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An interpretative phenomenological analysis of young men's experiences of addressing their sexual health and the importance of researcher reflexivity.

Abstract

This article reports one overarching theme from an Interpretative phenomenological (IPA) study which sought to discover the experiences of young males (aged 20-24) addressing or failing to address their sexual health. Owing to the sensitive subject under investigation, these participants were hard to reach for research purposes. Recruitment of participants and collection of data are discussed. The researcher was a young female (aged 20-30), in contrast with participants, affecting data collection and analysis; for this reason the importance of reflexivity in IPA is discussed. It is suggested that IPA is a particularly suitable method for nursing research, which not only allows but embraces the influence and attributes of the researcher. This article considers one superordinate theme in depth, chosen because the researcher's attributes are a significant factor in its recognition.

Key words

Interpretative phenomenological analysis (IPA); sexual health; sexually transmitted infections, young men's experiences, sensitive subject, hard to reach, reflexivity.

Introduction

Historically, men have not accessed sexual health services in the same numbers as women (Pearson, 2003a; Pearson, 2003b; NHS Digital, 2016) and they may have less knowledge about how to access services than their female counterparts (Bersamin et al., 2017).

Consideration of sexual health related behaviours is timely due to the poor state of sexual health in England and Wales, which has been recognised by government policy (Welsh Assembly Government, 2009; Welsh Assembly Government, 2010; Department of Health, 2013). Recent data shows that diagnoses of infections have risen and people continue to put themselves at risk of contracting STI (Public Health Wales, 2017; Health Protection Agency, 2013). The incidence of some sexually transmitted infections is higher in males than females and young people have a higher burden of sexual ill health (Health Protection Agency, 2008; Public Health England, 2016). New strains of infection are being identified (Soni et al., 2018; BASHH, 2018), some of which may become resistant to antibiotics, meaning that prevention is increasingly important.

Whilst incidence of STI and attendance at sexual health services is known, there is little information available about attitudes to seeking sexual health help, especially in young men. There has been research about help-seeking for mental health problems in men (Tang et al., 2014; Yousaf et al., 2015; Wendt and Shafer, 2016), suggesting that gender may be a factor in willingness to seek help. Holland et al. (2004) investigated young people's attitude to AIDS and HIV and found that gendered behaviours affected interactions with members of the opposite sex. Young women were particularly disadvantaged by their gender ideals, which affected their ability to act autonomously. Young men expressed gender ideals which could affect their health and behaviours; however, this has not been researched to any degree in South Wales where unhealthy masculine ideals have previously been identified (Baker et al., 2006). This dearth of evidence has influenced and motivated this study to explore the experiences of young males and their lived experiences of addressing, or failing to address, their sexual health.

As gender and its expressions is individual and influenced by time and place, I have chosen to refer to males and females in this article, except when discussion relates to manifestations of gender ideals (Clayton and Tannenbaum, 2016).

Methods

Young males (aged 16-20) were recruited to take part in this study because there is strong evidence that the highest rates of STI are evident in males aged 20-25 (Health Protection Agency, 2004a; Health Protection Agency, 2004b; Lavery et al., 2006) and investigating the attitudes of younger men before they reached this age could enhance understanding. Young men in the 16-20 age group have also been found to have the least knowledge about their sexual health (Carver et al., 1990; Blake, 2004). This sample has previously been defined as 'hard to reach' owing to the difficulty in accessing them for research purposes about this sensitive subject (Sydor, 2013). As a result, a purposive, convenience sample was recruited from three local authority leisure centres across South Wales; it was deemed inappropriate to attempt to recruit participants from any health care facility as these young men would, by virtue of their presence there, have some knowledge of accessing health services. Posters and leaflets were placed around the leisure centres. Although this did not result in any direct contact with potential participants it did raise the profile of the study and meant that, when approached, young men were potentially aware of the study. Difficulty recruiting young men for research of this type is not uncommon and has been reported (Brown, 2012). Local authority leisure centres were chosen as they are widely accessed in the South Wales valleys and options for accessing this group for research purposes have previously been discussed (Sydor, 2013). This meant that a sub-group of this population were therefore recruited as the sample.

