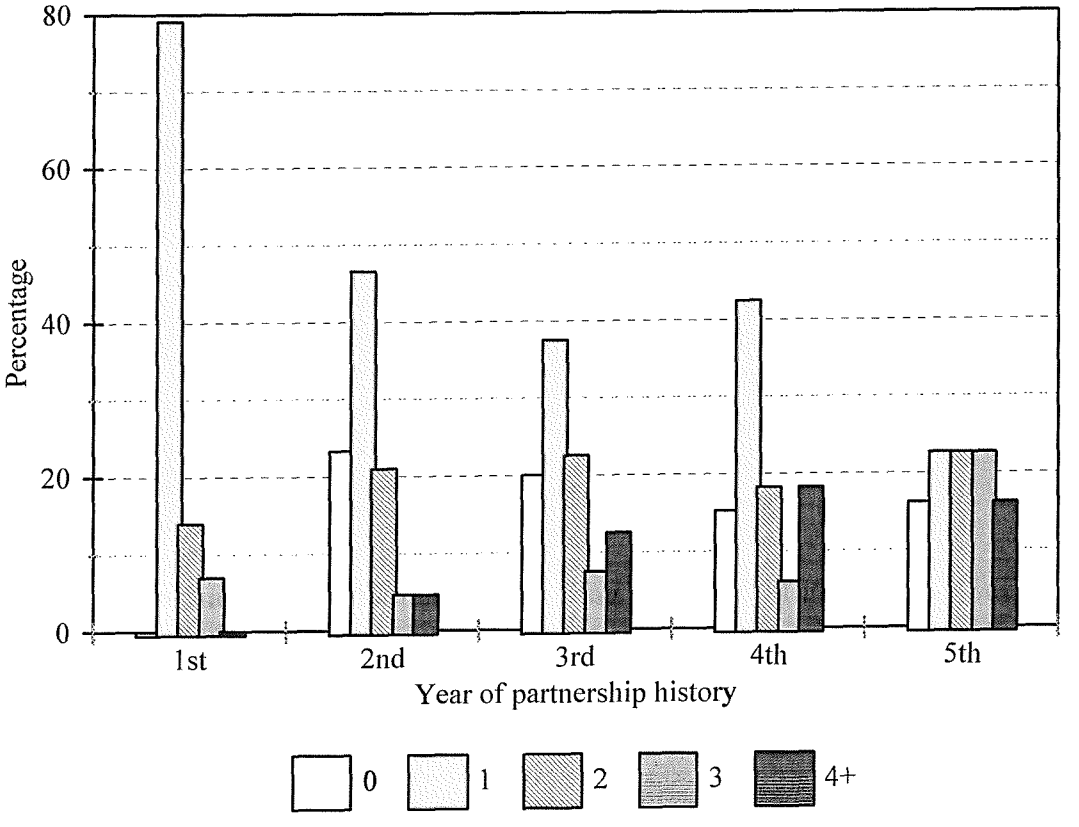
The last column of Table 5.2 shows each respondent's reported number of partnerships per year; however, this is an average number for the first five years of the partnership history. Looking at each year of a history reveals peaks and troughs in partnership numbers. Figures 5.5 and 5.6 illustrate changes in the reported number and self-defined status of partnerships during the first five years of the respondents' partnership histories. It is interesting that the level and spread of partnership counts increase with successive years. The percentage of respondents reporting three or more partnerships in a year steadily increases from the first to fifth year. Also note that only 9 of the 43 respondents (21%) report having two or more partnerships in the first year of their partnership history[16]. No clear trend emerges from Figure 5.6, although there is a slight tendency for respondents to report more casual than steady partnerships as their partnership history progresses.

How do respondents report their subsequent interest in, and incidence of, sexual partnerships immediately after first-ever intercourse? Several factors influence these outcomes, including the characteristics of first-ever intercourse, how long the first partnership continued, sociosexual interest and social activity in this period. Some respondents who were disappointed in their first experience of intercourse report either a) wanting to experience more sexual activity to see if it improves, or b) losing interest for a period, assuming that sexual activity in the future would be as unsatisfactory as the first time. The respondent quoted below (who earlier in the interview described the unexpected and demanding physical *"gymnastic manoeuvres"* [178:33] involved in first-ever intercourse) expresses this latter theme:

> *(Did having sex that first time change the way you thought about sex?)* Umm, (pause) I can remember thinking, "Fucking hell, I hope there isn't gonna be this kind of hassle every single fucking time." Yeah, it did. There's always this image of sex being this wonderful moving experience and I can remember thinking, "Fuck, I bet no one else has ever had this problem". [178:33]

[16] Zero partnerships, of course, is not possible in the first year of a partnership history. There is concern that the partnership timing difficulties discussed in section 5.1 may be distorting this figure. It is likely that more respondents actually experienced a second partnership within an *absolute* period of one year after first-ever intercourse.

Figure 5.5 - Percentage of Respondents Reporting Numbers of Penetrative Sexual Partnerships, by Year of Partnership History.



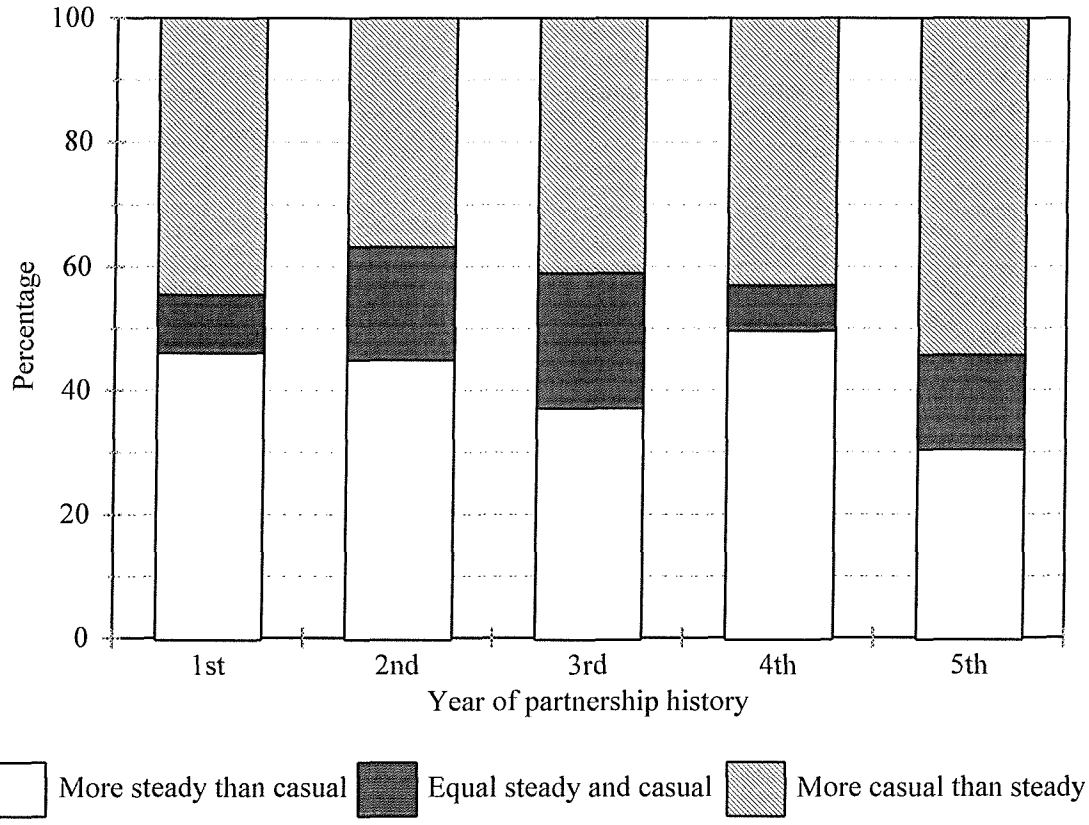
Notes:

Year	Median	n
1st	1 partnership	43
2nd	1 partnership	43
3rd	1 partnership	40
4th	1 partnership	33
5th	2 partnerships	31

'Partnership history' is defined as the time between the year of first-ever intercourse and year of interview.

Partnerships lasting more than one year have been counted in the start year and successive years as applicable.

Figure 5.6 - Percentage of Respondents Reporting a) More Steady than Casual , b) Equal Steady and Casual, and c) More Casual than Steady Penetrative Partnerships, by Year of Partnership History.



Notes:

Year	n
1st	43
2nd	43
3rd	40
4th	33
5th	31

Percentages exclude respondents who report no partnerships in a year.

'Partnership history' is defined as the time between the year of first-ever intercourse, and year of interview.

Partnerships lasting more than one year have been counted in the start year and successive years as applicable.

Another group of respondents recall no immediate interest in experiencing additional sexual partnerships in the period after first-ever intercourse as they felt they had already proved their masculinity by losing their virginity. For the remaining respondents, however, the occurrence of first-ever intercourse was followed by a high level of interest in experiencing more sexual activity. This activity may continue with the first sexual partner. One third of the respondents' first sexual partnerships lasted for more than three months after first-ever intercourse. This period occurred between the ages of 15 and 19 for most respondents, when a young man and most of his peer group are also in the early stages of their sexual partnership history. It is then that the respondents report they felt under most pressure from peers to be sexually active:

> Umm, I think sex, through school when we talked about it until about 17, 18, it was more of a conquest, it's something you've got to get out the way as quick as possible and sort of go back and tell people about. There didn't seem to be any deep meaning, it was purely a physical activity. Umm, but as that's gone on I think it's developed, you put more into it from yourself, there's deeper things involved now where I think you could really get to know someone. [183:39]

Using the frequency of partnerships as a measure of sexual activity[17], periods of high and low activity can be identified. Across the sample, the highest reported partnership frequency is twenty-five partnerships over a ten week period, the lowest one partnership in five years. Different factors are cited to explain changes in partnership counts, although some respondents appear unable to explain fully why they experienced a change. Using a metaphor of British public transport for sexual partnerships, this respondent reports being *"mystified as to why all the buses came along at once"* [185:31] after an inactive period. Another respondent who had a long period with no partnerships reports the next partnership *"was like losing your virginity again, it was like being a born again virgin or something"* [174:62].

Changes in partnership counts are explained in reference to factors discussed in sections 4.2, 4.4 and 4.5. As a reminder, these factors affect a young man's level of heterosexual interest, his social opportunities for meeting potential sexual partners, and his success in using interpersonal strategies. Periods of the highest partnership counts, therefore, are when these

[17] Wight (1994b) argues that a more useful and neglected indicator is frequency of intercourse.

factors combine to produce the most favourable personal and social context for sexual activity, and when a young man's sexual interest is greatest.

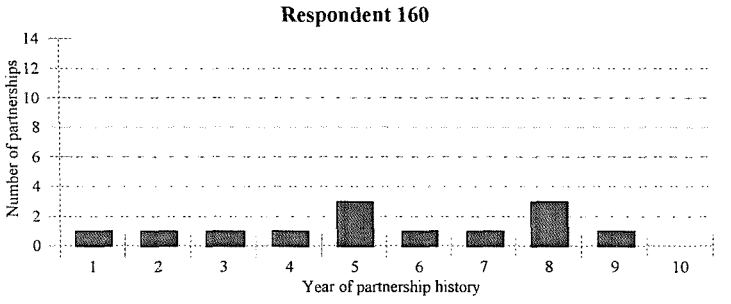
The importance of these factors varies by individual respondent over time. Evidence from Figure 5.5, for example, suggests that the first few years of many respondents' partnership histories are characterised by comparatively low partnership counts. Higher counts become more apparent in the third, fourth and fifth years. This coincides with a period of greater social opportunities outlined in section 4.4.2, for example, attending higher education away from the parental home. However, this is not the only pattern over time; Figure 5.7 illustrates partnership counts by year of partnership history for six selected respondents, here looking beyond just the first five years. Respondent 164 experienced a peak around his third and fourth years corresponding with a very active social life. Respondent 180's distribution of partnerships over time is more explained by employment opportunities that brought him into contact with many casual partners around his seventh year. Respondent 160, however, displays a more regular partnership count over his history.

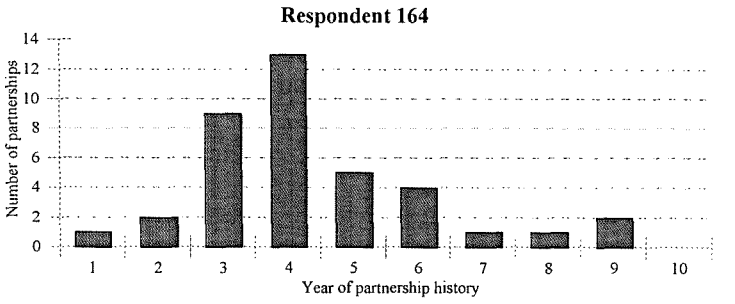
5.6.3 Changing roles and meanings

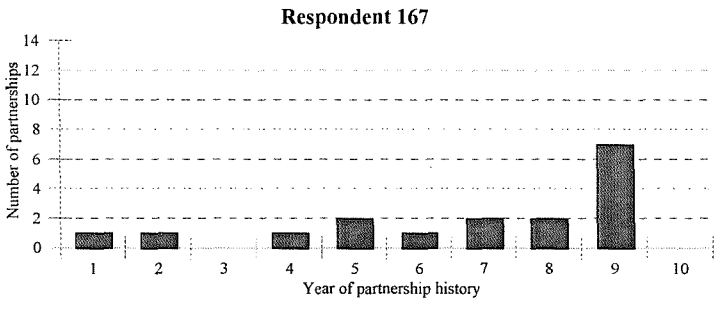
The change over time of the roles and meanings attached to sexual activity outlined in Respondent 180's quotation on the previous page is evident in other interviews. This is a change from sexual activity being the primary, motivating factor for partnerships to occur (described by one respondent as *"the be all and end all of life"* [147:59]), to sexual activity being viewed as one component of the couple's emotional relationship. Alternatively, it can be thought of as a change from subscribing to the 'Lads' to the 'Friendship' strategy. This initial emphasis on sexual activity may be driven by factors including pressure from peers, physical enjoyment and curiosity to learn about sex. Holland and colleagues (1993) suggest this 'bastard syndrome' is especially conspicuous at the beginning of a male sexual career.

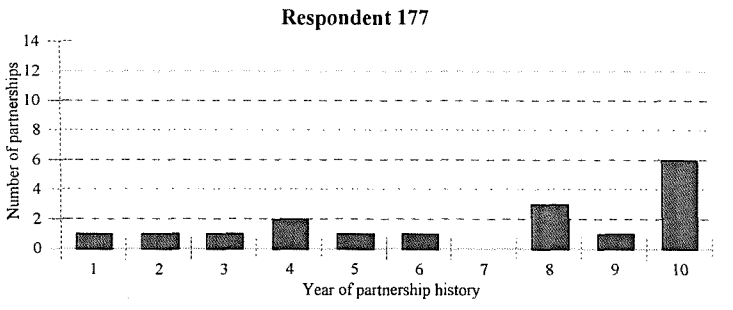
Why does this change occur? Some respondents explain the transition with reference to greater understanding of the emotional meanings partners attach to sexual activity. Other respondents refer to the maturation and learning process of growing up: the first few sexual partnerships provide learning on the physical aspects of sexual activity, and emphasis can therefore switch to the emotional relationship with a partner. In addition, as discussed in

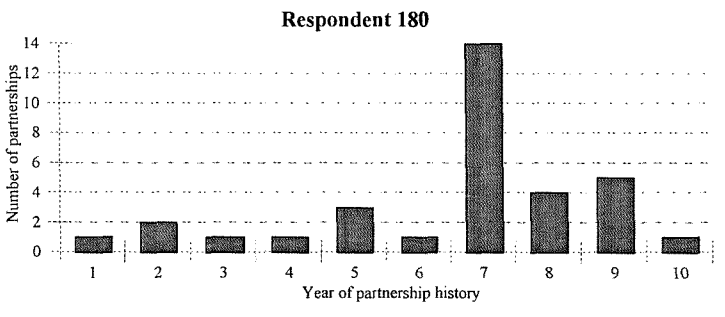
Figure 5.7 - Number of Reported Penetrative Sexual Partnerships by Year of Partnership History, Selected Respondents.

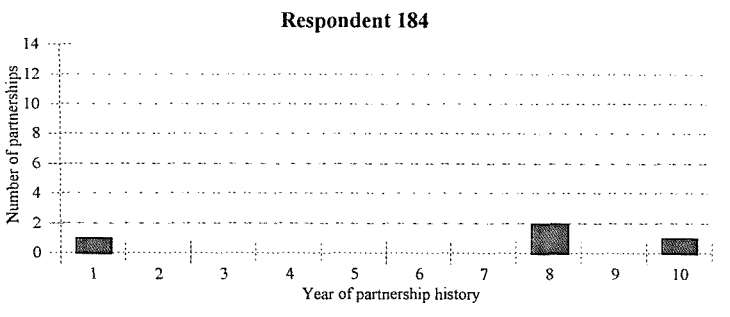












Notes:

Partnerships lasting more than one year have been counted in the start year and successive years as applicable.

section 4.3.2, pressure from peers to be sexually active can have less influence as a young man becomes older.

However, this change in meanings is also reported to have occurred in the chronologically reverse direction. Here, a young man initially associates sexual activity as inextricably linked to the emotional relationship with a partner, but then changes to viewing sexual activity as a physical pursuit with fewer emotional connotations. This can occur after the ending of a long-term steady partnership (see next section) or because of changes in external influences, for example, mixing in a social group in which the members primarily have casual partnerships.

Another interesting change evident centres around physical performance in sexual activity. As noted in section 5.5.4, some respondents were concerned about whether they would perform satisfactorily during first-ever intercourse. 'Performance' indicators identified by respondents include time between penetration and a young man's orgasm, how much pleasure his partner appears to have (in particular, whether female partners have an orgasm), and penis size. Concerns like these are influenced by the competitive nature of some young men's early sexual activity. Not only are their peers judging them on their ability to attract and have sex with young women, but they feel they are also being judged on their sexual performance by partners. Holland and colleagues (1993) describe this as a fear of turning from a gladiator into a wimp. A poor sexual performance reported from a partner to a young man's peers could affect his prestige. This respondent, in the third year of his partnership history, expresses this concern:

> *(What do you think about when you're having sex?)* Umm, am I doing it right, are they enjoying it, I think about the other person a lot, I like to make sure it's good for them. It's a reputation, if you get a reputation for being shit, you know? (*So whether you're good or not in bed will get back to everyone else?*) It probably wouldn't, like I haven't ever had people like say "Oh, I heard you're shit" or "You're really good" or something like that but umm, I've heard other girls saying "Oh, I've heard about your penis" and stuff like that, all the girls do talk to each other. [148:54]

These concerns can decrease over time, due to increased confidence gained through sexual experience, or realising that most partners do *not* usually gossip on an individual's sexual performance. However, other respondents report increasing concerns around sexual performance as they progressed through their partnership history. One reason for this is

greater comprehension of the nuances of sexual activity; for example, increased awareness that a partner desires sexual satisfaction. An indicator of this satisfaction is whether a female partner has an orgasm; if this does not happen, the young man may feel he is to blame. As this 20-year-old respondent reports, as a young man progresses through his sexual history, his partners are *themselves* more likely to have had many sexual partners. Therefore, the young man's sexual performance gets compared to a wider panel of 'competitors':

> At the end of the day there's like a 90% probability that anybody I sleep with from now on isn't going to be a virgin, and therefore my respect for them as a woman would be less. It's just something that some blokes have, if you weren't the first, there's a high chance that you're not the best, and not being the best is a problem, you know. 'Cause like with Natalie, if she's slept with 15 people, the chances of me being the biggest and the best are very slim, which leads to all sorts of sex problems with insecurity. [156:35]

5.6.4 Important partners

Besides changes in personal and social circumstances, a young man's experience of previous sexual partnerships can influence his partnership history. For some respondents, one partner is identified as having particular personal importance and meaning to them. This may be a young man's first steady, long-term sexual partner, or his first partnership in which all facets of the relationship (such as friendship, social activity, sexual activity) combine together well. Alternatively, it may be the first partner who is (as one respondent terms) the *"true love of my life"* [171:26], even if that love was not felt to be reciprocated.

The ending of an important partnership can affect a person's attitudes towards future partnerships, particularly in the short-term. While some partnerships end fairly amicably, other endings are more awkward and involve much emotional upset. At the time of interview, this respondent had recently left a year long relationship that ended acrimoniously:

> After the break up with Rosie, I've been going out just to, I reckon my attitudes changed 'cause she like hurt me. And, umm ... *(So what's changed about your attitude?)* Umm, now I'm more like one of the lads. If I go out and pull then I'd rather just sleep with a girl and just leave it at that, I probably wouldn't see them afterwards. I'd always now go for a stranger, I wouldn't go for someone I know. [148:42]

A pattern of experiencing casual partnerships in the aftermath of a long-term steady partnership is common. Respondents explain this behaviour with reference to four factors. First, casual partnerships act as a counterpoint to the conditions of the previous steady partnership. Casual partnerships offer greater freedom in social activities, opportunities to meet and get to know new people, and absence of the emotional commitments of a steady partnership. A second related explanation is the ending of a steady partnership gives a young man the opportunity to 'catch up' on his sexual partnership count. This explanation implies that time spent in a steady partnership is time out of the sexual 'market' when the young man could have been experiencing casual partnerships. Third, casual partnerships are cited as boosting personal confidence after the break up of a long-term partnership when a person may be feeling downhearted.

Fourth, an increase in the number of casual partnerships after a steady partnership is explained as being on the *"rebound"* [170:31] or *"latching on"* [148:49] to new partners. This refers to when a steady partnership ends, and a young man enters a new partnership to try to re-create and relive the conditions of the previous steady partnership. However, the great expectations placed upon the new partnership are not met, resulting in the partnership ending after a short time. This situation is then repeated with successive partners. One respondent refers to the emotional *"shields"* [181:31] he placed around himself after a long, steady partnership ended. These 'shields' hinder a new partner forming a close, emotional relationship with the respondent, therefore reducing the likelihood of a new steady partnership developing.

A second example of a partnership assigned a special status is one in which the nature of sexual activity is particularly notable. For example, this respondent remembers the high quality of sex in this partnership:

> Yeah, Trudi, it wasn't, it was a sexual relationship, she's like a bit of a nymphomaniac. She loves her sex and she was very dominant and I loved it, I was 15 and couldn't get enough of it and that just gave me confidence at the weekends, 'cause I only used to see her during the week, to go out at school and that and get as much [sex] as I could. [172:26]

An effect of this partnership, therefore, was to boost the respondent's confidence around sex, thus helping him to feel more able to initiate other sexual partnerships. The context of a sexual partnership may similarly bolster a young man's sexual confidence. An example

given by one respondent [166:21] is a casual, one-off partnership in a semi-public location with a partner who was unknown to him before the encounter. The partner-led initiation of the encounter, her positive verbal comments concerning his physical appearance and the fact that she wanted to have sex with him purely on physical grounds were taken as complemental. This increased his self-esteem, particularly valuable as he was feeling dispirited after recently exiting a long-term partnership.

5.7 SUMMARY

a) While the distinction of partnerships as steady or casual is useful, these labels encompass a range of features including the emotional involvement, duration and faithfulness of a partnership.

b) Respondents are motivated to have sexual partnerships due to factors including the physical pleasure, emotional meanings, companionship and indication of sexual prowess they involve. Steady partnerships are more likely to be experienced by respondents who attended a mixed-sex secondary school, report a 'warm' family environment, and good learning about sex from school and parents.

c) Even accounting for one-night stands, most partnerships have a short duration before intercourse occurs. Some respondents believe a relationship should develop to an appropriate stage before intercourse occurs, although even this belief can be undermined by the occurrence of an atypical, casual partnership.

d) The symbolic importance of first-ever intercourse is confirmed. First-ever intercourse occurs either on the first night of a partnership, or as part of a steady partnership. The former context is typically an unexpected event driven by the immediate context of the sexual encounter. Loss of virginity in the latter context is more of a planned, event and reflect the couple's developing relationship.

e) Diversity exists in the number, timing and type of partnerships experienced by respondents. Higher partnership numbers are characterised by casual, short-duration partnerships. The sample shows an increasing level and spread of partnership counts over the first five years of the partnership history.

f) Changes in partnership rate and type are explained in reference to factors including changing sociosexual interest, social opportunities and interpersonal strategies. The ending of an important steady partnership can result in a subsequent high rate of casual partnerships. The transition from a 'Lads' to 'Friendship' strategy over the partnership history is common.

CHAPTER 6 - USE OF CONTRACEPTION

6.1 INTRODUCTION

The policy-relevance of previous chapters is strengthened when combined with a discussion of unwanted outcomes of sexual activity such as an unintended conceptions or sexually transmitted infections. This requires understanding why the respondents report use and non-use of contraception in their sexual partnerships. Therefore, this chapter aims to:

a) discuss how the respondents conceptualise the risks involved in sexual activity
b) identify strategies aiming to protect against these risks
c) identify associated factors that may explain why young men adopt certain protective strategies
d) consider briefly the role of communication of contraceptive intentions in sexual encounters.

First, a few words on the limits of analysis, and the quality of reporting. Only contraceptive use in heterosexual partnerships is considered as opposed to prophylactic use in homosexual partnerships due to the low number of homosexual partnerships reported. Similarly, analysis is restricted to use of contraception in *vaginal* intercourse. In the NSSAL, 8% of men aged 16-24 report having heterosexual anal intercourse in the last year, compared with 71% reporting vaginal intercourse (Wellings *et al.*, 1994). Although a rarer heterosexual activity, it is still of epidemiological interest as a mode of infection transmission. Breakwell and Fife-Schaw (1991) provide useful information on young people's prophylactic behaviour in heterosexual anal intercourse. Ten of the forty-three respondents in the current study (23%) report a total of 16 partners with whom they had heterosexual anal intercourse. This low number and shortage of information on prophylactic behaviour make it difficult to identify or explain any protective strategies.

The primary outcome variable for the analysis is the method(s) of contraception used in the respondents' sexual partnerships. For consistency with Chapter 5, only partnerships occurring in the first five years of a partnership history are considered. However, not all partnerships in this period have a contraceptive outcome reported. Similar to the factors in section 5.1, respondents reporting a high number of partnerships or partnerships occurring a

long time prior to the interview have difficulty recalling what contraception was used. Although information on contraceptive use for specific partnerships may be missing, such respondents usually recalls their *general* contraceptive behaviour during the relevant period.

The time available and flexibility of an interview allows the interviewer to use probing, follow-up questions to obtain an accurate report of contraceptive use. Some responses to initial enquiries were found to be inaccurate through follow-up questions. For example, a respondent initially reports no contraception was used when, in fact, either the pill or withdrawal was used. Three factors explain these inaccurate responses. First, if the interviewer's initial enquiry is phrased "Did you use contraception?", does the respondent interpret 'you' as singular or plural? Some respondents thought the question referred to whether he used a male method of contraception, whereas others responded on whether a method was used by themselves *or* their partner. Second, 'traditional' methods such as withdrawal and fertility awareness may not be reported if they are not perceived as 'real' methods of contraception. On a similar point, phrases like 'method of protection' or 'birth control' can be interpreted as referring to only certain methods of contraception, as in this example:

> *(So did you and Kirsty use any precautions that first time?)* No. *(Nothing?)* No. *(You didn't withdraw?)* She was on the pill. *(She was on the pill, right. So, there was a precaution against birth control?)* Yes, sorry, yeah. [151:18]

A third issue is how a respondent knows whether contraception is being used. Few doubts exist (apart from recall) for a conspicuous method such as a condom, but what about the pill? Three sources of knowledge on use of the pill are reported. First, immediately before or during the sexual encounter the partner explicitly states that she uses the pill. Second, a respondent implicitly is aware that his partner uses the pill. Information may have emerged in earlier, general conversation, or he may see her taking a pill. Third are respondents who, despite receiving no explicit confirmation, assume their partner is using the pill. After a respondent suggests use of a condom, his partner's subsequent reassuring comments such as *"It's all right, don't worry"* [167:35] or *"Oh, [you] don't need that"* [171:26] are interpreted as confirming she is using an inconspicuous method of contraception. More worryingly, a few respondents interpret a partner not mentioning contraception before intercourse as suggesting she is using an inconspicuous method.

6.2 METHOD CHARACTERISTICS

Young men, like any user group, have distinctive needs and experiences of contraception. What methods are available to young men, and which methods are used most? Section 1.2 introduced the notion of 'male' and 'female' methods of contraception. Diller and Hembree (1977) suggest three factors to make this distinction:

i) whether the man or woman initiates use of the method
ii) whether the method is directed at the male or female reproductive physiology
iii) whether action is needed by the man or woman for compliance and successful use of the method.

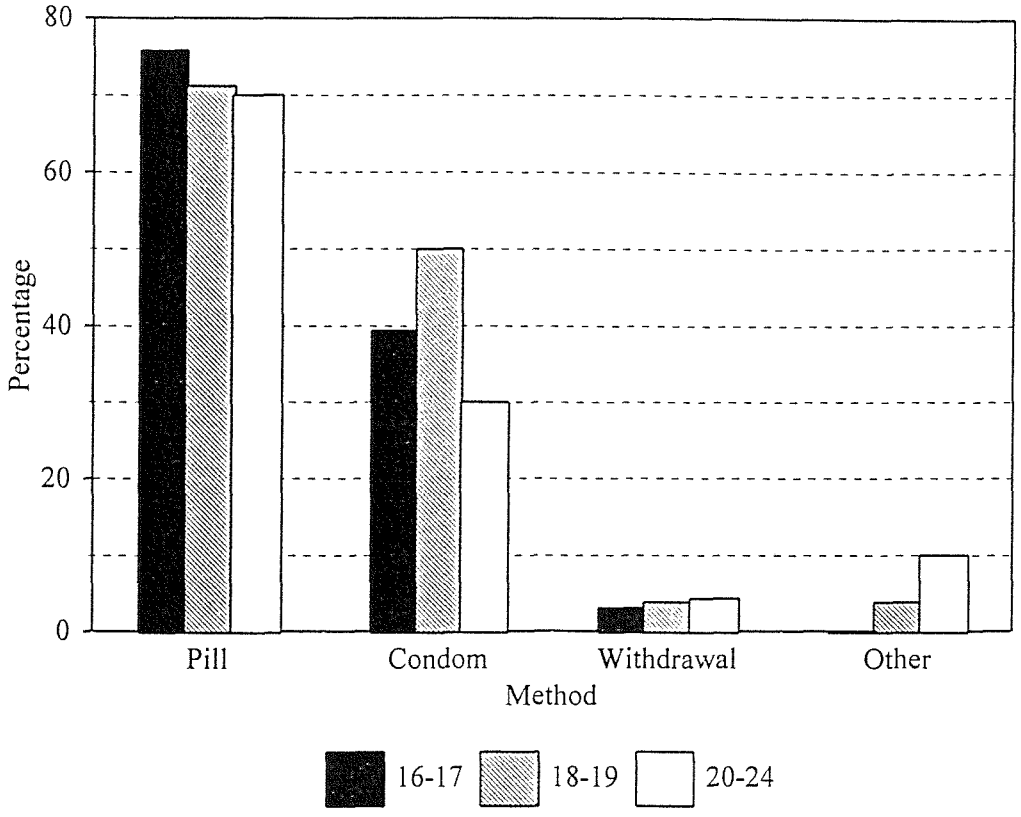
Using each factor independently would result in different categorisations depending on the contraceptive roles played by the couple. For descriptive purposes, factor iii) provides the best indication of whether the man or woman is most involved in method use. Thus, 'female' methods include oral contraceptives (the pill), intrauterine device (IUD), cap, diaphragm, sponge, female condom, injectable, implant, female sterilisation, emergency contraception and fertility awareness methods. 'Male' methods include the male condom, withdrawal and male sterilisation.

Using this classification, of the 58% of women aged 16-24 in the 1995 General Household Survey who were currently using contraception, 77% were using a 'female' method and 40% a 'male' method[1] (Office for National Statistics, 1997b). Figure 6.1 displays the specific methods being used by women in this age group. The list in the paragraph above and sexual health promotion material suggest a variety of methods are available to young people. In practice, however, the pill and condom dominate use in this age group, with withdrawal the third most reported method.

Some literature on men's attitudes and experiences of using contraception exists, although sparse when compared with women. Knowing about men's experiences of using methods is

[1] Percentages add to more than 100 because of rounding and some women were using more than one method, most likely the pill and condom.

Figure 6.1 - Method Use of Women Aged 16-24 Currently Using Contraception, by Age Group, 1995 GHS.



Notes: Base figures for percentages are women currently using at least one method of contraception. As shown below, this proportion increases with age group.

Age group	Percentage using at least one method	Number using at least one method
16-17	33%	72
18-19	52%	81
20-24	70%	396

The question, included in a self-completion questionnaire, was phrased "Which of the following method(s) of preventing pregnancy, if any, are you (and your partner) usually using at present?"

Percentages add to more than 100 because of rounding and because some women were using more than one method.

'Other' includes IUD, cap, safe period, spermicides, injection, female sterilisation and male sterilisation.

Source: Office for National Statistics. (1997b). Living in Britain. Results from the 1995 General Household Survey. London: The Stationery Office, Table 11.5.

crucial in understanding the protective strategies adopted to prevent risk. The pill, condom and withdrawal methods are considered separately.

6.2.1 Pill

The pill is the quintessential female method of contraception; most male partners have limited involvement in its provision or use. The main advantages of use reported by men are similar to those reported by women; efficiency in preventing conception and convenience of use (Morton-Williams, 1976; Farrell, 1978). Although the pill does not interfere with the sexual encounter, men have reported the inconvenience for women in remembering to take the pill daily at the same time (Farrell, 1978). Male partners are trusting the pill is taken properly and regularly every day, a negative aspect raised by young men in Wessex (Cooper *et al.*, 1992a).

Lack of protection against sexually transmitted infections is a major disadvantage of pill use (Cooper *et al.*, 1992a; Mathie *et al.*, 1992; Wight, 1994b), an important factor determining the contraceptive protection styles. A second reported disadvantage is health side-effects for the user (Cartwright, 1976; Farrell, 1978; Cooper *et al.*, 1992a). Work in the 1970s suggested men perceive greater health risks associated with pill use than women (Schofield, 1973), although this could reflect women's better knowledge and experience of the pill (Morton-Williams, 1976).

6.2.2 Condom

The male condom is the only highly effective method of contraception that young men can obtain and use themselves. Used correctly, male users report a condom has the advantages of protecting against conception and infections (Morton-Williams, 1976; Mathie *et al.*, 1992), especially HIV (Abrams *et al.*, 1990; Wellings *et al.*, 1994).

However, correctly using a condom requires more user proficiency than other contraceptive methods. The young man (or couple) needs to put the condom on at the right time, open the packet without tearing the condom (sometimes in the dark), ensure the condom is not inside

out, pinch the air out of the teat, roll the condom down the penis, ensure the condom remains in place during intercourse, and withdraw the penis after ejaculation with the condom still in place. The ease with which these steps are accomplished depends on the user's experience and confidence with condoms and the context of the sexual encounter. Difficulties in using condoms are reported as a disadvantage (Farrell, 1978), especially if the man is worried about appearing inexperienced or inept with a new partner (Spencer, 1984). The interruption in sexual activity is also reported as inconvenient (Morton-Williams, 1976; Spencer *et al.*, 1988; Cooper *et al.*, 1992a), particularly as it contradicts the idea of sexual activity as spontaneous and unfettered, and can result in loss of erection (Cragg *et al.*, 1993).

Perhaps the most common complaint from men is less physical sensation and therefore less pleasure when using a condom (Farrell, 1978; Nicholl, 1989; Ford, 1991). Intercourse using a condom is perceived as less enjoyable or authentic than intercourse without a condom. Examples of similes of this attitude express how a synthetic barrier diminishes tactile sensations:

a) *"Like sucking a sweet with the paper still on."* (Anonymous, 1965, p.97)
b) *"It's a bit like washing your feet with your socks on."* (Farrell, 1978, p.38)
c) *"Like having a shower with a raincoat on."* (Chapman & Hodgson, 1988, p.100)
d) *"It's like paddling in your wellies."* (Kent & Davies, 1993, p.18)

However, less physical sensation is cited advantageously by some men as it prolongs penetrative intercourse through delaying orgasm (Spencer *et al.*, 1988).

