



Health Development Agency

Boys' and Young Men's Health

Literature and practice review

An interim report

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on behalf of the
Health Development Agency*

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This report, which accompanies the Practice Examples, comprises the first stage of this piece of work. Stage 2 will identify key learning points from a range of different young men's projects in terms of 'what works and why'. At least 15 projects will be involved, drawn from those identified in the mapping exercise, and will include projects from both the voluntary and statutory sectors.

The learning from Stage 2 will be disseminated in Autumn 2002, via an evidence-based resource, to be written by Working With Men. This will provide guidance on how to establish an effective young men's project, whether it be based in the voluntary or statutory sector.

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Introduction

Working with Men was asked by the Health Development Agency (HDA) to carry out a literature review and to map innovative work with boys and young men concerning their physical and mental health.

The objectives of the review were to:

- provide a picture of what we know about young men's health
- identify gaps in both literature and practice
- recommend initiatives that HDA and others could take in addressing young men's health.

The scope of the literature review was:

- age range 11–25 years
- about 20% to focus on school-aged boys and young men
- main focus on literature written since 1995 (acknowledging that for some issues documents produced before 1995 would need to be taken into account).

We were also specifically asked to identify vulnerable groups, especially those affected by deprivation and poverty.

To complement the literature review, we were asked to map innovative work with boys and young men, specifically in England. This was not envisaged as mapping all of the work being developed, but as identifying significant practice-related themes and 'good practice' (whether evaluated or not).

There was an expectation that most of the work covered should be working with boys and young men by design, not by default. This means that 'gender awareness' has formed part of the approach (excluding, for instance, mainstream drugs work, unless there is a specific awareness of gender issues).

How we went about the literature review

A number of book and journal searches were carried out. These included: Medline, Royal College of Nursing, National Youth Agency and National Children's Bureau; and literature sources were then snowballed.

Two publications in particular were significant starting points: Catherine Dennison and John Coleman's *Young People and Gender: A Review of Research*, a report submitted to the Women's Unit, Cabinet Office and the Home Office's Family Policy Unit in September 2000; and John Coleman and Jane Schofield's *Key Data on Adolescence* from the Trust for the Study of Adolescence in 2001.

Men's health

There is no agreed definition of what constitutes 'men's health' – this has been highlighted as one of the barriers to professionals taking up men's health as an issue (Lloyd, 1996). Even recent publications addressing men's health skirt around defining it. In the preface of an introductory text for nurses and health professionals, the authors argue that 'relegating men's health to disease association alone would be a retrograde step in our understanding of the concept of health as a whole', but then fail to go on and define what they think it is (Harrison and Dignan, 1999).

A similar introductory volume for general practitioners takes a stab at what it is not, and then at what it is, suggesting: 'any theory that attempts to explain the evidence will need to look beyond purely biological concepts of gender to social ones of masculinity. Until very recently, masculinity was invisible, with maleness being seen as the norm and femaleness defined in contrast to it. However, if we wish to tackle the burden of male illness, we shall need to understand why men take more risks than women, why they are more reluctant to see their doctor, and to what extent such behaviours are bound up with core ideas of masculinity' (O'Dowd and Jewell, 1998). For O'Dowd and Jewell, men's health is therefore about risk, reluctance and masculine behaviour.

For the purpose of this review, we will be using Richard Fletcher's definition, adapted from the US Public Health Service's definition of women's health: '... conditions or diseases that are unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men' (Fletcher, 1997).

This broad definition allows for a range of conditions, behaviours, underpinning issues and differences in clinical practice, while still maintaining a recognisable framework. But for some, problem-based definitions such as this are part of the problem. We have taken this definition as a half-way house between the two extremes of 'men's health as biology', and definitions that include such issues as education, family life and adolescence – which all have a significant bearing on a young man's health, but would certainly make this publication unmanageable.

Adolescent health

2 Calman suggests that: 'adolescence is the transitional phase between childhood and adulthood, characterised by experimentation and rapid change. It is a key time for learning, mainly by exploration of new ideas and behaviours, for consolidating health-related values, attitudes and lifestyles, and for making decisions about various behaviours which have important consequences for future health. The purpose of adolescent healthcare is to support this process and to enable young people to become healthy and competent adults' (Calman, 1994).

The period we call adolescence has expanded. While puberty, sexuality, independence and experimentation have always been components of this transition, the extension of education (more than 75% of young people are in education or training until they are 18); the shortage of cheap housing (which traditionally enabled young people to leave the family home); and the continued lack of career job opportunities have increased the dependence of young people into their early 20s. This is especially the case for young men.

There is also evidence that puberty and social pressures have led to children looking for adolescent experiences increasingly earlier. There is strong evidence to suggest that the period between childhood and adulthood may well be more than a transitional adolescent phase.

These changes have led to a number of tensions, including, for some, earlier experimentation at ages when parents and others believe children still need protection. This carries a need for negotiation between young people and their parents at a time when they would previously have been in independent housing.

Sex and relationship education is one of the issues caught in the crossfire. Young people continue to tell teachers and researchers that they would like sex and relationship

education earlier than it is currently delivered, while for some parents, teachers and educationalists the fear of encouraging premature experimentation and spoiling childhood innocence has led to heightened tensions.

These tensions have a gender component. The World Health Organization's report on *Gender Health and Adolescence* concludes that: 'health risk behaviour obtains a specific meaning in this context. Adolescents are explicitly looking for gender-loaded body expressions or methods that make the construction of sexuality appear easier for them. Male-connoted alcohol excesses and female-connoted diet behaviour are just the right signs for them, since the expression of femininity and masculinity is thus obviously connected with a special way of dealing with one's body. Thus health risk behaviour serves particularly to express or confirm that one is (or is becoming) a man or a woman' (WHO, 1999).

While this 1950s notion of gender (that both young men and women are looking to fit neatly into their 'appropriate gender slot') is dated, these gender-related behaviours are certainly part of the context of adolescent experimentation and exploration, resulting in adult ambivalence and sometimes fear. It is within this complex and rapidly changing territory that we have to look at the health of boys and young men.

We cannot ignore more traditional understandings of adolescence that continue to have a huge bearing on young people's health. Self-esteem (while an over-used and not consistently understood concept) is thought by many to be a primary measure of whether an individual is coping and adapting (Dennison and Coleman, 2000), as well as being a decisive element within health decision-making. While gender has been a part of the self-esteem (and identity) debate, Dennison and Coleman conclude that there 'are no clear gender differences across the whole of the age span'. However, there is an acknowledgement that context may be very significant. Coleman and Schofield illustrate this with: 'A young woman in school might have high self-esteem when considering her ability in the art room, but low self-esteem when playing a game of hockey' (Coleman and Schofield, 2000). Harter (1990) suggests that physical appearance in early adolescence may be particularly important; Heaven (1994) argues that peer group pressure may be significant in early adolescence. Muuss, for example, in his literature review, concludes that: 'among males, identity achievers and moratorium respondents tend to be closely grouped. They are usually internally controlled and more resistant to

manipulation of self-esteem. They also tend to score higher on tasks such as concept attainment' (Muuss, 1988).

Self-esteem, peer pressure, identity and coping styles all have gender elements that make them important aspects of a review of young men's health. We will return to these themes later in this review.

A note about this report

An academic literature review usually takes a particular form. However, the primary audience for this review will be practitioners developing work with boys and young men, or involved in policy issues. We have therefore written this report to review and comment on the literature, especially drawing attention to gaps. These comments are found in the conclusion to each section, and sometimes within the text itself. With such a wealth of material, our aim is to produce an accessible document that practitioners will use to inform their practice.

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Working With Men

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The context of men's health

We have found a number of descriptions of men's health, but very few definitions.

The CMO (and many others since) starts with the overall mortality difference between women and men – at least 5 years throughout the past century (Calman, 1993). Most authors then highlight a series of conditions, risk factors and causes of death where men are statistically more likely to appear: suicide, heart disease, alcohol abuse, drug use and accidents, and then the gender-based testicular and prostate cancers (O'Dowd and Jewell, 1998; Harrison and Dignan, 1999). A minority start from an understanding of men, followed by the implications for health (Sabo and Gordon, 1995; Davidson and Lloyd, 2001).

Most of the statistical data on incidence (whether levels of drinking, deaths, or visits to GPs) are presented 'in relation to' the incidence for women. Most conditions are regarded as a cause for concern because the incidence is higher for men, or not a concern because they are lower for men.

This, unfortunately, sets us on a path of comparison which sometimes leads to competition and rivalry, with little discussion about what might be reasonably expected. So, for instance, with attendance at GPs' surgeries (where women, on average, attend twice as often as men), it is argued that men are poor users. Maybe they are, but we rarely ask whether women use services too much? This question may bring accusations of being 'anti-women'; but the more popular literature is developing its own 'statements of fact' that need constant review, and it should be recognised that we are in gender territory which can be laden with tensions and misunderstandings.

Waldron (1995) raises some important questions about gender differences in mortality, including the questions: 'What have women to gain from addressing men's health?' and 'What have men to gain from addressing women's health?'. So, for example, developing perpetrator programmes to tackle domestic violence would appear to be beneficial for both men and women, while teaching boys to look after their own health will remove the responsibility from their mothers (Waldron, 1995).

It is at this stage that the literature diverges into a number of traditional directions: biology; health beliefs; men's behaviour (particularly risk-taking); poverty; the male role; and health agencies' reluctance to develop appropriate services.

There is evidence that biology plays a part in the gender differences in mortality. Women are thought to have a consistently lower neuroendocrine and cardiovascular reactivity to stressors than men (Manuk and Polefrone, 1987), and men are thought to have a lifelong sensitivity to certain prostaglandin metabolites that puts them at higher risk of vascular damage and coronary disease than women (Ramsey and Ramwell, 1984). At a general level, it is thought that genetic differences protect women from genetic diseases, and hormonal differences make men vulnerable to certain diseases (Kilmartin, 1994).

Previous suggestions that female hormones make women vulnerable to depression and other psychiatric illness have been discounted more recently (Golombak and Fivush, 1994), although the views that testosterone causes male aggression and adrenaline has an impact on male levels of risk-taking still have their supporters (Edley and Wetherell, 1995). Recent studies suggest that the relationship is slightly more complex. Kimmel (2000) reports that 'previously it has been shown that males have higher levels of testosterone and higher rates of aggressive behaviour; what's more, if the level of testosterone is increased in a normal male, his level of aggression will increase. Castrate him – or at least a rodent proxy of him – and his aggressive behaviour will cease'. However, Sapolsky has found that testosterone does not cause aggression, but facilitates aggression that is already there, and that, in fact, testosterone is produced *by* aggression (Sapolsky, 1997). This has brought into question a number of commonly held beliefs about men and aggressive behaviour.

Other developments in this field include Caruthers' assertions that there is a male menopause, brought on by low testosterone activity, and that men also have a three-monthly hormonal cycle which can include dramatic mood swings (Caruthers, 1996).

Although there is clearly still a lot to learn about biological, genetic and body-induced chemicals, it is generally accepted that these differences do not wholly account for the mortality rates. Some studies have suggested that biological protection can be removed by behavioural factors – the increased risk of cardiovascular disease for postmenopausal women, for example.

Templer *et al.* (1993) suggest that alcohol misuse accounts for an appreciable number of male life years lost; while Waldron (1988) posits that half of the mortality sex difference can be attributed to smoking. Reddy *et al.* (1992) conclude that gender differentials in health are less a result of genetic factors and more a result of conforming to behaviour socially defined as appropriate for men and women.

Men's behaviour has been interpreted on a number of levels. At a popularist level, Carroll (1994) suggests that 'men in general tend to neglect their health ... ask a man how he feels and he will invariably say he's fine, regardless of how severely or for how long he has been suffering from a health problem ... men are certainly badly informed about many important aspects of their health'. For others, behaviour has a more general impact: 'Most of the leading causes of death among men are the result of men's behaviours – gendered behaviours that leave men more vulnerable to certain illnesses' (Kimmel and Messner, 1995).

A range of behaviours is often described. Carrol (1994) emphasises neglect and being poorly informed. Harrison and Dignan (1999) suggest that men are combative and competitive, physically active and independent, and that this leads men to ignore their health. They go on to suggest that 'men's health, particularly that of younger men, is often put at risk and indeed is often subject to moderate to severe or fatal injury by dangerous, combative and competitive activities and sports, examples including high-speed and reckless driving, playing rugby and soccer hooliganism'. Helman (1994) suggests that men are actively encouraged to drink more alcohol and smoke more cigarettes, both activities being a validation of masculinity, 'oiling the social wheels of male bonding'.

Harrison and Dignan (1999) suggest that 'the male gender culture in many aspects is pathogenic rather than protective of health and the majority of the negative aspects can be categorised under the rubric of "lifestyle choices and occupation" '.

The point made by these authors is that many men may be

aware that they are ill, but actively decide not to seek help. They argue that the male gender role dictates that sickness is seen as an expression of weakness, so in the event of illness, stoical, strong and silent bravery (encouraged by the male gender culture) kicks in. This leads to reluctance to seek professional help, which can be counter-productive to health (Helman, 1994). So men may ignore a serious condition and seek help too late, or may play down the symptoms, causing the doctor to underestimate the seriousness of the problem. Others have stressed differences in the way young men and women are socialised into related characteristics. So, Sabo and Gordon (1995) suggest that 'if a little girl falls down and is hurt, she can expect to be picked up and cuddled, almost rewarded for the injury, and she is made to feel better. Little boys, on the other hand, can expect to be picked up and told not to cry, but to be a "brave little boy" .' Another example is the view that parents are thought to interact on an emotional level with females more than males, leaving girls (and women) more able to understand and interpret their emotional experiences (Golombak and Fivush, 1994).

A series of characteristics, attitudes and themes about men and masculinity emerges from the literature, including:

- men and women are socialised differently, and part of this difference has implications for health beliefs, attitudes and behaviours
- core themes of traditional masculine characteristics and attitudes inhibit health-enhancing behaviour: strength (physical and emotional); proving you are a man (by not showing weakness or vulnerability, and by taking risks such as drinking too much); independence (not asking for help); being self-contained (self-healing and able to look after yourself); putting work needs before health needs and emotions
- these masculine characteristics and attitudes can lead to having little interest in health knowledge and healthy activities, becoming poor users of health services such as dentistry, counselling and most primary healthcare services, leaving symptoms longer than necessary, and being reluctant to ask for or accept help.

For some, this relatively simplistic model has been enough; but for others the emphasis has also been on the dramatic changes in the labour market, followed by a questioning of the traditional male role.

The Samaritans, for example, have concluded that the increase in young men's suicide is a result of their uncertainty about their role now that traditional male industries and

manufacturing have disappeared (Samaritans, 1993). This theme also highlights the difficulties some men have in adapting to dramatic life changes such as moving from primary to secondary school, entering the workplace, leaving further education, divorce, separation, unemployment and retirement. All of these changes seem to be more difficult for men than for women to adjust to (Lloyd, 1997).

As well as male characteristics and the impact of men's changing roles in society, some authors highlight evidence that the professional attitudes, knowledge and approaches of the health services towards men are not always helpful or appropriate.

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Evening surgery opening hours, information on the Internet, and targeting places men already visit (sports activities, pubs, etc.), have all been highlighted as important aspects of a men's health targeting strategy (Cooper, 2000). The 1980s and early 1990s saw a substantial increase in street and club work by local health promotion specialists wanting to target gay young men with literature and advice relating to HIV. The recognition that information and advice may need to *go to* men has been one of the primary strands of development in men's health work; but this shift in emphasis will come about only if there is a change in the attitude and activity of professional workers (Hoare and Walsh, 2001; Robinson, 2001).

Seex (1996), in a study of family planning clinics, suggests that staff need to develop their understanding of young men and their skills in working with them, highlighting that staff have had little experience of young men using their clinics, so new skills are required.

Education provides a more substantial literature of teachers' understanding and the need for new skills. Arnot (1998), in her summary of school-based literature, identifies a number of local studies with implications for staff. She reports: 'It has been argued that the messages conveyed by common stereotypes influence teachers in the way they respond to their pupils, and that this happens from an early stage in the process of education'.

Cullingford found that his sample of year 7 pupils did think that teachers imposed stereotypical attitudes. They *did* believe that boys and girls were treated differently and they were all concerned about the 'unfair' treatment of boys in particular. But they also assumed that this was in response to differences in behaviour, and not the result of a preconceived bias on the part of the teacher' (Arnott, 1998).

The area of teachers' responses to young men whose behaviour is distracting to disruptive is one that Lenderyou and Ray (1997) pick up in their guide to sex and relationships education with young men. They suggest that 'as we work with the present questions and attitudes of boys, we need to "look behind the mask", to consider the vulnerabilities that hide behind so-called macho behaviour and identify another set of needs'.

The suggestion is that professionals are often distracted by the behaviour of (especially) young men, and miss the real issue. Again within the educational setting, Lloyd reports the words of a young man who had difficulty reading at primary school and did not want this to be discovered: 'They never noticed, I didn't show it. I preferred to make trouble, cover it up. I wouldn't say it, I'd pick a fight or break a window. I know what I was doing, basically when I was asked to read, I'd do something bad and get sent out on my turn.' (Lloyd, 1999).

In contrast to this view that boys' behaviour needs to be understood and seen beyond, a number of authors believe these approaches are too sympathetic, suggesting instead that the focus of work with young men should be on their unwillingness to take responsibility for themselves, and particularly on the impact of their behaviour on others (Tett, 1998).

Connell (1995) highlights the need to recognise the benefits men gain from the decisions they make and, in particular, the status that the non-reading young man may have gained with his peers by taking the action he did. Others would argue that health services are there for men to use, and it is up to them to use them.

The same tensions can be found in much of the domestic violence literature. Are programmes developed for men to deal with their violence, or to protect women and children? This basic question has led to the development of services that are supportive of men dealing with their violence and those that emphasise 'men's responsibilities to others' (Newburn and Mair, 1996; Hearn, 1998).

