A post-structuralist inquiry into health and health discourse in the lives of young men aged 11 to 19 in the UK

By

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Abstract

Background

There is increasing attention on young people’s health amidst concerns about their health related behaviours including diet, substance use, and exercise. Little is known about how young people respond to this increased attention, with young men being particularly absent in this area of research.

Aims and objectives

This research aimed to better understand young men’s perspectives on health and health information, and to explore how this may differ depending on context. The study also examined what influences young men’s perspectives on health. The ways in which young men make sense of, and respond to, the health information and knowledge that they are subject to is also considered.

Methodology

This post-structuralist case study utilised focused ethnography to examine the ways in which young men constructed ideas about health and a healthy body. Ethnographies are effective for identifying dominant socio-cultural discourses. Interaction in the everyday lives of participants can lead to a better understanding of their beliefs, motivations, and behaviours. A post-structural ethnography involves acknowledging and addressing the power relations within the research dynamic, including those involving the researcher.

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Research took place in two contrasting locations for eight weeks between January and May 2014. Using two locations for data collection has highlighted how such responses can differ depending on context. Data collection took the form of observation and documentary data, as well as individual and group interviews with fourteen young men aged between twelve and eighteen. Data was analysed through thematic and discourse analysis.

Findings

The study explored the topics the young men in each site raised in relation to health, and how they conceptualised different approaches to 'being healthy'.

The key themes that were identified as being important to health were: the privileging of mental health over physical health, particularly in relation to the importance of happiness; belonging within family and friend groups and the behaviour that might facilitate this; and how they coped with life through means of the emotional support they needed and could access through professional services, family, friends and use of smoking, alcohol, and substances.

There was a lack of trust in 'official' health information, underpinned by the belief that official information needed to be assessed in relation to their own lives and their peers. The young men often responded to health information by neutralising the dominant discourse, thus repurposing 'official' messages to meet personal needs. The young

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men also privileged information taken from personal experience over other health information that they perceived to be biased.

Context was observed to be a key factor in how the young men in this study understood and embodied health. Their ability to critically consider health information appeared influenced by the discourses available to them. The similarities in how the young men made sense of the health-related information available to them appear to be more marked than the differences.

Conclusion

The research undertaken in these two sites reveals both similarities and differences in the influence of a variety of factors on understandings of health. There is a high degree of complexity when attempting to understand performances of young masculinities in relation to health.

This research builds on the findings of previous research in order to propose a model that represents factors forming and contributing to the health of adolescent boys. This model goes further than previous models in considering the role of context, socioeconomic status, education, and access to capital, discourse, and masculinities. The co-creation of conceptualisations of health is also considered with communities of practice being active in specific contexts, with the agency to contest, resist, assimilate, and repurpose knowledge in order to mitigate risk.

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1.0 Introduction

Mark Twain once suggested that “at the age of 12 a boy starts imitating a man and just keeps on doing that for the rest of his life”. Osherson (2018) argues that boys do not get a lot of help in negotiating what it means to be a man and how to be comfortable with the man they are becoming. This research is concerned with how young men find, and make sense of, the health information available to them, and how this intersects with their emerging identities.

With this in mind, this research aims to better understand young men’s perspectives on health and health information, and how this may differ depending on context. The research will also examine what influences young men’s perspectives on health, as well as how young men respond to these forms of health information and knowledge (i.e. assimilation, contestation, resistance) and how this may differ depending on context.

1.1 Young people and health

There is a lack of general agreement on the health status of young people. On the one hand, as a socio-demographic group young people have been said to be relatively healthy (MacDonald and Shildrick, 2012) with health inequalities less obvious in this age range (West, 2009). However according to the 2012 Annual Report of the Chief Medical Officer (Viner et al., 2012) adolescents have experienced the least improvement in health status of any age group in the British population over the last 50 years. Adolescence has previously been seen as the

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26 healthiest time of life however, in all high-income countries globally,

27 mortality among adolescents is now greater than in one to nine year

28 olds (Viner et al., 2011). According to Viner et al.

29 *"…this shift has been driven by the 'health' transition*
30 *from infectious diseases to injuries and non-*
31 *communicable diseases [leaving] adolescents*
32 *vulnerable to the largely preventable morbidity and*
33 *mortality related to injuries, mental health and non-*
34 *communicable diseases such as asthma, cancer,*
35 *diabetes and obesity." (2012, p.4)*

36

37 Viner et al (2012, p.1) also suggest that adolescents appear to have

38 benefited less than younger children from the "epidemiological

39 transition" that has reduced all causes of mortality among children. In

40 2012, an estimated 1.3 million adolescents died; mostly from

41 preventable or treatable causes (WHO, 2014). Childhood immunisation

42 has reduced adolescent deaths and disability significantly (WHO,

43 2014) but adolescents are still dying from common infectious diseases

44 (WHO, 2014).

45

46 Laski's (2015) paper is based on a review of evidence based inputs

47 received from public consultations conducted by the Partnership for

48 Maternal, Newborn and Child Health and expert meetings organised by

49 the UN Population Fund (UNFPA) in 2015 as part of the UN secretary

50 general's Global Strategy for Women's, Children's and Adolescents'

51 Health. As a result of this review, Laksi (2015) concluded that the health

52 related behaviours that have been associated with major non-

53 communicable diseases have been shown to start during adolescence.

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54 Habits such as tobacco and alcohol use and diet and exercise patterns

55 associated with obesity could affect the morbidity and mortality of

56 adolescents as they age; this could also affect future generations

57 According to Laksi (2015, p.17):

58 *"…developing programmes to provide them with the*
59 *skills they need for their health and development*
60 *countries can ensure adolescents will contribute fully*
61 *to their societies and develop the judgment, values,*
62 *behaviours, and resilience they need to be safe, to*
63 *end discrimination and violence, and to help create*
64 *and sustain national and global peace. In turn, this*
65 *healthy generation will nurture the next so that it can*
66 *participate effectively in a rapidly changing globalised*
67 *world."*

68

69 As an attempt to address some of the issues raised by Laksi (2015), the

70 HeadStart programme is a five-year programme set up by the Big

71 Lottery Fund. HeadStart aims to improve the mental wellbeing of ten to

72 sixteen year-olds and prevent serious mental health issues before they

73 develop. HeadStart has been labelled the largest ever population based

74 survey of children's mental health and wellbeing in England. As part of

75 the project, researchers at University College London (UCL) and the

76 Anna Freud National Centre for Children and Families analysed survey

77 responses from 30,000 children aged eleven to fourteen (Deighton et

78 al., 2018).

79

80 HeadStart is taking a 'test and learn' approach to find out what works,

81 and what can be effectively replicated. The programme is currently only

82 two years into its five year timeframe. The Big Lottery responded to the

83 'Transforming Children and Young People's Mental Health Provision: a

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84 Green Paper' (Department for Health and Social Care)DHSC and DfE,
85 2018) with some of their learning so far in order to support the
86 Government in meeting its ambitions around the mental health of
87 children and young people (Big Lottery Fund, 2018). The Big Lottery
88 stressed the importance of putting young people in the lead when
89 designing and delivering services; involving the community beyond the
90 school in supporting young people's mental health; and taking a
91 lifecycle approach to improving young people's mental health.
92
93 HeadStart has found that white children were more likely to suffer
94 mental health issues than those from black, Asian, mixed and other
95 ethnic groups (Deighton et al., 2018). Deighton suggests that this could
96 be due to these ethnic communities having "*better family cohesion or*
97 *having a more diverse group of friends, bringing more social capital*"
98 than their white counterparts (Turner, 2018, p.1). Deighton also
99 questioned if it was more socially acceptable for white young people to
100 talk about their emotional issues than their peers from other ethnic
101 backgrounds, therefore to be more likely to report their mental health
102 issues (Turner, 2018, p.1).
103
104 There were also gender differences within HeadStart with the finding
105 that girls were more likely to report internalising issues such as
106 depression or anxiety, and boys being more likely to externalise
107 problems through aggression and school issues (Stapley and Deighton,
108 2018). Higher percentages of white boys described experiencing

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109 explosive anger, lack of friends, struggles with learning and behaviour,
110 and perceived victimisation by teachers (Stapley and Deighton, 2018).
111
112 In 2016, five year sustainability and transformation plans (STPs) were
113 developed, aimed at covering all aspects of National Health Service
114 (NHS) spending in England (NHS England, 2016). The Kings Fund
115 (2017) drew attention to the fact that children's services did not feature
116 in most STPs. The Kings Fund highlighted that services for children and
117 young people had experienced larger funding cuts than any other area
118 of public health in 2016/17.With regard to current health policy, key
119 policies such as the current plan for reducing childhood obesity (The
120 Child Obesity Plan, (HM Government, 2016) have been criticised as
121 insufficient (The Kings Fund, 2016).
122
123 In preparation for the UK 2017 General Election, The Kings Fund
124 (2017) reported on the policies needed to improve the health of
125 children. Health and wellbeing in childhood are particularly important for
126 public policy, because there is evidence that they influence health in the
127 subsequent generations of adults (Marmot et al., 2010). However it
128 cannot be assumed that issues affecting children and young people's
129 wellbeing, and their experience of them, will be the same as those
130 affecting adults (The Kings Fund, 2017). Therefore, policy development
131 should incorporate information from children and young people about
132 their lives.
133

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134 With regard to existing public policy, the Association for Young People's
135 Health (AYPH) Report (2017) assessed a number of initiatives and key
136 policy and guidance documents. They highlighted the need to do more
137 work on how to promote young people's health in the existing outcomes
138 frameworks and health service incentive programmes. These include,
139 for example, the NHS Outcomes Framework (NHSOF) (DoH, 2016), the
140 Public Health England Outcomes Framework (PHOF) (Public Health
141 England, 2012), the Quality and Outcomes Framework (QOF) for
142 primary care (NHS Digital, 2018), and the Care Quality Commission
143 (CQC) inspection standards (CQC, 2017).
144
145 It is also important to consider wider influences such as social and
146 economic factors when considering the impact of policy. There is
147 evidence of variation in health outcomes by region as well as the
148 specific effects on young people. Social determinants of health, such as
149 living in areas of multiple deprivation have been shown to be a
150 vulnerability factor in relation to health outcomes (AYPH, 2017).
151
152 Public Health England data shows that young people's outcomes vary
153 enormously by area (Public Health England, 2019). These variations
154 have also been usefully highlighted in the Royal College of Paediatrics
155 and Child Health (RCPCH) 'State of Child Health Report' (2017). This
156 report focuses on society's responsibility to create the optimal
157 environment for children and young people to survive and thrive.
158

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The RCPCH (2017) report concludes that, in order to improve the wellbeing of children and young people, it is essential to strengthen and protect individual and social determinants and improve their position in society (RCPCH, 2017). The Organisation for Economic Co-operation and Development (OECD) credit actions aimed at reducing inequity related to income, gender, ethnicity or sexuality as being vital in improving the wellbeing of children and young people (2016). Of course, it is important to understand how issues like these impact on the health of children and young people. It is with this in mind that this chapter moves on to exploring the issue of gender and health.

1.2 Young men and health

Although young men in many societies have been observed to benefit from opportunity, privilege, and power that are not equally offered to young women (Hawkes and Buse, 2013), these advantages do not necessarily lead to better health outcomes (Baker et al., 2014). There is considerable research about varying health outcomes in relation to gender and age, but this often fails to qualitatively address the reasons why these outcomes might be so different.

Ricardo et al. (2006) argued that discussions of gender have often ignored the gender-specific vulnerabilities of young men and boys. Although young women are generally more at risk of health and development problems, young men in most places have been found to suffer from higher morbidity and mortality rates (WHO, 2000). To explore this further, WHO (2000) conducted a literature review of

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184 existing and available literature on adolescent boys and their health and
185 development. The purpose of this document was to analyse this
186 research with reference to implications for programme and policy and
187 identify areas that require additional research. The WHO took a gender
188 perspective to argue that a focus on meeting the needs of boys could
189 also promote greater gender equity for adolescent girls.
190
191 The WHO (2000) report identified some assumptions that have been
192 made about the health and development of adolescent boys: that they
193 are progressing well, with fewer health needs and developmental risks
194 than adolescent girls; and that adolescent boys are often described
195 disruptive, aggressive and hard to work with (WHO, 2000). The WHO
196 (2000) report found that research on adolescent boys, as for
197 adolescents of both sexes, tends to focus on problems and risks. These
198 generalisations do not account for the fact that adolescent boys, like
199 adolescent girls, are not a homogenous population. The research
200 presented within the report argued that the health risks associated with
201 boys are strongly influenced by the way that they are socialised.
202
203 Within Western countries, young men tend to be influenced by
204 traditional masculine ideals (Oliffe et al., 2010). Most boys in Western
205 countries are socialised to embody hegemonic masculine ideals that
206 actively discourage vulnerability, weakness, or emotional expression
207 (Evans et al., 2011). Mason-Jones et al’s (2012) systematic review
208 found strong evidence that men begin to disconnect from health-care

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209 services during adolescence. However, expressions of masculinity can
210 be described as diverse (Connell, 1995), with some young men
211 constructing a pluralistic masculine identity (Mullen et al., 2007).
212
213 The WHO (2000) review provided a strong basis for designing more
214 effective policies and programmes related to adolescent boys. These
215 findings may help to address some of the assumptions about boys. The
216 WHO (2000) review concluded that boys can be engaged if their needs
217 and concerns are listened to and approached in positive ways. The
218 review confirmed the evidence that adolescent boys have gender-
219 specific potentials and risks. A challenge was raised by the review as to
220 how young men can be offered opportunities to explore their roles and
221 expectations as men, whilst being engaged in ways that promote
222 healthy development and well-being for themselves, their partners and
223 their communities (WHO, 2000).
224
225 As a result of this report, the WHO (2007) conducted a project to
226 assess the effectiveness of programmes seeking to engage men and
227 boys in achieving gender equality and equity in health. The studies that
228 were reviewed appeared to confirm that reasonably well-designed
229 programmes and interventions with men and boys can produce short-
230 term change in attitudes and behaviour. Programmes that showed
231 evidence of being gender-transformative tended to show more success
232 in changing behaviour among men and boys. These behaviour changes
233 can help lead to better health outcomes for men and society in general.

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The WHO recognised that, in order for this local work with boys and men to be more widely effective, policy must be addressed (WHO, 2010). Associated policy processes and mechanisms were identified as key elements to engage men and boys in achieving gender equality in health outcomes. As a result of this report, the WHO recommended that governments now integrate appropriate policies and programmes into existing national plans and platforms and rapidly take them to scale.

The Children's Society (2016) state that gathering and acting upon information directly from them children and young people about their lives is key to improving wellbeing. With this in mind, this research has attempted to give young men voice about health, specific to their communities, and beyond school. The hope is that the dissemination of this information will help influence policy and health promotion in the UK.

1.3 Overview of chapters

This thesis is presented in nine main chapters. Chapter one introduces the issue of young men's health and establishes the context for the study. As well as this, it outlines the researcher's position and aims of the study. Chapter two provides an overview of the literature around health outcomes in relation to gender, young people, and particularly young men. Chapter three moves on to review the body of evidence in this area before considering what this thesis intends to add to the conversation. Chapter four discusses the methodology and research design that was selected for this research study. The rationale for using

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259 such a design is also explained in light of the researcher's
260 epistemological and ontological stance. Chapter five covers the
261 important issue of reflexivity and how this threads though the study and
262 thesis.
263
264 The results and discussion section begin in chapter five with an
265 overview of the context of each research setting in order to get a sense
266 of and understanding of the contexts in which the research took place.
267 Chapter six explores what the young men in each site talked about
268 being important to health. Chapter seven is concerned with presenting
269 the findings related to how the young men made sense of the health-
270 related information available to them. Chapter eight discusses the
271 overall findings of the study in relation to the study's research questions
272 and proposing a model representing the factors that form and contribute
273 to the health of adolescent boys. Chapter eight also concludes the
274 research findings by discussing limitations, implications, and suggested
275 ways forward for policy, practice, and future research.
276

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2.0 Overview of the literature

This chapter will provide an overview of the literature around health outcomes in relation to gender. This will begin with an overview of gender differences related to health across the lifespan, before focusing on young people, and particularly young men.

The health outcomes for young men will then be considered in relation to the health discourses that exist around these issues. How this issues around masculinity relates to this discourse will be studied. The construction of the health information within wider health discourse will be examined, as well as how young people have been shown to make sense of this information, and the potential impact of this.

2.1 Health outcomes – gender differences

The Global Burden of Disease study showed that between 1970 to 2010, women had a longer life expectancy than men (Barker *et al.*, 2010). Globally, the average life expectancy gap between men and women is 4.6 years, with women outliving men in all countries, and a gap of over 10 years in some cases (Global Health Observatory (GHO) Data, 2018). In many societies, men have been shown to possess more opportunities, privileges and power than women, yet these advantages do not appear to translate into better health outcomes (Elias and Beasley, 2009 , Barker et al., 2010 , Baker et al., 2014). Despite overall improvements in life expectancy, rates of premature male mortality (particularly for men in areas of socioeconomic deprivation) remain an

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301 important issue of concern in the United Kingdom (Robertson and
302 Baker, 2017).
303
304 According to the WHO's European Region's review of the social
305 determinants of health, men's poorer survival rates reflect several
306 factors:

> 307 *"– greater levels of occupational exposure to physical*
> 308 *and chemical hazards, behaviours associated with*
> 309 *male norms of risk-taking and adventure, health*
> 310 *behaviour paradigms related to masculinity and the*
> 311 *fact that men are less likely to visit a doctor when*
> 312 *they are ill and, when they see a doctor, are less*
> 313 *likely to report on the symptoms of disease or illness"*
> 314 (UCL Institute of Health Equity, 2013, p.139)

315
316 The social determinants of health have been found to have a
317 disproportionate impact on mortality in men. White et al. (2018)
318 conducted a study into the state of health of the male population in
319 Leeds to guide public health commissioning decisions. The findings of
320 this study highlighted that there were large differences in both morbidity
321 and mortality for men across different areas of Leeds, suggesting that
322 the health challenges the men were facing were more than a biological
323 issue specific to being male. This is one of the reasons why it is
324 important to consider context as well as gathering a range of qualitative
325 data to gain a more detailed overview of the phenomenon.
326
327 In addition to social determinants, sex and gender affect a wide range
328 of physiological functions and influence both pharmacokinetics and
329 pharmacodynamics. Sex and gender can also have an impact on a

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330 wide range of diseases including those of the cardiovascular,
331 pulmonary, and autoimmune systems, as well as diseases involving
332 gastroenterology, hepatology, nephrology, endocrinology, haematology
333 and neurology (Oertelt-Prigione and Regitz-Zagrosek, 2012).
334
335 Regitz-Zagrosek's (2012) seminal paper on evidence-based sex and
336 gender medicine identified more than 10,000 articles dealing with sex
337 and gender differences in clinical medicine, epidemiology,
338 pathophysiology, clinical manifestations, outcomes and management.
339 Amongst the conclusions of this paper were that sex and gender
340 differences in cardiovascular diseases are particularly well-investigated
341 because there is strong epidemiological evidence that men and women
342 face different risks and have different outcomes.
343
344 Some examples of the difference risks and outcomes between and men
345 and women occur with heart disease. Ischaemic heart disease was
346 observed to develop on average seven to ten years later in women
347 compared with men in most western societies. However, the overall
348 incidence of myocardial infarction is in decline worldwide in all
349 population groups except young women (Lloyd-Jones et al., 2010).
350 Young women have perhaps not been reached by prevention
351 programmes, and also face increased cardiovascular risk owing to
352 lifestyle changes—such as smoking or experiencing increasing job
353 stress (Regitz-Zagrosek, 2012).

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354 Kure et al (2016) identified differences in men and women with heart
355 disease in respect of psychological determinants, cognitive impairment,
356 and responses to secondary prevention; gender also appeared to
357 modulate cardiovascular-specific outcomes (Kure et al., 2016). Kure et
358 al. (2016) recommend early detection of psychosocial factors through
359 routine screening and gender-specific secondary prevention.
360
361 Other examples of conditions showing different risks and outcomes
362 between and men and women include neurological disease and
363 asthma. Many neurological diseases have been shown to display
364 gender biases, with one sex possessing a greater incidence or severity
365 of the disease. Neurological diseases in the young and the elderly have
366 also exhibited gender-specific responses to therapies (Li, 2014). In
367 asthma, there are gender differences in regard to sociocultural origin,
368 presentation, doctor's diagnosis, and treatment of asthma symptoms,
369 as well as the coping strategies utilised by the person being treated
370 (Koper et al., 2017).
371
372 Despite the amount of data on these differences, it has been argued
373 that medical practice does not adequately consider gender when it
374 comes to diagnosis, treatment, or disease management. Regitz-
375 Zagrosek (2012) identified almost no systematic analyses of treatment
376 differences between women and men.
377

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378 Hawkes and Buse's (2013) review of gender and global health argues
379 that, despite the evidence, gender disparities do not tend to be fully
380 addressed in the health policies and programmes of the major global
381 health institutions, including the WHO.
382
383 Regtiz-Zagrosek's (2012) review agrees that in Europe, relatively few
384 public health organisations or health policies promote gender-sensitive
385 health care. Baker et al's (2014) bulletin for the WHO posited that, even
386 when gender is recognised, policy-makers often assume that
387 approaches to health improvement are predominantly about women
388 rather than about both sexes.
389
390 Regtiz-Zagrosek's (2012) review suggested that there are important
391 biological and behavioural differences between men and women which
392 affect the manifestation, epidemiology, and pathophysiology of many
393 widespread diseases and the approach to health care. The lack of
394 gender-specific health care potentially prevents more efficient health
395 care, as gender-based prevention measures or therapies are probably
396 more effective than a 'one-size-fits all' approach (Regitz-Zagrosek,
397 2012).
398
399 Some experts argue that gender-based medicine will eventually
400 become irrelevant with the advent of personalized medicine (Regitz-
401 Zagrosek, 2012). However, the analysis of large databases reveals that
402 gender remains an independent and important risk factor after

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403 controlling for age, comorbidities, scored risk factors and ethnicity
404 because some genetic variants convey a different risk in women and
405 men (Regitz-Zagrosek, 2012). Kolip and Lange (2018) suggest that the
406 gender gap may be narrowing but that gender equality policies are still
407 necessary and will have an effect on women's as well as men's health.
408
409 Regtiz-Zagrosek's (2012) work also showed that gender can determine
410 access to health care, use of the health care system, and the
411 behavioural attitudes of medical staff. Gender norms were shown to
412 influence access and control over resources needed to attain optimal
413 health, including economic (income, credit); social (social networks);
414 political (leadership, participation); information and education (health
415 literacy, academic); time (access to health services); and internal (self-
416 confidence/esteem) (WHO, 2015). Gender norms, roles and relations
417 were associated with differences between men and women in:
418 exposure to risk factors or vulnerability; household-level investment in
419 nutrition, care and education; access to and use of health services;
420 experiences in health-care settings; and social impacts of ill-health
421 (WHO, 2015).

422 2.1.1 Sex and Gender

423 Regitz-Zagrosek (2012) also highlighted the importance of
424 distinguishing between sex and gender and their respective effects on
425 health. Sex differences are said to be based on biological factors
426 including reproductive function, sexual hormones, and the expression of
427 genes on X and Y chromosomes. Gender refers to the socially

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428 constructed characteristics of women and men, including the norms,
429 roles and relationships that exist between them.
430
431 These behaviours may also be defined by sociocultural expectations
432 (Mahalik et al., 2003). What may be considered a neutral behaviour in
433 one culture may be considered a masculine behaviour in another
434 culture. Unfortunately, as Miller (2014) points out, gender is often used
435 incorrectly, including by scientists and clinical investigators, as
436 synonymous with sex.
437
438 In practice, it is often not easy to separate the influence of sex and
439 gender (Regitz-Zagrosek, 2012), particularly as gender comes to be
440 expressed in non-binary terms. It is also important to recognise
441 identities that do not fit into the binary male or female sex categories.
442 Koper et al. (2017) suggest that taking both gender and sex specific
443 differences in health issues into account would contribute to improved
444 individual diagnosis and therapies (Koper et al., 2017).
445
446 Gender has been described as influencing health and wellbeing across
447 three domains: (i) through its interaction with the social, economic and
448 commercial determinants of health; (ii) via health behaviours that are
449 protective of, or detrimental to, health outcomes; and (iii) in terms of
450 how the health system responds to gender, including how it affects the
451 financing of and access to quality health care (Hawkes and Buse, 2013
452 , Payne, 2006).

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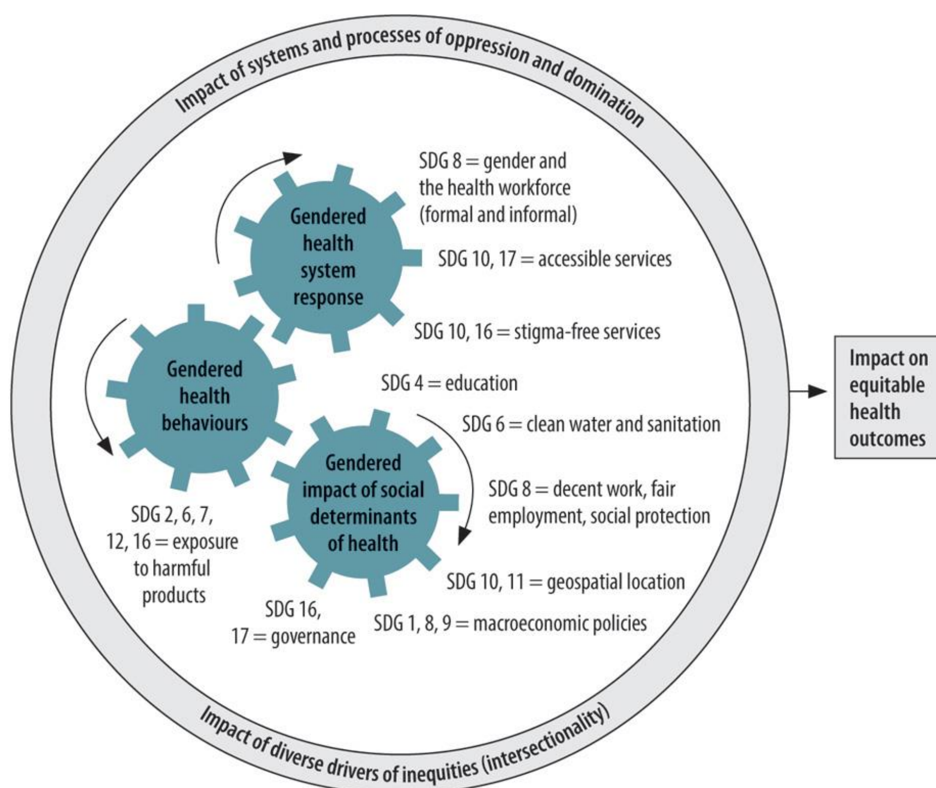
453 Manandhar et al. (2018) have considered how gender and health
454 interacts with the United Nations (UN) 2030 agenda for sustainable
455 development (2015)including its targets for health and well-being, and
456 the impact on health equity. They have developed a framework to show
457 how a number of the sustainable development goals (SDGs) impact on
458 the three domains mentioned previously.



459

460 *Figure 1 Conceptual framework to show interactions between*
461 *sustainable development goals 3 (health) and 5 (gender) with other*
462 *global goals across three domains of gender and health (Manandhar et*
463 *al., 2018).*
464

465 The domains also all operate in a wider socio-political, cultural and
466 historical context, shaping a range of intersectional drivers of
467 inequalities, exclusion and discrimination that operate alongside
468 gender. Manandhar et al., (2018) concluded that outdated
469 understandings of gender fail to explicitly acknowledge and address the

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470 underlying power and hierarchy relations that shape health through a
471 complex interplay of health determinants, behaviours and health-system
472 responses.
473
474 More attention is also needed to how masculinities as collective
475 patterns of behaviour affect men's as well as women's health.
476 Manandhar et al., (2018) also suggest that studies and official statistics
477 reporting statistical differences in health do not show the impact of
478 gender in driving those differences.
479
480 Manandhar et al. (2018) advocate for need additional, more nuanced,
481 qualitative analyses of gender influences in their specific contexts,
482 involving participants as individuals; Manandhar et al. (2018)
483 specifically mention the need for studies that focus on how sex
484 differences are shaped by social inequalities and power differentials
485 rooted in gender norms.

486 2.1.2 Men and Health

487 Gender norms have led some research to argue that men are less likely
488 than women to seek help from health services while at the same time
489 being more likely to engage in social practices that put their health 'at
490 risk' such as substance-misuse, smoking, and violence (Hunt et al.,
491 1999 , Banks, 2004 , Phillips, 2006).
492
493 Negative stereotypes of men have also led health-care providers to
494 assume that men are not interested in their health - an attitude that can,

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495 consequently, discourage men from engaging with health services

496 (McKinlay et al., 2009). Why–and indeed if–this is the case is much

497 debated (Davies et al., 2000 , Doyal, 2001) and attention has turned to

498 how the experience of being male can affect men's health (Addis and

499 Mahalik, 2003).

500

501 Watkins et al. (2012) argue that somewhat linear arguments that tend to

502 homogenise men of all ages have been presented around the process

503 of socialisation for men and its potential impact on their health

504 practices. These arguments have been criticised for their lack of nuance

505 in helping understand how different masculinities across the lifespan

506 result in different health-related practices (Watkins et al., 2012).

507 Similarly, Mac an Ghaill and Haywood (2012) criticise the application of

508 understandings of men and masculinities based on adult men to the

509 attitudes and behaviours of pre-adolescent and adolescent boys.

510

511 Mac an Ghaill and Haywood (2012) also highlight an apparent

512 homogenisation of males across social class, 'race'/ethnicity and

513 sexuality. This can lead to the conceptualisation of a:

514 *"…'cause and effect' model of masculinity [that]*
515 *presents men as 'damaged and damage doing', with*
516 *masculinity providing the normative parameters*
517 *through which males undertake destructive*
518 *behaviours" (Mac An Ghaill and Haywood, 2012*
519 *p.483).*

520

521 While comparing gender and sex based on a binary system

522 comparisons can highlight important ways that biologic sex and social

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523 roles of gender influence health, there is a need to also consider
524 intersectionality; not all men's opportunities for health and wellbeing are
525 equal (Saewyc et al., 2012). Socioeconomic factors, culture, physical
526 environment and individual behaviours all interact to influence health
527 (Saewyc et al., 2012). Men can experience wide differences in health
528 depending on these determinants of health, and some groups might be
529 vulnerable to multiple factors (Saewyc et al., 2012).
530
531 Cardiovascular disease (CVD) is an example of a men's health issue
532 that illustrates these health inequalities in relation to occupational group
533 and ethnicity; deaths from coronary heart disease are three times
534 higher among unskilled men than among those considered to be
535 working in professional roles. This figure is around 50% higher in South
536 Asian communities than in the general population (CQC, 2009).
537
538 However, being male appears to be a protective factor in the case of
539 severe chronic obstructive pulmonary disease. The National Center for
540 Chronic Disease Prevention and Health Promotion (US) Office on
541 Smoking and Health identified that, among men and women who smoke
542 tobacco, women appear to develop severe chronic obstructive
543 pulmonary disease at a younger age than men and with lower
544 cumulative cigarette smoke exposure (2014).
545
546 In 2011, WHO member states signed up to the 25 × 25 initiative. This
547 initiative constituted a plan to cut mortality caused by non-

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548 communicable diseases by 25% by 2025 (Stringhini et al., 2017).
549 Stringhini et al. (2017) compared the role of socioeconomic status to
550 mortality and years-of-life-lost with that of the 25 × 25 predicted risk
551 factors (high alcohol intake, physical inactivity, current smoking,
552 hypertension, diabetes, and obesity).
553
554 Stringhini et al. (2017) found that men within lower socioeconomic
555 groups had higher mortality rates when compared with those within
556 higher socioeconomic groups. They concluded that socioeconomic
557 circumstances, over and above the 25 × 25 factors, should be targeted
558 by local and global health strategies and health risk surveillance in
559 order to reduce mortality rates (Stringhini et al., 2017).
560
561 It is clear, therefore, that gender norms can influence health outcomes
562 and the achievement of mental, physical and social health and well-
563 being (WHO, 2015). Gender inequality has been shown to affect health
564 outcomes and prevention strategies; it also contributes to avoidable
565 morbidity and mortality rates in men throughout life (WHO, 2015). The
566 WHO (2015) conclude that gender-responsive health programmes can
567 be beneficial in addressing gender inequality and can improve access
568 to and benefits from health services. However, it is also important to
569 consider the role of socioeconomic factors.
570
571 So far, this review has focused on gender differences in health
572 outcomes across the male life span. It is also important to consider how
573 age might also affect health outcomes. This will be addressed by

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574 examining the research around young people in relation to health,

575 before moving on to focussing specifically on young men.

576 2.2 Health outcomes – age and gender

577 The WHO and United Nations Children's Emergency Fund (UNICEF)

578 define adolescents as people aged ten to nineteen, ‘youth’ as those

579 aged fifteen to twenty-four and ‘young people’ as those aged ten to

580 twenty-four (UNICEF, 2007). In 2012, there were calculated to be 1.2

581 billion adolescents aged ten to nineteen, worldwide. This is considered

582 to be the largest group of this age range in history, forming 20% of the

583 global population (Patton et al., 2012). Adolescence is therefore

584 becoming a key priority for governments and health systems worldwide

585 (Viner et al., 2012).

586

587 UNICEF identified adolescence as a key time of opportunity for

588 preserving life-long health (UNICEF, 2007). Britain today has more

589 adolescents than at any time in its history and this population has the

590 potential to influence the future of Britain over the next 50 years (Viner

591 et al., 2012). There is an emerging agreement that investing intensively

592 in adolescents’ health and development is not only key to improving

593 their survival and wellbeing but critical for the success of the future

594 generations (McCoy, 2009).

595

596 Adolescence has been described as a complex stage, typified by

597 substantial cognitive, emotional and behavioural changes. Adolescents

598 have been found to be strongly focused on and empathic to peers,

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599 receptive to their close environment, lacking impulse control and the
600 ability to regulate their emotions and behaviour, and struggling to link
601 action with long-term consequences. These characteristics can all
602 potentially negatively affect the ability to make decisions in difficult, or
603 emotional situations (Galván et al., 2006 , Steinberg, 2010).
604
605 According to the WHO (2017) many behaviours that impact health later
606 in life, such as physical inactivity, poor diet, and risky sexual health
607 behaviours, begin in adolescence. Brain-based changes associated
608 with emotional, motivational and cognitive processing may motivate
609 risk-taking and decision-making tendencies in adolescence. This could
610 make this making age range vulnerable to participation in addictive
611 behaviours (Balogh et al., 2013). Such characteristics have also been
612 associated with higher rates of risky behaviours and accidental death
613 among adolescents in comparison to childhood and later adulthood
614 (Willoughby et al., 2013 , Committee on Improving the Health Safety
615 and Well-Being of Young Adults et al., 2015).
616
617 Adolescents appear to be especially at risk of accidental death and the
618 development of disorders such as substance abuse, anxiety and
619 depression (Paus et al., 2008). It is important to note that Hammerslag
620 and Gulley (2016) identified a sex (or gender) difference in this
621 vulnerability, with females being more likely developing disorders
622 characterised but internalisation of emotion, males being more likely to
623 participate in risky behaviour and drug use. It may be the case that sex

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624 differences in adolescent neurological development may lead to sex
625 differences in the characteristics of risk taking in adolescence.
626 Hammerslag and Gulley (2016) accuse existing reviews of the research
627 around risk taking behaviours related to issues such as substance
628 misuse as tending to focus on adulthood, and not considering the role
629 of sex differences.
630
631 While both sex, gender, age, and other social determinants have been
632 shown to have a significant impact on health outcomes, it has been
633 argued that the phenomenon described as health discourse is also
634 highly influential in how people experience and conceptualise health.
635 The next section will move on to explore this in more detail.

636 2.3 The discourse around health

637 Discourses on health include the ideas that exist about, and the
638 explanations offered for, what health is and what determines it, as well
639 as the particular practices that are produced by these ideas (Robertson
640 1998). It is important to consider how these discourses affect how
641 men's health is viewed and how this affects how men view their health.
642 However, before turning to men's health specifically, it is important to
643 establish a broad overview on how 'health discourse' is conceptualised.
644
645 Lupton (2012) argues that the social phenomenon or 'culture' of
646 medicine and health can be understood as the accumulation of
647 meanings, discourses, technologies and practices that amass around
648 medicine within society. People's beliefs, concepts and understandings

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649 around health are shaped by their encounters with health-care
650 professionals and through dominant health discourse as well as
651 personal experiences, interactions with others, information from the
652 mass media and the internet and membership of social class, gender,
653 generational and racial/ethnic groups. The analysis of this discourse
654 has the potential to demonstrate the process by which biology and
655 culture interact in the social construction of health and the way in which
656 western culture uses health to define social boundaries.
657
658 Modern day public health discourses dominate everyday life with people
659 becoming pre-occupied with managing health-related risks.
660 Increasingly, everyday activities such as what people eat and the
661 amount of exercise that they get are analysed and subject to the
662 scrutiny of medical discourses, where features of our lives are modified
663 through medical language (Rich and Miah, 2009). This translates into a
664 lived experience of heightened health risks with judgement placed upon
665 which lifestyles are deemed acceptable (Komesaroff, 1995 p.4).
666
667 Rich and Miah (2009) argue that this approach to health care can be
668 seen in health promotion strategies where physical activity, alcohol use,
669 diet, smoking and body weight are subject to medicalisation and
670 scrutiny with the purpose of preventing ill health.
671
672 Fitzpatrick (2001 p.1) suggests that contemporary culture is saturated
673 with an

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674 *"…endless series of health scares that are reinforced*
675 *by governments and health agencies, which*
676 *encourage an individual responsibility for disease".*

677

678 The perceived necessity for whole populations to protect themselves
679 from the risk of presumed disease reflects a wider shift towards
680 'surveillance medicine' (Armstrong, 1995). This surveillance medicine
681 involves the localisation of illness outside the physical space of the
682 body and into society as a moral rather than a physical concern. This
683 includes the problematisation of normality with a refocusing of the
684 relationship between symptom, sign and illness (Armstrong, 1995).

685

686 Surveillance medicine moves the focus of medicine away from the
687 pathological body and towards each and every member of the
688 population (Petersen et al., 1996). Flynn (2002) argues that the
689 Foucauldian concept of 'governmentality' provides a useful heuristic
690 framework for understanding the characteristics of this surveillance and
691 the increasingly complicated ways that the state intervenes through
692 public policy.

693

694 Foucault's theory of governmentality (Foucault, 1991) rejects the simple
695 concept of power as being held by the state and political institutions,
696 social classes, or individuals. Foucault sees power as entrenched in
697 social relations, discourses and practices. Governmentality concerns
698 the disciplining and regulation of the population without direct
699 intervention. This privatises and individualises risk and good citizens,

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700 who are held responsible, as far as possible, for the prevention of
701 illness and the self-management of health (Pickard, 2009).
702
703 Governmentality sees health and the proper management of illnesses
704 to have become individual moral responsibilities to be fulfilled through
705 improved access to knowledge, self-surveillance, prevention, risk
706 assessment, the treatment of risk, and the consumption of appropriate
707 self-help/biomedical goods and services (Clarke et al., 2003). From this
708 perspective, health becomes something to work towards. Terms such
709 as "health maintenance," "health promotion," and "healthy living"
710 highlight the mandate for work and attention toward attaining and
711 maintaining health (Clarke et al. 2003).
712
713 Within the context of health promotion, ‘surveillance’ is used to refer to
714 activities such as public health campaigns which are designed to
715 monitor, regulate and induce good health practices in both individuals
716 and the population in general (Nettleton et al., 2013). Health promotion
717 refers to those planned activities that are designed to prevent illness
718 and improve the health of the population.
719
720 The concept of surveillance originates from the work of Foucault (1979)
721 and in particular the concept of ‘disciplinary power’. Disciplinary power
722 refers to the ways in which bodies are regulated, trained, understood
723 and empowered and is most evident in institutions such as schools and
724 hospitals (Nettleton et al., 2013). Foucault refers to this process as

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725 power/knowledge. Disciplinary power works at two levels. First,
726 individual bodies are trained and observed (anatomo-politics) and then
727 concurrently monitored by regulatory controls (bio-politics). Health
728 promotion therefore forms the political and practical manifestations of
729 'surveillance medicine' (Armstrong, 1995) oriented towards identifying
730 and monitoring risk factors for disease.
731
732 Petersen and Lupton (2000) suggested that the surveillance medicine
733 approach helped to prompt a new paradigm of public health referred to
734 as "the new public health". The New Public Health (NPH) (Thanem,
735 2009) has been described as the dominant discourse within
736 contemporary western public health. The purpose of public health is to
737 prevent the spread of disease and health problems across the
738 population and to improve people's health.
739
740 Under the NPH, this involves preventing the incidence and extent of
741 non-communicable diseases and health problems such as cancer, heart
742 disease, stroke and obesity. The NPH tends to associate such diseases
743 with poor diet, lack of physical activity and smoking (Parish, 1995). It
744 uses health campaigns to help people eat more healthily, become more
745 active, and quit smoking (Petersen et al., 1996).
746
747 NPH is a term that was popularised in the 1980s to describe an
748 increased interest in the social, economic and environmental
749 determinants of health and the advocacy of public policy around health,

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750 rather than health services, to improve the population's health (Tones
751 and Green, 2004). Petersen and Lupton (1996) view the NPH as
752 exercising a form of power where its discursive practices construct
753 particular kinds of subjective individuals, which is often related to the
754 concept of neo-liberalist management.
755
756 In a European context, neo-liberalism often refers to the dismantling of
757 the welfare state as well as a focus on the freedom and personal and
758 moral responsibilities of individual citizens (Thanem, 2009). The neo-
759 liberalist tone of the NPH means that people are ostensibly given the
760 freedom to voluntarily choose between different health behaviours, but
761 this is coupled with a duty and responsibility to make the choice that is
762 expected of you, as a responsible citizen.
763
764 Till (2017) suggests that this emphasis on prevention and identification
765 of potential future illness (through risk analysis) leaves all citizens to be
766 categorised as "pre- symptomatically ill". This overrides the simple
767 binary between health and illness. This view could lead to the concern
768 for possible physical health problems dominating people's lives and
769 potentially contributing towards stress and anxiety, and other mental ill
770 health.
771
772 The NPH as articulated in recent health policy suggests a more
773 individualistic lifestyle approach, for example the Change4Life social
774 marketing campaign. This campaign, run by Public Health England,

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775 aims to encourage individuals to make simple changes by using
776 language that makes it straightforward and easy for people to
777 understand how to make ‘good choices’ for the health of both
778 themselves and their family (Barker, 2016).
779
780 The Change4Life campaign and its techniques can be seen as an
781 example of the neo-liberal turn of the NPH. Thanem (2008) accuses
782 such campaigns of turning people into ‘health consumers’ under the
783 guise of trying to help them improve their health by ‘managerialising’
784 their bodies and everyday lives. The uncertainty of these techniques
785 suggests that the campaign and the NPH may be resisted and
786 subverted by individuals practising alternative forms of embodiment and
787 subjectivity (Thanem, 2008). Thanem (2008) suggests that further
788 research is required to expand our insights into how people engage in
789 and enact bodily resistance practices.
790
791 Joyce (2001) argues the NPH concepts are all aspects of an attempt to
792 make healthcare open to political action. An understanding of health in
793 terms of quality of life, as in the NPH formula (Joyce, 2001), is one such
794 approach. The health providing agencies, therefore, have to show that
795 they are concerned with the overall level of quality of life for a
796 population. One of the consequences of this is that preventative
797 strategies will be emphasised as part of health promotion.
798

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799 Defining population health as dependent on individual behaviour can
800 lead to pressure on the 'responsible citizen' not to engage in behaviours
801 that could lead ill-health. The associated fear of becoming a burden on
802 society through requiring extra health care is another way to encourage
803 'responsible citizens' to manage their own health in ways set out by the
804 state. The result of this could lead to movement away from restorative
805 medicine towards health promotion.
806
807 The individual citizen is expected to self-govern elements of their lives
808 that may increase the risk of poor health (Joyce, 2001). This
809 encourages the concept of blame being attached to those who are
810 defined as in poor health, particularly if this is seen to be as a result of a
811 lack of self-governance. This pressure can lead citizens to manage one
812 another's behaviour through judgement, blame, and shame.
813
814 The fact that citizens can potentially manage each other's behaviour
815 leads to a more detailed consideration of the role of community in
816 health discourse. It is to this topic that this section will now progress.

817 2.3.1 Health discourse – the role of community

818 Our health, well-being, and general quality of life are embedded in the
819 structure and content of our relational lives (Goldsmith and Albrecht,
820 2003). Each of us belongs to a number of different communities based
821 on factors such as location, demographics, and interests. Along with
822 family, formal education, and various forms of media, it is within these
823 communities that we construct our health beliefs, obtain our health

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824 information, and feel the social pressures that reinforce or undermine
825 our health behaviours.
826
827 Members of a community create and sustain shared cultural meanings
828 through a common set of customs, rituals, rules, language, and other
829 communicative practices (Adelman and Frey, 1997 , Geist-Martin et al.,
830 2011). In this way, communities actively participate in the creation and
831 perpetuation of culture. This perspective implies that the emotional
832 connection, interdependence, and mutual influence inherent in
833 supportive communities are performances of the various cultural
834 conceptions (e.g., of health, aging, disease, pain) that shape the values
835 and behaviours of community members (Rothenbuhler, 1991).
836
837 Communication scholars have primarily conceptualised community by
838 focusing on four general attributes: physical, support, influence, and
839 meaning making (Underwood and Frey, 2007). Each of these attributes
840 is grounded in social interaction, and all of them may overlap.
841
842 Definitions of community often incorporate a geographically defined site
843 or group; these may include a physical location, an organised group, or
844 an online community (Yamasaki, 2017). The shared experience that this
845 site offers includes relational connections with others and an emotional
846 bond to a place (Altman et al., 1992), which helps comprise the support
847 attribute of a community.
848

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849 The shared experiences within the community and the narratives
850 formed from these stories also serve to influence the community by
851 regulating social order, inspiring collective action and justifying
852 behavioural norms (Underwood and Frey, 2007). These norms will help
853 shape meaning making attributes such as shared belies, attitudes and
854 values that affect the identity and ideology of a community.
855
856 Many health issues, including at the level of the local community, are a
857 function of gender-based social status or roles (Public Health Agency of
858 Canada, 2013). Gender concerns the social relations within and
859 between groups and men and women, boys and girls; it is an interactive
860 process that also has health implications (Annandale, 2013). Gender is
861 widely considered to be an important determinant of health practices,
862 perspectives and outcomes (Alexander et al., 2010 , Charles and
863 Walters, 2008). Moving back to the wider societal level this leads us to
864 consider the health discourse around men and masculinity (Schofield,
865 2014).

866 2.3.2 Men and masculinity within health discourse.

867 Within the discourse around men and health, there is no agreed
868 definition of what represents 'men's health' or a masculine healthy
869 body; this has been highlighted as one of the barriers to professionals
870 adopting men's health as an issue (Lloyd, 1996). The Health
871 Development Agency (HDA) (2001) adopted Fletcher's definition (1997)
872 in their literature and practice review of boys and young men's health.

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873 Fletcher's definition (1997) is, in turn, adapted from the US Public

874 Health Service's definition of women's health:

875 *"…conditions or diseases that are unique to men,*
876 *more prevalent in men, more serious among men, for*
877 *which risk factors are different for men or for which*
878 *different interventions are required for men"*
879 *(Fletcher, 1996 p.1)*

880

881 This definition allows for a range of conditions, behaviours,

882 underpinning issues and differences and allows for a 'halfway house'

883 approach between the pure biological definition of men's health and the

884 inclusion of social issues (HDA, 2001).

885

886 Social constructions of masculinity have been associated with the poor

887 health observed in men. However, it is important to recognise that

888 masculinity is complex and multifaceted. In fact some elements of

889 masculinity can prove health-promoting (Gough, 2013). For example,

890 qualitative research (Sloan et al., 2010) with men who were identified as

891 following a healthy lifestyle found that masculine positions such as

892 agency, autonomy, and self-reliance were drawn on by the men as a

893 way to reject what they viewed to be poorer health practices.

894

895 Emslie et al. (2013) found that drinking alcohol with other men was

896 seen as enabling friendships and providing a perceived gender

897 appropriate conditions for the discussion of emotions that may not have

898 been endorsed in other situations.