6.2.3 Withdrawal

Little has been written on how British men feel about using withdrawal. This may be because some men (and, possibly, researchers[2]) do not acknowledge withdrawal as a contraceptive method (Schofield, 1965; Cartwright, 1970), just referring to 'being careful' or 'pulling out'. Besides doubts on its effectiveness in preventing conception, men have complained about the self-control needed to withdraw immediately before ejaculation

[2] See Rogow and Horowitz (1995), and Santow (1993) for further discussion.

(Farrell, 1978), especially with the desire to penetrate deeply at orgasm (Chng, 1983). Withdrawal is also cited as unnatural and failing to give sexual satisfaction to the man or woman (Morton-Williams, 1976; Farrell, 1978). The main reported advantage of withdrawal is a lack of provision or planning needed (Morton-Williams, 1976; Farrell, 1978), useful if intercourse is unplanned, episodic or if a person has difficulties obtaining contraception.

6.3 RISK

6.3.1 Introduction

Before considering how and why young men adopt strategies to protect against risk, their attitudes around risk behaviour need to be clarified. What risks are present in sexual activity, and how do young men assess the degree of these risks? Risk behaviour has received much attention in health psychology, with some prominent models introduced in section 1.5. Risk behaviour models provide a useful framework for discussing how individuals assess risk, and therefore hold any risk-preventing intentions. Four important components in assessing sexual risk can be identified (Ingham, 1991; Klepinger *et al.*, 1993):

a) awareness of the determinants of the risk
b) collecting any partner-specific information on the determinants of the risk
c) assessing the likelihood of exposure to, and seriousness of, the risk
d) weighing the risk against other factors affecting use of contraception.

All four components are apparent in the respondents' discussions, although they may not be applicable for all the sexual partnerships, or be considered in the above order. Criticisms of these psychological approaches were discussed in section 1.5. Nevertheless, the relative merits of using contraceptive methods (including their ability to protect against risk) are cited when respondents explain and justify their contraceptive intentions, and to a lesser extent, behaviour. Although not totally accounting for reported behaviour, estimation of risk is an important component.

Components a), b) and c) listed above are discussed below: component d), the weighing of risk against other factors, is incorporated in the discussion of protection styles in section 6.4. Two main sexual risks are identified by respondents; conception (usually termed the risk of 'pregnancy') and sexually transmitted infections[3]. Evidence from previous research suggests that most young people perceive the risk of conception greater than the risk of infection (Holland *et al.*, 1991a; Ingham *et al.*, 1991; Mathie *et al.*, 1992; Rudat & Speed, 1993; Wight, 1993a).

6.3.2 Risk of conception

Awareness that penetrative vaginal intercourse involves the risk of conception is universal among respondents. Some question the risk of conception using withdrawal, but this mirrors a similar debate in the literature (Rogow & Horowitz, 1995).

The *likelihood* of conception occurring requires more consideration. Generally, any penetrative vaginal intercourse without use of contraception is perceived to present a high risk of conception. If contraception is used, some respondents discuss the efficiency and consistency of use of different methods, and the associated likelihood of contraceptive failure. Knowledge of method effectiveness rates reflects learning from school and other sources, and their (and their peers' reported) experiences, for example, with condoms failing.

In a few examples, a partner's characteristics can affect the perceived risk of conception. For example, a different risk can be assigned to a partner due to her inconsistent use of the pill, reported infertility or use of other drugs, as in this example:

> If Abigail had fallen pregnant then I'd have stood by her. *(Yeah.)* But there was, you know, a small risk of that, even though she was on the pill. There was a risk because she did drugs, and drugs fuck up the pill, so there was a risk. [174:56]

Another contextual factor affecting the risk of conception (and consequently contraceptive behaviour) is the phase of the partner's menstrual cycle. The exclusive and planned use of

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[3] However, it is acknowledged that a more holistic view of sexual activity considers other risks; for example, lack of physical pleasure, unwanted emotions, sexual pressure and violence.

fertility awareness methods of contraception is rare, but examples are reported for the following situations:

a) in combination with withdrawal during unsafe phases of the menstrual cycle
b) for unplanned sexual encounters when other contraception is unavailable
c) by respondents aiming to avoid using a condom (see section 6.4.6).

Effective use of fertility awareness methods requires information on the current phase of a partner's menstrual cycle - information that, similar to the pill, a respondent has to take on trust. Unfortunately, some respondents who had used fertility awareness methods incorrectly identified the fertile and infertile phases of a menstrual cycle in the interview.

The seriousness of a conception is referenced to the potential decisions around termination or maternity, and the consequences of a child being born. Stereotypes of single men as uncaring and fancy-free are not reflected in the interviews; most respondents acknowledge the serious implications of an unintended conception. These include the psychological, emotional and health consequences of an abortion for a partner, the personal, financial and relationship implications of fatherhood, and similar types of consequences for the mother. Although acknowledging they may eventually want to be fathers, the underlying message is having a child at that stage of their life is undesirable.

However, other respondents view the consequences of a conception as less detrimental. Some older respondents view an unplanned birth as less of a predicament given the stability and emotional closeness of their current sexual relationship, as in this example:

> Nicki and me are quite steady so, you know, we both feel comfortable with each other and trust each other, so sometimes there's less of a need [to use contraception], because if anything goes wrong then we're together anyway, and also there's the morning after [pill] which she's taken once. [170:31]

Other respondents report less concern about a conception occurring due to the perceived lack of personal consequences for themselves. Either they feel no responsibility for dealing with an unintended conception, or their casual partnerships are so short and transient that future contact with a partner is unlikely. This respondent's job mobility reinforced this attitude:

(Did you not worry about pregnancy?) At that stage, no. *(No. Is there any particular reason?)* Well, they didn't have my surname. *(Oh, right, you couldn't be traced!)* I was umm, I was working all over the place as well, like at the age of 19. I was in [City] one week and somewhere else ... I was all over the country. [182:56]

Of course, a person's assessment of the risk of conception (and infection) is not fixed, and can be influenced by changing personal circumstances, increased knowledge and sexual experience. Several sensitising moments can be identified when an event changed a respondent's perception of risk, and subsequently their contraceptive intentions. Examples of events are shown in Table 6.1. Two relate to conception; Respondent 173's partner's pregnancy test, and Respondent 183's involvement in an unintended conception.

Table 6.1 - Examples of Sensitising Moments Resulting in Changes in Respondents' Contraceptive Intentions.

Event	Quotation
Partner's pregnancy test	Rachel started a lot of awareness sort of, thinking "I don't need any trouble" cause we had a pregnancy kit with her, and then it sort of hit home, "Oh, my god." *(Even though you were using condoms all the time?)* Yeah, 'cause one split. [173:56]
Unintended conception	As soon as she said it I didn't sort of think "Oh, that could be so and so's", instantly I had to deal with this because it's my problem as well. It was only after the event I started to think. *(Right. Did it have any influence on you, the feeling that you'd made somebody pregnant?)* It did, I mean, it made me aware of how easy it can happen. [183:35]
Sexually transmitted infection	AIDS has really scared me, actually. *(Yeah?)* Yeah, because when I got cystitis I sort of thought, "God, that means I can get AIDS, doesn't it, really." You know, it's that easy. [146:86]
Information on risk status of partner	Since meeting her I really sort of, because of the ... I mean at the time when I was seeing her she wasn't escorting but what she was telling me of her life experiences doing that, whatever, it made me really think. [164:60]

6.3.3 Risk of infection

Health promotion literature on sexually transmitted infections (for example, Health Education Authority, 1993) and epidemiological data (Department of Health, 1996c) show the range of sexually transmitted infections present in the heterosexual population.

Infections have different levels of prevalence in a population, symptoms, treatments and health consequences. Most of the respondents' discussions of infections in the interviews focussed only on HIV. This reflects awareness of HIV but not other infections among the British population (Office for National Statistics, 1999a). The analysis in this section, therefore, focuses on HIV infection. Awareness of other infections increased for some respondents, however, as their partnership history progressed and they (or a partner, or friend) experienced an infection. Such an event is cited as explaining a change in Respondent 146's contraceptive protection style, quoted in Table 6.1.

It is unsurprising that the respondents are well aware of HIV and its routes of transmission. Public awareness in Britain increased from the mid 1980s, with the first national campaign implemented in 1986 by the Department of Health (Perl, 1991). Given the ages of respondents at time of interview, the prominence of HIV during the first five years of their partnership histories varies. In 1986, around one third of the respondents were aged 11 years or less, with another third of secondary school age (12-16 years). Around 20% report experiencing first-ever intercourse by the end of 1986, with another 40% losing their virginity by the end of the decade. Thus, some respondents learnt about sex and started their sociosexual experiences before HIV/Aids was a visible issue, some were having their first experiences when the virus was most prominent among public awareness, and others began their sexual history in what can be termed the 'Aids era'.

Previous research suggests that although awareness of HIV is high, many British people do not consider HIV infection through heterosexual activity a salient risk (Abrams *et al.*, 1990; Woodcock *et al.*, 1992b; Cragg *et al.*, 1993; Wight 1993ab). The respondents report diverse attitudes on this point. To understand why some respondents feel at risk of HIV infection, and how this affects their contraceptive intentions, the four highlighted stages of the risk estimation process need to be considered. There is an important contrast to conception, however; the risk of conception is inherent in most women of reproductive age, whereas the risk of transmitting HIV is not. Information on perceived personal vulnerability, prevalence of HIV and a partner's characteristics play more of a role.

First, how do partner characteristics influence a young man's perception of the risk of HIV infection? Waldby and colleagues (1993) refer to a separation of safe and risky partners as a 'cordon sanitaire', with men creating a mental map of clean women nearby and unclean

women distanced by an imaginary margin of safety. Previous research identifies criteria reported by young men to construct this 'distance' of risk, including whether a partner is 'sleeping around' (Spencer, 1984; Cooper *et al.*, 1992a); lack of resistance to, or herself initiating, sexual advances (Waldby *et al.*, 1993; Wight, 1993a); agreeing to sexual intercourse on the first day of a partnership (Spencer, 1984); social and family background (Cragg *et al.*, 1993); physical appearance, both of dress and health (Stephenson *et al.*, 1993; Wight, 1993a), and area of residence (Wight, 1993a).

While similar risk factors are reported by respondents, what context are the remarks made in? Two contexts are evident; a) as part of a general discussion of characteristics thought to increase the risk of infection, and b) in relation to risk estimation of specific partners. The focus here is on the latter. Table 6.2 displays the range of information cited by respondents to estimate risk of infection. This is a comprehensive list, that is, not all respondents cited or prioritised all the information. Note how the horizontal structure of the Table reflects the epidemiological basis on which risk estimation is being made. Successive Table rows provide more information on whether a partner has been infected during her sexual history. The epidemiological validity of some characteristics is debatable, but the underlying thought process is sound.

However, a difficulty of Table 6.2 is that some of the information listed is detailed, personal, sensitive, and can require recollection of events a long time ago. Is it too simplistic to suggest that a person could obtain this amount and quality of information? Do young men also account for the reliability of information? How are separate pieces of information combined - for example, conflicting facts? Two *sources* of information are cited by respondents; information explicitly provided by a partner, and information obtained indirectly from friends through 'gossip networks' (Dockrell *et al.*, 1993; Wight, 1993b). For this respondent, the first source provided good information on a partner's history:

> *(So what did you know about Angie's sexual history?)* Everything, we're great friends, only one thing that I don't know. I knew she was using condoms with people she'd slept with other than me, basically. *(How did you know that?)* I asked her and I feel confident that she was telling me the truth. The one that she didn't [use a condom with], she and I knew the history of anyway. [156:28]

However, as Ingham and colleagues (1991) discuss, good reasons exist why this type of discussion may not occur before first intercourse, particularly in casual partnerships. More

Table 6.2 - Partner Characteristics Cited by Respondents to Estimate Risk of Sexually Transmitted Infection.

Partner's characteristic	Low risk	High risk
Personal attributes	• Low-risk sexual 'reputation' • Not forward in sexual advances • Does not have one-night stands • Recent test showing negative HIV status • Resides in low HIV risk country	• High-risk sexual 'reputation' • Forward in sexual advances • Has one-night stands • Recent test showing positive HIV status • Resides in high HIV risk country
Contraceptive intentions	• Insists on condom use • Currently not using pill	• Does not insist on condom use • Currently using pill[1]
Number of previous partners	• Zero, or low number	• High number
Attributes of previous partners	• *Same as personal attributes*	• *Same as personal attributes*
Use of contraception with previous partners	• Consistent condom use	• Inconsistent or non-use of condom
Previous partners' use of contraception with their previous partners	• Consistent condom use	• Inconsistent or non-use of condom

[1] - Taken to imply the partner has had intercourse recently without a condom.

information may be shared if the partnership continues, leading to a greater sense of 'knowing' your partner - an issue underlying the 'trusting relationship' protection style considered in section 6.4.5.

The second source, gossip from friends and acquaintances, can be as fruitful as the first, although perhaps not as detailed. Section 3.2.2 highlighted the importance of sexual gossip as a topic of conversation among young men. Also, section 5.2.3 suggested that many of some respondent's sexual partners were known as friends or acquaintances. Therefore, it is possible that a partner's sexual history can be determined through gossip. However, the last rows of Table 6.2, details of a partner's contraceptive behaviour with previous partners, are unlikely to be available through this source. Gossip becomes less reliable later in the partnership history as partners have more partners, and for casual partnerships in which little is known about the partner. Both these issues are reflected in the contraceptive intentions discussed in the next section.

To summarise, how much information respondents had before intercourse on the likely risk of a partner varied greatly. Some respondents were confident they had accurate knowledge of a partner's sexual and contraceptive history, particularly for partners known as close friends or who had experienced few partnerships. Other respondents accepted they lacked critical information to decide a partner's risk. As before, considerations like these play a role in understanding contraceptive protection styles.

A next component of risk estimation is to quantify the likelihood of exposure to HIV, as this respondent discusses in relation to his partnership history:

> As far as I'm concerned, I think that the chances of [previous partners] having sex without a condom with somebody that has HIV is very slim. Obviously you shouldn't be taking any real risks with your life ... I've forgotten what I was going to say now. Umm, I don't know, I think it's just an accumulation of percentage chances really, and at the end of the day, you've got them multiplying up quite largely where you can say, certainly if you were doing physics or chemistry, there's absolutely no chance at all, really. But there is always a chance. [156:31]

Likelihood of infection can be disaggregated into two elements; first, the chance of having a sexual partner who is HIV positive, and, second, the chance of transmission of the virus. The second element is not identified by respondents as variable; any penetrative intercourse without using a condom is thought to involve the risk of HIV transmission if the partner is HIV positive. Therefore, the key consideration is meeting a risky partner, as identified by the characteristics in Table 6.2.

Given the variety in partnerships discussed in Chapter 5, and the different ways in which respondents assess risk, it is unsurprising they hold contrasting views on whether their past and future sexual experiences could involve meeting risky partners. Four ways in which respondents express their personal risk of HIV infection are identified:

a) Respondents who believe that, regardless of their behaviour or the prevalence of HIV in the heterosexual population, infection will not happen to them. This belief of personal invulnerability has been noted in previous research (Ingham *et al.*, 1992), and is expressed in this quotation:

> *(So you think [HIV infection] could never happen to you?)* Yeah, I'm one of those people who lives in their own little private bubble thinking, "Nothing bad's gonna happen to me. I'm not going to get hit by a bus, it only happens to other people."

(But why do you think it's not going to happen to you?) I don't know, I suppose it's just the way people like to think, really, more than anything. It's just strange that I don't think of it ever happening to me. I couldn't imagine it. [147:58]

b) Respondents who believe the prevalence of HIV in the heterosexual population is so low that they have a minute chance of meeting an HIV positive sexual partner. Therefore, contraceptive intentions need not take account of the virus.

c) Respondents who, although acknowledging that HIV is prevalent in the heterosexual population, believe their preferences for, and experiences of, partners exclude the possibility of meeting a risky partner. Consider this respondent who, after discussing the low risk of one partner, relates his partnership preferences to risk:

(Did you think there were any other risks?) No, 'cause I trusted her. I knew she didn't sleep around, I think, but I knew she'd had one other boyfriend at university. I was I think about the fourth boyfriend. The first she'd had about [age] 15 or something, so the feeling was she wasn't in a risk category. *(So it's not that it didn't cross your mind, it did cross your mind but you trusted her?)* Yeah. I don't think I'd have gone out with her in the first place if she was in a risk category. I wouldn't have been attracted to that sort of girl at that time. [186:29]

Referring to Waldby and colleagues' (1993) 'cordon sanitaire', the issue here is whether a young man can accept their sexual partner could be unclean. How could a person you are physically attracted to, emotionally involved with, and about to share intimate sexual activity with, be dirty and tainted with an infection? Conflicting feelings of this nature may explain why some young men are reluctant to acknowledge that partners could present a risk of infection.

d) Respondents who acknowledge that HIV is prevalent in the heterosexual population and that their sexual behaviour may involve meeting a risky partner, a factor therefore taken into account in their contraceptive intentions.

The final aspect of risk estimation is the severity and consequences of HIV infection. As expected, many respondents cite the fatality of HIV infection as an extremely worrying and frightening consequence. For some, the implications of HIV infection outweigh any considerations of the prevalence of the virus or the chance of meeting a risky partner. The existence of a fatal sexually transmitted infection is the key consideration determining their contraceptive intentions.

6.4 PROTECTION STYLES

6.4.1 Introduction

Leading on from section 6.1, information is available on what method (if any) of contraception was used for most of the partnerships described in Chapter 5. Diversities in partnership types and numbers are matched by diversity in contraceptive use. Method use can vary between a respondent's partnerships, within a partnership and even within a sexual encounter. None, one, or multiple methods can be used for a sexual encounter. Another important dimension is how efficiently a method is used. Any simple measure of contraceptive use will conceal some of these intricacies.

Nevertheless, an attempt must be made to construct a measure that a) reliably represents a respondent's use of contraception in his sexual partnerships, and b) aids understanding of any determinants of use. One way of achieving these aims is to represent contraceptive behaviour using **protection styles**. Protection styles encompass themes representing intentions and experiences of contraceptive use in sexual encounters. Through a comprehensive and detailed description of respondents' contraceptive use, the constructed protection styles classify respondents according to the causative factors determining contraceptive intentions. A protection style can also reflect the role of the partner in contraceptive use, and the context within which sexual activity occurs. The protection styles used here are based upon styles constructed by Rademakers and colleagues (1992), and used by the research team who conducted the interviews used in this thesis (van Zessen, 1995; Ingham *et al.*, 1996). Rademakers and colleagues (1992) constructed eight styles to help explain how condoms are used to prevent infection in heterosexual encounters.

The protection styles are constructed based upon an analysis of the respondents' use of contraception in the first five years of their partnership histories. Three levels of information were derived for each respondent:

a) Method(s) used in each partnership, including any change in use over the partnership's duration
b) The respondent's explanations around contraceptive use for each partnership

c) General attitudes and intentions around sexual risk and use of contraception across the partnership history.

These three layers of information were then analysed to see whether the styles formulated by Rademakers and colleagues (1992) were applicable to the respondents' experiences. At this stage, definitions of some protection styles were revised to account for contraceptive methods other than the condom, and to reflect the prominent themes present in the current interviews. Next, the appropriate protection style(s) were allocated to each respondent; the ease of this task was influenced by four factors. First, the complexity and diversity of some respondent's contraceptive experiences hinder the allocation of one (or more) protection style. Second, reliability and clarity of reporting vary, as discussed in section 6.1. Third, contraceptive intentions and behaviour may change over the five years, so more than one protection style may be assigned to a respondent. Fourth, the definitions of the protection styles allow the allocation of more than one style to the same period of a partnership history. However, two levels of prominence of the styles have been identified, labelled as 'Yes' and 'Somewhat' in Table 6.3. The 'Somewhat' level is assigned, for example, if the style occurs in an occasional, atypical partnership, or a respondent exhibits some elements of a style, but not to the extent of other more prominent styles.

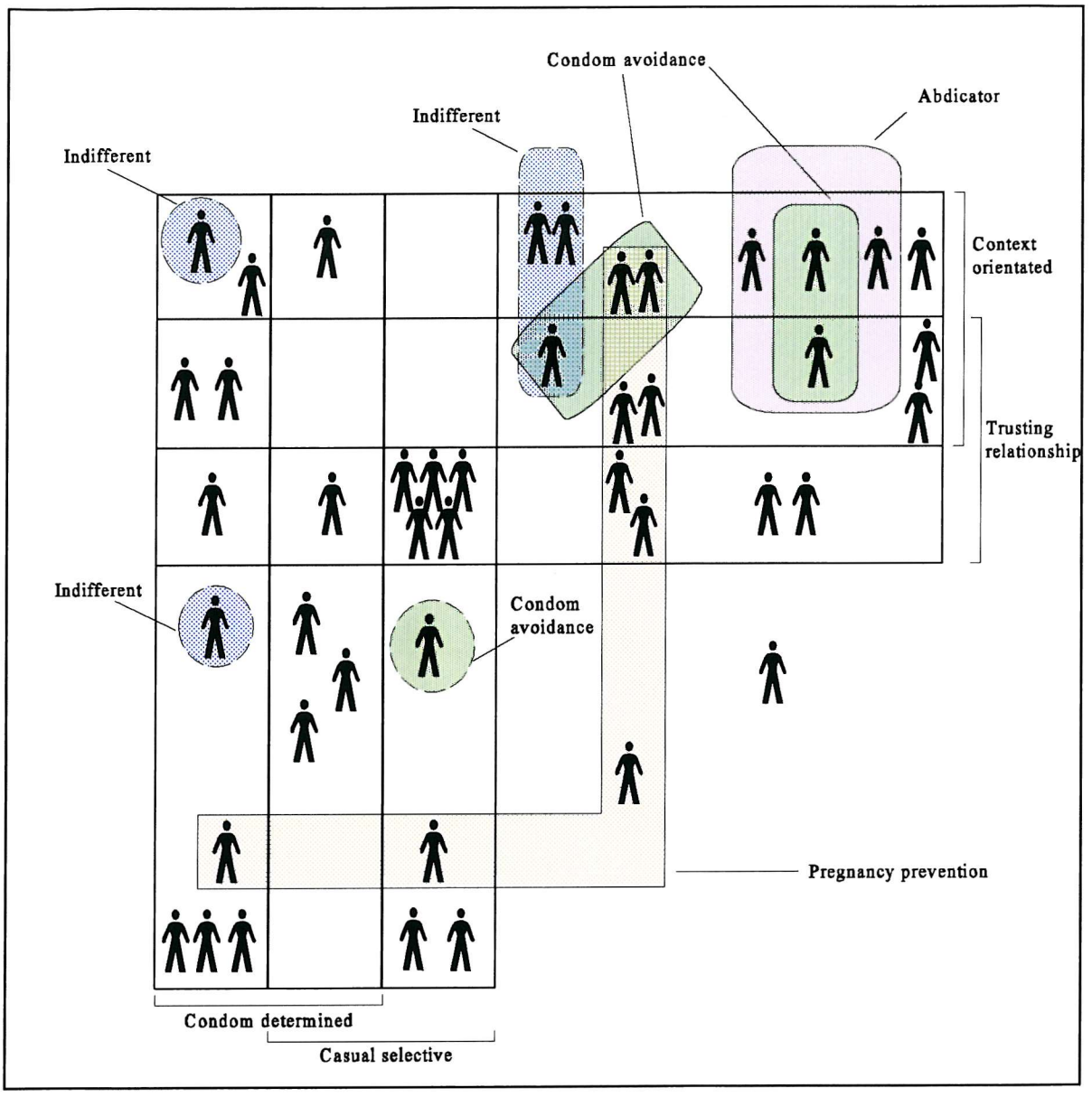
The eight main protection styles are summarised in Table 6.3. Table columns display use of contraception, perceptions of the risk of conception and infection, and the frequency of styles among all respondents. While the protection styles are considered separately in the sections 6.4.2 to 6.4.9, how do the styles overlap across respondents? This is displayed in Figure 6.2, a type of Venn diagram developed by Anderson and Cleaver (1965) to display more than five categories. Each respondent is in an area of the diagram according to the one (or more) protection styles he exhibits in the first five years of his partnership history. The complexity of the diagram reflects the complexity of the respondents' contraceptive behaviour. Clusters and patterns apparent in the diagram will be identified in the discussion in subsequent sections.

Table 6.3 - Summary of Main Contraceptive Protection Styles.

Protection style	Method use	Consistency of method use	Conception a salient risk?	Infection a salient risk?	Number of respondents using style in first five years of partnership history (n=42[1])		
					Yes	Somewhat	Total
Condom determined	Condom	High	Yes	Varies	14	1	15
Pregnancy prevention	Any effective method	High	Yes	No	7	2	9
Casual selective	Condom for a risky partner, any method for a safe partner	High	Yes	Yes	8	5	13
Trusting relationship	Condom at start of partnership, then changing to pill	High	Yes	Yes, to No	6	13	19
Condom avoidance	Any method apart from condom	Varies	Somewhat	No	1	5	6
Context orientated	Varies	Low	Somewhat	Somewhat	6	13	19
Abdicator	Varies	Varies	No	No	4	1	5
Indifferent	Varies	Low	No	No	4	1	5

[1] - One of the forty-three respondents did not experience any *heterosexual* partnerships in the first five years of his partnership history.

Figure 6.2 - Venn Diagram Showing Overlap of Respondents' Contraceptive Protection Styles.



= one respondent.

Four of the protection styles are defined by the horizontal and vertical rectangles. The remaining four styles are defined by the coloured shapes. Due to the complexity of overlaps, the indifferent and condom avoidance styles are presented as discontinuous areas.

6.4.2 Condom determined

Contraceptive use

Young man intends to use a condom for every penetrative sexual encounter.

Rationale

Although resulting in the same outcome, different factors motivate this intention. The most common are:

a) to reduce the risk of conception

b) to reduce the risk of sexually transmitted infection

c) to personally ensure that contraception is used

d) to enable a steady partner to avoid health effects of using the pill.

The method characteristics of the condom discussed in section 6.2.2 make it ideal to meet these objectives. A condom protects against conception and infections, can be obtained and used by a man, and is unlikely to have health side-effects for the user. It is interesting how some followers of this strategy stress its default nature, as though no other contraceptive behaviour is possible. Believing that new partners automatically expect use of a condom, it is therefore a courteous and caring gesture to offer to use one.

Associated variables

Condom determined is a popular style for the younger respondents. This could reflect their experiences of learning about sex and having their first sexual partnerships in the era of Aids. HIV/Aids awareness campaigns have a central tenet of encouraging condom use in penetrative sexual activity. As a result, condoms became more conspicuous items, coming out of the shadows of barber shops and chemists and into the public realm. Growing up in this enlightened environment, this respondent views condom use as the norm contraceptive behaviour:

> It was just something that I should do because of everything, like. I mean, it wasn't for any specific reason, just, that's what I'd sort of learnt, you know, everyone had said "Wear a condom". You know, you learn it in school, TV, that sort of thing. [159:44]

However, this style's popularity among younger respondents is also a reflection of their shorter partnership history prior to interview. Use of a protection style is tested and updated constantly by new information and experiences, aspects lacking in a shorter partnership history. This 22-year-old respondent with experience of two sexual partnerships appears uncertain how he would deal with a common contraceptive situation:

> I always think, you know, I'm going to use protective sex, that's fine. As I say on that occasion I didn't and that's just ... what can I say about it, but in general I would try to use protection and avoid that 'cause I'm always aware of [Aids]. (*What about if you met somebody and she said to you "Well, I'm on the pill so don't worry about using a condom?"*) That's good. I don't think I've really thought about it. That would cause me some trouble. [155:31]

The condom determined style is associated with respondents who report a high number of casual partnerships. With a short time before sexual intercourse, knowledge of a partner's sexual history may be limited. The condom determined style, therefore, enables protection against this unknown risk, and requires little planning apart from ensuring a condom is carried or easily obtainable.

Regarding any social factors, two patterns emerge that are worth noting. First, respondents using the condom determined style are more likely to report emotionally 'cold' families and restrictive parental regimes during their childhood and early teenage years. This is not just a reflection of the younger age profile of condom determined respondents, as younger respondents generally report emotionally 'warmer' families and more relaxed parental regimes. Could the mechanisms of this association relate to any strict parental messages concerning contraceptive use? Referring to section 3.5.3, a common parental message is to 'be careful', that is, ensure a condom is used in sexual encounters. Some condom determined respondents received explicit parental messages on condom use, and cite them to explain their current contraceptive behaviour:

> My dad used to talk to me about diseases you could catch in general, you had to be careful to use condoms. (*Was pregnancy a big issue or was it more diseases?)* Diseases. Pregnancy, well yeah he used to talk about that, mum, you know, she'd say "Be careful what you're doing". I wasn't worried about pregnancy 'cause I was always using condoms, always. *(Umm, diseases?)* Admittedly, I was never worried about diseases because I used condoms. I'd just do it, put a condom on. [167:16]

However, explicit parental messages like these are not reported by all the condom determined respondents. A more implicit influence may be present. Condom determined is

the most prescriptive and inflexible of the eight strategies - perhaps the style reflects the strict parental regime in which the respondents grew up.

The second factor relates to early socialisation with young women. Respondents using this protection style are more likely to come from the 'Shy boys' group discussed in Chapter 4, reporting little social contact (and associated discomfort) with young women in their early teenage years. Is this important? It could be argued that the protection style does not require communication with a partner, as the user determines the outcome before the sexual encounter. Therefore, the contraceptive behaviour may reflect lack of confidence or familiarity in interacting with young women. Against this, however, the condom determined style *does* require interactional skills to ensure the contraceptive outcome be achieved if the partner does not want to use a condom. This, however, was a rare event in the respondents' partnership histories.

6.4.3 Pregnancy prevention

Contraceptive use

Young man intends to use an effective method of contraception for every penetrative sexual encounter.

Rationale

The young man considers himself at low risk of acquiring a sexually transmitted infection, but is concerned about the risk of conception. Which particular method of contraception is used is unimportant, providing it is effective at preventing conception. Reasons why a respondent does not feel at risk of acquiring an infection, usually expressed about HIV, were identified in section 6.3.3. For respondents using the pregnancy prevention style, three prominent explanations are:

a) believing they are invulnerable to such a rare and deadly event
b) believing that HIV has a very low prevalence in the heterosexual population
c) believing that their partners are unlikely to be HIV positive.

Sexual intercourse therefore occurs with any effective method, as with this respondent who reflects that his 'choice' of contraception is not really a choice at all if intercourse is to occur:

> *(And did you use any precautions?)* Oh yeah. Condoms. *(Is that all the way through?)* Yeah. *(How was that decided?)* Umm, well she wasn't on the pill, so it was Hobson's Choice, that was that.[4] [150:43]

Associated variables

Compared with the other protection styles, this group of respondents share few common characteristics. As the crux of the strategy relates to the perception that infection is not a salient risk, and the reasons behind this perception are varied, this result is perhaps understandable. One common characteristic apparent is that older respondents use this style because their partnership history began before HIV infection was a risk.

The only other factor worth noting is that respondents using this strategy identify themselves as early (compared with their peers) sexual developers, with no delay between first sexual interest in young women, and first sexual experiences.

6.4.4 Casual selective

Contraceptive use

Young man intends to use a condom as a prophylactic and contraceptive method for a partner who is believed to present a high risk of sexually transmitted infection. If a partner presents a low risk of infection, then any effective method of contraception can be used.

Rationale

This style, contrary to the preceding two, has different outcomes depending on a partner's characteristics. If a partner presents such a high risk of infection as to outweigh any other considerations around contraceptive use, then the intention is to use a condom. Criteria and procedure for estimating the risk status of a partner were explained in section 6.3.3. The

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[4] 'Hobson's Choice' refers to a situation in which apparent freedom of choice is, in fact, no choice at all. Thomas Hobson was a 17th century liveryman who offered every customer the choice of any horse they wanted, so long as it was the horse nearest the door.

word 'casual' is used because this style is used for casual as opposed to steady partnerships. Referring to section 5.2.3, a low degree of emotional or romantic involvement exists between the couple in a casual partnership, and the time before intercourse is shorter. These factors have implications for the amount and quality of information available for estimating the risk of a partner. However, a similar decision process is inherent in the trusting relationship strategy discussed in the next section.

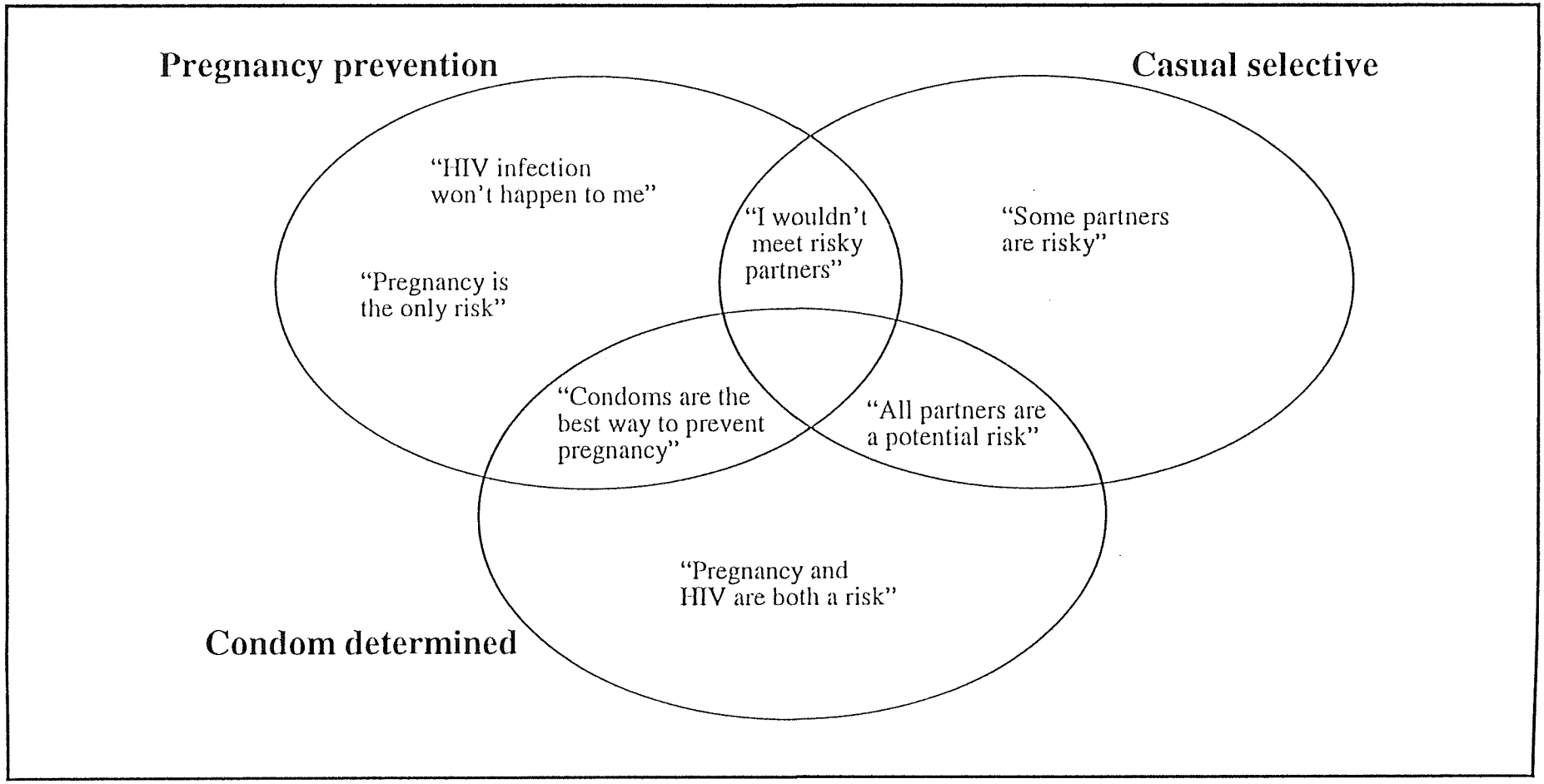
While the first three protection styles have been presented as distinct and separate, a closer examination reveals some overlap. The Venn diagram in Figure 6.3 illustrates this association, with some respondents exhibiting elements of two of the three styles simultaneously. In each segment are paraphrased, typical attitudes to explain contraceptive intentions. For example, a young man who uses condoms as the best way to prevent conception, but does not perceive HIV infection as a risk, is in the overlap between pregnancy prevention and condom determined. A young man who acknowledges risky partners are in the heterosexual population, but believes his partnership preferences make him unlikely to meet any, displays elements of both the pregnancy prevention and casual selective styles. The third overlap, between casual selective and condom determined, represents young men who view all partners as a potential risk for HIV infection. This may be because they feel their sexual lifestyle involves meeting high-risk partners, or they do not have enough time prior to intercourse to make a reliable risk assessment. Comparing Figure 6.3 to Figure 6.2, however, reveals that among the respondents, the first and second overlaps are rare.