We have identified three common components in the recent literature relating to men's health:

- traits, beliefs, characteristics, attitudes and behaviour often seen in men that relate to their perceptions of masculinity and affect their attitudes towards health and their use of health services

- recent societal and role changes that have had an impact on both individual men and perceptions of the gender
- professionals' attitudes and practices with men that will affect men's attitudes and behaviour towards services that are targeting them.

Difference and contradictions are also a common theme within the literature. The value of the general theme of masculinity, and of 'men' as a unitary label, has been questioned for some time. Connell (1995) suggests that there are a number of competing masculinities (influenced by sexuality, race, culture, religion, geography, etc.), and that these bounce off and relate to 'hegemonic masculinity' (the ideology based on an imbalance of power between men and women), and that individuals construct an identity from these.

Connell also questions what he calls 'categorical thinking', where gender is 'presumed to be biological and the relationship between them a collective or standardised one' (Connell, 1995). An example of this would be the view that all men are unable to express their feelings, or all men are reluctant to go to see their doctor.

Connell and others (eg Mac an Ghail, 1997) have highlighted the importance of not just looking at gender as the only factor. Within the context of health, social class has again emerged as of primary importance, and quite rightly (Drever and Whitehead, 1997; Acheson, 1998). Here the case is set out for: 'concerted action to tackle not just the causes of disease, but the causes of the causes: poverty, inequalities, social exclusion, unemployment, and the other features of the physical and social environment that converge to undermine health' (*Our Healthier Nation*, 1998).

Most health conditions that have a negative impact on men have a greater effect on men in social classes IV and V than on men in social classes I and II; in some instances the difference between social classes I and V is larger than that between men and women. Too many advocates of men's health have been slow to incorporate this into their practice, keeping their analysis at a 'gender difference' level only. Kimmel (2000) is particularly critical of what he believes are the motives of those advocating on young men's behalf. In the USA, concerns about boys are similar to those here, mainly hinging on education, role, suicide and violence (which takes on a particularly deadly form of shooting and homicide). Kimmel questions some of the educational statistics, arguing that it is working class boys, and African-American boys, who are underachieving (which is not new),

while some authors are talking about 'a war against American boys'. He goes on to suggest that many of these advocates identify lone parent mothers, teachers in junior schools (mainly women), and the feminization of boys as some of the main reasons for the crisis, and suggests that this is the primary motivation for some to advocate on boys' behalf (Kimmel, 2000).

Another important theme to emerge is the extent to which a men's health approach has been incorporated into developing practice. There are those who have used statistics to identify issues where boys and young men are over-represented, but have done nothing with this information. The Social Exclusion Unit's report *Rough Sleeping*, for example, tells us that around 90% (of rough sleepers) are male (SEU, 1998), but fails to (or chooses not to) comment on this.

Kimmel has talked about the 'invisibility of masculinity'. He suggests that masculinity is hidden within terms such as 'youth crime', 'teen violence' and 'gang violence' (Kimmel, 2000). Noting that 90% of those sleeping rough are male, and leaving it at that, is given as an example of making masculinity invisible.

Others suggest that the number of homeless young women is under-reported, because they may be hidden in unsafe environments (prostitution and other exploitative settings). This provides a gender difference which may have implications for differing need and interventions, but unless this is explicit, gender again remains invisible.

Another common approach in the literature is what Hearn has described as individualising masculinity. He writes: 'In this view, masculinity is individually possessed. It is a "something" that is held differentially by different people' (Hearn, 1996). Authors such as Katz, who divide young men into groups of 'Can-do Boys' and 'Low-Can-do Boys', concludes that rather than there being a crisis in masculinity, 'most boys are managing reasonably well. Some do particularly well. But, 20% of boys have been in trouble with the police, 11% are depressed or suicidal, 17% are deeply alienated from school. Low-Can-do boys are more susceptible to having one or more of these difficulties' (Katz, 1999).

The methodology used by Katz to arrive at her 'Can-do' analysis has been criticised by Dennison and Coleman (2000). Although Hearn also criticises this type of approach because it ignores the institutional levels and social relations between men and women (Hearn, 1996), it is an attractive approach

for practitioners as it helps them to understand young men and to know 'how to deal with the increasingly long tail' (this was how a head teacher of a Dorset boys' grammar school described the school's increasing number of underachieving boys).

To date, there have been very few examples of masculinity being fully integrated into men's health studies. One exception is Helgerson's work on coronary heart disease (CHD) (Helgerson, 1995), which integrates masculinity theory into the ways that men cope and adjust to CHD. She highlights the overlap between type A characteristics (identified as behaviour patterns most likely to lead to CHD) and what she calls 'trait masculinity', and finds a strong correlation between the two.

She also notes that some aspects of traditional masculine behaviours may have a positive effect on adjustment to illness. She suggests that exercise, self-confidence, independence, and being focused and task-orientated are all characteristics that may help with the recovery and adjustment process; but impoverished social networks, poor health service use, hostility towards health professionals and restricted emotionality may inhibit recovery.

Some characteristics can be both positive and negative. Helgerson suggests, for example, that a common way for some men to cope with stressful events is to avoid, deny or distract themselves from the problem. She comments: 'on the positive side, denial has been associated with reduced psychological distress, return to work, resumption of sexual activity, better medical outcomes during hospitalisation, and less mortality in the coronary care unit. On the negative side, denial has been associated with non-compliance (eg smoking in the hospital, failure to follow a medical regimen in and out of the hospital) (Helgerson, 1995; Helgerson and Mickelson, 1997).

Gordon (1995) deals with the same tensions in his study of testicular cancer. He suggests that: 'constructing a traditional masculine identity had both positive and negative effects for the men. Using the traditional model to interpret their cancer as a struggle that proved their courage and toughness enabled them to feel more self-confident and more masculine. Traditional masculinity can also help maintain advantaged positions within marriages. The most important

negative effect evident in these interviews was difficulty in coping with a less desirable body image' (Gordon, 1995).

He also found that some men were able to adapt to the illness by redefining their image of masculinity.

Harrison and Dignan (1999) suggest that 'on the one hand they (men) are expected to be achievement orientated and unemotional, while on the other hand there is an expectation of emotional intimacy with women'. Contradictions and difference are important aspects of men's health that need to be identified and integrated into policy and practice.

Conclusions

- Men's socialisation can have an impact on men's health in a range of different ways, including having little interest in health knowledge and healthy activities; becoming poor users of health services; leaving symptoms longer than necessary; and being reluctant to ask for or accept help.
- Professionals' attitudes and skills can inhibit men's use of health services.
- Tensions exist between those who are supportive of and antagonistic towards young men. Both approaches are at risk of simplifying the impact of masculinity on young men's health.
- Men's health analyses have been based too much on comparisons between men's and women's health, and this has led to a view that men's and women's health are in competition and a primary site for 'sex wars'.
- Gender is often invisible in the broader health-related literature. When it does make an appearance, it is too often used in a very simplistic and/or generalised way.
- Masculinity has both negative and positive impacts on men's health. The complex nature of masculinity needs to become a more prominent component of men's health literature and practice.
- Masculinity suggests four underpinning themes that are important within men's health:
 - men's social roles and status, particularly in terms of work, relationships, marriage and family
 - men's individual help-seeking behaviours
 - levels of negative risk-taking
 - the impact masculinity may have on individual men's health decision-making processes.

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Conditions

Accidents and resulting disabilities

Road traffic accidents

There are approximately *three times* more road traffic fatalities among males than females. For 15–19-year-olds, this is as high as 3.5 males to one female. Deaths of motor vehicle drivers and passengers currently account for around half the road traffic mortalities among males, with pedestrians accounting for about a quarter.

Road traffic mortality peaks in both the elderly (75 years and over), and men aged 15–24 years. Road traffic accidents are thought to account for around 3% of the years of working life lost among men, and 1% amongst women, approximately 100,000 and 30,000 years, respectively. This is lower than the years of working life lost due to suicide, but higher than the number due to drug-related deaths among males (ONS, 1999a).

Fatal accidents are, predictably, clustered in metropolitan areas where road density is high. For males, there are also large numbers throughout the south-east and the Midlands (ONS, 1999a).

Mortality from road traffic incidents has declined by over 40% since the early 1980s. Among men, the most striking declines have occurred in pedestrian and motor cycle mortality rates, both of which have halved since the early 1980s (DETR, 1998). This decline is thought to be, at least in part, a result of a sharp fall in the number of motor cycle and pedal cycle miles travelled in recent years. Since the early 1980s, the estimated motor cycle mileage in GB has roughly halved, while pedal cycle mileage has fallen by around a third (DETR, 1998). Similarly, the distance walked per person has fallen by nearly 20% since the mid-1980s (DETR, 1998).

These trends probably do account for much of the long-term reduction in deaths among users of motor and pedal cycles. Over the same period, the distance travelled using other motor vehicles has increased dramatically.

Another feature of the reduction in motor cycle and pedal cycle mileage is the apparent decline in the number of deaths

attributed to skull fractures since the early 1990s (ONS, 1999a). There has also been a fall in neck, trunk and limb fractures. Some of the decline in deaths due to fractures is thought to be associated with the change in the coroner's form in 1993, which led to less detailed information on injuries being recorded (Rooney and Devis, 1996). It appears that many of the deaths previously attributed to fractures are now classified as being due to internal injuries of the chest, abdomen and pelvis, or to multiple injuries.

The decline in road traffic mortality may be related to a number of risk factors and prevention measures, probably acting in combination, including:

- number of people using different modes of transport
- reduction in traffic speed due to increased volumes
- overall decrease in motor cycle sales
- introduction of a two-part motor cycle test and restriction on provisional motor cycle licences to 2 years in 1982
- stricter drink-driving controls, including number of breath tests
- introduction of speed cameras
- seat-belt legislation
- improved car design
- improvements in treatment for those involved in traffic accidents.

Studies of driving behaviour are rare, which is particularly surprising given the media focus on road rage over the past five years. One exception is a Canadian study carried out by Vavrik (1997), exploring the role of personality factors in adolescent male drivers. Summarising previous approaches, he highlights studies that point to male aggression and alienation from the educational system as significant in risky driving. He describes another study that found risky driving to be an outlet for aggressive and hostile young males with poor coping and communication skills, and other studies that found a relationship between social deviance and impulsive decision-making (Vavrik, 1997). In his own study, Vavrik concludes that both individual personality factors and issues related to the 'social context within which many risky, symbolic behaviours are often created and legitimised' contribute to risky driving (Vavrik, 1997).

Williams, reviewing the literature, makes three important assertions. He first suggests that most interventions have concentrated on limiting speed by enforcement and punishment (which is acknowledged to be important), but he goes on to suggest that we need to 'understand what factors in adolescent development promote and support risky behaviours of this type. There has been a tendency to focus on single behaviours, especially alcohol and driving, in isolation from other related problem behaviours related to crash involvement' (Williams, 1998).

12 His second, related, assertion is that there is a subgroup of drivers who reflect 'certain personality traits (rebelliousness, alienation, independence, defiance of authority), risky driving practices (speeding, drinking and driving), reduced parental influence, and crashes and violations'. He concludes from his study of drivers in four US states that a graduated licensing system that 'deals with the issue of inexperience by providing the opportunity for on-road driving experience in protective settings' will either coerce those drivers with problem driver characteristics, or ban them from driving. He points to New Zealand's graduated licensing (introduced in 1987), but suggests that the monitoring of the scheme was inadequate.

Connell, rather than concentrating on individual personality traits, points to the social context of some risky driving. 'When a group of young men in a car drink, drive and crash, they are not being driven to it by uncontrollable hormones, or even an uncontrollable male role. They are acting that way in order to be masculine. The dangerous driving is a resource for their making of masculinity. Here the active construction of masculinity is a key to the risk-taking behaviour, and to strategies of prevention' (Connell, 2000).

All other accidents

Young males are involved in a greater number of accidents, ranging from fatal to those not requiring treatment from medical practitioners (Haselden *et al.*, 1999; DTI, 2000). Annual major accident rates per 100 persons were estimated to be 31 per 100 for boys aged 2–15, and 42 per 100 for men aged 16–24. The corresponding figure for girls and young women was 22 per 100, the overall rate being the same for those aged 2–15 as for those aged 16–24 (Prescott-Clarke and Primatesta, 1998).

For younger males, some of the increase in the major accident rate reflects an involvement in sports and exercise accidents. After the age of 13, however, the incidence of these accidents declines, although the overall major accident

rate was (at least partly) maintained by an increase in the rate of motor vehicle accidents and accidents caused by the use of a tool, implement or piece of electrical or mechanical equipment (Prescott-Clarke and Primatesta, 1998).

By the age of 13–15 years, only 12% of major accidents involving males and 26% of major accidents involving females occurred in the home or garden. At this age, when sports and exercise accident rates are at their peak, 50% of major accidents to males and 35% of major accidents to females occurred in a place for sports or recreation. For the older age group (20–24), close to a third of accidents occurred in the workplace, school or other public building. The pattern for minor accidents was broadly the same (Prescott-Clarke and Primatesta, 1998).

While there has been significant analysis of accident rates for young people (DETR, 1998; ONS, 1999a), and particularly of the high level of male accidents, there has been surprisingly little discussion about why this is, or what can be done about it. Accidents are often identified as a reflection of young men's high levels of risk-taking (Calman, 1994), or alcohol use and inexperience (Hibert, 1996). It has also been suggested that accidents (for young men) are not random events, but are associated with a particular lifestyle (Hibert, 1996).

Avery and Jackson point out that 'boys are more likely than girls to have accidents. This fact has been confirmed by virtually all studies. The only age at which this is not the case is in the first year of life. From about 9 months onwards boys are involved in more accidents than girls. More boys are involved in fatal accidents, more are admitted into hospital because of accidents and more visit Accident and Emergency departments for treatment' (Avery and Jackson, 1993).

However, Avery and Jackson do not put this down to gender, but instead suggest that '... maybe they are exposed to more situations in which an accident is possible. For example, boys have more cycle accidents than girls, but this may be entirely explained by the fact that boys ride their bicycles more frequently than girls do. It does not mean that they are inherently less able or safe on the road' (Avery and Jackson, 1993).

They suggest that this is not only a result of situations and frequency, but also because of innate activity: 'This is probably related to boys being exposed to more risk and to their innate level of physical activity and aggressiveness. To what extent this is genetically determined or culturally

imbued by parents' and society's expectations of boyish vigour remains open to debate' (Avery and Jackson, 1993).

They back up this claim by referring to the British Births Survey: 'It was found that aggressive behaviour was associated with all accidental injuries after adjustments for social class, crowding, mother's psychological distress, age, marital status and the child's sex. Over-activity was also associated with injuries not resulting in hospitalisation after the same adjustments have been made. Children who scored highly in behavioural tests to ascertain aggression and over-activity were nearly twice as likely (1.9 times to be exact) to sustain injuries requiring hospitalisation than those scoring low marks on the same tests' (Avery and Jackson, 1993).

Stillion (1995), after reviewing premature death rates in the USA, suggests that 'there is no question that males live in a much more dangerous world than do women'. Within her analysis she develops a hierarchy of influence on types of cause of death. So, for example, stage one is terminal genetic illness, where the influence an individual has is relatively low, with stage eight being suicide, which Stillion suggests (from a range of aspects including socialisation, environment, genetics and individual choice) has the largest individual choices on the spectrum. She then argues that the more individual the choice, the more men (statistically) make that choice (Stillion, 1995).

Gender (whether biological or behavioural) is not the only factor to take into account. Avery and Jackson also report that boys in social class V are seven times more likely to be killed in pedestrian road accidents, 15 times more likely to be killed in an accidental death by fire, and nine times more likely to drown than those in social class I (Avery and Jackson, 1993).

Kendrick makes the same analysis: 'children aged 0–14 with fathers in social class V are twice as likely to die from any cause as their counterparts born to fathers in social class I. However, such children are three times more likely to die from an accident and five times more likely to die from being hit by a car; and the gap between classes for deaths caused by fires, falls and drowning is even higher' (Kendrick, 1995).

These class differences in accident-related mortality are thought to be greatest in 1–4-year-olds, and for boys. In this age group the mortality ratios between social classes V and I are 3.38:1 for boys and 2.58:1 for girls. The figures for 5–9-year-olds are 2.07:1 for boys and 1.85:1 for girls; and the ratios for 10–14-year-olds are 1.77:1

and 1.58:1, respectively (Pharaoh and Alberman, 1990).

Roberts and co-workers argue that 'much of the academic literature also evades the inequalities debate by focusing on the behavioural, cultural, familial and maternal factors that predispose children to accidents' (Roberts *et al.*, 1995).

It has been suggested that child accidents are a consequence of poor people making poor parents and exposing their children to unnecessary risks. Increased parental knowledge about safety and child development are seen as solutions to this problem. However, in contrast, Roberts and co-workers argue that 'poor children are in greater danger than more affluent children because the environments in which they grow up are intrinsically riskier', and that accident prevention policies, including environmental interventions (safer transport and housing), and targeted strategies are the answers. They also make the point that most accidents occur in hazardous environments; accident prevention needs to be concerned as much about environmental change as with behaviour modification.

They go on to suggest that 'most educational schemes to reduce road traffic accidents attempt to adapt children to traffic, rather than to segregate them from it or to target the behaviour of drivers ("teaching children to swim in a pool full of alligators" remains unadvised by safety initiatives)' (Roberts *et al.*, 1995; Towner *et al.*, 1996).

Avery and Jackson suggest that minority ethnic communities are also at increased risk from environmental factors because they are more likely to experience a combination of poor housing, more overcrowding, and a lack of awareness of hazards in a new culture (Avery and Jackson, 1993).

It has been estimated that children's accidents result annually in 700 fatalities, 120,000 hospital admissions, and about 2 million casualty department attendances in England and Wales alone (CAPT, 1989).