899

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900 Social constructionist perspectives on gender move away from
901 socialisation as the origin of gender differences; people do not simply
902 internalise gender roles as they grow up but respond to changing
903 cultural norms in society (Deutsch, 2007). Masculinity and health can be
904 seen as being constructed within a relational context. Health risks
905 among men can be influenced to by the ways in which men construct
906 masculinities, as well as different social structural influences
907 (Courtenay, 2009).
908
909 Robertson and Baker (2017) suggest that many of the difficulties in
910 improving and promoting the health of men lie with a:

911 *"…market-driven neoliberal policy context that*
912 *engenders inequality through the inequitable*
913 *distribution of and access to material resources and*
914 *through individualistic approaches to health*
915 *promotion that serve men from economically and*
916 *socially disadvantaged locations least well" (p.102).*

917
918 Contemporary theories of masculinity have been typified by a number of
919 key concepts and assumptions. Key to most theories is the view that
920 masculine identities and practices are socially constructed. Key
921 theorists such as Connell (1989 , 1995) have examined the production
922 of dominant philosophies of 'ideal' or normative masculinity; these
923 philosophies tend to be referred to as 'hegemonic masculinities'. These
924 dominant concepts tend to favour specific representations of
925 masculinity to the detriment of femininities and other, relatively
926 subordinate, masculinities (Cornwall and Lindisfarne, 2003).
927

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928 Connell (1995) describes masculinity as a social construction
929 dependent on a specific historical time, culture and locale. This
930 captures the complexity of men's lives and moves away from a binary
931 system that defines men and women. Masculinity is also described in
932 relational terms, in contrast with femininity (Connell, 1995 , Messner,
933 1996). In any society, there is hierarchy of masculinities with the ideal
934 version being dominant or hegemonic, defined by Connell (1995) as an
935 idealised form of masculinity at a given age and time.
936
937 Connell (1995) comments that, in western culture, contemporary
938 hegemonic masculinity is associated with being white, heterosexual and
939 middle-class as well as demonstrating stereotypical masculine traits
940 such as assertiveness, dominance, control, physical strength and
941 emotional restraint.
942
943 Connell suggests that only a small percentage of men meet the
944 hegemonic version of masculinity (Connell, 1995). This is significant in
945 relation to men's health practices – particularly for boys and men who
946 risk their health attempting to express this ideal. The pursuit of
947 hegemonic masculinity and its associated power and privilege has been
948 found to lead men to come to harm (Clatterbaugh, 1997); for example
949 thought a refusal to acknowledge or admit to pain (Kaufman, 1994).
950
951 Social practices and behaviours that compromise men's health are
952 often associated with structuring and acquisition of power; for example,

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953 the suppression of their own needs and refusal to admit and
954 acknowledge pain (Kaufman, 1994). Other health related beliefs and
955 behaviour used in the pursuit of hegemonic masculinity include the
956 denial of weakness or vulnerability, exhibiting emotional and physical
957 control, being strong and tough, dismissing help, constant interest in
958 sex, and displaying of aggressive behaviour and asserting physical
959 dominance (Courtenay, 2009).
960
961 These behaviours reinforce strongly held cultural beliefs that men are
962 more dominant and less vulnerable than women; that men's bodies are
963 inherently more efficient than, and superior to women's bodies; that it is
964 feminine to ask for help and care for their health; and that the most
965 powerful men are not concerned about health or safety. Their difference
966 from women in regard to health is what is often consider to make men
967 'superior' (Courtenay, 2009).
968
969 To engage in more 'positive' forms of health behaviour (e.g. applying
970 sunscreen to prevent cancer), men may need to reject certain
971 constructions of masculinity (Courtenay, 2009). Men or boys who try to
972 engage in behaviours that demonstrate feminine norms can be
973 consigned to the subordinated masculine status of 'wimp' or 'gay'
974 (Smith, 2007).
975
976 When access to social power and resources is limited, men may not be
977 able to construct hegemonic masculinity. This may lead men to seek

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978 other ways to validate their masculinity. Knight et al. (2012) drew on in-
979 depth interviews with 15–24-year-old men to explore the discourses that
980 existed around sexual health communication with their peers and sex
981 partners. They situations whereby the young men utilised a discourse of
982 'manning up' to (i) exert power over others whilst discounting potential
983 consequences and (ii) used power to sustain and reify their own hyper-
984 masculine identities. Other examples of hyper-masculine practices
985 might include forms of destructive and exaggerated masculinities
986 centring on violence and crime, as observed by Torbenfeldt
987 Bengtsson (2015) among socially marginalized men.
988
989 Addis and Mahalik (2003) argued that most boys are socialised to
990 embody hegemonic masculinity and 'take it like a man' at an early age.
991 They might also be deterred from showing feelings of vulnerability or
992 weakness. The resultant social expectation of toughness and
993 independence have been shown to lead to social isolation, the
994 suppression of emotion, and resistance to asking for help (Good et al.,
995 1989).
996
997 Although Connell's masculinities framework, and those associated with
998 it, have significantly influenced masculinity theory, they have also been
999 subject to critiques. Particularly relevant here are critiques from post-
1000 structuralist perspectives, where hegemonic masculinity has been
1001 viewed as suggesting a fixed, and binary division of hegemonic and
1002 marginalised masculinities (McInnes, 2008).

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1003 Connell's multiple masculinities approach has also been critiqued for
1004 not accounting for movement between categories, or the occupancy of
1005 a number of 'categories' (hegemonic, subordinate, complicit and
1006 marginalised) (Pringle, 2005, p.266). It has been suggested that the
1007 relationship between masculine is more multi-layered and complex than
1008 Connell's model of "hegemonic masculinity" allows for (Hirsch and
1009 Grosswirth Kachtan, 2017).
1010
1011 Bartholomaeus (2013) operationalised Beasley (2008) and Elias and
1012 Beasley's (2009) concept of a discourse of hegemonic masculinity; the
1013 most influential in defining what is most 'masculine' in an agreed
1014 setting. This usage allows a clear distinction to be made between a
1015 discourse of hegemonic masculinity related to practices and ideals, and
1016 the discourse viewing power as 'held' by, or relating only to, particular
1017 boys (or men). This can allow for movement between discourses and
1018 the combination of hegemonic and alternative behaviours
1019 (Bartholomaeus, 2013). This also allows the consideration that multiple
1020 discourses could be engaged in, moved across, and combined rather
1021 than trying to fit practices into a singular pattern (Bartholomaeus, 2013).
1022
1023 Bartholomaeus (2013) points out that the privilege associated with
1024 hegemonic masculinity can be reinforced by the research focus on the
1025 hegemonic masculinity of boys. This focus can also potentially overlook
1026 differences amongst boys and the multiple practices that individual boys
1027 engage in. Drawing on empirical research in two South Australian

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1028 primary schools, Bartholomaeus (2013) emphasised that a division
1029 between hegemonic and other masculinities and practices is not as
1030 clear as has often been theorised. She found that age, school, culture,
1031 classroom and context all provided different circumstances for a range
1032 practices. Boys were observed to engage in plural practices, which
1033 were sometimes combined with, or challenging, to a discourse of
1034 hegemonic masculinity (Bartholomaeus, 2013).
1035
1036 The discussion of hegemonic masculinity has included movement away
1037 from the concept of a singular masculinity to the idea of 'masculinities',
1038 which are 'multiple and plural, differing over time, space and context'.
1039 This expansion allows for the consideration of intersectionality, where
1040 masculinities intersect with "…*variables such as race and ethnicity,*
1041 *class and age*" (Robinson, 2008, p.59). If masculinities are plural,
1042 provisional and situated, there is therefore a need to consider how
1043 these identities are established in different settings and socio-temporal
1044 locations, as well as the significant relational aspects.
1045
1046 Richardson (2010) argues that it is important to consider the extent to
1047 which theoretical understandings of masculine identities as contested,
1048 contingent and reflexively constructed map onto everyday experience.
1049 Young men are progressively being faced with a variety of ways to be
1050 considered 'successfully' masculine. If the construction of masculine
1051 identity is characterised as contested and contradictory, then it
1052 becomes potentially fragile and uncertain (O'Donnell and Sharpe,

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1053 2000). It is important to consider the implications of this on the identities
1054 and practices of young men.
1055
1056 Some research has suggested that men and boys are subject to higher
1057 social pressure than women and girls to sanction prescribed forms of
1058 gender. Blum, Mmari, and Moreau (2017) started the Global Early
1059 Adolescent Study by asking young people and their parents about their
1060 experiences of growing up as a boy or girl in their communities. They
1061 found that there is a comprehensive set of influences from schools,
1062 parents, media, and peers reinforcing hegemonic myths that boys are
1063 strong and independent (Blum et al., 2017).
1064
1065 However, according to social constructivist theory, men are not passive
1066 victims of socially prescribed roles, nor socialised by cultural context.
1067 Men are considered active agents in the construction and
1068 reconstruction of prevailing norms of masculinity; they have agency
1069 (Courtenay, 2000). If the social diversity of men is taken into account,
1070 then 'traditional' men's health discourse is challenged by the
1071 heterogeneity of men (Schofield et al., 2000).
1072
1073 Related to this is the question of who or what is 'allowed' to count as
1074 masculine. Boys' behaviour can be observed as being strongly
1075 reinforced by peer group. The idea of 'capital' may be an important part
1076 of explaining this behaviour. Capital has been defined as constituting
1077 the different forms of power held by social agents; this includes social

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1078 capital (Bourdieu, 1986). Social capital is generally defined as the social
1079 resources that individuals gain through membership of in/formal social
1080 networks and which may impact on their life experiences and health (de
1081 Visser and McDonnell, 2013). This can be related to what can be seen
1082 as masculine capital. Masculine capital relates to being perceived by
1083 others as more or less masculine (Anderson, 2009 , de Visser et al.,
1084 2009).
1085
1086 De Visser at al. (2009) found that, although men do not need to engage
1087 in all masculine behaviours to be considered masculine, performing
1088 additional masculine behaviours (such as sporting performance, alcohol
1089 use and violent behaviour) increases the opportunity for them to be
1090 considered masculine (de Visser et al., 2009). Masculine 'insurance'
1091 (Anderson, 2002) or 'credit' (de Visser and Smith, 2007) can also be
1092 gained by demonstrating competence in traditionally masculine
1093 behaviours.
1094
1095 This concept can be used to allow or compensate for what may be
1096 considered as non-masculine behaviour; for example, men who do not
1097 drink can boost their masculinity if they are good athletes. Thus,
1098 behaviour considered as less masculine can be accommodated within
1099 an identity that is considered to be predominantly masculine (McGuffey
1100 and Rich, 1999 , Anderson, 2002 , de Visser et al., 2009).
1101

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1102 Gough (2013) explored how masculinities work in different health-
1103 related situations. He identified a theme concerning how masculine
1104 capital can operate to both limit and support healthy practices (Gough,
1105 2013). De Visser and McDonnell (2013) have shown that 'masculine
1106 capital' is gained when men engage in masculine relevant health
1107 behaviours, such as alcohol consumption or physical activity. This
1108 capital can then be exchanged for the opportunity to engage in forms of
1109 behaviour that are considered to be more feminine (and healthier), such
1110 as reducing saturated fat consumption (de Visser and McDonnell, 2013
1111 , Emslie et al., 2013).
1112
1113 This section has concentrated on men and masculinity within health
1114 discourse without offering detailed consideration of age and life stage.
1115 The thesis will now move on to consider health discourse specifically
1116 with young people.

1117 ### 2.3.3 Health discourse – young people

1118 Wills et al. (2008) argue that public health and health promotion
1119 agendas are usually regulated and governed by adults. They found that
1120 young people's definitions of health often run in opposition to dominant
1121 public health and health promotion discourses. This position risks
1122 ignoring young people's conceptualisations and experiences of health
1123 and health-related behaviours (Wills et al., 2008).
1124
1125 The changes in emotional and cognitive functioning that are said to take
1126 place during adolescence and puberty have implications distinctive to

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1127 this age group (Tylee et al., 2007 p.1565). Teenagers develop an
1128 increased capacity for abstract thinking and planning which helps
1129 develop autonomy and, alongside this, a need for privacy and
1130 confidentiality (Tylee et al., 2007 p.1565).

1131

1132 Elkind (1998) suggests that higher risk-taking in this age group
1133 compared to other ages may be linked to the constructions of the
1134 "imaginary audience" and the "personal fable". Examples of such
1135 constructions would be "*everyone is interested in me*" and "*this*
1136 *behaviour may be risky for others, but not for me*" (Tylee et al., 2007
1137 p.1565). The way in which these developmental changes interact with
1138 the social contexts in which young people work, live and play have an
1139 influence on health and health-risk behaviours and outcomes in addition
1140 to other effects from childhood (Patton et al., 2005).

1141

1142 Evans et al (2008) criticise the focus of UK Government Policy on
1143 obesity as a determinant of health. They argue that this has led to:

1144 > *"…unprecedented levels of surveillance over all*
1145 > *aspects of people's lives in the interests of 'health'*
1146 > *and explicitly sets out to define thinking and practice*
1147 > *on obesity/health issues in the UK…" (Evans et al.,*
1148 > *2008 p.117-118).*

1149

1150 Furedi (2005) links this to the 'medicalisation' of daily life
1151 where 'normal anxieties' in relation to food, relationships, exercise and
1152 work are repositioned as medical issues (Evans, 2008);

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1153 *"…problems that might previously been thought of as*
1154 *existential – that is a problem of existence – now*
1155 *have a medical label attached"*
1156 *(2005 p.1).*

1157

1158 Furedi suggests that illness is now as normal as health (and wellness).
1159 From this perspective, wellness becomes something that everyone has
1160 to work on, aspire to, and achieve. If we do not subscribe to this
1161 discourse then we revert to 'being ill' (Furedi, 2005 p.1). Of importance
1162 is the fact that in this discourse, certain categories of people risk being
1163 labelled abnormal for either being unwilling or unable to achieve or
1164 engage with healthy practices (Campos, 2004 , Evans, 2008). This
1165 relates to young people, and a belief that:

1166 *"…'youth' and their parents and carers need*
1167 *protection and correction from their inclinations to eat*
1168 *badly and exercise too little…" (Evans et al., 2008*
1169 *p.118).*

1170

1171 Adolescents begin to develop close relationships outside the family unit,
1172 with the peer group taking on an important role in their lives (Brown and
1173 Larson, 2009). Adolescents also begin to develop their own sense of
1174 identity, with appearance becoming more important to them (Anderson,
1175 2007).

1176

1177 Peers have been simultaneously held accountable for some of the more
1178 problematic aspects of adolescent functioning and as beneficial to
1179 adolescent health and well-being (Brown and Larson,
1180 2009). Adolescents are seen as being particularly vulnerable to peer

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1181 influences with a ‘window of vulnerability’ described in reference to
1182 undertaking risky behaviours around ages fourteen to seventeen years,
1183 particularly when with their peers (Steinberg, 2010). This has led to
1184 media and government problematisation of youth with regard to such
1185 risky health related behaviour (Robb, 2007).
1186
1187 The presentation of risk information, primarily through the means of
1188 media discourse, has been criticised for promoting negativity and
1189 contributing to an increased sense of anxiety about health and young
1190 people (Austen, 2014).
1191
1192 According to Wills et al. (2008) the theoretical framework offered by the
1193 social studies of childhood (James et al., 1998 , James and James,
1194 2004) supports the argument that adults can gain insight from exploring
1195 the everyday lives of young people and the meanings that they ascribe
1196 to health-related behaviour. This can be useful for informing and
1197 building healthy public policies (WHO, 1986). There may be more
1198 inclination to involve young people in these activities when new policy
1199 agendas are being developed, and then “…*to ignore young people’s*
1200 *views the rest of the time*” (Wills et al., 2008, p.250).
1201
1202 Young people are often not seen as having expert voices with
1203 worthwhile opinions, and even when given the opportunity to
1204 participate, adults still seem to find it hard to listen to or act on what
1205 they have to say (Wills et al., 2008). Such experiences can disempower

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1206 young people, especially when adults take a failure to ‘comply’ as
1207 evidence for further adult involvement (Wills et al., 2008). Policies which
1208 span a range of ages are less likely to involve young people and
1209 incorporate their views, which can lead to recommendations that are no
1210 embedded in research and do not resonate with the experiences of
1211 young people (Wills et al., 2008).
1212
1213 Patient and public involvement has been described as a key part recent
1214 reforms to UK health services (Blades et al., 2013). The UK Department
1215 of Health has developed a pledge for improving children’s health
1216 outcomes (DoH., 2013) and responded to the Children and Young
1217 People’s Health Outcomes Forum (DoH., 2013) both with a suggestion
1218 to involve children in the planning of health services.
1219
1220 However, The Office of the Children’s Commissioner has highlighted
1221 the lack of a coherent programme of work for achieving this for all
1222 health bodies making strategic or commissioning decisions (Blades et
1223 al., 2013). There is also a lack of consideration as to how those
1224 planning health services will access and share the resources and
1225 support materials, they need to meaningfully engage children (Blades et
1226 al., 2013).
1227
1228 There is a body of recent research that has considered young people’s
1229 perspectives of health. On the whole, this has been determined
1230 according to predefined areas such as sexual health (Hyde et al.,

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1231 2005), alcohol (Järvinen and Gundelach, 2007), smoking (Haines et al.,
1232 2009), mental health (Johansson et al., 2007), physical activity (Gosling
1233 et al., 2008), and healthy eating (Bauer et al., 2004). There is little
1234 evidence however that these studies have allowed young people to
1235 guide the research questions according to the areas that they
1236 themselves define as pertinent to their health (exceptions include
1237 (Aggleton et al., 1998 , Spencer, 2008).
1238
1239 The Ottawa Health Promotion Charter (WHO, 1986, p.1) emphasises
1240 that health promotion should go *"beyond healthy lifestyles to well-*
1241 *being*". It seems that young people's health orientations to health
1242 behaviour contrast with the continuing adult focus on surveillance and
1243 risk in relation to their age group. It is therefore of the utmost
1244 importance to consider evidence emerging from research that engages
1245 with young people themselves – it is to this research that we now turn in
1246 chapter three.
1247

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1248 # 3.0 Literature Review

1249 This chapter will review the research that has previously been done in
1250 this area, before considering what this thesis intends to add to the
1251 conversation and body of evidence. Finally, the research questions will
1252 be identified and qualified in terms of how they emerge from this
1253 literature review.

1254

1255 Two literature searches were conducted in order to identify the gap in
1256 current research around young men and health. In some ways, there is
1257 a considerable amount of research around young men and health, but
1258 this is limited to researcher defined topics of focus. The researcher in
1259 this thesis felt it important to identify the scope of this issue and
1260 consider the implications of this when compared to the dearth of
1261 research that was focused on the topic of 'health' more generally.

1262 ## 3.1 Young people's perspectives of health

1263 The first literature review undertaken here will be conducted relating to
1264 the broad categories of young men and health. The search strategy
1265 utilised the electronic databases *Scopus, Web of Science*, and
1266 *Pubmed. Scopus* and *Web of Science* had filters that were used to
1267 refine the search options. Searches were refined using inclusion and
1268 exclusion criteria, as well as topic areas that had been identified from
1269 pervious reading around the area.

1270

1271 *NUsearch* (University of Nottingham online library tool for searching
1272 electronic library collections)*,* and *Library Plus* (University of Derby

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1273 online library tool for searching electronic library collections) were used
1274 to cover all of the accessible databases within these institutions.
1275 Psychological databases such as *PsychInfo* and Social Sciences
1276 databases including *ASSIA* were also searched but did not highlight any
1277 additional results, so saturation was deemed to have been reached.
1278
1279 The search terms utilised Boolean operators to focus the search and
1280 result in more focused and productive results. Truncation of words was
1281 also utilised in order to broaden the search by retrieving varying
1282 endings of the search term. In order to choose descriptors for health, a
1283 set of examples from a core list of areas arising in previous reading
1284 around the research were used. This resulted from a number of more
1285 informal literature searches as a means of identifying commonly used
1286 terminology in order to find the widest range of relevant research in this
1287 area.

1288 *Table 1: Search terms for literature review 1.*

Men	**Age**	**Health**
Man	Young*	Health*
Male	Teenage*	Well-being
Masculin*	Adolescen*	Help-seeking
Gender*	Child*	Alcohol*
Boy	Youth*	Sex*
		Self-esteem
		Drug*
		Marijuana

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		Eating
		Fitness
		Physical*
		Exercis*
		Smok*

1289

1290 In order to focus on contemporary literature this search excluded
1291 studies published before 2000. In the early 21st century, public health
1292 was subject to complex tensions and conflicting impetuses (Berridge,
1293 2007). There were important changes to how health was positioned and
1294 talked about. The New Labour Government was elected in 1997 and
1295 began implementing health reform. One of the policy foci of New Labour
1296 Health Reform was tackling health inequalities by combating social
1297 inequalities on a national and locality basis (Bywaters and McLeod,
1298 2001). As gender and SES have been identified in this research as
1299 contributing to health inequality, this period was deemed to be
1300 appropriate to focus on in the literature review.

1301

1302 Also important around this time was the Department of Health's (DoH)
1303 National Health Service (NHS) Plan of July 2000; a core principle of this
1304 plan was to "…*provide information services and support to individuals in*
1305 *relation to health promotion, disease prevention, self-care, rehabilitation*
1306 *and after care*" (DoH, 2000, p.3). The plan aimed to strengthen the role
1307 of NHS Direct in helping patients navigate the "…*maze of health*
1308 *information*" (p.88); expand delivery of health information to different

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1309 channels; and harness NHS expertise and experience to kitemark the
1310 best materials. The plan also introduced the concept of patient versions
1311 of NICE Guidance. This all increases patient involvement in choice
1312 about their healthcare, without necessarily considering how this
1313 information may be operationalised.

1314

1315 The age range 10-19 was chosen in order to reflect the category of
1316 adolescence defined by the WHO (UNICEF, 2007).

1317 *Table 2: Inclusion and exclusion criteria for literature review one*

Inclusion criteria	**Exclusion criteria**
Qualitative studies	Articles not in English
Western settings	Articles not in Western settings
English language	Quantitative studies
Studies published after 2000	Studies published before 2000
Young men between ten and nineteen	Mixed method studies
	Young men aged over nineteen/under ten.
	Studies that did not differentiate between data of different genders/age groups.
	Focus on adult/policy identified areas of importance related to health.

1318

1319 The search was limited to qualitative studies due to the post-
1320 structuralist nature of the research. The researcher took the position

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1321 that quantitative studies would not include the richness needed for an
1322 exploration of this kind. It may be that mixed methods studies would be
1323 included in future developments of this study. Western settings were
1324 chosen to be able to offer some reflection when considering the body of
1325 evidence with the findings of this research study. The age range was
1326 chosen to reflect the category of adolescence as defined by UNICEF
1327 (2007). Studies not in the English language were excluded due to the
1328 researcher not reading other languages.
1329
1330 The results of this search after allowing for exclusion and inclusion
1331 criteria left a total of 22 articles (Appendix 1). A systematic review was
1332 not chosen as a method for this literature review due to the exploratory
1333 nature of this study. New and specific topics such as this area often do
1334 not have enough primary research data upon which to produce an
1335 appropriate conclusion for a systematic review (University of California
1336 San Francisco, 2019). This review took more of an iterative process that
1337 began with informal, exploratory literature searches and developing a
1338 search strategy based on this. Having said this, it is important to note
1339 that this literature review was systemised and followed a clear search
1340 strategy at this stage.
1341
1342 The overview of the 22 identified studies reveals a body of evidence
1343 that is made up of studies from 2008-2017. Populations addressed
1344 include young people aged between eight and twenty-one from different
1345 socioeconomic and cultural backgrounds and different geographical

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1346 locations. Where young women or age ranges other than those in the
1347 inclusion criteria were part of the data collection, only data specific to
1348 the relevant age group/gender group was used.
1349
1350 Six of the 22 papers were part of larger studies (Randell et al., 2016b ,
1351 Randell et al., 2016a , Hyde et al., 2008a , Hyde et al., 2008b). One
1352 study employed a qualitative design to explain the findings of
1353 quantitative surveys (Lee et al., 2009). Brown (2012) and Akre et al.
1354 (2010) were both pilot studies with limited sample sizes.
1355
1356 The dominant area of research within the literature review was sexual
1357 health which was the topic of focus in fifteen of the studies:

1358 *Table 3: Studies in literature review one with a focus on sexual health.*

1	Hayter and Harrison, 2008,
2	Hyde et al., 2008a,
3	Hyde et al., 2008b,
4	Hyde et al., 2009,
5	Cohan, 2009,
6	Akre et al., 2010,
7	Richardson, 2010,
8	Brown, 2011,
9	Ekstrand et al., 2011,
10	Norman, 2011,
11	Watkins et al., 2012,
12	Elmerstig et al., 2014,

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13	Arrington-Sanders et al., 2015,
14	Litras et al., 2015,
15	Limmer, 2016.

1359

1360 The distribution of the studies suggests there is a bias towards research

1361 looking at issues around sexual health.

1362

1363 Mental health and well-being were also focused on in four studies:

1364 *Table 4: Studies in literature review one with a focus on mental health*
1365 *and well-being.*

1	Landstedt et al., 2009,
2	Oransky and Marecek, 2009,
3	Mac an Ghaill and Haywood, 2012,
4	Randell et al., 2016a.

1366

1367 Help and information seeking (Best et al., 2016), physical health (Lee et

1368 al., 2009) and health in more general terms Randell et al., 2016a,

1369 2016b) were the focus of the remaining studies. Lee et al (2009) and

1370 Randell at al. (2016b) were also concerned with geographical location

1371 and topics related to health. This helps get an idea of the main areas of

1372 interest and identify the significant gaps in the literature.

1373

1374 Six of the studies were based in England (Hayter and Harrison, 2008;

1375 Richardson, 2010; Brown, 2012; Mac an Ghaill and Haywood, 2012;

1376 Watkins et al., 2012; Limmer, 2016). Five studies were based in

1377 Sweden (Landstedt et al., 2009; Elmerstig et al., 2014; Ekstrand et al.,

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1378 2011; Randell et al., 2016a, 2016b). Four studies were undertaken in
1379 Ireland (Hyde et al., 2008a, 2008b, 2009; Best et al., 2016). Three
1380 studies took place in the USA (Cohan, 2009; Oransky and Marecek,
1381 2009; Arrington-Sanders et al., 2015). The remaining studies were
1382 based in Switzerland (Akre et al., 2010), Canada (Norman, 2011) and
1383 Australia (Lee et al., 2009 , Litras et al., 2015).
1384
1385 The difference in cultural backgrounds of the young people in each
1386 country will be significant. Healthcare and education in each country are
1387 very different and will limit the generalisability of the results, and
1388 potential relevance to this research.
1389
1390 When considering the methods utilised in the research within the
1391 literature review, there are some limitations that can be identified.
1392 In many of the studies, the sample sizes were small (Hayter and
1393 Harrison, 2008; Cohan, 2009) which may limit transferability to other
1394 settings, cultures and care contexts. Ekstrand et al. (2011) listed a
1395 sample size of 37, but in the findings section it was identified that 15 out
1396 of the 37 did not participate in the qualitative portion of the study. The
1397 majority of the studies also focused on an small age range, such as 13-
1398 15 (Norman, 2011) or 14-16 (Oransky and Marecek, 2009).
1399
1400 Many samples also included an over-representation of young men who
1401 identified as White European and were of low SES which may not allow
1402 for the elicitation of cultural differences (Hayter and Harrison, 2008;

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1403 Cohan, 2009; Limmer, 2016; Richardson, 2010; Elmerstig et al., 2014).
1404 Oransky and Marecek (2009) did have a sample of young men who
1405 were middle class, with the majority identifying as White American.
1406 Arrington-Sanders et al. (2015) was the only study that focused their
1407 research on young black, same-sex attracted men.
1408
1409 Further studies that include a broader range of ethnicities and SES
1410 would provide additional insights that could build on the results of these
1411 studies. This also relates to Brown's (2012) pilot study where she
1412 identified that, in a future study, it would be important to put in place
1413 recruitment strategies that were sufficiently wide ranging and inclusive
1414 to ensure that young men from different class and educational
1415 backgrounds are included in the research.
1416
1417 Litras et al. (2015) recruited 35 young men aged 16–19 years, which
1418 made it one of the largest Australian qualitative studies of young men in
1419 the area of sexual health. However, the entire sample was recruited
1420 from trade schools leaving a potential for bias. Litras et al. (2015) also
1421 commented that sexual preference could also have an impact on
1422 findings because all, but one participants identified as heterosexual.
1423
1424 Other studies included an over-representation of young men who
1425 identified as heterosexual (Elmerstig et al., 2014; Limmer, 2016). It may
1426 be the case that the findings of these studies are not generalisable to
1427 young men who identify as attracted to those of the same-sex.

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1428 However, it may also be the case that this may be a reflection of the
1429 reluctance of young men to define themselves as gay in the context of
1430 these studies.
1431
1432 Lee et al's (2009) paper was taken from data that was part of the Life
1433 Activity Project, a study of the place and meaning of physical activity in
1434 young people's lives, funded by an Australian Research Council Grant.
1435 The sample within this study was made up of 39 young men and 45
1436 young women, all Australian, aged between fifteen and eighteen. The
1437 participants were selected from a range of different school sites allowed
1438 for the inclusion of a range of young men from different geographical
1439 locations, social classes, and cultural backgrounds.
1440
1441 The studies all utilised qualitative methodology with data being gathered
1442 through focus groups, interviews, and observation studies. A number of
1443 studies utilised photo-elicitation and case-study information in order to
1444 stimulate discussion through a third-person source (Hayter and
1445 Harrison, 2008 , Akre et al., 2010 , Best et al., 2016 , Limmer, 2016).
1446 Photo-elicitation uses visual images to elicit discussion in qualitative
1447 research methods. These elicitation techniques can sometimes limit
1448 findings by limiting the scope of the focus of research and therefore the
1449 richness of the data (Hayter and Harrison, 2008). Working with
1450 scenarios also does not produce data on participants' own experiences
1451 but on hypothetical situations to which they might not have been
1452 confronted (Akre et al., 2010).

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1453 Elmerstig et al. (2014) conducted interviews within their research. Any
1454 studies relying on interviews are limited by being based on accounts
1455 that people choose to provide, and not on observations of actual
1456 practices. However, Elmerstig et al. (2014) contend that this form of
1457 qualitative research is important for identifying cognitions that can be
1458 further explored and tested in other settings.
1459
1460 The use of focus groups was identified as a potential challenge in
1461 conducting this research as well as analysing results. Hayter and
1462 Harrison (2008), Hyde et al. (2008a, 2008b, 2009), Cohan (2009)
1463 utilised focus groups. Where single sex focus groups were conducted
1464 rather than individual interviews, Hayter and Harrison (2008) reflected
1465 on the potential peer pressure towards enacting stereotypical 'male' and
1466 'female' behaviours. They concluded that this peer pressure was
1467 indicative of 'real world' contexts and that the discussion generated by
1468 the focus groups was helpful in exploring attitudes.
1469
1470 Landstedt et al. (2009) identified that power relations and hierarchies
1471 within their focus groups could have restrained some participants from
1472 speaking out or bringing up certain topics. Another possible limitation
1473 associated with self-selected and single-sex groups is that the
1474 familiarity can imply that some things are not discussed since they are
1475 taken for granted or are perceived as potentially sensitive or taboo.
1476 They also highlighted that variations such as SES, sexual orientation,

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1477 age, ethnicity, or other social positions and identities were not
1478 investigated in this study.
1479
1480 Hyde et al. (2008a, 2008b, 2009) also reflected on their use of focus
1481 groups in their studies. There can be a complexity involved in analysing
1482 the performance of the group and identifying the differences between
1483 data that reflects the normative group dynamics of the culture, and
1484 what can be taken at face value as actual experiences (Hyde et
1485 al., 2005). In addition, focus groups may also inhibit participants
1486 sharing things that may be considered unusual or embarrassing
1487 perspectives or experiences.
1488
1489 Watkins et al. (2012) described their focus groups as appearing to more
1490 closely resemble the young men's everyday experiences of being with
1491 their friends. They observed this to enable a more interactive discussion
1492 and allowed the researcher to observe the dynamic within groups of
1493 young men. However, in Cohan's (2009) study where the focus groups
1494 were made up of pre-identified friendship groups, the researcher noted
1495 that they could not document or support the existence of these groups
1496 outside of the research space, nor could they guarantee that the young
1497 men talked in the research in the same way that they did in their social
1498 lives. This is also a key reminder of the post-structuralist concept of the
1499 situated nature of knowledge.
1500

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1501 Data analysis was undertaken using predominantly the constant
1502 comparative approach derived from Grounded Theory (Hyde et al.,
1503 2008a, 2008b, 2009; Brown, 2012; Landstedt et al., 2009; Oransky and
1504 Marecek, 2009; Akre et al., 2010; Watkins et al., 2012; Randell et al.,
1505 2016a, 2016b) and thematic analysis (Hayter and Harrison, 2008;
1506 Cohan, 2009; Richardson, 2010; Best et al., 2016; Limmer, 2016; Litras
1507 et al., 2015). Other analysis methods used include latent content
1508 analysis (Ekstrand et al., 2010); categorical and contextualising analytic
1509 methods (Arrington-Sanders et al., 2015); and discourse analysis (Lee
1510 et al., 2009; Norman, 2011; Mac an Ghaill and Haywood, 2012).
1511
1512 Moving on from looking at the methods of the studies, the following
1513 section will consider the findings of the studies identified through this
1514 literature review.

1515 *3.1.1 The role of context*

1516 Only one study considered the role of context in young men's
1517 experiences around, and understandings of, health. Lee, et al's (2009)
1518 paper emerged from an Australian longitudinal study collecting
1519 qualitative data on the place and meaning of physical activity and
1520 physical culture in the lives of young people. However, the statistical
1521 data did not explain how these variables played out in people's lives.
1522 Through further qualitative research, Lee et al. (2009) found that
1523 schooling, geographical location and access to capital played important
1524 roles in the intersection among masculinities, participation in physical
1525 activity and engagement with physical culture.

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1526 Participants in Lee et al's (2009) paper were observed to form a habitus
1527 that was consistent with their social and cultural fields, as well as their
1528 geographical location. The concepts of habitus and field emerged from
1529 Bourdieu's sociological work (Bourdieu and Nice, 1977 , Bourdieu,
1530 1990). The habitus refers to the way that cultural capital is inscribed in
1531 our bodily performances. This includes culturally developed habits,
1532 skills, dispositions, and preferences. Bourdieu also referred to habitus
1533 as the "feel" for the social situations or "games" people participate in.
1534
1535 The field refers to the "game" itself. Bourdieu theorised that the social
1536 world being divided up into a variety of "fields" of practice. Examples of
1537 these areas might include religion, art, or education. Each area has
1538 considered to possess own set of positions and practices that people
1539 navigate in order to acquire capital and be seen to be "winning" the
1540 game.
1541
1542 The capital that a person possesses determines an individual's
1543 relational position in a social space. Bourdieu describes three forms of
1544 capital: economic, cultural, and social capital (Bourdieu, 1986). Social
1545 capital is defined as something that is acquired through the
1546 achievement of other forms of capital. This capital is defined by the
1547 social group in question. Cultural capital is seen as obtained through
1548 skills, qualifications, and knowledge. Bourdieu thought that the more
1549 economic capital a family has, the more cultural capital that their
1550 children can have (Bourdieu, 1986). Each of these forms of capital can

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1551 be considered as a resource that might be useful for acquiring or
1552 maintaining good health (Abel, 2008).
1553
1554 Lee et al. (2009) found that gender stereotypes and inequalities linked
1555 to social class were evident in the young men's engagement with
1556 physical activity/culture. The young men from a higher socioeconomic
1557 status (SES) background had more access to variety of team and
1558 individual sports (through their schools and clubs). This provided them
1559 with the means to acquire forms of physical capital and dispositions to
1560 health and physical activity with higher symbolic value in contemporary
1561 Western societies (Bennett et al., 2001). The young men in the lower
1562 SES setting had fewer physical activity experiences.
1563
1564 Bourdieu (1978) suggested that viewing the body as "an object of
1565 cultivation for its own sake" is a trait of the upper classes or of those
1566 with greater cultural capital (Wilson, 2002, p.6). Bourdieu observed the
1567 lower SES, working class as having a "instrumental" relation to the body
1568 (Bourdieu, 1978), where health and fitness was valued as a means of
1569 securing productive work and the ability to undertake daily tasks.
1570
1571 However, within Lee et al's (2009) study, the relationships that the
1572 young men had with their bodies appeared to transcend SES. Young
1573 men in both settings appeared to value the effect that doing physical
1574 activity had on their appearance. This was consistent with what Smith
1575 Maguire (2002) called a "lifestyle discourse" where there is a focus on

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1576 “*care and improvement of the body rather than as a means to do work*”

1577 (p. 454). This suggests that Bourdieu’s theories around class and the

1578 body may need development for application in this area.

1579

1580 Shilling (2004) offered a pragmatic development of Bourdieu’s ideas

1581 that allowed for moving beyond their limitations. This involved an

1582 exploration around how the relationship body, capital, and social field

1583 could be affected by actions informed by habitual action, embodied

1584 crisis, and creative revelation. Shilling (2004) commented that although

1585 class-based conditions might deeply affect the conditions in which these

1586 actions occur, they are in no way reducible to class and do not

1587 guarantee social reproduction.

1588

1589 It is important to note that Lee et al’s. (2009) study was conducted in

1590 Australia, with only four participants. The healthcare system in Australia

1591 is very different to in the UK, and the young men in rural locations would

1592 have had very different access to services due to the geographic

1593 remoteness in rural Australia. It was, however, a UK doctoral student

1594 (Jessica Lee) who focused on the area of gender, geographic location

1595 and health and analysed the research data in her thesis.

1596 *3.1.2 Masculinity and 'doing gender'*

1597 Masculinity and 'doing gender' appeared to be a theme cross-cutting all

1598 of the research. The studies reviewed agreed that there is pressure on

1599 young men to subscribe to hegemonic masculinities and normative

1600 heterosexual male behaviours. These masculinities tended to be

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1601 observed as shaped through the cultural resources available to the
1602 young men and established discursively in their wider social settings.
1603 Heterosexual masculinities were seen to be constructed predominantly
1604 through performing for other young men (Richardson, 2010 , Cohan,
1605 2009 , Landstedt et al., 2009 , Norman, 2011) and normative
1606 heterosexual discourse appeared to be powerfully compelling (Hayter
1607 and Harrison, 2008 , Hyde et al., 2008a , Hyde et al., 2008b , Oransky
1608 and Marecek, 2009 , Watkins et al., 2012).
1609
1610 A sense of 'male fraternity' mediated a sense of masculinity and
1611 belonging which appeared important to the young men (Cohan, 2009).
1612 Performances of masculinity were observed to be conscious
1613 performances at times with the young men having limited scope to
1614 resist these hegemonic masculinities (Hyde et al., 2009). The social
1615 control of groups leads to limited resistance to collective understandings
1616 of appropriate health related behaviour (Cohan, 2009). Having said this,
1617 it appears that the practices associated with dominant masculinity can
1618 promote positive mental health. Landstedt et al. (2009) suggested that
1619 this might be associated with young men occupying beneficial positions
1620 relative to girls and a low degree of responsibility taking.

1621 *3.1.3 Sources of health information*

1622 The studies reviewed suggest that young men's existing health
1623 knowledge came from various sources including family, the Internet,
1624 friends and pornography (Akre et al., 2010 , Arrington-Sanders et al.,
1625 2015 , Best et al., 2016 , Litras et al., 2015). The young men viewed

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1626 information obtained from the internet, friends and pornography as
1627 unreliable (Litras et al., 2015).
1628
1629 Many of the young men in Litras et al's (2015) study acknowledged the
1630 potential of the internet for providing incorrect or unreliable information
1631 and some avoided the internet as a source of information for this
1632 reason. Those who did use the internet did not have a strategy for
1633 finding reliable information, rather accessing what the search engine
1634 suggested first. There was also resistance to the idea that some of the
1635 information may be incorrect (Litras et al., 2015).
1636
1637 GPs were seen as a source of trust-worthy information but were often
1638 not approached due to embarrassment (Litras et al., 2015). A concern
1639 for confidentiality and avoidance of embarrassment was seen to have a
1640 significant influence on young men's information seeking preferences
1641 and behaviours. There was a view that GPs would talk to their parents
1642 and would not be confidential if they were under 18.
1643
1644 The internet was highlighted as a perfect initial step in dealing with
1645 problems like sexual dysfunction and deciding whether to consult,
1646 although it was acknowledged that it could be difficult to know where to
1647 find answers on reliable websites (Akre et al., 2010). The internet
1648 allowed the young men to preserve anonymity, protect their pride, and
1649 give a feeling of freedom and access at a time to suit them (Akre et al.,

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1650 2010). This raises the issue of health literacy and the young men's
1651 ability to locate and appraise the quality of information online.
1652
1653 This review of the literature suggests the way young men view,
1654 experience, deal with, and value health is complex. There seems to be
1655 a difference between health as an experience and health as a concept.
1656 Gendered practices have an impact on young men's perspectives of
1657 health which supports theories on health as a social construction of
1658 interconnected processes.

1659 3.2 Young men and health discourse

1660 It is notable that the research reviewed above has been predominantly
1661 framed by researchers according to predefined areas. There appear to
1662 be limited studies that allow young men to guide research according to
1663 the areas that they themselves define as pertinent to their health.
1664
1665 This felt like a gap that the researcher wanted to address therefore a
1666 further literature search was undertaken. The aim of this search was to
1667 assess the amount of research specifically involving health as defined
1668 by young men. If also felt important to consider how the young men had
1669 come to these definitions and understandings of health, including how
1670 young men made sense of this, where they got the relevant information,
1671 and what they did with it. This literature search identified very different
1672 research to that emerged from the previous literature review and
1673 demonstrates the dearth of research in this area.
1674

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1675 As with the previous literature review, the search strategy utilised the

1676 electronic databases *Scopus, Web of Science*, *NUsearch, Pubmed*,

1677 *PsychInfo*, *ASSIA*, and *Library Plus*.

1678 *Table 5: Search terms for literature review two*

Men	Age	Health	Information	Response
Man	Young*	Health*	Informati*	Respon*
Male	Teenage*	Well-being	Perspective*	Assimilat*
Masculin*	Adolescen*	Help-seeking	Understand*	Contest*
Gender*	Child*		Concept*	Resist*
Boy	Youth*		View*	Accept*
			Knowledge*	Listen
			Comprehen*	React*
			Insight*	
			Awareness	
			Perce*	
			Inform*	
			Litera*	

1679
1680 Inclusion and exclusion criteria were the same as the previous literature

1681 review.

1682

1683 The resultant search identified only one additional paper (that related to

1684 a previous research paper) and 20 of the papers in the previous

1685 literature search were excluded.

1686

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1687 Wright, O'Flynn, and Doune (2006) drew on Foucault's 'practices of the
1688 self' to examine how young people take up, negotiate and resist the
1689 imperatives of a public health discourse concerned with the relationship
1690 between health, fitness and the body. 'Practices of the self' relate to the
1691 active formation of the self. In-depth interviews were conducted as part
1692 of a wider study and discussed in relation to the ways the young men
1693 talked about their own and others' bodies.
1694
1695 Participants took part in up to five semi-structured interviews over the
1696 course of two years. This was also the same data set used in Lee et al's
1697 (2009) research in the previous literature review. This data set has been
1698 analysed for many different questions with the research data provided.
1699 There may be a question as to the original intention of the research and
1700 how this may have affected the findings in papers with a different
1701 objective.
1702
1703 The young people were asked what being 'healthy' and 'fit' meant to
1704 them. They were also asked to identify the difference between the two,
1705 how they would rate their own health, and what they would need to do
1706 to become healthier. Data was analysed for particular discourses
1707 associated with health and the body drawn on, and the ways in which
1708 this was done. Wright et al. (2006) then identified how these particular
1709 ways of talking about health were congruent with discourse from the
1710 literature identified in the literature review.
1711

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1712 Wright et al. (2006) found that the young women and men engaged in
1713 the health discourse very differently, For the young men, health was
1714 associated with fitness as an embodied capacity to do physical work.
1715 Wright et al. (2006) described dominant health discourses as being
1716 negotiated and internalised in different ways both within and across
1717 genders. Wright et al. (2006) concluded that the ways that these young
1718 people talked (and did not) talk about health suggest that the
1719 identification as male or female still has a strong impact on how people
1720 feel about their bodies and the ways in which health discourses are
1721 taken up.
1722
1723 Due to the lack of qualitative studies exploring adolescent boys'
1724 perceptions of health, Randell et al. (2016a) aimed to explore how
1725 adolescent boys understand the concept of health and what they find
1726 important for its achievement. Purposive sampling was utilised to obtain
1727 maximum variation in three upper secondary schools in a town in
1728 Sweden. Semi-structured interviews with 33 adolescent boys aged
1729 sixteen to seventeen in Sweden were analysed using grounded theory.
1730
1731 Randell et al. (2016a, 2016b) utilised a constructivist grounded theory
1732 approach, which involved gathering the data and performing the
1733 analysis simultaneously (Charmaz, 2006). Within this theoretical
1734 approach, both data and analysis are seen as created through an
1735 interactive process between the data, researcher and participants. The

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1736 study was however conducted in one Swedish town and the
1737 generalizability of the findings might therefore be limited.
1738
1739 The study found that there was a complexity in how health was
1740 perceived, experienced, dealt with, and valued. The participants were
1741 observed to mainly understand health as an emotional and a relational
1742 experience. The mind and body were seen as interconnected, with
1743 health described as a holistic concept. However, referring to their own
1744 health, a more dualistic view was utilised where the emotional and
1745 relational mind and the functional body were seen as different, with the
1746 body being subordinate within this.
1747
1748 Health was considered as an emotion, with the ability to 'feel' health.
1749 Major influences to experiencing health as an emotion were identified:
1750 the existence of positive emotions, experiencing self-esteem,
1751 possessing balance in life, trusting relationships, and experiencing a
1752 sense of belonging. Health was also experienced interactively; this
1753 consisted of relationships at home, in the immediate environment, and
1754 in the community. The quality of relationships and being part of a group
1755 was seen to contribute to the overall experience of health.
1756
1757 The functional element of health was understood as 'doing health'.
1758 When 'doing health', boys performed activities using their bodies to feel
1759 good, to achieve something, or to gain better body image. A boy's
1760 ability to perform using his body was regarded as important, such as in

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1761 relation to sporting prowess. Within this conceptualisation, the body's
1762 impact on health was described in relation to three aspects: as a tool to
1763 achieve health, as energy, and as a condition.
1764
1765 Randell et al.'s (2016a) findings indicated that the health of young men
1766 is principally experienced through emotions and relationships. This
1767 supports theories on health as a social construction of interconnected
1768 processes. If their findings are valid, health could be portrayed as a
1769 predominantly relational and emotional experience, where the impact of
1770 physical health seems to be of lesser importance for adolescent boys.
1771
1772 Randell et al. (2016b) also published an additional paper linked to their
1773 study that aimed to explore adolescent boys' views of masculinity and
1774 emotion management and their potential effects on well-being. This
1775 paper reported two main classifications of masculine conceptions in
1776 adolescent boys: gender-normative masculinity with emphasis on
1777 group-based values, and non-gender-normative masculinity based on
1778 personal values.
1779
1780 Gender-normative masculinity was seen to encompass two ostensibly
1781 contradictory emotional masculinity orientations, one towards
1782 toughness, and the other towards sensitivity. Both orientations were
1783 seen to be highly dependent on contextual and situational group norms
1784 and demands. An inclination towards toughness was indicated through
1785 the possession of a masculine attitude, including characteristics such as

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1786 demonstrating a cool or tough image, hierarchical positioning, and
1787 concealing emotions.
1788
1789 In contrast, boys with a preference towards sensitivity appeared to
1790 appreciate being able to show expressions that were traditionally
1791 considered feminine. They emphasised particular qualities related to
1792 appearance, such as being well groomed or well dressed. Showing
1793 sensitivity may not be an appreciated quality in certain peer groups
1794 which can lead such boys to experience themselves as weak. Non-
1795 gender-normative masculinity included a tendency towards sincerity
1796 and emphasising personal values. Emotions were observed to be
1797 expressed that were inconsistent with peer group norms. These
1798 findings suggest that different masculinities and the expression of
1799 emotions are strongly interconnected.
1800
1801 From the studies of Wright et al., (2006) and Randell et al., (2016a,
1802 2016b) it appears that the way health is perceived, experienced, dealt
1803 with, and valued by young men is complex. Self-identified gender was
1804 found to affect how people feel about their body and the ways in which
1805 they take up health discourses. Context was also important in that the
1806 relational and community setting contributes to a person's overall health
1807 experience. The emotional aspect of health was also seen to be
1808 privileged over the importance of physical health. However, it is difficult
1809 to generalise from the findings from these two research studies.

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1810 Following the findings of the literature reviews, the current study aims to
1811 contribute to this small body of research to consider how young men in
1812 the UK find, and make sense of, health discourse. By exploring this
1813 discourse and the young men's response to this, there may be the
1814 opportunity to provide alternative ways of knowing, and different ways
1815 of understanding health, selves, bodies and masculinities, as well as
1816 encouraging critical thinking in young men in order to inform health
1817 promotion.
1818
1819 These reviews have suggested that young men view, experience, deal
1820 with, and value health in complex ways. By enhancing our
1821 understandings of young men's perspectives of health and a healthy
1822 body we may develop a more nuanced overview of this complex area.
1823 This will include an exploration of the difference between concepts of
1824 health, and how health is experienced in the lives of the young men.
1825 Gendered practices have been shown to impact on young men's
1826 perspectives of health and explorations of this can add to theories
1827 around the social construction of health.
1828
1829 There have been suggestions that political policies for health may not
1830 match the health-related concerns of young people (Percy-Smith, 2006
1831 , Spencer, 2008 , The Kings Fund, 2017). The majority of the studies
1832 within the evidence and research discussed have been framed
1833 according to predefined areas of health behaviour (e.g. sexual risk
1834 taking, physical activity) rather than allowing the young men to guide

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1835 research according to the areas that they define as pertinent to their
1836 health. This imposes an adult, policy related agenda onto the young
1837 men and prevents them becoming more active agents of issues related
1838 to them.
1839
1840 This relates to the importance that the AYPH (2017) places on the
1841 importance of good, robust data that highlights the experiences and
1842 outcomes for the age group 10-24, as distinct from those under ten or
1843 over 24. This information will help inform evidence-based policy, which
1844 will in turn more positively impact health outcomes.