Associated variables

Similar to condom determined, this style is popular among the younger respondents. The emergence of HIV dramatically changed the contraceptive environment for younger cohorts of respondents. Contrast the sexual risks and contraceptive roles in the periods before and after HIV. Conception was the primary risk in the former period, with the woman primarily expected to be responsible for protection. In the latter period, however, a fatal, sexually transmitted infection is prevalent, and protection against this risk involves use of a male method of contraception.

Related to this generational effect is another possible determinant; respondents using this protection style cite more sources of information for learning about sex, and appear more

Figure 6.3 - Overlap between Condom Determined, Pregnancy Prevention and Casual Selective Protection Styles.



Quotations are paraphrased examples of attitudes held by respondents located in each area of the diagram.

sexually knowledgable than other respondents. Similarly, they are more likely to report mention of HIV in school education. Given the rich learning environment for younger respondents identified in Chapter 3, this pattern is to be expected from this group. Even so, respondents using this style include early sexual learners, and young men self-motivated to learn about sex.

The casual selective style is more likely to be used by respondents reporting a high number of partnerships. These respondents are experiencing many partnerships and, probably therefore, a variety of partners. As discussed earlier, an individual's contraceptive intentions are challenged and possibly refined as partners with different characteristics (including their perceived risk status) are met over a partnership history. This respondent discusses how the high number of partners met as part of his lifestyle involves different risk estimations:

> Yeah, I've usually got one [a condom] on me but generally everyone you meet will generally have one. At a club especially, especially if they're on the pull, if they're going to come back to your place they will have a condom on them, which is a total surprise. *(Right. So do you have any policy like a one night stand you will always use a condom?)* Oh yeah definitely, you just don't know them, I mean if you've never met the girl before in your life, use a condom for definite. *(Okay, so when have you not used a condom?)* Umm, well when basically like this, a couple of girls the occasional affairs in term. *(Yeah.)* But you know they've been sort of like going on for a while sort of like on and off so you think, oh no, no, you know, you also probably know the people she's slept with as well because it's all a very close knit society ... (laughing) [157:26]

One other pattern in the data is worth noting, although its relevance is uncertain. Respondents using this style report themselves as very happy at time of interview, with a high level of self-esteem evident.

6.4.5 Trusting relationship

Contraceptive use

The young man aims to use a prophylactic method if there is a risk of sexually transmitted infection from a partner. However, use changes to a more convenient and non-prophylactic method (usually the pill) as the partnership progresses.

Rationale

This style is a common explanation for non-use of condoms in steady sexual partnerships. A switch to a non-prophylactic method of contraception has been found in several quantitative (Ford, 1992b; West *et al.*, 1993) and qualitative (Holland *et al.*, 1990; Cooper *et al.*, 1992a; Kent & Davies, 1993) studies. Research with Dutch young men suggests this change in method use can occur after sexual intercourse has taken place only a few times (Vennix *et al.*, 1993). For respondents in this study exhibiting this protection style, the timing of the change in method use ranges between *"after the first time"* [162:49] to six months, with a median of around one month after first intercourse[5].

The method characteristics outlined in section 6.2.1 favour pill use in a steady partnership. An effective, non coitus-dependent method of contraception is appropriate for a partnership in which the frequency of intercourse is likely to be higher (Cooper *et al.*, 1992a; Stephenson *et al.*, 1993). However, changing to a non-prophylactic method suggests the risk of infection is outweighed by the advantages of the new method. What has changed since the start of the partnership to enable this change?

The answer to this question lies in the theme of trust. For example, this respondent describes the change from using condoms to the pill three months into a partnership:

> I think it was all part and parcel really, she did know that I had slept with another girl without wearing a condom, but I think I more or less convinced her that there was no way that the other girl could have possibly had any STDs. I convinced her of that and so that then wasn't a problem, and we just sort of moved up to the pill really, trusted and felt comfortable with each other. [170:40]

Trust can entail different notions; some with a sound epidemiological basis, others of a more emotional nature. Trust is a quality that develops in a couple's relationship as they spend more time together, learning more about each other's personality, past and current behaviour. A young man can be:

a) trusting a partner will use the pill regularly and effectively

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[5] Timing may be affected by the need for a woman to start using the pill on a specific date of her menstrual cycle (Belfield, 1993).

b) trusting a partner will not have any concurrent sexual partnerships and therefore expose him to the risk of an infection

c) trusting a partner will not transmit an infection.

Point c) needs clarifying. If a partner has not had any concurrent sexual partners since the start of the partnership, then her risk of transmitting an infection has not changed. What has changed, however, is the young man's *assessment* of this risk. As a sexual partnership continues, more information is available for assessing a partner's risk. In negotiating the change to pill use, respondent 170 quoted above provided his partner with details of his sexual history. Sharing sexual histories may become easier as a couple's relationship develops and they feel more comfortable sharing personal and sensitive information. A longer duration relationship also enables a young man to judge how truthfully and fully his partner is reporting her sexual history. Contrast the information available to this respondent at the start and later in a partnership:

> I think she slowly just, in dribs and drabs, gave me little bits of information to say, "Look you don't need to worry". (*Right so it was always quite implicit, it wasn't like you sat down and said* ...?) Just as we got to know each other more and more. I never found it particularly polite to say to someone "Look, let's go out, what's your previous sex history?", I never did that. But it's only as I got more snippets of information and then I just asked straight out, but that took me months to ask her straight out exactly what she'd done prior to that. I think it was implied that she'd not done it [intercourse] before, and there was no chance of me catching anything. [165:23]

In a few cases, the decision to change to pill use was accompanied by the couple verifying their low risk by each having an HIV antibody test.

Beyond increased knowledge of a partner's sexual history, however, is a more abstract notion of trust. Ending condom use can have symbolic importance by signifying more emotional commitment being assigned to a partnership. Using a contraceptive method associated with preventing diseases conflicts with the intimacy and romance of a close, interpersonal relationship. Given a couple's love and commitment to each other, how could one person possibly infect the other? This respondent discusses the incompatibility of condoms and steady partnerships:

> I feel when you get to know somebody it's impersonal to use a condom if you love somebody or if you care about somebody. Condoms are for strangers and for people that you've just met, not for people you're in love with or care about. [162:55]

Finally, an example of how the trust and sharing aspects of the trusting relationship style are taken to an extreme. Being in a stable partnership can involve sharing many aspects of a partner's life - including, for this respondent, a sexually transmitted infection. The last sentence on this quotation is intriguing:

> I mean, we've got a really really good relationship. Not a lot of people have got what we've got. It's really special, they really don't ... and for me there's not any risk involved. If I catch something off her, I catch something off her, you know? [153:37]

Associated variables

First, as might be expected, this style is associated with respondents who experience longer duration, steady partnerships. Section 5.3 discusses reasons for preferring steady as opposed to casual partnerships. One group in this category are respondents older at time of interview, who are more likely to report steady, and a lower number of, partnerships.

Second, respondents using this style report similar socialisation patterns in their teenage years. Recalling themselves as leaders or insiders (as opposed to outsiders) of social circles, they also exhibit the 'Lads' interpersonal strategy described in section 4.5.1. Trusting relationship respondents also report themselves as early or average sexual developers, with a quick progression through the increasingly intimate sexual activities displayed in Figure 4.1. It is unclear whether there is an association present. Perhaps the leaders and insiders of social groups have the confidence and social status to be first to form steady relationships. However, the 'Lads' interpersonal strategy seems more associated with experiencing casual than steady partnerships.

6.4.6 Condom avoidance

Contraceptive use

A young man intends that any contraceptive method *apart* from a condom is used. This is because use of a condom causes him difficulties in the sexual encounter. Intercourse occurs with another method, for example the pill or withdrawal. Alternatively, a few respondents suggest non-penetrative sexual activity.

Rationale

This protection style is the only one primarily determined by the characteristics of the contraceptive method. Referring to section 6.2.2, physical consequences of using a condom leads some respondents to ensure one is not used for penetrative intercourse. Consequences can include loss of erection, desensitised physical feelings, interruption of the spontaneity and flow of the sexual encounter and hastened orgasm during penetration. Loss of erection is this respondent's major concern:

> *(Does it bother you that when you use a condom the whole thing peters out?)* Well, I can tell you honestly cause it's totally umm, I mean the few times I've used a condom it's never been kind of, you don't feel much. *(Yeah.)* It's kind of vague, a vague feeling, it's not as ... *(Not as real?)* Not as real, it's more, umm, how do you describe it, a condom it's ... that's why I just go totally limp because I can't feel anything really. [177:54]

The metaphor of a condom acting as a barrier seems appropriate for the physical consequences reported by these respondents. A condom acts as a barrier to spontaneous sexual activity, physical pleasure, intimacy and 'natural' sexual activity. To appreciate this point, consider the context in which this respondent uses condoms:

> I'd go through the foreplay and she'd like say, "Hang on", leap out of bed and go and root through her drawer for them. She swore blind that she had some condoms somewhere in her bedroom and she spent about 20 minutes looking for them, and that sort of destroyed it as well. *(Yeah, I can imagine.)* And she had a big box, like, an empty 24 or 48 box, one of the big boxes you get in ['Local health service'] by her bed and it was empty, and that didn't make me feel particularly brilliant, you know (both laughing) cos I hadn't used any of them. It was from her previous relationship. *(Right.)* Umm, and like she didn't have any like Mates or Durex, it was always dotty, what you call them, cruddy ones which don't fit, and it was like just such trouble with condoms when I was going out with her. They never fit and they just fall off, and some used to hurt. (pause) It was just so unromantic. [171:31]

Around half the respondents report disliking using a condom, whereas the other half report no dislike or problems in use. Among the former group, a continuum exists of the effect this dislike has on contraceptive behaviour. This protection style encapsulates respondents at the upper end of the continuum, that is, those who actively determine their behaviour to avoid condom use.

Associated variables

The characteristics and behaviour of men reporting negative attitudes towards condoms have been identified in several studies (Chapman & Hodgson, 1988; Pendergrast *et al.*, 1992;

Grady *et al.*, 1993; Browne & Minichiello, 1994). Of interest is whether the condom avoidance respondents share any characteristics, and whether their difficulties develop with age, as, for example, erectile dysfunction does (Bancroft, 1989).

Respondents exhibiting this style are older at time of interview than other respondents. Some respondents report the problem developing with more recent partners, whereas others cite problems since their first-ever penetrative partnership. For example, Respondent 177 quoted above is in the former category, and cites increasing concerns on his sexual performance (see section 5.6.3) as a contributory factor. Second, respondents using this protection style are more likely to report first-ever intercourse occurring on the first day of the partnership, being unplanned, and are less likely to have used contraception for that encounter.

Third, there is evidence of some social discomfort relating to young women in the teenage years, for example, belonging to the 'Shy boys' group in Table 4.1. Respondents using the condom avoidance style are also more likely to report emotionally 'cold' families. Various questions in the interview schedule aimed to gauge a respondent's emotional status at different stages of his life. Recalled feelings of loneliness and happiness were gauged for childhood, from age 16 upwards and time of interview. Recollections of any periods of major upheaval, stress or emotional crisis were recorded. Condom avoidance determinants report above average emotional crisis from age 16 onwards, and emotional upset at time of interview.

Considered together, these factors could be interpreted in two ways. First, these respondents' early social and sexual experiences are not conducive for learning about interacting with young women and using contraception. This may be associated with later difficulties in using a condom. Second, recent and current emotional distress may reflect an underlying psychological problem with psychosexual implications for condom use. Lack of social confidence and worries around sexual performance may reinforce problems with using condoms.

6.4.7 Context orientated

Contraceptive use

The young man intends to use one of the other protection styles, but the context of the sexual encounter overrides this intention. Intercourse occurs with an unintended or no contraceptive method. Emergency contraception may be used after the encounter.

Rationale

The importance of contextual factors in explaining unintended or non-use of contraception is so prominent they deserve their own protection style. Four commonly reported contextual factors are:

a) Getting 'carried away'

Referring to section 5.3, a primary motive for having sex is physical pleasure. This contextual factor categorises respondents who report the physical sensations, lust and passions of a sexual encounter override any contraceptive intentions. Sexual activity is typified as spontaneous and natural, with an associated need to maintain ambiguity on whether sexual intercourse is to occur (Kent *et al.*, 1990; Cragg *et al.*, 1993; Wight, 1993b). This respondent contrasts how sensible thoughts expressed in the context of an interview may not be reflected in practice:

> I mean, realistically I'm going to try and use a condom, but when push comes to shove, I might not. I don't know why, this is how I feel at the time. I mean, me being the sensible person, thinking about it rationally now, I'd say yes, I'll use a condom, but me the umm, "Quick, let's jump into bed and have a bonk", it might be a different animal. [174:71]

b) Intoxication

A large amount of literature (primarily American) exists on the association between young people's intoxication, and sexual and contraceptive behaviour. Researchers are particularly

interested in the relationship between 'risky' contraceptive behaviour, and the 'risky' behaviour of drug consumption[6].

A full review of the literature is beyond the scope of this work. To summarise, evidence is mixed on whether a causal relationship between intoxication and contraceptive and sexual behaviour is present (Currie, 1990; Bagnall & Plant, 1991; McEwan *et al.*, 1992; Weatherburn *et al.*, 1993; Wight, 1993a). Three explanations are cited for the presence (or absence) of an association between variables measuring these behaviours (Plant, 1990; Ford, 1991; McEwan *et al.*, 1992; Plant & Plant, 1992):

i) Since many sexual encounters with a new partner begin in social situations where alcohol consumption is the norm (pubs, clubs, parties and so on), any association between alcohol consumption and sexual or contraceptive behaviour is coincidental.

ii) People who take risks in certain aspects of their life (for example, alcohol or drug consumption) are more likely to take risks in other aspects (for example, use of contraception). Therefore, an association between two variables of risk at the gross level reflects this inter-correlation.

iii) Society and culture promote certain acceptable behaviours as associated with drug consumption. Physiologically, alcohol depresses sexual arousal, but people who have (or think they have) consumed alcohol exhibit higher levels of sexual arousal (Ford, 1991). Research suggests that attribution of 'deviant' behaviour and changes in risk perception are associated with intoxication. Although behaviour may be recognised in retrospect as atypical and improper, alcohol is used as an opt-out clause to help explain that behaviour (Dockrell *et al.*, 1993; Stephenson *et al.*, 1993).

c) Absence of condom

The importance of this simple factor should not be underestimated; 36% of men in the Durex Report survey (Durex Information Service, 1997) identified this factor (more than

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[6] Warwick and Aggleton (1990) argue persuasively that interest of this type reflects social science's fixation with the stereotype of the risky and irresponsible adolescent.

any other) to explain not using a condom with a new partner[7]. If the time and location of intercourse are known beforehand, there is a greater likelihood that at least one member of the couple will have a condom available. If not, however, one strategy is for condoms to be carried in social situations in which potential partners are met. Little information is available on the prevalence of condom carrying. A study of 16-24 year olds in south-western England (Ford, 1991) revealed 20% of men and 5% of women report always or often carrying condoms when out socially. This was more likely for those reporting a higher frequency of sexual partners. Young, single men in Wessex reported carrying condoms was a popular strategy (Cooper *et al.*, 1992a).

Some attitudinal data suggest that most young people think that carrying condoms should be acceptable for both sexes (Reader *et al.*, 1988; Abrams *et al.*, 1990). However, strong social and cultural factors may inhibit women from carrying condoms to preserve their social reputation. Perceived negative reactions from peers and potential partners include believing that the carrier is sexually available, is actively seeking sexual activity and is willing to 'go all the way' (Bury, 1991; Kitzinger, 1993).

d) Being overwhelmed by symbolism

This factor has been included in this protection style to refer to the context of first-ever intercourse, discussed in section 5.5. Contraceptive use at first-ever intercourse is a commonly used research indicator, with quantitative studies showing it to be a good predictor of subsequent contraceptive behaviour (Træen *et al.*, 1992). However, section 5.5 illustrated the importance and meaning some young men place upon losing virginity. This symbolism can be used as an opt-out clause to explain non-use of contraception in first-ever intercourse. The importance of losing virginity overwhelms consideration of the risks of conception or infection, and use of contraception.

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[7] The reliability of this statistic could be questioned given the survey is conducted by a condom manufacturer, the survey methodology is described in brief, and the statistic supports the need for people to buy more of the manufacturer's product. However, the second most reported factor is 'dislike using condoms' (cited by 32% of men), a negative finding from the manufacturer's perspective.

Associated variables

Although the four contextual factors may suggest different causes, all are characterised by an individual's inability to implement their contraceptive intentions. Whether these factors are causing these inabilities, or whether they are being reported to excuse 'deviant' behaviour is unknown. Elements of both explanations are probably present for some respondents. However, respondents exhibiting this protection style do share several characteristics that may help understanding of their behaviour.

First, context orientated respondents report high levels of social activity from age 16 upwards, with a wide circle of male and female friends, and preferring casual as opposed to steady sexual partnerships. This reflects a social lifestyle in which new, casual sexual partners are met in social situations in which drug consumption is customary. Context orientated respondents are more likely to exhibit the 'Lads' interpersonal strategy in their teenage years, a lifestyle also associated with high levels of socialising.

Some common social factors are evident. First, respondents exhibiting this style are older at time of interview. Second, they report having had a generally supportive parental regime, with clear and fair parental rules. The respondents' parents are more likely to have belonged to a non-professional socio-economic group, and the respondents are more likely to have attended a mixed-sex secondary school. The timing and relevance of school sex education seem particularly poor, and few other important sources for learning about sex are reported. A link between poor learning about sex and inability to implement contraceptive intentions might be expected. However, a confounding variable is age, as the older respondents are more likely to have received poor school sex education. How and whether the parental regime influences this protection style is unknown.

The other interesting pattern is the context orientated respondents' emotional wellbeing over their partnership history. Their childhood and early teenage years seem happy, but from age 16 onwards more emotional crisis is reported, with unhappiness and pessimism evident at time of interview. The timing of this change approximately coincides with when the respondents' social activity increased and they exhibited more elements of the protection style. For example, this respondent refers to his general approach to life during a period when he was less concerned about using contraception:

> *(And on that occasion that you had penetrative sex, what contraception did you use then?)* None. *(None. Why was that?)* Because I was drunk, she was drunk, we'd tried before to have sex and failed, she I think was on the pill. And I was in a very carefree, didn't give fuck type stage of my life? *(Do you think she was on the pill though, yeah?)* I think so. *(But condoms just weren't mentioned?)* No. [178:38]

An inability to implement contraceptive intentions may reflect underlying psychological problems that also emerge when reporting emotional wellbeing. This explanation is given some credence by a cluster of protection styles evident in Figure 6.2. Note how the condom avoidance, abdicator and indifferent protection styles (indicating difficulties in contraceptive behaviour), mainly overlap with the context orientated style.

6.4.8 Abdicator

Contraceptive use

The decision to use any method of contraception is left to the partner.

Rationale

Here is a strategy in which the partner's role and intentions are vital. Underlying a respondent's decision to abdicate responsibility for contraception is the belief that he is not at risk of acquiring a sexually transmitted infection. The thinking behind this belief was discussed in section 6.3.3. In contrast to the pregnancy prevention style, however, the respondent is also unconcerned about the risk of conception. Because most of the consequences of an unintended conception would affect his partner, not himself, she should be more concerned with, and take responsibility for, contraception. Use of this style does not mean a young man will not suggest using contraception, but that he is unconcerned whether contraception is used. Some respondents offered use of a condom, for example, but did so believing this was a polite act, which would impress their partner.

Associated variables

Abdicator respondents share some similar characteristics to the context orientated respondents, which is understandable given the clustering of protection styles apparent in Figure 6.2. The pattern of reporting supportive parents and a generally happy childhood and early teenage years is apparent, as is a deterioration in emotional wellbeing from age 16

onwards. As before, by the time of interview these respondents report themselves as unhappy and pessimistic. Psychological problems could help to explain a contraceptive behaviour in which control and responsibility for a decision are transferred to another person. Similarly, an individual may perceive risks as lower, or engage in riskier behaviour.

Two other shared characteristics relate to the respondents' first sexual experiences and partnership histories. First, abdicator respondents report themselves as early sexual developers, and experienced first-ever intercourse at an earlier age than respondents not exhibiting this protection style. Use of contraception in first-ever intercourse was poor; risks of pregnancy and infection were less likely to be thought of, and contraception was less likely to be discussed or used. Perhaps experiencing early sexual activity when a young man's interaction and communication skills are less developed, coupled with poor use of contraception in first-ever intercourse, set the pattern for future partnerships.

Second, respondents exhibiting this style are more likely to originate from the 'Shy boy' and 'Friendship' groups described in Chapter 4, and are more likely to experience steady as opposed to casual partnerships. Having had less social contact with young women as 'Shy boys' might be associated with difficulties in communicating about contraception, but would not communication be easier in a steady as opposed to a casual partnership? The notion of abdicating responsibility for contraception seems at odds with the trust and emotional commitments of a steady partnership. Perhaps this association is a reflection of the older age of abdicator respondents, whose partnerships occurred in the pre-Aids era when pill use was the norm. As noted in section 1.2, contraception was primarily a woman's responsibility during this period.

6.4.9 Indifferent

Contraceptive use

The young man shows no clear intentions around contraception.

Rationale

This protection style is more difficult to discuss, given the respondents' inability to fully and clearly explain their contraceptive intentions and behaviour. As suggested by the title,

underlying themes are less concern about the risks of sexual activity, and no clear contraceptive intentions. Unlike other protection styles, assessments of risk are rarely reported or evident in their contraceptive behaviour.

Reasons behind this behaviour are uncertain. It is not unawareness of the risks of conception and infection, more lack of interest or concern in their consequences. Use of the style coincides with periods of a partnership history characterised by psychological and emotional crisis, or risk-taking in other aspects of a respondent's life. Respondent 164 quoted below changed protection styles three years into his partnership history. Before this point, he was condom determined, but after the emotional upset of an important partnership ending (see section 5.6.4), changed to indifferent for many casual partnerships:

> It was just like going to a club, having a few drinks, met somebody, umm, things developed one step at a time, just went on and things happened and that was it, didn't sort of stop and think. *(But before then you had thought about pregnancy quite a lot and you were very concerned about it, so what made you switch?)* I don't know. *(Don't know?)* I don't know, I think it was (pause) I'd been dumped quite a few times and maybe I just didn't think about it, just didn't think about it really. [164:58]

Associated variables

A number of interesting features emerge. First, indifferent respondents are more likely to report emotionally 'cold' parents, with a restrictive parental regime. They also report school sex education as too late for them, and they did not take it seriously.

Similar socialising patterns in the teenage years, and transitions into their sexual partnership histories, are evident. Respondents exhibiting the indifferent style are more likely to belong to the 'Shy boys' and 'Lads' groups, particularly with a transition from the former to the latter. Over this period, however, is a delay in early sociosexual experiences. Despite having early sexual interest in young women, indifferent respondents report a delay until first snog and intercourse, and label themselves as late sexual developers.

Again, early social and sexual experiences with young women are associated with contraceptive behaviour. The indifferent respondents did not have the easiest of beginnings to their partnership history, with less parental support and poor learning about sex from school. The respondents favoured the 'Lads' strategy, behaviour more concerned with achieving sexual activity than any emotional or friendship aspects of a couple's relationship.

An indifference to the feelings and needs of a partner may also reflect in their contraceptive behaviour.

Finally, respondents exhibiting the indifferent style report a higher number of partnerships, particularly casual partnerships. This reinforces their labelling as a high-risk sexual group.

6.4.10 Others

While the previous eight styles are the most prominent in the sample, two other interesting styles followed by individual respondents are worth mentioning briefly:

a) **Self casual selective** - similar to the casual selective style, however this respondent uses a condom when he assesses *himself* to be at risk of transmitting a sexually transmitted infection. He has an infection with symptoms recurring at intervals, and uses a condom to protect his sexual partner when the symptoms are present.

b) **Withdrawal determined** - one respondent, who reports physical difficulties using a condom, uses withdrawal to reduce the risk of HIV infection and conception. This is in combination with regular health tests for sexually transmitted infections. Withdrawal is less effective at preventing infection than condom use, but whether it provides any protective effect is unknown[8] (Rogow & Horowitz, 1995).

6.5 COMMUNICATION

6.5.1 Introduction

According to Byrne's (1983) five steps for successful use of contraception, the fourth is to communicate with the sexual partner about contraception. Although not necessary true (for example, a woman uses the pill, her partner is unaware of this, and intercourse occurs without any communication on the subject), many sexual encounters will involve some

[8] In any case, protection is likely to be for the receptive, not the insertive, member of the couple.

discussion of contraception prior to use. Most communication within a sexual encounter is non-verbal; moving to a more private location, removal of clothes, intimate physical contact, and so on. Non-verbal communication on contraception also can occur; for example, a condom is produced and used without verbal discussion (Kent & Davies, 1993).

Social and cultural factors can constrain verbal communication on contraception, especially early in a sexual partnership. First, the social construction of sexual activity as spontaneous and wild, and an associated need to maintain ambiguity on whether intercourse is to occur, are likely to inhibit free and open discussion (Kent *et al.*, 1990; Cragg *et al.*, 1993; Wight, 1993b). Second, Ingham and colleagues (1992) refer to the mystique of sex. Parents' and teachers' embarrassment and avoidance of the topic, media representations (see Goodchild, 1984), and jokes and innuendoes from peers help to construct sex as a mysterious and taboo subject. Communication with a new partner, therefore, may be problematic, with feelings of embarrassment and lack of an acceptable language (Spencer *et al.*, 1988; Holland *et al.*, 1990; Paalman, 1992).

Simply calling this interaction communication, however, undermines that there are two individuals involved in the sexual encounter, each with potentially different characteristics, attitudes, intentions and skills. More useful is to think of the interaction as negotiation, in which the outcome can be decided by tactics including agreement, compliance, bargaining, promises (kept or unkept), coercion and refusal. Can one partner assume a more powerful role and exert a greater influence on the outcome of the negotiation? Power differences may exist through a couple's disparate ages, levels of sexual experience, and gender (Ingham *et al.*, 1992). The first two factors may act in combination; an older partner is presumed to have more sexual experience, and the younger partner may therefore defer to their position in the negotiation.

Previous research suggests men exert an unequal amount of power in heterosexual relationships and contraceptive negotiation. This is due to the social construction of heterosexuality, and especially sexual intercourse, as a primary site of male dominance (Dworkin, 1987; Hite, 1989). Unequal power manifests itself in different ways. A man's threat to end a relationship if intercourse does not occur or contraceptive use is insisted upon could be persuasive given the social pressure some women feel under to be in a heterosexual relationship (Kitzinger, 1993). Heterosexuality that gives male sexual pleasure (primarily

vaginal penetration) prominence over female sexual pleasure, and men being expected to initiate and control sexual activity, are argued to favour the male role in negotiation (Holland *et al.*, 1990; Kent & Davies, 1993). Unfortunately, few qualitative studies have investigated the role of gender in contraceptive negotiation. The most comprehensive British study is provided by the Women, Risk and AIDS and Men, Risk and AIDS Project (Holland *et al.*; 1990, 1991ab, 1993, 1994, 1998), although see also Gilfoyle and colleagues (1992) and Wight (1993a).

Discussion of the respondents' contraceptive behaviour is incomplete, therefore, if the interplay of couple's contraceptive intentions, communication or negotiation, and the role of gender are not considered. How suitable are the interview data for investigating these topics? A reliable analysis of contraceptive communication requires two attributes: detailed event-specific information on contraceptive behaviour, and reporting from both members of the couple. The second attribute is lacking, given the current interviews are with respondents only, not any of their partners. Understanding the dynamics of communication and negotiation is difficult unless both persons' positions are represented.

The first attribute is available from the interviews, although to varying degrees. As discussed in section 6.1, information on contraceptive use is available for many of the respondents' sexual partnerships, including reporting of the circumstances of use and communication between the couple. However, this information is not available in sufficient detail for *all* respondents, and representative of *all* a respondent's partnerships. Respondents with fewer and more recently occurring partnerships are likely to report their contraceptive use in greater detail.

The interview schedule did, however, collect detailed information on contraceptive use for two specific sexual encounters: first-ever intercourse, and first intercourse with the most recent partner prior to interview. Caution is needed, however, before these two events are used to represent a respondent's contraceptive behaviour. First, sections 5.5 and 6.4.7 argue that first-ever intercourse is a distinct sexual event with unique meaning and importance. First intercourse with the most recent partner presents a similar difficulty. Chapters 5 and 6 focus on the first five years of the respondents' partnership histories. For 28 of the 43 respondents, however, first intercourse with their most recent partner did not occur in this

period. Given the potential change in behaviour over a partnership history, using this event as representative of the first five years is unwise.

Therefore, while event-specific details of communication of contraception are not available, enough information is present to enable a simpler analysis. Each respondent has been assigned a value for three ordinal variables across the first five years of their partnership history:

a) who mainly initiates discussion of contraception (respondent, mixed, joint, partner)
b) respondent's ease of discussing contraception (easy, mixed, somewhat, difficult)
c) who mainly decides the contraceptive outcome (respondent, mixed, joint, partner).

These three variables are useful for understanding any associations between contraceptive intentions and behaviour, although the exact links between these two factors will not be fully determined. Nevertheless, values for the three variables show wide variation between respondents, and investigating why some respondents are more likely to initiate discussion of contraception, appear at ease discussing contraception, and exhibit more control over their contraceptive outcomes is useful.

6.5.2 Communication and protection styles

Table 6.4 provides a useful starting point by juxtaposing a young man's and his partner's contraceptive protection styles. For the purposes of illustration, the Table assumes young women use the same protection styles as derived from the respondents' experiences. Although unlikely to be completely true, the range of protection styles incorporate diverse contraceptive intentions, and are therefore likely to represent some styles used by young women. The unshaded cells represent situations in which the respective protection styles seem compatible, and therefore only communication about contraception needs to occur. The shaded cells represent situations in which a conflict is apparent, and therefore negotiation about contraception may need to occur. Shaded cells include situations in which the couple clash on whether any method is to be used (for example, context orientated versus most other styles, indifferent versus most other styles) and situations in which the

Table 6.4 - Potential Contraceptive Outcomes of a Young Man's and his Partner's Protection Styles.

			PARTNER								
			Condom determined	Pregnancy prevention	Casual selective		Trusting relationship	Condom avoidance	Context orientated	Abdicator	Indifferent
					High risk	Low risk					
YOUNG MAN	Condom determined		Condom	Condom	Condom	Condom				Condom	
	Pregnancy prevention		Condom	Any	Condom	Any	Condom to pill	Not a condom		Any	
	Casual selective	High risk	Condom	Condom	Condom	Condom				Condom	
		Low risk	Condom	Any	Condom	Any	Condom to pill	Not a condom		Any	
	Trusting relationship			Condom to pill		Condom to pill	Condom to pill			Condom to pill	
	Condom avoidance			Not a condom		Not a condom		Not a condom		Not a condom	
	Context orientated								None	None	None
	Abdicator		Condom	Any	Condom	Any	Condom to pill	Not a condom	None	None	None
	Indifferent								None	None	None

Shaded cells represent situations in which the intentions of the two protection styles are incompatible, and negotiation may therefore need to occur.

choice of method is conflicting (for example, condom determined versus condom avoidance, trusting relationship versus condom determined).

Note that whatever style (except abdicator, when the decision is left to the partner), successful use can require both communication and negotiation, depending on the partner's intentions. Table 6.5 presents a summary of crosstabs of the three contraceptive communication variables versus the eight protection styles. The prescriptive condom determined style typically is initiated by the respondent, with the outcome mainly decided by the respondent, or a mix over his partnership history. Respondents using the pregnancy prevention style again display few common characteristics, although a pattern of the partner mostly deciding the contraceptive outcome reflects the common use of the pill for this style. Casual selective and trusting relationship, earlier identified as styles with a common underlying theme, share respondents at ease discussing contraception. This may reflect the information sharing and negotiation inherent in these protection styles. The final four rows of Table 6.5 are 'riskier' protection styles, that is, with common outcomes of non-use of contraception or non-use of a condom. Respondents exhibiting difficulties communicating about contraception are associated with these styles, and the partner plays an important role in determining the contraceptive outcome.

Table 6.5 - Patterns of Communication Around Contraception for Eight Contraceptive Protection Styles.

Protection style	Who tends to initiate discussion of contraception?	Respondent's ease of discussing contraception	Who tends to decide use of contraception?
Condom determined	Respondent	Mixed	Respondent/Mixed
Pregnancy prevention			Partner
Casual selective	Respondent	Easy	
Trusting relationship		Easy	
Condom avoidance	Partner	Difficult	Partner
Context orientated		Difficult	Joint/Partner
Abdicator	Partner	Difficult	Partner
Indifferent		Difficult	

An empty cell indicates no clear pattern evident in the data.

6.5.3 Initiating discussion

Raising the topic of contraception with a partner is not necessarily indicative of a successful contraceptive user, but it can represent individuals with strong contraceptive intentions who want the topic discussed before sexual activity becomes too passionate. However, some respondents with clear, strong intentions to use contraception avoid initiating discussion to maintain ambiguity around sexual activity. As discussed in section 4.5.2, some respondents feel that men are expected to pursue, initiate and control heterosexual encounters. However, one aspect of the encounter left in the control of the partner is whether penetrative intercourse is to occur, a gender role identified by other authors (Spencer, 1984; Kent *et al.*, 1990). Suggesting use of contraception implies a desire for intercourse to occur. Some respondents felt uncomfortable doing this as they did not want to pressurise their partner to have intercourse. As this respondent discusses, by introducing the topic of contraception herself, a partner gives implicit approval for intercourse to occur:

> The majority of the time it's got to the stage where everybody knows that something more was going to happen, and usually it's got to the stage where I've been asked, myself, for [condoms]. *(Right. So that's because you're kind of leaving the ball in their court?)* Yeah. See, I don't want to be pushy. I don't want to be thought of as out for all I can get, and if she didn't say, "Have you got any condoms", then the chances are, 80% of the time, we wouldn't have sex anyway because I wouldn't ... *(You wouldn't push it?)* Yeah. [160:47]

Nevertheless, are there common characteristics of respondents who usually initiate discussion of contraception, those with more mixed histories, and those who leave initiation of discussion to their partner?