According to an OPCS survey, there were an estimated 360,000 disabled children aged 16 and under in the UK, with two-thirds of these having at least one type of disability (OPCS, 1990). More recent figures have yet to be made available.

Disability definitions vary enormously. The World Health Organisation has suggested a predictably medical notion of disability with: 'a restriction or lack of ability to perform normal activities which has resulted from impairment of a

structure or function of body and mind' (WHO, 1980). More social models stress a 'disability rights perspective' (eg Morris, 1998), where barriers to access and equality are highlighted, not physical impairment. We will return to this later in this review; at this stage we concentrate on the impact of physical impairment following an accident.

For non-fatalities, we know very little about the prevalence of disability from injuries to adolescents. Barker and Power estimate that prevalence of permanent disability at the age of 23 following an injury is 28 per 1,000 (Barker and Power, 1993). Savage, in an American study, estimated that 1 out of every 25 students will experience some form of head trauma by the time they leave school, and that as many as 20% of all special education pupils are believed to have sustained a traumatic brain injury that occurred before their special education status (Savage, 1991).

Young men aged 17–30 are the largest population group with significant head and brain injury (Powell, 1994). Two Scottish studies have looked at hospital admissions and head injuries. Thornhill *et al.* analysed almost 3,000 people admitted and found that four out of five were male; almost half fell; almost a third were involved in an assault; and alcohol was involved in at least seven out of 10. Unfortunatly no age or gender analysis was made in this study (Thornhill *et al.*, 2000).

Another study, by MacCallum and co-workers, analysed over 35,000 young people aged 15–34 years who were discharged from hospital after sustaining a head injury between 1990 and 1994. They found that assaults were the most common cause (40%), followed by falls (23%), strikes (19%) and road traffic accidents (12%). The significant factor for men was assault; while they reported a high level of alcohol use, the authors were reluctant to name this as a contributing factor without further investigation (MacCallum *et al.*, 2000).

Child development has also been offered as a significant factor: 'The development of the visual function is not completed until about 16 years of age. The peripheral vision of children is different from adults. Six-year-olds for example cannot see traffic out of the corner of the eye as adults can ... small children with normal hearing levels can mistake the direction of sound and consider it to be coming from a different or even the opposite direction. The implications of both these aspects of development are very important in

traffic safety' (Avery and Jackson, 1993).

In the literature, there is very little faith in behaviour change strategies. Joshi *et al.* (discussing cycle helmet use) suggest that 'campaigns aimed at young people have not on the whole been successful. We should not be too optimistic, however, about the extent that health education can increase helmet use. Even very imaginative health education may not overcome the compelling counter-pressures operating in this area.' (Joshi *et al.*, 1994). Silbert (1991) came to a similar conclusion, saying that 'there is very little evidence that education influences the behaviour of young people significantly and it has been the making of changes to the environment that has prevented accidents to children.'

This view appears to have been taken to heart, as there have been very few campaigns or initiatives targeting young people. Behaviour change campaigns have tended to be extremely specific – 'wear your cycle helmet'; 'clunk-click every trip' (Towner *et al.*, 1996). In contrast, there are many examples where environmental changes have been introduced to prevent injuries: speed cameras, seat belts, better testing of motor cycle riders, and traffic calming, for example (Hibert, 1996).

Conclusions

- There is a strong gender component in road and other types of accidents, as well as class and individual factors.
- The literature does not reflect gender in any significant way, even though the statistical evidence suggests that the connection between young men and accidents needs to be addressed.
- Factors involved in road and other accidents are complex, and strategies to reduce them are likely to be the same.
- While structural and environmental approaches are important in reducing accidents, behaviour – particularly young men's behaviour – is important to address, as those at risk of accidents are likely to demonstrate other risk-taking behaviours.
- Both individual risk-taking, and accidents involving more than one young man (and possibly alcohol), are worthy of further investigation.
- Very little is known about the incidence, impact and long-term effects of severe injuries caused by (particularly) road accidents on the lives and families of young men.

Statistical evidence about disabled young people (in fact all disabled people) is very poor.

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Children and adolescent cancers

Calman (1994) reported that 'about 900 new cases of cancer are reported annually in people aged 10–19 years in England and Wales. Hodgkin's disease and other lymphomas account for 22% of cases, followed by leukaemias and brain tumours at 16% and 14%, respectively. Gonadal tumours account for 9% of cases in both sexes combined, with 6% incidence of testicular tumours in boys' (Calman, 1994).

16 Stiller suggests that the pattern of cancer among adolescents differs from that among young children, and while incidence is relatively rare, it raises certain clinical issues. Stiller says that 'a diagnosis of cancer can be devastating for patients and their families at any age, but adapting to the effects of the disease and its treatment may be particularly hard for the adolescent. They must cope with loss of personal control; changes in social relationships; prolonged absences from school, college, or a first job; and uncertainty about the future' (Stiller, 1994).

There are some distinct gender differences: leukaemias and bone and brain tumours are all twice as likely to affect males as females. Testicular cancer is rare: recent data report 1,322 cases and 103 deaths for 1995 (OPCS, 1995). It occurs in men aged between 15 and 39 years old at the rate of 8.4 cases per 100,000, compared to one case of lung cancer per 100,000 males, or 4.8 cases of skin cancer per 100,000 males (OPCS, 1996). Over recent years there has been a trend of increasing incidence. This trend is not exclusive to the UK, and is seen in both the USA and, particularly, Scandinavia.

Hamilton (2001) reports that the incidence of testicular cancer varies considerably in different regions (ranging from 4.5 per 100,000 in North East Thames to 7.4 in Wesssex). Data from the USA show that it is more common in higher socio-economic groups, and five times more common in white than black populations (Bosl and Motzer, 1997; Kincade, 1999). Hamilton suggests that 'epidemiological and biological evidence indicates that the factors influencing the development of this cancer act early in life, possibly before birth (Kristensen *et al.*, 1996). In some countries there is an association with dairy product consumption (Davies, 1994), while trauma and infection have also been suggested as causative factors, but no actual links have been established' (Hamilton, 2000).

Tumours of the testicles are diverse with respect to histopathology, clinical evolution, presentation and sensitivity to treatment. However, they tend to fall into one of two main

groups: either seminomas or malignant teratomas. These tumours may occur separately, together, or combined in one tumour. Seminomas are more common and have a slightly higher rate of cure, currently in the region of 90%. Teratomas are rarer and are cured in about 80% of cases (ICRF, 1996).

Only two risk factors have been identified with certainty – a history of undescended testes in childhood, and infantile inguinal hernia. The most important UK study (Forman *et al.*, 1994) confirmed previous reports that developmental urogenital abnormalities result in an increased risk of testicular cancer. In particular, undescended testes and inguinal hernia, respectively, are the most and the second most definite risks. The study also found strong links between three markers of the early onset of puberty (taken to be prior to the age of 14 years) and risk of development of testicular cancer: voice-breaking, nocturnal emissions and starting to shave. Infertility also emerged as a risk.

There remain several other hypothetical risks for which evidence is unavailable or mixed. These include the link with occupation and with absence of exercise. Environmental factors, linked to occupation, may be associated with increased risk, for example exposure to chemical or biological agents, but evidence is limited. Finally, it is important to recognise that precise derivation of some of the known risk associations is not clear. For instance, it is thought that some cases of undescended testicles in infancy and infertility later in life may share a common cause, the true risk association. It has been suggested that low sperm count – an indicator of risk of testicular cancer – may be a marker of exposure in the womb to high levels of oestrogen derived from use of the contraceptive pill by mothers.

Testicular cancers are highly responsive to treatment. As with most cancers, early detection is the key factor in effective treatment. Early symptoms are usually a swelling of one of the testes and/or the development of a small lump or lumps on the front or side of the testis. Occasionally there may be a dull ache or dragging sensation in the scrotum, and rarely, acute pain. Diagnosis is usually confirmed by specialist investigation via ultrasound scanning of the scrotum and accompanying blood tests.

Treatment requires the removal of the affected testis. If metastases are present, surgery is followed by chemotherapeutic treatment with cisplatin and etoposide, drugs with an efficacy so superior to previously available treatments that the rate of full recovery rose in the 1970s, when they were developed, from 25 to 85%.

Radiotherapeutic treatment is necessary in a minority of cases to treat metastases in the lymphatic system. The presence or absence of metastases at orchidectomy is currently regarded as the most important indicator in determining the prognosis for the patient.

Given that testicular cancer is currently not preventable, and that early diagnosis and treatment offers such high levels of recovery, the importance of encouraging men to examine their own testes and report abnormalities is clear. Testicular self-examination (TSE) strategies encourage men to inspect their testes by rolling them between thumb and forefinger to detect any lumps, swelling or other abnormalities. TSE is highly effective if performed properly, because men are well placed to detect any changes over time in the bodies, and because it is highly cost-efficient. However, awareness of testicular cancer among young men is low, and unwillingness to undertake TSE is great. There is also a view that encouraging TSE will raise anxiety more than it will help identify incidence. Campaigns to promote TSE have been popular with health education and promotion units despite the low incidence of testicular cancer. For some it has been an easily identifiable men's health issue, while for others it has been a valuable method to encourage young men to reflect on their sexual and general health.

The somewhat dated research of Ganong and Markovitz provides insight into the effect of masculinity on dealing with sexual health. They report that young men are wedded to a belief that they are invulnerable to illness – it is perceived as an affliction of old age. They state that men actively avoid health education aimed at them both because it is regarded as unmanly, and because it challenges beliefs about wellbeing (Ganong and Markovitz, 1997). In regard to testicular cancer and TSE, they make a link between TSE, masturbation and homosexuality. In addition, because younger men are relatively rarely ill, they are not easily accessible to be offered health education by primary carers, and have little contact with any health professionals.

In a study of how young men adapted to the loss of their testes, Gordon found that 'first, when faced with a serious health crisis, creating a satisfactory self-definition became crucially important for these men. The potential threat to masculinity posed by testicular cancer led to attempts to define themselves as men, and having a clear-cut masculine identity of some kind became very important. Although most of the men were influenced by the traditional model of masculinity and focused on some of its features, this was not their only alternative' (Gordon, 1995). Preventive responses

to testicular cancer are reliant on either medical screening or sporadic or holistic health promotion approaches.

Conclusions

- Gender appears to play a significant role in adolescent male cancers, particularly testicular cancer. Early recognition may be inhibited by some young men's lack of knowledge and their possible reluctance to seek help.
- While the incidence of leukaemias and bone and brain tumours are twice as high in adolescent males than females, little is known about why.

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Weight, eating disorders and gender

Eight per cent of young people are thought to be obese or overweight. For 16–19-year-olds, the overall figure for young men and women is the same, although it is 11% for 18-year-old men compared to 7% for women of the same age, and 11% for 19-year-old men compared to 9% for women (HEA, 1992). *Today's Young Adults* (HEA, 1992) concluded that 'there seems to be a general preoccupation with body weight. Over half (56%) of the young people interviewed who were technically overweight thought their weight to be about right, and over a third (34%) who were of normal weight believed they were overweight'. The report continues:

18 'Body image is very important to both males and females in the 16–19 age group. Nineteen per cent of males think they are overweight compared with 40% of females ... Twenty-five per cent of males think they are underweight compared with 12% of females, and although GPs will occasionally see anorexic males, all eating problems are far more common in females of this age group (HEA, 1992).

In the same study, more young men (16–19) saw themselves as being very fit (19% male, 11% female), while these percentages were reversed for those seeing themselves as unfit. More young women saw a healthy diet as important (38% female, 25% male), whereas 58% of young men thought that you can eat what you like as long as you are reasonably active, compared to 44% of young women. More young men found healthy foods boring (38% male, 30% female). More young women were trying to diet (39% female, 7% male), and more young women were vegetarian or vegan (12% female, 4% male).

More young women looked at food labels, especially for information about calories, energy and fats, while similar numbers of young men and women looked for nutritional information (HEA, 1992). While this study is now relatively old, it provides the latest detailed account of young people's eating habits and attitudes.

Eating disorders (especially anorexia nervosa and bulimia) are thought to be a much bigger issue for young women than for young men. The ratio of males to females is usually placed between 1:10 (RCP, 1992) and 1:20. Girls from a higher-income family are more likely to express a desire to be thin than girls from a lower-income family, and very few boys indicate a desire to be thinner, regardless of income (Hall *et al.*, 1985). Anderson indicates that while the numbers of eating disorders are relatively low, they are growing, particularly among young men, and that particular subgroups

of men might be especially vulnerable (Anderson, 1997).

Copperman, in her study carried out for the Eating Disorders Association, estimated that '10% of people with eating disorders are men and approximately 20% of men with eating disorders identify as gay, which is double the proportion for gay men in the population' (Copperman, 2000). Schneider *et al.* (1996) suggest that gay men make up a significant proportion of those men suffering from anorexia nervosa, and that more gay men report binge eating, and define themselves as less overweight because they compensate for their compulsive eating by exercising.

However, Schneider *et al.* also found that 'overweight gay men had more disordered eating attitudes and behaviours. In our sample, those gay men who wished to be thinner were less satisfied with their appearance and more disinhibited eaters, yet exercised less than gay men who wanted to maintain or gain weight'. Schneider concluded that gay men may be at risk of eating disorders, and, interestingly, that 'heterosexual men's lack of concern about obesity and its health implications should be examined as a disordered eating phenomenon in its own right' (Schneider *et al.*, 1996).

Copperman (2000) found that childhood bullying and teasing for being overweight were usually the triggers for eating disorders.

Anderson also suggests that professionals are less likely to recognise eating disorders in men, and that men, for a variety of reasons, are less likely to be involved in self-help groups (Anderson and Holman, 1997). In a study carried out for the Eating Disorders Association, Copperman found that 'the general lack of recognition of eating disorders in men makes it more difficult for them to access specialist eating disorder services. Their problems are less likely to be recognised and diagnosed by professionals including GPs and psychiatrists and therefore their illness may be well established before treatment is offered'. She also concludes that 'men find it hard to acknowledge they have an eating disorder and then to seek help. For example, weight loss is more likely to be attributed to physical causes rather than to psychological ones' (Copperman, 2000).

However, some studies of children aged between 8 and 14 years have found a much higher number of males affected. Anorexia nervosa in boys and young adolescent males remains relatively poorly documented. A number of studies have suggested that, in this younger age group, the male–female ratio is higher than in older adolescents and young

adults presenting for treatment for anorexia nervosa. Bryant-Waugh found this to be over a quarter (27%) (Bryant-Waugh, 1994).

It is generally agreed that both males and females display the same characteristics, which include fear of fatness, refusal to maintain a normal weight, and rigidity in thinking about eating habits (Bryant-Waugh, 1994).

The same study reported that '... over the past five years or so we have been seeing a much wider range of types of eating disorders in boys attending our clinic', and that '... a greater proportion of boys present with other disorders characterised by low weight and eating difficulties, which are clearly not anorexia nervosa' (Bryant-Waugh, 1994). These other childhood eating disorders include what Higgs and co-workers have identified as 'food avoidance emotional disorder, or other highly selective eating patterns, usually involving only two or three different foods' (Higgs *et al.*, 1989).

Research into eating disorders has, to a large extent, been limited to anorexia nervosa and bulimia, so significant questions have not been asked about boys and young men. McPherson and Macfarlane (1998) have suggested that men are more commonly prone to compulsive exercise as a means of weight control.

Women perceive themselves as being overweight, whereas many men are more likely to see themselves as underweight and wanting to be heavier (Rolls *et al.*, 1991). Bulk muscle tone and fitness are more significant for men, while in contrast, weight and body shape are more significant for women. Even a serious beer gut is acceptable for some men.

Rolls and co-workers found that men and women react to being overweight in different ways, and that they eat for different reasons. Women reported they ate more in response to mood states and periods of low self-esteem, whereas men reported overeating in social situations. The author concludes that sex-specific weight-loss programmes would be beneficial (Rolls *et al.*, 1991).

Earlier studies have suggested that men are more successful in reducing weight, but several recent studies have contradicted this view (Rolls *et al.*, 1991). However, in contrast to the view that weight is the important factor, Egger and Mowbrey (1993) suggest that waist-to-hip ratio is a more accurate measure for health concerns in men.

Egger and others developed 'Gutbuster waist-loss programmes' for men in the early 1990s along the east coast of Australia. These programmes targeted working men, based on the principle of developing a programme that was 'non-threatening and requiring non-disruptive changes to men's lifestyles in order to be successful' (Egger *et al.*, 1996). While these programmes targeted older men (where waist-to-hip ratio is more significant), a gendered approach and style was used, based on men's physiology, attitudes and behaviour. The success of these programmes indicates the value of a coherent gendered approach. Modified versions of these programmes have been trialed in both Dorset and Derbyshire (Wilkins, 2001).

Rolls *et al.* (1991) found that 'men consume more calories than women and the sexes have different eating styles, which indicate that women have been socialised to eat in a more feminine manner', and that men eat larger mouthfuls. In another study, Mori and Pliner (1987) found that female subjects ate significantly less when with a desirable male partner than with other females or a less desirable male.

Some studies have looked more at weight control more widely. For example, Rosen *et al.* (1986) defined pathogenic weight control as 'the daily implementation of one or more of self-induced vomiting, laxatives, diuretics and diet pills for at least a month'. Cockerill and Quinton (1995) found that 'overall, both men and women used pathogenic weight control, but most of the work in this area has tended to focus upon the latter (women). It may be true that pathogenic weight control is associated principally with them, yet the possible greater reluctance by men to admit such behaviour needs to be taken into account before precise conclusions can be drawn about the extent of its implementation among both sexes'.