Young men were approached at the leisure centre and invited to take part; information sheets were distributed to them on their way out of gym or exercise classes and they were offered verbal information about the study with the aim of recruiting six young males. Potential participants were given time to consider taking part, an appointment was arranged to sign the consent form and a subsequent appointment was arranged for the interview. This recruitment process allowed opportunity for potential participants to decline without giving a reason, in line with Health research authority guidelines (Health Research Authority, 2018). If young men did not arrive for prearranged appointments, it was assumed that consent had been withdrawn and they were no longer willing to take part. These young men were not contacted again. Seven young men took part in the study but ten more withdrew during the recruitment process described.

A room was arranged in the leisure centre in which the young participant had been recruited and semi structured interviews were conducted; this is a method suitable for use in IPA studies (Smith et al., 2009) as it enables detailed and responsive exploration of participants' sense-making. An interview structure was developed and utilised during the interviews (see supplementary files) but participants were encouraged to talk about their experiences and were questioned in order to expand and develop their ideas. This meant that conversations were led by the participant, but a depth of discussion could be reached, clarifications were sought with participants during the interview and answers probed further. The interviews were tape -recorded and stored with consent; a total of seven participants took part. Five individual interviews and one joint interview were undertaken. This was because two participants jointly expressed that they would be uncomfortable alone; this was not questioned or challenged but the researcher reminded them that they could withdraw at any time. It is possible that interaction within this joint interview had an effect on the data as the potential effects of gender on focus groups have been well described, for example in the assertion of masculinities when other men are present (Kassab et al., 2014; Measor, 2000).

Ethical permission was sought from the University and permission given by the local authority to use their facilities for data recruitment and collection.

Data was transcribed and then computer software, NVivo, was used to facilitate the ordering of themes and sub- themes; this enabled sections of text to be coded and ordered, but no automatic searching or ordering functions of the computer software were used. In line with suggested guidance in IPA, the six steps of analysis (Smith et al. 2009) were used to inform the process . This meant that the data was considered and themes deriving from it developed, these were rooted in the participants descriptions of their experiences. Themes were grouped together and a structure emerged of sub-themes and superordinate themes (Smith and Osborn, 2003) (see supplementary files). Each transcript was analysed separately and then commonalities identified. A second researcher was involved in the early stage of analysis to ensure that themes were substantiated and rooted within the participants' sense -making. The nature of the double hermeneutic in IPA means that the analysis is constructed by the participant and the researcher, findings are the researcher's sense making of the participants' sense making of their experiences (Larkin, 2012; Smith, 2009). It is for this reason that findings were not checked with participants after analysis, although they were offered the report on the findings of the study.

The double hermeneutic

IPA was chosen to undertake this study owing to its methodological suitability; particularly the acceptance of the researcher's influence in data collection and analysis. This method has been developed in the field of health psychology by Smith (1996; 2004) and seeks to discover participants' lived experiences during a process of data analysis into which the researcher enters (Reid et al., 2005). The lack of objective reality in this process has been acknowledged previously (Larkin et al., 2006); but the depth of analysis enables a deeper understanding to be gained of participants' sense making and experiences. Data analysis using IPA involves the researcher trying to make sense of the participants' making sense of their own experiences; Smith (2004) describes this as a double hermeneutic.

In IPA, the researcher is accepted as an integral part of the analysis, becoming part of the research process. In order to ensure that analysis is rooted in the data, the researcher must be reflexive, accepting that putting their own preconceptions aside may be impossible. Assuming that the researcher's experiences, knowledge and beliefs can be removed completely from the research process may disguise the depth of their effect on analysis. It was because of this that IPA was particularly suitable for use in this study, because as a young female, I would never experience the same world view as the participants and yet my own gender may have affected my interpretations of their sense making. This disparity is the reason that a potentially sensitive superordinate theme has been chosen for discussion here; the importance of the researcher is illustrated in consideration of this. Similarly to other qualitative methods, IPA data analysis should demonstrate the audit trail from data to themes generated and interpretations; this ensures that findings can be grounded in the participants experiences.