Respondents who initiate discussion tend to be younger at time of interview, whereas the older respondents report more mixed experiences across their history. Family environment also emerges as a differentiating factor. Respondents who report an emotionally 'warmer' family, with no major tensions, good physical availability of parents and no parental change in their teenage years are more likely to report *partner* initiated discussion of contraception. Conversely, respondents reporting a problematic family background, and a restrictive parental regime, are more likely to initiate discussion of contraception *themselves*. This respondent links skills learnt from his parents to his ease of discussing topics with women:

> My theory is that a lot of that is due to the fact that with my parents I learnt my communication skills from my mother. I learnt practical things from my father and communication skills from my mother, so I, I know how to talk to women. I mean, still when I phone and my father answers the phone, when I phone up, and we talk about cars and weather and computers, but with my mum I can talk about a lot more things. [185:13]

Sources for learning about sex show a less clear pattern. For example, respondent-led discussion is associated with 'limited' parental education (see section 3.5.2), and much discussion of sex with friends from age 16 upwards. Respondents with more mixed experiences of discussion across their history report well-timed and relevant school sex education, but little parental education. Finally, respondents whose partners mostly initiate discussion report more reliance on books, pornography and personal experience for learning about sex. This pattern generally matches the sources for learning for sex cited by different age cohorts of men, identified in section 3.1.

In Chapter 4 it was suggested that socialisation patterns in the teenage years, particularly non-sexual interaction with young women, may influence a respondent's subsequent ease of communication of contraception in sexual partnerships. Respondents who tend to initiate discussion of contraception report less social activity over this period, with a small group of friends and acquaintances. However, they report being comfortable socially interacting with young women in this period, as do respondents with more mixed experiences of initiating discussion of contraception. This latter group are more likely to socialise in male-only groups at ages 12-16, and exhibit the 'Lads' strategy. Finally, those respondents reporting partner led initiation of discussion do not exhibit any discomfort aged 12-16 relating to young women, but were not particularly socially active during this period.

6.5.4 Ease of communication

Once the subject of contraception has been raised in a sexual encounter, both members of the couple need to express clearly any contraceptive intentions. Consider this example in which a respondent's assertion to his partner that *"You'll be all right"* [161:89] was misunderstood:

> She thought I was going to withdraw and she didn't tell me or anything you know, that she wanted me to withdraw before I ... (*Before you came.)* Before I came,

whatever, you know. *(Right, so she didn't tell you that before?)* No, and then she said, "Oh, I thought you were going to withdraw," and I said, "Well you didn't tell me did you?" *(Right. So you assumed that she was on the pill, and she assumed that you were going to withdraw?)* Yeah. [161:90]

The literature summarised in section 6.5.1 highlights factors that can inhibit open and clear discussion of contraception. Using a similar range of predictor variables as in the previous section, what types of respondents appear more confident and at ease discussing contraception?

First, as elsewhere in the chapter, the younger respondents display more positive attributes, appearing more at ease discussing contraception. A stricter parental regime, with some physical punishment and an emotionally 'cold' relationship between parents is more likely to be reported by respondents at ease discussing contraception. These features are not just a reflection of age, as the reverse pattern is expected for the younger respondents.

Sources for learning are interesting, with respondents at ease discussing contraception reporting a higher quality school sex education in terms of timing, relevance and coverage of sexual risks, including HIV. This is a pattern expected for younger respondents. Socialisation patterns support the notion that young men who experience more social interaction with young women are at ease discussing contraception. Respondents at ease discussing contraception report comfortable social interacting with young women, having young women as close friends, and feeling part of a social crowd during the teenage years. Finally, respondents more at ease discussing contraception report a higher number of partnerships (both steady and casual) than other respondents.

6.5.5 Decision making

Of the three outcome variables, this is the hardest to interpret given the range of (some unidentifiable) factors that may determine contraceptive behaviour. Despite lacking information on the exact dynamics of the contraceptive decision, the interviews do suggest decisions can be primarily determined by the intentions of one member of the couple, or more joint negotiation. For example, this outcome is decided primarily by a partner:

> *(So why did you not use a condom as well, was there any reason?)* Umm, as far as I can remember I wasn't given a chance more than anything, she was quite forceful on that. She did, she did take control. [152:21]

Whereas this respondent exhibits more control over his contraceptive behaviour in this partnership:

> Catherine didn't give a damn, but I was absolutely adamant that I was going to use ... She was of the 'earth mother' mentality and knew when she was going to get pregnant or not. I didn't believe her, so I got condoms on my own and used them even though she didn't want me to. [168:30]

And, for completeness, an example of a jointly decided outcome:

> We used condoms the first time. *(And whose was that?)* That was hers. *(And how was it talked about that you would use it?)* She said, "With or without?" and I said, "With", because this was around about the time when AIDS was talked about. *(So she had one and said "With or without?")* Yeah, she didn't care, 'with or without', she preferred 'with' the first time, she did say, the first time. [162:42]

Some intriguing predictor variables emerge for the simple outcome variable of whom mainly decides use of contraception, be it the respondent, partner, or jointly. As before, an age pattern is apparent, with older respondents more likely to have use decided by their partners, and younger respondents more likely to decide the outcome themselves. Family factors present a less clear pattern; first, respondents deciding the contraceptive outcome themselves report happy teenage years, with little emotional neglect or conflict with parents. Equally, respondents experiencing partner led decisions are associated with emotionally 'warm' parents, particularly the father. Contrastingly, respondents who report more *joint* decisions around contraception report a 'cold' relationship between their parents, some emotional neglect and above average conflict with their parents.

On sources for learning about sex, a contrast is apparent between respondents who report partner as opposed to joint decision making on contraception. Partner-led decision making is associated with *good* parental education and *poor* school education, whereas the reverse is true for joint decision making. This is not a reflection of the respondents' ages; poorer parental education is reported by the older respondents, but is associated with the partner-led decision making (and older) respondents.

Socialisation patterns reflect more social interaction with young women for respondents who experience more *joint* decision making around contraception, with the reverse true for respondents controlling the contraceptive outcome themselves. Finally, timing of sociosexual experiences shows a pattern; *partner*-led decision making is reported more by early sexual developers, and *respondent*-led decision making by late sexual developers.

6.6 SUMMARY

a) Although many methods are available, young people's contraceptive use is dominated by the pill and condom.

b) A complex process can lie behind an individual's assessment of the main two risks involved in sexual activity, conception and infection. Judging the risk of infection can involve weighing information provided from the partner and obtained through gossip.

c) HIV infection may not be viewed as a risk due to perceived invulnerability, believing HIV has an extremely low prevalence in the heterosexual population, or believing one's sexual lifestyle would not include meeting a risky partner.

d) Eight contraceptive protection styles provide useful ways of representing the respondents' contraceptive behaviour. These are constructed according to the respondents' assessments of the risks of conception and infection, the characteristics of contraceptive methods, the role of the partner, and the relationship and context within which intercourse occurs.

e) Certain factors are associated with use of protection styles. The period when respondents were experiencing partnerships, the emergence of HIV, non-sexual social interaction with young women and learning about sex from parents and school are offered as factors explaining these associations.

f) Due to the limitations of the data, communication about contraception is only briefly considered. Younger respondents are more likely to initiate discussion of contraception, appear at ease discussing contraception, and decide the contraceptive outcome themselves. More non-sexual social interaction with young women in associated with easier discussion of contraception and joint decision making.

CHAPTER SEVEN - SEXUAL HEALTH SERVICES

Previous chapters have set the social and personal context within which young men's sexual behaviour takes place, and examined the circumstances around use of contraception. This chapter builds on these discussions to consider young men's use of sexual health services, and how services can promote themselves to young men. Chapter 1 raised the point that, as most contraceptive methods are aimed at the female user, so are most sexual health services. Do young men want to use services on offer? If so, which specific services, and how should a service promote itself to encourage male use?

The main source of data for this chapter is the focus group discussions with young men, fully described in Chapter 2. This chapter starts with a review of the various sexual health services available to young men in Britain, and examines data on trends in men's use of these services. Next, the services offered are compared with the services young men express interest in using. This is done by considering the decision making process around sexual health through discussion of hypothetical sexual health dilemmas. Next, the respondents' knowledge and attitudes towards sexual health services are outlined. Finally, all elements are combined to identify effective methods of promoting sexual health services to young men.

7.1 SERVICE USE

What is the current sexual health service environment available to British young men? The main outlets of service provision are considered separately, namely family planning clinics, general practitioners, young people's sexual health services and genitourinary medicine clinics. The provision of condoms from retail and other outlets is also considered, as these sources account for around 90% of all condoms sold in Britain (Mintel International Group, 1994). The features of these outlets can affect whether young men would consider using a health service to obtain condoms.

7.1.1 Family planning clinics

The 1967 Family Planning Act and 1974 Department of Health and Social Security Memorandum of Guidance on Family Planning (DHSS, 1974) ensured that free contraceptive services are available to anyone, regardless of marital status, age, or gender. Part of this service is provided by family planning clinics, which the NHS took over the running of in 1974. Use of family planning clinics by young men may be for two reasons; visiting on their own, or accompanying a partner for contraceptive provision and/or advice.

Figure 7.1 shows the trend in the number of first contact clients[1] (and the percentage who are male) attending family planning clinics in England. Although men accounted for only 6.2% of first contact clients in 1997/98, this number has doubled over the past six years (Department of Health, 1999a). Since 1987, unfortunately, the ages of male clients were no longer recorded on the annual KT31 return form as they continue to be for female clients. Whether this increase is due to more attendance from *younger* men, therefore, is not known. The increase is *not* accounted for by male clients choosing vasectomy as the main method of contraception, as this percentage has declined from 40% in 1988/89 to 14% in 1997/98 (Department of Health, 1999a). It is also possible that the increase in the number of male clients reflects increasing attendance from couples where the main contraceptive method chosen is the condom. Due to the Department of Health's definition of a first-contact client[1], these attendances are recorded as a male client. For sole female clients, the use of the condom as the main method of contraception has increased over this time (Department of Health, 1999a). However, the number of clients who attend as part of a couple is not recorded and therefore unknown.

Over the 1990s, more sexual health services have been aimed specifically at young people. Some of these services receive funds from the NHS (Peckham *et al.*, 1996) and will therefore be recorded in the data shown in Figure 7.1. It is feasible, therefore, that part of the increase in male clients is accounted for by young men attending youth-oriented services.

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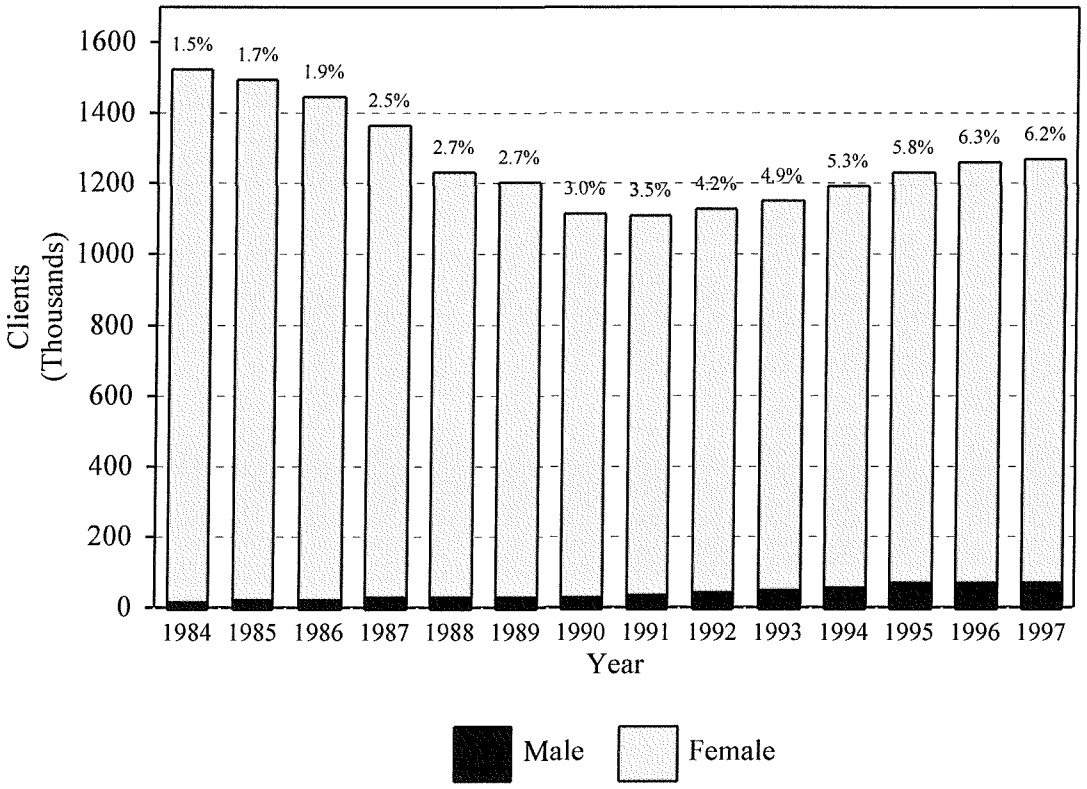
[1] "A first contact is the first time a client is seen in the financial year by the family planning service. Where a couple are seen together only one first contact is recorded; where either vasectomy or the male sheath is the main method chosen, the first contact is recorded as one with a man, otherwise as one with a woman." (Department of Health, 1997a, p.3).

Figure 7.1 - Number of First Contact Clients Attending Family Planning Clinic Services, by Sex, England, 1984 to 1997/98.



Notes: The value at the top of each bar is the percentage of clients who are male.

Data cover all family planning services provided by NHS trusts in clinics and as domiciliary visits, Brook Advisory Centres, and other clinics funded wholly or partly by the NHS.

"A first contact is the first time a client is seen in the financial year by the family planning service. Where a couple are seen together only one first contact is recorded; where either vasectomy or condom is the main method chosen, the first contact is recorded as one with a man, otherwise as one with a woman." (Department of Health, 1997a, p.3)

From 1987, collection of data changed from year ending 31 December to year ending 31 March.

Source: Department of Health. (1999a). NHS Contraceptive Services, England: 1997-98. Bulletin 1999/5. London: Department of Health Statistics Division 2B, Table 2.

7.1.2 General practitioners

Most general practitioners offer sexual health services to male and female clients, including advice and information on sexual heath, prescription of contraception (a notable exception, discussed below, being condoms), and advice and treatment for sexually transmitted infections. General practitioners may also refer clients to hospitals, family planning clinics or genitourinary medicine clinics. National data on service use only include clients in respect of whom a fee is payable to the general practitioner for providing contraceptive services (for example, pill prescriptions or IUD insertion) (Department of Health, 1996b). Therefore, men receiving advice and information about sexual health, or who are referred, are not recorded. The number of women seen by general practitioners for contraceptive services increased by one third between 1988/89 and 1994/95 (Department of Health, 1996b).

Few studies have considered general practitioner provision of sexual health services (Peckham *et al.*, 1996). Cooper and colleagues' (1992abc) study of family planning provision in the (former) Wessex Regional Health area asked providers how often they provided services or advice to certain client groups. As shown in Table 7.1, only 11% of general practitioners reported seeing single teenage men in the past month, as compared with 96% seeing single teenage women. Other studies focus on why young women attend general practitioners for sexual health services (Allaby, 1995; Seamark & Pereira Gray, 1995), but few studies have asked young men similar questions.

One reason young men are unlikely to use a general practitioner for sexual health services is the unavailability of condoms on prescription. At the British Medical Association Annual Representative Meeting in 1975, it was decided that general practitioners should receive item-of-service payments for family planning provision (British Medical Association, 1975). An implication of this decision was that general practitioners have been unwilling to prescribe condoms. Justifications for this decision are usually based upon the perceived cost and time involved in prescribing condoms, a more important factor since the introduction of fund-holding general practices in 1993. Recently, renewed calls have been made for condoms to be prescribed through general practice, both as a contraceptive method and to protect against HIV infection (Kirby, 1991; Spencer 1991). Similar sentiments are

Table 7.1 - Percentage of Family Planning Providers Reporting Providing Family Planning Service or Advice to Client Groups at least Once a Month, Wessex, 1992.

Client group	Seen by general practitioner	Seen by family planning clinic doctor	Seen by family planning clinic nurse
Single teenage women	96	95	97
Single teenage men	11	31	44
Women with children wishing to delay or space further pregnancies	97	92	95
Older men	19	43	24
Base (100%)	*419*	*80*	*116*

Source: Cooper, P., Diamond, I., & High, S. (1992). [The provision of family planning services by general practitioners and family planning clinics]. Unpublished raw data.

expressed by the public; 82% of men in one survey agreed that general practitioners should be able to prescribe free condoms (Mathie *et al.*, 1992).

In 1992, the NHS Executive published guidance for regional health authorities on providing family planning services (NHS Executive, 1992). One recommendation was that health purchasers allocate HIV ring-fenced money for condom provision through general practice. Because of these guidelines and aims of meeting *The Health of the Nation* sexual health targets, some health authorities introduced condom provision schemes in general practice. Schemes have been run in Sheffield, Derbyshire, North Yorkshire, Southampton (all cited in Burton, 1996), Camden and Islington (Parham *et al.*, 1995), Oxfordshire (Pengilley & Kay, 1995) and Waltham Forest (Davidson & Lloyd, 1994).

Clients join a condom provision scheme through an opportunistic referral by a general practitioner or practice nurse, direct advertising (for example, a poster, leaflet or newspaper advertisement) or word of mouth. Condoms are then distributed on site to the client, usually by a practice nurse, with accompanying verbal and/or written information on sexual health issues around condom use[2].

[2] Although the consistency and quality of this information have been questioned (Burton, 1996).

Few schemes have been systematically and comprehensively evaluated (Burton, 1996). Some studies collect basic information on the demographic characteristics of participating clients. The percentage of clients who are male have been low, for example 13% of 269 clients in the Oxfordshire scheme (Pengilley & Kay, 1995), and 17% of 73 clients who completed a questionnaire in an evaluation of the Southampton scheme (Burton, 1996). This low proportion of male clients probably reflect men's general low levels of use of general practice services, discussed later in section 7.2.2.

7.1.3 Young people's sexual health services

Besides provision through family planning clinics and general practice, some sexual health services in Britain are aimed primarily at young people. Peckham and colleagues (1996) conducted a questionnaire survey of NHS family planning clinic managers and young people's services identified as providing contraceptives and sexual health advice. Based upon 177 responses[3], they identified 27 family planning clinic services and 53 family planning 'projects' providing services for under 25s only, making a total of 80. Similarly, Aggleton and colleagues' (1996) *Compendium of Family Planning Service Provision for Young People* lists 82 young people's sexual health services operating in the eight NHS Health Regions[4]. Twelve of these eighty-two services (15%) report they offer a service specially dedicated to young men.

As some young people's sexual health services are provided by NHS trusts through clinics, client attendance is recorded on the Department of Health's annual KT31 return form (Department of Health, 1999a). However, published data do not identify services specifically aimed at young people, or the ages of male clients. A search by the current author of the 560 documents collected by Peckham and colleagues (1996) resulted in 34 data values on the sex of clients attending selected young people's sexual health services between 1986 and 1996. These data are shown in Figure 7.2 and described in Appendix 6. The

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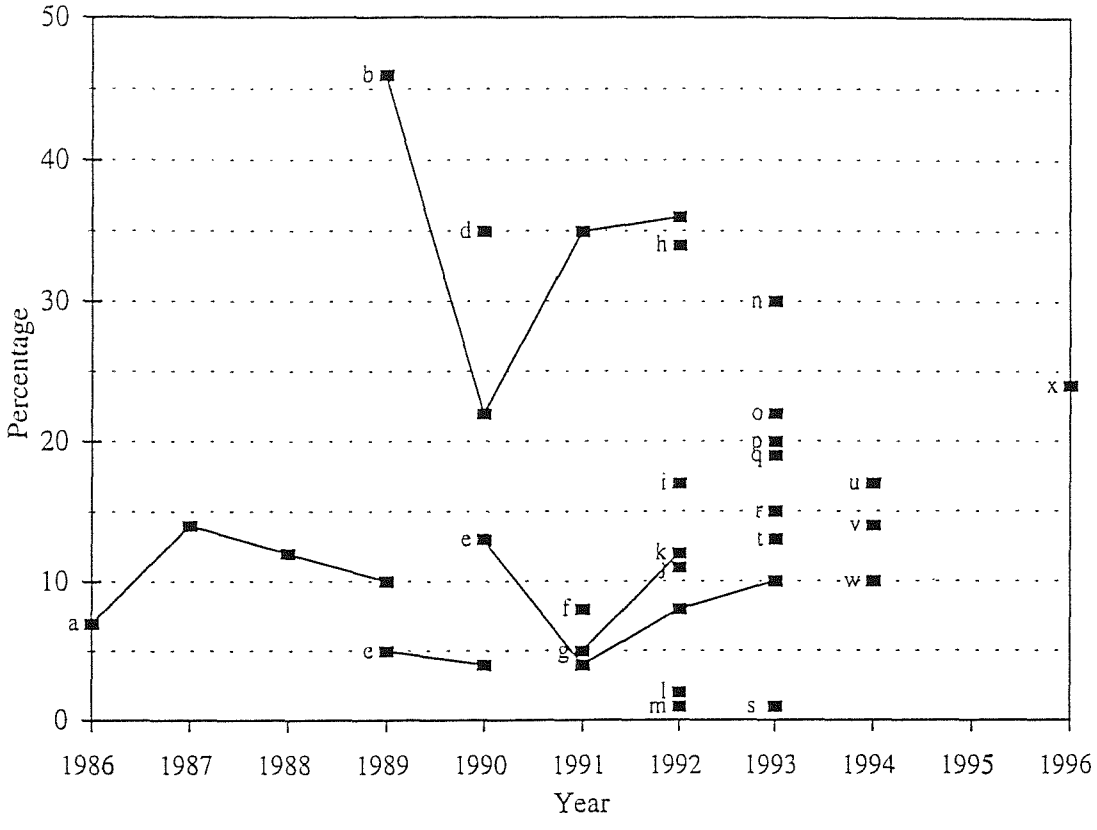
[3] The study had a response rate of 40%; however, the authors had difficulties constructing a complete sampling frame.

[4] However, as the authors point out, this is not a fully comprehensive compendium as only agencies offering contraceptive advice and nominated through each Health Region's Director of Public Health are included.

Figure 7.2 - Percentage of Clients who are Male Attending Selected Young People's Sexual Health Services, 1986 to 1996.



Services

a	St. Helens and Knowsley Health Authority Family Planning Clinics	l	Morley Street Young People's Clinic, Brighton
b	'Under 18' Family Planning Session, Woodhouse Park Clinic	m	Market Street Young People's Family Planning Clinic, Greenwich
c	You 2, Milton Keynes	n	Young Person's Drop In, Women's and Girl's Resource Centre, Merseyside
d	Under 20s Drop-In Clinic, Barnstaple Health Centre	o	Streetwise, Newcastle-upon-Tyne
e	Cwmbran Young People's Clinic, Gwent	p	Bassetlaw Teenage Clinics (three venues)
f	Portsmouth and SE Hampshire Health Commission Family Planning Clinics	q	Young People's Advisory Service, Weymouth
g	Young People's Clinic, Stockport	r	Derby Teenage Clinics (three venues)
h	Brynmawr Young People's Clinic, Gwent	s	Lothian Health Board Family Planning and Well Woman Clinics
I	You 2 Drop-In Sessions around Milton Keynes	t	Carnegie Youth Advisory Clinic, Dunfermline
j	Options Young People's Clinic, Clwydia	u	Youth Advisory Doncaster Clinic
k	Newport Young People's Clinic, Gwent	v	Just For You Clinic, Solihull
		w	Greyfriars Clinic, Great Yarmouth
		x	Sex Sense (six venues), Portsmouth

Sources: Please refer to Appendix 5 for data sources and brief details of services.

incompleteness of these data and the shortage of data on the same services over time does not allow the identification of any trends. However, wide variation between services is apparent, with young men accounting for between 1% and 46% of clients. A more comprehensive review of client data from young people's sexual health services would provide valuable information on the characteristics of services popular with young men.

Brook Advisory Centres, a network of centres offering young people confidential contraceptive and counselling services, does collate and publish attendance data differentiated by age and sex. Brook has long recognised the importance of encouraging young men to use their services (Hayman, 1983; Frater, 1985; Jewitt, 1995). Figure 7.3 shows the number and sex of clients[5] at Brook Advisory Centres between 1987 and 1997/98. Over the 1990s the proportion of clients who are male has increased steadily, accounting for 11% of the 94,000 clients seen in 1997/98 (Brook Advisory Centres, 1999). Seventy percent of male clients are aged 19 or under.

Clients who attend a service as a couple are not usually recorded in attendance data. It is likely that published data underestimate the number of young men attending sexual health services. Looking at data from the General Household Survey (Office for National Statistics, 1997b), three quarters of women aged 16-24 using any form of contraception use a method prescribed to the woman (pill, IUD, cap or injectable). When couples attend together, most services only record the client to whom a contraceptive method is prescribed. Hypothetically, therefore, the female member of a heterosexual couple will be solely recorded as the client for three quarters of couples in this age group who attend a service together.

Unfortunately, it is unknown how many young men attend a service as part of a couple. One tantalising exception is provided by a young person's sexual health service in Brighton that recorded all attendances of young men over an eight-month period in 1992/93 (South Downs Health NHS Trust, 1993). This was part of the duties of a male youth worker who talked to male partners while their female partners were being seen. The 77 young men who attended during this period are categorised in Table 7.2.

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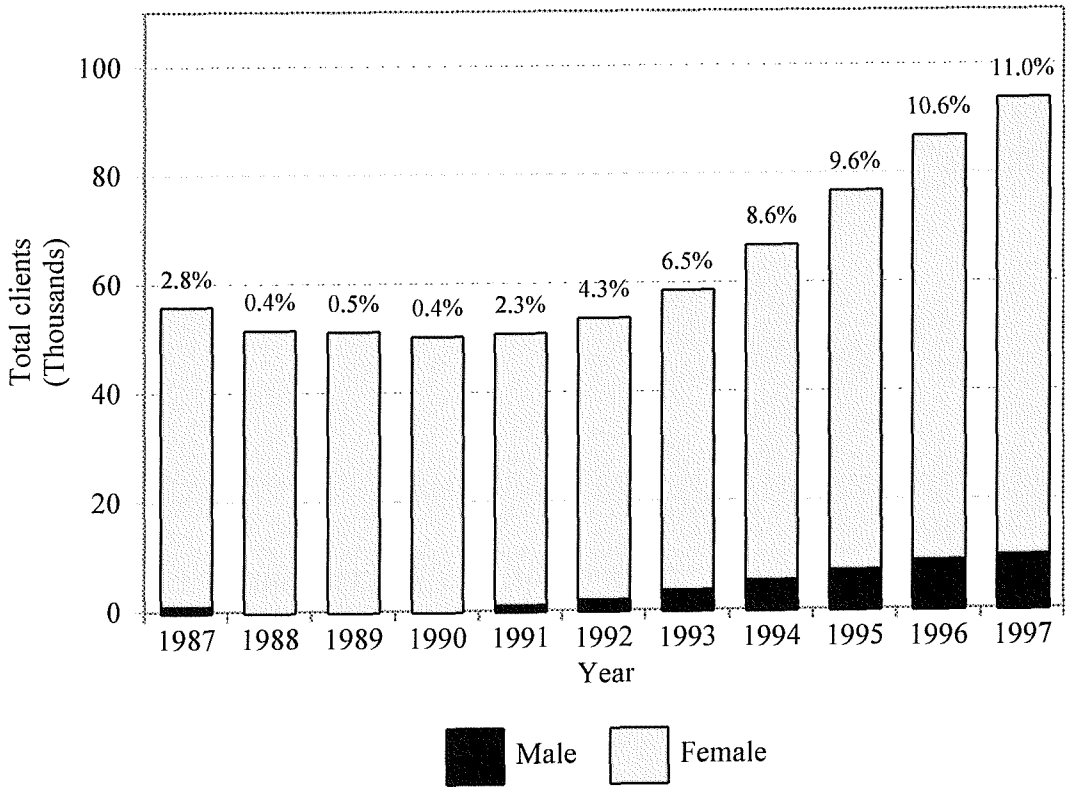
[5] Total clients include new clients and return clients seen in each year. The number of male clients does not include men who may have accompanied their partners to a Centre and were part of a joint consultation (Brook Advisory Centres, 1996).

Figure 7.3 - Total Number of Clients Attending Brook Advisory Centres, by Sex, 1987 to 1997/98.



Notes: The value at the top of each bar is the percentage of clients who are male.

Total clients includes new clients and return clients seen in each year. The number of male clients does not include men who may have accompanied their partners to a Centre and were part of a joint consultation.

From 1987 collection of data changed from year ending 31 December to year ending 31 March.

Sources: Brook Advisory Centres. (1993, 1994, 1995, 1996, 1997, 1998, 1999). Brook Advisory Centres Annual Report London: Brook Advisory Centres.

Whitehead, S. (1997). [Attendance of young men at Brook], personal communication, 4 August.

Table 7.2 - Young Men's Reasons for Attendance at Morley St. Health Centre Drop-In Clinic, Brighton, 1992/93.

Reason	Percentage (n=77)
Attended with a partner and accompanied her for consultation	18%
Attended with a partner but did not accompany her for consultation	55%
Attended on his own and received consultation himself	13%
Attended for condom supplies only with no consultation	14%

Source: South Downs Health NHS Trust. (1993). Annual Report on Young People's Clinics, Morley Street Health Centre, Brighton.

Of interest is that three-quarters of the young men attended as part of a couple. However, 55% had a non-active role in the consultation, merely accompanying their partner to the service venue. Whether these young men are actually *using* the service is debatable. However the fact that a young man has accompanied his partner may suggest the decision to use a service has been made jointly. If such a pattern is typical for other services, young men's level of involvement with sexual health services is underestimated by routine client attendance data.

7.1.4 Genitourinary medicine clinics

Under the 1916 Venereal Disease Regulations Act, services for the diagnosis and treatment of sexually transmitted infections became available to anyone who wanted them (Munday, 1990). Currently, more than 200 genitourinary medicine clinics[6] operate in England (Department of Health, 1993c), offering advice, counselling, testing and treatment of infections. Health promotion material on safer sex often recommends genitourinary medicine clinics as places to obtain anonymous and confidential HIV testing. Increasingly,

[6] Other titles that have been (or are currently) used for genitourinary medicine clinics include VD clinics, STD clinics, sexual health clinics and HIV/Aids clinics.

genitourinary medicine clinics are also offering general sexual health services including the provision of contraception (Masters *et al.*, 1995; Walsh, 1996). Of 206 genitourinary medicine clinics who replied to a questionnaire survey organised by the Family Planning Association, 100% report providing condoms, 72% emergency contraception and 57% oral contraceptives (Walsh, 1996). Of clients attending for family planning services in 1997, only 6% were male (Hughes *et al.*, 1998).

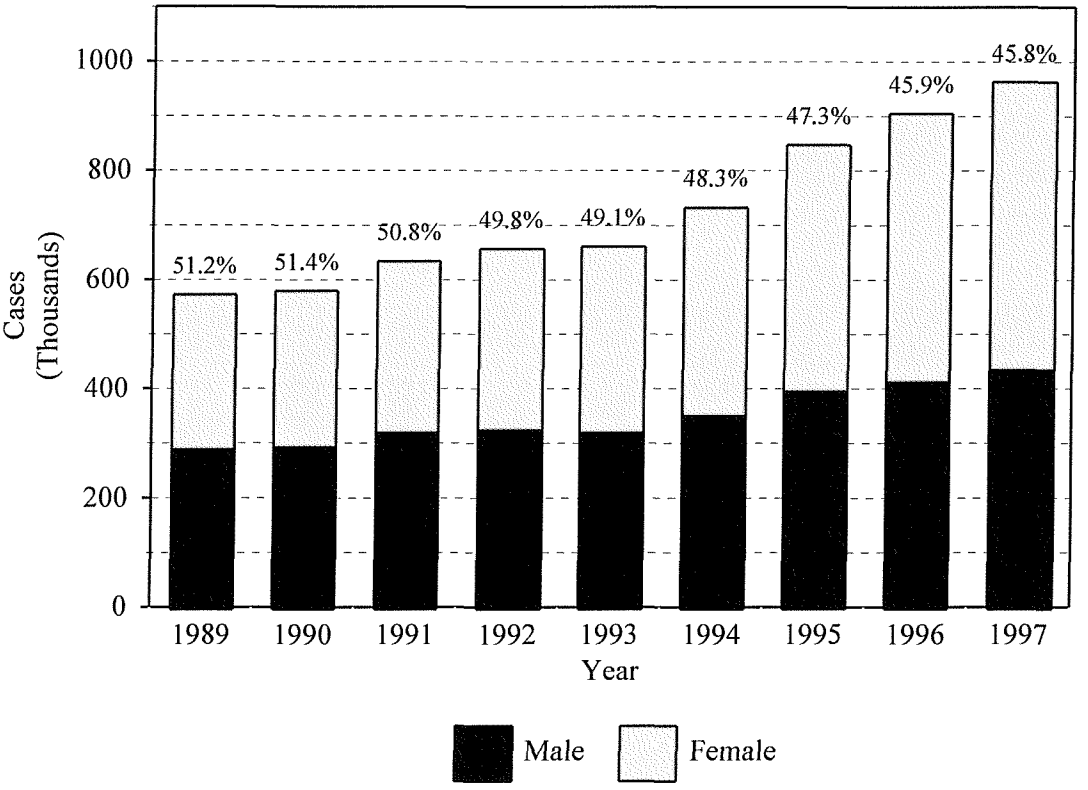
Routine statistics on the number of cases[7] seen at genitourinary medicine clinics are collected by the Public Health Laboratory Service on the quarterly KC60 return form. It is estimated that most serious occurrences of certain infections are seen at genitourinary medicine clinics (as opposed to no treatment, or treatment from a general practitioner) (Ross, 1995; Department of Health, 1996a). Therefore, case statistics reliably indicate the prevalence of certain sexually transmitted infections.

Figure 7.4 shows the number of male and female cases seen at genitourinary medicine clinics between 1984 and 1995. As compared with other sexual health services, the ratio of male to female cases is approximately equal. The number of new cases of chlamydia, gonorrhoea, syphilis, genital warts and herpes have increased significantly since 1994, due to changes in incidence and health-seeking behaviour (Hughes *et al.*, 1998). The increase in the total number of new cases also reflects more people attending for HIV counselling and testing (Allen & Hogg, 1993). Of the 440,000 male cases seen in 1997, 44% presented with a sexually transmitted infection (excluding HIV/Aids), 18% presented for HIV counselling and testing and 20% of cases did not require treatment (Hughes *et al.*, 1998). Unfortunately, the published data do not fully present cases by age, sex and sexual orientation so reporting specifically on young men, or heterosexual young men, is not possible

The NSSAL (Wellings *et al.*, 1994) included a question on STD clinic attendance; responses are shown in Table 7.3, categorised by age group and sex. Two and a half percent of 16-19 year old men reported having ever attended a STD clinic, rising to six and a half percent of

[7] "The KC60 return includes all conditions seen in clinics, whether or not treatment is required and whether or not any identified condition is sexually acquired. The figures recorded do not provide a count of persons seen, or of episodes. An individual will be recorded under each condition identified as present and may be recorded more than once in each year for different courses of treatment" (Department of Health, 1996c, p.5).

Figure 7.4 - Number of New Cases Seen at NHS Genitourinary Medicine Clinics, by Sex, England, 1989-1997.



Notes: The value at the top of each bar refers to the percentage of cases occurring to clients who are male.

The KC60 return includes all conditions seen in clinics, whether or not treatment is required and whether or not any identified condition is sexually acquired. The figures recorded do not provide a count of persons seen, or of episodes. An individual will be recorded under each condition identified as present and may be recorded more than once in each year for different courses of treatment.

Cases include diagnoses of conditions, episodes not requiring treatment, HIV antibody counselling and testing, family planning and cervical cytology.

Sources: Department of Health. (1996b). Health and Personal Social Services Statistics for England, 1996 Edition. London: HMSO, Table 8.3.