1845 3.3 Aims and objectives

1846 As a result of the literature review, the following aims and objectives
1847 have been set as a means of answering some of the questions left
1848 unanswered by previous research:

1849 *Table 6: Research aims and objectives*

Research Aim:		
To better understand young men's perspectives on health and a 'healthy body'.		
	Research Objectives:	Research questions:
1.	To examine the importance of context on young men's perspectives on health and a healthy body.	What are the contexts within this thesis?
2.		How do young men define health and a healthy male body?

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	To examine young men's perspectives on health and a healthy body.	How does context affect this?
3.	To examine what influences young men's perspectives on health and a healthy body.	What forms of discourse are accessed by young men in youth groups and youth work settings?
		What are young men's perspectives on this discourse?
		How do they respond to this discourse? (i.e. assimilation, contestation, resistance).
		How does context impact this?

1850

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1851 # 4.0 Methodology and Methods

1852 This chapter will discuss the methodology and research design that was
1853 selected for this research study. The rationale for the choice of
1854 methodology and research design will also be discussed. As explored
1855 through the literature review, what 'health' means has changed quite
1856 significantly over the last century (Lupton, 1995) and is differently
1857 understood by different cultural and socio-economic groups (Wright and
1858 Burrows, 2003). A post-structural approach will allow for an exploration
1859 of the subjectivity inherent in understandings of health. Methodology will
1860 be discussed before moving on to research design and ethics.

1861 ## 4.1 The rationale for a post-structuralist methodology

1862 Relatively little is known about how young people respond to the health
1863 information available to them – not just how they assimilate this, but
1864 how they may contest, resist and redefine this communication within the
1865 contexts of their everyday lives. Health provides a rich site for
1866 examining specific relations between context, the body and identity; or
1867 in post-structuralist terms, subjectivity (Wright, 2003).

1868

1869 As this thesis aims to explore the discourse around health, and how
1870 young men make sense of this, it was appropriate to use a post-
1871 structuralist methodology. Post-structuralist methodology allows the
1872 identification, resistance and challenge of discourse. Post-structuralist
1873 epistemology proposes that there is no absolute truth (Gavey, 1989).
1874 From this perspective, identities are seen as changeable and relative.
1875 Rabinow (1977, p.151) posits that both researcher and participants

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1876 “...live in a culturally mediated world...there is no privileged position, no
1877 absolute perspective." In light of this, ethnographers cannot claim to
1878 view cultural ways-of-life from an objective standpoint (Thompson et al.,
1879 2011).
1880
1881 Although this research focussed on young men, principles of feminist
1882 methodology were drawn on in that the research was not only about the
1883 young men but designed to help them as well. Part of this research was
1884 to identify which discourses have most prominence for the young men
1885 in this study and with what consequences.
1886
1887 Research from a post-structuralist perspective can help highlight the
1888 relationships between the ways individuals construct their identity and
1889 the sets of social meaning and values circulating in society. It can also
1890 demonstrate how particular meanings are more powerful than others
1891 and the effects of this (Wright, 2003). Exploring the ways that young
1892 men contest, resist and redefine health information offers the
1893 opportunity to explore alternative ways of knowing, conceptualising and
1894 understanding health.
1895
1896 There is no single or unified set of theories outlining the post-
1897 structuralist "method" (Alloway and Gilbert, 1997). Solsken and Bloome
1898 (1992) suggest that post-structuralism might best be viewed as “...*a set*
1899 *of perspectives broadly outlining stances toward knowledge, power and*
1900 *society*” (1992, p. 121). Post-structuralism raises questions about we

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1901 constitute our identities, and how power-knowledge relations change
1902 across time, place, and in the context of different social, political, and
1903 cultural contexts (Wright, 2003).
1904
1905 Post-structuralism questions binaries such as adult and child, and male
1906 and female; rather than take such categories as set and inevitable, it
1907 questions the relations of power that are constructed and maintained by
1908 conceding "…*normality, rationality and naturalness to the dominant*
1909 *term*" (Davies and Gannon, 2005, p.312).
1910
1911 Constructivist and post-structuralist feminism deny the distinction
1912 between 'sex' and 'gender'. The goal of this is to undermine the belief in
1913 natural sex categories and innate sexuality. This is seen as a way of
1914 acknowledging difference and variability and providing greater
1915 possibilities for self-definition. Such feminists are unable to provide a
1916 single determining cause of sex and conclude "that the biological sex
1917 binary is a construction or a continuum, and that there are no
1918 mechanisms tending to divide bodies into two types" (Hull, 2006, p.71).
1919
1920 Connell (1995), a key theorist in gender and masculinity, describes
1921 masculinity as a social construction dependent of a specific historical
1922 time, culture and locale. This captures the complexity of men's lives
1923 and moves away from a binary system that defines men and
1924 women. Masculinity is also described in relational terms within social

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1925 constructionism (Connell, 1995 , Messner, 1996) which is why data
1926 collection in this study took place in settings that catered to all genders.
1927
1928 However, in order to contribute to the body of evidence within which this
1929 research is positioned, it was necessary to set some parameters that
1930 allow this research to be mapped onto existing evidence. With this in
1931 mind, set categories of 'man' and 'adolescent' were utilised, with an
1932 awareness that these definitions can be contested from a post-
1933 structuralist perspective.

1934 ### 4.1.1 Epistemological position taken within this research

1935 This research took a social constructionist view of gender and
1936 masculinity. In line with the principles of feminist methodology that have
1937 been drawn on within the methodology of this research, social
1938 constructionism can also be described as a feminist analysis of gender
1939 as a structure of social relations, especially involving power (Connell,
1940 1995).
1941
1942 In any given society there can be a hierarchy of masculinities, with the
1943 ideal version being considered dominant or hegemonic (Connell,
1944 1995). In Western culture, contemporary hegemonic masculinity is
1945 largely associated with being white, heterosexual and middle-class and
1946 holding traits deemed to be stereotypically masculine. Such traits
1947 include assertiveness, dominance, control, physical strength and
1948 emotional control. This can lead many men to experience subordination
1949 and marginalisation as a consequence of not measuring up to the ideal

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1950 standard against which all men are judged. Connell suggests that only
1951 a small percentage of men actually can and do measure up to the
1952 hegemonic version of masculinity (Connell, 1995).
1953
1954 Hegemonic masculinity is constituted through existing discourses and
1955 sets of meaning within a specific culture and society – it is these
1956 discourses that are the central objects of investigation for post-
1957 structuralism. This links to the epistemological underpinnings of this
1958 research. The next section will consider how these discourses will be
1959 considered in this research project.
1960

1961 4.1.2 Post-structuralism and discourse

1962 Post-structuralism recognises the power of discourse to shape reality
1963 and inscribe the social onto the individual (Somekh and Lewin, 2011).
1964 Kress (1985) defined discourses as sets of statements that demarcate
1965 what is available to say and do in a given context. The contexts in which
1966 people exist will produce particular discourses that make some ways of
1967 being feasible and not others (Willig, 2000). This conceptualisation of
1968 discourse informs the study's understanding of the young men's
1969 identities and performance in relation to context.
1970
1971 Discourses make certain positions available for citizens to adopt; these
1972 positions are defined in relation to other people (Hollway, 1984). Young
1973 men make sense of themselves through the interaction of these
1974 discourses. The young men will take-up, reject, resist, and challenge

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1975 these discourses in various ways that are complex and flexible, as well
1976 as being contingent on historical context (Weedon, 1997). Not all
1977 definitions of health will have the same resonance for all individuals and
1978 in all contexts (Wright, 2003). These meanings do not remain fixed, but
1979 continue to be reconstructed, redefined, re-inflected, challenged and
1980 contested (Vick, 2006). Post-structuralist theories focus on subjectivity,
1981 discourse and the plurality of meaning (Alloway and Gilbert, 1997).
1982
1983 Post-structuralist discourses allow for the possibility of reading the
1984 complexity of the multiply positioned and constructed human subject
1985 (Alloway and Gilbert, 1997). Francis (1999) detailed the ways in which
1986 people become active participants in their own social positioning by
1987 means of the creation of narratives to structure or describe their lives
1988 and experiences. The current study was conducted to identify the
1989 dominant discourses and meanings that may influence the young men,
1990 and the extent to which they are evident, represented, or resisted.
1991
1992 Consequently, the data sought was instances of discourse. In keeping
1993 with the theoretical basis of post-structuralism that takes knowledge as
1994 socially constructed, the researcher does not claim to be capturing
1995 truths, but some of the different ways in which individuals and groups
1996 construct health and a healthy body, and with what effects. Within this
1997 epistemology, there is also a need to consider the ‘knowledge’ that is
1998 produced, and how this has been ‘co-constructed’. This will be explored
1999 further in a section on reflexivity within this chapter.

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2000 ## 4.2 Research design

2001 The research design took the form of a qualitative, ethnographic,
2002 instrumental case study. Qualitative research has been identified as
2003 particularly useful for providing a voice to culturally diverse groups of
2004 men, as well as marginalised groups (Isacco, 2015).

2005 ### 4.2.1 Ethnography

2006 Ethnography is commonly defined as a written report about an
2007 understanding of a cultural setting gained through fieldwork (Joy, 1991 ,
2008 Van Maanen, 1988). Ethnographies are effective for identifying
2009 dominant socio-cultural discourses (Gallant, 2008). Interaction in the
2010 everyday lives of participants can lead to a better understanding of their
2011 beliefs, motivations, and behaviours (Tedlock, 2000). A post-structural
2012 ethnography involves acknowledging and addressing the power
2013 relations within the research dynamic, including those involving the
2014 researcher.
2015
2016 Saukko (2003) describes a 'new ethnography' that aims to recognise
2017 the emotional side of lived experience. 'New ethnography' represents a
2018 balancing act '... *of being true to the lived experience and being aware*
2019 *of the commitments and limits of its "truth*"' (Saukko, 2003, 56). This
2020 approach aims to "…*acknowledge the validity of the personal, including*
2021 *the emotional side of lived experience*" which may not come to light
2022 through the dominant discourses (Tsolidis, 2008, p.272). However, it is
2023 important to remember that this emotional side of lived experience is
2024 also shaped by discourse, and by the historical and social context, in

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2025 which it is located (Saukko, 2003). It is important to critically analyse the
2026 social and institutional discourses that are embedded within any lived
2027 experience, including the assumptions that the researcher brings to this
2028 lived experience.
2029
2030 As ethnography as a method has become applied various research
2031 disciplines, the original intention has been adapted (Wall, 2015).
2032 'Focused ethnography' (FE) has emerged as a methodological
2033 innovation to adapt to changing times and purposes (Wall, 2015). An
2034 FE usually focuses on a specific problem in a defined context
2035 (Knoblauch, 2005 , Mayan, 2009 , Morse and Richards, 2002 , Roper
2036 and Shapira, 2000).
2037
2038 According to Higginbottom et al. (2013) provide guidance on performing
2039 FE with an emphasis on health care research; their research concludes
2040 that FE can have "meaningful and useful application" in healthcare
2041 practice and can be a "pragmatic and efficient" way to capture data on
2042 specific topics (2013, p.1). In fact the genre could be said to have
2043 originate in research where various ethnographers explored how
2044 context related to the ways in which cultural beliefs determined health
2045 practices (Carr, 1996 , Morse, 1984 , Brink, 1982).
2046
2047 Higginbottom et al. (2013) elaborated that FE can be applicable to any
2048 discipline where there is a focus on exploring "…specific cultural

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2049 perspectives held by sub-groups of people within a context-specific and
2050 problem-focused framework” (p.1).
2051
2052 Research that may also be referred to as an FE might also be
2053 described as mini-ethnographies, or “quick and dirty” ethnographies
2054 (Millen, 2000 , Muecke, 1994). However vom Lehn (2019) would
2055 challenge this view due to the fact that FE requires that researchers
2056 acquire detailed knowledge of the field and, ideally, have participated in
2057 the activities on which their research focuses. Focused ethnographies
2058 are also typified by an interest in a specific research question, a
2059 researcher with background knowledge of researched group, and
2060 intensive methods of data collection (Higginbottom, 2013; Knoblauch,
2061 2005; Morse and Richards, 2002; Millen, 2000).
2062
2063 Within FE topics of inquiry and pre-identified, participant observation is
2064 within specific timeframes, and interviews are highly structured around
2065 the pre-selected issues (Higginbottom et al., 2013). Knowledge from
2066 professional practice and literature will help determine questions. The
2067 researcher in a focused ethnography will focus on common behaviours
2068 and shared experiences (Cruz and Higginbottom, 2013 , Mayan, 2009 ,
2069 Morse and Richards, 2002).
2070
2071 Concern has been raised about the generalisability of the data gained
2072 from focused ethnographies due to their often relatively brief time frame
2073 and limited scope (Muecke, 1994). However, it is perhaps the

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2074 sociological focus on cultural understandings and descriptions that
2075 could be said to define ethnography, rather than the form and amount of
2076 data collected (Knoblauch, 2005; Wall, 2015). There is not general rule
2077 about the 'right' amount of time to spend in the field (Wall, 2015). Time
2078 spent in the field does not necessarily guarantee that the usefulness of
2079 data (Wall, 2015). Limited time in the field can be offset by a higher
2080 intensity and volume of data, such as the data that can emerge from in-
2081 depth, semi-structured, audio-recorded interviews (Heyl, 2001 ,
2082 Knoblauch, 2005 , Morse and Richards, 2002).
2083
2084 The methodological adaptations within focused ethnographies make it
2085 possible to use ethnography in situations where they may not have
2086 worked, for example in healthcare research (Wall, 2015).
2087

2088 4.2.2 Case study

2089 A case study is a research approach that is used to "*generate an in-*
2090 *depth, multi-faceted understanding of a complex issue in its real-life*
2091 *context*" (Crowe et al., 2011, p.1). The approach that the case study
2092 takes depends on the epistemological standpoint of the researcher.
2093 Mohammed et al. (2015) propose that the value of post-structuralist
2094 case study lies in the flexibility and comprehensiveness of the
2095 methodology. Post-structuralist methodology aims for a more detailed
2096 understanding of the discourses around a phenomenon, as well as how
2097 power and knowledge relations shape people's behaviours and
2098 perceptions.

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2099 Case study research such as used within this research focuses on what
2100 Wittgenstein called “the epistemology of the particular”. This works by
2101 developing and honing the vocabulary and expressions used by
2102 researchers, practitioners, policymakers, and citizens to talk about
2103 social practices. This process referred to as heuristic generalisation
2104 (Tsoukas, 2009). This enables the researcher draw more subtle
2105 distinctions and comparisons between social practices in different
2106 contexts (Greenhalgh et al., 2011). It becomes a heuristic process in
2107 that this discussion is placed in the public domain in order that
2108 reflection, discussion, and debate can help achieve a greater
2109 understanding that can be more broadly applied (Greenhalgh and
2110 Russell, 2009).
2111
2112 Stake (2000) defined three different types of case study; intrinsic,
2113 instrumental, and collective. An intrinsic case study is undertaken to
2114 learn about a unique phenomenon, and to identity its uniqueness; an
2115 instrumental case study identifies a particular case to use in order to
2116 gain a wider understanding of an issue; a *collective* case study involves
2117 studying a number of cases simultaneously or sequentially in an
2118 attempt to generate an even broader understanding of an issue or
2119 phenomenon (Crowe et al., 2011).
2120
2121 The process of building a case has been identified as allowing and even
2122 encouraging the collection of multiple sources of data (Stake, 2000 ,

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2123 Yin, 2009). This allows post-structuralist researchers to strategically
2124 select the kind of data to collect (Mohammed et al., 2015,).
2125
2126 One of the most important aims of post-structuralist inquiry is to critically
2127 examine how people's patterns of thinking and action are shaped by
2128 broader discourses (Mohammed et al., 2015). The 'cases' in this study
2129 were selected instrumentally in order to gain a wider understanding of
2130 how young men conceptualise health. The geographical cases have
2131 been selected to include viewpoints from multiple participants and data
2132 sources from multiple levels, such as the local and personal, as well as
2133 the institutional and social. Yin (2009) describes the importance of data
2134 triangulation, whilst post-structuralism uses these multiple sources to
2135 consider tensions between social actors or discourses (Mohammed et
2136 al., 2015).
2137
2138 Another important aim of post-structuralist research is to consider how
2139 power/ knowledge relations are established and function within a setting
2140 (Mohammed et al., 2015). Since case study research is concerned with
2141 how participants operate and act within contexts (Stake, 2000), this
2142 methodological approach also lends itself well to examining the multi-
2143 faceted ways that people resist power relations (Mohammed et al.,
2144 2015).
2145
2146 Hall (2001, p.136) argues that those interested in social change should
2147 think about life outside school when trying to make sense of adolescent

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2148 meaning-making processes. This led to the cases being based in youth
2149 and community groups. This also allowed the researcher to meet the
2150 young men at a site that they had chosen to spend time in that provided
2151 an intersection between the different elements of their lives. The hope
2152 was that this would allow access to a range of young people and young
2153 men in order to explore the phenomenon of health.
2154
2155 Woodman (2012) believes that there has been false prominence given
2156 to 'spectacular' elements of youth culture and 'at-risk' young people.
2157 This has resulted in number of researchers arguing for greater attention
2158 to the 'ordinary' in sociological youth research (Cohen, 2003 ,
2159 Macdonald, 2011 , Roberts, 2011 , Woodman, 2012).
2160
2161 'Ordinariness' is defined in different ways by the different researchers.
2162 Woodman (2012) problematises a definition of 'ordinariness' and
2163 suggests an alternative conceptualisation. Woodman (2012) supports
2164 challenging the use of binaries and typologies as categories (or boxes)
2165 into which particular young people can be placed. Woodman (2012)
2166 suggests that it is possible to be 'ordinary', or at least recognised as
2167 ordinary by others, in some aspects of life (such as at work), while
2168 concurrently categorised as at risk, and treated as such, in others (such
2169 as at school).
2170
2171 With this in mind, the research sites chosen were predominantly
2172 constituted of 'ordinary' boys, as opposed to those with 'special

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2173 educational needs and disabilities', 'behavioural difficulties', or 'gifted
2174 young people', for example. These boys accessed the freely chosen
2175 youth provision in their social time, outside of their education setting. Of
2176 course, it is important to note that young people may have their own
2177 ideas about whether aspects of their lives are ordinary and may not
2178 agree with the conceptualisations discussed here (Woodman, 2012).

2179 4.2.3 Case study field site selection

2180 The importance of looking at multiple sites in the search for fuller
2181 understandings of adolescent meaning making established itself in the
2182 literature in the 1990s (Heath and McLaughlin, 1993 , McLaughlin et al.,
2183 1994 , Borman and K., 1999 , Brown and Theobald, 1998 , Muller and
2184 Frisco, 1998 , Newman, 1998 , Schneider and Stevenson, 1999 ,
2185 Borman, 1999).
2186
2187 Two sites were chosen for this instrumental case study. Each site was
2188 chosen with the aim of finding young men from contrasting demographic
2189 backgrounds. Each site provides a local social context and meets
2190 Wenger's (1998) criteria for a community of practice; mutual interaction
2191 of members, common purpose, and shared discourses and behaviours.
2192 Ten local youth provisions were contacted with a view to undertaking
2193 field work at their site. Four sites were happy for data collection to take
2194 place at their provision. See table seven for process of site selection:
2195
2196
2197

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2198 *Table 7: Process of site selection*

	Action
1	Search youth projects in 20 mile radius.
2	Send letter explaining project.
3	Receive responses and arrange visits to discuss in further detail.
4	Four projects able to participate.
5	Data collection takes place in each site for 8 weeks at a time.
6	Insufficient data in sites one and two due to lack of availability of young men to participate in interviews. These sites only provided sessions once a week so there was very limited time.
7	Final two sites provide all data.

2199

2200 Data collection took place in four sites, but there was not enough data
2201 for two sites due to lack of availability of young men to participate in
2202 interviews. These sites only provided sessions once a week so there
2203 was very limited time. The final two sites were chosen because they
2204 offered daily access to young people and were able to offer full time
2205 access to the researcher for the time period requested. They were also
2206 able to accommodate interviews with the young men due to the
2207 regularity of contact. They also provided a good contrast to each other
2208 due to the socioeconomic differences of each site. One case study was
2209 based in a youth centre in a city centre location, and one in an ex-
2210 mining town (pseudonym Minetown).

2211

2212 There does not appear to be a formalised and minimum length of time
2213 in which to spend doing field work, and an ideal time to spend in the

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field is difficult to establish (Jeffrey, 2004). Decisions were based on pragmatic issues such as the time the researcher had available, and the time that they were allowed to spend in the site. It tends to be the case that familiarity with the site or context may mean less time needing to be spent in the setting.

The researcher has been an experienced youth worker and counsellor with children and young people for over ten years; working in this capacity helped to gain experience in building rapport with clients in this setting. In addition to this, young people in youth work settings are used to new people undertaking placements for eight weeks at a time as part of their university courses, so are not unfamiliar with this kind of experience. Based on this assessment, eight weeks was spent in each group with the researcher attending every weekday and evening that the provision ran. This is a considerable amount of time spent in this setting and could be seen as a strength of this research.

Demographic data was taken about and from each setting in order to create a narrative to understand each context. This will be presented in the next two sections.

4.2.3.1 City overview and area context

The city centre based youth provision in this study was based in Nottingham City Centre and served young people all over the city and county. An overview of Nottingham City and relevant surrounding areas will be provided using statistics from a variety of sources, including the 2015 Indices of Multiple Deprivation (IMD) (Ministry of

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2240 Housing, Communities and Local Government) MHCLG, 2015 ,
2241 (Nottingham City Council) NCC, 2016) and the 2011 Census (NCC,
2242 2011 , (Office for National Statistics) ONS, 2011).
2243
2244 Nottingham City is a unitary authority comprising of 20 wards. It has a
2245 young and ethnically diverse population, covering an area of
2246 approximately 75 square kilometers (Nottinghamshire County Council)
2247 NsCC, 2017). The University of Nottingham and Nottingham Trent
2248 University are both located in the city, as is the Queen's Medical Centre
2249 Teaching Hospital. Nottingham has a history in industry, including
2250 tobacco, lace, and bicycles. Nottingham City has a young population
2251 compared to both Nottinghamshire and England; this is due to largely
2252 (but not entirely) to the student population and the presence of two
2253 universities in the city (NsCC, 2017).
2254
2255 Full time university young people account for approximately 1 in 8 of the
2256 population (NsCC, 2017). 15.5% of the population is in the 20-24 age
2257 group compared to 6.6% nationally (NsCC, 2017). Of the 80,900 aged
2258 50+ living in the city, 44,700 are aged under 65, 26,300 are aged under
2259 75 and 10,900 are aged over 75 (NsCC, 2017). Nottingham has an
2260 ethnically diverse population with over a third of the population defining
2261 themselves as black minority ethnic (compared to 20% nationally)
2262 (NsCC, 2017).
2263
2264 Nottingham City is made up of the city centre boundary and a 'Travel to
2265 Work Area' (TTWA) ().

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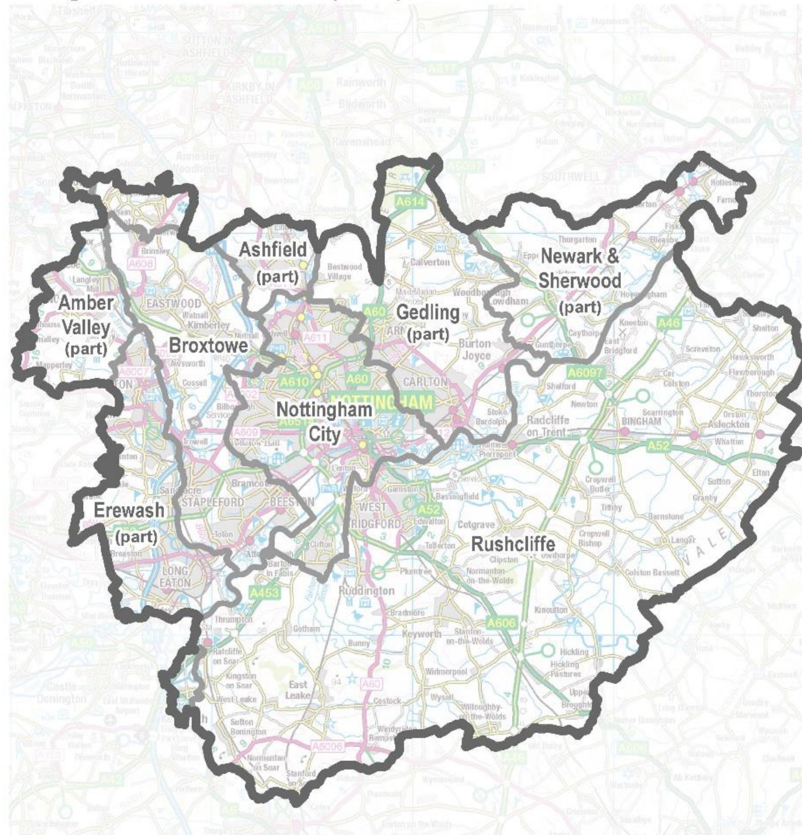
2266 *Figure 2: Nottingham Travel to Work Boundary Map (NCC, 2017)*

2267



2268 These more affluent TTWAs have created a “doughnut effect” where,

2269 whilst the city centre has prospered, the “inner suburbs” have crumbled,

2270 leaving many trapped between the prosperous centre and the

2271 affluent outer suburbs. The inner suburbs tend to have limited mobility

2272 whilst the TTWAs tend to have increased mobility. It is interesting to

2273 note that the attendees of the city youth provision tended to come from

2274 these more affluent TTWAs. It is important to note how these

2275 inequalities can skew some of the statistical data related to

2276 Nottingham.

2277

2278 In reference to deprivation, Nottingham is categorised as the eighth

2279 most deprived district in England in the 2015 IMD. This is relative fall

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2280 from being considered the 20th most deprived in the 2010 IMD (NCC,
2281 2016). In England, there are also 32,844 lower super output
2282 areas (LSOAs) and each one has been ranked according to the
2283 measures of deprivation with one as the most deprived and 32,844 as
2284 the least deprived (NsCC, 2017). Nottingham City comprises 182
2285 Lower LSOAs (NCC, 2016). Around a third of LSOAs in the city are in
2286 the worst ten per cent nationally and the rest are in the worst twenty per
2287 cent nationally (MHCLG, 2015).
2288
2289 Health and Disability is the Indices of Deprivation domain on which
2290 Nottingham does worst, followed by Education, Skills & Training and
2291 Crime (NCC, 2016). A higher percentage of people aged 16-64 in
2292 Nottingham claim some form of benefit than regionally and nationally.
2293 The unemployment rate is also higher than the regional and national
2294 average (NCC, 2016). There are high levels of child poverty in the city
2295 with around a third of children and young people living in workless
2296 households (NCC, 2016).
2297
2298 Looking to health in more detail, in responses to the 2011 Census
2299 (ONS, 2011) where people were asked to assess their general health
2300 over the twelve month period prior to Census Day, within Nottingham
2301 City 79.9% assessed their health to be either very good or good (NCC,
2302 2011). This was below that for England as a whole (81.4%) (NCC,
2303 2011). A further 13.6% stated their health to be fair, while 6.4% stated
2304 that their health had been bad or very bad over this period (NCC, 2011).

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2305 Although this represents over 305,000 residents, it is still above the

2306 rates expressed across England (5.5%) (NCC, 2011).

2307 *4.2.3.2 Minetown overview and area context*

2308 The town youth provision in this study was based in an ex-mining town

2309 in the borough of Broxtowe; throughout the study this town will be

2310 referred to as 'Minetown'. An overview of Minetown will be provided

2311 using statistics from a variety of sources, including the 2015 IMD

2312 (NsCC, 2017) and the 2011 Census (NCC, 2011). The section will also

2313 add context to this by utilising information about Minetown gathered

2314 from interviews with staff and young people.

2315

2316 Minetown is located within the County of Nottinghamshire and is

2317 approximately around ten miles from the City of Nottingham.

2318 Minetown is situated in the borough of Broxtowe. Broxtowe is one of the

2319 most densely populated in the East Midlands (Broxtowe Borough

2320 Council) Broxtowe Council, 2014). Broxtowe has a proportionally lower

2321 number of younger people (0 – 24 years) than nationally (BC, 2014).

2322 Conversely, the borough contains a higher proportion of older people

2323 (45 years and over) than the national average (BC, 2014).

2324

2325 Over 90% of Broxtowe Borough residents identify their ethnicity as

2326 white compared to 86% in the general population (BC,

2327 2014). Minetown is a commuter town with many of the employed

2328 population working elsewhere. A significant proportion of those in

2329 employment commute into the City of Nottingham as they are

2330 potentially unable to afford the property prices in the city.

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2331 In some ways, it is not useful to look at Minetown in the context of
2332 Broxtowe due to the relative gaps between the affluent and deprived
2333 areas; Broxtowe is a relatively affluent borough and is ranked 218th out
2334 of 326 English local authorities in the 2015 Index of Multiple Deprivation
2335 (IMD) (where one = most deprived) (MHCLG, 2015). A significant part
2336 of Minetown is within the top 20% of the most deprived areas in the
2337 country. Minetown is in the 10% most deprived LSOAs in the district for
2338 the IMD domains of crime, education, skills, and education,
2339 employment, and income. Child poverty in Minetown exceeds the
2340 national figure, and there are also higher than average levels of fuel
2341 poverty.
2342
2343 Residents in Minetown also rates highest in the self-assessment of bad
2344 or very bad health in the borough of Broxtowe; this represents one in
2345 twelve people and is indicative of the extent of the relative deprivation in
2346 the ward. In a CCG mapping exercise to produce a profile of local
2347 needs across the borough, Minetown was in the top four wards of
2348 highest need.
2349
2350 It is vital to consider the history of Minetown as an ex-mining town and
2351 the impact that this has had on the area. We have seen how far some
2352 of the indicators of deprivation are from the national averages and that
2353 this has led to significantly above-average levels of deprivation. Foden,
2354 Fothergill, and Gore (2014) conducted a report on the economic and
2355 social conditions in the former mining communities of England, Scotland

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2356 and Wales; they concluded that, although that the miners' strike of

2357 1984/5 may now be disappearing from history, the associated job

2358 losses are still part of the routine economic reality of most ex-mining

2359 communities. The consequences are still in evidence within statistics on

2360 jobs, unemployment, benefits, and health (Foden et al., 2014).

2361

2362 The previous sections have considered demographic data from each

2363 setting in order assist in understand each context. This will be

2364 elaborated on further in the findings chapters. The next section will

2365 consider the wider ethics involved in conducting this research project.

2366 4.3. Ethics

2367 Ethics are extremely important in research practice. Specifically

2368 sensitive ethical approaches are necessary when working with children

2369 and young people (Alderson, 1995 , Alderson and Morrow, 2004 ,

2370 Matthews et al., 1998 , Aitken, 2001 , Holloway and Valentine, 2000 ,

2371 Valentine, 1999).

2372

2373 The ethics of research with children is a balance between ways of

2374 preventing and moderating harm in research whilst also avoiding

2375 suppressing and dismissing children's voices from research about their

2376 views and experiences (Boddy et al., 2018).

2377

2378 Some of the key principles that appear within human rights and

2379 research contexts are: respect for human dignity; informed consent;

2380 individual autonomy; equality; privacy and confidentiality; freedom of

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2381 expression; access to information; and justice (Bell, 2008). While each
2382 principle applies equally to children and adults, the United Nations
2383 Convention on the Rights of the Child (UNCRC) (UN, 1989) positions
2384 principles such as 'freedom of expression' and 'access to information'
2385 as fundamental rights.
2386
2387 Some of the research participants in this research were under eighteen.
2388 Participatory ethical perspectives argue that research about children
2389 under eighteen that involves their participation should be 'authentic',
2390 provide the opportunity for children to contribute to knowledge which
2391 has the potential to improve their lives, is 'ethical', and 'empowering.
2392
2393 Research that includes children's voices can potentially access
2394 knowledge that has been previously neglected, as well as providing
2395 more nuanced information (Cahill, 2004 , Grover, 2004). The knowledge
2396 produced is therefore argued to be more reliable, which aligns more
2397 closely with the ethical principle of fidelity.
2398
2399 However, whilst it can be beneficial to attend to the experiences of
2400 children, this must be presented in a critical and reflexive way. I'Anson
2401 (2013) cautions against the reporting of the child's voice as "self-
2402 evidential and beyond challenge" (p. 112). This approach must be
2403 considered critically, as it can be used appropriate children's voices,
2404 justifying an adult researcher's specific interpretations (I'Anson, 2013).
2405 Rabinow (1997, p.xix) advises the researcher to utilise reflexivity in

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2406 order to "*cultivate an attention to the conditions under which things*
2407 *become 'evident'*". Davies and Gannon (2009) also advocate inquiry
2408 into the kinds of truths that are produced (Davies and Gannon, 2006).

2409 4.3.1 Consent

2410 4.3.1.1 Informed consent with children and young people

2411 The difficulty in obtaining ethical approval for research studies can be
2412 seen to reduce the opportunities for participation in research involving
2413 children and young people. It has been argued that institutional ethical
2414 guidelines can deny children's and young people's capability and
2415 competence to make decisions about their own lives (Skelton, 2008).
2416
2417 The UN Convention for the Rights of the Child (1989) exists to ensure
2418 that children have participatory involvement in all matters affecting their
2419 lives, including research (Bell, 2008). The British Educational Research
2420 Association (BERA) (2018) guidelines cite the UNCRC noting that
2421 "children who are capable of forming their own views should be granted
2422 the right to express their views freely in all matters affecting them,
2423 commensurate with age and maturity. Children should therefore be
2424 facilitated to give fully informed consent" (BERA, 2018, p. 15).
2425
2426 Research with children in youth group settings can raise particular
2427 ethical issues in relation to individual consent where research
2428 participation is conducted as a whole-group activity. As discussed
2429 earlier, although post-structuralism questions set categories such as
2430 'adult' and 'child'; many codes of ethics insist on the ignorance,

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2431 innocence, and vulnerability of childhood (Economic and and Social
2432 Research Council, 2018 , BERA, 2018) and state that parental consent
2433 must be obtained.
2434
2435 However, this study took the stance that this homogenises the category
2436 of 'child' and may not do justice to the capacity of many young people.
2437 A person's ability to make decisions is more reliant on their ability to
2438 understand and consider options than their age. It is disingenuous to
2439 say that involvement of children and young people improve policies,
2440 practice and research yet also question their capacity to consent on
2441 their involvement in this.
2442
2443 Each site in this research offered their clients confidential support and
2444 did not ask for information pertaining to parents/guardians. The city site
2445 worked with young people from aged 11-25, and the town site worked
2446 with young people from eight to eighteen. Requiring information or
2447 consent from parents/guardians can often create barriers, limiting
2448 access to services, and resulting in a poorer experience. A requirement
2449 to seek parental consent for this research may put the young people at
2450 risk due to this disclosing that they were accessing the youth provision.
2451
2452 Staff and young people disclosed that their parents/guardians did not
2453 know that they attended the site due to other young people that
2454 attended, as well as condoms being given out for free at each site.
2455 Ethical procedures required consent to be granted and, after

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2456 discussions with the management teams of the two organisations, it
2457 was decided that the organisations would provide blanket consent on
2458 behalf of the parents/guardians for the participant observations. Young
2459 people were able to opt out themselves in addition to this (Appendix II).

2460 #### 4.3.1.2 Gaining consent

2461 From a post-structural perspective, Gallacher and Gallagher (2008,
2462 p.506) write that "Neither researchers nor their participants can hope for
2463 anything more than a partial, contextual and incomplete understanding
2464 of what they are doing. Discrepancies between researchers' and
2465 participants' understanding of a project may be hard to spot, and may
2466 also be unstable, changing over time as the research unfolds". This
2467 means that providing full information, and therefore gaining informed
2468 consent, might not be possible. This leads us to question the extent to
2469 which children can ever fully understand the implications of the
2470 research in which they are invited to participate (Gallacher and
2471 Gallagher, 2008).
2472
2473 See table eight for details of processes detailing the processes of
2474 recruitment and consent:

2475 *Table 8: Process of recruitment and consent of participants*

	Action
1	Meetings take place at each site – sites advised that they would provide blanket consent on behalf of the parents/guardians for the participant observations. Young people were able to opt out themselves in addition to this.

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2	Posters and leaflets were provided in each site to ensure that this information and any contact information is readily available.
3	Information sheets were also provided to the young people to share with their parents at their discretion.
4	Dates set for interviews and all young men present that met age criteria, and assessed as Gillick competent were approached to participate in individual or group interviews.
5	Participants provided consent for themselves.
6	An information sheet was provided to participants including contact information for relevant external support services.
7	Dates set for second interviews and all young men who participated in first interview and were present on these dates were interviewed.

2476

2477 All staff and young people were informed that the research was taking
2478 place through information provided and discussions at the group. The
2479 researcher made an effort to introduce herself to staff and young people
2480 in each site in order to provide an explanation for their presence. The
2481 staff and young people were familiar with new people arriving in their
2482 settings for set periods of time on placement, so the presence of the
2483 researcher for a set period of time was not unique.

2484

2485 Participants were able to see the researcher around the site and ask
2486 questions in order to provide informed consent. Additional posters and
2487 leaflets were provided to ensure that this information and any contact

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2488 information is readily available (appendix III, IV). Information sheets
2489 were also provided to the young people to share with their parents at
2490 their discretion (appendix V).
2491
2492 Gillick competency was also operationalised here as a safeguard to
2493 capacity to consent. 'Gillick competency' (Gillick, 1985) is a tool that is
2494 often used to assess the children's capacity to provide informed
2495 consent. Fraser Guidelines, based on the Gillick Ruling (Gillick [1985] 3
2496 All ER 423), are not intended for – but may be applied to – research
2497 (Boddy et al., 2018). Gillick competency (Gillick, 1985) can be used to
2498 assess whether the young person can understand information given
2499 and has sufficient maturity to understand what is involved.
2500
2501 Lord Scarman (Gillick, 1985) states that the child's rights to make their
2502 own decisions should supersede the parent's once they reach sufficient
2503 understanding and intelligence to be capable of making up their own
2504 mind. This is based on the assumption that a child who possess the
2505 necessary understanding can provide consent and that, under such
2506 circumstances, a parent has no right to supersede their child's wishes
2507 (Wiles et al., 2006).
2508
2509 Children over the age of sixteen are deemed to be competent to give
2510 consent for themselves. Children under sixteen are assessed on an
2511 individual basis. To ensure that autonomy is genuinely respected and to
2512 protect against personal interest, Gillick competency should be

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2513 assessed by an individual who has no interest or involvement in the
2514 research (Hunter and Pierscionek, 2007). Due to the researcher's
2515 personal investment in the research, Gillick competency in this case
2516 was assessed by senior staff members of the organisation.
2517
2518 Any young person not assessed as Gillick competent would not be
2519 included in observations or focus groups/interviews. Gillick competency
2520 is used as standard within these settings in order to decide whether to
2521 give out contraception, so staff were familiar with using this measure.
2522 Staff advised on the capacity of each participant to provide informed
2523 consent due to the potential bias of the researcher. Only one potential
2524 interview participant was not deemed to be Gillick competent due to
2525 their additional learning needs and was excluded from the study.
2526 However, even when consent had been achieved for observations, on-
2527 going consent cannot be assumed (Simons and Usher, 2000).
2528
2529 The researcher is a trained counsellor and as such, trained to observe
2530 non-verbal cues. The researcher was committed to being sensitive and
2531 responsive to any negative reactions the staff or young people might
2532 have to being observed. These reactions may include turning away
2533 from the researcher or whispering rather than talking openly. Such cues
2534 would lead the researcher to cease observing those particular people in
2535 order to respect their privacy.
2536

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2537 The researcher remained dependent on staff's relationships with the
2538 young people to identify their often subtle signs of discomfort on a
2539 longer term basis. During the early stages of data collection, the
2540 researcher attempted to establish open, dialogical relationships by
2541 encouraging staff and young people to let them know immediately if
2542 they feel that her presence was having an adverse effect on them; this
2543 did not occur in the research.

2544 #### 4.3.1.3 Dealing with potential disclosure

2545 The information discussed brought up potentially sensitive issues such
2546 as health, sexual health issues, drugs and alcohol, diet and exercise
2547 related behaviours. An information sheet was provided to participants
2548 including contact information for relevant external support services
2549 (Appendix IV). In addition, the researcher is a trained counsellor and
2550 experienced in with working with young people so equipped to be able
2551 to support the young person in that moment before referring on for
2552 further support.
2553

2554 The researcher also worked closely with the staff team on both sites to
2555 ensure that participants were given access to any support required. All
2556 organisations had a code of conduct for staff and young people,
2557 including information about disclosures, that all have to agree with
2558 before accessing services. The researcher adhered to this and in the
2559 event of any concerns would refer to the lead worker at the centre after
2560 discussing the issue with the young person. No situations arose where
2561 a disclosure had to occur.

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2562 ### 4.3.1.4 Gaining ethics committee approval

2563 This research was based in the School of Health Sciences at the
2564 University of Nottingham. Therefore, ethical approval was granted by
2565 the University of Nottingham Faculty of Medicine and Health Sciences
2566 Research Ethics Committee in February 2014. The ethics reference
2567 number was G14112013 SoHS (Appendix VI).

2568 ## 4.5 Data collection

2569 Post-structuralist research uses verbal and visual textual data, including
2570 'subjective' narratives (Kendall and Wickham, 1999 , Czarniawska,
2571 2004). Narratives have been acknowledged as some of the most
2572 influential elements affecting how people construct their knowledge and
2573 understanding.
2574
2575 Data collection within the current study was undertaken using multi-
2576 method ethnographic techniques including observation, field notes,
2577 documentary data, and semi-structured individual/group interviews.

2578 ### 4.5.1 Documentary data

2579 Within focused ethnography, a range of documents can be consulted
2580 including policy, census data, maps, and biographical materials
2581 (Higginbottom et al., 2013). This documentary data can be used to
2582 confirm or contrast interview and observation findings (Higginbottom et
2583 al., 2013). Documentary demographic data was obtained for the
2584 geographic area that the site served, as well as those attending the
2585 provision. Some of this data was provided by the setting, and some was
2586 sourced online from local and national government reports.

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2587 The historical background of each provision was also explored in order
2588 to give some context as to why the service was developed, and the
2589 purpose it was intended to serve; again some of this data was provided
2590 by the setting, and some was sourced online from local and national
2591 government reports, as well as media outlets such as local newspapers.

2592 ### 4.5.2 Participant observation

2593 Fieldwork and participant observation are the main ethnographic data
2594 collection methods (Shweder, 1996). Participant observation places the
2595 researcher in dual roles as participant in, and observer of, the host
2596 community. The ethnographer is expected to be simultaneously an
2597 insider *and* an outsider (Spradley, 1980). Participant observation
2598 assumes that it is possible to participate in the lives of the people being
2599 studied, whilst simultaneously maintaining enough analytical and
2600 intellectual distance to allow observations, analysis, and interpretation
2601 (Wind, 2008).
2602
2603 According to Wind (2008), in the best of ethnographic worlds the
2604 ethnographer will find a credible role from which they can participate in
2605 the lives of the people studied; this role will be one that is an
2606 appropriate place from which to build trust and rapport so that they can
2607 join in different situations and activities.
2608
2609 Schensul, Schensul, and Lecompte (1999) define participant
2610 observation as "the process of learning through exposure to or
2611 involvement in the day-to-day or routine activities of participants in the

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2612 researcher setting" (p.91). Bernard (1994) adds the importance in this
2613 process of the researcher then removing themselves from the setting or
2614 community in order to allow full immersion in the data. This allows
2615 space to consider the data in order to understand what is going on and
2616 be able to write about it
2617
2618 Observation provided the opportunity to become familiar with each
2619 context and its members, and for the members to become familiar with
2620 the researcher. Observations also helped provide context and
2621 exploration of the forms of health education and knowledge are
2622 available to young men in youth groups and youth work settings.
2623
2624 There are four main observer stances (Gold, 1958); complete
2625 participant, participant as observer, observer as participant, and
2626 completer observer. The complete participant would be a member of
2627 the group being studied and conceal their researcher role (Kawulich,
2628 2005); this would not be possible in this study due to the gender and
2629 age of the researcher. The participant as observer is a member of the
2630 group being studied, with the group being aware of the research activity
2631 (Kawulich, 2005). In this stance, the researcher is considered to be
2632 participant in the group who is observing others but with more interest in
2633 observing than in participating (Kawulich, 2005); again, this was not
2634 appropriate in this case due to the age and gender of the researcher.
2635

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2636 A complete observer would completely hide themselves or their role in a

2637 public setting, with the observed public studied being unaware of being

2638 observed (Kawulich, 2005). The role of the researcher in this research

2639 was limited to ‘observer as participant’ where it was possible to

2640 participate in group activities but not to be part of the group due to age

2641 and gender. Adler and Adler (1994, p.380) note, this "peripheral

2642 membership role" enables the researcher to:

2643 *"…observe and interact closely enough with*
2644 *members to establish an insider's identity without*
2645 *participating in those activities constituting the core*
2646 *of group membership."*
2647 *(Adler and Adler, 1994, p.380)*

2648

2649 This role is argued as being the most ethical approach to observation,

2650 as the researcher's observation activities are transparent to the group

2651 being studied, including staff, yet the emphasis for the researcher is on

2652 collecting data, rather than participating in the activity being observed

2653 (Kawulich, 2005). Focused ethnography typically utilises this approach

2654 because it is not as time consuming (Higginbottom et al., 2013).

2655 ### 4.5.3 Field notes taken during participant observation

2656 Field notes were taken of what the researcher observed as well as

2657 notes around reflexivity issues (Appendix VII). Field notes are widely

2658 recommended in qualitative research as a means of recording

2659 contextual information and “*constructing thick, rich descriptions of the*

2660 *study context*” (Phillippi and Lauderdale, 2018, p.381).

2661

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2662 Contextual information within field notes frames the study in a time,
2663 place, or population (Phillippi and Lauderdale, 2018). Comprehensive
2664 field notes, especially those that include critical reflection, were in
2665 guiding other data collection methods within the study; they created a
2666 record of the study's development and were valuable during analysis
2667 (Phillippi and Lauderdale, 2018).

2668

2669 Kutcsche (1998) suggests first mapping out a physical map of the
2670 setting, using as much detail as possible which was completed in the
2671 field notes of this research; this could then be referred to later in any
2672 written notes. Schensul, Schensul, and Lecompte (1999) add that the
2673 researcher should take a count of attendees, including such
2674 demographics as age, gender, and race; how participants use the
2675 space; and a description of the activities being observed, detailing
2676 activities of interest. This map was taken at the start of the research in
2677 each setting (Appendix VII) in order to help the researcher gain a better
2678 understanding of the social setting in the early stages of participation
2679 (Schensul, Schensul, and Lecompte, 1999). This was more an exercise
2680 for the researcher to familiarise themselves than a tool for analysis.

2681

2682 DeWalt and DeWalt (1998) describe field notes as both data and
2683 analysis, because the notes deliver an accurate report of what the
2684 researcher observes, as well as being the result of the observation
2685 process itself. Field notes within the current study included what was

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2686 observed and overheard, conversations with participants, records of
2687 activities and reflective notes including questions to ask later.
2688
2689 The researcher wrote observation notes during the data collection as
2690 things happened rather than going away and completing them
2691 afterwards. Participant observation took place for the whole period of
2692 immersion in the site. The researcher had a notebook on hand at all
2693 times. This was an attempt to separate observations and
2694 interpretations.
2695
2696 Although a post-structuralist study, field notes were separated into
2697 observations written as description and process notes in the margins
2698 which were the researcher's interpretations. The researcher used a
2699 notebook and pen to write notes. The participants showed interest in
2700 the researcher's notes at first and the researcher explained what they
2701 were and why they were doing them. The participants became familiar
2702 with this activity after a few days and ceased to ask questions about it.
2703
2704 The researcher stepped out of the setting at regular intervals to capture
2705 what has been said but this was sometimes difficult. Sometimes
2706 conversations did have to be written up afterwards rather than interrupt
2707 the flow in order to write down. The researcher believed that it was
2708 more important to be present and show interest in what the young
2709 person was saying in order to embody an interest in gathering their
2710 perspectives.

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2711 ### 4.5.4 Sampling participants

2712 In a focused ethnography, the most common type of sampling
2713 technique is purposive, with snowballing sampling often built in as a
2714 complimentary strategy (Higginbottom et al., 2013). This purposive
2715 sampling results from the fact that the identified participants have been
2716 observed to have specific knowledge or experience that is judged to be
2717 of interest to the research (Crookes and Davies, 1980; Higginbottom et
2718 al., 2013). Data saturation often decides the sample size (Higginbottom
2719 et al., 2013).

2720

2721 Within each site, based on the objectives of the study, purposive
2722 sampling was utilised in order to select participants who were self-
2723 identified young/teenage men aged 10-19. Post-structuralism questions
2724 set categories such as these age categories, however operationalising
2725 such categories will be allowed results to be targeted to people working
2726 with this age group. When referring to existing research and debates,
2727 this research attempted to match their language while at the same time
2728 trying to indicate the messiness of such 'life stages' (Skelton, 2008).