A few studies have looked at sport, especially those sports where weight is a serious asset or deficit. Jockeys and boxers have traditionally fasted, restricted fluid intake, and used a sauna to 'make weight'. Cockerill and Quinton suggest that 'traditional methods used by athletes for weight control have been supplemented by procedures which can lead to the clinical conditions of anorexia and bulimia. While exercise probably remains the most popular form of weight control, some research has shown that as high as 40% of participants in some sports are likely to possess an eating disorder, while other studies have shown this to be as low as 4%. There appears to be a greater incidence of pathological weight-control behaviour in women than in men' (Cockerill and Quinton, 1995).

Klein (1995) found that 'the use of steroids by male bodybuilders is essential because it enhances their quest for physical massiveness – for the look of the powerful male who is in control and master of his destiny and all that is around him. The very exaggerated nature of this look and what it is supposed to suggest indicates a fundamental vulnerability, for most people have long since given up the grandiose fantasies of comic book male heroes. Those who still require some sort of validation through social membership in such a world suggest that their mortality and vulnerability are more than they can cope with effectively. And so they strive to look the opposite of what they truly feel inside. Steroids promote aggressiveness, strength, size, and feelings of empowerment, all of which are valued by male bodybuilders. That steroids also enhance sexual appetite only fuels the ties between masculinity and bodybuilding'.

Klein goes on to say 'more important, for these men the fear of being small, of appearing less than fully masculine is so frightening that anything, including death, is preferable ... Steroid use may be understood as a more extreme version of proving one's masculinity, but it is still part of the cultural legacy that is dangerous to men's wellbeing' (Klein, 1995).

Conclusions

- The incidence of anorexia nervosa in younger men is significant enough for concern, but a wider view of eating disorders needs to be taken to address the needs of boys and young men.
- Weight loss may not be the most significant issue; weight control and perceptions of being underweight may be more important aspects to address.
- Boys' concerns about being underweight may be related to power and strength (or their lack of it), and in turn with their image of being a man. Unless these issues are addressed we may be underestimating the weight control issues for boys and young men.
- The few studies that exist indicate a higher proportion of gay young men with eating disorders, and they are of significant concern.
- Some professionals' attitudes towards men and weight loss and control are a barrier to young men seeking, and receiving, appropriate help.

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Smoking, drinking and drug use

Concerns about young people's health often hinge on their willingness to take risks; none more so than smoking, drinking and drug use (especially illegal drug use). Large amounts of data are available in all of these areas, although studies are not always comparable because of the different methods used.

Many of these studies concentrate on one type of risk only, with few taking a step back and considering these individual risks as part of risk-taking in general. Concerns about young people taking up adult habits that will have a negative impact on their health are common in the literature, while those studies concentrating on risk start from a broader base.

Moore *et al.* (1997) suggest that risk behaviours emerge from a 'consistent pattern of relationship between risk participation and outcome judgement, with perceived pleasantness and likelihood of positive outcomes, and unpleasantness of negative outcomes, strongly associated with behaviour ... If the positive strongly outweigh the negatives, then the behaviour is not usually considered risky except by the most cautious of people'. Risk is then a 'behaviour for which the outcome is uncertain and which involves potential negative consequences (or loss), but balanced in some way by perceived positive consequences (gain)'. Individual risk factors should be seen in this context. Risk-taking will be returned to later (p. 44).

Smoking

Goddard and Higgins (1999) found that very few pupils are smokers when they start secondary school: among children aged 11 in 1998, only 1% were regular smokers, and four in five had never tried smoking. By the age of 15, however, 24% of pupils were regular smokers, and only 30% had never tried a cigarette.

McPherson and Macfarlane suggest that 10% of 11–15-year-olds smoke regularly, consuming an average of 50 cigarettes a week, that regular smoking starts between the ages of 12 and 13, and by 15–19 many smokers want to give up. They also suggest that factors affecting cigarette consumption include affordability, tobacco advertising, others smoking in the family, friends who smoke, and the availability of cigarettes (McPherson and Macfarlane, 1998).

While the highest percentage of children who have ever tried smoking (35%) are in group AB, there is little variation

between the socio-economic groups. Children in social group DE smoke, on average, 50% more cigarettes per week than children in group AB. More in group DE also thought that they would or might be a smoker at age 20, compared to 18% of children in group AB. Both women and men in the 20–24 age group are the most likely to smoke (GSS, 1998). The same study found that women and men in the manual groups are more likely to be smokers than those in non-manual categories.

Although there has been a dramatic reduction in the number of smokers in socio-economic groups AB professional (falling from 33 to 12% between 1972 and 1996/97) and among employers and managers (falling from 44 to 20% of males), the reduction has been much smaller in the semi-skilled manual (from 57 to 41%) and unskilled manual groups (from 64 to 41%) (ONS, 1998).

Research suggests that the gender balance is more complex than it seems at first glance, and differs with age. Younger males are slightly more likely than females both to have tried a cigarette and to be regular smokers (Lloyd and Lucas, 1998). Then the gender gap begins to close again – at 18 years old, 40% of young men are smokers as compared with 30% of young women (Prescott-Clarke and Primatesta, 1998).

Haselden *et al.* (1999) found that young men aged 11–16 were slightly more likely than young women to agree that smoking has positive repercussions. For example, more young men agreed that it makes you look more grown-up and can help you make friends more easily, and that smokers have more fun. Conversely, young men were also more likely than young women to believe that smokers are more boring. Other gender differences seemed to be interrelated with age. For example, young men in school years 7 and 8 (11–13 years) were more likely to agree that smoking can help calm you down and can put you in a better mood, while a significant number of young women in school years 9 to 11 agreed with these statements.

Although girls are more likely than boys to be regular smokers, among those who do smoke, boys smoke more cigarettes. In 1998, boys who were regular smokers had smoked an average of 65 cigarettes in the previous week, compared with 49 for girls. Among occasional smokers, too, boys' consumption was higher than girls' (Goddard and Higgins, 1999).

The same study found that boys were more likely than girls to

say they found it difficult to buy cigarettes from a shop (26% compared with 18%), and that pupils who smoke, are more likely to drink than other pupils, and *vice versa* (Goddard and Higgins, 1999). The likelihood of having ever used drugs is strongly related to smoking experience: 63% of regular smokers had used drugs, compared with only 1% of those who had never smoked (Goddard and Higgins, 1999).

Alcohol

Coleman and Schofield (2001) concluded in their review of data that 'alcohol consumption appears to have increased significantly during the 1990s. This is especially striking since the same increase is not apparent among the 25–44 year age group. Although there is no clear explanation for the trend among 11–15 year-olds and 16–24 year-olds, it is a worrying development and will undoubtedly have implications for health promotion policies'.

At 16 years old, 35% of men and 27% of women are regular drinkers, and by 19 this has risen to 75% compared with 59% (McPherson and Macfarlane, 1998).

Eleven per cent of men aged 16 have been involved in a physical fight after drinking, and this level rises to 20% at age 19. The proportion of men who have been in trouble with the police after drinking rises steadily, from 5% at 16 to 12% at 19. Twenty-four per cent of men admitted to having a 'one-night stand' after drinking alcohol – this was three times more common than with women (HEA, 1992).

The percentage of children aged 9–15 who have tried alcohol is highest in the AB group (at 70%) and lowest in the DE group (at 58%). Some 16% of children in socio-economic group AB report that they drink at least once a week, more than double the percentage in group DE.

Men are more likely to drink alcohol than women, and are also more likely to drink heavily. In 1996/97, 27% of men drank more than 21 units per week, and 14% of women drank more than 14 units per week. There is some evidence that the drinking habits of women are converging slightly with those of men, as there has been an increase in alcohol consumption for women in all age groups since 1994 (GSS, 1998).

The frequency with which young people drink alcohol and the amount they drink are greatest amongst young men. Young men of school age are more likely to say they drink 'quite a lot of alcohol' or that they 'drink heavily' (Haselden

et al., 1999). The same study concluded that young men drink more beer and lager, and young women more spirits and wine.

The 'Health of Young People' survey reported that young men aged 16–19 are more likely to say they had been unable to stop drinking, had drunk to steady their nerves, and had been drunk in the past 3 months. By the criteria of the study, more males than females were classified as 'problem drinkers' (15 compared to 7%) (Prescott-Clarke and Primatesta, 1998). The same study suggested that 'gender does appear to be interlinked with class. Up to the age of 16, young men and young women from the lower social classes are the least likely to have had a whole alcoholic drink and most likely to have never tasted alcohol'.

Gender differences in drinking behaviour appear to emerge from differences in the way young men and young women think about drinking. This theme tends to have been explored only as part of smaller scale, more in-depth studies. Pavis *et al.* (1997) examined the 'social context' of drinking, and noted that the groups who drank on street corners and in parks were composed mainly of young men. Young men were more likely to drink in groups, and these young men saw a relationship between having friends who drink regularly and consuming alcohol themselves.

Wright (1999) noted that as a result of drinking alcohol, young women were more likely to report emotional experiences or negative social consequences, while young men were more likely to report involvement in criminal activities. Canaan (1996) found that the incidence of violence is commonly linked with drinking alcohol, especially among young men. It is thought that aggressive behaviour leads to heavy drinking, and that drinking and aggression may also have shared antecedents (Wright, 1999).

Pavis *et al.* (1997) suggest that 'young men aged 13 to 15 saw drinking as a competitive activity with others in the friendship group. Peer influence worked to encourage them to drink more in order to prove their masculinity. From 16 they started going to pubs and were divided into those who drank in mixed groups and those who drank only with same sex friends. Those in the former tended to have more mature attitudes to drinking' (Dennison and Coleman, 2001).

Mathrani (1998) found that 'Muslim young men have greater freedom and therefore more opportunity to drink. They reported drinking to relieve stress. Amongst African–Caribbean young people, families were described as being

more relaxed than those of other ethnic groups’.

Studies looking at alcohol and gender are rare, which is surprising given the gendered nature of problem drinking. In one exception, Harnett *et al.* (2000) developed a model of eight drinking styles to describe the meaning of young men’s attitudes to their drinking behaviour. Harnett concluded that ‘drinking styles varied with family and peer group norms and changed with changes in drinking venue, drinking day and drinking time.’

They suggest that between 12 and 16 years ‘the young men viewed drinking as a *rites of passage*, where “getting sick” or “getting lary” were important credentials and part of the process of growing up. For most, their “adolescent drinking style” was practised infrequently and lasted a short period.’

They also concluded that ‘at around 16–17 years of age the young men’s styles of drinking, in general, became more fragmented and diverse. Instead of reporting drinking on a single context “adolescent drinking styles”, respondents drank in a number of ways depending on with whom they drank, where they drank and on what day they drank’ (Harnett *et al.*, 2000).

Drug use

Approximately half the 16–19-year-olds in the UK have been offered drugs, most usually cannabis (39%), followed by acid (21%), amyl nitrate (19%), magic mushrooms (19%), ecstasy (17% and rising), and amphetamines (13%). Men are significantly more likely than women (37%) to have been offered class A drugs (heroin, crack, cocaine, ecstasy or acid), and 50% have been offered class B drugs (mainly cannabis).

Actual experimentation with drugs is also higher amongst men (37%), and this rises with age. McPherson and Macfarlane (1998) found that over half the men studied (52%) agreed that most young people will try out drugs at some time, despite the fact that 91% thought that taking drugs harmed their health (HEA, 1992).

Those in the 16–24-year-old age group were most likely to have used drugs in the past year (GSS, 1998). By age 18, young men were only slightly more likely to have been offered drugs, to have tried drugs, and to have used drugs within the past year. However, by 18 young men were

considerably more likely to have used drugs within the past month (Parker *et al.*, 1998).

Tasker *et al.* (1999) found that in a sample aged 11–35 years, the peak age range of those using drugs in the past month was 16–19 in young women and 20–24 in young men. In all age groups, males reported greater use in both the past 3 months and in the past month (Tasker *et al.*, 1999). Plant and Plant (1992) suggest that levels of drug use do not differ according to class, but that the type of drug taken does.

Tasker also found that there were gender differences in the perceptions of which drugs were riskier to use. Young men were more likely to see cocaine as extremely or very risky across the whole 11–19 age range (Tasker *et al.*, 1999). In contrast, Goddard and Higgins (1999) found that rather than gender being the main variable dividing attitudes, whether young people have taken drugs before seemed to be the main factor that separated groups.

Parker *et al.* (1998), analysing attendance at a drug clinic, found that there were more than 2:1 males to females (nearly 6,000 young men of 15–19 years attended, compared to 2,400 young women). Over half of all attendances were because of heroin use, with cocaine, cannabis and amphetamines each accounting for a further 10–15% of attendees.

Goddard and Higgins (1999) found that virtually no children who had never smoked or drunk alcohol had ever used drugs, but as many as 75% of regular smokers who drank at least once a week had done so, suggesting a strong association between drug use and both smoking and drinking.

Conclusions

- Despite the much higher incidence of young men’s alcohol and drug use (and misuse), gender has not attracted much interest from researchers and policy-makers. The few studies that have explored this relationship have tended to emerge with interesting and useful conclusions.
- Studies have found that drug use is likely to be associated with cigarette and alcohol use, and that alcohol use can lead to general criminal activity and violence.
- General risk-taking studies may have much to say about these individual risk factors.

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Sexual health and behaviour

The age at which young men report becoming sexually active has been steadily declining since at least the 1950s. There is also a trend towards having greater numbers of sexual partners and being more sexually adventurous.

The National Survey of Sexual Attitudes and Lifestyles (NATSSAL) remains the most reliable source for data on male and female sexual activity in the UK. NATSSAL found that among a sample of 1,798 16–19-year-olds, 28% of young men reported their first experience of heterosexual sexual intercourse occurred before they were 16 years old. This contrasted with 19% of young women of the same age. Data on first sexual experience (kissing, cuddling, petting) show that for these earlier starting young men, this generally occurs 3 years earlier. This contrasts with a slighter shorter gap for young women, although the gap for both sexes between first sexual experience and first intercourse is decreasing. The median age for first intercourse for young men was found to be 17 years old (Wellings *et al.*, 1994).

NATSSAL identified associations between the age of first sexual intercourse and both social class and faith. The median age for first sexual intercourse of boys from social class I was nearly 18; that of boys from social class V around 16.

Boys reporting a religious belief or active adherence to any faith tended to report a later first sexual intercourse. About a quarter of black African and African–Caribbean boys, compared to a fifth of white and a tenth of Asian boys, reported their first sexual intercourse before age 16. Boys' first sexual partner is generally of the same age, whereas the norm among girls is for older partners.

About 40% of boys and half the girls reported that their first sexual intercourse took place in the context of an established relationship. Among boys, a further 30% reported that they had known their partner for some time, although it was not a steady relationship. This compared to 16% of girls. There are significant gender differences when it comes to feelings associated with first intercourse. Eight out of 10 boys compared with six out of 10 girls felt their first experience of sexual intercourse came at the right time, and 15% of boys compared to 36% of girls regretted their experiences.

The NATSSAL study stressed the inadequacy of the fixed heterosexual and homosexual identities in mapping sexual behaviour and experiences, and used a Kinsey scale (Kinsey *et al.*, 1948) to rate experiences of same-sex feelings and sexual

experiences. This ranks behaviour along a continuum from exclusively heterosexual to exclusively homosexual. Data show that about 7% of young men between 16 and 24 years old had experienced homosexual attraction, 5% homosexual experience, and 3% genital contact.

The NATSSAL study, drawing on Schofield's earlier work (Schofield, 1965), showed that there were differences for male and female teenagers in their main motivations at first sexual intercourse. For both girls and boys, a sense of curiosity, feeling love, or that to have sexual intercourse was a natural development in their relationship were the highest-rating factors. However, only 17% of boys compared to 38% of girls reported being in love as being their main motivation, and 11% of boys compared to fewer than 1% of girls reported losing their virginity as an important factor.

These data have been understood to reflect a broad view among young men that sexual activity, especially losing their virginity, is a positive achievement in terms of personal and social development. The anxiety that can build up for young men about becoming sexually active may well contribute to ongoing concerns about sexual capacity, appetite and performance. This generally focuses on worries about adequacy compared to other young men, rather than satisfying the emotional or physical needs and desires of girls. As Deakin has noted, this pursuit of 'sexual excellence' by men produces a raft of concerns which can undermine their ability to form intimate emotional bonds. They can end up preoccupied with penis size, maintaining an erection, making sexual intercourse last a long time, and achieving simultaneous orgasm (Deakin, 1988).

Smith *et al.* also suggest that biological factors function in association with social factors to predict the onset of the first heterosexual sexual experience and intercourse for young men. For young men who reach puberty early or are rapid developers, and who have sexually active male friends, there is an association with early sexual activity (Smith *et al.*, 1985).

The youngest sexually active respondents to NATSSAL reported the highest numbers of sexual partners of any generational group. Eleven per cent of young men aged between 16 and 24 reported having 10 or more partners in the past 5 years. This is a much higher proportion than among young women. The continued importance and value to some young men of being, and being seen to be, sexually successful may contribute both to more enthusiasm for seeking new partners for sexual activity, and to over-reporting.

Nearly three-quarters of young men between 16 and 24 years old reported four or fewer partners in the past 5 years. For around 80%, these relationships were either their only relationship or one of a series; only the remaining 20% reported maintaining concurrent sexual relationships (Wellings *et al.*, 1994).

The shift to premarital and shorter sexual relationships has probably led to a decline in young men's use of the commercial sex industry. In the 16–24 age group, NATSSAL identified only 2% as ever having paid for sex. Purchase of sex commercially was associated with lower social class, being single, working away from home, and homosexual sexual experience.

These data have generally been endorsed by subsequent studies. However, it is notable that in the 'Health in England' survey, fewer young men than young women reported having had heterosexual intercourse prior to age 16 by a ratio of nearly 2:3. In addition, among the same group of 16–19-year-olds, 42% of young men reported never having had a sexual partner, compared to 29% of young women (Rainford, 2000).