Department of Health. (1996c). Sexually Transmitted Diseases, England 1995: New Cases seen at NHS Genito-Urinary Medicine Clinics. Statistical Bulletin 1996/14. London: Department of Health and the Government Statistical Service.

Hughes, G., Simms, I., Rogers, P. A., Swan, A. V., & Catchpole, M. (1998). New cases seen in at genitourinary medicine clinics: England 1997. Communicable Disease Report, 8 (suppl. 7), 1-11, Tables 3,4.

men aged 20-24. No significant gender differences exist at these ages, although men aged 25-29 are more likely than women to report having ever-attended a STD clinic. Multivariate analysis of these data for all ages suggests clinic attendance by a man is most associated with number of heterosexual partners and male sex partnerships being reported (Johnson *et al.*, 1996).

Table 7.3 - Percentage of Respondents Reporting STD Clinic Attendance, by Age Group and Sex, NSSAL.

Age group	Men	Women
16-19		
In the last year	1.8%	2.0%
In the last five years	2.5%	2.6%
Ever	2.5%	2.6%
Base (100%)	*571*	*655*
20-24		
In the last year	1.7%	1.4%
In the last five years	6.2%	5.8%
Ever	6.5%	6.5%
Base (100%)	*1075*	*1211*
25-29		
In the last year	1.7%	1.4%
In the last five years	6.6%*	4.3%*
Ever	10.2%*	7.1%*
Base (100%)	*1098*	*1458*

* - Denotes statistically significant difference between the sexes at the 1% level.

The question, included in the self-completion section of the questionnaire, was phrased "Have you ever attended a sexually transmitted disease (STD) clinic or special (VD) clinic?"

Source: Wellings, K., Field, J., Johnson, A. M., & Wadsworth, J. (1994). The National Survey of Sexual Attitudes and Lifestyles. [Unpublished raw data].

7.1.5 Condom sale outlets

The contraceptive method young men are most likely to be involved in obtaining is the male condom. A man in a heterosexual partnership is often responsible for obtaining condoms (United Kingdom Family Planning Research Network, 1989; Cooper *et al.*, 1992a), with

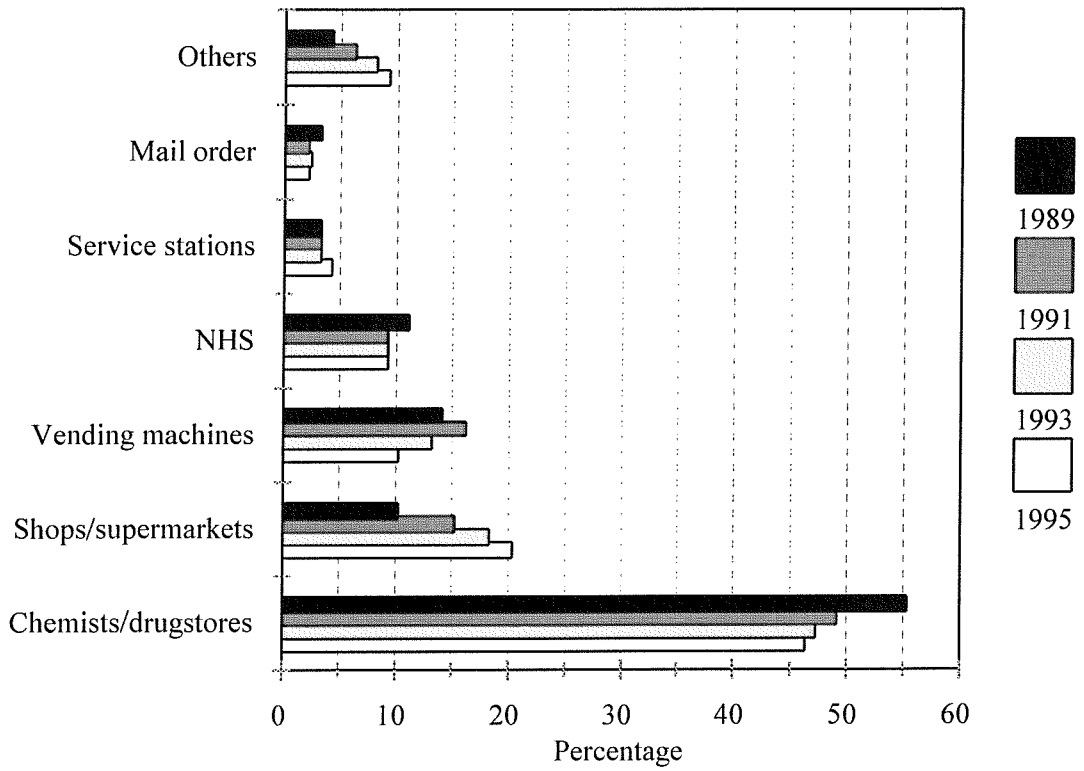
72% of male users of condoms in a survey reporting they normally purchase the condoms, as opposed to shared or partner purchase (Durex Information Service, 1997). Therefore, it is worth considering the sources from which condoms are obtained, and any information on young men's attitudes towards these sources. Few of these sources will offer advice and information on sexual health, although chemists may do, and written information is usually available in condom packets.

In 1996, around 160 million condoms were sold in the UK (Mates Healthcare, 1997). Figure 7.5 shows the trend in condom sales by outlet. In 1995, just under half of all condoms were obtained through chemists and drugstores, with less than 10% obtained through the NHS (McGovern M., personal communication, 4 July 1997). A trend over this period has been increased purchasing from shops, supermarkets, video and record stores, accompanied by decreased purchasing from the traditional outlets of chemists, drugstores and vending machines.

a) Chemists and other retail outlets

Chemists have always been an important source for obtaining condoms. In Schofield's 1965 study, 40% of young men reported obtaining condoms from chemists, with a similar percentage at re-interview at age 25 (Schofield, 1973). The major reported disadvantage of using retail outlets is a feeling of embarrassment (Bostock & Leathar, 1982; Spencer, 1984; Hastings *et al.*, 1987; Ford, 1991), particularly if served by a female member of staff (Morton-Williams, 1976; Mathie *et al.*, 1992; Cragg *et al.*, 1993), or if attention is drawn to the purchase (for example, a price check in a supermarket [Cooper *et al.*, 1992a]). However, a shop is a more anonymous source than, say, a family planning clinic, in that the reason for attendance is not obvious to other people present. Some men prefer obtaining condoms in the clinical setting of a chemist as opposed to the informal atmosphere of shops and supermarkets (Abrams *et al.*, 1990). The availability and convenience of obtaining condoms from local retail outlets are also reported as an advantage (Mathie *et al.*, 1992).

Figure 7.5 - Sales Outlets for Condoms by Percentage of Volume Sales, United Kingdom, 1989-1995.



Sources: 1989, 1991 and 1993 data - Mintel International Group. (1994). Mintel Marketing Intelligence, Contraceptives, August 1994. London: Mintel International Group Ltd..

1995 data - McGovern, M. (1997). [Mintel Marketing Intelligence, Contraceptives, 1995], personal communication, 4 July 1997.

b) Vending machines

A major advantage of obtaining condoms from vending machines is the lack of human contact in the transaction, therefore reducing any embarrassment (Spencer, 1984; Cooper *et al.*, 1992a). For vending machines located in toilets, however, a young man may be embarrassed if other men are present (Cragg *et al.*, 1993). This source may be especially popular among younger men (Mintel International Group, 1994; Talbot, 1995), with one study in the late 1970s reporting 39% of teenage male condom users using vending machines in pub toilets (Farrell, 1978). The easy availability of vending machines, especially during the evenings when other sources may be unavailable and the need for condoms may be greater, is also cited as an advantage (Mathie *et al.*, 1992). However, concerns have been voiced over the quality of condoms supplied, and the reliability of machines (Mathie *et al.*, 1992).

c) Barbers

From the late 19th century until the 1970s, barbers were an important source of condoms for men. Barbers were keen to supply condoms due to the significant profit offered by condom manufacturers, primarily the London Rubber Company (Ferris, 1993). A sample of men aged in their 20s in the early 1970s reported this source as the second most popular outlet for obtaining condoms (Schofield, 1975). Since then, however, the provision of condoms from this outlet has probably declined to a very low level.

d) Others

Apart from the above outlets, a few other sources for obtaining condoms have been reported in various studies. 'Friends' were mentioned as a source by one third of Schofield's (1965) sample of male condom users. The informal provision of condoms by male friends may still be important for some young men, although their friends still have to obtain the condoms from somewhere. Three other sources reported are official 'agents', surgical stores and mail order (Schofield, 1973; Morton-Williams, 1976; Ferris, 1993). Current use of these sources is low, although mail order may be popular among regular users.

7.2 SEXUAL HEALTH SEEKING BEHAVIOUR

7.2.1 Introduction

Although different types of sexual health services are available to be used by young men, it needs to be ascertained whether they are interested in using any of the services on offer. As discussed in section 6.1, the only highly effective method of contraception young men can obtain and use themselves is the condom. One possible desired service, therefore, is obtaining condoms, but what of other services such as advice and information on relationships, sex or contraception? One way of answering this question is to see how young men discuss hypothetical dilemmas around sexual health, and whether services play a role in how they deal and resolve the dilemma.

In the focus groups, seven hypothetical dilemmas were introduced by the moderator. These aimed to cover a range of sexual health situations that are broadly applicable to both young men and women. The seven dilemmas were:

Where would you advise a friend to go, or who would you tell them to talk to, if:

a) They were thinking of having sex for the first time and wanted to talk about it

b) They had had sex and now they were worried about something

c) They thought their partner was pregnant

d) They thought they had caught something from having sex

e) They were experiencing pressure to have sex

f) They wanted to talk about sexual abuse

g) They were experiencing feelings for someone of the same sex and wanted to talk about it.

The dilemmas are worded to allow responses in the third person as this format should elicit more free and honest responses in a group discussion. It is recognised that the choice of these specific dilemmas (as opposed to others) may have inappropriately prioritised them as issues. However, the groups tend to point out quickly when they feel a dilemma is unlikely

to occur or, if it does occur, is a trivial issue. A problem with this technique is that a respondent's approach to dealing with a sexual health issue (as reported to the researchers and group) may not necessarily reflect his actual behaviour should he ever face that issue. Still, the discussions produced some useful themes underlying young men's approaches to their sexual health.

Different pathways for making a decision on a dilemma are evident. The pathways include decisions on whether to discuss the problem with anyone, whether to collect some relevant information, and whether to use a sexual health service for information, advice or treatment. For example, this respondent describes the stages he would go through when dealing with a sexual health issue:

> *M: (So you'd see someone [at the youth centre] or your mates?)*
>
> R: Yeah, and say like you get an opinion off him, him, and him and you pile them together and they'll all near enough say the same, and then you go and see someone with a bit more experience and see what they've got to say, for instance 'Youth Worker'. See what he's got to say, and then if 'Youth Worker' seriously advises you to go and do something about it and see the doctor if it's that serious, then you'd go. [M07:35]

7.2.2 Confidants and experts

First is the question of whether a young man would discuss the problem with anyone. This varies considerably by respondent; some felt they would not need to talk to anyone as they already knew enough about sexual health and local services. Others report being unlikely to discuss personal and sensitive issues due to embarrassment or lack of trust. Individuals identified as potential 'confidants' and sources of information include a friend, parent, sibling, doctor, sexual partner, youth worker and teacher/tutor or guidance counsellor at school/college. Who of these respondents would approach depends on two factors; the nature of their relationship, and that confidant's knowledge of sexual health, two themes discussed below.

The sources young men learn about sex from, including characteristics of people young men feel comfortable talking about sex with, were discussed in Chapter 3. Themes raised in the interviews mirror those from the focus group discussions, especially the nature of the

relationship between the two parties. Important characteristics of this relationship include its closeness and friendship, whether a young man trusts the other person to be confidential and discrete about an issue, how good a listener the person is, and the person's likely initial reaction. For example, whether male friends would be approached was discussed in all the focus groups. Concerns are raised that some male friends would not take the subject seriously, make fun of the young man, or be indiscrete and tell other people. The most appropriate peer for approaching on personal issues is a close friend with whom the respondent has a close, trusting relationship. In some friendship groups, one member is recognised as the person to approach to discuss personal problems.

Favourable personal characteristics also extend to health professionals; the respondents report they are more likely to approach service personnel if they anticipate a friendly but serious response, with confidentiality all important. A warm initial welcome and non-judgemental reaction from the service provider is identified as very important. Anonymous discussion is important for some respondents, whereas others feel they can only discuss personal issues with someone they know. Confidentiality and trust are worries for approaching school or college teachers; the nature of the student/teacher relationship is felt to be incompatible with discussion of personal sexual health issues[8,9].

Second is how **knowledgable** a person is on sexual health, with more knowledge associated with more appropriate and useful advice. The label of 'experts' is assigned by groups to individuals whose profession or personal history mean they are likely to have more understanding, a more sympathetic reaction and provide more useful advice on a sexual health issue. In these respects, sexual health service personnel are seen as appropriate people to approach, as for this group who compare approaching service staff to their parents:

R: My dad would just laugh in my face.

M: (How about for all the situations, then?)

---

[8] Although some respondents recognise their school or college has a guidance counsellor available, operating a confidential service.

[9] Department for Education (1994) advice to teachers on this issue discourages them from offering sexual health advice to a pupil. Instead, teachers are encouraged to tell the pupil to seek advice from parents or an appropriate health service. However, one recommendation of the Social Exclusion Unit's (1999) report on teenage pregnancy is the production of more "credible" (p.93) advice.

R: Depends what sort of relationship you've got with your parents.

R: Well, why go to like a couple of untrained people when you could get like specialists on the job. [M09:19]

Another 'specialist' is a general practitioner. Some respondents identify their general practitioner as the best person to approach as they could either deal with the problem themselves or have enough knowledge of local services for referral. Although a popular source for buying condoms, chemists are rarely mentioned as possible sources of advice or information on sexual health, with one respondent dismissing pharmaceutical staff as *"just sales assistants"* [M04:32].

Another group of experts are people who, although not trained specifically in sexual health, are likely to know about local sexual health services. An example is provided in one focus group (M07) in which all the respondents frequented a local youth centre. A male youth worker working at the centre is cited as a person the respondents would approach regarding many dilemmas. Not only is there a good personal relationship between the respondents and the youth worker, but he is thought to offer sensible advice and have good knowledge of local services. Such people, therefore, act as 'go-betweens' for a young man and a service.

Other experts identified include people who are likely to have greater knowledge of sexual issues through their personal experiences. Examples include older siblings (see section 3.5.4), and older friends or relatives, particularly men who can provide a male perspective on any issue. In this respect, fathers fit the profile of good potential confidants (being male and older); however, very few respondents report they would approach their father (if one was available). Similar to the findings in section 3.5.2, respondents who feel they could approach their father to discuss personal topics report an open and close relationship with him.

It is worth briefly mentioning the use of telephone information and helplines as a source of information on sexual health. It has been suggested that the anonymity of this medium enables men not to 'lose face'; an effective method, therefore, for offering sexual health information and advice (Hobbs, 1995; Baker, 1997). Although men accounted for 30% of

calls made to the Family Planning Information Service helpline in 1986[10] (Belfield, 1988), the figure currently stands at around 10% (Urwin, J., personal communication, 14 August 1997). A series of three programmes entitled *Talk About Sex* on BBC Radio One in 1992 prompted 2,700 calls to a helpline, of which 73% were from men[11] (Rowlands, 1993). The most common topics of calls from men were feelings of sexual inadequacy, safer sex, masturbation and HIV testing. Conversely, a widely publicised helpline operating during weekly men-only drop-in sessions in the *Brook and Men Project* was rarely called (Jewitt, 1995).

Some respondents in the current study suggest sexual health information telephone helplines (either human or computer operated) as an effective service. The anonymity and lack of face-to-face contact of a phone call is felt to facilitate more open discussion of a sexual health problem for an embarrassed or nervous young man. For example, some respondents report they would phone their doctor's surgery and ask the receptionist for information on a local sexual health service, but they would never visit in person to obtain this information.

7.2.3 Men's health

A conflict is apparent in the groups' discussions of sexual health. Although the respondents accept that some sexual health issues can be very worrying for a young man and require action, factors act to prohibit discussion of, or seeking care for, sexual health. This is particularly apparent for the dilemmas around emotions and relationships. In this extract, the first respondent tries to explain how personal feelings should be discussed. The other respondents initially appear uncomfortable with the idea:

> R: Like if you're saying that like you can't hold it inside because it does your head in.
>
> R: Does it? (laughter)
>
> R: Whose idea was this?

---

[10] This percentage is high because 1985 saw the launching of the Family Planning Association's 'Men Too' campaign, aiming to raise awareness of contraception among men (Urwin, J., personal communication, 14 August 1997; Wellings, 1986).

[11] Compared to the normal audience of Radio One which the author reports to be 57% male.

R: No, like, you know ...

R: I sound like a right fag.

R: You can't like keep it all in, you know, yourself when you've got a problem. You can't keep it inside, can you lads?

R: No you can't.

R: So you've got to tell someone, so you can't sort it out yourself, so ask for advice and stuff like that. [M08:21]

Section 3.2.2 suggested the discussion of emotions and relationships is a taboo subject within some male social groups, with discussion only occurring in private between close, trusted friends. This prohibition is recognised to be associated with men's but not women's friendship groups; some respondents speak enviously of the perceived ease with which young women can talk seriously about emotions and relationships with their female friends.

This unwillingness to seek advice may also extend to using sexual health services. Although most respondents recognise that, for example, young people's services offer advice and information, many report that they would not currently use such a service, and are unlikely to in the future. The respondents report they are most likely to consider using sexual health services for either **routine** or **crisis** reasons. Routine reasons exclusively refer to obtaining free condoms. Crisis situations are when a young man realises that something is wrong with his sexual health and requires attention. For example, he may have symptoms of a sexually transmitted infection, as this respondent discusses:

M: (And do you think people would be happy to say, go to the VD clinic in that situation?)

R: I think you might have no choice in a way. Yeah, if they think they might have caught something I think no matter what they might feel it's important to find out. [M01:16]

This pattern of service use for routine or crisis reasons was also identified by Davidson and Lloyd (1994) in their audit of sexual health service provision for men of all ages. Is it restricted to sexual health, or apparent in other aspects of health? As illustrated by the selected indicators presented in Table 7.4, men's use of health services is different to women's. Men have lower general practice consultation rates than women, and are less likely to report having talked to a doctor and/or health professional in the last year. Men's

Table 7.4 - Selected Indicators of Use of Health Services, by Sex.

Indicator	Men	Women	Age	Year	Source
Talked to doctor and/or health professional in last 12 months	53% *(n=231)*	71% *(n=286)*	16-24	1995	Department of Health (1997b), Table 2.28.
Consulted a NHS general practitioner in last 14 days	10% *(n=4345)*	18% *(n=4547)*	16-44	1995	Office for National Statistics (1997a), Table 7.19.
Patient consulting rates for general practice per 10,000 person years at risk	6,192	8,942	16-24	1991/92	OPCS (1995), Table 19.
Hospital inpatient cases, all diagnoses (excluding pregnancy)	4,806,000	5,053,000	all	1994/95	Office for National Statistics (1997a), Table 5.11.

health service use rates are equal to those of women only when considering hospital inpatient cases, an indicator of more serious health problems (Department of Health, 1993a). Table 7.4 is understandable, however, if men are generally healthier than women, and have fewer requirements from health services. British men have higher mortality rates than women at all ages (Tickle, 1996). The relationship between gender and morbidity is harder to determine as morbidity data usually rely on self-reporting. In two recent surveys, men aged 16-24 report a slightly higher level of health as compared with women of the same age (Office for National Statistics 1997b; Department of Health, 1997b). The level of self-reported chronic and acute illness in the General Household Survey generally is similar for men and women aged 16-44 (OPCS, 1996). Macintyre and colleagues (1996) question an underlying assumption prevalent in the medical sociology literature that women have higher levels of morbidity, and suggests the relationship between gender and morbidity varies by health condition and phase of the lifecycle.

Evidence, therefore, points to under-utilisation of health service by men. Although this is becoming more of an issue among health professionals[12], there is a dearth of research on the subject (as compared to research on women's use of health services), particularly on

[12] For example, the Chief Medical Officer's 1992 Annual Report (Department of Health, 1993a) discussed men's health as the special topic.

promotion methods to increase service uptake among men (Davidson & Lloyd, 1995; Robertson, 1995).

Some authors argue that male gender roles prohibit men's health-seeking behaviour, and therefore use of health services. As Bruckenwell and colleagues (1995, p.6) state, "the pressures to be manly - tougher, harder, more successful, more daring and violent - get in the way of our attempts to look after ourselves". Part of this manliness is an unwillingness to acknowledge symptoms of illness (signs of weakness) and to discuss feelings (traditionally feminine characteristics) (Hobbs, 1995; Rees, 1995; Robertson, 1995). One author translates these attitudes into the first commandment of masculinity, namely:

> "Thou shalt not cry or expose feelings of emotion, fear, weakness, symptoms, empathy or involvement before thy neighbour." (Rees, 1995, p.39)

While these attitudes are fostered in the public arena (particularly in male peer groups), many decisions about health are taken in private at the individual level, creating a potential conflict. Lloyd (undated) suggests health campaigns targeted at men must take account of both spheres of influence. While there is merit to these arguments, such writing rarely is based upon empirical or qualitative research asking men about their health beliefs and behaviour. To accept blindly the importance of these factors creates a danger of extending stereotypes and hiding important variations between men that undoubtedly exist (Watson, 1993).

In the focus groups, some respondents' apparent reluctance to discuss sexual health issues with male friends might reflect this conflict between the public and personal domains. The need of some young men to preserve their social standing in front of peers may prohibit discussion of issues undermining status. For example, the dilemma of discussing worries around first-ever intercourse is reported to be unlikely to occur between friends or peers, as these respondents explain:

> R: It's harder for boys 'cause they've got images and stuff, you don't want to ruin your images with your mates.
>
> *M: (Right. What kind of image would this be?)*
>
> R: Don't know, sort of a macho image isn't it, you've got.

R: 'Cause if you walk up to a friend and say, "Look, I'm going to shag me girlfriend and I'm a virgin, what am I going to do about it?", they're going to laugh at you.

R: So there's no point speaking to your mates, is there? (laughter) [M02:09][13]

Similarly, some young men's reluctance to use sexual health services for advice and information may be explained by issues around masculinity. This includes the need for a young man to be highly knowledgable about sex (raised in section 3.1.1), and an unwillingness to expose weakness by admitting to needing help or advice, as these respondents discuss:

R: I think on some things a bloke would feel like he couldn't talk to anybody 'cause he'd feel really stupid for letting it actually happen.

R: Yeah (lots).

R: But a girl you ... I don't know, they probably feel stupid for letting it happen, but they'd be able to talk to someone because it's just sort of ...

R: Yeah, it's more acceptable for girls, I suppose.

R: Well, something like that. [M01:22]

7.3 IMPRESSIONS OF SERVICES

7.3.1 Previous research

a) Knowledge

Previous studies asking young men their knowledge of local sexual health services have usually been health authority commissioned reviews of services, or assessments of young people's health needs. These studies usually use structured questionnaires administered to a sample of local young people, often recruited through school or youth centres. Variations in sampling methods, question phrasing (in particular, whether participants are prompted with a list of local services) and a lack of differentiation of results by sex, limit their usefulness

[13] Interestingly, in another focus group discussion (M07) of the same dilemma, one respondent revealed a male friend *had* approached him regarding this exact issue.

for present purposes. Bearing this in mind, studies have found variations in young people's level of knowledge of local sexual health services, including

i)	Very high	(Campbell & MacDonald, 1996)
ii)	Reasonable	(Cave, 1991)
iii)	Fairly low	(Cooper *et al.*, 1992a; Ford, 1992b; Brown & Hardaker, 1993; MacKintosh & Eadie, 1993; Peckham *et al.*, 1996).

Variations have been reported by

i)	Gender	(Cooper *et al.*, 1992a; Hirst, 1994a; Peckham *et al.*, 1996 - men reporting less knowledge)
ii)	Age	(Scott, 1994 - under 16s reporting less knowledge),
iii)	Location of service	(Campbell & MacDonald, 1996 - greater knowledge of services near to school)
iv)	Type of service	(Mackereth & Forder, 1996; Peckham *et al.*, 1996 - varies).

b) Experiences and perceptions

Three studies in the 1980s investigated the ease with which men could obtain condoms from **family planning clinics.** A 1981 questionnaire survey of 1,300 family planning clinics in England and Wales found that the provision of free condoms was by no means universal. Where condoms were issued, the number given was often limited and unrelated to the needs of the couple (Chambers, 1984). Clinic staff stated finance as the main reason for not suppling condoms, followed by concerns of upsetting female clients by encouraging men to visit the clinic, and believing that condoms given to men would be resold. Two other studies, using male researchers as bogus clients, investigated how family planning clinics dealt with a man on his own asking for contraceptive advice and condoms (Howard & Whittaker, 1981; Duncan, 1987). Of the 20 clinics visited in London, most did issue free condoms, but information on the use of condoms and related topics was less forthcoming. Both sets of researchers complained of feeling uncomfortable and embarrassed when entering a clinic and waiting for an appointment, and a general feeling of being the 'odd man out'.

Has the clinic provision of sexual health services for men improved since the 1980s? Evidence from a study in the Wessex region involving focus group discussions (Cooper *et al.*, 1992a) suggests men are still unwilling to use family planning clinics. Not only are the clinics' locations and opening hours not widely known, but they are viewed as women-oriented, with some younger men also perceiving them as only providing services for older, married couples. This view is reinforced by the title - 'family planning' clinics (Chambers & Roe, 1982). Many respondents in the Wessex study knew that family planning clinics provided free condoms, but few used this service. Explanations included the perceived time and hassle involved (including providing personal information), believing that a poor choice of condom brands was available, and that the condoms distributed were cheap, poor quality and too thick.

Some men-only sessions in family planning clinics have been implemented. Men-only sexual health services introduced in two clinics in Manchester in the 1980s were quite well attended (84 attenders during 10 evening sessions), although much promotion was needed (Elton & Blair, 1987; South Manchester Health Authority Community Unit, 1989). The most common reason for attendance was to obtain condoms. Similar findings have been reported for a men-only session at a Sunderland family planning clinic, a young men's sexual health service in Hackney, London (both cited in Davidson & Lloyd, 1994), and a men-only session at a family planning clinic in Lewisham, London (Jewitt, 1995).

The most detailed evaluation of a men-only sexual health service is provided by Jewitt (1995), who describes the setting up and running of *The Brook and Men Project*. This project included two drop-in services at a community centre and at a Brook Advisory Centre, targeted at 13-19 year old men. Condom distribution was provided for clients who registered, with accompanying information on condom use and other sexual health issues. The community centre drop-in also reached other young men through theme evenings, theatre and opportunistic interventions. In the first 11 months, around 100 young men used these drop-in services, with Brook staff reporting young men were being offered a better and more appropriate service than before the Project started.

The Wessex study (Cooper and colleagues, 1992a) included discussion of how men felt about **general practitioners** as a sexual health service. Overall, and as found in other studies (Morton-Williams, 1976; Cave, 1991), most men stated they would prefer to see

their general practitioner than visit a family planning clinic, partly due to the negative perceptions of clinics (discussed above). Concerns about anonymity (especially in a small, rural community), preference for a younger doctor (more important for younger men), and the general convenience of visiting a general practitioner were views also expressed.

A few published studies have asked clients' views on the provision of services from **genitourinary medicine clinics**, collected using structured questionnaires (Munday, 1990; Rogstad, 1991; Monteiro, 1995) or semi-structured interviews (Evans & Farquhar, 1996). Issues addressed include clinic access, atmosphere, staff attitudes and preference for a male or female doctor. Characteristics of an accessible clinic identified by male clients include:

a) the option of attending without making an appointment (as most clinics offer)
b) sessions in the late afternoon and early evening when men are less likely to be working
c) a suitable location, that is, easily accessible but also discrete.

The Department of Health's (1988) Monks Report found the location, accommodation and layout of many genitourinary medicine clinics below standard. Similar problems were identified by researchers in the early 1990s (Allen & Hogg, 1993), particularly regarding soundproofing, privacy and confidentiality. The needs for a clinic to have a relaxed, non-institutional atmosphere (Thin & Lamb, 1990) and to appear friendly to young people (Cowan & Mindel, 1993) have also been suggested. Another Department of Health recommendation was that a single reception and waiting room be provided (Thin & Lamb, 1990), although this conflicts with the views of some clients who prefer separate receptions and waiting rooms for men and women (Rogstad, 1991; Evans & Farquhar, 1996). Evans and Farquhar's (1996) study found that the recommendations of friends affect likelihood of service use, and preference for clinic staff who treat clients in a friendly, respectful, non-judgemental way.

7.3.2 Knowledge

One objective of the current study is to ascertain what 'knowledge' of a service entails, sources of knowledge, and whether lack of knowledge impedes service uptake. Each focus

group was encouraged to discuss knowledge of local sexual health services[14]. Knowledge of local services varies considerably; some services are totally unknown, a few are very well known by a group, while others are 'known about' to varying degrees. What 'knowing' a service consists of, however, varies; different levels of knowledge are:

a) heard of the type of service
b) heard of a specific local service
c) heard of and have knowledge of the location of the service
d) heard of and have more detailed knowledge of the service (for example, location, who the service aims at, services available and opening hours).

For example, most respondents have heard of a family planning clinic - a familiar name used nationally. However, many are then unaware of whether a family planning clinic exists in the locality. A local service with a distinct name will not have the same recognition factor as a branch of a service operating under a well-known name.

Despite this variation, overall the level of knowledge about local sexual health services is low. The naming by the moderator of some local services resulted in silence and blank expressions on the respondents' faces. Local services best known are either a) located close to where most of the respondents live or attend school/college, or b) services known through effective promotion methods. Table 7.5 summarises typical levels of awareness, impressions and likelihood of use for the main types of sexual health services. As shown, sexual health services aimed specifically at young people are the best known, followed by family planning clinics and genitourinary medicine clinics. All respondents are familiar with general practitioners.

Discussion of details of services is dominated by assumptions and speculations from respondents who lack knowledge of the services. Some respondents know the exact location of a service, others have no idea, while others assume a service would be at a medical location, for example, a local hospital or health centre. Most respondents offer suggestions on the range of services offered, but these are based mostly upon educated

[14] Before each group, a local sexual health worker had prepared a list of local services. The respondents were first asked unprompted which services they knew of, and second were prompted on local services unmentioned.

Table 7.5 - Summary of Focus Group Respondents' Knowledge of, and Attitudes towards, Sexual Health Services.

Service	Typical level of knowledge	Impressions of range of services offered	Impressions of service	Likelihood of use
Family planning clinic	• Most have heard of the name, but are unaware of a local clinic	• Provision of contraception • Free condoms • Advice and counselling • Emergency contraception	• Women-oriented • Clinical, slightly unfriendly • Confidential	• Unlikely, but possibly for free condoms if hassle-free service
Young people's sexual health service	• Varies by specific service from very high to very low	• Provision of contraception • Free condoms • Advice and counselling • Pregnancy testing	• Women-oriented • Friendliness and warmth varies by specific service • Confidential • Anonymous	• Yes, for free condoms if hassle-free service
General practitioner	• Universal	• Provision of contraception • Advice and information • Tests for sexually transmitted infections	• Not anonymous • Friendliness varies; affected by prior relationship with GP • Too busy for counselling and advice	• Varies; some will for crisis situation, others less likely
Genitourinary medicine clinic	• Very low - some respondents more familiar with term 'VD clinic' or 'Aids clinic'	• Tests for sexually transmitted infections, including HIV/Aids	• Medical, unfriendly • Painful medical tests	• Yes, if had symptoms of a sexually transmitted infection

Note: This table only summarises some common themes reported in the group discussions. It does not accurately reflect the diversity of views reported.

guesses. The types of services most associated with sexual health services, shown in Table 7.5, are free condoms, advice, information (verbal and written), counselling, pregnancy tests, emergency contraception and tests and treatment for sexually transmitted infections.

Respondents who did know of a local service were asked for the source of that information. This is useful to identify the pathways through which details of a service may be transferred, discussed in section 7.4.1. A range of sources are evident, including (in approximate order of frequency of mention):

a) Friend, word of mouth
b) Visiting speaker (at school, college or youth club)
c) Poster, leaflet, flyer or business card
d) Sign outside the service
e) Girlfriend, older sister
f) School or college
g) Youth worker
h) parent, older relative
i) radio or television advertisement.

Lacking knowledge of a service may not be a hindrance to service use, however, as some respondents are confident that they could easily find out the information if need be. This is an important point; a low level of knowledge of a service for does not necessarily imply a lack of awareness or interest, merely that the young men would consult secondary sources of information if they wanted to use the service. Secondary sources include a telephone directory (an easier task if they already know the service's name) and a leaflet or poster (assuming they know a location where posters or leaflets are likely to be, discussed in section 7.4.2). Another option is to ask someone for that information, particularly the experts and confidants identified in section 7.2.2, or a female friend or girlfriend.

7.3.3 Experiences and perceptions

The level of service use among the focus group respondents, shown in Table 7.6, is determined from their responses to the short questionnaire completed at the end of each group:

Table 7.6 - Focus Group Respondents' Use of Sexual Health Services.

Question	Percentage reporting 'Yes' (n=74)
Have you ever visited/used a family planning clinic?	29%
Have you ever obtained contraceptives from a G.P. (doctor)?	14%
Have you ever visited/used a Brook Advisory Centre?	8%
Have you ever used a youth advisory or counselling service?	14%
Visited or used at least one of the above	*42%*

This level of service use is high as compared with national data reviewed in section 7.1, for example, 29% of the sample reporting visiting or using a family planning clinic. However, the current data are whether a respondent has *ever* used a service, whereas national data record use over one year. Two other factors contributing to the high level of service use are a) interpretation of the question - the phrase 'visited or used' allows for reporting of group visits organised through schools or youth clubs, and b) the study's recruitment scheme (see section 2.3.2) may have resulted in an over-representation of service users.

Nevertheless, it is useful to see whether respondents reporting use of a service have different characteristics to those report non-use, shown in Table 7.7. Both groups have similar ages and occupations, however difference exists in reported sexual behaviour. Respondents reporting having ever used a sexual health service are *more* sexually active than those who report having never used a service. More of the former group report ever having sex, having had sex before age 16, and report a higher median number of sexual partners. Ever-users of a service are also more likely to report usual use of contraception and occurrence of unprotected sex, two indicators probably reflecting their higher level of sexual activity.

Table 7.7 - Comparison of Focus Group Respondents Reporting Ever-Use and Never-Use of a Sexual Health Service.

Characteristic	Ever-use of a sexual health service	
	Yes	No
Age		
≤15	13%	7%
16	35%	23%
17	23%	35%
≥18	29%	35%
Median	17 years	17 years
Base (100%)	*31*	*43*
Occupation		
School or college	61%	70%
Work	9%	5%
Looking for work	23%	21%
Other	6%	5%
Base (100%)	*31*	*43*
Have you ever had sex?		
Yes	93%	68%
Base (100%)	*31*	*43*
Of those reporting having had sex		
Sex before age 16?		
Yes	71%	56%
Base (100%)[1]	*24*	*27*
Number of sexual partners		
1	33%	33%
2	8%	24%
3	8%	24%
≥4	50%	19%
Median	4	2
Base (100%)	*24*	*21*
Usual use of contraception?		
Yes	82%	73%
Base (100%)	*28*	*26*
Usual source of contraception		
Family planning clinic	39%	
General practitioner	9%	19%
Vending machine	35%	59%
Chemist	22%	33%
Other	30%	10%
Base (100%)	*23*	*21*
Had sex without using contraception?		
Yes	77%	57%
Base (100%)	*26*	*21*

[1] - Excludes seven respondents who were aged below 16 at the time of focus group.