Findings

Six superordinate themes: sexual health knowledge and attitudes, feelings about masculinities, communication, feelings about health care, feelings about working and keeping fit, were identified. Each of these themes consisted of many sub-themes. These superordinate themes are derived directly from the data; after consideration of these themes and the data, three overarching themes were developed. These enabled me to develop ideas about the participants' explanations and sense making, drawing together themes to explain what these might mean for participants (Larkin, 2012).

These are illustrated in table one; they are grounded in all the participant's data but contain insights that were not initially apparent, representing my sense making and interpretations. Implicit within these themes were the participant's underlying beliefs and attitudes. It is the analysis revealing one of these overarching themes, the hidden moral code, which is discussed here. Other themes have been discussed and presented previously (Sydor, 2010). Participants have been given pseudonyms to protect their anonymity.

The 'hidden moral code'

This overarching theme was neither overt nor referred to, but its existence was implicit within participants' discourse. Some behaviours and people were discussed in a manner that suggested they were distasteful in some way, negative outcomes were associated only with these situations; for example, participants linked behaviours deemed to be blame worthy to an increased risk of contracting an STI. Participants decided whether a condom was necessary or not by vetting potential partners based on their reputation or how they had met the woman. This separation of different behaviours into acceptable and not, amounted to a hidden moral code, participants did not acknowledge it explicitly and yet it was implicit in their decision making. Participants' quotes here fitted into the themes of sexual health knowledge and attitudes and communication (See table one).

Aneurin said "I hadn't done anything" and also said "I don't go around just sleeping with anyone like when I have just met them I don't go out and just...well you know I don't go in for one night stands". David alluded to this idea when he said of certain forms of sexual behaviour "when someone tells me something is bad, I am quite scared of things". Huw also considered some forms of sexual behaviour to be riskier than others, and his language conveys an idea of blame associated with these behaviours "like say... like... I met someone at a party, not that I would, but like if I met someone at a party then and anything happened I would make sure like if I had never met the girl before". Gwyn felt that concern about STI was dependent on behaviour "It depends though doesn't it...if you have got anything to worry about". These statements show that participants thought of some forms of behaviour as acceptable and others not. As well as referring to their hidden moral codes, participants were introducing their risk management strategies, they felt that by avoiding morally unacceptable behaviour, they were also protecting themselves from the risk of contracting an STI. Strategies were similar between participants, Aneurin avoided casual sex and Huw alluded to the same strategy by stating that he did not have sex with women he had met at parties. David's comment referred more clearly to a moral link with behaviour; he felt that some behaviours were bad and should therefore be avoided.

The projection of this idea is that participants must have ascribed some blame to those who did contract an STI. The cause of infection is located within the behaviour which led to it and thus those who become infected with an STI must have been in some way culpable. This idea is harmful to both the participants and those around them, it could lead to a delay in help seeking. The reliance on poor management strategies, such as those discussed above, may also have prevented participants from utilising effective risk management, such as condoms. The stigma associated with an STI also affects help seeking and willingness to disclose to partners, thus perpetuating the cycle. Huw explained this stigma by saying "I would probably just feel embarrassed or I wouldn't want people just to know that I got a sexual infection".

The idea that some people were more at risk of STI was also alluded to by Gwyn who said: "like if the girl has a reputation you would want to use protection even if she was on the pill". He further elaborated saying: "but if she doesn't [have a reputation] or like... it's her first time or something and she is on the pill well you don't have to worry". Gwyn did not refer to refraining from sex with

partners whom he considered to be risky; he merely suggested he would ensure that with these women he would use a condom; an ineffective risk management strategy as it is impossible to know who might have a sexually transmitted infection. It also means that Gwyn may possibly have made judgements about potential partners, deciding his behaviour on the basis of his appraisal.