The interim results from a randomised, controlled trial of teacher-led sex education in Scotland provide some reliable contemporary data on young people who have heterosexual sexual intercourse prior to 16 years (Wight *et al.*, 2000). Eighteen per cent of boys and 15% of girls with a mean age of 14 years and 2 months report having had heterosexual intercourse. Of these, the majority had their first experience between 13 and 14 years old.

The results of a slightly earlier study with Scottish teenagers 14–16 years old (Graham *et al.*, 1998), which reports 27.5% of young men experiencing sexual intercourse, illustrate the extent to which young men become sexually active and experience their first heterosexual intercourse around this time. This study again describes a significant difference between the numbers of young men and young women reporting sexual intercourse, with about 5% more young women doing so.

In general, the 'early starters' surveyed by Wight *et al.* report satisfaction with the timing of their experience, although about a quarter of the boys felt it was too early and 5% felt it should not have happened at all. This contrasts with 30 and 13% of girls, respectively, for these measures (Wight *et al.*, 2000). For both sexes, regret was associated with having been drunk or 'stoned', suggesting a loss of control of

events. Most importantly, reported regret was greatest among young men who also reported applying the most pressure on young women at first intercourse.

This contrasts with studies involving a longer retrospective gap between first intercourse and data collection, where more young women express regret. This research clearly indicates that young men are well aware of the pressure that they apply to young women for sex, and experience considerable *post hoc* regret.

Data on pressure at intercourse relate to information reported elsewhere about coercive sexual encounters and rape. A national survey on sexual behaviour in New Zealand (Dickson *et al.*, 1998) found that 7% of young women aged 21 described their first sexual intercourse as having been forced on them. While this is three times the rate reported in NATSSAL, and nearly twice that of an equivalent study in the USA (Laumann *et al.*, 1994), it provides evidence that in an important minority of cases male pressure on young women translates into rape.

This study in New Zealand also identified that, for many young men, their first sexual partner at intercourse was also a virgin, within 1 year of their age, and very often known to them even if not described as a partner in a steady relationship. More young men than women report the relationship status to be transient, and first heterosexual sexual intercourse to take place within weeks of meeting their partner.

British research, in common with that in most other European countries, had consistently shown a decrease in the age of first intercourse and increasing numbers of partners for young men. However, a reverse trend has been noted in the USA (Sonenstein *et al.*, 1998), where between 1988 and 1995 there was a reduction from 60 to 55% in the number of 15–19-year-old white young men reporting ever having had sexual intercourse. The rates for black and Hispanic young men remained unchanged and, as in the UK, those for black young men exceeded those for the other two groups.

In all groups, condom use at most recent intercourse rose significantly by about 10%, to between 67% (white) and 74% (black) of young men. Consistency of condom use was also improved, and by the same margins. However, incidences of unprotected sex in the past year are still relatively high, between 27 and 39% (for white and black young men, respectively), indicating continued exposure to risk of pregnancy and disease. It is assumed that these shifts

in trend are a result of successful health education programmes that have sought to promote condom and contraceptive use. If this is the case, it illustrates the importance of social norms and values, as well as of psychological and social factors in determining young male sexual behaviour.

In summary, it is clear that for most young men first heterosexual sexual intercourse takes place between ages 14 and 17. For the majority, the context is often within a short relationship with a young woman who is known to them, even though not one described as a steady partner. Both young men and women typically described their chief motivations as curiosity and feeling that intercourse is a natural progression from other sexual contact. However, young men more often report that a desire to lose their virginity motivates them, as does a perception that their male peers are sexually active and their own sexual activity will maintain or enhance their status in this peer group. Alcohol and other drug use plays a part in expediting first intercourse.

The influences of social class, ethnicity, and the quality of relationships within the family are also associated with age of first intercourse. Interestingly, families in which there is more open communication about sex prove to be protective against early intercourse (Ingham, 1998). Those young men who are early starters on their sexual careers are more likely than others to have a greater number of sexual partners over time, and to have concurrent relationships.

Qualitative research provides a more detailed and sociological complement to these accounts of young men's sexual behaviour. The importance of masculinity, male identity and gender role in forming sexual attitudes and their impact on behaviour are often the focus of attempts to understand behaviour that carries health risk for young men or their partners, such as not using condoms.

Studies show that although many young men are aware of, and refer to, what can be termed traditional masculine stereotypes about sexual identity and behaviour, few act in line with these. Wight (1996) notes the diverse range of heterosexual relationships that young men engage in, and the relative rarity of the promiscuous young man or 'serial shagger'.

Walker and Kushner (2000) identify how this stereotype functions to differentiate public display and discourse about sexual behaviour from private thoughts, feelings and experiences, and differs widely from the interior world of

young men who experience ignorance and anxiety about sexual matters and a longing for emotionally satisfying relationships.

The 'masculinity' these studies seek to elucidate is well described by Mike O'Donnell and Sue Lees, who do not restrict themselves to an account of masculinity that is confined to health, let alone sexual health. They identify class and ethnicity as important factors in theoretical differentiation of masculinities, and in determining attitudes, beliefs and behaviours that have a direct impact on sexual behaviour and health (O'Donnell and Lees, 2000). The importance of toughness, male solidarity, territoriality, having fun and openly opposing authority are central to white working-class masculinity. For young black African-Caribbean men, a macho image is important in forming an identity. This is not at the expense of sensitivity, which in O'Donnell's and Lees' study they often report feeling more than white young men, but is realised in terms of fairly rigid beliefs about gender roles for men and women.

In addition, the young black men in this study often perceive themselves to be 'toughening up' in reaction to racial prejudice. Strongly reflecting traditional patriarchal gender roles, Asian young men are described as tending towards conservatism in relation to beliefs about gender roles and relationships between men and women.

O'Donnell and Lees are at pains to point out the diversity of identities and behaviour which are formed, at least in part, in reaction to these models and images, and their symbolic importance. They conclude that 'there is a minority [of young men] who viewed partner relationships democratically, and a minority of "male chauvinist pigs"'. However, more common than "new man" or "mcp" was "mixed up man" who had learned something from the gender equality agenda but still retained significantly patriarchal and sexist attitudes and patterns of behaviour' (O'Donnell and Lees, 2000).

These data on sexual behaviour and the qualitative studies are all based on the majority experience of male sexuality and behaviour as heterosexual. This is indeed the case, and little is known about behaviour, its context or meaning for homosexual and bisexual young men. In the main, data are collected from self-selecting samples of gay-identifying young men who provide retrospective accounts of their adolescence.

These are overwhelmingly negative. The endemic dominance of homophobic attitudes among young people, particularly young men, renders them invisible, and the relative cultural

weakness of relevant role models may mean that any positive non-heterosexual identity is almost unavailable to these young men. The work of Stonewall describes horrific violence against young gay men (Mason and Palmer, 1996), and Rivers and Frankum provide some limited insight into issues about other aspects of everyday life (Rivers, 1995; Frankum, 1996). Experiences of bullying, truanting from school to avoid victimisation, fear of being 'found out' by family and friends, conflicts of loyalty between disclosing identity or challenging homophobia and potentially losing friendships are all reported. Anxiety is frequent around forming same-sex relationships, about what constitutes 'proper' emotional content, and the nature of relationships between gay men, against the background of powerful assumptions that all relationships between gay men come down to sex, and promiscuous anal sex at that.

Sexually transmitted diseases including HIV/AIDS

There is substantial sexual ill-health among male teenagers in England and Wales. Data for 1996 (Nicoll *et al.*, 1999) show a continuing trend in increases of gonorrhoea (31%), chlamydia (18%) and genital warts (13%) among young men who visited sexually transmitted disease clinics. The rises were steepest among young men aged between 16 and 19.

These data may be partly influenced by the rise in numbers of young people seeking out sexual health services, but are more likely to be indicative of sexually risky behaviour. Predictably, as the data reported below describe, only a minority of sexually active young men visit any clinical service for advice, diagnosis or treatment of sexually transmitted diseases, and those young men at greatest risk may be the least likely to have or seek access to relevant healthcare and advice.

The number of young people infected with HIV also continues to rise (Anon., 2000a). The epidemic in the UK is now driven almost entirely by infections through sexual behaviour. Intravenous drug use accounts for a decreasing proportion of new infections: about 10% of the total number of infections ever, and less than 2% of the total number of new infections for the first half of 2000.

In 1997 the number of people known to be newly infected with HIV was 2,445; in 1998, 2,568; in 1999, 2,723; and up to mid-2000, 1,171. Of the 42,065 people known to be infected with HIV by June 2000, 34,240 are male, and the peak age for diagnosis of infection is 25–29 years old; 7,517 cases (22% of all infections to men) were reported between these ages.

The trend here is for a shift away from transmission via sex between men accounting for the largest percentage increases in new infections, to transmissions between young heterosexual people, although men infected via homosexual contact continue to be the largest single group of people affected by the virus. The greatest increase in new infections arising from heterosexual sexual contact is among older teenagers and young people in their early twenties. Among men reportedly infected via heterosexual intercourse, the numbers have risen 125% between 1990 and 1999, from 252 to 568 known cases.

Reports at the end of 2000 show new infections of men via sex with other men constitute 71% of all infections. Eighty-two per cent of all infections are to men, and 'latest indications are, including trends in other sexually transmitted infections, that risk behaviour as well as HIV transmission remain high and have shown no improvement in this group since the start of the 1990s' (Anon., 2000b).

The majority of heterosexual infections to men have been acquired outside the UK, and travel and tourism have been identified as contexts in which sexual risk may rise for some gay and straight men (Black, 1997; Clift and Forrest, 1999). For both gay and straight men, loss of inhibitions due to being away from home, freedom from responsibilities and normal domestic routines, and the opportunity for romance and sex are important factors in risk-taking. Looking specifically at young people travelling and holidaying in south-west England, Ford (1991) has shown that similar factors influence sexual risk-taking along with alcohol consumption, and that 'casual' sexual interaction increased and condom use decreased during the summer holiday period.

There are regional differences in HIV infections. These centre on London, which accounts for over 50% of all cases of infected people being seen for care and treatment. The south-east and north-west account for the next highest numbers, with approximately 9 and 7%, respectively.

The number of young men diagnosed with AIDS has stabilised and may even be expected to decrease over the next few years. This is the direct result of the increased efficacy and effectiveness of anti-retroviral treatments for HIV infection. However, while the benefits of treatment improve the situation to one in which people may be living with a chronic illness for longer, the social complications are difficult for many to manage. Infected men are confronted with the need to consider how to manage sexual lives as a long-time

infected-but-not-ill partner to other men or women.

Young gay men remain particularly vulnerable to HIV infection. Dodds has shown that in London about a third of gay men socialising on the 'scene' report unprotected anal intercourse in the last year (Dodds *et al.*, 2000). They identify significant associations with being younger (under 25). For young men who do not necessarily identify as gay, or who are new to accessing the 'scene', other work has shown that homophobia and an unresolved sense of self-identity (Forrest and Reid, 2000) have a negative impact on their ability to manage condom use for penetrative sex.

Contraceptive use

The greatest single risk factor in the transmission of sexually transmitted diseases is the non-use or failure of barrier contraceptives, particularly the male condom. NATSSAL (Wellings *et al.*, 1994) shows that contraceptive use for first heterosexual sexual intercourse is more likely among women than men, and among older people than younger people. In the data for young men aged between 13 and 15 at first intercourse, 26% report using a condom and 55% no contraceptive. Condom use rises to 37% among those young experiencing first intercourse between 16 and 17, and peaks at 42% among 18- and 19-year-olds.

The proportions reporting no contraceptive use fall at roughly the same rate. Patterns of young women's contraceptive use show very similar percentages (within one or two percentage points), and there is a rise in use of the contraceptive pill from about 5% at 13–15 to 20% at 18 and 19 years old.

A fairly consistent pattern of condom use then emerges, with most young men tending to use condoms in the early stages of sexual relationships with new partners, but – probably due to young women's shift to use of the contraceptive pill – this tails off. However, among the most active young men (those who report having two or more different sexual partners in the last week) there is significantly less likelihood of condom use.

More recent data from Scotland (Wight, 2000) reporting the sexual behaviour of young people around 14 years old shows that about 60% used condoms at first intercourse, 9% withdrew the penis before ejaculation, and 19% used no contraception.

The Durex 1999 Global Sex Survey of 16–21-year-olds found that 68% of UK respondents used a condom at first

intercourse and a further 16% used some other contraception, the same percentage using no contraception (Durex, 1999). The Durex 2000 report on sexual attitudes and behaviour in Britain reports that 19% of 16–17-year-olds and 17% of 18–20-year-olds have had unprotected sex with a new partner. This is an increase of 6 and 2% from the previous survey in 1998 for each respective age group (Durex, 2000).

Data from the USA (Ku *et al.*, 1994) show a similar pattern, condom use declining with increasing age and the probability that the female partner uses the contraceptive pill increasing. Condom use was more likely for men who thought that their sexual partner was inexperienced, and less likely if they suspected that their partner was at risk of a sexually transmitted disease. The pattern is described here as the 'sawtooth'. In this model, condom use is dynamic and dependent on a number of factors. As each relationship begins condom use is high, and then tails off, starting at a peak at the beginning of each subsequent relationship. As sexual relationships stabilise, the contraceptive pill is likely to overtake condom use as the primary choice of contraception for most young people. Although young men in this study were very likely to report condom use primarily as a means of preventing conception, there were indications that this may be a 'comfortable' response for men who felt it was easier to cite pregnancy prevention as a motive than implying that they have suspicions about their partner's sexual health.

Condom use in heterosexual encounters is influenced by the situation – the characteristics of a sexual relationship and of the specific encounter – but also by a wider cluster of factors. Access to sexual health services and other sources of contraception are important (see below). Confidence and knowledge about how to use condoms and knowledge about contraception are also important. Among the factors most likely to have a negative influence on young men are beliefs that condoms will 'interrupt' sex, be embarrassing to use, and may affect their ability to obtain and maintain an erection (Braeken, 1997).

Awareness and beliefs about vulnerability and susceptibility to infection or conception also affect on condom use. For young men who perceive themselves to be at low risk of infection, condom use is not so important as for those who are more concerned about pregnancy or infection. Alcohol and drug use are also negatively associated with successful condom use.

Attitudes to condoms and condom use underpin behavioural

intention and predict subsequent condom use – young men who are positive about condoms are more likely to use them than their less confident peers. These attitudes seem to be associated with social background factors. Where more sexist attitudes prevail, and there is less confidence about communicating about sex within families and between young people, condom use is less easy for young men. These factors may be more prevalent among young men from lower class backgrounds and those from particularly strong macho cultures and/or religiously conservative views about sexual matters.

Negotiation and communication about sex and contraception prior to intercourse is a most important factor. Although negotiation and communication are often emphasised in sexual health promotion strategies aiming to improve condom use among young people, research shows that non-verbal strategies may be effective and appealing for first intercourse with a new partner, especially for young men (Coleman and Ingham, 1999). Young men may be particularly likely to choose non-verbal strategies, especially putting on a condom without consultation, with 'one-night stands', where 'this non-verbal communication based strategy was preferred mostly by young men, as a means to ensure condom use without causing any embarrassment or conflict between partners'. However, condom use is more frequent among young people who do manage to communicate verbally and negotiate condom use.

Despite their best intentions, condom failure affects about a quarter of young men at some point (Duberstein *et al.*, 1997). Experience with condoms and education about condom use are positively associated with successful condom use, whereas ever having had a sexually transmitted disease, or having a partner with one, and low household income increased the likelihood of experiencing a condom breakage between two and three times.

Among gay men, condom use is related to the prevention of infection with sexually transmitted diseases, particularly HIV. The promotion of condom use for anal intercourse has been active and regarded as a success, partly as a result of considerable mobilisation within gay communities. However, as the larger pool of infection is among gay men, exposure to infection is potentially more frequent.

There are factors in common with straight men which predict and shape gay men's condom use. In particular, the disinhibiting effects of alcohol and drugs, and beliefs about a partner's disease status. The four main factors identified by recent qualitative research (Fenton and Power, 1997) are:

- a calculation of risk (weighing evidence such as a partner's recent HIV testing status, knowledge of their sexual history, and their trustworthiness)
- emotional needs and drives (includes a man's desire to express and experience love and physical and emotional intimacy)
- lapses of control (most often through alcohol and/or drug use, or emotional vulnerability)
- pressure not to suggest condom use with a regular partner where condoms had not been used before (implying one or other partner has been having sex with someone else).

Constituencies of men who have sex with other men, but do not identify themselves as gay, are at much higher risk from failure to use condoms for penetrative sex.

Unplanned pregnancy

Unplanned pregnancy has taken on the status of a pathological condition, although it has no negative sexual health outcomes for young men. Public policy has largely focused on preventing unplanned conceptions by working with young women, to the exclusion of young men. Little is known about the experience of the 'teenage fathers'.

In at least one important respect, attitudes towards and experience of teenage fatherhood have health implications. As the research reviewed by John Coleman and Catherine Dennison indicates, far from being feckless and wanting no responsibility for their children or any active part in their upbringing, young fathers may be deterred from taking responsibility by a number of obstacles – particularly the instability of the relationship with the mother and poor relationships with members of her family. Additionally, young men may find contact difficult because of work or training commitments. This enforced absence may have a negative impact on young fathers' mental health and wellbeing (Coleman and Dennison, 1998).

Allen's work has identified fathers of children conceived by teenage mothers to be 23 years old, on average. A third have left school with no educational qualifications, and they are likely to come from families where parents no longer live together. Young men who have contact with the mothers of their children are predictably more likely to have a shared responsibility for caring for the child and supporting it than fathers who have no contact with them or who are in new relationships (Allen, 1998). In their urban sample, 69% of fathers were of white ethnic origin, while 11% were either black Caribbean or black African, and a further 11% Indian,

Pakistani or Bangladeshi, and the remainder of other ethnic origin. Importantly, young fathers were generally more positive about continuing an unplanned pregnancy than their partners.