The mix of ever-users and never-users of sexual health services in the focus groups produces a range of experiences and perceptions of services. Respondents who have not used a service report their perceptions based upon any prior knowledge (from sources considered in the previous section) and any assumptions or intuitive guesses. Combining these perceptions with the experiences of respondents who *have* used a service produces information on what image a service should promote, and the quality and scope of services. The last two columns of Table 7.5 summarise typical impressions of specific health services, and are elaborated upon below.

First are the **characteristics of clients** (including age, sex, and relationship status) the service aims to attract. A common theme in the discussions is that although services are recognised as theoretically available to both sexes, they are more oriented towards, and therefore likely to be used by, women. This bias is explained in groups with reference to three factors:

a) the types of services offered are women-oriented (for example, contraceptive provision, pregnancy tests and advice and information)
b) women are in greater need of sexual health services as they are at risk of conception
c) women are more careful and safety conscious in sexual activity than men.

Views b) and c) expressed in the group setting contrast with the views of the interview respondents in Chapter 6. It appears attitudes towards contraceptive responsibility and risk-taking may be reported differently in the public and private domain.

The **name** of a service also suggests the nature of its intended client base. The inclusion of 'young person' or 'young people' in the title (or subtitle) obviously suggest the service is aimed at young people. Some groups interpret the phrase 'family planning' as implying that the service is aimed at couples and older people in stabler relationships, as this extract illustrates:

> *M: (You don't think people your age would go to [the family planning clinic]?)*
>
> R: Not yet, not until we started family planning, and that's when we'd go basically.
>
> R: You've got to settle down, and then the girl who you're with, you've got to be with her for at least six years.

R: Settling down - that's when you're planning. [M07:42]

Two other examples of the influence of a service's name; one respondent interprets the phrase 'drop-in' as suggesting *"it was just for old people if they just want to drop in and have a cup of tea"* [M02:37]. Another group jokingly surmise a genitourinary medicine clinic is involved with dentistry as the initials spell 'gum'.

Second is the ease with which a young man feels he can **enter** a service. As service staff confirm, one of the most difficult aspects of using a service is crossing the service threshold for the first time. This may be difficult for younger men at the start of their partnership history who are embarrassed about using a (what is perceived as women-oriented) service and do not want to be seen entering by their friends. Although a potential user will form an impression of the reception they are likely to receive from a service, it is still very much unchartered territory. While some respondents think a service entrance should be obvious and clearly marked (to enable easy access and act as promotion for passers-by), others feel a discretely located and unmarked entrance is more appropriate:

R: [The clinic] is in the middle of town.

R: But then again it has to be accessible.

R: Aye, it's the best place for it, like, you couldn't stick it out in the suburb.

M: Damian?

R: If you're in the middle of town and you're walking in like, I mean there's hundreds of people walking round and how do you know one of them's not your mum or your dad? You're walking into the family planning and like you get home and, "Where were you this afternoon?", "Oh, just ...", you know, it's got to be a bit out of the way there. [M04:39]

Other worrying aspects of entering a service are whether a user has to ask an intermediary receptionist, and inform staff immediately of their reason for attendance.

One strategy young men have been observed to use in their initial (and possibly, subsequent) use of sexual health services is what may be termed as 'safety in numbers'. This refers to when a group of young men enter a service *en masse*, with associated bravado, boisterousness and sometimes intimidating behaviour. This strategy may be used to overcome any embarrassment members of the group have using the service on their own, to

test the staff on what is acceptable behaviour, or as part of normal, male social group 'messing about' behaviour. Service staff have written of the difficulties in dealing with this behaviour and the disruptive effect it can have on female clients present (Frater, 1985; Nyman & Metcalf, 1991; You 2, 1993; Jewitt, 1995). However, with men-only sessions, or disaggregating the group by taking members into another room for individual or small group counselling, behaviour can become more cordial, as this service provider discusses:

> "By the time the boys reached the counsellor's room, they were considerably chastened, partly because we saw them in only smaller numbers and they lost group support, and partly because it soon became apparent that it wasn't necessary to keep up the macho image in front of a lone woman counsellor." (Frater, 1985, p.9)

Related to the ease of entry into a service is a third factor, the perceived **ambience** of a service. Services are rated by respondents on a scale of warmth, friendliness and clinicalness. At one extreme are services perceived (or based upon experience, reported) to be 'cold', clinical and generally unfriendly. Respondents who have not visited a family planning or genitourinary medicine clinic imagine these services would have this atmosphere, an assumption reinforced by their medical and sanitary titles. The latter service also provokes unpleasant images in this group of painful medical tests on the penis:

> R: I don't know personally, it's just what I've heard, like the pain and the treatment what you have, like they've got like this umbrella thing and they ...
>
> R: Upside down.
>
> R: Yeah, and pull it out and like it scrapes it all inside. If they told you all that, you wouldn't be as likely to go sleeping round with anybody, would you? [M08:06]

Young people's sexual health services are assigned more mixed impressions, although most are rated as more friendly and welcoming than family planning or genitourinary medicine clinics. One focus group [M05] was conducted in a young people's sexual health service that most of the respondents had heard of, but none had visited or used. This provided an opportunity to compare the respondents' prior impressions to subsequent views having seen the interior of the service. Before the focus group, the respondents imagined the service would be *"cold"*, with *"lots of desks and tables"*, *"lots of leaflets"* and *"all women"* [M05:30]. However, the group seem surprised on entering the service, calling it *"pleasant"*, *"not too bad at all"*, and *"cosy"* [M05:31].

Although groups seem to prefer a service with a friendly, warm atmosphere, a danger is if the service appears too friendly and keen to involve a young man. Some respondents want contact time with a service to be as short as possible[15], with no personal questioning or counselling from service staff. In this extract, the group construct a metaphor of a police interrogation for a hypothetical visit to a service:

> R: [They] take you into this little room and put you on a bean bag and then ... (laughter)
>
> R: And they lock the door, and say "Do you want to talk about it?"
>
> R: It's a bit of an intimidating atmosphere for a 14 year old 'cause like there's loads of people sat round having coffee there, and then they take you off to a little room and like there's a wooden chair in there, it's crude, some guy walks round ... (laughter)
>
> R: A spotlight shines in your face.
>
> R: Another mirror hanging on the wall, two way mirror hanging on the wall.
>
> R: Yeah, and then they just like say "What do you want?", and you say, "Can I have some condoms real quick, I want to get out of here."
>
> *M: (All right, so you're saying it's not really a friendly atmosphere?)*
>
> R: Yeah, it's over friendly though, it makes you want to cringe. [M09:26]

Contrasting themes are present in this extract; on the one hand, the service has features associated with a friendly and welcoming atmosphere (people talking, having coffee, bean bags). However, the humorous metaphor of the 'interrogation' that occurs in the consultation room implies the approach is too friendly and involving for the simple requirement of obtaining condoms.

Continuing this theme of the ambience of a service is the fourth factor, the characteristics of service **staff**. For respondents who had not visited a sexual health service, a stereotypical image of a staff member is a woman who is old, patronising (that is, dealing with the young person as a child, not an adult) and judgemental (that is, exhibiting a disapproving attitude towards young people's sexual behaviour). The following two extracts, on the topic of family planning clinics, illustrate these images:

---

[15] This contrasts with the view that a problem with general practitioners is that they are too busy and cannot spend enough time with a patient.

a) R: The staff are old nurses who leer at you because you're young.

R: "You shouldn't be doing that at your age, sonny."

M: (Do other people feel this?)

R: A big fat matron like in the 'Carry On' films. (laughter) [M01:32]

b) R: It's seats and rows and it's just offices, and it smells like a hospital really, you're sitting in rows of chairs, like wooden chairs.

R: And when you go there to get free condoms, there's this big woman who comes out and she looks all disapproving of you, the way she looks at you.

R: She looks at you as if you're, like, heathens. [M05:33]

While some groups express preference for a staff member with the experience and expertise seen to come with age, they also prefer someone without morally disapproving beliefs associated with older generations, and someone who is young enough to understand the lifestyles of current young people. Although all-female staff is felt to reinforce the image of a women-oriented service, a staff member's gender is rarely raised in groups as an important issue.

A final consideration is issues relating to a young man's **anonymity** when using a service, and whether a service is **confidential**. Referring to section 7.2.2, views differ on whether it is easier talking about a problem to a known or unknown health professional. Although in the minority overall, respondents who would prefer to speak to a service provider they personally know report they would visit their general practitioner. A concern with using a general practitioner is whether the visit would be confidential, that is, the doctor (or practice nurse or receptionist) would not tell anyone (particularly the young man's parents) about the visit's purpose or outcome. If the doctor knows the young man's parents, for example, in a small, rural community, this becomes even more of a concern. Groups disagreed on whether legally, doctors are required to maintain confidentiality. Generally, doctors are thought to be less confidential than other sexual health services, particularly young people's services and genitourinary medicine clinics[16].

[16] The high degree of confidentiality associated with genitourinary medicine clinics may be due to their provision of HIV tests, a service known to be confidential and anonymous.

Confidentiality is important for many respondents, but perhaps not to the same extent as identified among young women (Allen, 1991; Cooper *et al.*, 1992a). This may be because young men are less concerned about being identified as sexually active (as discussed in sections 4.3.2 and 5.6.3, a desirable indicator in some male social groups), or because men are less likely to use a service for advice and counselling when confidential information may be revealed.

As raised in section 7.2.3, the one service young men express most interest in is the provision of condoms. Getting anything free, particularly items that are not cheap, is bound to be an attractive proposition. However, some groups discuss associated financial and personal costs that outweigh the advantage of obtaining condoms free. First are travel costs, a factor for young men who have to travel by public transport to reach a service located in a city or town centre:

> R: No one can really be bothered to sit on a bus for ages and spend their money just to come up city.
>
> R: To get some free rubbers and go home. (laughter)
>
> R: It's not worth the hassle.
>
> R: You might as well just go in the corner shop and buy a packet, it's the same money as you're paying to come up here. [M02:26]

Second are the perceived personal costs and hassle a service inflicts on a young man before providing condoms. In this group discussion, the respondents have considered obtaining condoms from a service, but were dissuaded because of the need to provide personal details:

> R: You have to fill those forms out as well, that's why we never went, they wanted personal stuff.
>
> R: What about?
>
> R: Can't you refuse them?
>
> R: They put you down on a computer and then you get the condoms. [M08:27]

An unwillingness to provide personal details could be related to

a) concerns about confidentiality, for example, whether the service would send any letters to a young man's home address

b) concerns that the service staff may ask questions on a young man's sexual behaviour

c) believing it is a general invasion of privacy.

The last respondent's assertion that the service *"put you down on a computer"* may suggest a concern about data privacy and therefore confidentiality. However, respondents in other focus groups are aware some services allow false names and addresses.

7.4 PROMOTION OF SERVICES

7.4.1 Introduction

The importance of effective promotion strategies to increase knowledge of a sexual health service and encourage service uptake is clear (Aggleton *et al.*, 1996; Mackereth & Forder, 1996). However, little is known on the extent and success of current promotion strategies (Allen, 1991), with the subject given only a cursory mention in the 'Family planning provision for young people' section of *The Health of the Nation HIV/AIDS and Sexual Health Key Area Handbook* (Department of Health, 1993b). The current government's commissioned report on teenage pregnancy (Social Exclusion Unit, 1999), however, identifies publicity as one of six key principles of effective young people's sexual health services).

Few published studies have asked clients how they heard about a sexual health service, particularly male clients. The most important source of information about services reported by clients is word of mouth, usually from friends, but relatives, neighbours and work colleagues have also been cited (Southampton and South West Hampshire Health Authority, 1991; Trickett, 1991; Jewitt, 1995). Eighty percent of clients interviewed by Allen (1991) reported being told about the service by someone. Of clients in Allen's study who reported seeing direct publicity, the most common methods were a phone book, poster, leaflet or business card. Few of the young men who used the *Brook and Men Project* described in section 7.3.1 had heard of the service by direct publicity. This was despite a promotion campaign that identified locations where young men spent time, and the distribution of many posters and leaflets (Jewitt, 1995). Referrals from a general practitioner, a general

practitioner's receptionist, other health clinics and school welfare officers have also been reported by service users (Allen 1991; Trickett, 1991).

Taking the alternative perspective, Table 7.8 displays information on the methods of promotion used by sexual health services. This table is constructed from two studies: Aggleton and colleagues' (1996) compendium of 82 young person's sexual health services, and Peckham and colleagues' (1996) research paper that collated responses from 175 family planning clinics and 'projects'. As these two studies used different methods, the table columns are not strictly comparable. Looking at both studies, most services report providing outreach work, that is, visiting schools, colleges and other youth organisations to give talks, run workshops, and so on. Posters, leaflets, flyers and booklets are the next most used methods. Between 8% and 20% of services report 'word of mouth' as a method of promotion. Although service staff report this method as the most important way young people hear about a service (Peckham *et al.*, 1996), they may not acknowledge it as a formal method of promotion, thus reflecting its low prominence in these two studies.

The rest of this section considers the groups' views on effective methods of promoting sexual health services to young people. The moderator encouraged discussion of promotion targeted at young men *and* young women. However, as the respondents are young men themselves, most discussion centres around promoting services to young men as opposed to young women.

A range of methods of promotion is suggested and discussed by the respondents, including (in approximate order of popularity):

a) Posters and billboards
b) Visiting speakers
c) Leaflets and flyers
d) Magazines and newspapers
e) Radio and television
f) Sign outside service
g) Visits, open days and special events
h) Stickers and business cards

Table 7.8 - Percentage of Sexual Health Services Reporting Using Methods of Promotion.

Method	(1) Young people's sexual health services	(2) Family planning 'projects'[1]	(3) Family planning clinics
Schools/colleges	78	33	62
Posters	69	80	82
Leaflets/booklets/flyers	65	93	84
Youth clubs	61	71	52
Telephone line	54	.	.
Newspapers[2]	37	41	41
Promotional events	33	3	4
Business cards	28	.	.
Telephone directory	28	75	75
Magazines[3]	17	30	11
Radio	17	46	22
Word of mouth	15	20	8
Nightclubs	11	.	.
Television	2	15	3
Others[4]	< 5	< 5	< 5
Base (100%)	*54*[5]	*74*	*101*

. - not asked. Percentages add to more than 100 as multiple responses allowed. Comparisons between the three categories of services are not strictly possible as column (1) is based upon unprompted responses, whereas columns (2) and (3) are from prompted responses.

1 'Projects' are youth advisory or contraceptive services that are not family planning clinics.
2 Includes advertisements, articles and advice columns.
3 Includes school, music, nightclub, church, festival and youth magazines.
4 Includes stickers, mailouts, professional referral, workshops/training, networking, directories, beer mats, wall planners and calendars.
5 Aggleton and colleagues' compendium lists 82 services; however 27 services are described jointly and 1 service reports no methods of promotion.

Sources:

Column (1) - Aggleton, P., Chalmers, H., Daniel, S., & Warwick, I. (1996). Promoting Young People's Sexual Health. A Compendium of Family Planning Service Provision for Young People. London: Health Education Authority.

Columns (2), (3) - Peckham, S., Ingham, R., & Diamond, I. (1996). Teenage Pregnancy: Prevention and Programmes. Research Paper. University of Southampton: Institute for Health Policy Studies and Centre for Sexual Health Research, Table 3.13.

This section does not consider each method of promotion individually, but identifies the common themes underlying all methods. Readers interested in more information on specific methods are referred to Pearson and colleagues (1996).

7.4.2 Locations

Choosing locations for placing promotional material should have the basic aim of ensuring that young men will see or hear the message. To achieve this, information is needed on where young men spend their time, best done by asking young men themselves. Adult perceptions on the issue may not always be accurate, as these respondents discuss:

> *M: (Football magazines, that was another idea you came up with.)*
>
> R: It should [be] though, because that's what boys read mostly, you know what I mean?
>
> R: That's what they're interested in.
>
> R: They're not interested in, like, youth clubs and stuff like that. [M04:45]

The groups identify a range of locations where young people are likely to spend time, including:

a) Schools and colleges
b) Cafes, fast-food and chip shops
c) Shopping centres
d) Youth clubs and centres
e) Bars, pubs and nightclubs
f) Leisure and sports centres

Within these categories, individual establishments will be more popular and frequented by young people, for example, certain pubs and nightclubs. Less formal but potentially equally frequented gathering places (for example, outdoors on the streets, in bus shelters, parks, recreation grounds) may also provide useful locations. One group suggests lamp posts as some young men spend much time 'hanging out' on streets.

The need to identify appropriate locations based upon young people's views is also apparent in the discussion of print media. Local newspapers are identified as good sources for promotion, although which newspapers and sections of the paper young men are most likely to read (for example, television listings, entertainment, sports and advice sections) need to be clarified. The discussion of magazines returns to a theme of section 3.1, with different learning sources available to young men and women. As discussed in this extract, some respondents feel that young women are fortunate to have a wider selection of magazines available to them:

> R: [Girls] have got a start, they read magazines as well, like 'Just 17' and things like that.
>
> R: Aye, problem pages and all that rubbish.
>
> R: Yeah, boys' magazines have just got 'Shoot' and 'Noddy'.
>
> R: But by the time you start buying them you know most of it anyway. You don't get like a problem page in 'Roy of the Rovers'! (laughter) [M04:05][17]

Leading on from the discussion of how young men make decisions about their sexual health and the role of information-gathering (section 7.2), two contexts for locating promotional material can be identified: situations in which a young man **actively** seeks information on a service (for example, through a phone directory or leaflet rack), and **passive** situations in which a young man is exposed inadvertently to promotional material (for example, a poster or radio advertisement). Most discussion in the focus groups revolves around passive exposure, but the importance of covering active locations for promotion is stressed. The pathways young men may use when seeking information about a service (identified in section 7.2) can also serve as repositories of information. If a young man knows the name of a service, the need for a clear and appropriately listed entry in a phone directory is essential. Other locations where respondents expect promotional material to be available include libraries, doctors' and dentists' surgery waiting rooms, and noticeboards in schools, colleges and youth clubs.

Underlying both passive and active exposure to promotional material is the need for the material to be located in a **safe** environment, that is, somewhere a young man can access

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[17] Although football magazines, fanzines or programmes were identified in groups as potentially useful material for promoting local services to young men.

information discretely and confidentially. Ideally, he should be able to find out about a service without anyone else (friends, parents) aware he is doing so. Two themes identified previously help to explain this requirement. First, as discussed in section 3.1, some young men feel they are expected to be knowledgable about sex, and therefore not in need of information on sexual health. Second, societal and peer influences prohibiting use of health services (considered in section 7.2) may also prohibit seeking information about a health service. Some groups also raise the embarrassment around sex evident in British society to explain need for 'safe' promotion locations.

Two ways in which promotion can be made 'safe' are to be in *private* locations (for example, a sticker on the back of a toilet door) or in *universal* locations (for example, a poster in a shopping centre, a visiting speaker giving a leaflet to every pupil in a class). Discretely viewing material in a universal location may still be difficult, as these respondents discuss concerning a poster with the word 'sex' displayed prominently:

> R: If you saw [poster 4] in the street and there was a crowd of people and you went over and looked at it, you'd get the piss took out of you 'cause you're looking at a sex poster.
>
> R: That's a bit ...
>
> R: You wouldn't have the courage to look at that along the street, would you?
>
> R: ... I suppose if I was stood there waiting for something and there was a poster on the wall, then I would have a look at them, maybe.
>
> R: Like at a bus stop or something.
>
> R: I wouldn't just stop and read them, I think I'd just pass it on, just leave it there and walk past it. [M07:68]

If the promotional material is designed sensibly, however, a young man can discretely access the material in a universal location. A crucial aspect of poster design is ensuring important text (particularly contact details) is legible from an appropriate (that is, not too close) distance. Another example of a safe, universal context for locating promotional material is radio. Groups discuss how much they listen to the radio at home, in cars and workplaces, and that good, frequently aired advertisements are remembered well. The medium is 'safe' as a young man can listen and learn without anyone aware he is doing so.

7.4.3 Messages and information

As discussed in section 7.3.3, young men construct vivid images and perceptions of sexual health services, the context within which service provision occurs, and the range of services offered. To reach a target audience of young men effectively, therefore, the content of promotional material should aim to:

a) promote positive aspects of service provision
b) counteract any negative perceptions
c) promote the services young men are most interested in
d) provide contact details about the service to facilitate service use.

How much information can be included in promotional material depends on the specific method, with limitations usually necessary. Messages and information need to be prioritised, with the quantity of information included dependent on the media. While a leaflet or booklet can include a large amount of information, much less space is available on a sticker, so careful prioritisation is needed.

One theme underlying all media is a desire for honesty and clarity, that is, clearly stating the nature of the service. Across all focus groups, respondents bemoan the inordinate amount of embarrassment around sex in British society. Therefore, promotional material that is honest about offering a service around sex is viewed positively, and presents a refreshing change from other institutions' (for example, the media and television) dealings with sex.

Disagreement is apparent on whether the messages of promotion should stress positive or negative aspects of service provision. One argument is that promoting aspects with negative connotations (for example, using the words 'problems', 'diseases' or 'pregnancy tests') results in a pessimistic, downbeat message. This is particularly inappropriate if the promotional material is located in an environment usually associated with pleasure and enjoyment, as illustrated by this discussion on beer mats. Advantages of putting promotional messages on beer mats are that the pub and club scenes are popular with young people, and some people collect beer mats. However, concerns are raised if the message is too explicit or negative:

M: (How about the idea of, beer mats were mentioned, would that work?)

R: No, it would put you off your pint, wouldn't it?

R: Herpes.

R: You're out with your mates on a Saturday night ... and you're sitting there and you're having a good laugh and you pick up your beer mat, like your pint and you go [mimes action of reading beer mat], everyone will be cracking on, won't they?

R: Yeah, and like you go out and have a few drinks like and you're dead set on pulling a woman, but when you see like 'herpes' and all that you think, "No, can't be bothered now." [M09:43]

However, a contrasting argument put forward by other respondents is that an effective way to increase service uptake (particularly from young men) is to highlight the risks associated with sexual activity, and how use of a service can mitigate those risks. Respondents suggest using messages associated with HIV and Aids, other sexually transmitted infections and unintended conceptions. This reflects familiarity with seeing health (particularly sexual health) promotion materials that include similar, risk-oriented messages. Indeed, this idea is in line with current government thinking - a main recommended action of the Social Exclusion Unit's (1999) report on teenage pregnancy for 'boys and young men' is a national publicity campaign stressing contraceptive responsibility and unwanted outcomes of sexual activity.

Related to the mood of promotional material is the need for a message not to be given in an authoritarian or patronising tone, a context the groups associate with being 'lectured at' in school or from parents. This removes the message from the critical and judgemental context respondents associated with typical health promotion (for example, anti-smoking posters) and places it within a setting that treats a young person more maturely by offering choices, rather than prescribing behaviour.

Regarding specific words and phrases to include in material, a popular suggestion is to use the word 'sex' as an eye-catching, focal point. 'Sex' is acknowledged to be a powerful, captivating word that always merits attention:

'Sex' is a big word, isn't it, it get's people's attention. You mention the word 'sex' in the middle of a conversation and then everyone just turns round and looks at you. [M02:42]

However, using the word 'sex' on promotional material can have drawbacks. First, a person viewing the material might think the word 'sex' has been included just as a cheap selling point, as happens, for example, in advertisements in music magazines and comics. Second, this approach undermines the need to access information discretely, as the subject of the material is obvious to other people at the location.

Other words and messages deemed to be important to include on material reflect the image a service should present. Words viewed positively include 'personal', 'confidential', 'private' and 'friendly'. To promote an informal atmosphere, content should avoid giving the impression that the service is medically oriented. Similarly, it should be clear the service is aimed at young people.

Not surprisingly, group ideas for promoting services on offer mirrors their suggestions about what services they are most likely to use, discussed in section 7.2.3. Stating 'free condoms' are available is the most popular suggestion, followed by messages relating to general services such as 'advice' and 'information'. Although some suggested messages are not directly applicable to young men (for example, pregnancy and smear tests), this is not raised as an issue.

The groups expect certain information to be present in any promotional material, particularly when space is clearly available. Posters lacking clear details on how to contact or locate a service are criticised. Although some materials are more limited in space than others, where possible the following information should be included:

a) Name of the service
b) Phone number of the service
c) Address of the service (plus a small location map if space is available)
d) Services offered (does not have to be fully comprehensive)
e) Opening days and times

7.4.4 Styles and images

Unlike consumer goods, a sexual health service usually does not have to compete with other sexual health services to obtain clients. However, some methods of promotion will be in locations where they *do* have to compete for a person's attention. A poster on a noticeboard is likely to be surrounded by many other posters, each publicising their own message. Promotional material in competitive environments, therefore, needs to be stylish, modern and attention-grabbing. This is especially important for current cohorts of British young people who have grown up in a consumer-driven society in which media and advertising play important roles. For example, focus group discussion of promotion is sometimes referenced to memorable poster or television advertisements current at the time of the group, (for example, shock tactics in Benneton and drink-drive advertisements). Groups stress the importance of ensuring the design and concept of promotional material are trendy and interesting, aspects sometimes more important than the information content included:

> *M: (Does [poster 1] give a level of information or does it tell you ... ?)*
>
> R: It doesn't matter, it could have all the information in the world on it but you're not going to read it 'cause it's so boring.
>
> R: Yeah, you need something short and to the point. [M09:52]

Based upon the discussions, attributes of effective and non-effective promotion design can be identified. In some respects, the suggestions mirror designs used in consumer advertising, although the sensitive and personal aspects of promoting a sexual health service are relevant. First is the need to maintain an appropriate **balance** between the information and the overall design and feel of the media. Promotional material that concentrates on providing information to the detriment of style (for example, a poster consisting primarily of text with few images) is very unpopular. Promotion needs to be taken out of a purely information-giving context and incorporated into the context young men are more accustomed to receiving messages in - the style-conscious domain of consumer advertising. Elements of visual promotional material contributing to its style include the brightness, mix and contrast of any colours used, the choice of any slogan or headline, the balance between text and images, and the shape and size of the material.

Second, the use of **humour** in promotional material generally is applauded by the respondents, provided it is funny and used appropriately. Humour can help to overcome any embarrassment associated with sex, and ensure the promotional material is noticed and remembered. This extract discusses a poster with a cartoon picture of trouser flies and the slogan 'Flies can spread diseases':

> R: And the funniness of that one, 'Flies can spread diseases' - you see that bit and then you want to read the rest of it.
>
> R: Using humour to get it across.
>
> R: [Sex] is generally regarded as very embarrassing.
>
> R: So if you can get people to laugh about it, they're going to be more open about it and read it.
>
> R: [You] feel more comfortable if you're enjoying yourself and you're joking, don't you? [M02:56]

However, humour should be used carefully. First, some aspects of service provision such as counselling and advice on 'crisis' situations (for example, contraceptive failure, sexually transmitted infections) can be very serious for the person involved. Dealing with these issues lightheartedly is inappropriate and in poor taste:

> R: That's the thing, I mean [poster 6] catches your eye initially with the, sort of, funny side of it, but then it gets more serious with the 'VD' bit.
>
> *M: (That's good?)*
>
> R: Aye, it's got to be good.
>
> R: ... You wouldn't be laughing if it was you though, would you?
>
> R: You don't want to make it too comical.
>
> R: No, but just the slight ... [M04:60]

Humour must also be funny. Groups had varied reactions when presented with promotional material using a 'humorous' theme. Some respondents plainly fail to get the 'joke', resulting in the promotion message being overlooked. Reactions also varied by geographical location of the focus group, reinforcing the need to test material with local young people.

Third, the use of **images** in visual promotional material was discussed a lot in the focus groups[18]. Generally, the groups applaud using images providing they enhance and relate to the message of the promotion. Images on some example promotional material used in the groups are seen as irrelevant to the service being promoted, or the people at whom the message is targeted.

Most discussion of images centres around photographs, as a series of photographs (listed in Appendix 5) was introduced as prompts in the focus groups. However, cartoons and line art drawings are also suggested, the former favoured by young men interested in comic and graffiti art. One advantage of non-photographic material is they are less likely to visibly 'date', giving the material a longer shelf-life. Cartoons can also display more explicit or possibly contentious images of sexual health than photographs.

One image subject felt to be appropriate for promotional material is a photograph of young people. The use of this image is felt by respondents to

a) ensure the promotional material is interesting and noticed
b) suggest the service is aimed at young people
c) reinforce a welcoming and friendly atmosphere for a service.

The characteristics of the young people in the photograph need to be chosen carefully. Preference is expressed for 'normal' young people as opposed to models. Models' polished appearances are criticised in this group:

> *M: (Any thoughts on that, having these people on the poster?)*
>
> R: They're too perfect. They're too perfect.
>
> R: You want to use everyday people, like that, or not perfect.
>
> R: People with, like he said, a few spots or something. They're all perfect. Not one of them's got a scar or a blemish, nothing facially. [M07:80]

Although the groups prefer images without models, they also state that any young people featured ought to have model-like qualities, in particular young women should be quite

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[18] This was because an objective of the original research steady was to gauge reactions to a series of photographs being considered for inclusion in promotional material.

attractive[19]. Attractiveness is gauged by features including facial and body appearance, clothing and hairstyle. Respondents are quick to notice and criticise clothing or hairstyles perceived as out-of-date, and clothing that young people rarely wear (for example, too expensive or perfectly new, clean clothes). Similarly, images of a normal, everyday setting are preferred to photographs obviously staged in indoor studios. Cafes and outdoor locations are liked as they are associated with chatting and talking, a positive image for promoting a service offering advice and information:

> R: [Photo 2] would be good for a drop-in service 'cause it's a very informal chat, it's a chat around the table, sort of thing.
>
> *M: (Yeah?)*
>
> R: This is the kind of thing that happens as well like, you see a bird that's passing, you might just give her a nice smile and chat to her.
>
> *M: (Right, so real, life like?)*
>
> R: Mmm. [M02:62]

The respondents prefer images of groups of young people of both sexes as opposed to single portraits. This format is felt to be more natural and appealing to a wide range of potential service users. An image of *only* young men is unpopular as it suggests the service is aimed at gay men. One grouping receiving many positive comments is one or more male-female couples, although not posing too 'couple-like' as to imply the service only caters to people in steady relationships. Having the couples talking or chatting to each other is commended for two reasons. First, it gives the impression of a natural situation in which people are discussing a problem, linking the image to the service being promoted. However, the people in the image should not look *too* serious or worried, but have a friendly, smiling demeanour (although not *too* 'smiley' as to suggest the service does not take a client's problems seriously). Second, some respondents liked the image of a male-female couple talking as it gives an impression that the man is 'chatting up' the woman. It needs to be clear, however, that the man is succeeding; for example, the woman is smiling or holding hands with him.

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[19] This, however, has the reported disadvantage of increasing the chance that a young man would deface or remove the material for a souvenir.

7.5 SUMMARY

a) Apart from genitourinary medicine services, use of sexual health services by men is low. However, an increase has been observed over the 1990s. National client data underestimate male service use as they do not reflect men attending as part of a heterosexual couple.

b) Qualities of good confidants for discussing sexual health include health professionals with expertise, or close friends who can be trusted to remain confidential. Gender roles around masculinities may prohibit some young men from admitting they need advice and information on sexual health, and therefore use of a service.

c) Respondents are most likely to attend sexual health services for routine or crisis reasons, particularly free condoms. Service use is more likely from focus group respondents reporting more sexual experience.

d) Knowledge of local sexual health services among respondents is low. However, lacking knowledge is not necessarily a barrier to service use.

e) A common reported stereotype of a sexual health service is still a female-oriented, clinic-based service. Scope exists for services to be made more youth-friendly and male-friendly. Provision of condoms to young men initially should be quick and free of hassles.

f) Young men may actively or passively view promotional material. Both contexts should be 'safe', so a young man can discretely access information.

g) While promotional material needs to contain basic details, the overall style and design need to catch a person's attention and promote a positive image of a service. Service promotion is judged alongside consumer advertising and other health promotion messages. Therefore, service promotion material needs to match the high standards of appearance, style and images seen in these media.

CHAPTER EIGHT - CONCLUSION

8.1 INTRODUCTION

As stated in Chapter 1, this thesis aims to increase understanding of young men's sexual behaviour and use of contraception, and to provide policy-relevant information to help young people live healthier sexual lives. This final chapter draws out the conclusions from the thesis, and discusses their meanings and importance. Suggestions are made for how findings can be incorporated into education, health promotion and health service provision to help improve young people's sexual health. The chapter sections are organised and labelled to coincide with the five results chapters (3-7), and two final sections reconsidering the theoretical perspectives and suggesting future research on this topic.

Although the thesis restricted itself to addressing a limited number of objectives, many, diverse aspects of young men's lives have emerged in the analysis. Even when investigating simple outcome measures such as numbers and types of sexual partnerships or use of contraception, a wide range of individual, social, cultural and contextual factors need to be considered. This reflects the complexity and richness of sexual and contraceptive behaviour, elements likely to be under-valued using simple attitudinal and behavioural measures collected with quantitative research instruments. The appropriateness and value of semi-structured interviews and focus groups for these research objectives have been confirmed.

One caveat accompanying the interview respondents' concerns their social and sexual background characteristics. Because of the original interview study's objectives and recruitment strategy, respondents mainly originate from the professional and managerial social classes, and the most sexually active[1] section of the population. Readers should not leave this thesis assuming that *all* British young men share these respondents' attitudes and behaviour. Some will: others will not. What is more important is that the reader acknowledges and appreciates the diversity in experiences, and the explanations and meanings offered for these experiences.

[1] As measured by their reported number of penetrative sexual partnerships.

Regarding the focus groups, the reader is reminded of the group context of the research instrument. Respondents are not reporting only to the researchers, but to the researchers *and* their fellow group members. This is ideal for understanding group impressions of sexual health services, and brainstorming ideas for promoting services. A topic it is less suitable for, however, is decision making around sexual health. This analysis (and previous research) have shown the importance of the private and public domain for men's management of their health. It is likely the focus groups failed to capture private decision making around sexual heath. Therefore, it is possible some respondents would have been more likely to use sexual health services, but were unwilling to report this in the focus group setting.

8.2 LEARNING ABOUT SEX

While much discussion of learning about sex focuses on obvious sources such as school and parents, many other sources are likely to contribute information and messages on masculinities, sexuality, sexual behaviour and use of contraception. It is difficult to disaggregate the overall learning experience, and associate the importance and content of messages with their respective sources. Still, varied experiences are apparent. Some interview respondents appeared fairly knowledgable and confident when beginning their sociosexual experiences, having received comprehensive and good quality learning. Others, however, had to learn 'on the job' through personal experiences, and relied on less reliable sources such as friends and pornography. Younger respondents typically report better learning about sex than their older counterparts, with school and parents playing a greater role. This probably reflects a more open and tolerant atmosphere around sex in the late 1980s and 1990s, partly prompted by the emergence of HIV. Previous research confirms recent improvements in school sex education.

A number of obstacles can restrict young men's learning about sex, and attention should focus on how parents, teachers and health professionals can help to overcome them. First, a feature of the norm masculinity in British society is for young men to be knowledgable about sex. In front of their peers and educators, with new sexual partners, in contact with health services - some young men feel they need to present an image of sexual wisdom and expertise. The dilemma, therefore, is trying to learn about sex while preserving this facade.

Thus, popular sources of learning are ones for which prior knowledge does not have to be revealed. This is a feature of media, television and pornography, and some discussions with friends and peers in which a young man can listen and learn from the more experienced and older members of the group. The lack of interaction in much school sex education also allows learning in a safe environment. Similarly, promotion for sexual health services needs to be placed in locations where a young man can passively and discretely view the material.

A second barrier is the content of much formal education on sex, focused on reproduction, gestation and contraception, is inherently directed towards women as opposed to men. The dominance of female-oriented methods of contraception, and therefore female-oriented sexual health services, still projects the message that contraception is primarily a woman's responsibility. The resurgence of the condom in sexual health promotion has re-addressed that balance somewhat, as educators and health professionals have to account for who physically uses the condom - the man. However, condoms can be obtained and used without contact with health services, in contrast to the other method of contraception mainly used by young people, the pill. Regular pill prescriptions provide opportunities for information, advice and counselling on sexual health, prompted either by the health provider or the client. Young men obtaining condoms from shops, chemists or machines do not have this opportunity. The focus group discussions highlight difficulties sexual health services have in complementing condom provision with sexual health advice and information - most respondents express preference for a quick, question and hassle-free service. Still, should this opportunity for education and support be neglected?