2729

2730 The age range 10-19 was chosen in order to reflect the category of
2731 adolescence defined by the WHO (UNICEF, 2007). However, such
2732 terms can give a sense that these identities are fixed in some way,
2733 when this is not the case (Aitken, 2001a , Maxey, 2004). It is also
2734 important to consider that there is, of course, a considerable difference
2735 between a child of ten and one of nineteen (Skelton, 2008).

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2736 Informed by post-structuralist epistemology, it was decided that
2737 accepting self-identification as male was appropriate and in the spirit of
2738 the research. This was tested when a transgender male was interested
2739 in participating in an interview. In the first stages, there was concern
2740 about including this young person in the interview stages due to the fact
2741 that he had been raised as female for some of his life. However, further
2742 thinking led to the conclusion that other young men were not being
2743 asked to 'prove' their biological gender or their 'male upbringing'

2744 4.5.5 Participant interviews

2745 Interviews can help validate observations and provide directions for
2746 future observations, as well as collecting data on issues that cannot or
2747 have not been observed, such as feelings (Roper and Shapira, 2000).
2748 Semi-structured individual and group interviews were undertaken to
2749 allow the researcher to engage more deeply with the young men in
2750 each setting. Semi-structured interviews, or focused interviews (Dane,
2751 2010), can be more flexible and allow the researcher to better
2752 understand the perspective of the interviewees (Daymon and Holloway,
2753 2002). If something interesting or novel emerges, the researcher is able
2754 to refocus the questions, or prompt for more information.
2755
2756 In interviews, the nature of the interviewee responses is significantly
2757 affected by the relationship between the interviewer and the
2758 interviewee. The interview will be affected and shaped by the
2759 collaboration between both interview participant and interviewer (King,
2760 1992). This interaction not only regulates the meanings that materialise,

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2761 but also develops the meanings and leads to new ones (Diaz, 2002).

2762 This process is referred to as reflexive heuristics and:

2763 *"…is based on the idea that meanings are created in*
2764 *the very process of verbalizing experiences or*
2765 *observing other people's lives" (Diaz, 2002, p. 253).*

2766

2767 The current study conducted a series of interactive interviews over time
2768 with the aim of encouraging the mutual development of deeper
2769 understandings. Again, it is important to acknowledge the researcher's
2770 influence in this process. In some respects, it was because of
2771 researcher influence that the data was able to be gathered – there can
2772 be an assumption that researcher influence is always negative,
2773 however in ethnography, it is the relationship between researcher and
2774 researched that allows exploration into the issues concerned.

2775

2776 The researcher is trained to participate in individual and group sessions
2777 around exploring the feelings and beliefs of clients. This transfers to
2778 interviews in relation to providing the conditions necessary to the young
2779 people to feel safe and open to talk. The researcher was aware to avoid
2780 leading questions and let the young men lead the interviews within the
2781 frame of the research questions. Repeated interviews over time also
2782 appeared to encourage the building of trust and relationships, as well as
2783 critical consideration of the concept of health.

2784

2785 Interviews were interactive in a reflexive heuristic manner – Diaz (2002,
2786 p.253) states that "*meanings [are] created in the very process of*

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2787 *verbalising experiences or observing people's lives*" (Diaz, 2002,

2788 p.253). Qualitative heuristics attempt to evoke the qualities of

2789 exploration and discovery into research (Kleining and Witt, 2000).

2790 Kleining and Witt (2000) suggest four rules to optimise the chance of

2791 discovery in research. Rule one states that:

2792 *"The research person should be open to new*
2793 *concepts and change his/her preconceptions if the*
2794 *data are not in agreement with them*"
2795 (Kleining and Witt, 2000, p.2).

2796

2797 This is where reflexivity comes in, as discussed earlier. Rule two states

2798 that "*The topic of research is preliminary and may change during the*

2799 *research process" (*Kleining and Witt, 2000, p.2). This research has

2800 evolved in response to the data gathered.

2801

2802 Rule 3 of Kleining and Witt's model stipulates that "*Data should be*

2803 *collected under the paradigm of maximum structural variation of*

2804 *perspectives*" (Kleining and Witt, 2000, p.2). Variation of the sample and

2805 of research methods can help avoid a bias in representation of the

2806 topic. Variation of questions can help to avoid just one answer. The type

2807 of variation will always depend on the theme being studied. Variation of

2808 the sample was achieved through investigation of more than one

2809 context. Variation was limited due to the ethnic profile of each setting

2810 being limited to White British. The sample was relatively varied in terms

2811 of age, socioeconomic status, education, and sexuality.

2812

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2813 The young men in each site were recruited for interview through
2814 conversations with the research as part of the observation stage of the
2815 FE. There were posters and leaflets distributed so that the young men
2816 knew about the interview part of the research, and they were
2817 encouraged to ask questions about this.
2818
2819 Many of the young men in the City site were keen to participate in the
2820 research as potential way to change some of what they saw happening
2821 in health. All of the young men who fit the age criteria within the City site
2822 were approached on a given day within the time that the youth club ran
2823 and asked if they would be happy to come and have a one to one
2824 interview with the researcher. All of the young men asked agreed to
2825 participate. In the Town site, all of the young men who met the age
2826 criteria were approached and asked to come in outside of the youth
2827 club time due to the lack of a private space to conduct interviews in
2828 within youth club time. This made it more difficult for some of the young
2829 men participate due to other commitments. This meant that not all of the
2830 young men asked to participate agreed to.
2831
2832 Two interviews were conducted with each participant; the first interview
2833 took place in week six, and the second in week eight. There were
2834 fourteen young men who participated in interviews. The young men
2835 were given the option of having an individual interview, or a group
2836 interview with peers. All but two returned for a second interview – the

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2837 young man in the City site had stopped using the provision and the
2838 young man in Minetown had been barred due to his behaviour.
2839
2840 All of the young men in the city setting chose to have individual
2841 interviews, whereas some in Minetown chose to go in with their peers
2842 for their first interviews – this took the form of three group interviews,
2843 and two individual interviews; all of the second interviews in Minetown
2844 took place individually at the choice at the young men.
2845
2846 Each interview lasted for approximately sixty minutes and was recorded
2847 for the purposes of transcription. Each interview followed a semi-
2848 structured schedule (Appendix VIII) to enable the participants to tell
2849 their stories and describe their views of the world. This helped facilitate
2850 a better understanding of how the participants made sense of health
2851 information. The first interview began simply with an invitation for the
2852 participant to discuss what came to mind when they thought of 'health'.
2853 Open questions were then employed to allow the participant to
2854 elaborate on their thoughts, and to clarify the researcher's
2855 understanding (Appendix VIII).
2856
2857 The second individual interview allowed for reflection on gaps in data
2858 that may exist and for member checking in interviews. Member
2859 checking is also known as participant or respondent validation, is a
2860 technique for exploring the credibility of results (Birt et al., 2016). This
2861 addressed the co-constructed nature of knowledge and interpretative

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2862 stance of qualitative research by providing participants with the
2863 opportunity to engage with, and add to, interview and interpreted data,
2864 after their first semi-structured interview (Birt et al., 2016).
2865
2866 Iterative analysis was undertaken in order to inform the schedule of the
2867 second interview. Between the two interviews in the City site, the
2868 researcher listed the behaviours related to health that the participants in
2869 had raised in the first interview. In the second interviews, the young
2870 men in the City were asked to rate these behaviours according to their
2871 perceived importance to health and wellbeing. The order that these
2872 were listed was not important, as this activity was used as a means of
2873 scaffolding a discussion on how they rationalised and made sense of
2874 these decisions.
2875
2876 In Minetown the same list of behaviours related to health were
2877 presented to the young men in interview two as a way to offer some
2878 comparison of the data – it is important to note that this could have
2879 potentially skewed the data and the analysis. Given the importance of
2880 context, if the opportunity again, the researcher would have gone
2881 through the same process in Minetown as in the City in order to use the
2882 behaviours related to health used by the young men in Minetown rather
2883 than as defined in a different site.
2884
2885 In order to assist with the communication of these issues, additional
2886 visual methods were employed within interviews in order to provide

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2887 some impetus for discussion as well as allowing participants to express
2888 their views in a variety of different ways depending on their
2889 preferences. This included looking at Men's Health magazines and
2890 discussing what they thought about the information and images
2891 presented within the magazine.
2892
2893 The use of such tools can facilitate interviews by encouraging
2894 communication. Although the use of a magazine can decentre the
2895 interviewee, they simultaneously create space for the interviewee's
2896 meanings and perspectives: when "*people discuss the meaning of*
2897 *photographs they try to figure out something together*" (Harper, 2002).
2898 Because people tend to see things differently, this discussion can lead
2899 to a 'negotiated understanding' (Heisley and Levy, 1991). Gough (2006)
2900 considered the assumptions within popular media discourse and
2901 identified a bias towards out-dated, masculine stereotypes around
2902 men's health. With Men's Health magazine purporting to be concerned
2903 with this very matter, the researcher was interested in the young men's
2904 response to these representations.
2905
2906 Each interview was recorded and transcribed verbatim. No corrections
2907 were provided in relation to grammar or idioms used in order to provide
2908 the young people with a voice and to avoid interrupting the narrative's
2909 flow (Townshend and Roberts, 2013). All data has been anonymised
2910 and participants and the group will not be identified in any study

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2911 reports. The name and location of the groups have also been
2912 anonymised.

2913 4.6 Data analysis

2914 As advocated by Armstrong et al. (2014), data analysis was undertaken
2915 throughout the research process. Field notes were analysed as part of
2916 the ongoing data collection.
2917

2918 Qualitative, post-structuralist research acknowledges the role of the
2919 researcher as shaping the results of the research (Berger, 2015 ,
2920 Thoresen and Ohlen, 2015). The process of reflection through field
2921 notes aids in refining the study approach and questions (Watt, 2007 ,
2922 Elo and Kyngas, 2008) allowing interview schedules to evolve as
2923 themes emerged over the course of the study.
2924

2925 In accordance with post-structuralist epistemology, interviews can only
2926 be understood as local contexts of meaning making (Popoviciu et al.,
2927 2006) with the focus on the epistemological significance of the results,
2928 rather than the results themselves.
2929

2930 Conducting observations, focus groups and individual interviews means
2931 that some cross referencing of data could occur. Whilst triangulation to
2932 improve validity is a post-positivist methodological strategy, Olsen
2933 (2004) argues that triangulation can go beyond validation, and help in
2934 widening and deepening understandings.
2935

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2936 Drawing on the observation and documentary data, an overview of each
2937 site was provided in order to provide the ‘story’ of each setting. Pen
2938 portraits were also created for each interview participant in order to
2939 outline their ‘stories’; the stories of each participant were integral to
2940 understanding the themes that emerged from the data. Each pen
2941 portrait was anonymised by giving each one a randomly selected name.
2942 Each pen portrait was structured in a narrative form in order to:

2943 *“…describe the cases in sufficient descriptive*
2944 *narrative so that readers can vicariously experience*
2945 *these happenings and draw conclusions (which may*
2946 *be different from the researchers)” (Stake, 2000,*
2947 *p.439).*

2948

2949 This narrative was informed by the researcher’s experience of each
2950 young person as well as some basic demographic information, and how
2951 they had described themselves.

2952 ### 4.6.1 Thematic analysis

2953 Analysing data from a focused ethnography requires that the researcher
2954 engage in an “…iterative, cyclic, and self-reflective process
2955 (Higginbottom et al., 2013, p.6).

2956

2957 The process of analysing FE is characterised by the identification and
2958 classification of data, progressing to abstract generalisations and
2959 explanation of patterns. It is with this in mind that data analysis took the
2960 form of thematic analysis.

2961

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2962 With regard to data analysis, establishing the significance or importance
2963 of themes or findings is crucial; the discussion will link these themes
2964 explicitly to larger theoretical and practical issues and analyse and
2965 interpret them through the appropriate ideological lenses. Thematic
2966 analysis allows us to see patterns in our dataset and narrative analysis
2967 adds temporality and plot (Floersch et al., 2010). The themes arising
2968 within thematic analysis should be used to interpret and make sense of
2969 the issue (Maguire and Delahunt, 2017).
2970
2971 Braun & Clarke (2006) distinguish between two levels of themes:
2972 semantic and latent. Semantic themes cover explicit or surface
2973 meanings whereas the latent level looks beyond what has been said
2974 and:

2975 *"…starts to identify or examine the underlying ideas,*
2976 *assumptions, and conceptualisations – and*
2977 *ideologies - that are theorised as shaping or*
2978 *informing the semantic content of the data" (p.84).*
2979

2980 Semantic themes were identified then moved up the theme tree
2981 (Appendix XI) to map these onto a more latent level in order to begin to
2982 theorise.
2983
2984 See table nine for more detail on the processes of data analysis and
2985 how thematic and discourse analysis related together:
2986

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2987 *Table 9: Processes of analysis*

	Action	
1	All transcripts read and annotated by hand in order to become familiar with the data.	Semantic thematic analysis
2	Generation of initial coding.	
3	Themes identified.	
4	Emerging themes were identified within each research question.	
5	Themes reviewed.	
6	A thematic map created (example Appendix IX).	
7	Analysis drew on the strategies used in talk that enabled the young men to achieve their roles, identities or aspirations and sustain these during interactions with others and related this to themes arising in semantic thematic analysis.	Latent thematic analysis and discourse analysis.
8	Results being linked to theory and data that emerged from the literature review, and reflected on in light of this	

2988

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2989 As per rule four in Kleining and Witt's (2000) reflexive heuristic
2990 methodology, analysis was initially directed at the discovery of
2991 similarities. Within this approach, observations which were most similar
2992 to other parts were grouped tentatively, with suggesting headlines for
2993 the groups and then headlines on top of headlines in a theme tree
2994 (Appendix XI). This mapped the progression from concrete parts to a
2995 more abstract general whole. All data was considered and incorporated
2996 ("100%-rule of accordance"). The analysis was integrated into the
2997 process of data collection and mutually dependent on it as an iterative
2998 process (Kleining and Hitt, 2000).
2999
3000 There were twenty six transcripts in total as well as field notes from
3001 observational data; all were read and annotated by hand in order to
3002 become familiar with the data. This is the first step described by Braun
3003 and Clarke (2006) in their six phase framework for doing a thematic
3004 analysis. Data was separated by site in order to provide results related
3005 to each site separately.
3006
3007 Step two of Braun and Clarke's (2006) framework describes the
3008 generation of initial coding. The data was initially coded using the
3009 question that asked the young men to rate health behaviours by
3010 perceived importance to health. The ratings for each site were gathered
3011 and sorted into mean average scores that were then ordered by
3012 importance. This highlighted key differences between sites in reference
3013 to their perceived importance to health; context was added by

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3014 qualitative data gathered though the thematic analysis. This covers
3015 stage three of Braun and Clarke's (2006) framework where themes are
3016 searched for and identified.
3017
3018 Data was sorted by each research question; each interview transcript
3019 and field notes from observational data were read through and sections
3020 were highlighted by which question they related to. Emerging themes
3021 were then identified within each research question. The researcher then
3022 reflected on the key differences between each site. This led to the
3023 themes being reviewed as per step four of Braun and Clarke's (2006)
3024 framework.
3025
3026 A thematic map (example Appendix IX) was created to define each
3027 theme and illustrate the relationships between them as in stage five of
3028 Braun and Clarke's (2006) framework. Stage six involved these results
3029 being linked to theory and data that emerged from the literature review,
3030 and then being reflected on in light of this.
3031

3032 4.6.2 Discourse Analysis

3033 Discourse analysis is interested in naturally occurring text and talk. That
3034 is 'real world data' which has not been edited and can be studied in the
3035 ways that come as close as is possible to their actually occurring forms
3036 in their 'customary' contexts (Barker & Galasinski, 2001). So, discourse
3037 analysis is a way of understanding social interactions. A discourse is a
3038 particular theme in the text, especially those that relate to identities.

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3039 Methods of discourse analysis of verbal data can be used to compare
3040 written communication about health. This can allow for rich descriptions
3041 of lived experience and its relation to official health discourse, and the
3042 spoken and written language in which health is framed. The UK health
3043 system operates within a larger social hierarchy of power and control.
3044
3045 Government health authorities seek to impose specific conceptions of
3046 health onto the population people, using health professionals and health
3047 promotion materials as the means. Their control is only as good as their
3048 means of assessing whether or not health professionals communicate
3049 ways of being healthy, health promotion is disseminated, and the
3050 population learns how to be ‘healthy’. Discourse analysis allows a
3051 means of checking the match or mismatch of these elements.
3052
3053 The themes emerging from the thematic analysis were subject to some
3054 level of discourse analysis. The themes were considered as to whether
3055 other themes could be abstracted about what was said by the young
3056 men within each site. This constitutes a thematic discourse analysis
3057 (Potter & Wetherell, 1987; Burman & Parker, 1993) as a means of
3058 considering common threads and inconsistencies embedded in the
3059 narratives. The semantic and latent themes identified using Braun and
3060 Clarke’s (2006) framework were considered in the context of how the
3061 participants constructed their social worlds and identities reflexively,
3062 rather than in attributing an underlying reality to the settings.
3063

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3064 In this sense, the thematic analysis was subject to discourse analysis.
3065 As such, the analysis drew on the strategies used in talk that enabled
3066 the young men to achieve their roles, identities or aspirations and
3067 sustain these during interactions with others (Fox, 2004).

3068 4.6.3. Computer-Assisted Qualitative Data Analysis (CAQDAS)

3069 Qualitative analysis software was not used in this thesis. Disadvantages
3070 of analysis software include increasingly deterministic and rigid
3071 processes and increased pressure on researchers to focus on volume
3072 and breadth rather than on depth and meaning (St John and Johnson,
3073 2000). The researcher preferred a manual approach to data analysis
3074 due to feeling more able to familiarise themselves with the data in more
3075 detail.
3076
3077 It is important to note that within this research the initial data analysis
3078 was completed by the researcher and not a team. Were this research
3079 completed by a team, a manual approach would not be appropriate due
3080 to the need for the team to be able to see what the other members were
3081 doing. Using CAQDAS allows for the utilisation of multiple researchers
3082 in a single project.
3083
3084 Rademaker, Grace and Curda (2012) investigated the use of CAQDAS
3085 within a collaborative project through comparing the findings of a
3086 traditional group hand-analysis of a project and using CAQDAS. The
3087 aim was to see if diverse researchers could work together using
3088 computer software to assist collaboration and if they would find

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3089 additional insights into one another’s ways of thinking about qualitative

3090 data analysis. Rademaker et al. (2012) and concluded that CAQDAS

3091 allowed easy storage and easy access to large amounts of language

3092 (and other types of) data. They also reported on the abilities of

3093 CAQDAS to assist in the manipulation of, and movement of, themes

3094 and codes.

3095

3096 The points made by Rademaker et al. (2012) confirm Ryan’s (2009)

3097 findings of the software’s ability to increase the researcher’s

3098 organizational abilities. Salmona and Kaczynski (2016) also advocate

3099 CAQDAS to increase the transparency data analysis and impact how

3100 quality is assessed in research.

3101

3102 In future studies the researcher would consider the use of qualitative

3103 analysis software in order to make the methodological processes more

3104 visible as well as enabling more rigorous analysis (Ryan, 2009).

3105 4.7 Reflexivity

3106 Reflexivity is grounded in the epistemological belief that it is impossible,

3107 and in fact undesirable, for the researcher to remain peripheral from

3108 which is being researched (Angen, 2000 , Lenzo, 1995) (Lenzo, 1995 ,

3109 Angen, 2000). Sullivan (2002) describes the intricate and complex

3110 impact of the language, theories and experiences that co-create the

3111 element being researched. The purpose of reflexivity can be described

3112 as the assessment of the ways that the researcher is impacting on the

3113 construction of meaning while they are engaged in research (Munhall,

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3114 2007). In focusing on the relationships between participants and
3115 researchers in the production of knowledge, Riley, Schouten, and Cahill
3116 (2003) define reflexivity as the "…*conscious attempt to identify how and*
3117 *what social understandings have been produced in the process of*
3118 *research*" (p.2).
3119
3120 From a post-structural perspective, however, there are limits to a
3121 researcher's ability to "self-critique" due to the number of 'selves that
3122 the researcher may possess (Lenzo, 1995). Finlay (2002) suggests that
3123 discussions have focused on disproportionate reflection at the expense
3124 of focus on the research participants. Gill (1995) and White (2001) and
3125 warn that reflexivity can become a tool to pre-empt external criticism,
3126 therefore reinforcing knowledge rather than challenging it.
3127
3128 One approach to engaging with the tensions between reflexivity and
3129 post-structuralism is to understand a reflexive account as one (of
3130 infinitely many) versions of the processes and experiences that
3131 occurred during the research (Riley et al., 2003). From this perspective,
3132 the reflexive account becomes an additional interpretation of (a past)
3133 reality, rather than some kind of expression of the past (Riley et al.,
3134 2003). As a version rather than a reproduction of reality, a reflexive
3135 account can be examined as a text and explored for the elements that
3136 make it meaningful. This meaning making is also understood as
3137 embedded within the power relations occurring within the research
3138 process.

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3139 One of the challenges of qualitative, ethnographic research is that the
3140 background and views of the researcher significantly impact the
3141 research in a number of ways (England, 1994). The ethnographer must
3142 make specific biases explicit (Pellatt, 2003). The use of a self-reflexive
3143 research process can provide some transparency about how results
3144 emerged (Diaz, 2002).

3145

3146 It is important to note that the researcher comes from a different culture
3147 than the research participants. Haw (1996, p.319) posed the question
3148 about whether cross-cultural research was valuable. While the research
3149 data gathered will be "coloured" by the position of the researcher, this
3150 does not leave the research invalid or inappropriate. Rather, research
3151 conducted by a variety of researchers with differing positionalities
3152 serves to provide "different perspectives" that:

3153 *"…can then be put into the theoretical 'melting pot'*
3154 *so that they can be critically examined, reworked and*
3155 *reinterpreted and in this way add to debate in the*
3156 *area" (Haw, 1996, p.319).*

3157

3158 4.7.1 Researcher identity

3159 The researcher was led to this research project through her work in
3160 practice. This research necessitated a transition from practitioner to
3161 researcher, with a need for the researcher to get to know herself as a
3162 researcher rather than as a practitioner. The adjustment from
3163 practitioner to researcher involved learning to deal with a new sense of
3164 time, a new language, new rules, new theoretical concepts and a new

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3165 identity. This involves the development of different ways of doing things
3166 that is focussed on other priorities. This process involves embodying
3167 the identity of the researcher and belonging in the research community.
3168
3169 The researcher's positioning as an adult white female researcher
3170 impacted on how people related to her and how she related to
3171 them. The epistemological standpoint of post-structuralist researcher
3172 adds to this relationship. It is impossible for the researcher to divorce
3173 herself from the research process; the research process became a
3174 product of the relationships developed between researcher, staff and
3175 young people, and affected the decisions of the researcher as well as
3176 how participants respond to these decisions.

3177 ### 4.7.2 How the researcher looks

3178 A central issue concerned how the researcher presented herself to staff
3179 and young people. First impressions count, and the researcher can only
3180 go so far to changing those once they are set. This means that this
3181 issue needed consideration before entering the sites; of course, this
3182 cannot be completely planned for, however these considerations went
3183 some way to helping consider the potential impact.
3184
3185 None of the sites had a dress code. The researcher has multiple
3186 piercings, tattoos, and hair that is dyed bright, unnatural colours. The
3187 researcher was not entering the site as a staff member or young
3188 person, but as a researcher; she was also there as a representative of
3189 the University of Nottingham so had a responsibility to make a good

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3190 impression, as well as to protect the site for future researchers. The
3191 researcher noted that if she had been going into the sites as a
3192 professional, she would have known how to act, and part of this process
3193 was getting to know she was there as a researcher rather than as a
3194 practitioner.
3195
3196 There were also expectations from the young people about how an
3197 adult within each provision 'should' look and act and this was an
3198 interesting process. The researcher did not want the young people to
3199 relate to her as a staff member, but as an adult in each provision she
3200 was put into this group due to not fitting into the client group. The
3201 researcher has historically found that looking different to other adults
3202 has been of benefit as it facilitates questions and discussions – this was
3203 also the case in this research.
3204
3205 The researcher also needed to understand how her position as an adult
3206 white female would play a role in influencing what the participants
3207 chose to say and do in her presence. Walkerdine (1981) recounts an
3208 incident where boys of nursery school age were disciplined by a female
3209 teacher; to subvert her authority, their introduced sexualised discourses
3210 to attempt to shift the dominant relationship from adult/child to
3211 male/female and therefore re-position the teacher into a more
3212 subservient role as an object of boys' talk.
3213
3214 The researcher is aware that she looks young and has found that
3215 'giving as good as you get' and remaining unflappable goes a long way

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3216 in this situation. She also believes that being congruent is important and
3217 to challenge behaviour that feels inappropriate – this can garner
3218 interesting discussion that may add to the richness of the data gathered
3219 as well as building trust and rapport. It is also important to note that the
3220 researcher is married and wears a wedding ring, so this went some way
3221 to making her unavailable to the young men in a sexual way.

3222 ### 4.7.3 How the researcher acts

3223 The young people and staff had their own expectations about what the
3224 researcher should do and how they should behave. It was important to
3225 try and identify and clarify their expectations when possible to address
3226 potential issues. As an adult within the site, the researcher may be
3227 expected to take on a 'staff' role, including assisting with discipline.
3228 England (1994) has noted that the researcher must acknowledge and
3229 make transparent the power relationship between the researcher and
3230 the researched. Whilst at the data collection sites, the researcher's role
3231 was made clear to the management and young people; however, as an
3232 adult, there were some implicit assumptions. There was an implicit and
3233 explicit expectation of the researcher to be a 'responsible' adult within
3234 the setting and follow the policies and procedures within the sites. This
3235 became more difficult when it came to enforcing rules around the way
3236 the young men chose to express themselves, perhaps through
3237 swearing or potentially offensive language, or breaking the rules in
3238 other ways.

3239

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3240 The researcher was there to build relationships with the young men in
3241 the group, but it was important to avoid undermining the rules within the
3242 project and affect accessibility for future researchers. Flexibility was
3243 possible with some rules that did not cause harm, for example around
3244 swearing and vaping (using E-Cigarettes) inside the projects. There
3245 were no situations where harm, or potential for harm, arose. It felt
3246 appropriate to explore and challenge potentially offensive language or
3247 comments as part of data collection around views towards other young
3248 people and their behaviour.
3249
3250 The first few weeks in each site involved understanding the social and
3251 geographical layout. This was done by observing and copying rather
3252 than asking lots of questions. Taking a less active and interfering role
3253 might have helped the researcher to be seen as less intimidating and
3254 with less power. It is the young men's interactions in the context that the
3255 research is most interested in rather than their interactions with the
3256 researcher directly.
3257
3258 It was also important that when young people did want to interact, that
3259 the researcher listened attentively to demonstrate genuine interest in
3260 their lives. In this respect the researcher engaged in their lives in a
3261 different way to other adults. This required maintaining an identity as an
3262 adult but changing it in a way that allows some access to the young
3263 people's experiences and perspectives. Mayall (2000) talks about
3264 presenting oneself as an unusual type of adult, one who is seriously

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3265 interested in understanding how the social world looks from children's
3266 perspectives but without making the dubious attempt to be a child.
3267
3268 The researcher was also aware that she would have built different
3269 levels of rapport with different participants. She did not want to fall into
3270 favouritism with particular young people but also did not want to avoid
3271 anyone. She was also aware that she did not want to affiliate herself too
3272 much with staff at the expense of building relationships with young
3273 people. She was aware of levels of popularity within youth settings and
3274 knew that she would need to be aware of and negotiate these
3275 hierarchies in order not to come to be linked with certain groups that will
3276 lead other groups to feel uncomfortable about speaking with her.
3277
3278 This was a question about how much of herself the researcher
3279 revealed. Staff and young people asked the researcher questions about
3280 her and her life. Young people in particular challenged around values
3281 and behaviour. It was important to reflect back to the young person that
3282 the researcher's life choices and decisions are unique to her and her
3283 experiences, so are neither right nor wrong, and that is the case for
3284 them as well.
3285
3286 With the young people being under 16 and under 18, the researcher
3287 had a responsibility to not advocate illegal activities such as alcohol,
3288 drugs, smoking and underage sex, but also felt a responsibility to not
3289 judge anyone for making those choices. The researcher is relatively

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3290 comfortable with herself and her life choices and has done a lot of self-
3291 awareness work as a counsellor and practitioner.
3292
3293 The researcher needed to be very clear of her boundaries as a
3294 researcher with regard to the reason she was at each site and the aims
3295 of her time there. With staff there was a need to remain clear that she
3296 was not there to assist them or discipline young people; she was also
3297 not there to offer them support. With young people she was not there to
3298 be their friend or support worker but to gather information as to their
3299 perspectives on the research questions.
3300
3301 It was important for the researcher to remain aware of her need to be
3302 liked and not to do things that were outside of these roles in order to ‘be
3303 liked’ such as collude with young people in regard to important
3304 discipline issues. She also needed to aware that she was not there as
3305 practitioner and to provide this role for young people or staff. The site
3306 had sufficient resources for this, and the researcher would refer on
3307 wherever necessary.

3308 ### 4.7.4 Endings

3309 The researcher was party to detailed information about young people
3310 and their lives and needed to develop strategies to be able to leave that
3311 information behind after that day as well as after data collection is over.
3312 These issues were reflected on in the researcher’s research journal as
3313 well in supervision.
3314

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Linked to taking issues home is endings. The data collection for this study will take place over four months. The researcher bonded with some staff and young people and needed to find ways to end these relationships appropriately. Within her role as a counsellor, making endings clear is very important so that both counsellor and client are working towards an ending from the start. It was important to transfer this to the research setting in order to remind both herself and participants that there is an ending date planned so that all work is directed towards ending the data collection.

A research journal was kept throughout the data collection in order to reflect on these issues during the research process. This helped the researcher remain reflexive and these experiences were then incorporated in the results and discussion sections when writing up this thesis.

Conclusion

This chapter has discussed the methodology and research design that was selected for this research study. With this research aiming to explore the discourse around health, and how young men make sense of this, it was considered appropriate to structure this research using a post-structuralist methodology.

The research design took the form of a qualitative, ethnographic, instrumental case study. Two sites were chosen for this instrumental case study. Each site was chosen with the aim of finding young men

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3340 from contrasting demographic backgrounds. Data collection was
3341 undertaken using multi-method ethnographic techniques including
3342 observation, field notes, and semi-structured individual/group
3343 interviews. Data analysis took the form of included thematic and
3344 discourse analysis in order to provide the 'story' of the research as well
3345 as establishing the significance or importance of themes or findings
3346 through a post-structuralist lens.
3347
3348 This research is being undertaken in part due to the researcher's
3349 political and theoretical ideals, based on experience and observations
3350 made in practice. The researcher believes that health information and
3351 education can have iatrogenic effects. The researcher has observed
3352 and heard anecdotally that young men do not feel the health information
3353 is aimed at them, although they are engaged with their health as they
3354 conceptualise it.
3355 The researcher is passionate that young people's voices are heard and
3356 to raise awareness of the capacity of young people to care about their
3357 health and wellbeing, using different priorities to those of adults. The
3358 researcher may allow these views to shape the evidence to support
3359 already supposed observations (Lenzo, 1995) and see what they
3360 believe (Newton, 2009). Attending to reflexivity in this research will
3361 allow some of this to be made explicit.
3362

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3363 The following results chapters will go on to explore each research site

3364 and add temporality and plot before further chapters use this context to

3365 situate arising themes.

3366

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3367 # 5.0 Findings 1: exploring each setting

3368 This ethnographic style study looks at the how young men construct
3369 ideas about health and a healthy body in two sites – a youth provision in
3370 a city centre and a youth club in an ex-mining town. The first objective
3371 of the research was to examine the importance of context on young
3372 men's perspectives on health and a healthy body. In order to define
3373 each setting and get a sense of the context, they will be explored in
3374 more detail in this chapter, starting with the city setting and moving onto
3375 the town setting.
3376

3377 ## 5.1 City centre based youth provision

3378 This section will describe the youth club setting within the study using
3379 monitoring information provided by the provision and data gathered
3380 from field notes taken during participant observation as well as
3381 documentary data.
3382

3383 The city centre based youth provision was opened in 2012 as part of a
3384 Government programme which arose from Aiming High for young
3385 people: a ten year strategy for positive activities (HM Treasury, 2007).
3386 The programme aimed to establish "'world-class' places for young
3387 people which will offer positive activities and access to a range of
3388 services" (Myplace Support Team, 2011, p.3). The project reports a
3389 focus on three predominant areas; the effect on the economic and
3390 social wellbeing of local communities; the welfare of young people; and

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3391 the provision of services for young people and local communities
3392 (Myplace Support Team, 2011).
3393
3394 The provision was aimed at all young people in Nottingham and
3395 provided a range of services and facilities from a fitness suite and
3396 recording studio, to counselling and health services. Despite being
3397 based in Nottingham City Centre, the demographic data showed
3398 attendance from all over the County. The service was open seven days
3399 a week for young people aged thirteen to nineteen to access a
3400 wide range of activities from music and film production, to dance, fitness
3401 sessions, courses, health and wellbeing support and somewhere to
3402 meet friends, relax and talk to youth workers (NCC, 2012).
3403
3404 To give some idea of service level use within the youth provision, in
3405 data quarter four of 2013-2014, there were 5000 total visits from 424
3406 individuals to the project. 284 young people used the project in January
3407 2014, 273 in February 2014 and 292 in March 2014. Most young people
3408 accessing the service in this data quarter were aged 12-16 with an even
3409 split of male and female visitors. 85% of service users self-identified as
3410 heterosexual although a staff member described there being lot of
3411 young gay men accessing the service.
3412
3413 A critique of the profile of male service users in the year one April 2009
3414 – 31 March 2010 (Hatfield, 2010) found that the typical male service
3415 user accessing health specific services with the nurse within the project

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3416 were aged between 17 and 21 years and White British. Men accessing
3417 the health service were found to only attend once, mostly for issues
3418 related to condoms or sexual health.
3419
3420 Many of the young people who accessed the youth club service
3421 appeared to be quite disengaged with other services. They were often
3422 not engaging in education or training. The young men who participated
3423 in the research reported accessing the youth provision due to issues
3424 around mental health, sexuality, homelessness, and inability to access
3425 education.
3426
3427 The provision was a collaborative project where organizational partners
3428 worked together to offer a one-stop-shop where young people could
3429 access support and advice on employment and training, health, and
3430 housing issues. These partners included YMCA, the local football club,
3431 the NHS, and a local homelessness charity. Young people were
3432 reported to have been involved in the project from the initial concept,
3433 choosing the building, to design and delivery to ensure that the project
3434 reflects their needs (NCC, 2012).
3435
3436 The youth club was situated down a side street in the city centre within
3437 a three storey building. The centre is brightly coloured and stands out
3438 from other buildings on the same street. Young people must be a
3439 member of the service and register for a card that allows them access
3440 to the building. Any young person could register with the service for free

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3441 and they were not allowed to access the building without this card;
3442 replacement cards cost £5. A hot lunch was available for service users
3443 to buy at lunch time with money that they load onto this card. If a young
3444 person was receiving certain benefits, or was homeless, then they were
3445 given tokens to get free lunch.
3446
3447 Although the service sold itself as a 'one stop shop', staff reported
3448 observing that service users could be secretive about who they were
3449 going to see, particularly in reference to the nurse. The staff also
3450 reported that there was little cohesion and collaboration between
3451 services, with staff working in silos. When talking to different staff
3452 members, it seemed that they did not know much about the provision
3453 offered by other services within the building. A staff member reflected
3454 that this might be due to the building having three floors with each
3455 service on a different floor.
3456
3457 There were different allocated for accessing different services within the
3458 building and this often related to age. This could appear very confusing
3459 and the researcher sometimes struggled to understand who was
3460 allowed in when. The researcher also observed arguments between
3461 staff and young people about who was and was not allowed to be in the
3462 building for different sessions.
3463
3464 Targeted services such as laundry, showers and support for 11-25-
3465 year olds ran from 10.30-12; lunch ran from 1200-1300 for 11-25-

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3466 year olds; workshops ran from 1300-1500 for 11-25 years olds,
3467 although those under sixteen were to be challenged about education
3468 and absence; and universal youth provision ran from 1600-2100 for 11-
3469 19-year olds. Health clinics and gym sessions ran at varying times on
3470 different days depending on staffing, and this could be inconsistent. A
3471 Lesbian, Gay, Bisexual, and Transgender (LGBT) group session ran on
3472 Wednesday evenings and a Refugee group ran on a Thursday
3473 afternoon.
3474
3475 The service was open in the afternoon to run health sessions, and
3476 young people were only allowed in the building if they were attending
3477 these sessions. The researcher observed that sessions felt "…*really*
3478 *strained, really difficult, they're not interested…they're not*
3479 *engaging.*" Staff members reflected that, often, they felt that the young
3480 people will come into workshops because they did not want to be
3481 outside. Some of the staff felt that the young people believed they knew
3482 everything they needed to know about drugs, and did not want to know
3483 more, so getting them engaged in health sessions could be difficult. It is
3484 worth noting that the young people did not appear to be involved in
3485 choosing the sessions that they felt would be most helpful to them, and
3486 the curriculum was chosen by staff members.
3487
3488 There appeared to be quite an established hierarchy amongst service
3489 users. It was interesting to note that this was very different to the town
3490 setting where hierarchies were maintained across community sites,
3491 including school and socially. Within the city site, the young people

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3492 often did not live in the same communities or attend the same schools,
3493 so their relationships only existed within this site. The hierarchy
3494 appeared to be maintained through the demonstration of fashion
3495 prowess, with young men wearing particular clothing brands, or styles.
3496
3497 The young people were observed to speak about the importance of
3498 wearing certain brands and looking good. A lot of effort was observed to
3499 put into presenting in a certain way, including hair styling, with some
3500 pride associated with this. Those who were not able, or not interested in
3501 maintaining the accepted fashion style came much lower down in the
3502 hierarchy and were often observed to be scorned for their appearance.
3503
3504 Within the LGBT group, this style was observed to be very different, and
3505 a different identity and community within the community was observed.
3506 This appeared to be more of a counterculture where adherence to the
3507 'norm' was discouraged.
3508
3509 Many of the young people who accessed the youth club service
3510 described lacking confidence in other settings, but within the project
3511 seemed confident about their position within the hierarchy. This may
3512 have been a reason that they accessed the service so often. If the
3513 researcher had seen them outside of the youth provision, they would
3514 have expected to see different behaviour due to the staff's descriptions
3515 of their lack of ability to cope in the outside world.
3516

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3517 Staff described the young men as often not able to maintain school
3518 attendance or jobs, as well as often being estranged from their families
3519 and with a lack of support networks outside of the service. It was
3520 sometimes difficult to imagine this when watching how the young men
3521 behaved within the service.

3522 *6.4.1 The young men from the city site*

3523 This section will provide short pen portraits of the young men from the
3524 city site who participated in the individual and group interviews within
3525 this research. These pen portraits were written by the researcher based
3526 on her experience of the young men and the information that that gave.
3527 The researcher did not have the opportunity to check out the accuracy
3528 of these descriptions with the participants. It is important to note that
3529 their descriptions of themselves may have been very different. It would
3530 have been beneficial to have been able to reflect on this.
3531
3532 Each name is a pseudonym. The code given will be used to identify
3533 when each young man's voice is used within the thesis, with their name,
3534 followed by age, and a C to denote that they are from the city site:

3535 *Table 10: Overviews of city site Participants*

Name	Age	Code	Overview
Giles	14	Giles, 14, C	Giles is a 14 year old male who identifies as homosexual. He lives in a close and stable family environment. Giles presents himself as a well-educated young man who has been raised in a questioning environment. His parents have suffered economic hardship, but he appears to be from a mainly middle class background. This may have affected some of his views related to health due to the privileges that he has enjoyed. A family member is currently recovering from an eating disorder and this may have affected some

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			of Giles' beliefs about health, particularly in reference to diet.
Justin	14	Justin, 14, C	Justin is a 14 year old male who identifies as heterosexual. Justin was not from the city and had been moved there recently by his care provider. Justin enjoys dancing and does loads of exercise and plays sports. Justin was quite socially isolated at the youth club and spent a lot of time by himself.
Kai	15	Kai, 15, C	Kai was a 15 year old male who was very guarded in the social space and in interviews. I did not learn much about him. He swims and plays football and feels that it is important for him to keep fit and healthy to be able to perform to the best of his ability in these sports.
Robert	16	Robert, 16, C	Robert is a 16 year old transgender male in the early stages of transitioning. He lives with his mother and little brother. He attended a private all girls grammar school and is a high achiever. His school was not supportive of his identity and associated mental health issues. He will be going to college as a self-identifying man and the college is supportive of this. He did not talk about his own behaviour in relation to alcohol, drugs, smoking and sex; although I never saw him smoking in the time I was at the youth group.
Kirk	17	Kirk, 17, C	Kirk was a 17 year old male who was very concerned about his health and appearance. Kirk lived with his mum and dad and reported being close to them. Kirk is on a sports scholarship so has to keep fit and healthy. Kirk was very anxious about health issues and talked to his parents, friends and regularly visited his GP to check on his health.
Simon	18	Simon, 18, C	Simon is a 17 year old male who identifies as homosexual. He lives with his mum, dad and sister but did not talk much about his family, instead describing his friends more as his chosen family. Simon felt that friends were more important than this family in relation to their ability to make him happy. Simon is unemployed; he was at college but found it too much for his mental health. Simon is now applying for jobs and looking at further education opportunities.

3536

3537 ## 5.2 Minetown youth provision

3538 This section will describe the youth club setting within the study using

3539 monitoring information provided by the provision and data gathered

3540 from field notes during participant observation.

3541

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3542 The youth club was built in 2012 at a cost of £2m after the closure of a
3543 youth club at the local Comprehensive School in 2002. The
3544 local Councillor and cabinet member for children and young people at
3545 the county council was keen to show support of the service, describing
3546 it as essential, although there was a significant gap between the closure
3547 of the original youth club and the opening of the new service.
3548
3549 The young people in the area were involved in the development of the
3550 service. The young people described feeling like this was the first time
3551 they felt that they had been asked about something in their town and
3552 been listened to. Some of the young people reported having been
3553 previously involved in local civic action to improve their town but were
3554 left demotivated after negative experiences with the local council. They
3555 had been promised more services in the area and become involved with
3556 raising money for these resources and had not seen what they had
3557 been promised. They felt that they were not a priority in the local area
3558 because they saw services being developed for babies and older
3559 people rather than people of their age.
3560
3561 The youth club in Minetown was only accessed by young people living
3562 within the town and is situated is on the outskirts of the town centre. It is
3563 situated behind metal fences and gates which are padlocked when the
3564 service is closed. There is a car park which is out of use due to legal
3565 issues and young people tend to use this space to gather whether
3566 the centre is open and closed. There is a multi-purpose basketball court

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3567 and football pitch in front of the building. The building is behind a large
3568 supermarket and opposite a pub at a crossroads; you can cut through
3569 to a supermarket behind the building. The building is clean and in a
3570 good state of repair with no rubbish or graffiti and is well lit when dark. It
3571 is in a residential area which caused issues when it was set up due to
3572 concerns from neighbours.
3573
3574 Sessions at the Minetown youth club ran on Mondays, Tuesdays,
3575 Thursdays and Fridays between 1900 and 2130. An under-
3576 fourteens night ran on Wednesdays between 1800 and 2000.
3577 Attendance cost 50p which included a toastie; this was because the
3578 youth workers felt that some young people were not getting enough
3579 food/hot food at home. The workers have also reported that they had
3580 found providing hot food to be a way of incentivising attendees sitting
3581 down and socialising together. The researcher did not observe
3582 attendees sitting down and socialising together, rather they stayed
3583 within their set groups and ate standing up.
3584
3585 There were 'Skills for Employment' workshops held every week day
3586 from 0900 until 1530. The sessions involved English, maths, IT and
3587 customer services and aimed to help 16 to 18-year-olds find jobs and
3588 training. There were also careers advice sessions from 1400 until
3589 1700 every Thursday and play sessions for kids every Monday from
3590 1600 until 1830. There was a coffee bar, meeting room, dance studio,
3591 music recording studio and office space. The researcher attended a few

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3592 of these sessions but attendance was low and there were no young
3593 men in the relevant age range in attendance.
3594
3595 Activities on offer at the £2m centre included DJ-ing, table tennis,
3596 football, pool, basketball and hockey, arts and crafts, quizzes, bingo,
3597 and computer sessions. A local Councillor volunteered at sessions and
3598 funded some of the equipment and was trying to get more sessions
3599 because it was so popular. The young people appeared to get on well
3600 with the local councilor and had a good rapport with him, in that they
3601 treated him no differently from the other adults at the project.
3602
3603 Attendance at the provision was high with 60-80 young people
3604 attending the youth club each evening. In some ways the success of
3605 the centre has meant that staff reported they have not been able to
3606 provide the service they would have wanted. Staff described how high
3607 attendance numbers have meant less time for conversations about
3608 things like health and relationships and other things that are either in
3609 the media or are an issue that young people have raised or an issue the
3610 youth workers have wanted to raise with them.
3611
3612 Reflective of the demographic profile of the local area, the attendees of
3613 the club were almost exclusively White British. There were only two
3614 young people in attendance that did not fit the white British
3615 demographic who were of dual heritage, black Caribbean, and white
3616 British. One of these young men was aware that he did not look 'black'
3617 and did not tend to openly disclose his heritage.

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3618 The club was closed in the holidays due to low numbers and a lack of
3619 funding. The young men would like the club to be open more often so
3620 that they had somewhere to go in the day and in the holidays. When
3621 asked, they reasoned that they would be more likely to engage in
3622 positive activities and less likely to cause trouble if they had something
3623 to do because it would change their attitudes.
3624
3625 The young men described sometimes feeling like, when the youth club
3626 was closed, that there was no point for young people their age because
3627 there was nothing for them to do. The young men reported being aware
3628 that they young people in the area had a reputation for causing trouble
3629 and spending time in places where they were not allowed to. They
3630 observed this as resulting in more people getting in trouble because
3631 they drink on parks instead – they thought that the main reasons they
3632 drank is that they have nothing to do. This in turn can affect the
3633 reputation of young people in the area and become a vicious cycle
3634 because there's perceived to be nothing to do, which leads the young
3635 men to drink and then not care which gets them in more trouble with the
3636 police which makes them look bad and the area look worse.
3637
3638 Minetown was described by a staff member as being quite isolated from
3639 the city. The staff member described Minetown as an insular community
3640 typical of a lot of ex-mining communities, with poor health and low
3641 aspirations. This was reinforced by some of the young men who felt that

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3642 it was hard to leave Minetown and explore surrounding areas, although
3643 many expressed a desire to leave.
3644
3645 Staff also elaborated on the hierarchies that they observed being
3646 maintained in the community with a lot of the families being seen to be
3647 connected in the local area. Staff described a masculine hierarchical
3648 structure that was focused on who was in good shape, or ‘hard’. The
3649 social position of the some of the young people was described as
3650 reflective of the social position of their parents in the community. In this
3651 way, it might have been difficult for the young people to build separate
3652 identities away from those of their families.
3653
3654 There is some anecdotal evidence that the youth centre has had an
3655 impact on the area. At the time of data collection, the local paper
3656 reported that anti-social behaviour had reduced by more than 20 per
3657 cent, with crime reducing by 23 per cent since the new
3658 youth centre opened. The staff were not surprised by these reports
3659 because the centre gave the young people somewhere to go, and
3660 something to do in the evening rather than getting involved in anti-
3661 social behaviour.
3662
3663 As well as a reduction in anti-social behaviour, the local paper reported
3664 that police crime figures showed a reduction of 68 per cent in drug
3665 offences, 68 per cent in sexual offences and 33 per cent in burglaries.
3666 This was supported by the reports of some of the young people who

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3667 reported that being able to access the youth club has changed them a

3668 lot and they have stopped drinking since it opened.

3669

3670 Staff did stress that the centre attracted a variety of people and not

3671 everybody who went there used to cause trouble out on the local

3672 streets. It is important to note that the local council are invested in

3673 showing their money being spent well, and staff in defending their work,

3674 so newspaper reports and staff reports may not class as objective

3675 evidence.

3676 *6.4.1 The young men from Minetown*

3677 This section will provide short pen portraits of the young men from

3678 Minetown who participated in the individual and group interviews within

3679 this research. Each name is a pseudonym, followed by the age, and an

3680 M to denote that they are from Minetown – see over the page for table

3681 eleven.