Other sexual health issues

Small numbers of young men also experience problems with genital development and sexual function. Larger numbers experience problems with intermittent or one-off cases of relatively non-serious complaints and conditions affecting the penis. Research on the former has been almost entirely limited to medical models of clinical diagnosis and treatment.

The personal and social difficulties encountered by young men who experience impotence, suffer from hypospadias and chronic (para)phimosis, or who experience injury to their genitals, are unresearched. The impact on these young men alone warrants further research on these points but, in addition, it is likely that their accounts may illuminate how sexual health is involved in constructs of male sexual identity.

Hypospadias affects about 1 in 300 male babies in the UK. In this condition the urethral opening is not at the end of the penis, but along the glans, the shaft of the penis, or even at its base. A relatively small number of boys experience a severe form of the condition where the urethra opens at the base of the penis or at the base of the scrotum. Rectifying surgery may be undertaken in infancy, but a number of boys seek cosmetic surgery around the time of puberty to rebuild their penis if it is or has been foreshortened (Reiner, 1999).

Phimosis is a tightness of the foreskin such that it cannot be pulled back over the widest part of the glans. Phimosis is a normal condition in boys up to the age of 2 or 3 years, but persists for about 10% of boys beyond this age. If it persists into adulthood, phimosis may cause men pain during masturbation and intercourse, even at erection. It can also result from injury to the foreskin and the formation of tough and inelastic scar tissue. Phimosis increases the predisposition to penile cancer, balanitis (see below) and tearing of the foreskin. Inconvenient and potentially embarrassing effects include a ballooning of the foreskin when urinating, which can make it difficult to pass water and may lead to leakage after urination (O'Donnell, 1999).

Paraphimosis is a constriction of the foreskin behind the glans which can occur during sexual activity. The tight foreskin hinders circulation in the penis and can be painful, even potentially leading to gangrene. In most cases the foreskin can be massaged back over the glans. Like phimosis,

circumcision may be required to prevent re-occurrence (O'Donnell, 1999).

Balanitis is the inflammation of the glans penis. The glans becomes red, sore and itchy. About 4% of boys under the age of 5 experience this. Older boys and men may experience it, particularly as a result of thrush. Balanitis is largely preventable with regular proper washing under the foreskin. It can be treated with antifungal cream; in extreme cases circumcision is required (Edwards, 1996).

Impotence is known to affect between 10 and 30% of all men at some point in their lives. The prevalence of impotence among young men is not precisely known. In about 40% of cases impotence has a physical basis, usually as a product of tiredness or stress. Other physical causes for impotence include the side-effects of some prescribed drugs, particularly beta-blockers, and disorders and diseases that impair the circulatory and nervous systems. Given the relative rarity of these kinds of disorders among young men, it may be that impotence is more often a product of anxiety or stress, or other psychological concerns. Feelings of fear, guilt and inadequacy are all associated with impotence (Kirby, 1994).

Young men are as likely, if not more likely, to experience premature ejaculation, especially early in their sexual careers. Premature ejaculation is largely a psychosomatic problem and, as such, definitions tend to relate to 'performance' anxiety and pressure at first intercourse, which is particularly acute. It is thought that over half of all men experience premature ejaculation at their first sexual encounter with a new partner. A man may be said to experience premature ejaculation if he comes before he wants to, or if he ejaculates prior to invagination or within one minute of invagination. The opposite situation, retarded ejaculation, can arise if a man experiences anxiety about sex, such as fear of or prior experience of being interrupted, or believes his partner has been unfaithful. In some cases it is thought to be associated with experience of condom breakage or other contraceptive failure, and consequent anxiety about conception. In the cases of both premature and retarded ejaculation, the definition of the condition as problematic relies heavily on expectations about what constitutes adequate and 'normal' male sexual performance and experience. Myths and beliefs with which young men are surrounded, and the expectations with which they load themselves about how long they should be able to maintain an erection and sexual arousal without ejaculation, are often hyperbolic – this can only lead to increased performance anxiety which may increase or cause either problem (Brewer, 1995).

Sexual health services

Young men are poor attenders of health services in general, and sexual health services in particular. Although family planning clinics, for example, have always been open to all in theory, in practice only around 3% of their clientele have been men (FPA, 1994). Even with the more active promotion of sexual health services to and for young men, the proportion of male clients has stayed stubbornly low at around 6% (Brindis *et al.*, 1998).

32 However, studies of school students in the USA have found that up to 12% of young men have obtained contraceptives from a family planning service. Importantly, this American research identified that male users of sexual health services are diverse in terms of background and needs, and that services need to be more sensitive to this. For example, a large proportion had been at risk of conceiving or had conceived with a female partner, or risked exposure to sexually transmitted infections. However, their contraceptive use varied greatly, from nearly regular users to infrequent users.

Many young men attended with many other compounding and even more grave concerns in their minds: unemployment, problems with talking at home, alcohol use, bereavement, homelessness and depression were foremost amongst these. In the US study, a disproportionately high number of male clients were from Hispanic and black ethnic populations.

John Seex identifies a number of factors that militate against young men using sexual health services. The preponderance of female staff and the traditional targeting of women with sexual health advice and services sets up an ethos of exclusion. Young men come to clinics mainly for free condoms, and skilled staff need to be available to initiate interactions that allow young men to return for other advice or treatment. Their sexual health needs are often hidden and are less clear (Seex, 1997).

Staff can be intimidated by groups of young men 'checking out' services, and may deter them from coming back. Services need to offer opportunity as well as physical and emotional space for young men to get over their own insecurities about expressing their real needs for reassurance, support and help. Reported anxieties that emerged over time included concerns about being pressured into a 'shot-gun' marriage; not being able to ejaculate; and obtaining emergency contraception (Seex, 1997).

Other research, less specific but also relevant, has highlighted the functional approach adopted by men, particularly young men, to using health services. This can be summarised under four broad attitudes.

- First, using health services is appropriate only when the need is evident and pressing (eg an injury), both because to do otherwise is to use up one's own and clinicians' time which could better be spent on other more needy people, and because most conditions are not sufficiently serious to warrant concern.
- Second, being healthy is strongly associated with being physically fit and, especially in the case of sexual health, because there is usually no sudden or chronic impairment of fitness, there is no real illness.
- Third, accessing health services is intrinsically 'unmanly' – young men run the risk of having their confidentiality infringed and of other people finding out what is wrong with them.
- Finally, men may find it difficult to talk about their health concerns when they relate to sexuality or sexual function, or to emotional concerns.

Young men who are geographically distant from services, and those who lack opportunity or confidence to access them, also have sexual needs. Some of these are identified by Childline in their helpful report on boys' calls for advice and help (MacLeod and Barter, 1996). Here the authors describe the range of topics raised and identify some of the perceptions of masculinity that obstruct young men from addressing them and seeking help in other ways. They report that few boys call in about pregnancy and partner relationships; more call about domestic violence, offending and school worries; and a disproportionately high number call about sexuality, drug use and abusing other children.

However, of all calls, only 18% come from boys. They report that boys talk less when they call, are less fluent and easy, and are highly self-critical about having to seek help at all: 'real boys don't feel'. MacLeod and Barter conclude that boys feel barred from talking because talk does not fit with their ideals of manhood, and because they sense and conform to social stereotypes which run along the lines: 'Boys act strong; they think it's soft to ask for help. Boys don't show their emotions as much, boys have to be tough, girls are more sensitive. Boys find it embarrassing and think it's their fault'. As these authors sympathetically conclude, 'helping boys is important for future behaviour as men, fathers and family members'.

Conclusions

- Academic research on young men's sexual health and behaviour has tended to be strongly influenced by public health agendas focusing on the control of sexually transmitted infections, particularly HIV/AIDS, and the prevention of unplanned teenage conceptions. This has identified patterns in sexual behaviour – earlier, more partners and more sexually adventurous – and demonstrated that a relatively small number of young men have high numbers of female partners and take more sexual risks. These young men tend to be from lower social class backgrounds and have fewer educational qualifications.
- Qualitative research suggests that this group of young men may adhere to masculine norms of which all young men are aware, although some manage to challenge them more successfully and modify them in their private lives. These norms place value on being relatively sexually predatory and sexist, and overtly macho.
- This behaviour and masculinity may be more prevalent among white and black young men who are, for different reasons, acting out a male culture in which resistance to the changing wider social norms about gender and sexuality is both valuable and protective.
- This research has tended to address gay young men only in that their sexual behaviour places them at potentially greater risk of sexually transmitted diseases, particularly HIV/AIDS, and to address bisexual young men and men who have sex with men not at all. This group is likely to be diverse in terms of social and cultural background.
- The epidemiologically common physical and psychological sexual problems experienced by young men are not subject to any direct social research. Not only are these interesting in themselves, but the lack of research suggests a lack of service or educational or social awareness and support of young men in these areas. There is clearly potential to look at their experiences in order to illuminate the emotional experience of sexuality for young men.
- The sexual behaviour and health of most young men is reasonably safe and presumably satisfactory. Despite considerable odds stacked against them, young men have developed a range of strategies for managing sexual relationships and reduction of sexual health risks – strategies that are probably no less successful, and possibly more so, than those used by the adult male population.
- Over and again, the literature suggests that conceptions of masculinity are problematic for health improvement among young men. Notions of masculinity can lead to risk-taking, obstruct negotiation, contribute to the

oppression of young women and homosexual men, and probably add to regret and other sexual dissatisfaction among young men. This has similar class and ethnic dimensions to other health issues, and may also relate to biological factors that interact with social factors. The links between early puberty, physical development and sexual activity which enhances a young man's social status and reputation are a case in point.

- A lot of protective sexual health behaviour appears to be dependent, at least in part, on access to information about services, information about sexual activity and contraception, and opportunities to improve interaction skills. It is logical to assume that for young men who are excluded from school, in care, detained or otherwise socially excluded, these paths are not open and their vulnerability is consequently higher.
- Attempts to address young men's perceived sexual ill-health and risk-taking may appear to young men to fly in the face of their beliefs about their bodies, and aspects of the formation and development of their sexual identity. This is not because the messages are (or are perceived to be) irrelevant, but because young men are inappropriately approached and/or the messages are unhelpfully expressed. For example, sexual health is still presented as a female-dominated area, with services being delivered by women for young men. Sexual health promotion can easily be seen as 'against' young men, in the sense that it demands behavioural compromise and change on terms that young men have not been involved in setting.

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Mental health

While girls and young women are twice as likely as boys to suffer a depressive disorder, 10 times more likely to suffer from anorexia, and more likely to feel lonely, young men are three times more likely to be alcohol-dependent and twice as likely to be drug-dependent (Coleman and Schofield, 2000).

Within the male population, those aged 20–24 are thought to be at particular risk (Meltzer *et al.*, 1995). An OPCS review found that neurotic disorders, anxiety states, depression and affective psychoses are all generally less common in males than in females. Adolescence is no exception to these findings. However, drug dependence is the opposite, with many more males being dependent on drugs than females (OPCS, 1992). This evidence suggests that gender plays a significant role in mental health issues.

Prior (1999) found that when numbers were broken down by gender, more men than women had a psychiatric disorder over their lifetime (36% of men and 30% of women), but men and women ranked the same in terms of their current (or active) experience of mental disorder, 20% of both groups reporting symptoms during the previous year.

The difference in lifetime prevalence has been explained by the significant over-representation of men in two areas – alcohol dependence and personality disorders (Prior, 1999). Pilgrim and Rogers suggest that 'it is mainly men who are over-represented in the most stigmatised and policed part of the mental health system, the 'special hospitals'. Though many in these institutions are there for sex offences and other violent crime and their behaviour or threat to society' (Pilgrim and Rogers, 1999). One reason offered by these authors is 'because men are diagnosed younger, when they are physically at their strongest, this may induce more coercive actions from professionals during a crisis' (Pilgrim and Rogers, 1999).

Bailey (2000) reports that child mental health services are increasingly asked to assess and provide treatment not only for victims, but also for perpetrators. He cites a study carried out by Dolan and others, who found that 'the majority of young abusers are male with a history of neglect, physical and/or sexual abuse, below average ability, and high rates of behavioural and psychological problems' (Dolan *et al.*, 1996).

Bailey also comments that 'the majority of adult sexual abusers of children started their abuse in their own adolescence, and yet there is as yet no diagnostic category

for paedophilia for those under the age of 16'. Vizard *et al.* (1996) suggest the creation of a new disorder, sexual arousal disorder of childhood, to help identify this vulnerable group who can, in turn, place vulnerable others at risk. There is currently a lack of epidemiological evidence concerning sexual conduct disorders in young people in the UK.

A recent study found that the proportion of children and adolescents with a mental disorder was greater among boys than girls: 11% compared with 8%. This disparity was evident in both younger and older children. Among 5–10-year-olds, 10% of boys and 6% of girls had a mental disorder. In the older age group, 11–15-year olds, the proportions of children with any mental disorder were 13% for boys and 10% for girls (Meltzer and Gatward, 2000).

Conduct disorder was twice as common among boys than girls, and for hyperkinetic disorders the ratio is even greater: 2% among boys of all ages compared with about 0.5% of girls (Meltzer and Gatward, 2000).

Particular populations were also more likely to have mental health problems. Almost half of the women in prison (45%), against one-fifth of men (20%), had been drug-dependent in the year prior to the survey, and a staggering 70% of women and 56% of men in prison had been drug-dependent at some time in their lives (Meltzer *et al.*, 1995).

Meltzer also found a strong association between mental disorders and unemployment (Meltzer *et al.*, 1995) and social class (Meltzer and Gatward, 2000). The SEU suggests that 'some 30–50% of rough sleepers suffer from mental health problems. The great majority (88%) of those with mental health problems became ill before they became homeless' (Craig *et al.*, 1993, cited by SEU, 1998). The same report concludes that 'as many as 50% of rough sleepers have a serious alcohol problem and some 20% misuse drugs' (Randall and Brown, 1994; Gill *et al.*, 1996, both cited by SEU, 1998).

In a study of adolescents in the care system, McCann found 67% of the in-care sample had a classifiable mental health problem (McCann *et al.*, 1996) compared to 15% in a control-led sample. The range of problems included conduct disorder (28%); anxiety disorder (26%); major depressive disorder (23%); attention deficit hyperactivity disorder (14%); and functional psychosis (8%).

Nearly 10% of white young people and 12% of black young people were found to have a mental health problem

(Dennison and Coleman, 2000). Young black men are over-represented in the mental health statistics (Prior, 1999), especially in terms of diagnosis for schizophrenia, which was three times the rate for African–Caribbeans compared to the white population (Nazroo, 1997).

Young African–Caribbean men are worthy of separate mention. There is substantial evidence of over-representation of hospital admissions, and more likelihood that they make contact with psychiatry via the police, courts and prison and come into contact with forensic psychiatry, and that they are under-represented in out-patient and self-referred services (Pilgrim and Rogers, 1999). They are also more likely to be admitted compulsorily, and to be placed in locked wards (Koffman *et al.*, 1997). African–Caribbeans are over-represented in psychotic disorders and under-represented in neurotic ones. Schizophrenia and ‘cannabis psychosis’ are often the diagnosis; both have been questioned as a valid diagnosis (Fernando *et al.*, 1998).

Francis has suggested that this indicates a ‘coalescence of the criminalization and medicalization of black people’ (Francis, 1991). Fernando *et al.* have argued that young black men in particular are misdiagnosed (Fernando *et al.*, 1998); institutional racism and the inadequacy of psychiatric knowledge have also been suggested (Littlewood and Lipsedge, 1988). Smaje (1996) suggests that the factors at play may be genetic, cultural, racial and/or material.

In his study of African–Caribbean young men in school, Sewell (1997) suggests that two strong models exist – young black men are either expected to conform (in what Sewell calls the McDonald model) and be more British than the English; or they are thought of as being ‘Yard man’ and expected to rebel. Sewell suggests that external expectations create identity and confidence problems for young black men, and these may lead to mental health problems.

Poor experiences of mental health services have been reported by many gay men (as well as bisexual people and lesbians). McFarlane found extensive prejudice among mental health professionals, and also that gay men were reluctant to reveal their sexuality for fear of discrimination (McFarlane, 1998). Anxiety, depression, self-harm, suicide and attempted suicide have all been linked with the combined effects of the prejudice and feelings of self-hatred, shame and low self-esteem (thought to be at least partly a result of homophobia).

Ramrakha *et al.* (2000) found a clear association between

risky sexual behaviour and common psychiatric disorders among young people in New Zealand, and suggests a need to co-ordinate sexual medicine and mental health services.

Catalan *et al.* (2000) highlights the need to develop (and adapt) mental health services for patients with HIV. They suggest that, with the development of treatments for the infection, the psychological and social consequences have given rise to a change in mental health problems. For example, there has been a reduction in adjustment disorders and an increase in depressive disorders as patients come to terms with an extended life expectancy.

Conclusions

- Most mental illness and health issues are gender-related.
- There is a very strong link between help-seeking behaviour and mental illness and health issues. There is also evidence that help-seeking itself is influenced by gendered attitudes and behaviour.
- Due to the stigmatisation of those with mental illness, men are even less likely to ask for help from the mental health services.
- Evidence suggests that many men have a reluctance to acknowledge difficulties and to ask for help.

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Suicide*

Overall, suicides fell from 5,655 in 1982 to 4,872 in 1996, a drop of 13.8% (Charlton *et al.*, 1992). However, while trends for men and women followed a similar pattern up to the early 1980s, they have significantly changed since then. The overall figure for men increased by 2.3% between 1982 and 1996, while it dropped by 41.3% for women.

As well as gender, age has been an important component of the increased figures for men. While suicides amongst the various age groups have gone up and down during the period 1974–90, the overall increases are significant in the three age groups between 15 and 44 years (15–24, an increase of 102%; 25–34, of 51%; 35–44, of 50%).

Whilst male suicide continues to occur largely among men aged 75 and over (in absolute terms), the increases in deaths of younger men have caused the most concern, in part because of the rises themselves, but also because of the years of life lost (Pritchard, 1995).