Assuming that young men do *not* need advice and information on condom use is wrong. The condom requires considerable user skills for successful use - around half the interview respondents express dissatisfaction using condoms, and condom failure is common among young users (Joffe, 1993). In contrast to the pill, the method is used during the sexual encounter and in front of a partner, thus exposing the user's skills and experience. The wider availability of condoms nowadays makes it likely that young men are able to practice condom use on their own, and good school sex education lessons include demonstrations and practice of using condoms, both to be recommended. Any other situations in which advice and information on condom use and related sexual health issues can be provided to a young man one-to-one should be identified and used.

A third barrier evident throughout this thesis is the other-worldliness, detached nature of sex in British society. The personal, embarrassment, and taboo meanings associated with sexual behaviour far removes it from other aspects of life. Given the inordinate amount of attention and interest sexual titillation and gossip generate among British people, it seems strange that sexual behaviour is not more openly accepted. Is it surprising young people may have difficulties discussing sexual activity and contraception in the intense, passionate atmosphere of a sexual encounter, when parents, teachers and media show similar difficulties in the dispassionate, cold light of day? The respondents' recollections of sex education from parents are a prime example of embarrassment around sex. For most, parental teaching was non-existent, or kept to a minimum and provided in a forced, embarrassed atmosphere. Common parental messages focus on appropriate moral and relationship contexts for a young man's sexual behaviour, unclear statements on sexual risk-avoidance, and reactions to having to face their child's sexuality when asked if a sexual partner can stay overnight in the family home. However, examples of good parental education are apparent, more likely when a warm and supportive relationship is reported between a respondent and his parents. It is interesting that with the parental partner change accompanying divorce and cohabitation, a more open atmosphere around sexuality in the family home is reported.

The interview respondents' school sex education tended to include only basic information on maturation, reproduction and contraception. At the time of interview, most respondents are knowledgable on the risks of conception, apart from some doubts on the fertile and infertile periods of the menstrual cycle. Is a missing component in school sex education, therefore, the emotional, relationship and communication aspects of sexual activity and contraception? Department for Education guidelines (1994) recommend inclusion of these topics, but how would they be appreciated by young men? Although some respondents baulk at the potential interactivity, emotional and sensitive aspects of such teaching sessions, their absence is identified as a deficiency of current sex education. Provision at an appropriate age (say, the middle teenage years), and the use of small group learning could improve the effectiveness of lessons. The pioneering publication from the Sex Education Forum (Lenderyou & Ray, 1997) on supporting sex and relationships education for young men is a step forward, and evaluating the success of the approaches and exercises suggested would be useful. Like other aspects of men's sexual and reproductive behaviour discussed

in this thesis, the danger is in having an *a priori* assumption that young men are *not* interested and do not require teaching on emotions, relationships and communication.

Friends have always been and will continue to be an important source for learning about sex, yet remain the one source parents, educators and health professionals have least influence over. The context and content of learning about sex between friends are quite diverse, and not all young men have equal opportunities to learn about sex from their peers. Young men at the fringes of social groups and with a smaller social crowd available to them have less opportunity to learn from the 'educators' of a male peer group, that is, the more sexually experienced and vocal members. Chapter 4 discussed how the typical social hierarchy in the middle and later teenage years places the 'Lads' group as the more prominent and socially prestigious social group. Therefore, 'Lads' messages on sexuality, relationships, young women and sexual behaviour can be widespread within the male peer group, and perceived as the norm. The three identified topics of discussion about sex between young men, mechanics, gossip and banter, reinforce a competitive and inflexible mode of masculinity, with appropriate modes of behaviour, and desirable levels of heterosexual activity, promoted.

8.3 SOCIAL CONTEXT

Chapter 4 began by considering the sexualisation of respondents, and how they make a transition from boys to young men. Other cultures around the world have initiation ceremonies and rituals to accompany this transition, often including sexual information and advice (Ottenberg, 1989). From the respondents' perspectives, losing virginity is a milestone of heterosexuality, signifying the loss of boyhood. Before this occurs, however, the physical and emotional changes of puberty can be as involving and important for young men as young women. However, the process of change can be more solitary and hidden for young men. Menarche among young women may be treated as a milestone event, signifying when girls become young women. Mothers and school educators recognise the importance of menarche, often providing education on menstruation before or immediately after its occurrence. What about young men? Their closest equivalent to menarche is semenarche or the onset of wet dreams. Both events have similarities to menarche - they signify the beginning of a person's fertility, and their development as a sexual human being. Unlike

menarche, however, these milestones typically are solitary events, unlikely to be celebrated in any form, or peers or parents told of their occurrence. Does this situation contribute to young men feeling excluded from learning about sex? Would a more open acceptance and tolerance of masturbation and wet dreams help young men's sexual development? A start would be ensuring the topics are included in school sex education. The idea that young women may receive an additional lesson on menstruation seems inequitable given that young men are going through equally important and involving changes in puberty. If young women do have a separate lesson on menstruation, should not young men have a concurrent, separate lesson on masturbation, wet dreams and other aspects of their sexuality?

'Peer pressure' often is cited by adults and media commentators as the root of the 'problem' of young people's sexual activity. Chapter 4 explored the structure and dynamics of young men's peer groups, and mechanisms for possible influence or 'pressure'. The structure of the male social hierarchy is most rigid and its influence greatest in the middle and secondary school years. 'Peer pressure' usually originated not from the interview respondents' friendship groups, but members of the wider social crowd they observe or occasionally meet. Cited examples of peer influence focus on the need to enhance sexual reputation; that is, a young man should increase his level of heterosexual interest, experience and activity.

The 'Lads' social group often occupies the higher stratum of social hierarchies during this period, and their behaviour can act as a prominent model for heterosexual behaviour. It is not suggested that all young men automatically subscribe to this behaviour, but some would have to formulate and justify their own behaviour within its authority. To promote or follow the alternative 'Friendship' strategy is difficult when the 'Lads' strategy is promoted as the appropriate norm. However, alternative modes of behaviour become easier to follow through mixing in separate social groups, or in the later teenage years when peer influence is reported as weaker.

Is peer influence an important issue? Although involving dissimilar attitudes and behaviour, it seems overly moralistic to suggest that the 'Lads' behaviour should be discouraged and the 'Friendship' behaviour promoted. Some respondents prefer following one mode of behaviour, and assuming that all young women prefer young men to follow only one of these strategies would be presumptuous. Where concern does arise, however, is if the 'Lads' behaviour acts as a prominent norm and prevents the expression or following of other

behaviours. Not all respondents could or wanted to adopt the 'Lads' approach - ideally, alternative expressions of masculinities and heterosexuality should be equally accepted within the male peer group. Once again, the Sex Education Forum publication (Lenderyou & Ray, 1997) provides useful advice and recommendations for work on masculinities and sexual relationships.

The social environment is an important factor cited by respondents to explain changes in their sexual partnership histories. Most sexual partners are met through socialising; this includes the 'chatting up' and 'pulling' associated with casual sexual partnerships, and partners met as friends or acquaintances for steady sexual partnerships. Some discussion of social activity in the interviews centres around factors that limit (or enhance) opportunities to meet young women. Residing in a rural location, attending a single-sex school and having 'male' leisure pursuits during the teenage years are three prominent examples of limiting factors.

One effect of such social limitations became apparent in some respondents' early sociosexual experiences. Respondents who had more social contact with women through family and friends are more comfortable and likely to use the 'Friendship' interpersonal strategy when interacting with young women. Socialisation without overt sexual interest may mitigate the 'shock' and difficulties some respondents exhibited when they suddenly wanted (or were expected) to be sexually interested in, attract and interact with young women. Once again, the other-worldliness aspect of sexual behaviour is apparent. Rather than seen as a 'natural' development of interpersonal relationships with young women, some respondents were perplexed how to behave and interact with young women in a sexual context. Parents, educators and other professionals who work with young men in 'limiting' social environments (for example, rural locations, single-sex schools) should be aware of the difficulties some young men have in subsequent social and sexual interaction with young women. Opportunities for mixed-gender socialising through education, leisure and social activities should be encouraged.

However, changes in personal circumstances over the teenage years support increased socialising. A typical transition involves a young man gaining more personal freedom and independence to engage in social activities of his choice. The move from school or college to attend further education is common among the respondents, understandable given their

social background. New and sometimes more permissive norms around sexual activity, increased social opportunities, and living away from home in a residence with single bedrooms support experiencing more sexual partnerships. Health providers in colleges and universities should be made aware of the change in sexual behaviour some young men experience, ensuring advice and information addresses safer sex in this liberating atmosphere.

8.4 SEXUAL PARTNERSHIPS

The interview respondents were selected on a criterion of reporting at least two sexual partners in the previous year. This high level of sexual activity is reflected in the predominance of casual partnerships, one-night stand partnerships, and short time in partnerships before first intercourse in their partnership histories. A high number of sexual partnerships makes this group interesting in terms of their sexual health. Experiencing many partnerships does not necessarily equate with high-risk or sexual ill-health, but they are likely to be experiencing a range of relationship and contraceptive situations. The types, patterns and meanings of partnerships evident in this group of young men may not be shared by other British young men with a lower frequency of sexual partnerships. The role of steady relationships and emotional meanings of sexual activity may have been under-represented given the focus on young men reporting the highest partnership numbers. Against this, however, is the fact that the selection criterion refers to the year *prior* to interview; before this, periods of high *and* low partnership numbers are evident in the respondents' partnerships histories.

The main message emerging from Chapter 5 is the rich diversity in sexual partnerships, between respondents and over time. Variation is apparent in the number, duration, type and meanings of sexual partnerships. Any generalisations and stereotypes about young men's sexual relationships are always going to conceal variation. Even respondents reporting a strong preference for sexual activity to occur within a certain type of relationship can have that pattern disrupted with a random, atypical partnership. Any teaching from educators or counselling from health providers discussing sexual relationships has to reflect this diversity of experiences. Discussion or advice relating to communicating with a partner about contraception, or knowledge of a partner's sexual history needs to be referenced to a young

man's experiences. Ideally, the health provider could ascertain the sexual lifestyle a client follows through a few descriptive questions, and then tailor subsequent information to match that lifestyle. A young man who experiences infrequent, steady relationships with partners known as close friends will have different needs to a young man who experiences a high frequency of casual partners previously unknown.

While the distinction of sexual partnerships as steady or casual is useful, these labels encompass features including the emotional involvement, duration and faithfulness of a partnership. These aspects are interpreted differently by individuals; one young man's casual partnership is another's steady partnership. Similarly, the meanings young men attach to sexual activity do not necessarily reflect the stereotypes. Some young men *do* want sexual activity for the thrill of the chase, physical pleasure and social prestige involved. Others, however, prefer the physical pleasure in combination with the emotional and companionship aspects of a sexual relationship. It is interesting that respondents typically experiencing steady as opposed to casual partnerships report an emotionally 'warmer' family environment, and better learning about sex from school and parents. Similar to the discussion of 'Friendship' versus 'Lads' strategies, suggesting that steady rather than casual partnerships should be promoted by educators and health professionals seems moralistic, although this fits the 'moral framework' for sex education outlined in the Department for Education's (1994) guidelines. However, a recommendation from the more recent Social Exclusion Unit's (1999, p.116) report on teenage pregnancy removes this moral consideration; schools are encouraged to "give young people the confidence and skills to judge what kind of relationships they want and put that into practice".

Even accounting for one-night stands, the interview respondents report a short time in a sexual partnership before first intercourse. For self-defined steady partnerships *only*, the median duration before intercourse is only two weeks. The couple may have intermittent social contact during this period, but the notion of dating or courting a partner for a longer period of time before first intercourse is rare. Some respondents do believe that a couple's relationship should develop to an appropriate stage before intercourse occurs, although even this preference can be negated by the occurrence of an unplanned, one-night stand partnership. The period of time before first intercourse has implications for contraceptive use, discussed in the next section.

The symbolic importance of first-ever intercourse is confirmed. Two contexts within which first-ever intercourse occurs are as a one-night stand, or in an ongoing, steady relationship. For young men who experience the former context, loss of virginity is typically an unexpected event determined by the immediate contextual circumstances of the sexual encounter. For young men in the latter category, loss of virginity is more of a planned, integral part of the couple's developing relationship. The strength of this relationship is shown by the quarter of the sample whose first sexual partnership lasted for equal to or more than one year.

External pressure for a young man to lose his virginity can be intense during the middle to late teenage years, mainly originating from male peers. Evidence suggests, however, that although first-ever intercourse is an important milestone to achieve, it is not necessarily immediately followed by many, successive partnerships. Some respondent took a few years before their sexual partnerships began in earnest. Due to the particular nature of first-ever intercourse, other research should be cautious in taking it as representative of young men's sexual or contraceptive behaviour. There may be associations between first-ever intercourse and successive partnerships, but its special meanings identify it as an atypical event. Similarly, age at first intercourse should not be taken as indicating the beginning of a period of high sexual activity.

Regarding patterns over time, the term 'serial monogamy' should be used cautiously. In its simplest form, it implies that partnerships occur one after another, with no concurrent overlap. However, a young man experiencing a series of one-night stand partnerships fits this definition. Due to the selection criteria, these respondents are expected to report fewer long-term, steady partnerships. Still, based upon their partnership histories, using the term 'serial monogamy' undermines the importance of the short-term, casual partnership. Most respondents are *not* experiencing partnerships of a few months or longer, followed by a gap, then another, and so on. The constructed partnership histories are more chaotic, with one-night stands scattered over time, atypical partnerships cropping up, long-term partnerships followed by a cluster of casual partnerships, concurrent partnerships, and so on. It is important to appreciate that some respondents had no sensible, rational organised plan behind their sexual partnerships - lots were driven by circumstance and opportunity, with unexpected and unplanned partnerships common.

A worrying theme for some respondents concerns their performance in sexual activity - how they will be compared with a partner's previous sexual partners, and their partner's sexual satisfaction. As discussed in section 4.5, a prominent gender role is for men to initiate and control heterosexual activity. If a young man assumes this role, combined with the sexual competitiveness evident in some male peer groups, it is understandable why he may feel anxious about his sexual performance. Alleviating these concerns requires challenging the gender roles around masculinity and heterosexuality. Some respondents clearly prefer both members of the couple to take equal control over the initiation and pace of a heterosexual encounter, instead of being expected to run things themselves. From a young woman's perspective, however, the negative social reputation of appearing sexually forward may prohibit this sharing of tasks.

8.5 USE OF CONTRACEPTION

Given the current government is planning a national campaign stressing the responsibilities of fatherhood to young men (Social Exclusion Unit, 1999), what does the current research suggest about its likely effectiveness? Remembering that the current interview respondents are more educated and sexually active, most seem aware of the risks of conception and the serious implications of fatherhood. However, these views are reported in the cold light of an interview, which may not be reflected in their behaviour in the heated and passionate atmosphere of a sexual encounter. Given the dissociation built up over the past few decades, any campaign raising awareness of the association between sexual behaviour and the responsibilities of fatherhood should be encouraged. The last similar initiative, the 1985 Family Planning Association's *Men Too* campaign (Wellings, 1986) generated much media publicity, increased use of sexual advice phonelines by men, and probably facilitated an increase in sexual health service uptake by men. Hopefully, a well orchestrated, promoted campaign could have similar effects. Whether the campaign produces a reduction in the number of teenage conceptions or infections, however, is much less certain.

It is difficult to discuss use of contraception without acknowledging the other prominent sexual risk - infection, particularly HIV. Respondents who learnt about sex and began their sexual history when HIV/Aids was present are more likely to use protection styles incorporating the possibility of being infected with the virus. Older respondents sexually

active before the emergence of HIV had a simpler contraceptive situation to face. Conception was the main sexual risk, and the widespread use of the pill relieved many men of any contraceptive responsibility.

However, not all respondents sexually active in the time of Aids share similar views on the risk of being infected. As explored in section 6.3, the thought process behind assessing risk of HIV infection can be complex, and for a variety of reasons many respondents feel HIV infection is not a salient risk. Sexual health professionals are aware of this issue, but it is worth reiterating some of the key points to emerge from the interviews.

One factor reducing some respondent's perception of their risk of infection is perceiving that even though the consequences of HIV infection are extremely serious, extremely few HIV positive women are in the heterosexual population. Therefore, the risk of being infected is so low that it need not be accounted for in contraceptive intentions. Is this perception valid? Although actual prevalence is unknown, cases of HIV infection in the UK have to be notified. Up to the end of March 1999, 38,000 individuals with HIV infection had been recorded (Public Health Laboratory Service, 1999b). Of these, 8,200 are presumed to have been infected through heterosexual activity. 6,200 of these individuals are presumed to have been exposed to an infected partner overseas, mostly sub-Saharan Africa. Investigations of 400 heterosexual cases are closed or continuing. That leaves around 1,600 recorded individuals presumed infected with HIV through heterosexual activity in the UK since the early 1980s.

Young men's perceptions of low HIV prevalence in the British heterosexual population are understandable considering these statistics. A conflict is apparent between safer sex campaigns that stress the risk of HIV infection through heterosexual activity, and young men's experiences of rarely knowing or hearing of cases, and being aware of the low number of cases recorded nationally. Why should safer sex be adopted when the risk of infection is perceived as so low? Any sexual health promotion messages based solely upon the risk of HIV infection through heterosexual activity may lack impact for this reason.

A second point relates to the roles gathering information and 'knowing your partner' play in risk assessment. Respondents using the casual selective and trusting relationship protection styles use information to assess whether a partner presents a risk of HIV infection. This

goes against safer sex health promotion messages stressing the ubiquity of HIV risk, and the difficulties in identifying an HIV positive person. Early on in a partnership history, and for partners known as close friends, some respondents felt they *did* have a good idea of their partner's sexual history. Given the details of the history, some respondents surmise the chances that their partner has had unprotected sex with an HIV positive person as extremely low, and therefore a prophylactic method is unnecessary. This thought process is evident in the casual selective style leading up to first intercourse, and the switch to pill use in the trusting relationship style. No risk assessment is going to be 100% reliable, but that is true of any risk, in any aspect of life.

Other respondents felt they did not have enough information to make a valid assessment of a partner's risk, so were determined to use condoms. This may be because their sexual lifestyle involves partners who are unknown before the encounter, so condom use protects against this unknown risk. It seems any simple, prescriptive safer sex message on 'knowing' your partner is going to be interpreted in different ways and prioritised to different extents by young men.

The construction and investigation of the eight main contraceptive protection styles highlight the diversity in contraceptive behaviour. Although a few simple outcomes of contraception for a sexual encounter can be identified (none, pill, condom, withdrawal and so on), the thought processes and reasons behind use are complex. Any education or sexual health counselling aiming to increase use of contraception could start by trying to identify which protection style a young man uses. A series of brief questions exploring contraceptive intentions and experiences should provide insight on the style used. Each style suggests issues, advice and support appropriate to the rationale and explanations for using that style. These are considered for each protection style below. It is assumed the underlying aim of sexual health promotion is to encourage contraceptive use *and* condom use.

a) **Condom determined** - as suggested earlier in the thesis, sexual health promotion encourages use of this style. Therefore, it could be argued that promoting any change in behaviour is unnecessary. However, the analysis suggests some followers of this style have encountered a limited range of contraceptive situations. Therefore, a health provider could explore how a client would deal with more diverse

contraceptive situations, for example, when a partner reports she uses a pill, and suggests condom use is therefore unnecessary.

b) **Pregnancy prevention** - the reasons why a user does not feel at risk of sexually transmitted infection were explored in section 6.3.3. Health advice and promotion should therefore attempt to address these factors. For example, perceived invulnerability could be countered by discussing anonymised examples of similarly aged men who have been infected. Although reported cases of HIV infection may be low (discussed earlier in this section), the increasing numbers of other infections could be cited to show how easily infection can occur.

c) **Casual selective** - in this style, some partners are judged to present a risk of infection, whereas other do not. Health promotion for users of this style could focus on the estimation procedure used by young men to assess a partner's risk. Discussion could centre on the uncertainty involved in estimation, particularly regarding the completeness and accuracy of knowledge of a partner's sexual history. Although users may argue this strategy is valid at the start of a partnership history (when partners are likely to have experienced fewer partners themselves), health providers should stress how its validity will likely decrease over time.

d) **Trusting relationship** - a similar approach to the suggestions for the casual selective style could be adopted to confront whether a user's risk estimation procedure is valid. However, the emotional and trust components of a steady relationship present an added barrier to overcome. The concept of 'trust' should be explored with the couple, focusing on how continuing condom use is not necessarily passing comment on the couple's faithfulness to each other, but the possibility of infection in each other's sexual history. Switching to pill use only after tests for sexually transmitted infections should also be promoted.

e) **Condom avoidance** - promoting the range (size, shape) of condoms available may enable a user to find a design causing fewer physical difficulties. Accompanying this promotion, however, should be instructions and practice on correct use of a condom to enable a user to feel more confident about condom use in front of a sexual partner. Strategies for easy and non-intrusive introduction and putting on a condom in a

sexual encounter could be explored. This suggestion is also applicable to young men reporting getting 'carried away' in the context orientated style below. For condom avoidance users, however, there may be psychosexual difficulties which need to be explored through counselling.

f) **Context orientated -** one strategy for users reporting getting 'carried away' is outlined above. Another important issue to explore with this group is whether the lust and passion of sexual activity is still compatible with the discussion and use of contraception. Stressing the protection from risk offered by contraception may help, although users of this style may argue any 'rational' decision is unlikely to be made in the heat of the moment of the sexual encounter. Perhaps advice on how putting on a condom can be incorporated into foreplay prior to intercourse may be useful.

If users are citing intoxication as a contributory factor for not using contraception, then health providers could draw upon the previous work of health promotion around alcohol and drug use. This literature would suggest appropriate strategies to try and overcome unhealthy behaviour associated with drug use.

The third major factor for this group, absence of a condom, could be addressed through improved condom provision for young men, discussed in Chapter 7. Additionally, however, users could be encourage to carry condoms in social situations where sexual partners may be met.

g) **Abdicator** - challenging a user's perception that he is at low risk of infection has been discussed above, and is applicable for this protection style. In this instance, however, users also exhibit little concern about the risk and consequences of conception. The government's proposed campaign to increase awareness among young men of the responsibilities of sexual behaviour may produce positive outcomes for this group.

h) **Indifferent** - probably the hardest protection style to address, but containing young men with some of the unhealthiest behaviour. Given the ambiguous and incomplete explanations respondents gave for this behaviour, simple health promotion messages are unlikely to succeed. One-to-one counselling may illuminate why a young man

uses this style, and offer factors to address. If no explanation is forthcoming, health advice on all aspects of sexual risk (and possibly, health in general) may be valuable.

Certain factors have been highlighted as associated with the contraceptive protection styles. Considered together, however, no clear conclusions emerge on which factors are associated with more positive contraceptive outcomes. For example, reporting an emotionally 'colder' family environment and less social contact with young women are associated with the more negative abdicator and indifferent protection styles, but also with the more positive condom determined style. Poor learning about sex is associated with the negative context orientated style, whereas good learning is associated with respondents using the casual selective style. A possible confounding factor behind some associations is shown by the different experiences of younger and older respondents. As stated earlier, the emergence of HIV has been incorporated into some younger respondents' contraceptive behaviour. Accompanying the emergence of the virus, however, have been improvements in school and (to a lesser extent) parental education on sex, and a more open social atmosphere around sex and condoms. Establishing whether any associations include causal mechanisms, therefore, is difficult.

Combining the protection styles and just looking at three constructed measures around communication of contraception also produced some associated antecedent factors. As elsewhere, the younger respondents report more positive experiences, with easier initiation, discussion and jointly decided outcomes. Good school sex education is reported by respondents with more positive experiences of discussing contraception. Whether a causal influence is present is uncertain, but the finding is encouraging.

Sexual health material promoting condom use should be wary of suggesting 'condom-sex' involves the same physical sensations and pleasure as 'non-condom sex'. Around half the respondents felt this was plainly not true, and a minority actively avoided condom use due to the physical difficulties resulting. Condom use can be difficult enough for inexperienced users, and misleading messages can only be counter-productive. Where space permits, messages should acknowledge that using a condom may decrease physical sensations, but this is outweighed by their ability to protect against the risks of conception and infection.

8.6 SEXUAL HEALTH SERVICES

Apart from genitourinary medicine services, it can be argued that most sexual health services marginalise heterosexual males. Their use of services is low, their sexual health needs are rarely recognised, and men-only services or sessions are rare. Is this a reflection of supply catering for low demand, or demand not being met? Elements of both explanations are evident from the focus group discussions. However, the number of young male clients of sexual health services *has* increased over the 1990s, although still very much in the minority as compared with young female clients. This increase is most striking for Brook Advisory Centres, who have experienced a fivefold increase in the number of male clients over the past five years. Two factors help explain this increase:

a) the increased use of condoms by recent cohorts of young people who have been educated and became sexually active in the time of HIV/Aids

b) an increase in the provision of sexual health services aimed specifically at young people to accompany health providers' aims of meeting *Health of the Nation* targets[2].

Evidence from Chapter 7 suggests that male attendance at sexual health services in under-estimated by routine attendance data due to men attending as part of a heterosexual couple. Most young men attending sexual health services on their own do so to obtain condoms. Of all condoms sold in the UK, less than 10% are obtained through the NHS; no evidence suggests this percentage is higher for condoms obtained by young men. Although the 1967 Family Planning Act states that free family planning services should be available to anyone regardless of age or gender, the current provision of condoms falls short of this aim. Imagine a hypothetical situation in which, although provision was available through the NHS, 90% of users of the contraceptive pill decided to obtain and finance the method privately. In such a situation, surely the NHS service would be deemed unsatisfactory. Why, then, are condom users not given equal attention? Although the availability of condoms through general practice has improved, the service is fragmentary across health authorities. Young male clients are unlikely to become involved with condom distribution

[2] It has been suggested that the provision of sexual health services for young people has been *over-emphasised* to the detriment of family planning for older age groups (J. Walsh, as quoted in Wynne-Jones, 1997).

schemes unless recruitment and promotion takes place outside the general practice environment.

The discussion of sexual health dilemmas in section 7.2 illuminated ways in which young men think about and manage their sexual health. As the dilemmas were hypothetical and most had presumably not been encountered by respondents, any reported intentions may not reflect future behaviour. Similarly, section 8.1 suggests the focus group discussions may not capture health-seeking behaviour operating in the individual, private domain. Although the stereotypical view is that men do not discuss their health, many respondents identify people they felt they *could* approach regarding a sexual health dilemma. These may be health professionals with expertise of sexual health, or close friends who can be trusted to remain confidential. Although taboos on discussing personal and 'non-masculine' topics exist in some male social groups, this is not the only forum of communication available to young men.

From the focus group discussions, it appears young men would most likely consider using sexual health services for routine or crisis situations. While this finding may initially be viewed negatively, it can be argued that most young women attend sexual health services for similar reasons, for example, contraceptive provision, emergency contraception and advice about an unintended conception.

Although variation between services exists, knowledge of local sexual health services among respondents is low. Distinction should be made between having heard of a service, and awareness accompanied by more detailed knowledge, a variable unlikely to be identified through structured questionnaire-based research designs typically used in service evaluations and needs assessments. While some respondents' lack of knowledge can be seen as a barrier to service use, other respondents are confident they could easily find out contact details and other information if they wanted to use a service.

The importance of word of mouth as a source of information about sexual health services is reconfirmed. This is a more limited channel of communication among young men than young women, as more young women use services and therefore more information and impressions are available to be conveyed. Once a core of young men attends a service and pass on (hopefully) positive comments to male peers, a snowball effect could result in

increased male service uptake. As before, the current culture is that young men do *not* use sexual health services. As more male 'pioneers' do use a service, word may spread and services may lose their image of catering only for women.

Aspects of service provision that do and do not appeal to young men have been identified; these can be used by service management and staff to determine the image a service should present in promotion and day-to-day operation. Scope exists for services to be made more youth-friendly and male-friendly, particularly regarding the entrance and initial welcome of a service (a current source of conflict between service personnel and groups of male clients who attend *en masse*). While a young man is becoming familiar with obtaining condoms from a service, the need for a quick and hassle-free service seems important. Opportunities for a young man to ask questions should be available, but he should not feel pressurised to engage in a more personal consultation.

Promotion should aim to increase awareness *and* advance a positive image of a sexual health service, areas identified by most focus groups as in need of improvement. Running an effective promotion campaign requires the opinions of local young people (including, of course, local young men) to test out material and identify suitable locations in which young people spend their time or expect information to be available. Some young men prefer to access information about a service without anyone else knowing they are doing so, that is, at a private and discrete location.

While promotional material needs to contain basic information about a service, the overall style and design of material may be more important to a) catch a person's attention, and b) promote a positive image of a service. Particularly for visual media, sexual health service promotion may be judged alongside neighbouring health promotion messages and consumer advertising. Therefore, the material needs to match the high standards of style, appearance and content of these other media in order for a message to be noticed and appreciated.

8.7 THEORETICAL PERSPECTIVES

Section 1.5 introduced some theoretical perspectives from the social sciences formulated to help understand sexual behaviour and use of contraception. Since the thesis is primarily a

descriptive and exploratory work, and no one theory was adopted as a principle framework, a full discussion of the theoretical implications of this work seems inappropriate. Nevertheless, what has emerged from the thesis in reference to these theoretical perspectives?

With regards to the **social psychological** approaches summarised in section 1.5, care should be taken when choosing outcome measures to represent contraceptive behaviour. The detailed exploration of contraceptive use in this work has shown variety in method use across a partnership history and even within a sexual partnership. Problems with recall and validity of responses to simple questions on contraceptive use have also been highlighted. While measures of behaviour collected with quantitative research instruments must remain simple, care should be taken in assuming they are good representations of an individual's actual experiences.

The other striking point to emerge is the essentially chaotic, unplanned nature of some young mens' sociosexual experiences. Based upon their reports, some respondents clearly had no great, underlying plan they were following, and were driven much of the time by partner and contextual factors. Such characteristics seem somewhat at odds with the rationality and planning inherent in some, but not all, social psychological approaches.

Gagon and Simon (1973) applied **symbolic interactionism** theory using the concept of 'sexual scripts'. However, this approach was not widely used in this work. It is clear some respondents amalgamated information from learning sources into a set of 'scripts' for appropriate sexual attitudes and behaviours. However as Chapter 3 explored, information learnt often presents a conflicting idea of what is the 'right' set of actions for a certain situation. Such conflicts may only be resolved through increasing experience and feedback from sexual partners.

The **discourses** constructed by Hollway (1984) and explored and expanded upon by other authors are apparent in this analysis, particularly the contrast and conflict between the 'Lads' and 'Friendship' interpersonal strategies. This work has provided more insight on how the social environment in the teenage years meant that these discourses were never or rarely able to be taken up by some young men. Also illuminating is the transition from the 'Lads' to 'Friendship' strategy over time, common within this sample. While assigning young men to

these constructed groups provides an easy conceptualisation, can these labels do justice to their diverse and complex experiences? Any use of discourse analysis should be accompanied by a full exploration of individual behaviour, and the range of experiences had by individuals identified as the subject or object of a particular discourse.

Regarding **feminist approaches**, section 1.5 stated the topics of power and masculinity were not prioritised in the original semi-structured interview study, so were not addressed in depth in this work. Although the respondents were aware of different gender roles around sexuality in British society, there was little unprompted discussion in the interviews of the privilege being male gave them. This is not in conflict with feminist theory, as power need not be consciously acknowledged to be present and used.

The prominence of the 'Lads' group in the teenage male hierarchy was apparent in the respondents' interviews. The inflexibility and prestige of this form of masculinity clearly caused some respondents difficulties. The notion that other expressions of masculinity should be acceptable within the peer group is in accordance with feminist notions.

8.8 FURTHER RESEARCH

The discussion in this chapter suggests several topics in this research area that might be worth further investigation. The following research questions seem particularly important to address:

a) What meanings do wet dreams, semenarche and masturbation hold for young men?

b) Is small group work in schools and other settings on masculinity, relationships and heterosexuality of benefit to young men? What format of learning is most effective, and could any attitudinal or behavioural outcomes be expected as a result?

c) What is the influence of changing family structures on discussion and general openness around sexuality in the family? Is the emergence of more non-traditional family structures helping to create a more open atmosphere?

d) This thesis has tentatively suggested associations between the family environment, learning about sex, and contraceptive outcomes. Can mechanisms for these associations be identified through further qualitative research? Alternatively, would multivariate analysis of quantitative data enable the associations to be isolated from possible confounding variables?

e) Using qualitative data from both members of heterosexual couples, what is the event-specific dynamics of communication around contraception in heterosexual encounters? How are intentions communicated, and decisions reached? Does one member of the couple assume more power in any contraceptive negotiation?

f) Do heterosexual couples make joint decisions around use of a sexual health service? Can men who do attend a service but are left in the waiting room be more involved in the consultation?

g) Certain sexual health services are particularly successful in attracting young male clients. What is it about their services that has increased male service uptake? Is it the service location, staff characteristics, services offered, recruitment and outreach work, or the image promoted?

h) In this thesis and the accompanying publication from the original research (Pearson *et al.*, 1996), approaches to promoting young people's sexual health services have been suggested. Do these work in practice? What obstacles have services found implementing these suggestions?

Appendix 1 - Semi-structured Interviews Schedule.

BLOCK ONE - THE PRE-INTERVIEW SCHEDULE

- Demographic characteristics

Interview code	Interviewer	Name	Age	Sex
				M/F

- Current relationship status?

Current Relationship	Y/N	How long for?
Married		
Living-together		
Steady relationship - Living apart		
Casual relationship		
Single		
Ever married/lived with partner?		When?

- Any Children?

Name	Age	Whose?	Live with you?

- Parental Situation

Original parents' marital situation. If no longer together then....	
Did they split or something else?	
When did it happen?	
Has father re-married?	
Has mother re-married?	

Appendix 1 cont.

- Parents' Occupation

Occupation	When you were a child	Now
Father		
Mother		

-General

Where did you grow up? Name of city/town/village. Urban/suburban/rural.	
Highest education level completed	
School - Mixed/Single sex	
School - State/Private/Public	
School - Religiously based? Which?	
Current Occupation	
Other source(s) of income	
Where do you live now? Name of City/town/village Urban/Suburban/Rural	
Accommodation type (house/flat/etc)	
Private Rented/Council Rented/Owner occupier	
Who do you live with?	
Are you religious?	
Which religion?	
How important is it to you in your everyday life? (1-5; 1 = very; 5 = not at all)	
What ethnic group do you feel you belong to?	
How did you vote in the last national elections?	

Appendix 1 cont.

BLOCK TWO - CHILDHOOD/FAMILY OF ORIGIN			
Topic focus	Core questions*	Suggested additional questions or prompts	Suggested expansion material
Atmosphere or climate at home between the ages of 0-12 years (child and parents)	What was the atmosphere like at home when you were a child?	How did you get along with your parents / step-parents / guardians? How would you describe your (step-) mother? What was her personality like? Was she available for you if you had any problems? How would you describe your (step-) father? How would you describe his personality? Was he there for you when you were child? What was the relationship like between your parents? What were your feelings towards your parents? How would you describe the relationship between your parents? To what extent did your parents show any physical displays of affection towards each other? To what extent were your family physically affectionate or emotionally demonstrative? Do you feel that you were generally loved and cherished as a child? Did you ever feel neglected?	Family problems Childhood problems Roles of mother and father within home
(child and siblings)		Did you get along well with your brothers and sisters? What were your feelings for your siblings?	Family hierarchy Sibling rivalry

Appendix 1 cont.