The underlying implication that females are the vectors of STI is implicit in Gwyn's statements. Huw made this explicit when discussing who he would talk to if he discovered he had an STI: "well if I had a girlfriend at the time, obviously her, if I got it off her". This blame was also implicit in David's statement about a friend of his: "he had some kind of rash after some kind of sexual encounter with this girl". The girl is described by David as the source of the rash and David's friend as the innocent party. It is possible that women view their sexual partners as the source of STIs in the same manner. Investigation of the way that other groups assess and manage their sexual health is required to properly explore this.

Gwyn also discussed how he would negotiate a complex sexual situation in which his partner had a reputation (thus posing a risk) but was also using hormonal contraception, negating the need to consider birth control. He said "you would just say to her you want to make sure like". This statement shows that Gwyn had considered the potential implications of insisting on condom use in some situations but not others; it also suggests the negative connotations implicit in suggesting risk to a partner. Gwyn did not consider his behaviour to pose his partners a risk nor did he consider it morally wrong; he sought to protect himself from females and their potentially risky previous behaviour.

Participants used their own risk assessments and their assertions about condom use as an expression of their masculinity. Many of their statements assert dominance in sexual interactions and condom decision-making. For example, Huw said "I would make sure I used protection if it was with like a girl I wasn't sure about"; this could be interpreted as portraying dominance over his sexual partner. There is no mention about how this might be perceived by a potential partner.

Discussion

The way that participants associated blame with STIs is not new. In Victorian Britain it was considered that venereal disease was the consequence of vice and promiscuity (Hall, 2000), women were seen as reservoirs of disease, a peril to men who were victims enacting their physical needs (Mason, 1994). Blame was also attached to syphilis, it was considered a punishment for debauchery; AIDS has been viewed similarly more recently (Allen, 2000). These ideas are detrimental to society; considering STI as a problem of others causes individuals to fail to manage their own risk. (ref?)

Aneurin, Huw, David and Gwyn labelled and categorised women in a manner similar to that described by Lichtenstein (2003) who found that females' sexual behaviour could categorise them as either 'good' or 'bad' people in a study conducted in sexual health clinics in the USA, suggesting that others also link perceptions of morality with sexual behaviour. Daley et al. (2015) suggest that certain STI are perceived as exclusively affecting women, who are also considered potential vectors of infection (Yankauer, 1994); these beliefs may contribute to poor risk management and stigmatising attitudes.

These attitudes may potentially be problematic for both young males and young females, if they result in poor risk management behaviours. It is important to challenge possible negative attitudes in a non-threatening way, in order to facilitate informed decision-making in patients. If nurses and other health care professionals make assumptions about patients' attitudes, the opportunity to challenge them and promote healthy decisions is lost.

Different behaviours are considered acceptable for women and men; this double standard has previously been described by Holland et al. (2004). The same levels of sexual promiscuity which might assert a young man's masculinities could quite possibly label a woman a 'slag'; negative reputations gained by women in this way are promulgated by both men and women. Recent media reporting of the sexual behaviour of young people on holiday has focused disproportionately on the unacceptability of sexually promiscuous behaviour of young women (Robson, 2014); whilst men are not portrayed as injured parties, neither are they admonished with the same vehemence as women. Martin et al. (2014) found that media reporting characterised men as a risk to women whilst asserting that women bore responsibility for both contraception and preventing sexual ill health. Women were described as vulnerable to men and depicted as unable to communicate or assert their wishes. In their qualitative content analysis of newspaper articles, however, Martin et al (2014), do not describe the gender of the authors or editors thus raising questions of gender bias in media reporting; transparency about this might lead to a deeper understanding of attitudes. The dominance of young men in sexual interaction was identified in my own findings; however, the young men's discourse asserted their dominance both in the discussion of sex in the interview and in their accounts of interactions with partners. Participants' discourse suggested that their female partners were passive and allowed young men to take decision-making responsibility. It is important to consider the nature of the interview and the possibility that some of the participants used it as an opportunity to assert themselves over me, a young female researcher. It is not possible to know the extent that participants asserted themselves in the interview or how this reflects what happens in interactions with female partners.