Name	Age	Code	Overview
Chris	12	Carl, 12, C	Carl is a 12 year old male who lives with his mum and her boyfriend and his older brother who was 16. He reported not seeing his biological father anymore and appeared very scathing of him, repeating things he reported hearing his family say about him. Carl reported not getting on with his older brother who he said found him annoying. He stated that he found family to be more important than friends; however Carl did not appear to have many friends and was observed to be bullied at the youth club.
Jamie	12	Jamie, 12, M	Jamie is a 12 year old male. He lives with his parents and struggles with his behaviour both at home and at school. He often seeks solace with his grandparents. He sometimes gets on well with his family and would talk to them if he was upset. He likes playing football and would like to

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			this as a career. He was quiet in the interviews and I do not feel that he disclosed much personal information.
Greg	14	Greg, 14, M	Greg is a 14 year old male. He lives with his mum, dad and 8 year old sister. Greg reported that his friends make him feel better about himself that his family and that he's got more friends that he can think of as family. Greg is still in mainstream education in year 9 and will be going into year 10 in the new academic year. Greg reported having got into a lot of trouble at school and appears disengaged with school. Greg is quite active although is becoming less so as he gets older. Greg is worried about getting into more trouble as he gets older, particularly around drugs.
Kevin	14	Kevin, 14, M	Kevin is a 14 young old man who lives with his grandparents. His father has never been around, and his mother was addicted to heroin when he was born, so he was put under the care of his grandparents. Kevin is often in trouble at school because he struggles to deal with his anger. He is trying to turn his life around like his brother, and when he gets older, he might want to go in the army or something good that you can do with your life, so he can stay out of trouble and earn a living.
Kyle	15	Kyle, 15, M	Kyle is a 15 year old young man who has just moved into the area. He lives with his dad and his step-mum and their little boy. He doesn't talk to his mum at the moment, but she is about to have a baby girl. Kyle got kicked out of the local school on his first day and has been attending a pupil referral unit. He is about to enter mainstream education full time.
Mark	16	Mark, 16, M	Mark is a 16 year old who identifies as a heterosexual male. He lives with his mum and dad and has a stable family environment. Mark describes his family as very important to him. He was very close to his mama (maternal grandmother) and reported that he found it very difficult to cope with his emotions when she died. Mark has left school after finishing his GCSEs. He is not sure how well he did in these. Mark's dad used to be in the army and Mark doesn't get the grades that he needs to go to college and train to be a plumber, then he reports that he will go in the army as well.
James	16	James, 16, M	James is a 16 year old who identifies as a heterosexual male. He lives with his family: it is a stable environment. James describes his family as important to him. James finished secondary school after GSCEs and shifted to a local football academy where is continuing his education. He is currently a scholar at a local football club; this means that he gets paid to train as a footballer whilst also working to complete an A Level PE qualification. James is aware that his comparative lack of success at school might be a problem for him in the future.

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			He sets himself somewhat apart from other young people in Minetown; he sees himself as having more aspirations and direction than most of his peers. He doesn't look down on other young people at the, but he finds it difficult to be with them. His lack of success at school was, he says, in part because he struggled with trying to fit in and at the same time do what his family wanted.
Carl	16	Carl. 16, M	Chris is a 16 year old who identifies as a heterosexual male. He lives with his parents and gets on with his family. He did not discuss his family situation in any detail. Chris finished secondary school after completing his GCSEs. Chris is preparing to join the army; this has led him to change some of his health behaviours in order to be accepted. Chris got into a lot of trouble at school and got expelled quite a few times. He is aware of his comparative lack of success at school but does not feel negatively affected by this as it will not prevent him from being accepted into the infantry section of the army. Chris was born in Minetown and fitting in is very important to him. Many of the behaviours that he adopts are those that mark him as masculine in the context in which he lives. Chris shares his peers' lack of aspiration and direction in some ways but is also set on joining the army and is making sacrifices related to his health behaviours in order to ensure that he is accepted. In this sense Chris has more of a sense of aspiration and direction than many of his peers.

3682 *Table 11: Overviews of Minetown Participants*
3683

3684 ## Conclusion

3685 This section has provided an overview of the social, political, and
3686 cultural aspects of Nottingham City and County, and Minetown from
3687 several sources including the 2015 Indices of Multiple Deprivation
3688 (IMD) and the 2011 Census (Office for National Statistics.
3689
3690 The context of each site is very different; the city site served young
3691 people from a variety of areas and demographic backgrounds whilst
3692 Minetown site served a limited geographic area with high levels of

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3693 deprivation. The city youth provision served as one of several services
3694 that the young people accessed, whilst the Minetown site provided the
3695 only provision available to the young people in the area.
3696
3697 The first objective of this thesis is to provide an examination of the
3698 importance of context on young men's perspectives on health and a
3699 healthy body. Before the thesis can address this objective, it is
3700 important to define the context of each site and the young men within
3701 them. This will help situate the subsequent findings chapters and
3702 provide a basis for the remaining research objectives.
3703

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6.0 Findings 2: what do the young men in each site consider as being important to health?

This chapter will address the second research objective; to examine young men's perspectives on health and a healthy body. The principal aim is to explore how young men define, enact, and embody health and a healthy male body. The contextual setting will be considered as this may impact how young men perceive these concepts.

What the young men in each site talked about in relation to health will be explored, as well as how they valued these things as part of 'being healthy'. Health and being healthy were identified as different and this informed the research interviews from an iterative perspective.

After the first round of individual interviews with the young men from the City, the researcher undertook iterative analysis to inform the second interviews. The researcher compiled a list of the topics that were mentioned by the young men in the City site, in relation to health and asked the young men to rate these topics in relation to their perceived importance to being healthy. In the City, the ratings were as follows in table twelve:

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3727 *Table 12: Table showing characteristics ranked from most to least*
3728 *perceived importance to health for young men in the City*

Characteristic	Ranking from most to least important to health - City
Good Friends	1
Support network/people to talk to	2
Mental health	3
Enjoying life	4
Good family	5
Being happy	6
No illness/disease	7
Physical health	8
Healthy weight	8
Healthy diet	10
Enough sleep	10
Being Attractive	10
Avoiding illegal drugs	13
Avoiding smoking	14
Avoiding alcohol abuse	15
Regular physical activity	16

3729
3730 In the first group, and individual, interviews with the young men
3731 in Minetown, the researcher again undertook iterative analysis to see if
3732 any further topics should be added to the list but no additional topics
3733 were identified., suggesting data saturation. Of the four different models
3734 of saturation defined by Saunders et al (2018); the one that is relevant
3735 here is termed ‘inductive thematic saturation’ which focuses on the
3736 identification of new codes or themes.
3737
3738 It is important to note here that the researcher used the same
3739 terminology in Minetown that was used in the City site, which may have
3740 had an impact on the results. Different language was used in each site.
3741 Retrospectively, the researcher would have allowed for different
3742 analysis of each site, allowing the topics to be labelled by Minetown, for
3743 Minetown rather than comparing with the City site.

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3744 In Minetown, the ratings were as shown in table thirteen:

3745 *Table 13: Table showing characteristics ranked from most to least*
3746 *perceived importance to health for young men in Minetown*

Characteristic	Ranking from most to least important to health - Minetown
Enjoying life	1
Good Friends	2
Good family	3
Being happy	4
Healthy diet	5
Enough sleep	6
Physical health	7
Healthy weight	8
Regular physical activity	9
Support network/people to talk to	10
Mental health	11
Avoiding smoking	12
Being Attractive	12
Avoiding illegal drugs	14
No illness/disease	15
Avoiding alcohol abuse	16

3747

3748 By looking at these ratings in comparison to each other (table fourteen),
3749 some similarities and differences can be seen in relation how the young
3750 men in each setting rated these topics in relation to their perceived
3751 importance to being healthy.

3752 *Table 14: Table comparing rankings between City and Minetown for*
3753 *characteristics ranked most to least perceived importance to health*

Characteristic	Ranking from most to least important to health - City	Ranking from most to least important to health - Minetown
Good Friends	1	2
Support network/people to talk to	2	10
Mental health	3	11
Enjoying life	4	1
Good family	5	3
Being happy	6	4
No illness/disease	7	15
Physical health	8	7
Healthy weight	8	8

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Healthy diet	10	5
Enough sleep	10	6
Being Attractive	10	12
Avoiding illegal drugs	13	14
Avoiding smoking	14	12
Avoiding alcohol abuse	15	16
Regular physical activity	16	9

3754

3755 This activity was undertaken as an initial way of sorting and coding
3756 information to allow the researcher to begin to make sense of the data.
3757 The activity of rating and comparing these topics is not aligned with a
3758 poststructuralist epistemology and this information is not presented as
3759 objective fact, or a positivist 'truth', but as one way of viewing and
3760 making sense of the information. The purpose of asking the young men
3761 to rate the topics in relation to health was to understand how they made
3762 sense of these decisions rather than to present the ratings.

3763

3764 It is interesting to note that the sections that relate to dominant health
3765 messages such as healthy diet, weight and avoiding smoking were
3766 rated least important in relation to the young men's perceptions of
3767 health in both sites. The most important elements rated in relation to
3768 health were in connection to being happy and enjoying life, and the
3769 things that helped them achieve these things, such as family and
3770 friends. These have been explored in the sections below under three
3771 overarching themes; the first of these considers the privilege of mental
3772 health over physical health, the second considers the importance of
3773 'belonging' and the third considers emotional support & coping
3774 strategies

3775

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3776 The coding used to identify the participants is the same as in the pen

3777 portraits, with the pseudonym, age and an 'M' to signify that the young

3778 man is from Minetown or a 'C' to show that they were from the City site.

3779 6.1 Mental health vs. physical health

3780 Mental health and happiness was seen as more important than physical

3781 health in some ways for some of the young men. For example, in the

3782 City, Robert (16, C) prioritised mental health over physical health, and

3783 classed "…*things that have a negative mental impact as being worse*

3784 *than something that has a negative physical impact*".

3785

3786 Giles (14, C) said that:

3787 *"…if you could see when you're going to die and*
3788 *you're going to live till 60, but you live 60 happy*
3789 *years, I think that's more healthy than someone*
3790 *who's lived to be 100 and had 100 sad years."*
3791

3792 In Minetown mental health appeared to be deemed more important than

3793 physical health in relation to certain 'unhealthy' behaviours (smoking,

3794 alcohol) which were described as potentially negating ill mental health

3795 or other unhealthy behaviours (anger, self-harm etc.).

3796

3797 This theme will be discussed in more detail in the following sections

3798 around mental health and being happy, happiness and its relationship

3799 to smoking, drinking and substance use, and barriers to happiness.

3800 6.1.1 Mental health and being happy

3801 In the City there seemed to be an attitude that mental health was really

3802 important to health because "*if you're healthy, mental health is half of*

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3803 *that*" (Giles, 14, C). This was assumed to be a common belief that was

3804 "*obviously…a concern for most people"* because *"your mental…*

3805 *health keeps you from not jumping off a bridge*" (Giles, 14, C).

3806

3807 Mental health in the City appeared to be synonymous with being happy.

3808 Giles (14, C) stated that "…*mental health, being happy and enjoying*

3809 *life, they're all very similar.*" Some of the young men in the City placed a

3810 high importance on mental health, with good mental health described as

3811 making you happy.

3812 *"If you have good mental health and physical health,*
3813 *first of all you'll be happy…I think the most important*
3814 *thing is mental health actually, so do things that*
3815 *make you happy…*
3816 *Giles, (14, C)*

3817 Giles also acknowledged that happiness and sadness were "*very*

3818 *difficult to quantify*" (Giles, 14, C).

3819

3820 In Minetown, being happy was also described as being of high

3821 importance with happiness being the "….*most important thing that*

3822 *anyone could ever ask for…if you're not happy, there's no point is*

3823 *there*" (Greg, 14, M).

3824 Simon (17, C) believed that it was "…*important to be happy in your*

3825 *mental health cos you know you'll be alright*". However, Simon

3826 sometimes found this difficult because:

3827 *"…you'll get those times when you just think, I'd*
3828 *rather just sort of push that to the back and not think*
3829 *about my mental health and*
3830 *just enjoy life, enjoy being happy and everything, but*
3831 *then, cos you always get to that point of when you*

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3832 *think about your mental health and you'll probably*
3833 *like go and self-diagnose yourself or something and*
3834 *that will just make you feel worse."*

3835

3836 Andrew (17, C) was the only young man in the City who differentiated

3837 between mental health and happiness, stating that "*mental health is*

3838 *important to me, that's the most important to me*" but that "…*being*

3839 *happy, I can do without that*". Andrew elaborated that, for him, it was

3840 looking like he was happy and enjoying life that was more important

3841 than actually doing so. Andrew had an ambition to be a singer, which

3842 had led to his concern with looking happy rather than necessarily being

3843 happy; he stated that he needed "…*to be attractive to be a good*

3844 *singer*". Andrew described how he would "…*always put on a front*"

3845 because he liked "…*to be alluring, I like to be pleasing to other*

3846 *eyeballs".*

3847

3848 When it came to how mental health affected the participants' everyday

3849 lives in the City site, there was some reference to mental health being

3850 about:

3851 *"…your lifestyle, what goes on around you and that,*
3852 *like at home and stuff like that" as well as "what can*
3853 *you do to sort that out, to help, to come up with ways*
3854 *to stop you being stressed out and stuff, what you*
3855 *can do"*
3856 *(Kirk, 17, C).*

3857

3858 In the City site, the young men had access to different activities as well

3859 as the economic means to take part in social activities that cost money.

3860 This meant that their social lives did not appear to revolve around the

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3861 youth provision. They would access the site by choice rather than

3862 necessity, or having nowhere else to go; it could also act as a

3863 convenient meeting place. Sometimes the young men would leave with

3864 their friends during a session, whereas this would never happen in

3865 Minetown due to the perceived lack of other places to go, and money to

3866 access additional activities.

3867 6.1.2 Happiness and 'unhealthy' behaviours

3868 Mental health appeared to be deemed more important than physical

3869 health when considering certain 'unhealthy' behaviours (smoking,

3870 alcohol) which were described as potentially negating ill mental health

3871 or other unhealthy behaviours (anger, self-harm etc.).

3872

3873 In the City, Simon (17, C) talked about "…*times when people do*

3874 *actually need it (nicotine), cos the first time I did smoke was when I was*

3875 *in college and I was stressed out about something".* Simon also related

3876 this to food:

3877 *"...it's comfort food…like if you've had a long day at*
3878 *college or if you've had one of those stressful days*
3879 *when you just feel like you need to have the junk*
3880 *food and then that advert (Change4Life Junk Food*
3881 *Swap) will come up, and you're just thinking "go*
3882 *away!" and you're not in the mood for healthy food.*

3883

3884 Ways of dealing with stress included eating food, smoking, and alcohol

3885 use. Carl (16, M) identified that he ate when he was stressed. In this

3886 regard, a lack of stress, or good mental health, was seen as healthy in

3887 relation to the area of weight. James rationalised that:

3888

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3889 *"…if you've got strong mental health, good friends*
3890 *and family then they'll help you maintain your weight*
3891 *because a lot of people eat cos they're mum and*
3892 *dad's argue and stuff, so if you've got good friends*
3893 *and good family you can speak to then you shouldn't*
3894 *be eating stuff like that (biscuits, crisps, pies etc.)."*
3895 *(James, 16, M)*
3896

3897 Carl (16, M) commented that one of his ways of dealing with stress was
3898 to eat. Mark and Carl, (16, M) also ate more when they were bored:

3899 *"…when I'm not at the gym or doing something*
3900 *active, I eat…I eat more when I'm not doing anything,*
3901 *like I'll sit at home and have 3 packs of crisps*
3902 *whereas if I'm at home and someone's round,*
3903 *obviously someone's round with me and we're doing*
3904 *something on the PlayStation or Xbox or whatever*
3905 *then I won't feel the need to have anything cos I*
3906 *won't be bored. When I'm bored, I eat."*
3907 *(Mark, 16, M)*

3908

3909 Some health behaviours were linked with feelings of happiness. For
3910 example, smoking was reported as feeling "…*nice and stuff and you get*
3911 *a little warm fuzzy high buzz sometimes*…" (Giles, 14, C).

3912

3913 Activities such as smoking and drinking were described in Minetown as
3914 something that could provide both something to do, and enjoyment.
3915 Smoking was described as "*fun*" (Greg, 14, M). Alcohol was described
3916 as "*the don*" (Carl, 16, M) and provided an opportunity to have fun;
3917 "…*as long as you're making no mistakes it's good innit*" (Greg, 14, M).
3918 Smoking weed (cannabis) was also "…*summat to do*…" but this activity
3919 could be limited, because "…*when you've smoked it, there's nothing to*
3920 *do and you just laugh at everything*" (Kevin, 14, M). In the City site,
3921 Giles talked about drinking alcohol, in particular, cocktails:

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3922 *"…so if you're drinking cocktails you don't know what*
3923 *the alcohol content is, you don't know what's in it, it*
3924 *just tastes nice and then you can get carried away,*
3925 *say if you have 2 or 3 of those, then, and that has*
3926 *happened to me before, I've been very drunk and not*
3927 *really known why"*
3928 *Giles (14, C)*

3929

3930 Robert (16, C) described enjoying going out to nightclubs drinking and
3931 dancing with his friends. In the City, the use of alcohol, drugs and
3932 smoking was less linked to having fun due to the range of additional
3933 activities that they had access to.

3934

3935 Smoking, drug use, and alcohol was seen in Minetown as having limited
3936 potential to provided fun, and becoming boring after doing it for a while.
3937 Kyle (14, M) said that "*it's (*smoking cannabis*) kind of boring now to be*
3938 *honest, cos I've been doing it for so long*" and Mark (16, M) "*stopped*
3939 *completely cos it* (smoking cannabis) *was boring me*". Greg (14, M)
3940 also observed that "…*it gets to that point where those new things*
3941 (drinking alcohol and smoking cannabis) *are getting boring and I want*
3942 *to try even more*".

3943

3944 Activities such as smoking and drinking could provide both something to
3945 do, and enjoyment, however these activities were highlighted as
3946 becoming boring after a while. It seemed to be that variety of activities
3947 was important.

3948

3949 Enjoying life and having fun appeared to be inextricably linked to
3950 friends. Family may feature here where access to things like alcohol

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3951 was concerned, as family could provide access to alcohol which may
3952 provide a social lubricant in family relationships.
3953
3954 Context was important here, as was social economic status. Fun and
3955 enjoyment were described as being limited for some of the young men
3956 due to the perceived negative circumstances that they often lived in,
3957 particularly in Minetown.

3958 6.1.3 Limitations to happiness

3959 Fun and enjoyment were limited for some of the young men in
3960 Minetown due to the perceived negative circumstances that they often
3961 lived in, such as poverty and being young carers; money was also an
3962 issue. The youth clubs provided "…*something to do*…" which was
3963 "*better than sitting on the park*" (James, 16, M).
3964
3965 The young people in Minetown described feeling pretty disillusioned
3966 about where they lived and the lack of opportunities to enjoy
3967 themselves and have fun. The young men appeared to associate
3968 having fun and friends with the youth club. Their social lives appeared
3969 to centre around the youth club. They were very grateful for the youth
3970 club and what it offered but would like it to be open more often so that
3971 they had somewhere to go in the day and in the holidays.
3972 Stress and depression were also reported to be issues for the young
3973 men in Minetown. Kevin (14, M) described sometimes struggling with
3974 his behaviour at home and reported that the reaction of his family
3975 "*affects me a bit, cos I feel like I'm, not unwanted but, unstable with*

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3976 *myself about what they feel, and it just makes me depressed.*" Mark

3977 and Carl (16, M) thought that stress would only become a problem

3978 worth acting on when someone tried "*to commit suicide or something*."

3979 This was seen as an acceptable time for someone to do something to

3980 deal with their difficulties and change their behaviour.

3981

3982 Some of the young men identified the effects of people not addressing

3983 stress at a stage before it became more extreme. Mark and Carl (16, M)

3984 believed that a lot of the fights in the town were because "*people don't*

3985 *know how to get rid of stress*." Mark (16, M) commented that "*being*

3986 *stressed, that can make you die early as well.*"

3987

3988 The young men in Minetown appeared happy to access any activities

3989 provided for them by the youth club (except for housework or cleaning,

3990 see above) but found it difficult to access activities by themselves and

3991 felt that they needed support to do this. They described how the youth

3992 club was before the new building was built; there was a bus that

3993 travelled around the area and offered provision from the bus. This was

3994 in a time when there was more money to spend on activities and

3995 detached youth workers had the resources to offer activities in

3996 exchange for engagement with the positive activities for young people

3997 (PAYP) that they offered.

3998

3999 PAYP was a targeted programme which aimed to work with young

4000 people aged 8-19 years that are most at risk of social exclusion,

4001 committing crime, and being a victim of crime. PAYP offered its client

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4002 group support, guidance, and the opportunity to undertake positive
4003 activities that help them avoid offending and fulfils their potential in
4004 education, training or employment. They described them and their older
4005 siblings taking part in activities such as camping, rock climbing,
4006 paintballing, go-karting, swimming, bowling and going to the cinema.
4007 The new Minetown youth club offered activities such as table tennis,
4008 pool, PlayStation™ games, quizzes and football; when compared with
4009 the activities that they had seen before the club was built, the young
4010 people sometimes felt that these activities were not enough.
4011
4012 Mark and Carl (16, M) said they would do the bigger activities
4013 themselves:

4014 *"…if we had the money…but it's obviously better*
4015 *when you go with the youth centre cos you've got*
4016 *more freedom…if you go with your mates, yeah you*
4017 *can do whatever you want, but when you go with the*
4018 *youth centre you feel like you're actually part of*
4019 *something."*

4020
4021 The young people also described feeling were also quite
4022 disenfranchised after negative experiences with the local council. They
4023 had been promised more services in the area and become involved with
4024 raising money for these resources and had not seen what they had
4025 been promised:

4026 *Mark: We get told we're getting a new skate park, it's*
4027 *been 2 years since that was meant to be built, and*
4028 *we was told we had enough money for it as well*
4029 *wasn't we?*
4030 *Carl: Yeah.*

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4031 *Mark: Like, we'd saved up enough, like, as an area,*
4032 *to get this new skate ramp for us and we were meant*
4033 *to have it 2 years ago and we still haven't got it.*
4034 *Carl: Getting told we were going to have youth clubs*
4035 *for the football club, we get, they then go bust.*
4036 *Researcher: So you get promised stuff.*
4037 *Carl: And leave us with nothing.*
4038 *(Carl and Mark, 16, M)*

4039

4040 They described feeling really "*buzzin'*" (Mark and Carl, 16, M) when they
4041 were promised the skate ramps because "…*at the time we all used to*
4042 *go on scooters and bikes*" (Mark and Carl, 16, M).

4043

4044 The young people in Minetown felt that "…*if we had more stuff to do,*
4045 *our attitudes would change loads* (Mark and Carl, 16, M). Mark (16, M)
4046 commented that being able to go to the youth club as changed him a lot
4047 because "*since this* (the youth club) *has been here is since I've not*
4048 *drank*".

4049

4050 Another example that they gave of this was that "*no one drinks on*
4051 *Fridays anymore, they all drink on Saturdays cos there's youth on*
4052 *Friday…*" (Mark and Carl, 16, M). There appeared to be a binary
4053 relationship between fun/something to do, and boredom. They identified
4054 that when there were not easy ways to have fun, such as when
4055 attending the youth club (referred to as "Youth", as in "see you at Youth
4056 later") they were more likely to drink because "…*there's nothing to do*
4057 *and when you drink that's something to do*…" (Carl, 16, M).
4058 They were aware that this exacerbated the problems that they
4059 experienced with adults in the area with "…*more people…getting in*

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4060 *trouble cos people are drinking on parks…*" because "…*when you get*
4061 *pissed you just don't care do you really*," (Carl 16, M) and "…*that gets*
4062 *us in more trouble with the police and that makes us look just as bad*
4063 *and makes this area look worse*" (Mark, 16, M). On talking about this,
4064 they commented that that had "…*never looked at it like this*," (Mark, 16,
4065 M).
4066
4067 They felt as if young people were not a priority in the local area because
4068 the council "…*get too busy doing stuff up for the babies…and old*
4069 *fucking biddies*…" when they feel that they have had nothing (Mark and
4070 Carl, 16, M).
4071
4072 There did not appear to be this feeling in the City site where the young
4073 men felt more in control of the choices available to them and reported
4074 accessing activities provided by a range of services, both private and
4075 statutory. Money was not reported to be a barrier for these young men.
4076 Mental health and happiness was seen as more important than physical
4077 health in some ways for some of the young men. Good mental health
4078 was seen as synonymous with being happy, with happiness given high
4079 levels of importance in relation to health.
4080
4081 With the privileging of mental health over physical health, behaviours
4082 that had been classified as 'unhealthy' on a physical level were often
4083 used as a way to avoid other unhealthy behaviours that affected mental
4084 health; so smoking cannabis reduced the tendency to become violent,

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4085 or drink to excess. It was observed that these behaviours were viewed
4086 as ‘unhealthy’, but only relative to what they could be doing. So some
4087 ‘unhealthy’ behaviours offset others. Mental health appeared to be
4088 therefore classed as being more important than physical health in that
4089 certain 'unhealthy' behaviours (smoking, alcohol) negated ill mental
4090 health or other unhealthy behaviours (anger, self-harm etc.).
4091
4092 The young men in Minetown appeared to experience many barriers
4093 when it came to enjoying life and were not equipped with coping
4094 strategies to help them deal with emotional difficulties. The young men
4095 in the City appeared to be more able to find ways of accessing support
4096 and this minimised their reported engagement with smoking, alcohol
4097 and substance use in comparison to the reported engagement in
4098 Minetown.
4099
4100 This leads the thesis to discuss the second key theme that arose in
4101 relation to the young men’s perspectives on health and a healthy body.

4102 6.2 Belonging

4103 A sense of belonging related to identity featured as an important factor
4104 in the young men’s lives. This will be discussed in relation to family and
4105 friends in this section.

4106 6.2.1 Belonging and friends

4107 Having friends was identified as one of the most important things
4108 related to being happy and staying healthy.

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4109 *Researcher: What makes you happy?*
4110 *Giles: Friends. If you're not happy, no point is there,*
4111 *just, don't, it's the most important thing you could*
4112 *ever, it's the best feeling as well, being happy*
4113 *(Giles, 14, M)*

4114

4115 In Minetown, enjoying life and having fun also appeared to be
4116 inextricably linked to friends. "*Being around friends and having a*
4117 *laugh…*" (Greg, 14, M) was seen as the easiest and best way to be
4118 happy. The young men in Minetown identified friends as being more
4119 important than family in terms of 'enjoying life and having fun'.

4120

4121 Engaging in some 'unhealthy' behaviours were described in both sites
4122 as helping with fitting in and this was of great importance to most of the
4123 young men. Enjoying life and having fun appeared to be inextricably
4124 linked to friends; this also related to fitting in where friends' or
4125 peers' behaviour could be an influence on behavior.

4126

4127 Simon (17, C) described how "*literally most of my friends smoke, and*
4128 *then there's, I am more of what I would class as a social smoker in a*
4129 *way*". Similarly Giles had started drinking out of:

4130 *"…curiosity actually, I kind of was very curious about*
4131 *it and I was like, my mate had one and he was like,*
4132 *'do you want one' and I was like 'yeah, whatever' and*
4133 *then I was like 'this is nice!' and then I was like 'I'll*
4134 *have another one' and then I was like, 'yeah!' and*
4135 *then here we are today"*
4136 *(Giles, 14, C)*

4137

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4138 In Minetown, friends' behaviour was seen as an influence on behaviour.
4139 Greg (14, M) described how he had started smoking at cadets, and that
4140 this was because of "*the people you hang around with*". Kevin (14, M)
4141 agreed, in that because "…*I hang around with people that smoke, it's*
4142 *hard not to really".*
4143
4144 Behaviour such as smoking, and drinking was often positioned as a rite
4145 of passage or 'normal' behaviour in teenagers. In the City, Simon (17,
4146 C) talked about the fact he does "*drink a bit when I'm out with my*
4147 *mates, like, when we got out; have a few drinks and, normal partying*
4148 *teenagers."*
4149
4150 Kevin (14, M) in Minetown described feeling "…*like, it's something to*
4151 *try…and some people want to carry on… you've got to try it* (smoking
4152 and drugs). Mark (16, M) added that "*everyone tries it…we all start*
4153 (smoking)". Greg (14, M) also agreed that "…*everyone tries it, and*
4154 *some people don't like it".* Greg (14, M) reported that:

4155 *"In primary school I was always the kid who would go*
4156 *on like 'I'm never going to take drugs, I'm never*
4157 *going to smoke'...But then, you get to the age where*
4158 *you've gotta do it".*

4159
4160 Certain rites of passage in Minetown were also described as being
4161 related to their geographical location:
4162
4163

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4164 *Kevin: I took weed...that's summat that comes and*
4165 *goes round here innit*
4166 *Greg: Yeah, it's like everyone's seeming to get on it*
4167 *at the moment*
4168 *Kevin, Greg (14, M)*

4169

4170 In Minetown, the behaviour of peers was often given as an excuse or
4171 reasons for their own behaviour, in a sometimes fatalistic tone. Some of
4172 the young men were talking about what sometimes happened when
4173 they got together:

4174 *Kevin: You just get into more trouble, you can't help*
4175 *yourself, but when you, I usually go 'let's have a*
4176 *couple of drinks lads, have a good time', but then it*
4177 *turns into…*
4178 *Jamie: It turns into people coming down with vodka.*
4179 *Kevin: Yeah, you usually have a drink with your*
4180 *mates and then they'll get more people down who's*
4181 *got spirits and everything so they're like 'do you want*
4182 *some' and you're like 'go on then' and then you get*
4183 *absolutely smashed.*
4184 *(Kevin, 14, M; Jamie, 12, M)*

4185

4186 Kevin reflected that if anything could have stopped him from starting
4187 smoking in the first place, it would have been the "*influence of friends, I*
4188 *think, like if they knew about it, support innit, like when you try to fit in,*
4189 *that's quite a big thing..."* (Kevin, 14, M).

4190

4191 Some of the young men reported having started smoking when they
4192 were drunk. Greg (14, M) reported having known all of the risks
4193 associated with smoking but was:

4194 *"…just drunk when I started, and then, it's cos, just*
4195 *because I was so young at the time, I thought 'I've*
4196 *already had one, what's the difference having*
4197 *another' and obviously now I know, I can't run."*

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4198 The need to fit in was not always seen as a good thing, with Kai (15, C)
4199 describing how he started smoking because he was "…*trying to fit in*
4200 *with the people that I used to hang around with*". He said that he didn't
4201 hang around with them anymore because "*basically, they said if I don't*
4202 *smoke then they'll beat me up or something..*." Kai reported feeling
4203 "…*pathetic for doing it, I didn't really, I should've just walked off and*
4204 *went home*."

4205 6.2.2 Belonging, family relationships and 'unhealthy' behaviours

4206 Young people in Minetown described enjoyed spending time with their
4207 families, particularly when this meant that they could take part in
4208 activities that they enjoyed, such as drinking and smoking. Access to
4209 alcohol and cigarettes could sometimes be limited due to their age. Age
4210 was also perceived as a barrier to "*doing the stuff we want to do…age*
4211 *restrictions…cos everything nowadays is based on age*" (Greg, 14, M),
4212 and parents could make this access easier in some cases. Greg (14, M)
4213 described how he and his dad would:

4214 > *"…order pizza and…were drinking together cos,*
4215 > *that's how we do it with the football…I'll drink with my*
4216 > *Dad gladly cos, me and my Dad think it's a way to*
4217 > *bond if we drink…"*

4218

4219 Mark and Carl (16M) both described getting on with their families but
4220 that it was "*fun to go out*" (Carl, 16, M) and that they "…*can't stand*
4221 *sitting around my family…they bore the living shit out of me*" (Mark, 16,
4222 M) or "*just moan…wanting me to do something*" (Carl, 16, M).

4223

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4224 In the City site, the young men would spend more time with friends than

4225 family and did not discuss participating in any of these activities with

4226 family. However, in the City, Simon observed the behaviour of family

4227 members and gave this as an excuse or reasons for their own

4228 behaviour, in a fatalistic tone. Simon (17, C) talked about how he might

4229 as well smoke:

4230 *"...cos my dad smokes at home so of course there's*
4231 *always that scent in the house, smoke getting into*
4232 *the system, and I've got friends that smoke, so*
4233 *again, more second hand smoke and then two*
4234 *second hands make one."*

4235

4236 Giles (14, C) had been around his mum drinking and described her:

4237 *"…alcohol tolerance is completely terrible...she had 2*
4238 *G&Ts, 2 Baileys and 2 glasses of wine and she got*
4239 *completely catatonic, so I think too much is for the*
4240 *individual, but she ended up sitting on the bathroom*
4241 *floor with her head on the toilet seat saying "bit white*
4242 *telephone big white telephone big white telephone..."*
4243 *anyway, we tried to put her in bed and she just got*
4244 *back out and went and sat in the toilet again, and*
4245 *that's quite a good example of what too much is"*
4246

4247 As a result of this, Giles thought that *"…you need to know your*

4248 *boundaries and I don't think she does"* with the implication that he did.

4249

4250 In Minetown these behaviours tended to be described as being part of

4251 bonding as a family in some cases. Greg (14, M) reported that:

4252 *"…me and my Dad think it's a way to bond if we*
4253 *drink, so we had like 3 bottles of Kopparberg each*
4254 *and we just bonded over that watching football and*
4255 *eating pizza and I thought, I thought that sort of*
4256 *drinking, drinking like that with my family is okay"*
4257

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4258 Greg (14, M) also had experience of drugs because "…*that's summat*
4259 *that goes in my family quite a bit, so, it's summat that I've grew up*
4260 *around really."*
4261
4262 Parental approval often acted to undermine official information in
4263 Minetown. Chris (12, M) knew that it was "…*not legal for me to buy it*
4264 *but, you know, if your mum offers if you, if your mum lets you have it…"*
4265 then that was seen as okay. Kevin (14, M) reported that his mum:

4266 *"…lets me smoke now...she understands...she'd be*
4267 *like 'oh, I knew what it was like when I was a kid and*
4268 *I wanted to do them things', she doesn't like me*
4269 *smoking, she wants me quit, but she'll let me.*
4270

4271 Kevin's mum also got him alcohol and felt that "…*if you drink it with your*
4272 *parents it's not as bad".* Kevin described that "*if I gave her the money,*
4273 *she wouldn't pay for it, I'd have to get the money, I'd have to earn the*
4274 *money, she'd be like 'you earn the money, I'll get it you'*". Jamie (12. M)
4275 reported that he was also "…*not bothered* (about drinking) *as long as*
4276 *my mum knows, like, my mum's not bothered as long as she knows*".
4277
4278 Not all parents and friends condoned certain behaviours. Greg (14, M)
4279 described how if he was caught smoking his mum "*grounds me and*
4280 *then she hits me with a metal thing, no, a wooden post thing".* The
4281 young men sometimes appreciated these actions in that Kevin lived with
4282 his grandparents and reported that if his grandad ever "*ever caught me*
4283 *smoking he'd probably have a go at me, but he'd understand*".

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4284 Overall upbringing and family behaviour, including joint family activities,

4285 had an impact on the young men's engagement in this activities. This

4286 served to potentially normalise. certain behaviours. This appeared to be

4287 the case in Minetown more than in the City site.

4288 6.2.3 Belonging in other forms

4289 In Minetown specifically, when it came to not participating in these

4290 behaviours and still fitting in, it appeared to be only when another

4291 behaviour deemed to be of equal 'value' could replace this that they

4292 might quit smoking. An example of a behaviour of equal value be

4293 around performance in football or another sport. Sports performance

4294 seemed an acceptable reason to stop unhealthy behaviours.

4295

4296 If someone did not engage in sport, for example, they may not

4297 otherwise be concerned about the effects of smoking. Mark (16, M)

4298 talked about quitting smoking because it had affected his football

4299 performance. If he did not play football, he "…*wouldn't feel the*

4300 *difference would I*". Jamie (12, M) was very clear about his decision not

4301 to smoke:

4302 *Researcher: Have you ever smoked?*
4303 *Jamie: NO.*
4304 *Researcher: Why not?*
4305 *Jamie: I don't want to.*
4306 *Researcher: What don't you like about it?*
4307 *Jamie: It'd fuck my life up.*
4308 *Researcher: How did you know that? Like, where do*
4309 *you find stuff like that out from?*
4310 *Jamie: Cos it fucks up your lungs and everything and*
4311 *I wouldn't want to do that cos I play football.*

4312

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4313 Other examples of when being 'different' and not joining in with

4314 behaviours such as drinking, or smoking were going in the army:

4315

4316 *Researcher: How often would you say you drank?*
4317 *Carl: I did use to do it every week-end.*
4318 *Researcher: Yeah, not anymore?*
4319 *Carl: No, going in the army.*
4320 *Researcher: Ah, so you've had to change some of*
4321 *your behaviours cos you're going in the army?*
4322 *Carl: Yeah, like can't smoke weed for 90 days can*
4323 *you, so, I haven't smoked weed.*
4324 *(Carl, 16, M)*

4325

4326 Other barriers to healthy behaviour were linked cost as a reason

4327 legitimately avoid a behaviour whilst still fitting in. Mark (16, M)

4328 described smoking as a:

4329 *"…waste of money, something that I did, but it*
4330 *bothers me that my life might get cut short for*
4331 *something that I don't enjoy, I thought, 'what am I*
4332 *doing it for?' and turned myself around"*

4333

4334 And James (16, M) described only smoking when he's drunk because

4335 "…*I throw up, I react to it weirdly, so I don't smoke…Cos it's just shit*

4336 *innit, plus money."*

4337

4338 A sense of belonging featured as an important factor in the young

4339 men's lives in both sites. The families of the young people in the City

4340 site were described as being supportive, and integral to health whereas

4341 the families of the young people in Minetown were often described as

4342 the source of a lot of difficulty. This meant that friends took a larger role

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4343 in the lives of the young men in Minetown, and were integral to this
4344 feeling of belonging.
4345

4346 'Fitting in' was important, and joining in with some 'unhealthy'
4347 behaviours like drinking, smoking, and drug use could help with this.
4348 The behaviour of these friends was described as influential. Activities
4349 like drinking, smoking, and drug use were positioned as a rite of
4350 passage or 'normal' behaviour in teenagers.
4351

4352 When it came to not smoking, drinking, or taking drugs and still fitting in,
4353 it appeared to be only when another behaviour deemed to be of equal
4354 'value' could replace this that they might quit smoking. Behaviours that
4355 could be deemed as 'equal' included sporting prowess, or future career
4356 aspirations around sport or the army.

4357 6.3 Emotional Support & Coping strategies

4358 Emotional support was described as being provided by family and
4359 friends, as well as professional services. These measures will be
4360 explored in more detail in the following section, building upon the
4361 section exploring the importance of belonging.

4362 6.3.1 Emotional support and professional services

4363 Simon (17, C) was the only young man in the City site who mentioned
4364 counselling as part of coping with life. Simon acknowledged
4365 that counselling might be useful because:

4366 *"…there's always that point where you need*
4367 *someone outside of the loop, cos like you don't want*
4368 *to put all your issues onto your friends and family cos*

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4369 *they've got their own things going on but there's*
4370 *times when you just need that outside person to give*
4371 *you that advice"*
4372

4373 Robert (16, C) also identified external, professional support as
4374 beneficial because "*although it's easier to rely on a friend or someone in*
4375 *the family, at the same time it can be difficult, already having that*
4376 *background with them*".
4377

4378 Sometimes, however, Robert (16, C) found it "*easier to talk to people*
4379 *that I don't know or haven't known for that long rather than people I*
4380 *have known for a long time"* because *"there's less weight on it*." Robert
4381 added that:

4382 *"…things like help lines and online support and stuff*
4383 *like that…cos there are still people that you know will*
4384 *be there in the way that you want them to be…"*
4385

4386 Robert reported being aware that *"if I had problems that I'd have more*
4387 *support if I carried on in like the female lifestyle*" and as a male he did
4388 not think that he would "*have the same level of support*" (Robert, 16, M).
4389 He thought that it might be more difficult for males than females to know
4390 where, and how, to access support and that there was:

4391 *"…a lot more sympathy for females than…for males,*
4392 *it's like if I go into somewhere as a female,*
4393 *then I'll get the whole 'are you okay? Do you need*
4394 *this, do you want to sit and talk about this?', if I*
4395 *go into a Dr's room as a male teenager they'll turn*
4396 *around and are like 'ah yeah, but you'll be fine, you*
4397 *don't need to worry about this no, worry when it gets*
4398 *bad'"*
4399 *(Robert, 16, C)*
4400
4401

4402

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4403 This "*surprised*" him as he had only just started noticing it:

4404 *"…recently when I've started to become a lot more*
4405 *myself and pass better and when I can be spoken to*
4406 *as a male it's very surprising, the difference that [he*
4407 *gets], like it's kind of the complete difference, like do*
4408 *you want to sit and cry about this or do you want me*
4409 *to give you a pat on the back and tell you you'll be*
4410 *okay? And um, like, it doesn't tend to bother me that*
4411 *much cos I don't let things get to me unless I know*
4412 *they have to, but then at the same time, it is*
4413 *surprising like, I wouldn't have expected it to be as*
4414 *dramatic as it has been."*
4415 *(Robert, 16, C)*
4416
4417 Robert (16, C) felt:

4418 *"...almost lucky in a way, cos if I go to one place,*
4419 *depending on how I go in I will get treated*
4420 *differently…when I go into new friendship groups…if I*
4421 *go in and I'm introduced as female then I'll get*
4422 *spoken to a lot differently than if it's the opposite way*
4423 *round."*
4424
4425 In Minetown, Greg (14, M) brought up counselling as something that

4426 had helped him, and said that the counselling "*made me really, really*

4427 *think about stuff and that felt good".* Greg said that he would "definitely"

4428 have counselling again because:

4429
4430 *"…it's like someone coming into the family who's*
4431 *nothing to do with you, who's just there to help, who*
4432 *doesn't know anything about your family, they can't*
4433 *bring up past experiences and that, and that's*
4434 *what I felt good about it, cos she couldn't bring up*
4435 *about any stuff that's already happened, or anything*
4436 *like that, she could just focus on what's going on now*
4437 *and what's going to carry on in the future, and*
4438 *obviously that helped quite a lot."*
4439 *(Greg, 14, M)*
4440
4441 Being able to talk to:

4442 *"…someone who knows, who's been through what*
4443 *you've been through, someone who can help you*
4444 *through those situations, like counsellors…made life*
4445 *easier"*
4446 *(Greg, 14, M).*

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4447 Support from people that understood had led Greg to "*wanna be a*

4448 *youth worker and help people*" because he "*could help people who are*

4449 *in my situation, I could guide them along the right track*". He felt like his

4450 life might have been different if he had had "*someone to look up to, like*

4451 *a youth worker who I could talk to and see on a regular basis*" (Greg,

4452 14, M).

4453

4454 Greg (14, M) had previously not spoken to anyone outside of his family

4455 about having counselling because he "*thought 'ah, people will*

4456 *think I'm unstable if I told them I'd had counselling, so I didn't really*

4457 *bring it up*". However, when Greg spoke about his experience, Jamie

4458 (12, M) and Kevin (14, M) also opened up about their experiences

4459 of counselling.

4460

4461 Jamie (12, M) said that he'd "*got it coming up soon"* and that he's had it

4462 before:

4463 > *"…not long back…cos I was always punching stuff*
4464 > *when I got mad or summat and then my mum took*
4465 > *me to there and they said I didn't have owt wrong*
4466 > *with me, they said I'd be alright and then a couple of*
4467 > *months after, last, 3 months ago, I started it again*
4468 > *so now I have to go to counselling…it will like make*
4469 > *me a better person."*
4470 > *(Jamie, 12, M)*

4471

4472 Kevin (14, M) added that he "wouldn't be embarrassed, I'd be pretty

4473 proud of meself" (Kevin, 14, M).

4474

4475 Within these discussions, and one that took place in another group

4476 interview, there were mixed views about

4477 how helpful counselling was. Kyle (15, M) reported that he "had to do it

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4478 at school" but was not convinced about how useful "just talking" could

4479 be because:

4480 *"…they can't exactly do owt about it, they can only*
4481 *talk about it, so, you know, it don't really make a*
4482 *difference does it…it's boring, they just talk about*
4483 *stuff that you, they don't take action or anything…"*
4484 *(Kyle, 15, M).*
4485

4486 Mark (16, M) also talked about his experience and reported that he

4487 had:

4488 *"…only had (counselling) once and that was*
4489 *when my mama passed away...one session, I didn't*
4490 *find it helpful at all, to be honest I just thought they*
4491 *was there to make you feel bad"*
4492 *(Mark, 16, M).*
4493

4494 Mark and Kyle both reported that they would not have

4495 counselling again. Mark added that counselling as a "*support network*

4496 *is wank, it don't help*" (Mark, 16, M). When asked what kind of support

4497 he might find helpful, Kyle (15, M) suggested that he would appreciate:

4498 *"…someone to help you, and not just*
4499 *emotionally…like literally helping you, you know, like*
4500 *within your life, if something shit's happening, they'd*
4501 *sort it out…"*
4502 *(Kyle, 15, M).*
4503
4504
4505 However, this "*depends on the situation*" because someone else getting

4506 involved "*could make it even worse*" (Kyle, 15, M). Kyle felt that getting

4507 practical support might be difficult because:

4508 *"I don't like getting told what to do, I'd be more than*
4509 *happy if someone asked me to do something but if*
4510 *they literally went: 'do this', I probably wouldn't"*
4511 *(Kyle, 15, M).*
4512

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4513 The young men in Minetown accessed the youth provision as their main
4514 source of support. When the youth club was closed, or when it was
4515 open for younger age groups, Mark (16, M) described that there was
4516 "*nothing*" to do, that he would "*go to bed tonight and think - 'what can*
4517 *we do tomorrow?' and basically you can't think of anything*."
4518
4519 This was described as being a particular issue when they had finished
4520 school due to their exams having finished. Mark (16, M) had previously
4521 been "*buzzin' for*" leaving school but had found it to "*shit*". Carl (16, M)
4522 described that on an average day, he would "*just sleep…until the end of*
4523 *school*" and Mark (16, M) added that they would then perhaps "*watch*
4524 *telly*" then get ready to go to the school to meet some of their younger
4525 friends who were still at school.
4526
4527 Their experience of life at the moment was described as being "*SSDD -*
4528 *same shit, different day*" (Carl, 16, M) with very little opportunity to get
4529 out and have any fun, or even do anything. The youth club was also
4530 shut in the school holidays which was a point of contention, "*this is*
4531 *shut…so we don't do fuck all"* and that they *"miss the youth* (club)"
4532 (Mark and Carl, 16, M).
4533
4534 Professional support was viewed differently depending on the particular
4535 experiences of the young men in each site. All accessed some form of
4536 professional support as part of accessing the youth provision, but

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placed differing degrees of importance on this and what they got out of it.

The young men in the City site talked more explicitly about the support that they accessed through professional services, whereas the young men in Minetown were more implicit in how the provision had helped them – linking it more to the importance of something to do than emotional support. However, the young men in Minetown did discuss the impact on their mood and coping when the provision was unavailable to them.

6.3.2 Emotional support and family

In Minetown, family was mentioned up as an important part of coping with life. Mark (16, M) described that he might "*sit down and say: 'Mum, got a problem', 'what's that?', 'got an STI', BOOM! She knows!*" This seeking support from his mum had stopped when he "*got to comp [comprehensive school]*" and now "*the only people I'd talk about stuff like that with now would be my Auntie and my Mama*" (Mark, 16, M). Greg (14, M) also spoke about getting support from his mum:

> *"…I can trust my mum, I'll always open out to my mum, I can sit there and have a nice conversation with her and talk about deep stuff that I wouldn't think of talking to anyone about and that's why, it's good to have someone like that"*
>
> *(Greg, 14, M)*

Other family members like grandparents often also played a substantial role in some of the young men's lives in Minetown, in some cases having taken on guardianship responsibilities due to parental drug use.

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4566 The young men reported that their grandparents were often a

4567 lot stricter with them than their parents. This was something that could

4568 make them angry, when boundaries were put in place that they did not

4569 agree with. Having said this, Greg (14, M) added that "*like I say I hate*

4570 *my nana and granddad, but I know they're only looking out for me*" and

4571 Kevin added that "*it's for our wellbeing though innit*" (Kevin, 14, M).

4572

4573 In the City, family was talked about less in terms of emotional support

4574 given, however, Robert (16, C) described family as coming before

4575 friends but would have liked to be closer to his family. When thinking

4576 about family, Robert thought about:

4577 *"…what family actually meant and I think I decided*
4578 *that, to me, family are just the people that will be*
4579 *there no matter what and I don't think blood has*
4580 *anything to do with it, I'm always going to be grateful*
4581 *to people who are technically family for being there*
4582 *but at the same time I think there are people that*
4583 *have been there more than people that would call*
4584 *themselves family to me".*

4585

4586 Family appeared to be of more importance to the young men in

4587 Minetown than in the City. This may be due to those in the City

4588 appearing to have access to, and accessing, a range of different types

4589 of emotional support compared to the more limited support available

4590 and accessed in Minetown.

4591 6.3.3 Emotional support and friends

4592 Families of the young people in Minetown were often described as the

4593 source of a lot of difficulty. Parents were in some cases suffering from

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4594 issues around substance misuse and ill health and young people felt

4595 that they had to take on the parental role in some cases. This meant

4596 that friends took a larger role in their lives as someone they:

4597 *"…can always trust and talk to…open up… knowing I*
4598 *can have someone to rely on, stuff like that...if I'm in*
4599 *a bad mood and I'm with my friends they always*
4600 *know how to cheer me up…"*
4601 *(Kyle, 15, M).*

4602
4603 Greg (14, M) described his friends as "*someone to rely on*" because

4604 "*emotions run a lot on my life, my life's basically based*

4605 *on my…my friends they always know how to cheer me up*."