BLOCK TWO (CONTINUED)			
(others)		Were there any major tensions at home? (brief descriptions) Did you have any adult friends or important adults in your life when you were a child? Who were they? What kinds of things did you do together?	Childhood friends Role of extended family
Early memories of self	What were you like as a child?	Were you a typical boy or girl? Would you say that you were generally a happy child? Why? Why not? Were you ever lonely as a child? Why? Why not?	Personality
Gauging the pedagogical regime within the family of origin	Were the rules clear and consistent?	How strict were your parents? Did you think of the rules as useful guidelines? Were the rules fair? Were rules broken? Why? How were they enforced? What types of punishments were there at home?	Positivity within the family setting
Ascertaining the nature and extent of negative experiences in childhood	Did anyone ever try to make you do anything sexual that you didn't want to do? (brief description) Did you ever experience any emotional neglect? (brief description) Did you ever experience any physical abuse or violence s a child? (brief description)	Did you ever experience any other sexual situation which was unwanted (for example, 'flashing')? (brief description) Do you remember any experiences of violence from your childhood? (brief description)	

Appendix 1 cont.

BLOCK TWO (CONTINUED)			
The nature and extent of sexual information and sexual communication in family during childhood	Was sex ever talked about at home (before the age of 12 years)?	What were you told about sex as a child?	Self and others dealing with puberty
		In what ways were sexual issues talked about?	
		Who initiated the discussions?	
		What was said, when, by whom, at what age?	Comfort with growing up
	Were conception, contraception, condom use, STDs, AIDS, discussed?	Were bodily changes discussed?	
		Was first period discussed?	
		What were the overt or implicit messages about sex?	Comfort with sexuality
		Did you ever see or hear your parents having sexual intercourse?	
	What general assumptions and ideals about sex were held by your parents and other family members?	What rules were set about sex?	
		Were these rules clear, consistent, useful?	
		Were they the same for men and women?	
		What were the sources of information about sex in your childhood (before the age of 12)?	
		Were these sources still available / utilised after the age of 12?	

BLOCK THREE - SOCIAL CONTEXT OF SECONDARY SCHOOL PERIOD			
Topic focus	**Core questions***	**Suggested additional questions or prompts**	**Suggested expansion material**
Tracing participant's development (12-16 years) within a sub-cultural context	How did you get along at secondary school (socially)?	Describe your general social life whilst at secondary school	School regime
		How many really close friends did you have when you were at school?	Role within school hierarchy
		How many were male / female?	How friends were made or chosen
		Describe typical activities with friends and why these were engaged in.	Group or society membership
	At what age, if ever, did you begin to smoke? do drugs? drink? be involved in any criminal activity?	How did you feel about doing these things?	
		Were you happy during this time? Why? Why not?	
		Did you ever feel lonely? Why? Why not?	

Appendix 1 cont.

Experiences and perceptions of sex education during this period	What topics were covered and when, by whom, and where? What are your views about the sex education you received at secondary school?	Was sex education taken seriously by you and your friends / classmates? Did you see the sex education you received as being relevant to you at that age? Did you discuss school sex education with your parents?	
Sex and gender issues salient during this period	Did you think that there were differences between the sexes? Was sex discussed with friends? in what ways? Were risks thought of? which ones?	Were any differences between girls and boys stressed at school? How did you think, feel and behave with the opposite sex? Was sex important to you at that time? Were there other sources of information about sex or sexuality apart from home, school and friends?	Dating Views and recollections of emerging sexuality

BLOCK FOUR - SOCIAL LIFE SINCE SECONDARY SCHOOL			
Topic focus	**Core questions**	**Suggested additional questions or prompts**	**Suggested expansion material**
Important events aged 16 years and older	Describe the major changes in your social life since leaving school	Have there been any important events which have changed your social life? Have there been any events in your life that have had a great impact on the way you act / think / feel about yourself? (brief description of any life-events / social changes / major influences) Has anything else important happened that we have not already discussed?	Descriptions of high and low points of social life
Present social life	What is your social life like at the moment? (general description) Do you ever talk about sex with friends? In what ways?	How many nights per week do you go out? On average, how many evenings per week do you go to pubs, clubs, bars, etc.? How many people would you say that you are really close to at the moment? How many of these close friends are male / female? What activities does your social life involve? On average, how much would you say that you drink per week / per month? What kinds of drugs do you take? How often? Are you involved in any form of criminal activity?	

Appendix 1 cont.

BLOCK FOUR (CONTINUED)			
General present well-being (Scale 1 to 10 1 = lowest score, worst, etc. 10 = highest score, best, etc.)	On a scale of 1 to 10, how would you rate your score on: a) appearances? Why? b) personality? Why? d) Emotional well-being? Why? How do you generally deal with any problems you might face?	Have you ever sought any professional psychological help or counselling of any kind? (brief description) Are you happy at this point in your life? Why? Why not? Do you ever feel lonely now? Why? Why not?	Membership of groups or societies

BLOCK FIVE - FIRST SEXUAL EXPERIENCES			
Topic focus	**Core questions**	**Suggested additional questions or prompts**	**Suggested expansion material**
Sexual development	At what age do you first remember being looked at or approached by someone sexually?	When do you recall first experiencing a sexual sensation? What did you think, feel and do about it? When did you first become interested in boys / girls / both as sexual partners or experimental partners? What did you think, feel or do about this interest?	Feelings about emerging sexuality Views on same sex activity Age at which various sexual behaviours occurred; reasons for engaging in those activities
	What sexual activities did you engage in before you had first sexual intercourse? (full description of development of sexual intimacy including kissing, petting, heavy petting, etc.)	When did you first fall in love or experience romantic thoughts about someone? How did you think and feel about this, and what did you do about this? At what age did you first masturbate? When did you first experience orgasm?	

Appendix 1 cont.

BLOCK FIVE (CONTINUED)			
First intercourse (CASE ONE)	Detailed description of interaction plus what, where, why, when, who, how? (context)	How old were you and your partner? How long had you known him / her and in what ways? What feelings did you have for your partner? What was your / their motivation for sex?	
	Was protection against pregnancy and / or STDs used? How was this protection / non-protection decided?	Were any risks considered or discussed? Did you try to influence the way things happened? How? Were you successful?	
	How did you feel about it afterwards?	How did you and your partner feel about it? Did either of you reach orgasm?	
	How would you evaluate your early sexual experiences?	How would you rate your first experience of sexual intercourse (then and later, emotionally and physically) How did you feel about sex after your first intercourse experience?	
	Do you feel that the speed of your sexual development was controlled by you? Or were other people or situations more in control of the pace of your sexual development? Why?	How important was sex to you at that age? In what ways do you feel that you did (or did not) control the pace of development?	

Appendix 1 cont.

BLOCK SIX - SEXUAL DEVELOPMENT THROUGH THE YEARS			
Topic focus	Core questions	Suggested additional questions or prompts	Suggested expansion material
Partners and sexual activities through the years to the current time (sexual history)	Can you give a detailed account of your sexual history? (*It may be helpful here to draw a timeline to aid recall*) Numbers of: a) sexual intercourse partners b) other partners (why no penetration with these?) c) male / female partners d) casual / steady partners Which forms of protection against pregnancy and STDs have you used - what, why, when and how was its use or non-use decided? Do you feel that you have been active in creating your sex life?	Are there any patterns or phases with many or few partners? Are you generally attracted to the same sex or the opposite sex or both? How long have you generally known / seen partner before sex? What normally leads to sex? What activities have you / do you normally engage in - oral sex? anal sex? vaginal sex? Why do you do some of these with some partners and not with others? Do these activities mean different things to you? Where do / did you obtain your protection from? Have condoms been used throughout the years? Why? Why not?? How do you decide when and when not to use them? Where are condoms obtained from?	Compare and contrast sexual partners with non-sexual partners Other sexual behaviours, for example, group sex, sado-masochism, etc. Feelings about and knowledge of, various types of sexual conduct and contraception

Appendix 1 cont.

BLOCK SIX (CONTINUED)			
Solosex: frequency, importance and patters (affect, behaviour, cognition and context)		For each of the following solosex activities: a) masturbation b) fantasies c) sex-lines (phone) d) reading erotic literature / porn magazines e) watching porno f) thinking about sex Have you ever done it? How often do you do it? Has this changed over the years? Why do you do it? How do you feel about it? Has this changed through the years? (A / B / C / C)	Describe situations Explore meanings
Paid sex	Have you ever paid someone for sex? (A / B / C / C)	Do you always have paid sex with the same person?	Describe situations Explore meanings
Sexual pressure, STDs and pregnancy experiences	Have you ever pressured anyone into sexual interaction? Have you ever been pressured by anyone into sexual interaction?	Have you or anyone you know experienced: a) sexual pressure / force? b) STDs or HIV? c) unplanned pregnancies? (brief description) What influence has this had (did this have) on you? (A / B / C / C)	Beliefs about appropriate sexual pressure Nature of sexual consent Other sensitising moments

Appendix 1 cont.

BLOCK SIX (CONTINUED)			
Reflection on development (*changes throughout life*)	Describe and explain the changes over the years in: a) your general sex life b) the amount of time and energy you spend on sex c) the meaning of sex and your feelings about it d) your feelings about relationships e) your perception of the differences between the sexes. Has HIV changed your life?	Have there been any other people, or has there been particular information, which have been influential in shaping your sexual thinking? How do you feel when you reflect on your sexual history - is it as you would have wanted?	Describe changes desired, why changes wanted, how to accomplish such changes

BLOCK SEVEN - CASE TWO AND CONTRAST WITH THE PAST YEAR			
Topic focus	**Core questions**	**Suggested additional questions or prompts**	**Suggested expansion material**
First contact with last new partner (CASE TWO)	Can you describe the fist time that you had sexual intercourse with your most recent partner? (Full description, including when, why, how, and what happened) (Probe specifically about the interaction and use of protection against STDs and pregnancy and decision making)	How exciting was the encounter? Did either of you reach orgasm? How old was your partner? Did you think any risks were involved? Why? Why not? Imagine that your partner had resisted / insisted on condom use, what would you have done? Did you try to influence the event in any way? Were you successful? How would you evaluate the event? How did the relationship develop?	Use of alternative cases Perceived regret (at time or subsequently)

Appendix 1 cont.

General pattern in the last year: Contrasting other partners or interactions with CASE 2 - how / why CASE 2 is similar or different? (*These questions relate to all sexual partners in the past year; some will have been covered in the previous block but need to be checked here*)	In the past 12 months, how many: a) sexual intercourse partners b) other sexual partners (non-intercourse) c) male / female partners have you had?	What types of people are you generally attracted to? How many times per week / per month have you had sex in the past 12 months? How frequently have you masturbated in the past 12 months? How do you think, feel about and behave towards the opposite sex?	Explore patterns and possible explanations
Focusing on the nature of sexual interactions	What usually leads to sex? What sexual activities do you normally engage in? To what extent do you try to influence the way things happen in terms of pleasure or protection?	How do you do this? Are you usually successful? Why? Why not? Who tends to control or steer sexual interactions?	
Respondent's feelings about sex	What does sex mean to you? Why?	What are you looking for in sex? What do you think about or feel whilst having sex? Do you feel more masculine / feminine during sex? Why?	Describe best sex and worst sex (consensual) Explore how these situations differ

Appendix 1 cont.

Sexual risk-taking and protective practices	With what percentage of partners have you always used condoms in the last 12 months? With what percentage of partners have you sometimes used condoms in the last 12 months? With what percentage of partners have you never used condoms in the last 12 months?	In what percentage of intercourses in the past year have you used condoms and / or some other form of contraception? Which sorts of contraception have you used? When and how is it decided that contraception will be used?	Explore risk-reduction strategies in detail Explore risk perception and justifications in detail Knowledge of HIV and AIDS

BLOCK SEVEN (CONTINUED)			
Sexual risk-taking and protective practices (*continued*)	To what extent do you think about any risks involved with sex? What action do you take in relation to these risks? Are you fearful of HIV generally? Why? Why not?	Do you consider yourself to be at risk? Why? Why not? Have you ever had an HIV test? Why? Why not? Have you ever asked a partner to have a test? Why? Why not? If so, how many, and when was the most recent test?	Explore circumstances under which a test would be taken
Evaluation of present sex life	How contended do you feel with your current sex life?	Describe and explain the easiest, most difficult, nicest and least nice aspects of your sex life at the moment.	Strategies for improvement or change

Appendix 1 cont.

BLOCK EIGHT - THE FUTURE			
Topic focus	Core questions	Suggested additional questions or prompts	Suggested expansion material
Respondent's general future orientation		Are you generally optimistic or pessimistic about the future? What are your educational, professional and relationship aspirations?	
Respondent's view of their future sexual life and his / her view of sexual risks	Describe your ideal sex life What do you think your future risks will be?	Do you have any plans or resolutions about your future sex life? How do you think that you will deal with risks in the future? What do you think is the best way to avoid the risks of pregnancy / HIV / other STDs? What needs to happen before this can be implemented (if appropriate)? What is needed for young people generally and you in particular to use condoms?	
Interview closure and reflection	How did you feel about the interview?	Can you think of anything else which might have been influential that we have not covered?	

Appendix 2 - Examples of Variables from Code Database for Semi-structured Interviews.

Source: Ingham, R., Jaramazovic, E., Stevens, D., Vanwesenbeeck, I., & van Zessen, G. (1995). Data Dictionary for Transcript Analyses: English Version. Protocol for Comparative Qualitative Studies on Sexual Conduct and HIV Risks. European Commission Biomed Concerted Action BMHI-CT941338.

DATA DICTIONARY FOR TRANSCRIPT ANALYSES:

For all cases, where no data pertaining to the variable exists, use the 'missing values' 9, 99, 999 etc. If the variable does not apply to the respondent use the 'not applicable values' 8, 88, 888 etc. For special cases where missing variables have specific meanings (eg some items are treated as 'not applicable in the case of rape or abuse), refer to the individual entry in the data dictionary. Empty rows have been left at the end of each block of respondent data in case additional variables need to be added during the course of data analysis. Each additional row is labelled with a variable number to ease entry into the spreadsheet.

variable number	variable name	variable definition	response options
001	Participant number	Personal identifier for individual respondent	GB 1-90 or NL 1-90
002	Country	Country where respondent was interviewed	1= UK 2= NL

variable number	variable name	variable definition	response options
005	Sex participant	Official gender of respondent (as defined at birth)	1= female 2= male
006	Age participant	Age of respondent in whole years. For example, if respondent is 20 years and 10 months write "20" etc.	write age
007	Relationship status	Current relationship situation of respondent	1= single 2= steady relationship 3= cohabiting/married
008	Ever previously married/cohabiting?	Whether respondent has ever been married or lived with a partner as if they were married (i e. not just flatmates)	1= yes 2= no
013	Secondary school, type 1	Whether the school(s) attended by respondent from the ages 11-16 was state-funded (comprehensive etc) or private/public (fee-paying).	1= state 2= private 3= mixture (this refers to cases where respondent went to a variety of schools during this period)
014	Secondary school, type 2	Whether the school was single sex (all male or all female) or co-educational (mixed sex)	1= single sex 2= mixed sex 3= mixture of schools
017	Highest level of education (completed)	This refers to the highest level of education actually completed by the respondent, it does not include any courses that they are currently enroled on, only those fully completed.	1= no qualification (only primary school) 2= mavo/lbo/o-level/gcse 3= havo/vwo/a-level 4= mbo/post 16 vocational 5= hbo/university 6= other
022	Religion	The religious grouping the respondent feels s/he belongs to, or was brought up to follow	1= none 2= Catholic 3= Protestant 4= Buddhism or Hinduism or Islam 5= other
023	Importance religion	How much importance the respondent attaches to religion in their everyday life. If no religion stated use the 'not applicable' code	1= very important 2= rather important 3= not important, not unimportant 4= rather unimportant 5= not important at all

Appendix 2 cont.

variable number	variable name	variable definition	response options
027	SES / 'highest' parent	The socio-economic status of the respondents parents. If there is a difference between the parents, opt for the parent with the highest SES. Here, parent is defined as either biological or step-parent.	~~0= professional (A)~~ 1= high level managerial (B) 2= C1/administrative/ white collar 3= C2/skilled manual/blue collar 4= DE/unskilled manual 5= none, long-term unemployed 6= other
032	Parental change	This item concerns the nature of the change in the respondent's parental situation. When gauging this, consider who left the family unit, rather than the family home. For example if the mother left the family home but took the children with her, this constitutes a "2" as the father was left out of the family unit etc.	1= mother left 2= father left 3= mother died 4= father died 5= other
033	Biological parent lived with is/was (while respondent still at home)	If there had been a change in the family set up whilst the respondent was at home, what was the relationship status of the parent with whom the respondent lived?	1= still single 2= remarried/re-cohabiting (heterosexual) 3= re-cohabiting (homosexual) 4= other
034	Foster parents/institutions (temporary)?	Did the respondent ever spend any time living with foster parents or in an institution (local authority care) as a temporary measure)?	1= yes 2= no
035	General emotional atmosphere	Respondents assessment of the amount of warmth experienced in the family setting	1= extremely cold 2= fairly cold 3= mixed/ambivalent 4= fairly warm 5= extremely warm
036	Physical availability/spending time with biological mother	Respondents perception of the amount of time they were able to spend with their biological mother, or how available she was when s/he needed her.	1= hardly/not available 2= medium availability 3= high availability
038	Emotional warmth biological mother	Respondents perception of how warm/loving his/her biological mother was toward the respondent as a child.	1= extremely cold 2= fairly cold 3= mixed/ambivalent 4= fairly warm 5= extremely warm
040	Physical availability/spending time with biological father	defined as above	1= hardly/not available 2= medium availability 3= high availability
042	Emotional warmth biological father	defined as above	1= extremely cold 2= fairly cold 3= mixed/ambivalent 4= fairly warm 5= extremely warm
056	Relationship between parents (getting along plus emotional intimacy)	This is an indicator of how well the respondent feels his/her parents (including both biological and step-parents) got on together, whether they shared warmth, appeared intimate etc.	1= extremely cold 2= fairly cold 3= mixed/ambivalent 4= fairly warm 5= extremely warm 6= dramatically changed across time/families
057	Nature of change due to change of parents	If code 6 used in previous item, i e there was a dramatic change reported in parents getting on together, what was the general nature of the change in climate? If code 6 not used in item above, use the not applicable code here	1= cold -> warm 2= warm -> cold
062	Reported feelings of loneliness	Respondents self-assessment of how lonely s/he felt as a child	1= not lonely at all/hardly 2= mixed/medium 3= very lonely
063	Reported feelings of happiness	Respondents self-assessment of how happy s/he felt as a child	1= not happy at all/hardly 2= mixed/medium 3= very happy

Appendix 2 cont.

variable number	variable name	variable definition	response options
127	Number close male friends	number of particularly close male friends reported during this period (not the total size of the respondents friendship group, closest friends only).	write number
128	Number close female friends	number of particularly close female friends reported during this period (not the total size of the respondents friendship group; closest friends only)	write number
129	Social circuit	predominant gender composition of the respondents friendship groups during this period.	1= mainly same sex 2= mixed 3= mainly other sex 4= none, ie no friends
130	Social integration	How respondent recollects his/her position vis-a-vis other children in his/her social milieu.	1= self acclaimed 'outsider' 2= outsider, but part of group, a 'hanger-on' or one friend 3= medium/change 4= insider, follower of a group 5= insider, leader of a group
149	Negative feelings reported towards same sex?	Did the respondent report any negative feelings (hatred, loathing intolerance etc) toward members of the same sex between the ages 12-16?. There should be no missing data or not applicable codes for this item.	1= yes 2= no
150	Negative feelings reported towards other sex?	Did the respondent report any negative feelings (hatred, loathing intolerance etc) toward members of the opposite sex between the ages 12-16? There should be no missing data or not applicable codes for this item.	1= yes 2= no
151	Reported discomfort in relating to same sex?	Did the respondent mention any discomfort or embarrassment (either sexually or socially) in relating to members of the same sex between the ages of 12 and 16? There should be no missing data or not applicable codes for this item.	1= yes 2= no
152	Reported discomfort in relating to other sex?	Did the respondent mention any discomfort or embarrassment in relating to members of the opposite sex between the ages of 12 and 16? There should be no missing data or not applicable codes for this item.	1= yes 2= no
153	Differences stressed	In considering the nature of males and females in general did the respondent think that the differences between people were mainly between the sexes (males being quite different to females) or within the sexes (individual differences within each gender being larger than those between the sexes)?	1= predominantly between the sexes 2= predominantly within the sexes 3= both/neither/mixed
211	Age first sensation	Age at which respondent first recalls having a sexual tingling/sensation/arousal. Here, the not 'applicable code' can only mean that the respondent has never experienced any form of sexual arousal/sexual sensations.	Reported age in complete years. If respondent states 12/13 take the lower estimate as the reported age.
212	Age first interest other sex	Age at which respondent reports first becoming interested in members of the opposite sex as potential sexual/experimental partners. This does not necessarily mean the age at which s/he first wanted to have sexual intercourse, merely a curiosity in this regard concerning the opposite sex. 'Not applicable code' here is reserved for respondents who have never shown any interest in the opposite sex	As above
213	Age first interest same sex	As above, but with members of the same sex.	As above
214	Age first kissing/snogging	Age at which respondent report first kissing a member of the same or opposite sex, whichever happened first. Here, kissing refers to full kisses, i.e. more than just a friendly kiss or a peck on the cheek etc.	As above
215	Age first heavy petting	Age at which the respondent first engaged in heavy petting, i.e. consensual touching/being touched in the genital region by another person	As above

Appendix 2 cont.

variable number	variable name	variable definition	response options
216	Age first masturbation	Age at which respondent first recalls touching him/herself sexually, however the respondent defines it. Here, the not applicable' code means that the respondent states they have never masturbated.	As above
217	Age first orgasm	Age at which respondent experienced what s/he defines as his/her first orgasm, whether this was through sexual activity with another person or during a solosex activity	As above
218	First experiences experienced as ...	This refers to how the respondent evaluates his/her early sexual experiences i.e. those experiences prior to first intercourse.	1= predominantly positive 2= mixed/ambivalent 3= predominantly negative
219	Period of delay (longing and frustration)?	Does the respondent recall a period of delay between wanting to have sex/experiment sexually but not having the opportunity to do so (eg no willing partner, no opportunities etc)	1= yes 2= somewhat 3= no
220	Experiences at too quick a pace?	Does the respondent feel that the range of sexual experiences prior to and including first intercourse were experienced too quickly, a pace which the respondent had little control over, a pace dictated by others (friends, partners etc).	1= yes 2= in between; some yes, others no 3= no
221	First learning about bodily pleasure is	How the respondent recalls first finding out about the experience of sexual pleasure (regardless of whether this experience led to orgasm/ejaculation) i.e whether it was through a private experience (solosex activity) or an experience shared with another person.	1= solo (masturbation etc) 2= with other (respondent active participant) 3= via other (respondent passive participant) 4= solo and others together (solosex and experiences with others occurred at around the same time)

Appendix 3 - Short Questionnaire Completed by Focus Group Respondents.

QUESTIONNAIRE TO BE COMPLETED BY PARTICIPANT
AT THE END OF THE FOCUS GROUP

Please note: This questionnaire is for research purposes only. You do not have to put your name on it, and anything you write will be strictly confidential.

AGE: .....years .....months

(Please circle or tick the answer that applies to you)

SEX: MALE
FEMALE

I AM: AT SCHOOL / COLLEGE
WORKING (Please state occupation).....
LOOKING FOR WORK
OTHER (Please specify).....

Section One - Services you may have used
(Please circle the answer that applies to you, and fill in the spaces)

1. Have you ever visited/used a family planning clinic? YES / NO

2. Have you ever obtained contraceptives from a G.P. (doctor)? YES / NO

   If **YES**, was it your own G.P. (doctor) or another one? OWN / OTHER

3. Have you ever visited/used a Brook Advisory Centre? YES / NO

4. Have you ever used a youth advisory or counselling service? YES / NO

   If **YES**, which one?.....

Appendix 3 cont.

Section Two - Your sexual experience

(This section is optional, however, all answers are anonymous and strictly confidential)

1. Have you ever had sex? **YES / NO**
   (If **NO**, please see end of questionnaire)

2. If **YES**, how old were you when you first had sex?

   .....years .....months

3. How many people have you had sex with? .....

4. Do you usually use some form of contraception? **YES / NO**

   If **YES**, what type of contraception do you usually use?

   .....

   If **YES**, from where is it usually obtained? (Eg: doctor, clinic, chemist, vending machines, etc.)

   .....

5. Have you ever had sex without using some form of contraception? **YES / NO**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE AND FOR TAKING PART IN THE FOCUS GROUP

PROMOTION OF YOUNG PEOPLE'S SEXUAL HEALTH SERVICES - QUESTION ROUTE

SECTION ONE - PREAMBLE

I would first like to thank you all for coming today. My name is ..... and I'm from the University of Southampton. I'd like to start by giving you a little background information about the project. Basically, the Health Education Authority in conjunction with our Department, is keen to find out what information young people have about where they would go to, or who they would talk to, about particular problems. So they've asked me to come and find out what services you know about in the local area, and if these are adequate or not. The areas we will talk about then, are:

1. Where you would go to with particular concerns

2. The local services you are aware of

3. How you found out about those services

4. What you think of the services - the impression you have of them

5. How best to promote these services - group work.

During the discussion, ... will be jotting down notes to keep track of what has been covered, and to remind me if I forget to ask certain things. However, so that s/he doesn't have to worry about getting every word down on paper, we'll also be recording the whole talk. But don't let that worry you; as soon as the tape has been transcribed, it will be wiped, so no-one will know who said what.

Regarding language, we want you to feel comfortable throughout the talk, so please just use the language that you are used to using when you chat with friends. Similarly, the whole point of the exercise is to get YOUR views, so there are no right or wrong answers; we just want you to be truthful. You can always answer in term of "My friend did this..." if you like, we don't mind.

Finally, please try and let everyone have a turn at saying something - ALL your views are important, and please try to keep the talk WITHIN the group.

ANY QUESTIONS?

Appendix 4 cont.

SECTION TWO - BRIEF INTRODUCTIONS AND ICE-BREAKING

Ask each participant individually:

1. Their FIRST NAME ONLY.

2. What courses or job they are doing.

Ask collectively:

1. What sex education they received at school.

2. If they think the sex education they received was adequate.

3. What else they would have liked to discuss at school:
(prompt: relationships, emotions, homosexuality, contraceptives)

SECTION THREE - DISCUSSION OF DILEMMAS

This is to gain some idea of the local services participants are aware of. By asking about these dilemmas we are hoping to tap into which (if any) services are used, and why. If participants keep saying they would just talk to their friends, prompt "... and what would they say?", Or "... and how could that help?", etc..

1. Where would you advise a friend to go to, or who would you tell them to talk to, if:

1. They were thinking of having sex for the first time, and wanted to talk about it.

2. They wanted to discuss contraception.

3. They thought they / their partner was pregnant.

4. They thought they had caught something from having sex *(prompt: STDs or HIV).*

5. They were experiencing pressure to have sex *(prompt: peers or partner).*

6. They wanted to talk about sexual abuse.

7. They were experiencing feelings for someone of the same sex, and felt they needed to talk about it.

2. **So, for the situations we just talked about, how good do you think the following people would be to talk to?**

    1. Friends

    2. Brothers / Sisters / Other relations

    3. Parent *(prompt: mother or father)*

    4. Teacher *(prompt: which one?)*

    5. G.P. / Doctor *(prompt: their own doctor, or another)*

3. **Are there any places that you know about locally that offer advice or information about sex and contraception?**

    1. What about family planning clinics? Which ones? *(List)*

    2. What about youth advisory services? Which ones? *(List)*

    3. And are there any other places around here that you could go to to discuss the issues we've been talking about? *(List)*

SECTION FOUR - DISCUSSION OF SERVICES MENTIONED

We've had a few services mentioned there, could we take them one at a time.

For each service mentioned:

1. How many people have heard of *(mention service) ? (Show of hands)*

2. How did you find out about *(mention service) ?*

3. Did you find it easy to get information about *(mention service) ?*

4. Do you know where it is? Do you know what hours it is open?

5. Do you know what services they offer there? Are they adequate?

6. What sort of reputation does it have? Do young people like it and recommend it to their friends, or do they think it's not so good?

Appendix 4 cont.

SECTION FIVE - DISCUSSION OF SERVICES NOT MENTIONED

There are a few other services in this area that don't seem to have been mentioned. For each one I read out, can you tell me:

For services they've never heard of, probe for what they think the service would be like, and how they form that impression.

1. How many people have heard of *(mention service) ? (Show of hands)*

2. How did you hear about *(mention service) ?*

3. Do you know where it is? Do you know what hours it is open?

4. Do you know what services they might offer there?

5. What sort of place do you think it might be? Why do you say that?

SECTION SIX - GROUP WORK ON PROMOTION OF SERVICES

Okay, now we're going to break up into smaller groups. In those groups, I'd like you to discuss how YOU as young people would promote a particular service to other people your age.

You have about 10-15 minutes, during which time I'd like you to think about how you would promote one of the services that we have talked about today. What we are particularly interested in is:

1. **Which service you would promote, and why.**

2. **How you plan to promote that service.**

3. **What message you want to get across about that service, that is, what you think is the most important thing that would encourage a young person to use that service.**

4. **What key images and words you would use to get across that message.**

5. **Where you would promote the service.**

Give each group paper & pens, and after 10-15 minutes ask each group to run through their responses.

Appendix 4 cont.

SECTION SEVEN - DISCUSSION ON ISSUES RAISED IN GROUP WORK

1. What are the key issues raised in the groups?

2. What image do you think the services should portray?

3. How important are issues such as:

    1. Confidentiality

    2. Access

    3. Situations they would use the service *(prompt: prevention / cure)*

SECTION EIGHT - EXAMPLES OF PROMOTIONAL MATERIAL

Now I am going to show you some examples of promotional material that are used in connection with these services. Have a good look at them. I'll hold each one up and I'd like you to give me your first impressions of them.

Show each poster one at a time.

1. What do you think of this poster?

2. Which is the best and worst? Why?

Show the photographs.

1. What do you think of these photos?

2. Which is the best and worst? Why?

3. How could they be used to promote a service?

SECTION NINE - CONCLUSION

Okay, I think we are reaching the end of the discussion. Does anyone have anything they wish to add before we turn off the tape? Well, thank you for taking part. I think it went really well. Do any of you have any comments on how you feel it went? Before you came, what did you think it would be like?

Just before you go, could you fill out this short questionnaire. It's to give us some basic information on who takes part in these discussions. Please do not put your name on it as it is anonymous, and confidential.

Appendix 5 - Example Promotional Material used in Focus Groups.

A. Posters

a) "Basics of Birth Control" [Contraception]. Family Planning Information Service, London.

b) "AIDS - It Won't Ever Happen To Me. Will It?" [HIV/Aids]. Health Education Service, Southampton.

c) "Do You Need Advice On..." [Youth advisory services]. Health Education Service, Southampton.

d) "Sex Sense. A Drop In Service For Young People" [Sexual health service]. Ella Gordon Centre & Off The Record, Portsmouth.

e) "You Don't Need To Sleep Around" [Sexually transmitted infections]. Health Education Service, Southampton.

f) "Flies Can Spread Disease" [Sexually transmitted infections]. Southampton and South West Hampshire Health Education Service.

g) "Henry Was The Eighth" [Sexually transmitted infections]. Health Education Service, Southampton.

B. Photographs

Eleven 8" x 10" glossy colour photographs of young men and women in different poses, groupings and settings, provided by the Health Education Authority, London.

1) Two women talking, head and shoulders.
2) Two men-women couples talking, cafe location.
3) Two women and two men smiling at camera, fairground location.
4) Two men and one woman smiling at camera, head and shoulders.
5) Two men and one woman sitting in street, looking away.
6) Two women talking, head and shoulders.
7) Similar to photo 6, more smiling.
8) One man looking away, studio location, head and shoulders.
9) One man looking at camera, outside location, head and shoulders.
10) Two men looking away, street location.
11) One man and one woman smiling at each other, street location.

C. Magazine advertisements

a) "Thinking Of Having Sex For The First Time? Try This Simple Foreplay" [First-ever sexual intercourse]. Health Education Authority, London.

b) "Only Have Sex Because You Want To" [First-ever sexual intercourse]. Health Education Authority, London.

Appendix 6 - Details of Young People's Sexual Health Services in Figure 7.2.

Letter code on Figure 7.2	Name of service	Client data	Year	Total number of clients	Male clients (%)	Reference
a	St. Helens and Knowsley Health Authority Family Planning Clinics	New clients under 20 years old	1986/87 1987/88 1988/89 1989/90	2023 2099 1789 1917	7 14 12 10	St. Helens and Knowsley Health Authority (1994)
b	'Under 18' Family Planning Session, Woodhouse Park Clinic	New clients	1989/90 1990/91 1991/92 1992/93	149 121 231 243	46 22 35 36	South Manchester Health Authority Community Unit (1993)
c	You 2, Milton Keynes	New clients	1989/90 1990/91	457 406	5 4	Clifford & Eisenstadt (1991)
d	Under 20s Drop-In Clinic, Barnstaple Health Centre	Attending clients	1990	138	35	Nyman & Metcalf (1991)
e	Cwmbran Young People's Clinic, Gwent	Attending clients	1990 1991 1992 1993	225 327 505 293	13 4 8 10	Connolly (1993)
f	Portsmouth and SE Hampshire Health Commission Family Planning Clinics	New clients under 20 years old	1991/92	4559	8	Portsmouth and SE Hampshire Health Commission (1993)
g	Young People's Clinic, Stockport	New clients	1991/92 1992/93	228 113	5 12	Klein (1993)
h	Brynmawr Young People's Clinic, Gwent	Attending clients	1992/93	221	34	Connolly (1993)
I	You 2 Drop-In Sessions around Milton Keynes	New clients	1992/93	≈1300	17	You 2 (1993)
j	Options Young Clwydia	Attending clients	1992/93	251	11	Clywdian Community Care NHS Trust (1993)
k	Newport Young People's Clinic, Gwent	New clients	1992/93	177	12	Connolly (1993)

Appendix 6 cont.

l	Morley Street Young People's Clinic, Brighton	New clients	1992/93	264	**2**	South Downs Health NHS Trust (1993)
m	Market Street Young People's FPC, Greenwich	New clients	1992	141	**1**	Spencer (1994)
n	Young Person's Drop In, Women's and Girl's Resource Centre, Merseyside	Attending clients	Three months of 1993	71	**30**	McLoughlin (1993)
o	Streetwise, Newcastle-upon-Tyne	Attenders of health sessions	1993/94	1431	**22**	Streetwise (1994)
p	Bassetlaw Teenage Clinics (three venues)	Attending clients	1993/94	"well over 500"	**20**	Bassetlaw Hospital and Community Services NHS Trust (1994)
q	Young People's Advisory Service, Weymouth	Attending clients	1993/94	491	**19**	West Dorset Community Health NHS Trust (1994)
r	Derby Teenage Clinics (three venues)	Clients in a survey	1993	115	**15**	Bartlett (1993)
s	Lothian Health Board Family Planning and Well Women Clinics	New clients under 24 years old	1993	6531	**1**	Lothian Health Board (1993)
t	Carnegie Youth Advisory Clinic, Dunfermline	Clients in a survey	1993	115	**13**	Roworth (1993)
u	Youth Advisory Doncaster Clinic	Clients in a survey	1993?	132	**17**	Harkins *et al.* (1994)
v	Just For You Clinic, Solihull	Attending clients	1994	.	**14**	Diaz (1994)
w	Greyfriars Clinic, Great Yarmouth	Attending clients	1993/94	188	**10**	Robinson (1994)
x	Sex Sense (six venues), Portsmouth	New clients	1996	2624	**24**	S. Randall (personal communication, 2 July 1997)

'New clients' refers to clients registered at their first visit to the service during the financial (or calendar) year, whereas 'attending clients' includes repeat visits during that year.

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