This may mean that their discussion around sexual decision-making with their partner may not have been reality, but the participants' wish to assert it is. The discourse of the participants around decision-making, however, remains interesting. Participants demonstrated their feelings around the need to assert their dominance; important regardless of whether it was actually enacted. It is possible that this may be an issue in other health care interactions and further research could help to illuminate the issue and propose management strategies.

Importance of reflexivity

The role of the researcher in interpreting the participants' sense making is a fundamental part of the IPA analysis, due to the double hermeneutic. In order to ensure that the interpretations are grounded within the participants' discourse, quotes from the data are given.

One of the reasons that IPA was chosen for this study was the dissimilarity of the researcher and the participants, namely, different genders and potentially different socio-economic backgrounds. IPA is also appropriate when a similarity of experience exists between the researcher and participants. The necessity of explicating one's own feelings and expectations means that the researcher is able to examine their preconceptions in order to come to a new sense making of the participants' lived experiences (Shaw, 2010).

The overarching theme discussed in this paper was revealed through my interpretation, meaning that my contribution to the analysis was central; the findings were constructed by me, making sense of the participant making sense of their experiences. The interaction between me and the participants was an important part of this. It was therefore important for me to examine my preconceptions and attitudes in order to ensure that I was able to understand and interpret the participants' sense making. The participants' role in the examination of their experiences is central, they discussed this with me during our semi structured interview. This interaction was created by me and the participant, meaning we were both significant in the construction of the data. My

characteristics or nature as a researcher may have caused me to focus in particular issues or affected the way that participants were able to examine and explain their experiences.

In relation to the main theme discussed here, I was caused to consider the way that society embeds moral attitudes within discussion of sexual behaviour and how this may have affected my decisions in undertaking the analysis. My background, for example, growing up in a religious household and having been provided with little sex education at school, have certainly influenced me but have also led to my interest in the subject and informed my approach to this research. For me, undertaking this research involved engaging in discussions of a sensitive topic, steeped in moral undertones. The participants did not have the same backgrounds, experiences or influences, in fact many lived in a different socio-economic backdrop and had different gender perspectives than my own.

My experiences as an adult have certainly influence me but also affected the data collection. I am a contraception and sexual health nurse, experienced in discussing sensitive issues that are usually off limits; this may have caused the interview to follow a more clinical structure, despite my determination to ensure that it remained a conversation with a purpose (Smith et al., 2009).

Conclusion

This study demonstrates the importance of gaining understanding of attitudes to young men's sexual health. It cannot be said that all young males will hold these attitudes, but sexual health nurses and other health promotion professionals need to consider the possible effect of underlying attitudes on health-related behaviours. This study contributes knowledge in relation to how young men negotiate their masculinities, and how they adjust their behaviours to balance what might be acceptable to themselves and others.

IPA is an important method for many kinds of nursing research. The double hermeneutic element means that the researcher enters the process of data analysis, becoming themselves an integral part of the findings which is particularly useful in research where there is either dissimilarity or similarity between the research and the participants. In this research, my experiences as a young female researcher with a different background to that of the participants necessitated the examination of my preconceptions and beliefs. The complete elimination of these was not realistic owing to their fundamental nature, for example gender and moral beliefs are examinable but maybe not removable.

Nurses or other health care professionals undertaking research often choose a topic about which they have prior knowledge or experience. The complexity of the perceived knowledge and understanding could make it difficult for them to hear and attempt to understand the sense making of participants. The importance of adopting the researcher role as opposed to a professional identity cannot be underestimated.

A number of elements of IPA enabled me to undertake this research which could have proved epistemologically difficult using any other approach; firstly, setting aside my pre-existing beliefs may have been impossible owing to their intrinsic nature making it difficult to judge their effects on my thinking. Secondly, IPA enabled me to enter the research process and analyse data as myself, reflexively considering my impact on this analysis.

Although difficulty accessing a large sample was anticipated; the depth of analysis used in the IPA approach yielded more than enough rich data for the study using a small group of participants.

Finally, the IPA method allowed me to examine and fully immerse myself as a female researcher into a topic and world view about which little is known.

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