4606

4607 Greg (14, M) also noted that:

4608 *"…friends make me feel more better*
4609 *about me self than my family do, which I find really*
4610 *weird, cos my family, it's family innit, I've got more*
4611 *friends that I can think of as family…friends, I've not*
4612 *got enough fingers to count to be honest."*
4613

4614 Friends in Minetown were described as people that you could talk about

4615 things with. This included sex and relationships. Carl (16, M) described

4616 how with his close friends he could talk about relationships - "*not sex,*

4617 *just being in the relationship, and not doing anything till they're ready*

4618 *and stuff.*" This kind of support may be counter to previous research

4619 about how young men talk about relationships.

4620

4621 In the City, family and friends were seen as being of more equal

4622 importance. Giles (14, C) felt that family were really important to mental

4623 health and that not accessing their help could be "...*very detrimental to*

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4624 *health because your family needs to help you through bad times*

4625 *and having bad health, family, and friends, and I think that can be*

4626 *useful*'. Simon (17, C) was aware that friends could be there when you

4627 fell out with family:

> 4628 *"…cos there's always that thing with me where,*
> 4629 *because, pretty much in every family you always*
> 4630 *have that moment where to tend to fall out with all of*
> 4631 *your family and be like 'no! I don't want to speak to*
> 4632 *you today!' and then the next day you'll be like 'so*
> 4633 *what's for tea?'"*

4634

4635 Friends were classed as being useful means of emotional support in

4636 both sites. Friends were able to help mitigate some of the difficulties

4637 caused by family relationships, particularly in Minetown. Friends were of

4638 huge importance to the young men in Minetown, whereas in the City it

4639 appeared that family and friends were given more equal status in terms

4640 of their capacity for emotional support.

4641 6.3.2 Unhealthy behaviours as coping strategies

4642 In Minetown town, there did not appear to be the more explicit

4643 awareness that existed in the City site of practicing positive or 'healthy'

4644 ways of dealing with their feelings and circumstances. It appeared

4645 to be acceptable to cope with "*feeling shit"* by drinking alcohol, smoking

4646 cigarettes, and drug use.

4647

4648 James (16, M) described a young man that he knew whose parents had

4649 just divorced who "*smokes weed all the time, to chill him out.*" This

4650 situation appeared to excuse the use of drugs and alcohol as a way of

4651 handling stress and difficult feelings. James (16, M) talked about the

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4652 different situations that some of his friends were in and how some of

4653 their behaviour might make sense, or not, considering this:

4654 *"His family like was good, his mum and*
4655 *dad was there for him, but I understand why X is, cos*
4656 *his mum and dad, his dad's the biggest ecstasy*
4657 *taker, his mum's always drunk, I think his mum's had*
4658 *8 kids."*

4659

4660 Mark (16, M) also reported that "*when I started smoking it was*

4661 *when my mama passed away…it was like, something to turn to*." Kevin

4662 (14, M):

4663 *"…started drinking to take the pain away from stuff,*
4664 *like I used to get dead depressed, so I just thought*
4665 *'fuck it, start drinking yeah', cos…when you drink,*
4666 *you'll have a good time."*

4667

4668 Mark (16, M) had identified that this had led him into other behaviours:

4669 *"…then I turned to drinking and then obviously*
4670 *drinking turned me to smoking and then obviously*
4671 *that got me onto weed, then I stopped weed."*

4672

4673 However this had caused a problem in that stopping this behaviour had

4674 not left anything in its place to help deal with emotions.

4675 *Researcher: So one of the reasons you said you*
4676 *smoked is to deal with stress, how do you guys deal*
4677 *with stress if you haven't got the alcohol or the*
4678 *drugs?*
4679 *Mark: I get angry*
4680 *(Mark, 16, M)*

4681

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4682 James (16, M) had used alcohol to try and cope with his feelings but

4683 viewed himself as "*not strong mentally*" because of this. He found

4684 drinking useful initially because:

4685 *"…when I used to drink, I didn't care what people*
4686 *thought of me, that's what made me do it a lot more,*
4687 *cos I wouldn't care, but then I realised, it's not going*
4688 *to help when I'm sober…cos I'm still bothered"*

4689

4690 Kyle (15, M) talked about how he dealt with stress:

4691 *Kyle: It chills you out (smoking weed), that's it*
4692 *Researcher: Do you need chilling out?*
4693 *Kyle: Yeah*
4694 *Researcher: Do you get stressed?*
4695 *Kyle: Yeah, everyone does*
4696 *Researcher: What else do you do to help when*
4697 *you're stressed? Just smoke weed?*
4698 *Kyle: Booze*
4699 *Researcher: Booze, so drinking and smoking weed?*
4700 *Kyle (8.1)*

4701

4702 Although some young men reflected that this had not been the success

4703 that they had hoped for. James (16, M) reflected that:

4704 *"…like when you have a drink as well you always*
4705 *cause stuff, and then when you wake up in the*
4706 *morning, you think 'oh my god, what have I done*
4707 *now?'*

4708

4709 This also applied to other young people's behaviours where certain

4710 peers would be excused for their health behaviours based on their

4711 perceived circumstances. Whereas others were judged as not 'needing'

4712 to engage in these behaviours due to the perceived lack of difficulty in

4713 their lives compared to others:

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4714 *"His family like was good, his mum and dad was*
4715 *there for him, but I understand why X is, cos his mum*
4716 *and dad, his dad's the biggest ecstasy taker, his*
4717 *mum's always drunk, I think his mum's had 8 kids."*
4718 *(James, 16, M)*

4719

4720 The feelings of anger that the young men in Minetown reported
4721 feeling were described as caused by "*boredom...some peer pressure*"
4722 but also acknowledged that "*some of it's to do with…mental*
4723 *state*" (Kevin, 14, M). Kevin (14, M) described how "*when someone*
4724 *says something to me, I never think before I act, then the consequence*
4725 *comes on me after*". In Minetown, if people get stressed and angry,
4726 "*most people resort to punching walls*" (Greg, 14, M). Greg (14, M) did
4727 add that this might be because "*if you haven't got good mental health,*
4728 *you're not thinking straight*."

4729

4730 Self-harm or 'cutting' was also mentioned as something that "*some*
4731 *people just resort to…but that's not the way forward*" (Kevin, 14,
4732 M). However, Kevin described having self-harmed before "*when I get*
4733 *proper angry and I can't do nothing else*." Kevin (14, M) talked about his
4734 use of self-harm and said he might do this in situations such as
4735 "…*falling out with my family, getting mad at meself for what I've done*
4736 *and stuff like that.*"

4737

4738 Kevin was aware that self-harm "*doesn't help me, but I just…flip at*
4739 *meself*" and that most of the time he can "*usually resolve it by punching*
4740 *a wall, or I can punch meself*" Kevin reported that he had "*only cut*
4741 *about twice, but that's if I've…done something really bad*" he said that

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4742 “*basically, I get mad at myself so I do it to myself, so that’s the thing I*
4743 *know I can hurt myself by doing”* (Kevin, 14, M).
4744
4745 With reference to self-harm as a way of coping with feelings, there was
4746 a differentiation made between “p*eople who do it for attention, and*
4747 *people who do it for a reason”* (Kevin, 14, M) which might be seen to
4748 relate to the stigma around mental health mentioned earlier.
4749
4750 In some ways, there seemed to be a perceived element of choice
4751 attached to mental health regarding the behaviours that caused and
4752 relieved mental health difficulties.
4753
4754 There were some more ‘healthy’ ways that the young men in Minetown
4755 used as a way of managing their feelings. This included music; two of
4756 the young men, Greg (14, M) and Kyle (15, M) wrote lyrics as a way of
4757 expressing their feelings. Greg (14, M) said that “*the only time I ever*
4758 *write stuff’s when I’m angry…*” and that “*it’s stress relief as well, cos it*
4759 *really helps.*” Kyle (15, M) worried that it sounded “*a bit crazy...a bit of a*
4760 *weird thing…*” but that it “…*gets me through the day innit, like, I can’t go*
4761 *to bed without writing a few bars*”. They both shared their music
4762 by ‘spitting bars’ with their friends; Greg felt that this often gave
4763 him “a *good confidence boost.*”
4764
4765 Within the City site there were a variety of ways that the young men
4766 accessed emotional support, and this meant that, although their did
4767 report occasional use of smoking, alcohol, and other substances, their

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4768 did not appear to rely on these for emotional support or as a means of
4769 coping.

4770 ## Conclusion

4771 The key themes that were identified as being important to health were
4772 the privileging of mental health over physical health, particularly in
4773 relation to the importance of happiness; belonging within family and
4774 friend groups and the behaviour that might facilitate this; and how they
4775 coped with life through means of the emotional support they needed
4776 and could access through professional services, family, friends and use
4777 of smoking, alcohol, and substances.

4778

4779 There were differences between each context in the importance of
4780 these themes, or how the benefits associated with them were achieved.
4781 In the City site, the level of education and socioeconomic status tended
4782 to be higher, and this appeared to have an influence on the ability to
4783 communicate their needs and have these needs met. In Minetown,
4784 where attainment and socioeconomic status were on the whole lower,
4785 access to support and the ability to communicate their needs and have
4786 them met appeared to be more of a challenge.

4787

4788 The next chapter will move on to discuss the third of the research aims:
4789 to examine what influences young men's perspectives on health and a
4790 healthy body.

4791

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4792 7.0 Findings 3 - making sense of health information

4793 This chapter will address the third of the research aims: to examine
4794 what influences young men's perspectives on health and a healthy
4795 body. In particular, the research is concerned with what forms of health
4796 education and knowledge are accessed by young men, as well as their
4797 perspectives on these and how they respond to these messages. This
4798 will be reflection of the dominant discourse in each site. These
4799 questions will be addressed in the following sections.

4800 7.1 What forms of health education and knowledge are accessed
4801 by young men?

4802 This section will address the research objective concerned with the
4803 forms of discourse that are accessed by young men in each setting.
4804 The health-related information available to the young men within each
4805 site, and their understanding of this, contributed to the dominant
4806 discourse within each of their communities of practice.

4807 *7.1.1 City*

4808
4809 With regard to accessing health information, the young men in the city
4810 found health information from a variety of sources, including GPs,
4811 dentists, hospitals, clinics, school and "*adults who know*" (Mark, 16, M).
4812
4813 The internet was a common source of health information and the young
4814 men acknowledged the need to be careful about which sites information
4815 was sought from because:

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4816 *"…there's a lot of information out there…but one of*
4817 *the main problems for going to things online is that*
4818 *there's a lot of over-dramatisation" (Robert, 16, C).*

4819

4820 Robert (16, C) gave an example of why it might be important to

4821 consider where he sought health information;

4822 *"…when there's websites for things like NHS and you*
4823 *put in things that are wrong with you and all you've*
4824 *got is a common cold or something, and all of a*
4825 *sudden, you've got cholera or something" (Robert,*
4826 *16, C).*

4827

4828 Kirk (16, C) also said that *"when I've got health problems, I look on the*

4829 *internet…*" but that this:

4830 *"…makes it worse, cos you get a lot of things that*
4831 *people put up there, they don't really know what*
4832 *they're talking about, but you still believe it for some*
4833 *reason". (Kirk, 16, C)*

4834

4835 Looking on the internet for health information has caused Kirk anxiety,

4836 and he described the process that he might go through:

4837 *"…first my heart starts beating really fast and then*
4838 *[he gets] really scared, then, it can be 2am and I'll go*
4839 *and wake my mum up and she'll be like 'go back to*
4840 *sleep, you ain't got nowt wrong with you', but I'll go to*
4841 *the doctor and make an appointment straight away"*
4842 *(Kirk, 16, C)*

4843

4844 Kirk (16, C) found it difficult to know which sites on the internet to

4845 believe; "*whatever looks more professionally said, I'll believe that…*"

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4846 Justin (14, C) felt more able to judge the factual basis of the information

4847 based on his computer skills. He said that the reason that he knew what

4848 information on the internet was true is because he was:

4849 *"…very good with computers and everything else,*
4850 *and I know what writing's wrong and what writing's*
4851 *absolutely correct, sometimes people just put it on*
4852 *their as their opinion, it's not actually the truth"*
4853 *(Justin, 14, C)*

4854

4855 Giles (14, C) also advised that people should "…*try not to use the*

4856 *internet (for health information) unless you go to the health websites like*

4857 *NHS…because NHS, if you die, that's where you go*" (Giles, 14, C).

4858

4859 The young men also talked about the health information that they had

4860 come across at school. There was some criticism about the information

4861 that school gave. In reference to healthy eating, Andrew (17, C) was

4862 critical of the health information about healthy eating that children are

4863 given. Families were seen as important in helping people learn about

4864 healthy eating, although Andrew (17, C), who had been in care,

4865 explained that: "*a lot of people learn a lot from school, their parents*

4866 *don't help them at all*".

4867

4868 Having said this, the young men were critical about some of the

4869 information that they had covered in school being insufficient, saying

4870 that "…*when I do have questions and things, I'll more likely go the*

4871 *library or internet before I would go to talk to an actual human person*"

4872 (Robert, 16, C).

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4873 Justin (14, C) had behavioural difficulties and had not been allowed to

4874 attend sex education lessons in school; this had led him to "*go on the*

4875 *internet and…research it and…watch other materials (pornography) on*

4876 *the laptop, that's kind of wrong in a way, but I thought (it) was sex*

4877 *education*". His friends had told him:

4878 *"…stuff to go on, you don't even know what this*
4879 *website is you go onto it and watch it…but then your*
4880 *mum and dad say no 'you're not allowed to do this*
4881 *cos this is wrong', they explain to you a little bit,*
4882 *but then you want know more but they're like 'no, I'm*
4883 *not telling you that'" (Justin, 14, C)*

4884

4885 Justin (14, C) had a conversation with his parents about why watching

4886 porn was wrong:

4887 *"…they said it was fake, the ones that I was watching*
4888 *and stuff, and I was like 'how is this fake?', and they*
4889 *explained it all and I was like 'great', so where am I*
4890 *supposed to find sex education then? And they're*
4891 *like 'in books and everything' and, sometimes, I tell*
4892 *you the truth, I don't read books that much, I'm not*
4893 *like a books type person" (Justin, 14, C)*

4894

4895 Justin (14, C) did feel that it was understandable that his parents had

4896 not wanted to share information about sex with him "*for my sake cos*

4897 *they might not want me doing it, not yet, until I'm older*" (Justin, 14, C).

4898

4899 With regard to eating, resources like the Change4Life Smart Swap

4900 Spinner (figure 4), five a day message and the Eatwell plate (Food

4901 Standards Agency, 2007, figure 4) were mentioned, all of which the

4902 young men had learned about in school.

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4903 When it came to knowledge about portion size and daily calorie
4904 allowances, this was reported as having come from school and the "*the*
4905 *back of packets tell you what the intake is supposed to be, and…how*
4906 *much you're supposed to have"* (Andrew, 17, C). Giles (14, C) read
4907 food packets because he thinks "*it's important to know what's in what*
4908 *you're eating, in a way, so you're not just shovelling or not eating*
4909 *enough*" (Giles, 14, C).
4910
4911 Kirk (17, C) also talked about the "*right portion size*" – he knew the right
4912 portion size having gone over the eatwell plate (Food Standards
4913 Agency, 2007, figure 3) in school. The eatwell plate shows how much of
4914 what you eat should come from each food group. This includes
4915 everything you eat during the day, including snacks. The Eatwell plate
4916 is updated at regular intervals as the relevant guidance changes with
4917 research.

4918 *Figure 3: Eat Well Plate*

4919

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4920 When discussing healthy eating, several of the participants referred to

4921 the Change 4 Life Junk Food Swap:

4922 *"…advert for swapping your junk food for healthy*
4923 *food like fruit...where you change, say, a chocolate*
4924 *bar, and you swap it for a banana instead to keep*
4925 *you on that healthy streak rather than bingeing on*
4926 *food" (Simon (17, C).*

4927

4928 Justin (14, C) had received the Change4Life Smart Swap Spinner

4929 (Figure 4) and he reported that he used that as a diet plan. The Smart

4930 Swap Spinner was developed as part of campaign to encourage

4931 families to make small changes to lower-fat or lower-sugar versions of

4932 commonly eaten foods and drinks (Public Health England, 2014).

4933 *Figure 4: Change4Life Smart Swap Spinner*

4934

4935

4936 Justin had received this tool in primary school and reported that he still

4937 used this concept now. Justin described the Smart Swap Spinner as:

4938 *"...this template with food stuff on it and then it says,*
4939 *you scroll it, it's like a spinner basically, you spin in,*
4940 *and when you were little kids, they used to say 'that's*
4941 *what we'll have'…" (Justin, 14, C)*

4942

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4943 Eating fruit and vegetables was raised as part of the Smart Swap, in
4944 that junk food could be replaced with these items. Interestingly, the Five
4945 a Day message was mentioned by all the young men in the city. In The
4946 UK, the National Health Service (NHS) advocates that people eat a
4947 minimum of eating at least five portions of a variety of fruit and
4948 vegetables every day due to the associated health benefits (NHS,
4949 2018).
4950
4951 The 5 A Day campaign is based on advice from the WHO, which
4952 recommends eating a minimum of 400g of fruit and vegetables a day to
4953 lower the risk of serious health problems, such as heart disease, stroke
4954 and some types of cancer (NHS, 2018). Simon linked the Five a Day
4955 message to the saying "*an apple a day keeps the Dr away*" (Simon, 17,
4956 C). When thinking about fruit and vegetables, Kai (12, C) knew that fruit
4957 and vegetables were healthy:

4958 *2 (Kai): Cos it's one of your five a day*
4959 *1 (Researcher): Where did you get taught about the*
4960 *five a day?*
4961 *2: School*
4962 *1: School? And what did they say about that?*
4963 *2: They said if you eat 5 fruits or 5 veg a day, you'll*
4964 *become healthy and active*
4965 *1: What if you don't eat 5 fruits and veg a day?*
4966 *2: Maybe you won't be active and healthy, and you*
4967 *won't be able to really run for that long or something*
4968 *1: So that helps you be more active*
4969 *2: Yeah*
4970 *1: What if you eat more than 5?*
4971 *2: Then that's even better*
4972
4973 With regard to the healthy eating guidance delivered in schools, Andrew
4974 (17, C) had a lot to say and recommended that rather than just say "'*it's*

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4975 *good to eat this this this this this, there you are, eat that, don't eat this,*

4976 *and then that's it"*. Andrew suggested that schools should "*tell you all*

4977 *the different things it's good to have"* and say:

4978 *"…it's good to have fruit, for example, apples, you*
4979 *can have an apple in the morning…give you (an*
4980 *apple), 'here's an apple, it's one of your 5 a day, here*
4981 *you go" (Andrew, 17, C).*

4982

4983 ### 7.1.2 Minetown

4984 When it came to seeking health information, the internet came up as a

4985 key source. Sites like the NHS and BBC were seen as the most likely to

4986 be trustworthy.

4987 *"…things like the NHS is probably the best way to*
4988 *go though 'cos they're getting paid to make sure*
4989 *you're okay, so they're not going to tell you're not if*
4990 *you aren't or the other way round, BBC things as*
4991 *well, they've had quite a lot of good on there, but at*
4992 *the same time, all writing is going to be biased from*
4993 *one way or another so you can never be too sure on*
4994 *that. I definitely would never advise for someone to*
4995 *look for what's wrong with them just going and typing*
4996 *into Google cos the stuff that comes up is just*
4997 *stupid" (Robert, C, 16)*

4998

4999 The information shared in school was seen as "*a load of crap"* (Greg,

5000 14, M). Greg (14, M) felt that:

5001 *"…the stuff they teach you at school's a load of crap,*
5002 *if I wanted drug advice or smoking advice the honest*
5003 *thing I'd do is go to Google and "Talk to FRANK",*
5004 *cos…I've always thought that "Talk to FRANK" was*
5005 *really good" (Greg, 14, M)*

5006

5007 Greg (14, M) described that on "Talk to FRANK", "…*they compare it to*

5008 *other people's experiences…I searched up smoking once and it brought*

5009 *on someone's experiences like lung cancer and stuff like that*" (Greg,

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5010 14, M). Greg felt that "Talk to FRANK" also provided a balanced story
5011 about smoking because "...*it said it was stress relief and stuff like*
5012 *that…*" (Greg, 14, M).
5013
5014 Greg (14, M) would prefer to talk to people who've actually gone
5015 through quitting smoking, for example, when thinking about how to quit.
5016 Information that was delivered in balanced way was more likely to be
5017 taken seriously; for example, stories from family members.
5018
5019 The experiences of friends and peers was also an influence on
5020 behaviour in encouraging people to stop smoking. Kyle (15, M) talked
5021 about smoking in his second interview and had reflected that it was
5022 "…*probably bad to smoke*". Kyle (15, M) had seen that Carl (16, M) was
5023 "…*trying to quit now…has got the army*…" and thought that "…*if I had*
5024 *something that's coming up that's important then that might get me to*
5025 *quit smoking*" (Kyle. 15, M). However, Kyle (15, M) was not intending on
5026 smoking "…*for the rest of my life, cos, you get proper ill when you're*
5027 *old innit…*" (Kyle, 15, M).

5028 ### *7.1.3 Analysis*
5029 With regard to accessing health information, the young men in both
5030 sites found health information from a variety of sources, including GPs,
5031 dentists, hospitals, clinics, school, the internet, and peers.
5032 Information received in schools was seen as insufficient and biased and
5033 there was sometimes embarrassment associated with seeking
5034 information from professionals. As a result, the internet was a strong
5035 source of health information and the young men acknowledged the

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5036 need to be careful about which sites information was sought from; sites
5037 like the NHS and BBC were seem as most trustworthy due to their
5038 position in society and perceived quality of their websites. Minetown
5039 added “Talk to FRANK” (2019) as another example of a trustworthy site
5040 that was impartial and unbiased, giving balanced views of drug use.
5041 “Talk to FRANK” was set up by the UK Department of Health and the
5042 Home Office in 2003 to provide contemporary, youth-friendly
5043 information and advice on the risks of illegal drug use.
5044
5045 The young men in both sites, and in Minetown in particular, valued
5046 personal experience in regard to health information. This could be their
5047 own personal experiences, those directly related to them, or case
5048 studies online that appeared representative. The perceived balance that
5049 this offered meant that this information was more likely to be taken
5050 seriously.
5051
5052 The perspectives of the young men on these information sources will be
5053 considered in more detail in the next section.
5054

5055 7.2 What were the young men’s perspectives on these forms of 5056 health education and knowledge?

5057 This section will address the objective within the third research aim,
5058 around the young men’s perspectives on the discourses that are
5059 accessed by them in each setting.

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5060 The young men's understanding of the health-related information

5061 available to them is often defined as 'health literacy'. Health literacy can

5062 be defined as:

5063 *"…the personal characteristics and social resources*
5064 *needed for individuals and communities to access,*
5065 *understand, appraise and use information and*
5066 *services to make decisions about health." (WHO,*
5067 *2015, p.1)*

5068

5069 WHO (2015) recognise that health literacy requires more than the

5070 communication of information. This definition develops the neoliberal

5071 focus on individual behaviour-oriented communication, and addresses

5072 the environmental, political and social factors that determine health.

5073 Health education from this perspective is achieved through methods

5074 that entail interaction, participation and critical analysis (WHO, 2015).

5075 According to WHO (2015), such health education leads to health

5076 literacy, which in turn leads to personal and social benefit, such as

5077 through facilitating effective community action, and contributing to the

5078 development of social capital.

5079

5080 From a post-structuralist perspective, this approach also recognises the

5081 issue of power and how power relations affect access to information

5082 and its use. This post-structuralist perspective allows the consideration

5083 of the power relations that have enabled the dominant discourse within

5084 each site. However, though dominant, there was not only one discourse

5085 in each site, there are alternatives that are varied, and will be

5086 addressed in these sections.

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5087 *7.2.1 City*

5088 The young men in the city observed a bias towards the negative impact
5089 of health behaviours in health promotion. This unbalanced reporting led
5090 them to be critical.

5091

5092 Giles (14, M) had a sister who was being treated for anorexia nervosa,
5093 which may go some way to explaining his views about calories. Giles
5094 (14, C) felt that "…*calorific quantities are forced down your throat on*
5095 *food packets…cos it's always on food packets*…" (Giles, 14, C).

5096

5097 Andrew (17, C) had criticisms for how healthy eating was covered in
5098 school. Andrew criticised the regularity that schools covered this topic:

5099 *"…you get told about it (healthy eating) in primary*
5100 *school and from when you're younger and then*
5101 *you're told about it once and then in secondary*
5102 *you're taught about it once, schools don't focus on*
5103 *educating you about healthy eating, they might do*
5104 *'ooh, it's healthy eating day!' and then you just forget*
5105 *about it" (Andrew, 17, C)*

5106

5107 Andrew (17, C) related this to teaching and learning styles and felt that
5108 healthy eating guidance needs to be more practical because:

5109 *"…people learn in different ways…so with healthy*
5110 *eating, why are you just going to say it out loud off a*
5111 *sheet 'blah blah blah, here's a picture', they need to*
5112 *be more enthusiastic about it…" (Andrew, 17, C).*

5113

5114 Andrew (17, C) felt that it was important to:

5115 *"…teach people from a young age, so they care*
5116 *about it when they're older, or expose them to it at*
5117 *least from younger and then explain it to them better*

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5118 *and in more depth about healthy eating". (Andrew,*
5119 *17, C)*

5120

5121 Where cooking was covered in schools, Andrew felt that "…*they don't*
5122 *teach you to cook anything that you would ever need to cook*" and
5123 observed that they tended to bake cakes when "*some people don't*
5124 *know how to cook an egg, some people don't know how to make*
5125 *general meals like pasta or meat*". Andrew had observed
5126 inconsistencies here in that the foods that they were taught to cook in
5127 school would not be allowed in the cafeteria, but "*you won't teach them*
5128 *how to cook the correct foods that they will probably need every day*".
5129 Andrew felt that learning to cook was important "…*cos otherwise you'd*
5130 *be eating out and that's very unhealthy, even if they say it's healthy, it's*
5131 *very unhealthy*." (Andrew, 17, C)

5132

5133 Where programmes around health eating such as Change4Life were
5134 mentioned, there was a feeling that these could be 'pushy':

5135 *"…sometimes it's alright but when you're sat*
5136 *watching TV cos you've got nothing to do and you*
5137 *see that advert coming up all the time, you feel like,*
5138 *"why does this keep coming on all the time? Is my*
5139 *TV trying to tell me something?!" just keeps showing*
5140 *the same advert…a bit pushy really…every time*
5141 *there's loads being pushed on you, "sign up for this",*
5142 *"get this" and "get that" and all sorts" (Simon, 17, C).*

5143

5144 This made Simon not want to listen to them, as he felt that they did not
5145 acknowledge the whole picture, and legitimate reasons why he might
5146 eat some of the foods that they mention as part of a balanced diet.
5147 There was a feeling that these programmes would exaggerate how bad

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5148 certain foods were, and this felt disingenuous, especially within a

5149 discourse citing balance and moderation as acceptable.

5150

5151 Conversely, there was also a sense of fatalism about health behaviour

5152 because "…*you're going to die eventually*…" (Kirk, 16, C). Kirk (16, C)

5153 felt that he did not:

5154 *"…know [what was] true, that's why I, just do what I*
5155 *do, like I've done till this age and I'm still alive, so I'll*
5156 *just keep doing what I do, you're gonna die*
5157 *eventually…" (Kirk, 16, C).*

5158

5159 Kirk (16, C) used cancer as an example for this:

5160 *"…all these people get cancer, all the money being*
5161 *put into it, and they've still found no cure – out of all*
5162 *the things they can find cures for…as soon as the flu*
5163 *epidemic comes out…hey can find a cure for that*
5164 *straight away, but cancer…I believe they don't want*
5165 *to find a cure for cancer, that's why I don't think I*
5166 *would…give anything personally to cancer research,*
5167 *because I believe…that they don't want people to*
5168 *find a cure for cancer cos…finding the cure for*
5169 *cancer would mean more population, I believe that*
5170 *the government don't want more population, the*
5171 *more population, the more money that needs to be in*
5172 *the world…the government wants as much money as*
5173 *they can get, they don't want to be giving more*
5174 *money out to people who are being born…" (Kirk, 16,*
5175 *C)*

5176

5177 Simon (17, C) identified inconsistencies with health messages around

5178 the effects of smoking and drinking. Simon (17, C) was aware that

5179 smoking was criticised more heavily than drinking but had seen

5180 evidence that drinking alcohol might be worse; Simon (17, C) described

5181 a programme he had seen:

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5182 *"…on BBC3 that was about that 'Killed by my*
5183 *Boyfriend'…on the last part…he came back and*
5184 *broke in and killed her with the ironing board, it was*
5185 *horrible, he's like come back…drunk, and he's done*
5186 *that…he's not allowed to smoke though, it's a public*
5187 *space… but, they can do all that, it's really*
5188 *backwards when you think about it" (Simon, 17, C).*

5189

5190 Another example that Simon (17, C) gave about the focus on smoking

5191 not making sense is that:

5192 *"…you're not allowed to smoke here, you're not*
5193 *allowed to smoke there, but you're allowed to drink*
5194 *on aeroplanes, you're allowed to get…bottles of*
5195 *alcohol on the aeroplane and be a bit pissed, but*
5196 *you're, one fag or anything and you can get*
5197 *arrested…" (Simon, 17, C).*

5198

5199 Conversely, it seemed that certain messages around drug use had the

5200 effects intended by health promoters. 'Hard' drugs such as cocaine and

5201 heroin were perceived by the young men as always causing death and

5202 ruining lives; this was not applied to other behaviours. Giles (14, C)

5203 started that:

5204 *"…with hard drugs it's very bad for your physical*
5205 *health, you see, cos it makes you lose weight,*
5206 *horribly, some do anyway and also, HIV if you share*
5207 *needles you can get HIV really easily and a whole*
5208 *microcosm of other things, like if you sniff drugs you*
5209 *can just die straight away, it's just a really bad idea."*
5210 *(Giles, 14, C)*

5211

5212 The taking of drugs like cocaine or heroin was seen as in a different

5213 league to that of cannabis; this may serve to allow for neutralisation

5214 (Sykes and Matza, 1957) where cannabis is not seen as being a 'real

5215 drug' in comparison.

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5216 *7.2.2 Minetown*

5217 The young men in Minetown also observed a bias towards the negative
5218 impact of health behaviours in health promotion. This unbalanced
5219 reporting led them to be critical. For example with cannabis, or 'weed',
5220 Carl (16, M) felt that "…*they never put down the positives*" and pointed
5221 out that "*there haven't been any recorded deaths for weed*" which was a
5222 good reason to not worry about the health implications.

5223

5224 The young men also viewed the media as exaggerating when it came to
5225 their coverage of health behaviours. This lack of balanced reporting
5226 caused suspicion about the credibility and perceived reliability of health
5227 messages. This means that the meanings taken from health information
5228 that the young men were aware of may not be the same as that
5229 intended by the designers.

5230 The young men were sceptical about government reporting about
5231 health issues due to perceived contradictions in messages and political
5232 debate. Carl (16, M) pointed out that when the government are:

5233 *"…trying to stop someone from smoking, half of them*
5234 *don't want to cos they earn so much money out of it,*
5235 *and the other half that do want it to stop, it's not cos*
5236 *of the bad health, it's just, someone's opinion and*
5237 *someone else's opinion…" (Carl, 16, M).*

5238

5239 Greg (14, M) reflected that:

5240 *"… saying stopping smoking, they (the government)*
5241 *are helping us by not wasting our money and then*
5242 *obviously they're making more money out of it cos*
5243 *they take…something out of everything, every profit*
5244 *that's made don't they, like tax payers money,*
5245 *everything like that, say if a shop makes 200 quid on*

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5246 *cigarettes a day, then the government takes tax out*
5247 *of that cos everything amounts to tax…" so "they're*
5248 *not that bothered…" (Greg, 14, M).*

5249

5250 Greg (14, M) felt that smoking was not that bad because:

5251 *"…if you think about it, it don't cause that many*
5252 *deaths…like my dad used to go through 60 fags a*
5253 *day…some people'll just do it until they die…my*
5254 *grandma, she quit smoking at about late 70s, it*
5255 *caught up when she was 90, she died from it, but*
5256 *that was 20 years later…" (Greg, 14, M).*

5257

5258 James (16, M) felt like the government could do more to support people
5259 to have a healthy diet and lifestyle, such as "*put the prices up of fat*
5260 *foods, fags, beer, anything what can put you weight on, or contains over*
5261 *a certain amount of fat, put the price up…*" but sees them "…*keep*
5262 *building McDonald's*" (James, 16, M). James (16, M) felt that the
5263 government should have some control over McDonald's "…*because*
5264 *they can't keep building them, cos they'll just put weight on, a lot of*
5265 *weight, that's why MacDonald's in America is massive and look at the*
5266 *obesity rates*" (James, 16, M).

5267 *7.2.3 Analysis*
5268 Across both sites, there was a lack of trust in 'official' health information
5269 and the feeling that any information provided needed to be assessed in
5270 relation to how it related to their lives and the people around them.

5271

5272 The young men observed a bias towards the negative impact of health
5273 behaviours. This unbalanced reporting led them to be critical. They also
5274 viewed the media as exaggerating although negative messages about

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5275 drug use tended to be taken more seriously in the case of hard or class
5276 A drugs (such as heroin, crack, or cocaine) which were seen as always
5277 causing death and ruining lives; this did not appear to be applied to
5278 other behaviours.
5279
5280 The young men in both sites had also noticed contradictions in some of
5281 the health information available to them. They could see gaps in logic
5282 around arguments used to limit drug and alcohol use, as well as
5283 smoking. Some of these gaps related to personal experiences or the
5284 experiences of those around them when they had observed situations
5285 that did not align with dominant discourse such as smoking causing
5286 cancer and premature death. Where this information had been seen to
5287 be undermined by their own observations, the young men wondered to
5288 what degree they could trust this information.
5289
5290 Conspiracy theories that they had seen on the internet or mentioned by
5291 those around them also featured as a means of undermining dominant
5292 discourse around, in particular, smoking and cancer. The young men
5293 were suspicious of the tax that the government received from cigarettes
5294 and how this might be a conflict of interests around the push to quit
5295 smoking. The involvement of the pharmaceutical industry in cancer
5296 research also caused doubt about the lack of existence of a cure, and
5297 the conflict of interest implicated in the money made from cancer drugs.
5298

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5299 The perception held by some schools and parents that information
5300 about sex and drugs was not appropriate to this age range seemed to
5301 give this type of information some value, which made it more interesting
5302 to seek out. Some resources providing information about this came
5303 from unreliable sources, such as peers and internet sites, which led to
5304 the proliferation of misinformation.
5305
5306 In particular, the site "Talk to FRANK" was mentioned - "Talk to FRANK"
5307 was set up with the intention of providing honest and impartial
5308 information about drugs. This was received well and reflected the type
5309 of honest dialogue that they valued from family and friends. The young
5310 men appeared to appreciate having their curiosity rewarded with
5311 honesty and valued sources of information that were perceived to be
5312 unbiased and treated them as adults.
5313

5314 ## 7.3 How do the young men respond to these health messages?

5315 This section addresses the research objective within the third aim, to
5316 consider how the young men respond to the health discourse available
5317 within each site. There were some themes around the ways in which
5318 the young men in both sites responded to the health discourse that they
5319 were exposed to. This includes observations of the neutralisation of
5320 dominant discourse and the repurposing of some of the discourses as a
5321 way to rationalise other behaviours.

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5322 ### 7.3.1 Neutralisation of dominant discourse

5323 #### *7.3.1.1 City*

5324 An example of the neutralisation of dominant discourse in the city site
5325 was in reference to units of alcohol where the young men preferred to
5326 work out their own 'tolerance' rather than adhering to recommended
5327 units. Giles knew "…*what a glass of wine will do to me, I know what a*
5328 *beer will do to me, I know what a shot of vodka will do to me*". With
5329 drinking, people's 'tolerance' to alcohol was seen as individual and how
5330 much someone should drink was seen as depending on the
5331 person. Giles (14, C) thought that "…*you need to know your*
5332 *boundaries*…" and should stop when you are "…*sort of not too drunk*
5333 *but not not drunk"*.
5334

5335 There appeared to be come confusion for Giles as to what appropriate
5336 levels of alcohol use might be. Giles (14, C) commented that:

5337 *"…alcohol and drugs are worse than smoking cos*
5338 *smoking is a minor effect on you, and you can smoke*
5339 *and still function in society… people can smoke and*
5340 *be functioning in society, not kind of drop-out" (Giles,*
5341 *14, C).*

5342

5343 Simon (17, C) was "…*not saying that it's good to smoke but it's not bad*
5344 *to smoke either cos…one fag won't hurt you…*" (Simon, 17, C). Simon
5345 (17, C) also got angry about messages about smoking;

5346
5347 *"if smoking's bad and you ban it from public spaces,*
5348 *what about drinking, or drugs, you're thinking, people*
5349 *are selling drugs normally and they get done for it*
5350 *because they're selling drugs but you're thinking,*
5351 *people will get drunk, people will end up going home*
5352 *drunk, they'll probably end up like abusing their*

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5353 *partners or something like that, so, that's basically*
5354 *saying 'oh yeah, smoking's not as bad as going,*
5355 *getting drunk and going back and smacking up your*
5356 *partner and stuff like that'…it's like they're basically*
5357 *saying 'oh yeah, smoking will kill you off but drinking,*
5358 *yeah you can go drink, get pissed, go back home*
5359 *and do what you like!' it just doesn't make*
5360 *sense…what is the government thinking?!" (Simon,*
5361 *17, C)*
5362

5363 This also applied to smoking were some of the young men in the city
5364 felt that the risks here had been exaggerated. Simon (16, C) felt that
5365 smoking was not as bad as it is made out to be because:

5366 *"…when it comes to thinking about smoking…my*
5367 *dad has smoked since he was…a teenager, and that*
5368 *was like 40 years ago, he's an old man!...he's still*
5369 *going and he's alright, like he gets the occasional*
5370 *heart burn but that's probably because he eats too*
5371 *much food" (Simon, 17, C).*

5372

5373 Simon's "…*dad's smoked since he was young, even when my mum*
5374 *was pregnant, and the thing is, my family's turned out alright*" (Simon,
5375 17, C). It was money that was the biggest issue for Simon because you
5376 can spend "…*6 quid on fags for 20 fags*" (Simon, 17, C) which was
5377 seen to be expensive.

5378

5379 Simon (16, C) also challenged the idea that smoking caused lung
5380 cancer because of his uncle who did not smoke but:

5381 *"…worked in a timber place and the amount of*
5382 *smoke from that came, and he had lung*
5383 *cancer…working in a timber place, cos you get more*
5384 *harmful smoke from all that burnt wood or burnt*
5385 *plastic and everything, whereas fags, you can smoke*
5386 *for years and years…" (Simon, 17, C).*

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5387 The young men in the city generally subscribed more closely to
5388 suggested guidance on health behaviours. There was less evidence of
5389 the inclusion of commonly held myths around certain behaviours, such
5390 as safe sex (standing up after sex, douching after sex to remove
5391 sperm). The social lives of the young men in the city were also less
5392 reliant on the use of smoking, drinking alcohol, or substance use than
5393 the young men in Minetown. Some of this was linked to economic
5394 capital where the young men had some disposable income to go
5395 shopping, to the cinema, and participate in other leisure activities.

5396 *7.3.1.2 Minetown*

5397 For the young men in Minetown, the wide social acceptability of drinking
5398 in the adults around them was seen to undermine health education
5399 messages around units of alcohol. Making mistakes and having bad
5400 experiences with alcohol was seen as a rite of passage, part of a
5401 learning experience to help them transition into more 'responsible'
5402 drinkers. The young men did not know a lot about units of alcohol and
5403 what this meant but they were more interested in their subjective use of
5404 alcohol.

5405

5406 Greg (14, M) talked about his drinking and said that he did not "…*drink*
5407 *that much…probably…every few weeks, but not a lot…probably have a*
5408 *4 pack to meself*" (Greg, 14, M). Greg (14, M) thought that "*a man's*
5409 *average unit is 4 units...about 2 pints*" but was aware that he was
5410 having about "…*4 pints…*" when he drank "…*but I am not a man so I*
5411 *should be on the women's and the women's units is 3 units, so I'm*
5412 *going a lot over it…*" (Greg, 14, M). Greg (14, M) reasoned that this was

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5413 okay because he doesn't "…*get drunk, I'll sit there, I'll have 4 cans and*

5414 *I'll neck 'em but I won't be drunk, I'll be a bit tipsy*" (Greg, 14, M).

5415

5416 For Greg, the best way of knowing if he had drunk too much was not

5417 referring to units, but whether he was drunk, and he knew this from trial

5418 and error; "*say if I went out and had 8 cans and I was absolutely pissed*

5419 *out my face, I wouldn't drink that much again, I'd limit meself*" (Greg, 14,

5420 M). The fact that he as having too many units was not a problem

5421 because he was "...*having fun at the end of it…so as long as you're*

5422 *making no mistakes it's good innit…"* and that people exaggerated how

5423 people behave when they are drunk because not everyone does

5424 "…*stupid stuff when [they're] drunk"*.

5425

5426 James (16, M) also reported knowing his limit for alcohol and that he

5427 stopped drinking:

5428 > *"…as soon as I can feel it...I have 2 pints of water, let*
5429 > *that settle in, go to the toilet for a few times and then*
5430 > *just start again if I need to, sometimes I don't need*
5431 > *to" (James, 16, M).*

5432 In the area of sex education, myths and rumours appeared to be rife.

5433 Examples of this included Dr Pepper killing sperm, and having sex

5434 standing up avoiding pregnancy. These myths were often

5435 operationalised in order to neutralise dominant discourse and present

5436 the illusion of knowledge around an area. Another example of personal

5437 evidence neutralising dominant discourse was around condom use.

5438 Condom use was very low among the young men in Minetown. James

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5439 (16, M) talked about his experience of not using condoms; he reported

5440 that he did not use condoms:

5441 *"…because I've learned from, my mistakes, I only go*
5442 *with people who haven't had sex, or I know the*
5443 *people they've been with…people who are clean,*
5444 *and you know they're clean…I'd only do it with*
5445 *people who've shagged someone who's clean"*
5446 *(James, 16, M).*

5447

5448 Pregnancy was not a concern because "…*a lot of people here now*

5449 *have got implants, everyone has, literally anyone who is involved in that*

5450 *has got implants*" (James, 16, M).

5451

5452 James (16, M) reported that did not know if it was better without a

5453 condom "*cos I've never tried one*" (James, 16, M). James (16, M)

5454 reported that:

5455 *"…people who have tried (condoms) always say*
5456 *they're not worth it and stuff like that, and basically it*
5457 *gets into your head that you don't need to try*
5458 *them…they say it just takes the feeling away and*
5459 *stuff like that" (James, 16, M).*

5460

5461 James would use a condom "*if I went on holiday to Ibiza or something*"

5462 when he did not know who they had sex with. This method has worked

5463 for James (16, M) and his evidence was that he has been sexually

5464 active since he was twelve and has recently "…*had 5 medicals and*

5465 *they've checked then, they do everything on my body…and they said*

5466 *everything's fine*" (James, 16, M).

5467

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5468 The taking of class A drugs like cocaine, heroin or M-Cat was seen as

5469 much more serious than cannabis; this may serve to allow for

5470 neutralisation (Sykes and Matza, 1957) where cannabis is not seen as

5471 being a 'real drug' in comparison. For example, in a conversation with

5472 Kevin (14, M), a distinction was made where cannabis was not

5473 considered as a drug:

5474

5475 *Researcher: So we're just talking about drugs*
5476 *Kevin: Oh, drugs, Oooh!*
5477 *Researcher: Why Oooh!*
5478 *Kevin: Everyone's done drugs in here, except from X*
5479 *and me*
5480 *Researcher: So you don't take drugs?*
5481 *Kevin: Well, I do, but not bad drugs*
5482 *Researcher: What's the difference between bad*
5483 *drugs and okay drugs?*
5484 *Kevin: Well cannabis*
5485 *Researcher: So that's not a bad drug*
5486 *Kevin: No, you can use it for medical reasons, so…*

5487

5488 Kevin (14, M) had heard about cannabis for medical use from an adult

5489 cartoon called 'American Dad':

5490 *"…He's having loads of, err, err, how can I say*
5491 *it...basically, having a wank loads round the house*
5492 *and then he's got that problem, that, where he gets*
5493 *depressed, so they give him bud, give him cannabis."*
5494 *(Kevin, 14, M).*

5495

5496 Cannabis was also not seen as being addictive "*like fags is*" (Jamie, 12,

5497 M). Kevin (14, M) commented that "*when I started smoking, at 11, I*

5498 *didn't even know that it was a drug, that smoking was a drug*" and that if

5499 he had "*It would have changed how I thought about it.*"

5500

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5501 For James (16, M), there also seemed to be a difference in the reasons

5502 that people took drugs that may neutralise dominant discourse. For

5503 James (16, M), there seemed to be a difference between people who

5504 took drugs due to difficulties in their lives, and those who had lost

5505 control and whose behaviour was unacceptable. One of his friends

5506 "*…smoked weed…*" because:

5507 *"…his dad's paralysed, his mum and step dad have*
5508 *just fell out, so now he's with this mum he has to*
5509 *spend 2 days with his dad, 2 days with his mum, 2*
5510 *days with his step dad, so he's all over the shop, but*
5511 *then that's why he smokes weed all the time, to chill*
5512 *him out" (James, 16, M).*

5513

5514 James was not overly bothered about people who smoked cannabis

5515 "*…cos everyone really does it, a lot of people do it, but, when it starts*

5516 *getting worse like Cat and stuff like that, it makes you wonder why*"

5517 (James, 16, M). It appeared as if some behaviour could be explained or

5518 excused by circumstance, whilst others could not.

5519 *7.3.1.3 Analysis*

5520 There was a lack of trust in health information across both sites and the

5521 feeling that any information provided needed to be assessed in relation

5522 to how it related to their lives and the people around them.

5523 The behaviour of the adults around the young men in each site served

5524 an example as to what behaviour could be excused. This also

5525 undermined some official discourse about the safety of such

5526 behaviours. Adults who smoked or drank themselves were not seen as

5527 qualified to judge their use of such substances.

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5528 In Minetown there was also a narrative around rites of passage, and the
5529 necessity of engaging in some behaviours as a means of learning to
5530 navigate them yourself and make your own decisions.
5531
5532 Information based on personal experience was privileged; this could be
5533 from people they did or did not know personally. The young men also
5534 applied this to the knowledge they had gathered from their own health
5535 behaviours and were prone to privilege their own experience over other
5536 health information. Although the young men knew about units of
5537 alcohol, this was seen to be a more personal issue, where different
5538 people had different tolerances. In Minetown, this was also the case
5539 with sex, where the existence of sexually transmitted infections was
5540 seen as proof of the success of sexual practices. This supported
5541 personal evidence that condoms were unnecessary.
5542
5543 There was also a hierarchy applied to the use of drugs, alcohol and
5544 cigarettes as means of legitimising certain behaviour in relation to
5545 others. There was a distinction made between ‘bad drugs’ and cannabis
5546 in Minetown – cannabis was associated with potential medical uses, no
5547 evidence of causing death, and seen as less addictive than smoking
5548 cigarettes or drinking alcohol. Smoking cigarettes and drinking alcohol
5549 were seen as potentially less harmful than other coping strategies such
5550 as anger, violence, or stress. Smoking was not seen as being as bad as
5551 drinking alcohol and using drugs due to the fact that someone who was
5552 smoking could still function in society. These comparisons acted as a

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5553 way of neutralising some of the negative messages associated with the

5554 behaviours.

5555 7.3.2 Repurposing of messages around balance and moderation

5556 *7.3.2.1 City*

5557 Health was seen as complex, and Robert (16, M) thought that health

5558 was "…*not a straightforward question…cos obviously there are so*

5559 *many different aspects of health and different people that you have to*

5560 *consider*" (Robert, 16, M). Robert (16, M) described a friend who

5561 "*experiments a lot with things like drugs and alcohol*…" which he:

> 5562 *"…wouldn't class that as healthy at all…cos it ruins*
> 5563 *you from the inside out…at the same time she's very*
> 5564 *active in terms of gym and stuff like that, then I've got*
> 5565 *other people that are the other way round…that*
> 5566 *won't take part in anything physical at all but in terms*
> 5567 *of lifestyle and food choices and stuff like that they*
> 5568 *are very self-conscious and healthy" (Robert, 16, M).*

5569

5570 Robert (16, M) thought that "…*it's just trying to find a balance, or which*

5571 *classes as balanced*…" (Robert, 16, M).