In contrast, 'deliberate self-harm' is three to four times more common in women than in men, and more common in younger adults. The term is generally used to cover all acts of self-harm, self-injury or attempted suicide (MHF, 1997). There are an estimated 100,000 people a year referred to hospitals in England and Wales for deliberate self-harm, mainly involving drug overdoses or self-injury. Approximately 19,000 of these are young people (Hawton and Fagg, 1992). Self-injury is also thought to be twice as prevalent among women as it is among men. However, statistics on self-harm and self-injury are thought to be very unreliable, with many of these incidents (especially scalds, cuts and burns) being dealt with at home and so not appearing in the statistics.

As for most other mortality figures, there are marked social class differences in the suicide rates. While social class I has seen a decrease, there is a progressive increase down the social class groups, both in terms of actual incidence and over time. For instance, there is a 3.5 times greater likelihood of a suicide in social class V than in class I (Drever and Bunting, 1997). Unfortunately, data correlating social class, gender and age are not available, but the indications are that young males from social classes IV and V are most at risk.

There have been a number of recent papers suggesting that suicide figures are under-estimates. Madge and Harvey suggest that 'there are many reasons for this including the constraints of registration policy and practice, uncertainty about the circumstances surrounding a death, an unwillingness – often for the family's sake – to affix a suicide label on a child, and perhaps the belief that the term "suicide" is not quite accurate.' As a result of their analysis of an inner London coroner's office over a 17-year period, they suggest that suicides may be up to three times the official recorded level (Madge and Harvey, 1999).

In terms of methods used, hanging and suffocation have increased steadily for men since 1983 (especially for the 15–44 age group), accounting for 34% in 1996; poisoning by gases and vapours (especially motor-vehicle exhaust gas) has also increased, to 23%; while poisoning by substance (especially drugs) is decreasing, but still accounted for 20% of all suicides in 1996.

Kelly and Bunting (1998) suggest that suicide methods are determined by ease of access, and possibly by fashion. They also suggest that one of the primary differences between the methods used by males and females is lethality. This is also thought to contribute to the suicide rate being predominantly male and the attempted suicide rate being predominantly female.

The effectiveness of hanging as a method is much higher than drug overdoses (where the user needs to know something about the drug and the quantity required); hanging is also a much quicker process, with the result that life-saving detection is far less likely to occur (Kelly and Bunting, 1995).

Most analyses of causes of suicide draw little distinction between different ages of males and females, but most agree that the causes are multi-faceted and include:

- *individual characteristics* such as mental illness, drug use, gender identity issues (especially for gay young men), and genetic or biological components
- *family issues* such as child abuse, suicide in the family, and family breakdown
- *social disadvantage and exclusion* such as economics,

*Suicide has been defined as 'suicide and deaths from injury and poisoning undetermined whether accidentally or purposely inflicted' (World Health Organization definition). Holinger (1981) has suggested that 'self-imposed risks and self-destructiveness appear to underlie many violent deaths. Unless self-imposed risks are reduced and strategies for understanding and curbing self-destructiveness are established, the mortality rates and years of expected life lost due to violent deaths will not be significantly improved.'

- discrimination, and school under-achievement
- *life events* such as relationship breakdown, confinement in mental hospitals and prisons, loss of a job, homelessness, and development of physical illness or disability.

Significant relationships have been suggested between suicide and a number of factors. Those with particular reference to young men are: psychiatric illness, particularly depression; schizophrenia; alcoholism; drug addiction; cerebral disorders (epilepsy, brain injury, mild dementia); personality disorder and neuroses. In some studies (albeit rather old ones), as many as 90% of those who committed suicide were judged to have some form of psychiatric illness (Barracough *et al.*, 1974).

While there appears to be a significant link between mental illness and suicide, this alone does not account for the differences in gender rates. The Mental Health Foundation has highlighted 'men's reluctance to admit problems; unwillingness to recognise a mental health problem or to seek help as important factors, as well as the men's abuse of alcohol and drugs, both of which are implicated in suicide' (MHF, 1997).

Estimates suggest that up to 60% of young men who commit suicide are suffering from a depressive illness (Lesage *et al.*, 1994). Another study suggested that schizophrenia is thought to be the most significant factor for younger men, especially if they are also unemployed and have a previous history of acts of deliberate self-harm and depressive episodes (Watts and Morgan, 1994).

While there is not a direct link between unemployment and young male suicide, there may be an indirect link from the effect of unemployment, especially poverty. Pritchard has suggested that 'a negative socio-economic situation worsens those already vulnerable and compounds any 'stress-related' situation, which increases the other psycho-social pressures linked to poverty and unemployment, of which suicide is one of the continuum. However, caution is necessary, as self-evidently the vast majority of unemployed people are not involved in suicidal behaviour, and unemployment is only one element in a complex equation' (Charlton *et al.*, 1992).

While most authors identify individual factors as risks, Stoelb and Chiriboga (1998) include homosexuality as a situational risk. Teague (1992) hypothesised that 'experiences stemming from identifying oneself as a homosexual or bisexual in a homophobic society may be even more confusing and painful for adolescents than for adults because adolescents " have

more limited life experiences and less developed life strategies" '.

There are numerous studies indicating a much higher rate of deliberate self-harm for gay men: for example, Bagley and Tremblay (1997) found that gay and bisexual men aged 18–27 in Canada were four times more likely to have self-harmed (11% against 3% of sample); Faulkner and Cranston (1998) found just over twice as many gay and bisexual men (with a mean age of 16) self-harming as heterosexual men (27.5% against 13.4%). Howard and Nicholas (1999) reported gay-identified males aged 18–24 and living in the Greater Sydney area as 3.7 times more likely to report making a suicide attempt.

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However, the evidence for successful suicides is much less conclusive. Rich *et al.* (1986), with a broader age group (21–42 years), found the incidence about the same for both gay and heterosexual males, although Muehrer (1995), reviewing the literature on suicide and sexual orientation, points out the limitations of existing research evidence, including the lack of data on the prevalence of homosexual identity in the general population. There is general agreement on a close association in suicides related to gay men with HIV infection, although Catalan (1999, 2000) has argued that new treatments for HIV may well reduce this number.

Surprisingly little has been written about maleness in relation to the incidence of suicide among men (except for the papers above dealing with differences between gay and straight men), although this is often mentioned by many as 'in the background'. Bradford and Urquhart (1998) concluded from a study of young men and women that 'changing patterns of employment, altered gender relations, new discourses of masculinity or femininity may undermine young men's sense of certainty and security, particularly when these are seen to damage opportunities for economic independence ... significant numbers of young men may need more support in finding their way on this rapidly changing terrain, and statistics on young men's suicide indicate that there is much work to be done to contain growing problems' (Bradford and Urquhart, 1998).

The link between masculinity and suicide is unproven, but writers such as Gilmartin have argued that gender-role strain (difficulties for men to live up to the masculine demands of work, success, physical strength, independence and invulnerability) has been a repetitive theme within the literature on men and depression, suicide, and alcohol and drug abuse (Gilmartin, 1994). While most commentators

have taken this as fact, they have failed to develop practice and intervention on the basis of this.

Stanistreet has suggested that 'in a culture that encourages men to obtain mastery over their environment, risk-taking behaviour may be construed as a popular operational definition of man's maleness. This type of behaviour may manifest itself in several different ways, including reckless driving, excessive drug use or, in a more overt form, commonly defined as suicide' (Stanistreet, 1996). Authors such as Stanistreet (and Menninger before her) have placed suicide at the end of a risk-taking spectrum, as well as identifying suicide as a mental health issue (Menninger, 1938).

While suicide and being male has been mentioned by a number of studies and articles (Samaritans, 1993), there have been few attempts to measure or really engage with this relationship. One such attempt has been made by Stillion, McDowell and May, who suggest three aspects of masculine socialisation that may play a part (Stillion *et al.*, 1989).

- Males show higher levels of aggression throughout their lifespan, thus aggression towards the self may also be seen to occur at a higher level, with males also tending to use more violent methods and lethal means of committing suicide than females.
- Their orientation towards success, status and problem-solving leads males to 'succeed' in carrying out the job of taking their life (they offer the distress experienced by those men who have been unsuccessful in committing suicide as evidence of this).
- The masculine norm of independence often leaves men alone with their problems and unable to ask for help, until this escalates to the point of contemplating suicide.

Gilmartin also speculates that, because adolescence and old age are the most sex-type times of life (becoming a man and 'masculinity fading away'), these high-risk developmental periods may be affected by feelings of not measuring up as a man (Gilmartin, 1994).

Lloyd, in a briefing paper for the Men's Health Forum, strongly recommends that 'local health authorities consider the gender implications in data collection, planning, delivery of services and clinical practice'. He also suggests a broader strategic approach than the mental health framework, at least in part because of the limited use young men make of mental health services on a voluntary basis (Lloyd, 2000). This is also the conclusion of Hawton, who suggests such

interventions as educational programmes in schools, a reduction in substance abuse, and the establishment of local multidisciplinary suicide prevention groups as important aspects of a local strategy (Hawton, 1996).

Conclusions

- There has been an increase in male suicides, especially in social classes IV and V and among younger men below 44 years.
- Men use more violent and lethal methods which are thought to contribute to the higher rate of actual suicide.
- The chains of causation remain elusive. Masculinity remains a relatively unexplored factor in young male suicides.
- Sexuality plays a part in at least deliberate self-harm, if not suicide.
- More studies and interventions that explore gender would be beneficial.

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Hyperkinetic disorders

A form of attention deficit hyperactivity disorder (ADHD) has been around in some form since the beginning of the 20th century. Paediatrician Frederick Still identified 'abnormal incapacity for sustained attention ... restlessness, fidgetiness' and argued that 'children had serious deficiencies in "volitional inhibition" of a biological origin' (Still, 1902).

42 By the 1950s a 'catch-all' term, minimal brain dysfunction, was applied to a range of behavioural and learning problems. The recognition that many of those diagnosed as having minimal brain dysfunction were 'hyperactive', led to hyperactive behaviours being seen as the defining features. By the 1970s the focus moved from hyperactivity to attention deficit, as it was increasingly felt that attention was the key feature (Douglas, 1972).

The establishment of 'attention deficit disorder' as a psychiatric category in the USA (APA, 1980) established the condition and led to the development of a series of standardised tests. Prevalence of ADHD has been estimated at just over 2% to almost 10% of children in the USA and Canada (APA, 1980), with a gender difference of three males to each female.

In Britain, the situation is very different. Rather than ADHD, the narrower World Health Organization definition for hyperkinetic disorder is preferred (WHO, 1990), as it requires both significant inattention and hyperactivity to be observed. Estimates are around 1.5% of 7-year-old boys in inner cities, and 0.5–1.0% of the whole child population (Taylor and Hemsley, 1995). While fewer in number, these children are thought to show more severe signs of symptoms than those diagnosed with ADHD (BPS, 1996).

YoungMinds estimates that as many as 360,000 of Britain's 12 million under-16s could have been labelled ADHD: the government estimates 1%; the Mental Health Foundation 5%, and figures are thought to be increasing. Professor Steve Baldwin (clinical psychologist at the University of Teeside) says that 'it is conceivable that in 1994 there were 4,000 children diagnosed while in 1999 there were 131,000' (Beck, 2000).

There has inevitably been controversy over definitions, as well as concerning the use of psychostimulant medication such as Ritalin. A number of subgroups have emerged: children with school-based problems; children who are exclusively inattentive, or predominantly hyperactive-impulsive, or both; and aggressive hyperactive and anxious hyperactive children (BPS, 1996).

Problems have arisen over a number of other issues.

- Definitions vary from study to study, making comparison difficult.
- Attention deficits are often associated with other disorders, making it difficult to tease out the specific contribution of attention problems.
- Longitudinal and population studies have produced a variety of contributing factors and causes, including children with very low birth weight, to a high risk of developing ADHD symptoms (Hack *et al.*, 1994). Some children grow out of attention problems and do well by early adult age, while many other children continue to show persistent attention problems well into adolescence and early adult life (Sandberg, 1996).
- A range of different psychological, environmental, social and biological causes have been suggested, including brain damage, poor teaching, understimulation, poor parenting, loss of the attentional filter, delay aversion, poor diet, food allergies, and a misdiagnosis for racism (BPS, 1996).
- Such a broad range of causes has inevitably meant that treatment options have been varied and often argued exclusively. Nutritionists, doctors, educational psychologists and teachers have all had a view and developed interventions. There has been a more recent call for a multi-dimensional model of assessment and intervention which 'takes into account the interplay between environmental and individual factors at all levels of analysis' (BPS, 1996).

While most studies show three of every four cases to be male, gender has not played a significant role in the literature. It has been argued that the apparent higher incidence in boys is a result of definitions and identification being male-oriented. In a New Zealand study, teachers identified problem behaviour in boys more readily than in girls (McGee *et al.*, 1985). A British study suggests that the diagnostic criteria and rating scales used to assess the condition 'heavily emphasise "male" behaviours rather than "female" ones such as verbal cruelty and sexual precocity' (Heptinstall and Taylor, 1996).

Block (1983), in an old but gender-focused study, argued that because males show a higher level of aggression and other anti-social conditions, leading to low attention and hyperactivity, they are more likely to be labelled ADHD. He also suggested that because general learning difficulties are more pronounced in boys, they provide a larger pool.

There is little evidence to suggest that hyperactive boys and girls show significantly different behaviours (Horn *et al.*, 1989). Others suggest that there are biological causes and maturity factors at play which place boys at a disadvantage and make them generally more susceptible to physical and behavioural problems (Gualtieri and Hicks, 1985).

Conclusions

- Hyperkinetic disorder and ADHD are gendered issues. Both conditions have an incidence of roughly three boys to one girl.
- The literature has tended to take gender as a fact, rather than considering it as a significant factor in intervention. Gender remains relatively unexplored in both cause and treatment. However, when treatment outcomes have been explored, differences have been minimal.
- For both of these conditions, gender needs to be an active consideration in terms of research, policy and intervention.

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Underpinning issues

Risk-taking

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It is now 8 years since the Chief Medical Officer's Annual Report detailed the mortality and morbidity data for men, and suggested that 'although some diseases, such as prostatic disease, are obviously unique to men, the main differences in mortality and morbidity relate to variations in exposure to *risk factors*' (Calman, 1993).

Some of these risk factors were genetic, others economic and social (such as poverty). However, many are behaviour- and attitude-based. We have looked at some risk factors above; here we review risk-taking as an underpinning issue for young men.

The literature addressing risk-taking is complex and sometimes contradictory, but a number of themes and issues emerge. Stereotypes about young people and risk-taking are strong. Filgueiras (1995) argues that '... adults still tend to view all young people as inherently irresponsible, rebellious, and risk-takers, always in a permanent search for immediate pleasure'. Some argue that adolescence is a natural stage of rebelling, a time to find your own views, for acting before thinking, being led, and acting without experience. Some have questioned the naturalness of this; others ask whether this is general to all young people, or applies to those who have a particular set of factors operating, such as lack of boundaries, poor school records, alienation and poor communication skills (Filgueiras, 1995).

While there are these external factors operating, there are groups of young people who do take excessive risks, but age appears to be a secondary factor to gender. Some young men think they are invulnerable, and will name external and internal pressures (in some cases these external pressures become internalised, such as beliefs about what constitutes a 'real' man; see Kilmartin, 1994; Gabbard-Alley, 1995). There is plenty of evidence to suggest that young men exhibit more risk behaviours and take more risks than young women (Goddard and Higgins, 1999).

Not all risk-taking is negative. Moore and Gullone (1996) identify four types of risk: those that are socially sanctioned; those that involve thrill-seeking; and those that reflect

rebellious risk; along with the more negative (and more usually discussed) reckless and antisocial risks.

Some authors emphasise the perceived benefits of risk-taking in comparison with the costs, and particularly their importance in the development of decision-making, for example, substance use, dangerous driving and adventure sports (Moore and Gullone, 1996; Parsons *et al.*, 1997). There is evidence that risk-taking is (for many) the primary means of role experimentation. Increased self-confidence, self-esteem, stress tolerance and initiative are all potential gains that may result from risky behaviours.

Jessor emphasises the complexity of the risk issue – for example, he stresses the multi-causality of risk, and warns against the oversimplification implied in the search for single causes (Jessor, 1998). There are also physiological and hormonal effects (particularly adrenaline), and other excitement and attractive sensations that come as a result of taking risks (Ramsey and Ramwell, 1984). Young men often emphasise the 'buzz', the fun, excitement, and the need to escape boredom. Some believe that people who don't take risks are 'freaks' and that 'most' young men engage in risk-taking behaviour, whether drugs, smoking, drinking, crime, violence or unsafe sex (Lloyd, 1998).

However, most of the literature focuses on risk-taking as a negative, and usually there is an emphasis on the inexperience of the young person. The risks include a possible lack of knowledge about outcomes; a lack of skills to resist pressure; a lack of supervision (many risks are taken in private, such as sex, under-age alcohol use, drug use); parents (and others) role-modelling risky behaviours; and false feelings of immortality (Kilmartin, 1994). Some men's inclinations to take both active and passive risks (driving fast; ignoring symptoms and not going to the doctor) have been identified, as has the influence of personality, with some individuals taking risks and others not (Lloyd, 1997).

An important aspect of risk-taking is that it affects not only the risk-taker, but also others who may have less choice about the risks they take. So, for example, 'the concept of risk behaviour as a situated rational response ignores the fact that every sexual relationship (for example) is a power

relationship. Conceiving of risk behaviour as a volitional act only makes sense in respect of the dominant party in the relationship: for example, in the case of unsafe commercial sex, we may refer to the client's behaviour as volitional, but not the male prostitute's. The point about power relationships applies more widely than the prostitute–client encounter: one party's choice is another party's constraint' (Kippax, 1994).