5572

5573 Giles (14, C) was confused about if it was possible to drink alcohol in

5574 moderation; on one hand he thought that:

> 5575 *"…alcohol is something that you don't do in compete*
> 5576 *moderation ever, I don't think anyone really*
> 5577 *moderates their drinking, they say they'll have one*
> 5578 *pint and they'll have like, three, or they say, 'I'll have*
> 5579 *one glass of wine' and they have half a bottle' (Giles,*
> 5580 *14, C).*

5581

5582 However, Giles (14, C) also reasoned that he did not think alcohol

5583 consumption was:

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5584 *"…dangerous as long as you do it in moderation, or*
5585 *on those special occasions…or one glass every night*
5586 *or half a bottle every night actually, cos that doesn't*
5587 *make you an alcoholic…these people that [he*
5588 *knows] that would have half a bottle of wine every*
5589 *night could go without it…" (Giles, 14, C).*

5590

5591 When asked what was worse – smoking, drugs or alcohol – Giles (14,

5592 C) commented that "…*alcohol can be worse…if you drink to excess it's*

5593 *worse than smoking*…" (Giles, 14, C). According to Giles (14, C)

5594 though, it did depend on how much you smoked; a pack of twenty

5595 cigarettes was the amount given that would start to cause a problem:

5596 *"…which is more than I have. I usually have like five*
5597 *a day, or six, so it's not too many…so I think that…if*
5598 *you did it over ten years…that would detriment your*
5599 *health less than if you drink excessively over that*
5600 *amount of time, or if you did hard drugs excessively*
5601 *for that amount of time" (Giles, 14, C).*

5602

5603 Giles (14, C) continued that smoking five or six cigarettes a day would:

5604 *"…do damage over your lifetime, cos it stacks up*
5605 *but…if I was drinking…equivalent to what I was*
5606 *smoking…it would be worse…cos then [he'd] be an*
5607 *alcoholic" (Giles, 14, C).*

5608

5609 For Giles (14, C) "…*any amount of drugs…would be worse (than*

5610 *smoking) cos I would be addicted to that and it would kill me in the end*"

5611 (Giles, 14, C).

5612

5613 Andrew (16, C) found smoking to be a way to control his hunger, and

5614 therefore his weight which helped him avoid gaining weight. For Andrew

5615 (16, C), smoking was not as bad as being overweight. Having said this,

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5616 Andrew was also using E-cigarettes (e-cigs) as a way to help him quit

5617 smoking. Andrew (16, C) reported that he used these because:

5618 *"…they've got less…nicotine in…they're*
5619 *healthier…they've not got the tar, poison and bleach*
5620 *and, but I think smoking in general's just bad*
5621 *anyway, it's a bad habit" (Andrew, 16, C).*

5622

5623 Robert (16, C) thought that smoking was less of an issue that drinking

5624 and taking drugs because:

5625 *"…problems with drugs will kind of tend to stem a lot*
5626 *quicker than things from smoking, for example*
5627 *smoking…takes longer before it can make a*
5628 *difference and for a lot of people it doesn't make a*
5629 *difference, obviously statistically like the whole things*
5630 *like lung cancer, that's what people are scared of,*
5631 *resulting from smoking, but at the same time a lot of*
5632 *people that will go through smoking will not have any*
5633 *of those problems, the thing with alcohol, I'd only put*
5634 *that above smoking really because its immediate*
5635 *effect and it becomes more dangerous as an*
5636 *immediate rather than a long term thing, but it has a*
5637 *long term impact as well" (Robert, 16, C)*

5638

5639 *7.3.2.2 Minetown*
5640 Chris (12, M) thought that, although alcohol could do quite a lot of

5641 damage, it might be okay to drink:

5642 *"once every few months, maybe at a party or*
5643 *something, have a few drinks then, as long as you*
5644 *don't have too much and get yourself drunk all the*
5645 *time, you'll be alright cos it wouldn't harm you that*
5646 *much and your body would be able to repair in the*
5647 *time if it does, so that'd be alright." (Chris, 12, M).*

5648 Mark and Carl (16, M) were using e-cigs as a way to quit smoking and

5649 improve their fitness. They were worried about the health of e-cigs

5650 because "…*apparently it's just like putting water into your lungs*" (Mark,

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5651 16, M) and "…you could drown your lungs (Carl, 16, M). A friend had

5652 told them this, although Mark (16, M) had countered that:

5653 *"…it (smoking e-cigs) was healthier than smoking*
5654 *and he said 'not really cos you're putting water in*
5655 *your lungs, so [he'd] rather do that and have my*
5656 *lungs do their job, they're going to do their job with a*
5657 *bit of water aren't they" (Mark, 16, M)*

5658

5659 For Mark and Carl (16, M) it was about choosing the best option health

5660 wise. Alcohol was seen as worse than smoking weed because:

5661 *"…it makes you in an angry state sometimes, if*
5662 *you're all over the place you can be sick, you don't*
5663 *know what you're doing, and it can damage your*
5664 *livers or kidney or whatever" (Kevin, 14, M).*

5665 Smoking cigarettes was also seen as worse than smoking weed. Kevin

5666 (14, M) thought that if you used a "*bong pipe"* as a way to avoid using

5667 tobacco, then this would be a "*healthier"* way of smoking weed,

5668 although it might be "*a lot stronger*".

5669

5670 The law also came into decisions about which behaviour was worse.

5671 James (16, M) has "…*always thought that drinking is better than*

5672 *smoking weed, just for the fact that when you're 18, drinking's legal, but*

5673 *at any age weed isn't…*" (James, 16, M). Kevin (14, M) thought that

5674 cannabis was "…*better than alcohol, cos it's easier than alcohol but it's*

5675 *illegal and alcohol isn't*". James found it difficult to understand the

5676 rationale behind this law.

5677 Kevin (14, M) would change the law to make alcohol illegal and

5678 smoking cannabis legal, although he would put an age limit on smoking

5679 weed; "*18, no, 16, no, about 17, 16, but younger if you've got cancer or*

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5680 *something, any age with cancer*" (Kevin, 14, M). It was interesting to

5681 note that Kevin (14, M) was under the age that he had given for

5682 smoking cannabis; he made this decision because he thought that he

5683 "…*can't handle it as much as I would when I'm older…*" (Kevin, 14, M)

5684 *7.3.2.3 Analysis*

5685 The young men in both sites observed some things being described as

5686 either healthy or unhealthy and appeared to prefer a discourse around

5687 balance and moderation. This was due to the fact that health was seen

5688 as something complex that required a balance.

5689 Within a hierarchy of health-related behaviours, some behaviours were

5690 seen as being worse than others, such as smoking cigarettes, using

5691 drugs, or drinking alcohol. A variety of different rationales were given for

5692 this. The young men described how they could offset the use of

5693 potentially harmful behaviours by managing their health more closely in

5694 other areas, such as through diet and exercise.

5695

5696 There was also a belief that engaging in one or two of these more

5697 harmful behaviours represented moderation, especially in the context of

5698 being a healthy weight. People who were seen as engaging smoking

5699 cigarettes, drinking alcohol, and taking drugs were not seen as able to

5700 moderate or balance their behaviour and were therefore judged

5701 negatively. The use of cannabis was the only drug that was deemed

5702 acceptable, and the use of any other drug was viewed as cancelling out

5703 any healthy behaviours, and potentially causing death.

5704

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5705 Some of this could be due to the inconsistency of health messages
5706 received, and an attempt to make sense of some of the perceived gaps
5707 in information.

5708 Conclusion

5709 There were two key overarching themes identified in this chapter.
5710 The young men appeared to respond to health information by using
5711 techniques to neutralise dominant discourse and repurposing these
5712 messages to meet their own needs. They also subscribed to a
5713 discourse of balance and moderation to allow for the engagement in
5714 behaviours sometimes considered harmful, as long as they balanced
5715 this with more positive health behaviours.
5716

5717 The young men described health campaigns such as the 5 a day or
5718 Change 4 Life as too pushy and as having negative effects on their
5719 mental health and self-esteem. Information based on personal
5720 experience was privileged; this could be from people they knew
5721 personally or the written personal accounts they found online at sites
5722 such as “Talk to FRANK”. The young men also applied this to the
5723 knowledge they had gathered from their own health behaviours and
5724 were prone to privilege their own experience over other health
5725 information; an example of this was in reference to units of alcohol
5726 where the young men preferred to work out their own ‘tolerance’ rather
5727 than adhering to recommended units.
5728

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5729 The young men appeared invested in a discourse more around balance
5730 and moderation. For them, this related mainly to eating behaviour
5731 where they viewed a 'healthy' diet as being one that could include
5732 'unhealthy' foods. Balance in eating was seen as preferable to a strict
5733 diet. Health was also viewed as a balance of behaviours where
5734 engaging in one unhealthy behaviour did not necessarily make
5735 someone unhealthy.
5736
5737 Some health behaviours were judged as worse than others, for example
5738 drugs and alcohol were seen as worse than smoking, with cannabis
5739 tending to be on a level with smoking. There was a split made between
5740 cannabis and other 'hard' drugs which were seen as always bad.
5741 Smoking only became an issue when it reached over twenty a day
5742 which was deemed to be an excessive amount. The cost of smoking
5743 was also seen as more of an issue that the health implications.
5744
5745 Unhealthy behaviours such as smoking, drinking, drug taking, and
5746 violence were situated on a continuum with some behaviours being
5747 worse than others. The level of assessing this was around the ability to
5748 function productively in society; this is why smoking was seen as less of
5749 an issue, although the detriment to long term health was acknowledged.
5750
5751 This chapter has addressed the third of the research aims: to examine
5752 what influences young men's perspectives on health and a healthy
5753 body. This chapter has looked at the forms of health education and

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5754 knowledge that are accessed by young men and their perspectives on
5755 these as well as how the young men respond to these messages. The
5756 thesis will now move on to consider this in more detail in reference to
5757 the contribution that these chapters make to the body of evidence.
5758

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5759 # 8.0 Discussion

5760 This chapter will consider the contribution that this research makes to
5761 the body of evidence explored in the literature review in chapter three.
5762 This will also address the final research objective to consider the
5763 importance of context in the understanding of health for the young men.
5764 It will consider how the findings of this study confirms those of previous
5765 research as well as identifying where the study adds to, or contradicts,
5766 previous findings. The chapter will conclude by addressing the
5767 implications for policy, research, and practice arising from the findings
5768 of this research.

5769 ## 8.1 Key findings

5770 This study looked at the ways in which young men constructed ideas
5771 about health and a healthy body in two contrasting locations – a facility
5772 for young people in a city centre and a youth club in an ex-mining town.
5773 As explored in chapter five, the history and context of each site was
5774 very different.
5775
5776 This research aimed to better understand young men's perspectives on
5777 health and health information, and to explore how this may differ
5778 depending on context. The study also examined what influences young
5779 men's perspectives on health, as well as how young men respond to
5780 the forms of health information and knowledge with which they are
5781 confronted (for example, strategies of assimilation, contestation and
5782 resistance (McGillivray, 2005). Using two locations for data

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5783 collection has highlighted how such responses can differ depending on

5784 context.

5785

5786 The study explored the topics the young men in each site raised in

5787 relation to health, and how they conceptualised different approaches to

5788 ‘being healthy’.

5789

5790 The key themes that were identified as being important to health were:

5791 were the privileging of mental health over physical health, particularly in

5792 relation to the importance of happiness; belonging within family and

5793 friend groups and the behaviour that might facilitate this; and how they

5794 coped with life through means of the emotional support they needed

5795 and could access through professional services, family, friends and use

5796 of smoking, alcohol, and substances.

5797

5798 Interestingly, it was found that location was highly influential, in that the

5799 young men’s levels of education and socioeconomic status was quite

5800 different in each site, and this appeared to affect the capacity for

5801 communication and support around health.

5802

5803 It is a finding of this study that these differences were related to the

5804 available and dominant discourses within the youth provision sites.

5805 There were key similarities, however, in how the young men appeared

5806 to make sense of these discourses and embody them as part of their

5807 lives.

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5808 The interviews conducted with young men also revealed that there was
5809 a lack of trust in ‘official’ health information, underpinned by the belief
5810 that official information needed to be assessed in relation to how it
5811 related to their own lives and those of the young people around them.
5812 The young men often responded to the health information available to
5813 them by using techniques to neutralise the dominant discourse, thus
5814 repurposing ‘official’ messages to meet their own needs. The young
5815 men also privileged information taken from personal their own
5816 experience over other health information that they perceived to be
5817 biased.
5818
5819 The young men had all internalised stigma towards mental health and
5820 obesity from the discourses to which they have been exposed. This
5821 shows that some information is permeating, but not allowing for a more
5822 nuanced representation of health that allows the young men to
5823 understand the messages that are being communicated to them, and
5824 the purpose of these.
5825
5826 Context was observed to be a key factor in how the young men in this
5827 study understood and embodied health. Their ability to critically
5828 consider health information appeared influenced by the discourses
5829 available to them. The similarities in how the young men made sense of
5830 the health-related information available to them appear to be more
5831 marked than the differences. The main differences appear to exist in the
5832 availability of identities available to the young men in each site, and

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5833 associated health-related behaviours. This relates more closely to the
5834 health-related behaviours that are considered less masculine,
5835 particularly in the areas of mental health and support networks.
5836
5837 This will be discussed in more detail within this chapter by considering
5838 what influences young men's perspectives on health as well as, how
5839 they respond to health information followed by consideration of the
5840 implications of context on this. The chapter will conclude by applying
5841 this findings to policy, research, and practice.
5842
5843 The next section will consider the ways in which the findings of this
5844 research contribute to the existing body of evidence around young men
5845 and their perspectives of health.

5846 8.2 What influences young men's perspectives on health?

5847 There has been a dearth of research that considers young men's
5848 perspectives on the concept of health; this study was different to the
5849 similar studies in that it allowed the young men themselves to guide
5850 conversations around health, rather than focussing on health-related
5851 topics selected by the researcher. However, a significant study that did
5852 allow young men to express their own ideas was that of Randell et al.
5853 (2016a), who aimed to explore how adolescent boys understand the
5854 concept of health and what they find important for its achievement.
5855
5856 The young male participants in the Randell et al.'s (2016a) study mainly
5857 understood health as an emotional and a relational experience. When

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the young men interviewed by Randell et al. (2016a) referred to their own health experiences and how they dealt with their health, they viewed the emotional and relational mind and the functional body as different, with physical health considered as less important. Health was considered as an emotion, that one could ‘feel’ health (Randell et al., 2016a). Major influences to experiencing health as an emotion were identified; these included: the presence of positive emotions, experiencing self-esteem, and balance in life, trustful relationships, and having a sense of belonging (Randell et al., 2016a).

Data collected for this current study support Randell at al’s findings that young men conceptualise health as primarily a relational and emotional experience, where the impact of physical health seems to be of lesser importance. The young men in the city site viewed mental health as accounting for more than half of overall health. The young men in Minetown described how starting smoking cannabis had allowed them to cope with some of the anger that they felt; this meant that they were less likely to get into trouble with the police. In their view, the physical implications of smoking cannabis were worth the risk due to the ability to cope with some of the difficult emotions. This is reflected in the talk in mental health and support networks where the activities that helped them bond in ways that were appropriately masculine also allowed them to access emotional support.

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5882 Spencer (2015) is another researcher who allowed young people to
5883 guide the research questions according to the areas that they defined
5884 as pertinent to their health. Spencer's research was not included in the
5885 literature review because the results did not differentiate between the
5886 results gathered from the young men and young women who
5887 participated in the study. However, in findings similar to Spencer
5888 (2013a), the young men highlighted the positive aspects of their health
5889 in terms of being happy and having fun. This also relates to the
5890 privileging of the emotional elements of health.
5891
5892 The young men in both sites valued their right to choose how they
5893 practiced health, along with the importance of enjoying themselves,
5894 regardless (and often in full knowledge) of the possible consequences.
5895 It seemed that the costs of some behaviours (such as smoking) often
5896 outweighed the risks (anger and isolation). This behaviour relates to
5897 theories around the neutralisation of risk, where health-related
5898 behaviours that they engaged in as an attempt to cope with negative
5899 feelings were seen to be seen as less problematic than mental ill health.
5900
5901 Moving on to consider the second aspect of Randell et al.'s (2016a)
5902 findings, that health is relational, the researchers found that health was
5903 experienced through interaction with others for the young men that they
5904 interviewed. Such interactions centred on relationships at home, in the
5905 immediate environment, and in the community setting. The quality of
5906 relationships, in particular feeling part of a group, was found to

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5907 contribute to the overall health experience. This links to the findings of
5908 the current study where being happy and having friends were rated as
5909 strongly linked to perceived importance for mental health in both
5910 locations, and in particular for the young men in Minetown.
5911
5912 Within the current study, health information based on personal
5913 experience was privileged; this could be from people the participants
5914 did or did not know. This was observed in the young men's talk about
5915 smoking in both sites, where they had observed people who
5916 contradicted the key messages that they had received about smoking
5917 causing cancer and premature death. The young men in this study were
5918 prone to privilege their own experience over other health information; an
5919 example of this was in reference to condom use where their rationale
5920 for continuing to have unprotected sex was that they had been able to
5921 assess girls as 'clean', and therefore avoid STIs.
5922
5923 This section has considered the factors that influence young men's
5924 perspectives on health. Within this study, there were some similarities
5925 between sites in the way that emotional health was privileged over
5926 physical health. The young men in each setting appeared keen to
5927 balance this with their right to make informed decisions around health,
5928 knowing the risks. Personal experience was a key factor in assessing
5929 risk, as well as the legitimacy of health information available to them.
5930 The next section will examine the ways that the young men in this study
5931 responded to health information.

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5932 ## 8.3 How do young men respond to health information?

5933 This study was interested in how young men respond to the forms of
5934 health information and knowledge with which they are confronted. The
5935 young men in this study used different ways of assimilating, contesting,
5936 and resisting health information depending on the discourse available to
5937 them in each setting. This section will offer discussion around the
5938 strategies of assimilation, contestation, and resistance utilised by the
5939 young men in each setting.

5940

5941 With regard to finding out about issues related to health, GPs were
5942 seen as a source of trust-worthy information but were often not
5943 accessed due to embarrassment. This supports the findings of Litras et
5944 al. (2015). Young men within the current study identified that their
5945 existing health knowledge came from various sources including family,
5946 the Internet, friends and pornography. However, the young men viewed
5947 information obtained from the internet, friends and pornography as
5948 potentially unreliable. This supports the findings of a number of the
5949 papers identified in the literature review (Akre et al., 2010; Arrington-
5950 Sanders et al., 2015; Litras et al., 2015; Best et al., 2016). The young
5951 men discussed needing to critically consider this information against
5952 what they already knew, as well as ways that they could do this.

5953

5954 Litras et al. (2015) found that young people often believe that sex
5955 education they have received in school did not meet their psychological
5956 needs nor was of practical use in sexual activity (Arrington-Sanders et

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5957 al., 2015). Some of the young men in Minetown suggested that they
5958 watched pornography for information due to dissatisfaction with the sex
5959 education undertaken in school.
5960
5961 Dawson, Gabhainn, and Macneela (2019) explored the pornography
5962 viewing habits of Irish university young people and found that that
5963 dissatisfaction with school-based sex education did not predict
5964 pornography use for sexual information; they also found that the use of
5965 pornography for sexual information did not lead to greater satisfaction
5966 with current sexual knowledge, rather an interest in finding more
5967 information.
5968
5969 Dawson et al. (2019) concluded that young people may use
5970 pornography for information regardless of their perceptions of the sex
5971 education that they received in school. This highlights the importance
5972 of supporting young men to become critical consumers of the
5973 pornography that they access (Dawson et al., 2019).
5974
5975 The personal experiences of people that they knew did inform the
5976 young men's understanding of health, although this was not accepted
5977 without consideration. However, myths and rumours could become
5978 assimilated into their 'knowledge' such as Dr Pepper killing sperm, and
5979 having sex standing up avoiding pregnancy; there appeared to be little
5980 critical thought around some of these beliefs despite acknowledging
5981 that the reports of friends and peers could be unreliable. Some of the

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5982 decision around what to accept appeared to be dependent on what
5983 provoked least cognitive dissonance (van Veen et al., 2009).
5984
5985 Maslow describes how “we can seek knowledge in order to reduce
5986 anxiety and we can also avoid knowing in order to reduce anxiety”
5987 (Maslow, 1963, p.122). Festinger (1957) demonstrated that under
5988 certain circumstances people prefer to seek out information that fits with
5989 their current knowledge. When people lack sufficient motivation to
5990 engage in health behaviours that do not fit into their current lifestyles,
5991 they may develop attitudes that would cast the avoidance of such health
5992 behaviours in a positive light (Ent and Gerend, 2016). Such attitude
5993 change can be a strategy to reduce dissonance (Van Veen et al., 2009).
5994
5995 Ent and Gerend’s (2016) research suggested that people may engage
5996 in dissonance reduction strategies when they perceive that their future
5997 health behaviours may be at odds with their current attitudes; this
5998 research also suggests that people may also attempt to reduce
5999 dissonance by adopting unfavourable attitudes toward health-promoting
6000 actions. The young men in the city address this directly and mentioned
6001 the fact that they would change their behaviour as they aged, as they
6002 were aware that there capacity to manage such behaviours as
6003 overeating may change. The young men in Minetown navigated this
6004 issue more implicitly with attempts to adopt unfavourable attitudes
6005 towards the motivations of health-promoting actions.
6006

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6007 With regard to information found on the internet, the NHS and BBC
6008 were seen as the most likely to be trustworthy websites to gain
6009 information from. However, even within such 'trustworthy' sources, the
6010 young men felt there was a bias stressing the negative impact of 'risky'
6011 health behaviours. Such unbalanced reporting led them to be critical of
6012 'official' sources, and to question the relevance of such information to
6013 their own lives. The website "Talk to FRANK" was cited as an example
6014 of a resource that was considered to be more 'honest' in that it
6015 presented what was perceived to be a more balanced picture of drug
6016 use, that acknowledged potential 'positive' benefits of drug use.
6017
6018 It seems that the young men responded to the dominant discourses in
6019 each site in ways that may have not been intended by health promoters.
6020 With particular reference to obesity discourse, it appears that the young
6021 men are taking on simplified message that being fat is bad rather than a
6022 more nuanced picture. This also relates to how this information is
6023 communicated and taught in schools and in the youth provision sites. It
6024 is perhaps the case that the messages communicated, or the way that
6025 the messages are communicated, lack the clarity needed to enable the
6026 young men to make informed decisions, or take on the intended
6027 message. The young men appear to be gleaning the 'highlights' from
6028 the health information without appropriate guidance on how to
6029 incorporate these into their health practices.
6030

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6031 The young men in both sites viewed the media as exaggerating risk
6032 certain behaviours such as smoking, alcohol use, and substance use,
6033 although this was less so in the case of drug use. Some categories of
6034 drugs were seen as always causing death and ruining lives, a
6035 judgement that was not applied to other 'risky' behaviours.
6036
6037 Rowling (2006) argued that the over-emphasis on risk in policy and
6038 research has resulted in young people being viewed through the lens of
6039 risk. Brown (2004) also suggested that this has a disruptive effect on
6040 young people's lives. The young men in this study viewed health
6041 information as tending to focus on the problems rather than supporting
6042 them. This appeared to increase the cognitive dissonance they felt
6043 around health information. This reduced the credibility of adults and
6044 health promotion literature (Brown, 2004) at a time when they would
6045 benefit from connection to adults and social institutions (Rowling, 2006).
6046
6047 Piggin and Lee (2011) highlighted the lack of research into the meaning
6048 making that occurs throughout the health research, health policy and
6049 health promotion nexus. Bunton (2006) notes that psychology and
6050 politics are inextricably linked, therefore the politics involved in the
6051 production politics of public health campaigns are important. The DOH
6052 along with various commercial marketing agencies utilised the
6053 principles of social marketing to develop Change4Life (Department of
6054 Health) DoH, 2010). One of the main tactics the Change4Life marketers

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6055 used was the development and dissemination of ‘simple’ messages
6056 (Piggin, 2012).
6057
6058 The young men in this study described health campaigns such as the 5
6059 a day or Change 4 Life as “*too pushy*” and as having negative effects
6060 on their mental health and self-esteem. The young men observed
6061 behaviours within these campaigns as being described as either healthy
6062 or unhealthy and appeared to prefer a discourse around balance and
6063 moderation. The young men showed a preference for, and increased
6064 trust of, more nuanced presentations of health information that
6065 balanced costs and benefits. Their response to what they perceived to
6066 be more simplistic campaigns was to use techniques to neutralise such
6067 discourse and repurpose the messages to meet their own needs. This
6068 can be seen to potentially add to the body of research around
6069 neutralisation (Sykes and Matza, 1957 , Peretti-Watel, 2003).
6070
6071 Peretti-Watel (2003) suggests that contemporary risk culture and risk
6072 profiling leads to the stigmatisation of unhealthy behaviours as ‘risky’.
6073 Peretti-Watel (2003) offers an updated model of Sykes and Matza’s
6074 neutralisation theory, namely risk denial theory. Neutralisation theory
6075 (Sykes and Matza, 1957) and risk denial theory (Peretti-Watel, 2003)
6076 refer to cognitive ways to deal with risky behaviours where people
6077 neutralise the ‘risky’ label using specific techniques.
6078

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6079 Although not a contemporary theory, neutralisation theory (Sykes and
6080 Matza, 1957) is still cited in theory for understanding health behaviours
6081 such as excessive drinking (Durkin et al., 2005 , Banister and
6082 Piacentini, 2006 , Piacentini et al., 2012 , McCreanor et al., 2008) and
6083 cannabis use (Peretti-Watel et al. 2003). Research in the area of
6084 neutralisation theory and health-related behaviours remains limited and
6085 under-theorised (Piacentini, et al., 2012).
6086
6087 Neutralisation theory lists five techniques for accounting for risky health
6088 behaviours. 'Denial of responsibility' is where the person believes that
6089 they are a victim of circumstance and have been pushed or pulled into a
6090 behaviour through forces beyond their control; some of the young
6091 people in Minetown felt that they smoked cannabis and drank because
6092 it was impossible to avoid doing so, particularly if their parents smoked
6093 cannabis and they had been surrounded by it for their whole lives.
6094
6095 'Denial of injury' occurs when the individual denies that their actions can
6096 cause any harm or injury; there was a feeling that the evidence
6097 supporting information about the harm potentially caused by smoking,
6098 for example, was exaggerated.
6099
6100 'Denial of the victim' is where the individual believes that their behaviour
6101 is acceptable or harmless due to the lack of a victim or believes that the
6102 victim deserves it; this refers more to where the young men felt that

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6103 they were misrepresented by some adults and felt that this might
6104 explain their anger towards them.
6105
6106 'Condemnation of the condemners' involves counter attack where the
6107 behaviour is blamed on the motives and behaviours of those that they
6108 feel attacked by; this was raised in relation to school and other adults in
6109 authority who put so much stress on them that they felt they needed to
6110 engage in behaviours like smoking and drinking to cope with this stress.
6111
6112 'Appeal to higher loyalties' occurs through the individual justifying
6113 temporary violation due to the needs of others; this occurred when the
6114 young men felt that their friends needed them, and bonding with them
6115 involved engaging in activities that they could all participate in, such as
6116 drinking at a social occasion.
6117
6118 Peretti-Watel (2003) further developed neutralisation theory into
6119 developed risk denial theory (Peretti-Watel, 2003). Risk denials can be
6120 sorted into three main types. Scapegoating involves identifying a border
6121 between the stereotyped 'them' (risky people) and 'us' (safe people).
6122
6123 The young people who participated in interviews in Minetown belonged
6124 to a group where everyone smoked marijuana but reported that they did
6125 not take other 'bad drugs'. 'Bad drugs' included drugs like MCAT
6126 (Mephedrone). The young men exhibited negative feelings towards
6127 other young people who participated in taking 'bad drugs'. This involved

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6128 a conceptualisation of the unhealthy ‘other’ relative to themselves.
6129 Peretti-Watel (2003) suggests that the ‘condemnation of the
6130 condemners’ is the most suitable technique of neutralisation for this
6131 rationalisation and the young men indeed suggested that people who
6132 would negatively label them for using drugs, smoking cigarettes, or
6133 drinking alcohol could be accused of more harmful behaviours related
6134 to diet and exercise, for example.
6135
6136 Self-confidence refers to the means by which an individual denies a risk
6137 by distinguishing themselves from anonymous ‘others’ because they
6138 have an ability to avoid or control risky situations. The young men were
6139 confident in their ability to control their consumption of substances or
6140 stop whenever their wanted to. Self-confidence was invoked through
6141 the privileging of information based on personal experience; this could
6142 be from people they did or did not know. The young men also applied
6143 this to the knowledge they had gathered from their own health
6144 behaviours and were prone to privilege their own experience over other
6145 health information.
6146
6147 A third way to deny a risk involves comparing it to similar risks that are
6148 already well-accepted. This type of denial tends to create more anxiety
6149 – someone might try and get rid of their anxiety by highlighting greater
6150 risks taken, for example smoking cannabis to manage anger issues or
6151 smoking or drinking alcohol rather than illegal drug use. The young men
6152 were observed to repurpose the discourse around balance and

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6153 moderation to mitigate risk by allowing comparisons to be made
6154 between different behaviours that were often labelled as risky.
6155
6156 Discourse around balance and moderation has traditionally been
6157 associated with food intake. The young men in this research also
6158 applied the idea of balance and moderation to their profile of health
6159 related behaviours. This meant that they theorised that if they drank
6160 alcohol and smoked, but did not take drugs, that this showed
6161 moderation and therefore was healthy. This would also apply to other
6162 behaviours looked at in combination. Some of the young people
6163 considered marijuana as less unhealthy than alcohol, therefore
6164 justifying their own behaviour by comparing it to a riskier one (i.e.
6165 comparison between risks).
6166
6167 This section has discussed the strategies of assimilation, contestation,
6168 and resistance utilised by the young men. They accessed health
6169 information from a variety of sources and discussed the need to
6170 critically consider this against what they already knew, as well as ways
6171 that they could do this. Personal experience was a key way of
6172 measuring the reliability of information, particularly as official health
6173 discourse was experienced as biased, and therefore perhaps
6174 untrustworthy. Risk denial theory (Peretti-Watel, 2003) was offered as
6175 an explanation of how the young men contested and resisted some
6176 health information in relation to risk.
6177

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6178 These findings were also affected by the context in which the young
6179 people lived and accessed the youth provisions. There were a lot of
6180 similarities between the two contexts despite the different demographics
6181 served by the two youth centres. The impact of context will be
6182 discussed in the next chapter.

6183 8.4 What are the implications of context?

6184 As mentioned in the methodology section and chapter one, each site
6185 provided a local social context and met Wenger's (1998) criteria for a
6186 community of practice. The differences in the shared discourses and
6187 behaviours between each site were evident in the results. This section
6188 will discuss the implications of context in more detail by first looking at
6189 both sites together, before going on to individual contexts.

6190 *8.4.1 Context and discourse*

6191 From the literature review, only Randell et al. (2016a, 2016b)
6192 considered the role of context in young men's experiences around, and
6193 understandings of, health. Randell et al., (2016a, 2016b) attempted to
6194 achieve maximum variation in their study by conducting semi-structured
6195 interviews with 33 young men aged between sixteen and seventeen in
6196 three upper secondary schools in a town in Sweden. The findings of this
6197 study also support the finding within the wider literature review on
6198 health behaviours by Lee et al. (2009) that community is an important
6199 influence on health knowledge with schooling, geographical location
6200 and access to capital important.

6201

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6202 The current research found that the language used within the health
6203 discourse available within each site appeared to be a central issue in
6204 the differences in how the young men understood these behaviours.
6205 The young men's understanding of terms like 'mental health' and
6206 'support networks' differed significantly between the sites. The
6207 perceived importance of healthy diet and regular physical activity were
6208 also rated very differently by each site, with the city site rating these
6209 areas as less important. These differences appeared to be related to
6210 the available and dominant discourses within the youth provision sites.
6211 This is related to the post-structuralist concept of discourse.
6212
6213 However, upon exploring the discourse further in Minetown, it appeared
6214 that there were very different views on support networks than in the city.
6215 Even when they understood the term, the young men in Minetown still
6216 did not value formal support networks. It might be more about the value
6217 placed on previous experiences of professional support that informs this
6218 view.
6219
6220 Foucault argues that discourse defines and produces what we know
6221 and governs the way that a topic can be meaningfully talked about
6222 (Hall, 1997). Discourse can also be seen to regulate the behaviour of
6223 others (Hall, 1997). Post-analytic philosopher Wittgenstein stated that
6224 "*the limits of my language are the limits of my world*." (1922, p.74). This
6225 links with discourse as something embedded within the particular social
6226 context. Orwell (1949) discusses this in relation to "Newspeak" in his

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6227 novel *Nineteen Eighty-Four,* where people thought what they were

6228 required to think "...*because the necessary words [to think otherwise]*

6229 *were not available*" (Orwell, 1949, p.249).

6230 *9.4.2 Context and the performance of masculinity*

6231 Adolescent and young adult men have been shown to do poorly on

6232 indicators of mental health demonstrated by increased rates of suicide,

6233 conduct disorder, substance use, and interpersonal violence in

6234 relation to their female peers (Rice et al., 2017).

6235

6236 It has been suggested that adolescent boys and young adult men are

6237 an underserved population in relation to their mental health

6238 needs (Szumilas et al., 2010). The development of mental ill health in

6239 adolescence and emerging adulthood potentially impacts on what is

6240 perhaps the most economically constructive life stage (Gore et al.,

6241 2011). This provides a good socioeconomic rationale for a greater

6242 understanding of mental health in young men.

6243

6244 Randell et al. (2016b) published an additional paper that aimed to

6245 explore adolescent boys' views of masculinity and emotion

6246 management and their potential effects on well-being. This study found

6247 two main categories of masculine conceptions in adolescent boys:

6248 gender-normative masculinity with emphasis on group-based values,

6249 and non-gender-normative masculinity based on personal values.

6250

6251 Both orientations were highly influenced by contextual and situational

6252 group norms and demands. Self-identified gender was found to affect

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6253 how people feel about their body and the ways in which they take up
6254 health discourses. Context was also important in that the relational and
6255 community setting contributes to a person's overall health experience.
6256 This supports the findings within this study and relates to the discourses
6257 available to young men in the contexts in which their find themselves.
6258

6259 Within this research, it was interesting that the researcher found there
6260 to be little or no gap between how the young men in the study
6261 expressed emotions and behaved in the group and in one to one
6262 interviews. This may be due to the subscription to contextual norms
6263 within each setting. It is important to note that each context was
6264 facilitated by youth workers and health workers who modelled a way of
6265 talking about emotions that may have been different to how the young
6266 men experienced this in other settings. Having not seen these young
6267 men in other settings, it is difficult to know if this had an impact and is a
6268 limitation of this study.
6269

6270 The performance of masculinity appeared to be very different within
6271 each site. The pressure on young men to subscribe to and perform
6272 hegemonic masculinities and normative heterosexual male behaviours
6273 was different depending on cultural capital, discourses, and identities
6274 available to young men in each setting. Young men in both settings
6275 appeared to occupy forms of marginalised masculinities. The ways that
6276 men with marginalized masculinities embody hegemonic masculinity is
6277 expressed differently depending on access to resources, social capital,

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6278 and social mobility (Colorado State University, 2019). However, due to
6279 the relative possession of economic capital of the young men in the city,
6280 the young men in Minetown were relatively less able to display
6281 behaviours that were not associated with normative heterosexual male
6282 behaviours.

6283

6284 Men who embody marginalised masculinities have been shown to
6285 emphasise aspects of themselves that come closest to the hegemonic
6286 ideal. So a young man who is physically weak may be able to stress
6287 material or economic success in order to maximise how his masculinity
6288 is perceived. This also works in reverse where a young man who does
6289 not possess as much material or economic success could develop their
6290 physical strength in order to maximise their masculinity. This idea links
6291 to Bourdieu's (1986) ideas around capital in which he defines capital as
6292 "*accumulated labour (in its materialised form or its "incorporated"*
6293 *embodied form)*" (p. 241).

6294

6295 Young men have been described as being highly conscious of the
6296 amount of masculine capital they have available (Rice et al., 2018).
6297 Masculine capital can be compared to credit gained that can be used to
6298 allow or compensate for behaviour that could be consider non-
6299 masculine. This means that they could potentially engage in behaviours
6300 considered non-masculine without losing face (de Visser and
6301 McDonnell, 2013).

6302

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6303 The more closely adolescent boys and young men conform to
6304 traditional masculine norms, the poorer their attitudes have been shown
6305 to be around help seeking; this has also been associated with greater
6306 risks to their physical and mental health risk status (Wong et al., 2017).
6307 This was perhaps observed to be the case in Minetown where the
6308 young men appeared to be more constrained by the pressure to
6309 conform to more normative masculine identities.
6310
6311 Some evidence suggests that the relationship between masculine
6312 norms and help seeking may less marked for those men who are
6313 considered more sexually diverse (i.e., same-sex attracted) (Vogel et
6314 al., 2011). This appeared to be the case in the city site where there was
6315 more evidence of sexual diversity than in the city.
6316
6317 Recent health research has paid much attention to economic and social
6318 capital but cultural capital lags behind in relevant studies (Pinxten and
6319 Lievens, 2014). This relates to the different contexts, in that there was
6320 more economic capital in the city context. The young men came from
6321 higher socioeconomic backgrounds and this is associated with the
6322 possession of more economic capital. Economic capital also affects the
6323 cultural capital and therefore masculinities available to each young
6324 man. In the city site, the young men were more able to embody
6325 marginalised masculinities emphasising elements of their cultural
6326 capital. This could be seen in their increased comfort with the
6327 exploration of sexuality and gender, as well as health behaviours.

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6328 These health behaviours included skin and hair care as a way of being
6329 attractive, which tend to be associated with femininity.
6330

6331 In Minetown, there was less economic capital due to lower SES. The
6332 young men in Minetown therefore appeared to have fewer masculinities
6333 available to them due to the lack of capacity to draw on other elements
6334 of capital to achieve masculinity. This could be seen in the young men's
6335 health behaviours. The young men in the city site were observed to be
6336 more likely to openly explore their sexuality and gender, whereas the
6337 young men in Minetown would be scathing towards homosexuality and
6338 shut down any discussion about this, unless it was related to women
6339 being lesbians, which was deemed acceptable.
6340

6341 Traditionally, some health-promoting behaviours such as diet or
6342 personal care have been viewed as 'feminised'. However, the
6343 possession of different amounts of capital may allow for young men to
6344 exercise choice in adopting health-promoting behaviours into their
6345 gender performance. 'Hybrid masculinities' refers to the selective
6346 incorporation of qualities associated with subordinate or marginalised
6347 masculinities, or femininities, into men's gender performance (Bridges
6348 and Pascoe, 2014). This was observed to be the case in the city site,
6349 and not in Minetown.
6350

6351 Hybrid masculinities mean that men can use different strategies to
6352 reshape what it means to be 'men' in different contexts because of their

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6353 ability to distance themselves from dominant forms of masculinity, *"but*
6354 *not from the associated privileges*" (Bridges and Pascoe, 2014, p.78).
6355 The young men in Minetown, for example, could be excused from being
6356 seen to avoid partaking in drugs and alcohol if they were good at sports,
6357 as this form of capital was a way of securing their masculine status.
6358 Within the city site, the young men were more able to adopt health-
6359 promoting behaviours such as skin care regimes and diets into their
6360 gender performance; using this theory, this could be explained as being
6361 affected by the privilege that their economic capital gave them.
6362
6363 Efforts to enact new ways of being were also hampered by hegemonic
6364 pressures outside the CoP, where traditional norms still dominated
6365 (Lomas et al., 2016). Connell and Messerschmidt (2005, p.850) suggest
6366 that although local forms of hegemony can be influenced by wider
6367 regional norms, they cannot "wholly" determine them.
6368
6369 Lomas et al. (2016) take this further and suggest that local forms can be
6370 radically different from the wider hegemony, leaving local and regional
6371 norms to exist in a state of tension and opposition. It could be
6372 suggested that it is this discrepancy between the local and regional
6373 hegemonic forms that draws the young men to the CoP – this could be
6374 said to be the case particularly in the city site; homosexuality is
6375 censured by traditional hegemony (Connell, 1995); but many gay young
6376 men were attracted to the City CoP because of the acceptance and
6377 refuge from homophobic discrimination (Lomas et al., 2016).

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6378 From the perspective of the researcher, the social order within the city
6379 site was very different to what it would have been for these young men
6380 outside of this CoP. Due to the marginal masculinities enacted by the
6381 young men from the city site, they would not have been able to fit well
6382 within the social order of the Minetown setting. The young men in
6383 Minetown warned that gay people would not be welcome and knew this
6384 so would not approach the site. They were also observed to use the
6385 term ‘gay’ as an insult and had a fear of appearing gay and so avoided
6386 physical contact with other young men, as well as displays of emotion.
6387 The accepting environment offered by the city site was perhaps unique
6388 to this type of provision and allowed exploration that may not have been
6389 supported elsewhere.

6390 *9.4.3 How discourse around young men shapes their views of health*
6391 *information*

6392 This study also supports some of Spencer’s (2015) general findings in
6393 that the young men’s opportunities to act in line with their own
6394 understandings of health were limited by the assumptions that were
6395 made about their lack of interest in health, inability to take responsibility
6396 for themselves, and regular risk taking behaviour.
6397

6398 Positioning the young men’s alternative views on ways to be healthy as
6399 a problem told the young men that their views were not seen as
6400 important, or taken seriously, and this affected their mental health.
6401 These attitudes affected their sense of autonomy and placed limitations
6402 on the capacity for achievement in the future. When some of the young
6403 men from Minetown were asked about things that made them feel bad,

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6404 they talked about their being stereotyped as 'chavs' without the people
6405 getting to know them and their personalities. This made them feel more
6406 disenfranchised and perpetuated negative relationships with adults.
6407
6408 The researcher found the young men to be highly engaged with the
6409 issues raised by this research, however this was not reflected by some
6410 of the adults around them who described them as disinterested in their
6411 health, education, other people, and their surroundings. This may be
6412 due to the young men feeling that there was no point in talking to adults
6413 about these issues, due to their perceived lack of interest and inaction.
6414 These dynamics appeared to be self-perpetuating. The young men
6415 called for the adults around them to begin to notice more of the efforts
6416 that they made rather than the mistakes.

6417 *9.4.4 Analysis*

6418 This study has found that context has a significant impact on the
6419 perspectives of health of the young men in the study. This supports the
6420 findings of previous research (Randell at al., 2016a; Lee et al., 2009).
6421 The language that was available to the young men had an impact on
6422 what they were able to express in terms of health, masculinity, and
6423 identity. The young men were also aware of the stigma surrounding
6424 their behaviour, and the positioning of them as 'risky'. This affected their
6425 sense of empowerment, as well as their trust in adults. These findings
6426 have important implications for policy, research, and practice, and these
6427 will be discussed in the following section.

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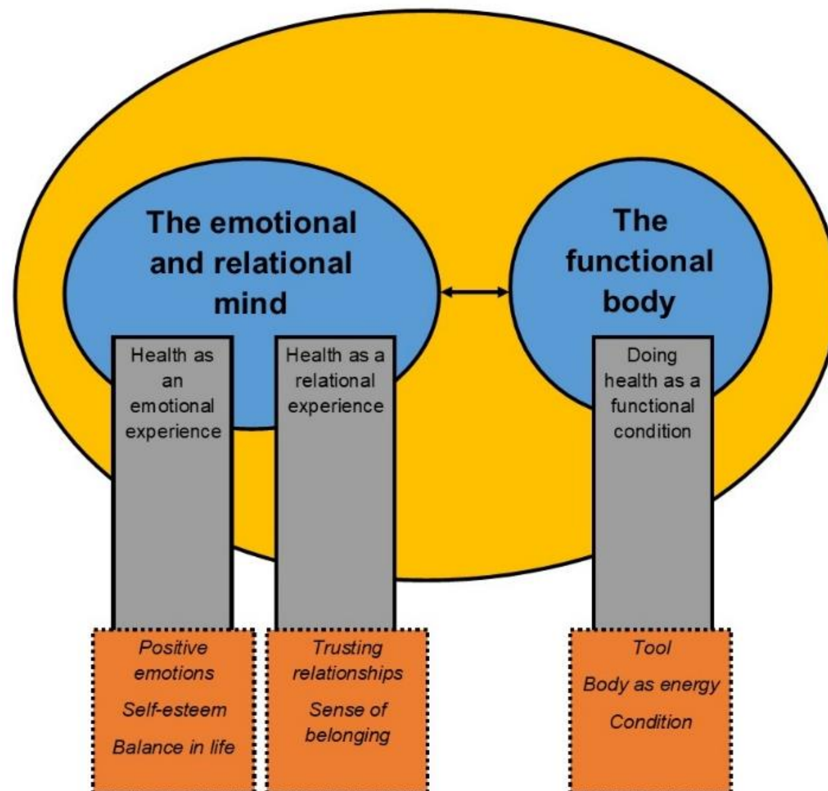
6428 ## 8.5 Proposing a model

6429 Randell et al (2016a) proposed a model

6430 *Figure 5: Randell et al. (2016a) model representing factors forming and*
6431 *contributing to the health of adolescent boys.*



6432

6433 Randell et al's (2016a) research identified several factors as being
6434 conducive to adolescent health and contributing to shaping the health of
6435 adolescent boys. Fig. 3 constitutes a visual representation showing
6436 connection and interrelation between emotional and social aspects of
6437 health, which formed the category of *the emotional and relational mind*.
6438 Bodily health was represented by the category of *doing health as a*
6439 *functional condition* where the body was described as a functional tool
6440 for health.

6441

6442 The research in this thesis develops this model further in considering
6443 the role of context, socioeconomic status, education, and access to

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6444 capital, discourse, and masculinities. The co-creation of

6445 conceptualisations of health is also considered with communities of

6446 practice being active in specific contexts, with the agency to contest,

6447 resist, assimilate, and repurpose knowledge in order to mitigate risk (fig.

6448 5).

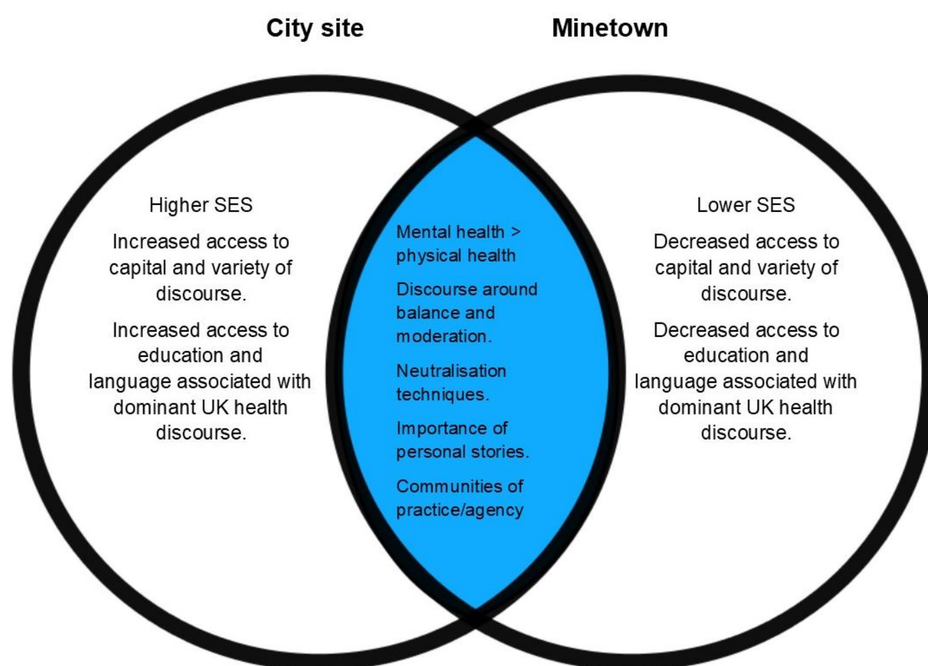
6449

6450 In the development of this further model, it was important to first

6451 consider the findings of this thesis in reference to the contexts

6452 researched. Fig. 4 shows a Venn diagram illustrating this comparison.

6453 *Figure 6: Venn diagram showing comparison between the two research*
6454 *sites.*



6455

6456 This informed a development of Randell et al's (2016a) model to

6457 incorporate these elements (fig.5).

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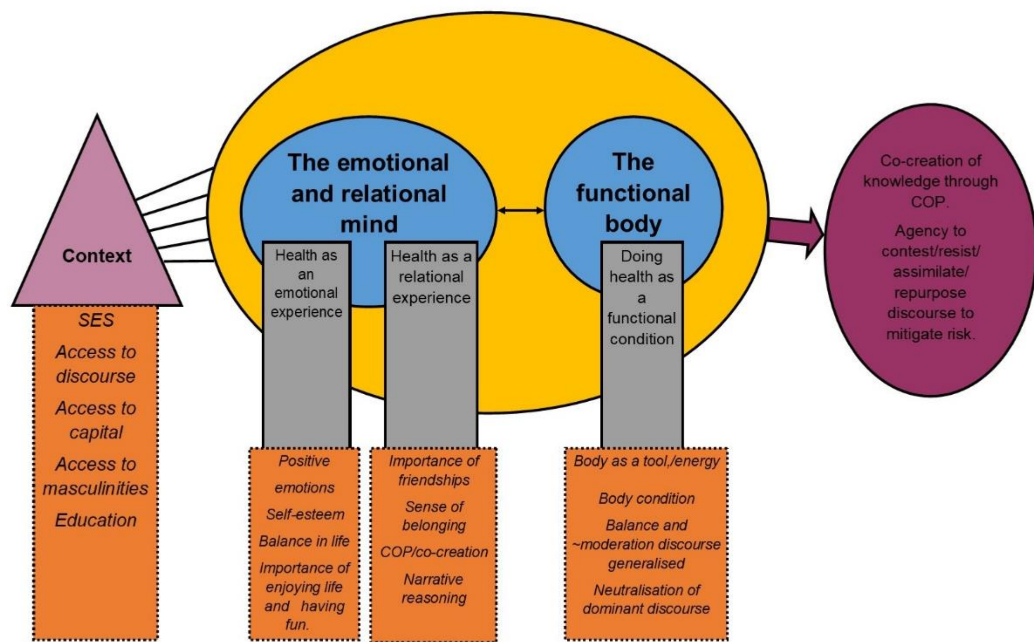
6458 *Figure 7: Development of Randell et al. (2016a)*



6459

6460 Elements have also been added to the sections on health as an

6461 emotional experience, health as a relation experience, and doing health

6462 as a functional condition in order to represent the findings of this thesis.

6463

6464 ## 8.6 Implications for policy, research and practice

6465 It is hoped that a study of this kind will help generate knowledge that will

6466 identify ways to make health promotion more targeted to young men's

6467 needs and perspectives.

6468

6469 Two general approaches to health promotion are behaviour change,

6470 and empowerment (Tengland, 2012). Behaviour change strategies

6471 tend to proscribe particular health behaviours or impose change on

6472 people whilst empowerment techniques suggest that individuals should

6473 indeed be empowered to be actively involved and engaged in deciding

6474 health their own priorities and the best way to promote their own health

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6475 (Tengland, 2012). The behaviour-change model does not respect the
6476 right to autonomy and risks increasing health inequalities (Tengland,
6477 2012).
6478
6479 We have also seen from this research that young men are sceptical of
6480 approaches to health promotion that do not allow for nuanced personal
6481 experience. Empowerment approaches respects the right to autonomy,
6482 increases the ability for autonomy, as well as other coping skills, and is
6483 likely to reduce inequalities; however this approach is more drawn out
6484 and will not achieve quick results. With a neo-liberal agenda, there is
6485 also a risk of empowerment approaches becoming a moral imperative
6486 that in turn reduces autonomy through governmentality (Foucault,
6487 1991).
6488
6489 One important ethical issue for health promotion and public health work
6490 is to determine what the goals of these activities should be (Brülde,
6491 2011). However, this assumes that health is a universal and relatively
6492 uncontested concept (Seedhouse, 2001) or that individuals and
6493 communities share the same understanding of health, and language to
6494 talk about health (and best ways to promote it). It also fails to question
6495 the power relations inherent in whose perspectives on health are
6496 attended to.
6497

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6498 Different demographic group's perspectives on health have been shown
6499 to differ from official health discourse (Katainen, 2006 , Harrison et al.,
6500 2011 , Lupton and Tulloch, 2002 , Spencer, 2013a , Spencer, 2013b).
6501
6502 These studies indicated that, similarly to the young men in the current
6503 study, some people may choose to engage in practices harmful to
6504 health whilst having full knowledge of the risks involved. It may also be
6505 that the perceived benefits for mental health and wellbeing outweigh the
6506 potential physical risks.
6507
6508 Empowerment is often positioned as being more ethical, and less
6509 paternalistic than behaviour change strategies (Spencer, 2015).
6510 However, if empowerment does not always result in positive health
6511 outcomes, this approach may seem problematic. This also resonates
6512 with Foucault's ideas around governmentality (1991) that were
6513 discussed in chapter 2.
6514
6515 It seems that current health promotion approaches aimed at reducing
6516 young men's engagement in practices deemed harmful to health (e.g.
6517 reducing smoking and drinking) may attempt to limit the very activities
6518 that the young men identified as being important to promoting their
6519 health. In fact, as Tengland (2012) suggests, we must realise that for
6520 some people, health is secondary to (other) quality-of-life goals.
6521 However, empowerment should also be focused on the things that are
6522 the most relevant for the health of the individual (or group, or

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6523 community, members). “To become healthy is to become empowered”
6524 (Tengland, 2012, p.41), since health could be said to be one important
6525 factor with which control over life is established.
6526
6527 Increased autonomy, self-confidence and self-esteem (empowering
6528 factors) are parts of mental health, and not just beneficial determinants
6529 for future health (Tengland, 2007). In empowering an individual, a
6530 group, or a community, even if the focus is not specifically on health, we
6531 will most likely get health ‘as a bonus’ (Tengland, 2012). Insights drawn
6532 from the literature (Spencer, 2015) and this research highlight the
6533 importance of developing some ethical reflexivity in health promotion.
6534 Professionals need to consider the impact that their assumptions about
6535 alternative ways of understanding health might affect the empowerment
6536 of the people they work with.
6537
6538 This study showed that the language used in some of the health
6539 promotion literature, and dominant discourse was not accessible to all
6540 of the young men. The young men in Minetown did not understand
6541 language such as “mental health” and “support networks” in the same
6542 way as the young men from the City. The young men in the City had
6543 been able to access a variety of places for health information, including
6544 the youth provision, school, and family and friends who had used this
6545 language.
6546

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6547 The young men in Minetown commented on the lack of Personal,
6548 Social, Health and Economic (PSHE) that they had been offered at
6549 school; they had not been exposed to the same language and been
6550 able to develop an understanding of the language. It seems that if we
6551 are to address the health inequalities within the UK, the inequalities in
6552 understanding need to be addressed first so that access to, and
6553 understanding of, health information is equal for all.
6554
6555 One of the ways that young people in education might be able to
6556 access this information is in school, however, PSHE education is a non-
6557 statutory subject. The Office for Standards in Education, Children's
6558 Services and Skills (OFSTED) (2013)found that the quality of PSHE
6559 education is lacking in a large percentage of schools in England
6560 (OFSTED, 2013). They found that many teachers lacked expertise in
6561 teaching sensitive and controversial issues, which resulted in some
6562 topics not being covered. This was because subject-specific training
6563 and support were often inadequate. Baggaley (2017) highlights the risk
6564 of PSHE having the potential to do harm if taught safely and effectively.
6565 Baggaley (2017) believes that it is vital that each school has a PSHE
6566 specialist teacher.
6567
6568 The Department for Education (DfE) (2017) made a statement aiming to
6569 make PSHE statutory in all schools from September 2019, subject to
6570 the outcome of a thorough consideration of the subject. This would help
6571 ensure universal coverage for all pupils and improved quality. From

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6572 Spring 2017, there has also been a specific requirement for all schools
6573 to include information about their PSHE education provision when
6574 publishing their curriculum this spring (DfE, 2017).
6575
6576 It may also be the case that health promotion resources and delivery
6577 can be tailored to context within statutory regulations. This research has
6578 highlighted different discourses and ways of expressing understanding.
6579 Language differences might allow important differentiation to ensure all
6580 young people can contribute and learn. Having said this, if all young
6581 people are given access to the same information at the same time, then
6582 this will help to ensure a basis of understanding that can map across
6583 health promotion.
6584
6585 It is also very important to consider how the young men may translate
6586 the messages communicated to them and involve them closely in the
6587 development of these resources in order to reduce iatrogenic effects.
6588 An example of this might be the “Talk to FRANK” campaign. A Home
6589 Office Report (2010) reported that there had been some unintended
6590 consequences to a campaign around legal highs, with 22% of those
6591 aged 15- to 18-years-old who visited the website claiming that they
6592 were now "more likely" to take legal highs in the future. However, due to
6593 a lack of research the full extent of any unintended consequences has
6594 not been assessed.
6595

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6596 The creative company responsible for the "Talk to FRANK" campaign
6597 stated that project had corresponded with a continued fall in drug use
6598 among 16- to 24-year-olds: from 28.3% in 2003/4 to 19.3% in
6599 2011/12.(Spence, 2013). The government spent approximately £3.2m
6600 on media and information activity to support the drug strategy between
6601 2010 and 2015, with almost of this this on "Talk to FRANK". However,
6602 the Home Office report states that there has been no marketing budget
6603 to promote "Talk to FRANK" since 2013/14 (Home Office, 2010). Having
6604 said this, the report cautions that "*…there is insufficient evidence to*
6605 *assess whether government media and information campaigns have*
6606 *directly changed behaviour or represent value for money*." (Home
6607 Office, 2010, p.72)
6608
6609 The 2010 Home Office report advocates "*carefully planned, targeted*
6610 *media campaigns alongside universal information programmes rather*
6611 *than traditional mass media approaches*" (Home Office, 2010, p.72).
6612 These findings have informed the new 2017 drug strategy, aimed at
6613 developing a "smarter*" and "*evidence-based approach*" (Home Office,*
6614 *2017).* The 2017 report advises that the evidence (Advisory Council on
6615 the Misuse of Drugs (ACMD), 2015) shows that the programmes that
6616 are

6617 > *"…least effective in preventing substance misuse are*
6618 > *those that focus solely on scare tactics, knowledge-*
6619 > *only approaches, mass media campaigns or the use*
6620 > *of ex-users and the police as drug educators in*
6621 > *schools, where their input is not part of a wider*
6622 > *evidence based prevention programme" (Home*
6623 > *Office, 2017, p.9)*

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6624 The 2017 drug strategy includes interventions to "…*build resilience and*
6625 *promote health and wellbeing among young people combined with*
6626 *targeted action for groups that are at risk*" (Owen, 2017, p.1). With this
6627 in mind, it might be that more general health campaigns should follow
6628 similar guidance. The turnover of government leadership will always
6629 undermine strategy put in place by previous leaders and parties, which
6630 can have wide reaching influences on the population.
6631
6632 If public policy and associated campaigns and health provision is
6633 evidence-based, then this may help mitigate some of the negative
6634 associated effects. However, politically Barnish et al's.
6635 (2018).systematic review concluded that welfare state generosity, left-
6636 of-centre democratic political tradition and democracy are generally
6637 positively associated with population health.
6638
6639 This chapter has considered the contribution that this research
6640 makes to the body of evidence explored in the literature review
6641 in chapter Two. The findings of this study confirm those of previous
6642 research, in particular that of Randell et al., (2016a, 2016b). It is
6643 important to note that, other than Randell et al., (2016a 2016b), no
6644 other studies have allowed young men to guide the research around
6645 what health means to them which is a key area of this study. This
6646 research has added to the current body of research by stressing the
6647 importance of context in how young men understood, and
6648 conceptualised health.

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6649 Discourse, and the availability of this in each setting was also a key
6650 factor in what the young men were able to express in terms of health
6651 related behaviours, identity and masculinity. This has important
6652 implications for policy, research, and practice, as well as the health and
6653 wellbeing of young men. Professionals need to consider the impact that
6654 their assumptions about health and risk might affect the empowerment
6655 of the people they work with. It might be the case the regulation of the
6656 provision of PSHE may be one way of ensuring more equality in the
6657 delivery of health information and the ability of young men from a
6658 variety of different contexts to understand this. There are of course
6659 limitations to this study and how the findings might be applied to the
6660 area of young men and health; this will be addressed in the following
6661 section.

6662
8.7 Limitations

6663 It is important to note that this research is embedded within a post-
6664 structuralist epistemology, therefore the generalisability of any results is
6665 limited.

6666

6667 It is also important to note that focused ethnographies usually take
6668 place in teams (vom Lehn, 2019) in order to incorporate a variety of
6669 views and stances towards the research findings – this was not possible
6670 in a PhD project. As part of this 'team approach, so called 'data
6671 workshops' have been described as playing a key role in the data
6672 analysis within FE. In these workshops the research team can discuss
6673 the data; participants from the field are also invited to share information

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6674 and to contribute to the interpretation of their actions (Knoblauch et al.,

6675 2015) – this would have added to the richness of the data in this study.

6676

6677 The time spent in each site was limited, and longer could have been

6678 spent in each context in order to get a deeper understanding of both the

6679 sites and the young men within them. Tsolidis (2008, p.281) points out

6680 that

6681 *"…if as ethnographers, we are serious about*
6682 *engaging" "…with the post-structuralist claims of the*
6683 *multiplicity of selves, notions of de-centred forms of*
6684 *power and the intersections of highly relational social*
6685 *categories (Popoviciu, Haywood, and Mac an Ghaill*
6686 *2006, p.410)" …we need to refuse a range of*
6687 *choices time or space, 'real' or not 'real'…and*
6688 *'proper' or 'improper' ethnography. Instead we*
6689 *have to develop creative methods that align to*
6690 *spatiality rather than remain restricted by site."*

6691

6692 With this in mind, it would have been beneficial to spend time with a few

6693 young men in different settings such as school, home, and at other

6694 social sites in order to reflect on the different ways that they may have

6695 behaved in each setting.

6696

6697 The focus of this study was young men due to the lack of research in

6698 this area. It might have been that attending to some of the young

6699 women in these settings might have given another perspective and

6700 allowed for a different insight into the lives, and behavior, of the young

6701 men. Young women also possess masculine traits and it might be

6702 interesting to consider how this might affect their behaviours.

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6703 The sites were made up almost exclusively of young men whose
6704 ethnicity was White British. It would be beneficial to conduct further
6705 research that covers a range of ethnicities to explore what this might
6706 add to the findings of the current study.

6707 8.8 Future research

6708 It is important that more research is conducted in this area in order to
6709 address the health inequalities in the UK for young men, particularly
6710 those with low socioeconomic status. It appears that, despite a
6711 proliferation of health promotion initiative and campaigns, being male
6712 continues to be a considerable factor in ill health and premature death.
6713 The impact of mental ill health has a considerable impact on the lives
6714 and wellbeing of young men. Suicide, smoking, alcohol and substance
6715 misuse continue to cause the death of young men in the UK.
6716

6717 Future research could focus on a wider community, as well as a larger
6718 range of geographic areas, and socioeconomic backgrounds. Having
6719 said this, from a post-structural perspective this would not increase the
6720 generalisability of the findings but may give additional bases for
6721 discussion.

6722 8.9 Final thoughts

6723 This study contributes to the growing literature on how young men
6724 embody masculinities and construct their lives. The research
6725 undertaken in these two contrasting contexts reveals both similarities
6726 and differences in the influence of a variety of factors on
6727 understandings of health. There is a high degree of complexity when

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6728 attempting to understand performances of young masculinities in
6729 relation to health. If there is to be a positive impact on the health and
6730 wellbeing of young men across the UK, then changes need to be made
6731 in how we communicate health information. Young men should be
6732 included in the research and development of resources, as well as how
6733 to communicate this information. This will increase the success of
6734 investment in this area, as well as mitigating potentially iatrogenic
6735 effects.
6736

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Appendix I – Literature review study table

	Study	Aims and Objectives	Participants	Methods	Findings
1	Hayter, M., and Harrison, C. (2008) Gendered attitudes towards sexual relationships among adolescents attending nurse led sexual health clinics in England: a qualitative study. **Journal of Clinical Nursing** 17: pp. 29643-2971	Explore gender differences in attitudes towards sexual relationships of adolescents attending nurse led sexual health clinics	• UK • 17 young men aged 14-16	• 10 focus groups (5 female, 5 male) • Thematic analysis	• Young men less likely to see partners point of view • Young men less aware of complex nature of relationships • Young men used aggressive language in the context of relationships • Young men socialised into behaviour that can place females under pressure to have sex, including the use of alcohol
2	Hyde, A., Drennan, J., Howlett, E., and Brady, D. (2008) Safer hetero sex: perspectives from young men in Ireland. **Sexual Health** 5(1): pp.25-30	Explore how young men make sense of risk regarding sexual behaviour	• Ireland • 124 young men aged 14-19 • Secondary school pupils	• 17 focus group interviews • Ground theory – constant comparative approach to analysis	• 3 themes ○ rumour, local hearsay and 'knowing' a potential partner ○ Social construction of 'slut' ○ Women as bearers of disease • Young women in social groups acquired a specific sexual identity, not necessarily through evidence of sexual history but through normative behaviour (dress, presentation, appearance). This was how sexual status was judged. Notions of safer sex were discursively produced in wider social settings beyond the sexual encounters between individuals
3	Hyde, A., Drennan, J., Howlett, E., and Brady, D. (2008)	To focus on issues of sexual coercion and identify discourses	• Ireland	• Focus groups of 12 – single sex	• Male participants reported social coercion to lose virginity by a certain age

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	Heterosexual experiences of secondary school pupils in Ireland: sexual coercion in context. **Culture, Health and Sexuality** 10(5): pp.479-493	invoked by the young people	• 124 young men aged 14-19 • Secondary school pupils	• Thematic content analysis	• Coercion propelled young men to subscribe to conventional heterosexual masculine behaviour.
4	Cohan, M. (2009) Adolescent heterosexual males talk about the role of male peer groups in their sexual decision making. **Sexuality and Culture** 13: pp.152-177	• Explore how heterosexual young men used talk to construct their sexual selves and present themselves as sexual decision makers	• Small, southern, USA college town • Racially and ethnically diverse sample • 17 adolescent males aged 14-19 • Virgins and non-virgins	• In-depth one to one interviews – 'active interview' technique • Coding, (NVivo)	• 8 of the boys drew on discourse that implicated male peer groups in self-productions • 'Male fraternity' mediates boys' sense of masculinity and belonging as well as their understanding of females as sex partners • Group context generates social control features that limit individual resistance to collective understandings about gender and sexuality • Adolescent talk and male peer groups implicated in the production of male sexuality and the denial of female subjectivity.
5	Hyde, A., Drennan, J., Howlett, E., and Brady, D. (2009) Young men's vulnerability in constituting hegemonic masculinity in sexual relations. **American Journal of Men's**	Accounts of young men on their experiences of **heterosexual encounters**. •	• Ireland. • 124 young men aged 14-19. • **Part of wider study** of adolescent sexuality in Ireland that	• Qualitative. • Focus groups.	• Elements of resistance to hegemonic manifestations of masculinity in way in which sexual pleasure was derived relationally for some young men through giving pleasure rather than just through mechanical, emotionally detached sexual acts that characterise hegemonic masculinity.

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	Health 3(3): pp. 238-251		aimed to explore post primary pupils' perspectives on sexuality, sex education and factors that affect their sexual knowledge and behaviour.		
6	Landstedt, E., Asplund, K., and Gillander Gådin, K. (2009) Understanding adolescent mental health: the influence of social processes, doing gender and gendered power relations. **Sociology of Health and Illness** 31(7): pp.962-978	• Explore 16-19 year old's perceptions of what is significant for mental health • Apply gender analysis to findings to advance understandings of gender patterns in adolescent mental health	• Sweden • 16-19 • Schools in 6 towns	• 29 focus groups • 12 groups with young men, 13 with young women and 4 mixed • Constant comparative analysis	• Young men had more positive mental health which appeared to be associated with a low degree of responsibility taking and occupying beneficial positions relative to girls • Males and females identify the same factors and conditions as important to mental health but explain them differently • Young men exercised more and experience more physical violence and verbal abuse (joking, banter) • The aggressive and abusive behaviour was part of reconstructing hierarchies and adjusting to cultural definitions of masculinity
7	Oransky, M., and Marecek, J. (2009)"I'm not going to be a girl" Masculinity and	Examine peer relations and emotion practice of adolescent boys in light of their expectations and	• Northeast USA	• Interviews • Systematic approach to	• You ng men assiduously avoided displays of emotion/physical pain and disparaged such displays in other boys

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	emotions in boys' friendships and peer groups. **Journal of Adolescent Research** 24(2): pp.219-241	assumptions about masculinities	• 25 young men aged 15-16 • Independent preparatory high school	thematic analysis • Inductive approach	• Tied tough, stoic self-presentations to manliness • Peer groups derided expressions of hurt, worry, care, or concern as 'gay' or 'girly' • Although these practise were hurtful, boys valued them as a means of bolstering each other's masculinity • Securing masculinity demands ongoing efforts • Feeling rules and emotional practices are important constituents of young white masculinities
8	Lee, J., Macdonald, D., and Wright, J. (2009) Young men's physical activity choices: the impact of capital, masculinities and location. **Journal of Sport and Social Science** 33(1): pp.59-77.	Add meaning to statistics based on quantitative surveys that suggest a declining participation rate and **satisfaction of young people in organised sports, recreational physical activities and exercise**.	• Australia. • **From larger study** • 2 young men selected out of 39 in mixed gender main study.	• 6 semi structured interviews • Data analysis - life history work	• Schooling, geographical location and access to capital play important roles in the intersection among masculinities, participation in physical activity and engagement with physical culture.
9	Akre, C., Michaud, P-A., and Suris, J-C. (2010) "I'll look it up on the Web first": Barriers and overcoming barriers to consult for sexual dysfunction among young men. **Swiss Medical**	Identify the barriers that young men face to consult a health professional when they encounter sexual dysfunction and where they turn to, if so, for answers	• Switzerland • 12 young men age 16-20 • Recruited from health care unit for adolescents and public high school	• 2 focus groups using vignettes about sexual dysfunction to trigger discussion • Narrative analysis based on grounded theory	• Young men preferred not to talk about sexual dysfunction with anyone and to solve them alone as it is considered an intimate and embarrassing subject which can negatively impact their masculinity • Problem of males' accessibility to services and lack of reason to consult ('Family Planning' clinic) • Would address problem if it was long-lasting and considered physical

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	Weekly 140(23-24): pp.348-353				• Internet unanimously considered as initial solution to solve a problem which could guide to a face-to-face consultation if necessary
10	Richardson, D. (2010) Youth masculinities: compelling male heterosexuality. **The British Journal of Sociology** 61(4): pp.737-756	To extend understandings of heterosexual masculine identities through an examination of what motivates young men to engage in **heterosexual practices** and relationships and what not having sex might mean for them	• UK • 11 young men aged 13-16.	• Qualitative study • Single gender focus group • Interviews	• Youth masculinities are often experienced in ways that are highly contradictory requiring young men to adopt a range of strategies to deal with this. • Heterosexual masculinity is constructed largely through performing for other young men.
11	Brown, S. (2011) Young men, sexual health and responsibility for contraception: a qualitative pilot study. **Journal of Family Planning and Reproductive Health Care** 38(1): pp.44-47	To understand the views of boys and young men regarding **sexual health** services and use of contraception, particularly with regard to responsibility for contraception	• UK 5 non fathers aged between 14-18	• Qualitative • Pilot study • 2 Focus groups • Analysed using constant comparative method to build up categories of data	• Engaging young men in research is very difficult, particularly those who are not in education or employment. • Young fathers proved impossible to recruit • Young men who took part in this study thought that responsibility for contraception was shared, although this was partly dependent on relationship status – regular partner or one night stand • Educational status is a factor in beliefs about responsibility
12	Ekstrand, M., Tydén, T., and Larsson, M. (2011) Exposing	Explore young men's perceptions of risk for themselves and their	• Sweden • 22 young men aged 16-	• Qualitative, semi-structured interviews	• Young men did not seem to worry about risks when having unprotected sex

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	oneself one one's partner to sexual risk-taking as perceived by young Swedish men who requested a Chlamydia test. **The European Journal of Contraception and Reproductive Health Care** 16: pp.100-107	partners in connection with unprotected sex, and the main barriers to practising safe sex	20 who had requested a Chlamydia test	• Open-ended topic guide
				• Coding – categorisation linked to the Health Belief Model
					• There was low perceived threat and they were more worried about personal consequences than those of their partner – they were confident that unintended pregnancy could be terminated which led to a reduced motivation to share pregnancy prevention with their partner
					• Main barriers to condom use :
					  ○ Interference with spontaneity
					  ○ Pleasure reduction
					  ○ Fear of losing erection
					  ○ Embarrassment
					  ○ Distrust
					  ○ Girls' use of hormonal contraception
					  ○ Difficulties in discussing safe sex

13	Norman, M.E. (2011) Embodying the double-bind of masculinity: young men and discourse of normalcy, health, heterosexuality, and individualism. **Men and Masculinities** 14(4): pp.430-449	Extend knowledge base on the embodied experiences of young men	• Canada • 32 young men aged 13-15	• Semi-structured focus group interviews • Post structural discourse analysis	• Young men take up, deploy, and perform discourses of normalcy, healthy active living, heterosexuality, and individualism as technologies of self in negotiating the double-bind of masculinity
14	Mac an Ghaill, M., and Haywood, C. (2012) Understanding boys': thinking though boys, masculinity and suicide. **Social**	• Questions viability of using normative models of masculinity as an explanatory tool for explaining boys' behaviour, suggests	• UK • 28 children aged 9-13 (12 male)	• Discourse analysis of semi-structured interviews	• Studies that use masculinity tend to reduce the formation of gender to the articulation of power across and between men and other men and women • Approaches to understanding boy's behaviour are simplistically grafting

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	Science and Medicine 74: pp. 482-489	that researchers in gender and **suicide** consider how boys' genders may be constituted differently • Develop new ways of conceptualising how we gender bodies. • Explore boys' understandings and experiences of schooling			masculinity as a conceptual frame onto boy's attitudes and behaviours • Existing models of masculinity may not be able to capture the generational specificities of boys • Younger boys may be forming their gendered selves through different social and cultural codes
15	Watkins, F., Bristow, K., Robertson, S., Norman, R., Litva, A., and Stanistreet, D. (2012) "I think boys would rather be alpha male": being make and sexual health experiences of young men from a deprived area in the UK. **Health Education Journal** 72(5): pp.635-643.	• Explore the experiences of young men aged 16-19, living in an area of high deprivation, when accessing local **sexual health services.**	• UK • Young men aged 16-19, living in an area of high deprivation.	• Qualitative design drawing on ethnographic methods. Multi-approach: one to one semi structured interviews, focus groups, participant observation.	• Young men demonstrated adherence to aspects of hegemonic masculinity buy this was extremely complex – suggests that a nuanced approach is needed to understand young men's attitudes to sexual health services • Perception that sexual health services were aimed at women and not suited to young men.

16	Elmerstig, E. Wijma, B., Sandell, K., and Berterö, C. (2014) Sexual interaction or a solitary action: young Swedish men's ideal images of sexual	Identify heterosexual young men's ideal images of sexual situations and expectations of themselves in these	• Sweden
			• 12 young men aged 16-20
				• Individual, in-depth qualitative interviews
				• Constant comparative analysis
					• Young men's concepts of normal sexual situations divided into 2 parts
					  ○ Sexual situations in relationships
					  ○ Sexual situations on one-night stands
					• An ideal sexual experience would be a balance of emotional and physical

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	situations in relationships and in one-night stands. **Sexual and Reproductive Healthcare** 5: pp.149-155				pleasure, intimacy, partners response and own performance – this is easier to achieve in relationships • In one night stands it is important to make a god impression by performing well and behaving according to masculine stereotypes • Need to encourage young men to see beyond stereotyped conceptions of masculinity
17	Arrington-Sanders, R., Harper, G.W., Morgan, A., Ogunbajo, A., Trent, M., and Fortenberry, J.D. (2015) The role of sexually explicit material in the sexual development of same-sex-attracted black adolescent males. **Archives of Sexual Behaviour** 44: pp.597-608	• Explore role of sexually explicit material in sexual development of same-sex-attracted black adolescent males	• USA • Black adolescent males aged 15-19 who reported having had any previous oral or anal sex with male partners • Recruited from clinics, social networking sites and snowball sampling	• Semi-structured interviews • Qualitative analysis using categorical and contextualising methods	• Most described using SEM before first same-sex sexual experience • Used SEM mainly for sexual development including learning about sexual organs and function, mechanics of same-gender sex, and to negotiate sexual identity. • Used SEM to identify readiness for sex, learn about sexual performance including sexual roles(top or bottom) and responsibilities, introduce sexual performance scripts and develop models for how sex should feel (pleasure and pain) • YM also engaged in sexual behaviour modelled on SEM (condom non-use and swallowing ejaculate.
18	Litras, A., Latreille, S., and Temple-Smith, M. (2015) Dr Google, porn and a friend-of-a-	Explore where young men obtain sexual health information in order to better inform GPs about	• Australia • 35 Young men aged 16-18	• One-to-one semi-structured interviews	• The young men were poorly informed about sexual health. • Their existing knowledge mainly came from school-based sexual health

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	friend: where are young men really getting their sexual health information? **Sexual Health** 12(6): pp.488-494	their unique position to improve sexual health knowledge in young men	• TAFE young people	• Thematic analysis	education, which while valued, was generally poorly recalled and provided only a narrow scope of physiological information. • Young men seek sexual health information from various sources including family, the Internet, friends and pornography, with information from the latter three sources perceived as unreliable. • GPs were seen as a source of trust-worthy information but were not accessed for this purpose due to embarrassment. • Young men preferred the GP to initiate such conversations. • A desire for privacy and avoidance of embarrassment heavily influenced young men's preferences and behaviours in relation to sexual health information seeking. • The current available sources of sexual health information for young men are failing to meet their needs.
19	Best, P., Gil-Rodriguez, E., Manktelow, R., and Taylor, B.J. (2016) Seeking help from everyone and no-one: Conceptualising the online help-seeking	• Conceptualise process of online help-seeking among adolescent males	• Northern Ireland • 56 young men aged 15-15	• Photo-elicitation techniques in 8 semi-structured focus groups • Thematic analysis within ontology of	• Informal online help-seeking pathways increased opportunity for social support and reduce stigma; also increases loss of control and reduces anonymity • Formal pathways offered increased anonymity but raised concerns about the participant's ability to locate and appraise the quality of online information.

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	process among adolescent males. **Qualitative Health Research** 26(8): pp.1067-1077			critical realism and epistemology of contextualism.	
20	Limmer, M. (2016) "I don't shag dirty girls": marginalised masculinities and the use of partner selection as a sexual health risk reduction strategy in heterosexual young men. **American Journal of Men's Health** 10(2): pp.128-140.	Understanding and addressing the **sexual risk taking** of young men in an attempt to improve the emotional and physical sexual health of young men.	• UK • 46 young men aged 15-17	• Purposively selected to include young men from a range of settings • Focus groups then in-depth semi-structured interviews • ATLAS.ti to analyse and explore interrelationships between masculinities, social exclusion and sexual risk.	• Describes a form of marginalised masculinity pertaining to socially excluded young men, which as a result of limited access to other tenets of hegemonic masculinity, is disproportionately reliant on sexual expertise and voracity alongside overt demonstrations of their superiority over women. • All young men shared: ○ conceptualisation of appropriate gender roles in sexual relationships acceptance of 'dirty'/'clean' dichotomy and faith in their ability to accurately label young women within it.
21	Randell, E., Jerdén, L., Öhman, A., and Flacking, R. (2016) What is health and what is important for its achievement? A qualitative study on adolescent boys' perceptions and	Explore adolescent boys understandings on concepts of health and what they find important for its achievement	• Sweden • 33 young men aged 16-17	• Interviews • Analysed using grounded theory	• Complexity in how health is perceived, experienced, dealt with, and valued • Health on a conceptual level is described as 'holistic', but health was experienced and dealt with in a more dualistic way with a differentiation made between mind and body

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	experiences of health. **The Open Nursing Journal** 10: pp.26-35				• Health experienced as mainly emotional and relation, with the body having a subordinate value • Presence of positive emotions, experiencing self-esteem, balance in life, trustful relationships, and a sense of belonging were important factors for health while the body was experienced as a tool to achieve health, as energy, and as a condition • Young masculine health largely experienced through emotion and relations • This supports theories on health as a social construction of interconnected processes

22	Randell, E., Jerdén, L., Öhman, A., Starrin, B., and Flacking, R. (2016) Tough, sensitive and sincere: how adolescent boys manage masculinities and emotions. **International Journal of Adolescence and Youth** 21(4): pp.486-498	Explore adolescent males' views of masculinity and emotional management and their potential effects on wellbeing	• Sweden
			• 33 young men aged 16-17
				• Interviews
				• Analysed using grounded theory
					• 2 main categories of masculine conceptions
					  ○ Gender normative masculinity with an emphasis on group-based values
					    ▪ Comprised 2 seemingly opposite emotional masculine orientations; 1 for toughness and the other for sensitivity, highly influenced by contextual and situational norms and demands

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					○ Non-gender normative masculinity based on personal values ▪ Including an orientation towards sensitivity emphasised by the personal values of the boys; emotions expressed more independently of peer group norms • Suggests that different masculinities and the expression of emotions is strongly intertwined and that managing emotions is vital for wellbeing

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Appendix II – Participant consent form

Research Consent

Consent form for Participants

Please complete, sign and give this slip to back to me

I give	
do not give	

(Please tick)

My consent for:
(Your name)

To be observed by the researcher	
To take part in focus groups/individual interviews	
To be tape-recorded during this project	

(Please tick)
Your signature

Please give this slip back to me by:

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Appendix III – Poster

What Makes A Man?

Actually, we were hoping you would tell us.

We really want to find out how you feel about being a man and how a healthy man 'should' look.
We're not going to name names - we're going to tell it like it is, and we need your help.

What now?

If you would like to know more, then please email me, Danielle at: **ntxds3@nottingham.ac.uk**
or send me a message on facebook: **facebook.com/danielle.sinclairphd**

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Appendix IV – Leaflet

Who am I? Why do I care?

I am a PhD student from the University of Nottingham. I have worked with young people for a long time and I really care about helping you get your voices heard.

It is hoped that this research will help understand young men's perspectives on health and a 'healthy body' in youth groups and youth work settings

This knowledge may help to explore different ways of understanding health.

I hope that the findings of this work will contribute to existing knowledge, and inform how health education is communicated.

What now?

If you would like to know more, then please email me:

ntxds3@nottingham.ac.uk

Additional Support

If you feel like you might need some additional support around issues raised in this research, please make sure you find someone to talk to.

If you do not feel like you can talk to anyone at the group/school/home, then these organisations might be able to help.

Childline: 0800 1111
www.childline.org.uk

Calm 0800 58 58 58
www.thecalmzone.net

Young Minds 0808 802 5544
www.youngminds.org.uk/

B-eat: 0845 634 7650
www.b-eat.co.uk

Men Get Eating Disorders Too
mengetedstoo.co.uk/

Information Leaflet for Young People

What is this about?

- There is increasing attention on young people's health amidst concerns about their health related behaviours – such as diet/exercise.
- Youth groups an important part in the communication of 'health' to young people.
- Relatively little is known however, about how young people respond to this information.
- Young men are particularly absent in this area of research...**that's where you come in!**
- Exploring the ways that young men make sense of this information might help to identify different ways of understanding health.
- This might have an impact on how health education is communicated to other young men.

The Project

- Getting involved in this project will mean talking to us about your life - what makes you feel good and what makes you feel not so good...
- We'll talk to you in groups and look at what happens in the group that you attend.
- It will all be private and confidential - there are limitations to this if I think that you or someone else is at risk of harm.
- I want you to be in control so will remind you of this if I think you're about to say something that might worry me.

What's in it for me?

- Well, for a start, *it's a chance for you to talk about what you think.*
- It's also a chance for you to tell people in authority what *you* think - maybe that way they can sort some things out so that things might be different for other young people.

What will happen?

- I am asking young men to take part in groups where we would talk about your experiences of feeling good/not so good about yourself and how you think others feel about themselves.
- I am also asking your permission to use a tape recorder to record what is said in groups.
- This material will not be broadcast or used for any purposes other than the research.
- I will ask regularly if you wish to take part in these groups.
- I will also observe what goes on in the group more generally.
- I would just watch for things about health and write brief notes about this.
- You will be able to withdraw from the research study at any time by letting me or your the form tutor know.
- No names, or the name and location of the group will be identified in any written reports of this study.
- Any information that I gather will be kept securely at the University of Nottingham.

Sensitivity: Confidential

Appendix V – Participant information

Participant Information Sheet
(Final version 1.0: 18/10/2013)

Title of Study: Young men's perspectives on health and a healthy body within youth groups and youth work settings.

Name of Researcher(s): Danielle Sinclair

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

This study seeks to better understand young men's perspectives on health and a healthy body within youth groups and youth work settings. It is hoped that a study of this kind will help generate knowledge that will identify ways to make health education more targeted to young men's needs and perspectives.

Why have I been invited?

You are being invited to take part because you are a young man aged between ten and nineteen. We are inviting 40 participants like you to take part

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

You will be asked to take part in two focus groups. A focus group is just a group of us who will have discussions. You will be in a group with 9 other young men from this youth group/youth work setting. In the focus group, we will talk about what information relating to health and healthy bodies is on offer to you, particularly what you pay attention you and what you think about it. The group will last up to 1 hour and will take place during the time in which you attend the group.

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There will be an option for you to participate via individual interview rather than in a focus group if you prefer.

What are the possible disadvantages and risks of taking part?

The information discussed may bring up issues such as health, diet, and exercise related issues. You will be given an information sheet including contact information for relevant external support services. We will also be working closely with the staff to ensure that you are given access to the support required if you need it.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help identify ways to make health education more targeted to young men's needs and perspectives.

What happens when the research study stops?

When the research study stops, we will go away and look at all of the information we have collected. We will put this in a report and make sure that we come back and let you know what we found.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the University of Nottingham. Details can be obtained from the University.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the group will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Sensitivity: Confidential

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What is said in the focus group or individual interview will remain confidential. However, if someone says something that leads me to believe that someone is at risk of harm or is a child protection issue then I will have to tell the child protection officer.

What will happen if I don't want to carry on with the study?

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you wish to withdraw, we will invite them to discuss your concerns if you wish, and if you still wish to withdraw, your notes and data will be removed from any files.

What will happen to the results of the research study?

All data will be anonymised and participants and the group will not be identified in any study reports.

The results of the study may be published after 2015. In the youth group/youth work setting, results will be fed back in a small group made up of staff and young men who participated in the study. A report will be provided to the manager for their reference; however, no identifying information will be included in this report.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham and is being funded by.

Who has reviewed the study?

All research in the university is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the University of Nottingham of Health Sciences Research Ethics Committee.

Further information and contact details

If you would like further information about this research please do not hesitate to contact us on Danielle Sinclair's university email: ntxds3@nottingham.ac.uk

Sensitivity: Confidential

Appendix VI – Ethics committee approval

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk 10th March 2014
Danielle Sinclair PhD Student
c/o Dr Grace Spencer Lecturer
School of Health Sciences QMC Campus
Nottingham University Hospitals NG7 2UH

Faculty of Medicine and Health Sciences
Research Ethics Committee Division of Respiratory Medicine D Floor, South Block
Queen's Medical Centre Nottingham University Hospitals Nottingham NG7 2UH

Dear Danielle

Ethics Reference No: G14112013 SoHS

Study Title: Young men's perspectives on health and a healthy body within youth groups and youth work settings.
Lead Investigator/Student: Danielle Sinclair, PhD Student, School of Health Sciences. Chief Investigator/Supervisors: Professor Pat Thomson, Professor of Education, Faculty of Social Sciences, Dr Grace Spencer, Lecturer, School of Health Sciences.
Duration of Study: 03.2014-08.2014 6mths No of Subjects: 44

Thank you for your letter dated 21st February 2014 notifying the Committee of a substantial amendment to the protocol no 1: 21st February 2014 as follows:

- Change of setting from Schools to 4 UK Youth Groups and Youth Work settings (aged 11-18)
- Change to multi-site qualitative case study. the following revised documents were received:
- Letter dated 21st February detailing the amendments made to the study protocol.
- Medicine & Health Sciences, REC Application form version 1.3 dated 2/21/2014.
- Young Men and Health: Protocol Final Version 1.3 24/02/2014
- Young Men and Health: Secondary School HPE Research Parental Permission Reply Slip Final Version 1.2 12/21/2013.
- Young Men and Health: Appendix i Parental Consent letter and Parental Permission Reply Slip Final Version 1.3 21/2/2014
- Young Men and Health: Appendix ii Participant Consent Form Final Version 1.3 21/2/2014.

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- Young Men and Health: Appendix iii Staff Information Sheet Final Version 1.3 21/2/2014
- Young Men and Health: information leaflet for children Final Version 1.3 21/2/2014
- Young Men and Health: information leaflet for Staff Final Version 1.3 21/2/2014
- Young Men and Health: Appendix iv Young People's Information Sheet Final Version 1.3 21/2/2014
- Young Men and Health: Appendix v Poster Final Version 1.3, 21/2/2014.
- Young Men and Health: Appendix vi Interview/Focus Group Themes Final Version 1.3, 21/2/2014.
- Appendix viii: copy of Nottingham City Safeguarding Board Base 51 Certificate: Introduction to Safeguarding Course for Danielle Sinclair dated 18th February 2014
- Disclosure & Barring Service: Enhanced Criminal Record Certificate number 001417172967 for Danielle Marie Sinclair, Child and Adult Workforce Researcher dated 5th September 2013.
- These have been reviewed and are satisfactory and the substantial amendment no 1: 21st February 2014 is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. Please submit copies of Letters/e-mails of permission from the 4 UK youth groups: Merlin Youth ABC, Merlin Youth Centre, Derby, Base 51, NGY, Nottingham, Déda (Derby Dance), Derby, Eastwood Young People's Centre, Eastwood when available for our records.
2. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
3. You must notify the Chair of any serious or unexpected event.
4. This study is approved for the period of active recruitment requested. The Committee also provides a further 5-year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.
5. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Dr Clodagh Dugdale
Chair, Nottingham University Medical School Research Ethics Committee

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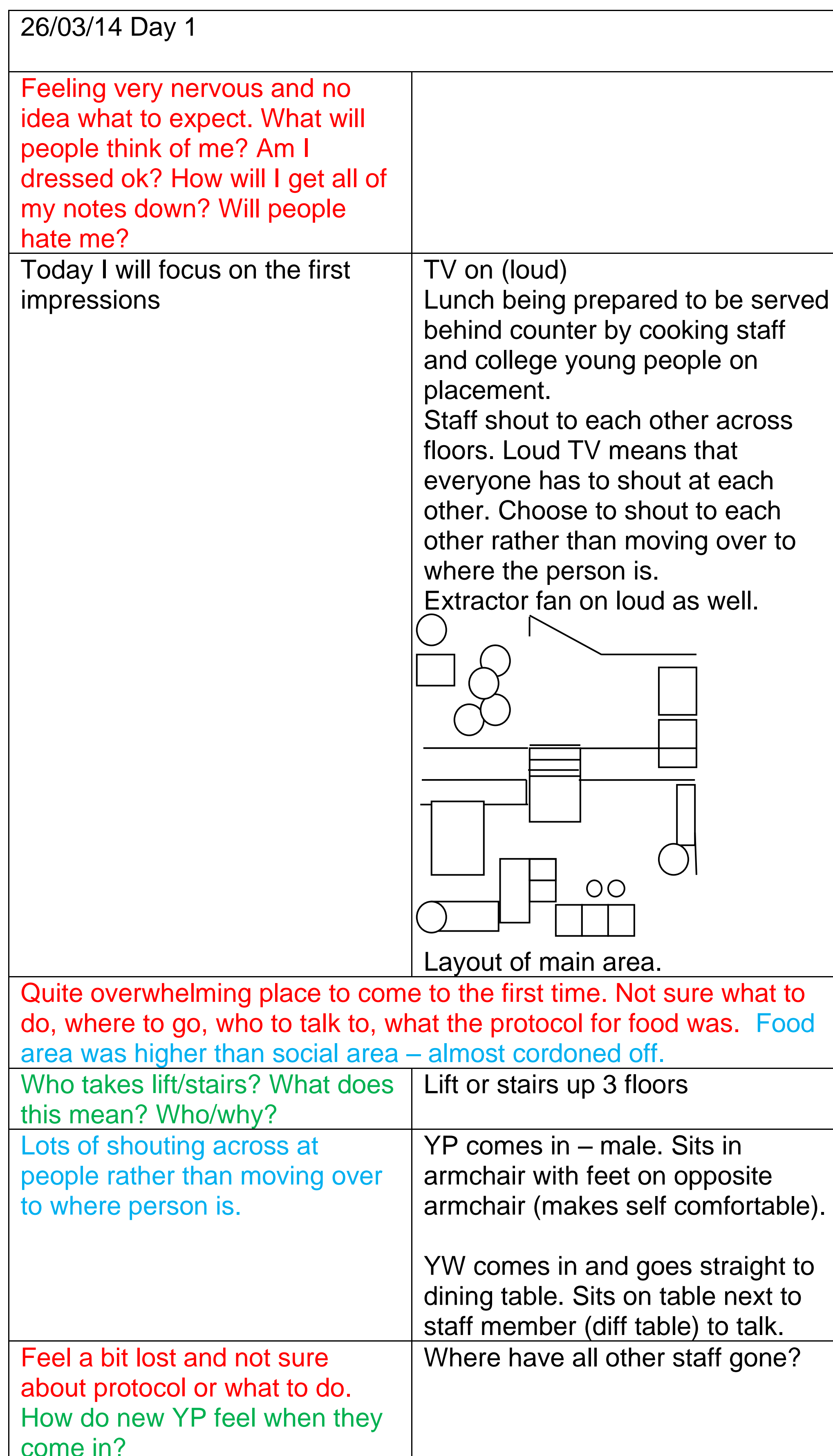
Appendix VII – Example of field notes for city site



26/03/14 Day 1	
Feeling very nervous and no idea what to expect. What will people think of me? Am I dressed ok? How will I get all of my notes down? Will people hate me?	
Today I will focus on the first impressions	TV on (loud) Lunch being prepared to be served behind counter by cooking staff and college young people on placement. Staff shout to each other across floors. Loud TV means that everyone has to shout at each other. Choose to shout to each other rather than moving over to where the person is. Extractor fan on loud as well. Layout of main area.
Quite overwhelming place to come to the first time. Not sure what to do, where to go, who to talk to, what the protocol for food was. Food area was higher than social area – almost cordoned off.	
Who takes lift/stairs? What does this mean? Who/why?	Lift or stairs up 3 floors
Lots of shouting across at people rather than moving over to where person is.	YP comes in – male. Sits in armchair with feet on opposite armchair (makes self comfortable). YW comes in and goes straight to dining table. Sits on table next to staff member (diff table) to talk.
Feel a bit lost and not sure about protocol or what to do. How do new YP feel when they come in?	Where have all other staff gone?

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Appendix VIII - Interview/Focus Group Themes

Lead investigator to do interviews (Danielle Sinclair, PhD Student Researcher).

The interview and focus group schedule will be informed by two months of observation in and around the youth group/youth work setting

Broad areas for discussion will include:

- What information relating to health and healthy bodies is on offer to young people?
- What information do they pay attention to?
- What do they do with this information?
- How does this impact they feel about their bodies?

Interview and focus groups schedules will also be informed by 'critical events' observed by the researcher during the course of fieldwork. The second focus group will follow a semi-structured format informed by previous sessions based on clarifying previous incidents/comments. Interview and focus group guides will be developed in consultation with supervisors.

Interview 1 started with the following questions:

- What do you think about when you hear the word 'health'?
- How important is health to you?
- How do you know who is healthy or not?
- Tell me about someone you know who us un/healthy – what makes them un/healthy?

Examples of the further questions used by the interviewer:

- What do you mean when you say that?
- Can you tell me more about that?
- What's that like for you?
- What do you know about that?
- What do you think?
- What/how did you do?
- How did you find out about that?
- How do you know that's true?

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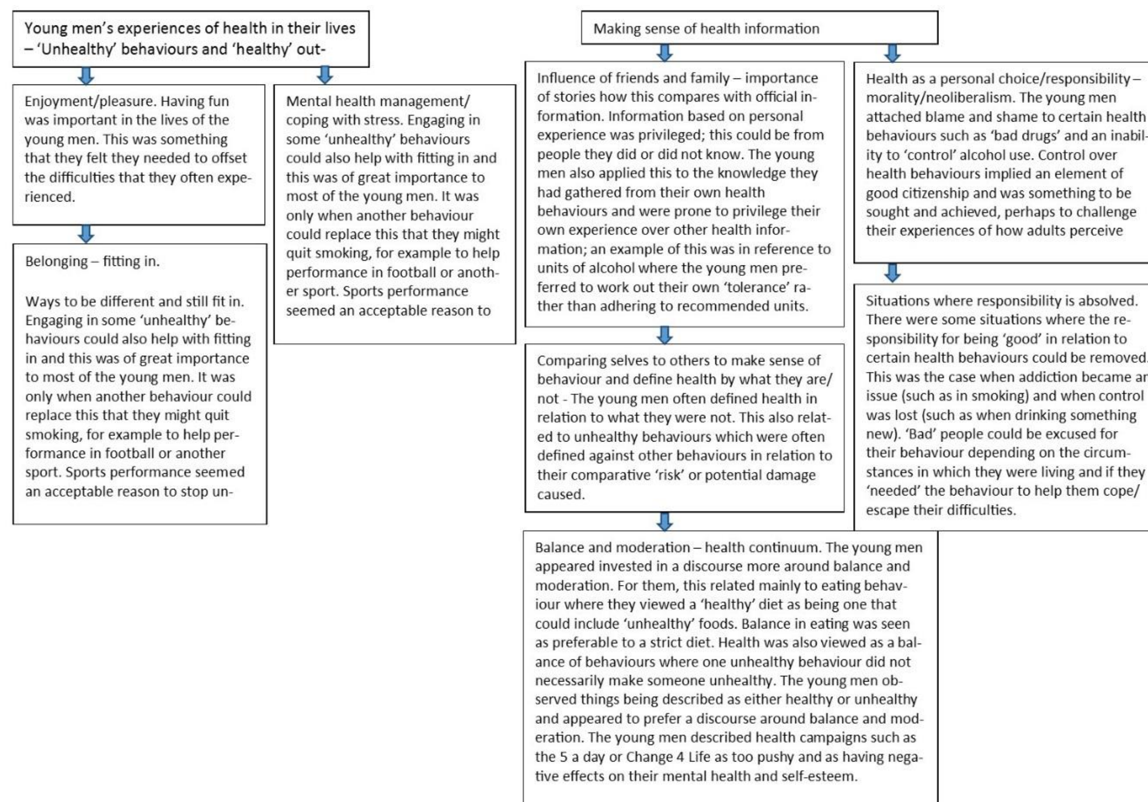
Appendix IX – Theme tree: Stage 4 of Kleining and Witt's Model (2000)



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