Plant and Plant (1992) place risk-taking and risk factors within a much broader context by suggesting that risk-taking 'varies enormously in different groups, cultures, different leisure, sport and other activities, different individuals and other social–psychological variables and entwined with life-style. It is also influenced by poverty, inequality and discrimination'.

While health promotion and even health education have concentrated on specific risks (particularly sex, drugs, smoking and alcohol), authors such as Silbereisen argue that we should study adolescents as whole persons, emphasising the complex nature of risk-taking, rather than concentrating on single risks (Silbereisen, 1998). There is evidence to suggest that the single-risk approach has its limitations; Jonah (cited by Plant and Plant, 1992) suggests that attempts to change a single form of health risk may be ineffective, as other forms of risk might simply be adopted as substitutes.

Conversations and reflection about general risk-taking have also been found to be a valuable approach in engaging with young men: 'they (young men) talked very openly about the risks they took, when they were asked directly about risk-taking. This approach avoided some of the barriers and resistances that young men can put up when asked about individual risks. We are of the view that an approach within schools (and other provision), that focuses on risk-taking, rather than the risks, would engage young men much more productively, and open up opportunities for reflection and attitude change' (Lloyd, 1998).

Plant and Plant (1992) suggest that there may be risk-taking personalities, that several risky behaviours are associated and often interconnected, and that there is evidence that young people may move in and out of different styles and degrees of risk. Others go further, to question whether adolescent risk-taking forms part of a broader personality trait such as sensation-seeking (Coleman and Schofield, 2001), and question whether we should isolate the different developmental pathways and risk-related characteristics (and

behaviours) that are linked with long-term as opposed to short-term risk-taking.

Ensuring young people are fully informed of the risks they take has remained a strong thread of health education, and 'harm reduction' has increasingly become a central aim of health promotion, especially in terms of drug use. These have been important developments in recognising the benefits or the inevitability of young people experimenting and taking risks. There has been much less emphasis on what may encourage young men to reflect on their risk-taking, and what may lead young men to reduce their level of risk-taking behaviour (especially for those young men who are thought to be endangering themselves or others).

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Lloyd (1998) found that young men knew they were taking risks: 'most of the young men identified risky behaviours as just that. They themselves saw drugs, smoking, drinking, violence and unsafe sex as risky, but for some, that was more of a reason to do them, than to avoid them. The dangers were part of the attraction'. In the same study, the young men were also able to draw a line between which risks were worth taking and which were not, as well as being able to assess risks. However, little thought was given to the consequences of their actions (Lloyd, 1998).

Plant and Plant (1992) explored the important issue of risk reduction, and suggest that 'to refrain from certain risks may necessitate resisting overwhelming social pressures or strong emotions and drives. Risks are often taken in association with others who provide encouragement, and who may actively deter risk avoidance or the adoption of harm minimisation procedures'.

While peer pressure is a well recorded theme, interestingly Lloyd (1998) did not find that the removal of peer pressure was a strong factor in young men's motivation to reduce their levels of risk-taking. 'Many believed that this was a phase they were going through, one where they didn't have responsibilities, and many envisaged that they would have jobs, kids, wives and other responsibilities when they were older and would behave differently. Others were more specific about what would lead them to change, some suggested "guilt", that they were "letting down their parents", adding that their families mattered. Some of those involved in crime said they would give up because they "feared prison" (many of these were of the view that while they were young they were invulnerable to the law). Others mentioned the arrival of "a good job" or a "baby" would

stop them taking risks and some even mentioned “feeling better about myself” as a motivation for reducing their levels of risk-taking’.

The relationship between risk-taking and responsibility appears to be a significant one, as illustrated in this quote from an African–American young man previously involved in drug dealing:

‘Since I got out, she told me if I go back to jail, she’ll leave me and since the baby’s been born, she told me “don’t even think about it”. I’ve been thinking about it – it’s always in my mind, cause it’s been there for so many years – you can’t just let it go. It’s like – money is out there to be made. It’s kinda hard, I feel sorry for myself, but I’m wakening up now, cause of the baby, I’ve got somebody to be responsible for, so in a way, he kinda helped me out when he came into this world.’

(Bowker, 1998).

In contrast, it has also been highlighted that a refusal to take responsibility plays a significant role in risk-taking behaviour. ‘When a person overcomes a risk this is typically attributed to individual prowess, such as bravery or skill. If the risk ends in disappointment, even tragedy, this will frequently be ascribed by the protagonist to “bad luck” or to external factors. Others, however, may ascribe such accidents and failures to incompetence, poor judgement or other personal flaws’ (Plant and Plant, 1992).

Conclusions

- Risk-taking is complex. It is both an important part of learning about the world, and also in its extreme forms dangerous and a threat to health.
- There appears to be a strong association between risk-taking and masculinity, and a possible association between risk-taking and responsibility. These relationships are important to understand if we are to reduce the level of risks that some young men take.
- Health promotion and education have tended to focus on individual risks, which has been important. However, an approach that also looks at ‘risk-taking’ as a general theme may be a particularly beneficial one to use with high-risk-taking young men (cost–benefit exercises within criminal justice, for example, have been useful ways to enable young men to reflect on the risks they have taken).

- In a society that may be moving towards over-protecting children from risks (parents’ increased fears of what might happen to their children, in the street, listening to Eminem, etc.), it may be beneficial to look at the opportunities children and adolescents have to learn from risks in their lives.

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Use of services and help-seeking behaviour

Just as there are differences in levels of incidence and what appear to be gendered conditions, males and females show different types of help-seeking behaviour. The main reasons usually given for the under-representation of men in the psychiatric statistics, for instance are: men are not good at seeking help and men are more likely to externalise problems (in crime rather than illness), women appear to be over-represented in mental health populations, whilst men predominate in criminal statistics (Pilgrim and Rogers, 1999); men are thought to be discouraged from acknowledging distress; male doctors are unlikely to see male distress as illness; and men are thought to have fewer real-life problems than women (Bussfield, 1996).

Both Connell (1995) and Edley and Wetherell (1995) suggest that the current psychiatric system is not 'men-friendly', in other words, not flexible enough to be helpful to men experiencing difficulties in relation to the male role or identity, or to men who are reluctant to acknowledge personal problems for fear that they might appear weak.

Prior takes up this theme, suggesting 'we now recognise that life is potentially as stressful for men as it is for women and that this fact has been masked until recently by different patterns of help-seeking behaviour and approaches to psychiatric diagnosis' (Prior, 1999).

Although psychological disorders are common among people consulting in primary care, only around 5% volunteer psychological problems as the main reason for their visit – others tend to cite physical complaints. Family doctors tend to assign a psychiatric diagnosis to only about half of those who present with mental health problems (Calman, 1996).

Jacobsen *et al.* have rightly said how important it is to be aware of the 'inverse care law' – those most in need are least likely to seek help (Jacobsen *et al.*, 1994). Walker and Townsend (1998), in their review of adolescent mental health, found very few primary healthcare initiatives targeting young people and mental health.

Young males and females appear to deal with anxieties and stresses in different ways. Males appear less able to ask for help from those around them. This may be a positive trait in some circumstances, but when things become really difficult, a lack of ability to ask for help clearly leaves young men seriously at risk (Dennison and Coleman, 2001).

Prior (perhaps a little optimistically) suggests that this is changing – 'the particular problems experienced by men are now being articulated in psychological and sociological literature on masculinity and are being confirmed in mainstream psychiatric research' (Prior, 1999).

Gender differences continue when we look at reasons for seeking help. Females are more likely to report problems with families, interpersonal relationships and health problems, whereas males are more likely to report educational problems and could have more difficulties disclosing other types of problems (Schonert-Reichl and Muller, 1996). A cross-European study found that young women are far more likely than young men to experience loneliness, while young men are more likely to feel under pressure from their parents (Eurostat, 1997). Girls are thought to have higher anxiety than boys, while young men are thought to feel more satisfied than young women across the adolescent age range (Balding, 1999).

There is some evidence that people with psychological symptoms delay seeking formal help for a long time. Rogers, Pilgrim and Lacey found that the time-lag between experiencing psychological symptoms and seeking professional help was more than 1 year for 20% of 516 post-discharge psychiatric patients (Rogers *et al.*, 1993). Couple this non-gendered reluctance with men's and young people's apparent resistance to service use (Macfarlane *et al.*, 1987; Briscoe, 1989), and this will have implications for young men's use of mental health services.

Pilgrim and Rogers also suggest that 'women, then, may be more likely to recognise and label mental illness than men or, put another way, men may be less likely to view their problems as psychiatric ones' (Pilgrim and Rogers, 1999).

Secular changes in patterns of family life expose children and adolescents to more frequent and earlier challenges: marital discord, parental breakdown and divorce, remarriage or cohabitation, and single-parent families have all been shown to be associated with negative outcomes in young people, with boys and girls being affected in different ways (Fombonne, 1995).

Boldero and Fallon found that males were less likely than females to ask for help from friends, and more likely to ask parents. They conclude that this may reflect the different functions friends fulfil for males and females. The same authors conclude that adolescence is an important time for intervention, suggesting that by the time adolescents enter

secondary education the pattern of gender differences in help-seeking has been established (Boldero and Fallon, 1995). Young women were found to be significantly more likely to seek assistance from parents, professionals and friends than were young men (Schonert-Reichl and Muller, 1996).

Young men are thought to use more active coping strategies – seeking information, using aggression and confrontation or, alternatively, trying to deny the problem's existence. 'Though some of these mechanisms may be advantageous, the lack of an ability to ask for help leaves young men vulnerable' suggest Dennison and Coleman (2001). The same authors conclude that these different gender-related coping styles may lead to the contrasting mental health problems of young women and men. During the past decade coping has been a common theme in social and clinical research focusing on adolescence (Frydenberg, 1997).

Walker and Townsend (1998) suggest that intervention during adolescence could help prevent the onset or continuation of health-damaging behaviour that may not yet be established as part of a lifestyle.

Conclusions

- There are significant differences in the ways many men and women seek help.
- We know relatively little about what conditions encourage young men to use services.
- We know relatively little about the extent to which young men perceive barriers to their use of services, or the level of their reluctance to use existing services.
- There may be value in focusing within the personal, health and social education curriculum on help-seeking for a substantial number of young men.
- How much embarrassment, and feeling they have to appear 'tough men', affects young men's use of services and help-seeking behaviour is worthy of exploration.

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'Physicality'

A number of themes have emerged from the different directions in which we have approached boys and young men's health. One of these themes, while ever present, was rarely named – we have called it boys' and young men's 'physicality'.

We have identified 'physicality' as a recurrent theme on a very broad spectrum, ranging from teachers' observations of boys who 'just can't sit still', through to elements of challenging and antisocial behaviour, and on to some men's violence towards their partners, brought on because 'she embarrassed me in front of my mates'. While this is, of course, an extremely broad range of activities that at some levels cannot be compared, there is a similarity in the physical base that appears to reflect a male bias.

This male bias can be found within, for example:

- accident books in nurseries
- numbers of pupils 'disruptive in class'
- behaviour difficulties within school
- pupils excluded (temporarily and permanently) from school
- antisocial and challenging behaviour
- attention deficit hyperactivity disorder.

Boys and young men are prominent in virtually any problem (or disorder) that involves high levels of movement and physicality. There are a complex series of factors involved – many of these physically driven behaviours occur at different ages and sometimes within different settings (at school, but not at home); however, there appears to be a common thread.

When professionals – and young men – are asked where they can learn, what they respond to and where they can communicate, this usually involves an active component. Youth workers state that young men talk around the pool table; young men will tell you they prefer active lessons where they can walk about; and the current preoccupation with sport as an alternative to crime also points to young men's positive response to physicality.

Alcohol and most drugs that young men will use (disproportionately to women) enhance their physicality (as well as decreasing emotional responses), sometimes making them feel stronger, or stay awake longer; and sexual performance is about 'going all night', with Viagra increasingly becoming a recreational drug. Again, it should

be stressed that many of these activities are not being compared; there is no suggestion that one leads to another, but that they all involve strong elements of physicality.

Most young children are physically active. Thorne reports that 'one of the teachers told me that groups of children reminded her of bumblebees, an apt image of swarms, speed, and constant motion' (Thorne, 1993). Thorne, in her excellent study of gender and play, observes that 'boys more often grabbed one another from behind, pinned down one another's arms, pushed and shoved, wrestled one another to the ground, and continually pressed the ambiguous line between "play" and "real fighting"'. When girls chased other girls, they pushed and pinned from behind, but they rarely shoved one another down or ended up wrestling, and their physical encounters never resulted in physical injury.'

She also observes the same in terms of verbal threats, which she believes are more common with boys. 'The threats – "Shut up Kevin, or I'll bust your head"; "I'm gonna punch you" – were sometimes issued in annoyance or anger, and sometimes in a spirit of play. Groups of boys in both schools talked at length about who had and could "beat up" whom. And when arguments erupted into serious physical fights, crowds gathered on the playground, and talked and stretched out the events for hours.'

Many of her observations of year 5 children suggest that, while boys and girls are both physical, boys tend to be more so, and have a tendency to take their physical activity further than girls and be more inclined to take their physicality out of what she calls the 'play framework' (Thorne, 1993).

In a review of anthropological and sociological literature, she also found that 'large, bonded groups of boys who are physically assertive, engage in "tough talk", and actively devalue girls, anchor descriptions of "the boys' world" and themes of masculinity. Other kinds of boys may be mentioned, but not as the core of the gender story' (Thorne, 1993). It is not only researchers who are captivated by the physicality of young men – but teachers, youth workers and other professionals talk extensively about "pack behaviour" and the "dominant males" .

While explanations for this physicality can be found in genetics (aggression gene); biology (testosterone, natural aggressive tendencies); physical development (puberty); family and social factors (divorce or death of parent, low literacy levels, peer pressure and being bullied); diet ('e' additives and fast food); and moral development (lack of

boundaries, not knowing right from wrong), one explanation in particular has a substantial impact on young men's health. When professionals are talking about young men whose behaviour exhibits a high level of physicality, they will often mention in tandem their difficulties with communication, and with verbal expression in particular.

There is substantial evidence that adolescent boys and girls often exhibit differences in emotional expression. Stapley and Haviland (1989) found that boys were much more likely than girls to deny that they ever had emotional experiences, while Walker and Wright (1976), in an old but significant study, found that when they asked university undergraduates to talk about intimate topics 'fifty per cent of the male subjects refused to cooperate with this direction. Men who did cooperate, however, did not differ from women in the intimacy level of their disclosures'. The authors concluded that emotional expression was more a reflection of different levels of 'sex typed' behaviour, rather than gender. So those young men who refused to talk were more likely to hold a more stereotyped view of men who do not talk about intimate topics.

Another reflection of this 'sex typed' determinate is seen in the finding that boys who have expressive fathers are as expressive as most girls (Balswick, 1988). The same study also found that in families where both parents are expressive, boys will not tend to view emotional expression as an exclusively female trait, and therefore the natural tendency to express themselves will emerge, as it is not associated with threats to masculinity. C. T. Kilmartin, in an unpublished study 'Gender differences in child and adolescent self-disclosure' (Virginia Commonwealth University), found that 'in general, girls tend to reveal personal information and boys tend to reveal what they are doing or thinking.' Kilmartin suggests that a consequence of restrictive emotionality is that 'many men deal with emotions by placing feelings outside of themselves, through externalising defences, by "acting out" emotional conflicts, and/or through physical symptoms' (Kilmartin, 1994). Quoting Block, he also comments that 'we have seen that, from early childhood, girls are encouraged to look inside of themselves and think about how they feel, and boys are encouraged to look outside of themselves and think about what they do' (Block, 1984).

Lobel and Winch (1986), measuring defensive styles in male college students, found that 'there was a tendency to deal with anxiety by finding an object to attack (acting out) or by splitting affect off from content and suppressing the emotion. Kilmartin, concluding his review of restrictive

emotionality, suggests that 'because of the overwhelming quality of these emotions, the man might punch a wall, drink heavily or compulsively, and desperately seek a new partner. In all of these strategies, solutions come from outside of the self. The man can take out his frustrations on an object or find something (alcohol or another person) that will hopefully soothe him, as he is not good at soothing himself' (Kilmartin, 1994).

Male inexpressiveness has been suggested as a major contributing factor to the reluctance of men to seek medical or psychological help (Good *et al.*, 1989; Kinder and Curtiss, 1990).

Conclusions

- Young men's 'physicality' is a theme worthy of further exploration by researchers and practitioners.
- Young men's 'physicality' has an impact in the classroom, on the streets, and in most health environments.
- There appears to be a link between young men's 'physicality' and their emotional expression; this needs further study, especially in the school environment.
- For many young men emotions may translate into discomfort and movement – this has significant implications for health education with boys and young men.

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Groups of young men

In a review of this kind, general themes are often given preference over specific subgroups. As we have worked through the conditions and underpinning issues we have (where the literature has something to say) highlighted particular subgroups that are affected in a specific way. In this brief section we list the issues and conditions that impact on certain subgroups of young men.

This is not an exhaustive list, but it does point to certain subgroups that may require special attention. This may also suggest that the subgroup's identity and/or status will have a bearing on the condition and theme which will need to be taken into account. In a review such as this, these factors cannot be explored in enough detail, but this listing offers signposts to the reader.

Black and minority ethnic men

- mental health
- sexual health and behaviour
- suicide
- help-seeking
- physicality

Gay young men

- mental health
- sexual health and behaviour
- suicide
- weight, and eating disorders

Young men in care

- mental health
- sexual health and behaviour
- suicide
- physicality

Young men who sleep rough

- mental health
- sexual health and behaviour
- suicide
- risk-taking
- use of services

Conclusions

The purposes of this review were to:

- provide a picture of what we know about young men's health
- identify gaps in the literature and practice
- recommend initiatives that could be taken by the HDA.

52 In a review this broad, there will be issues, groups and even conditions that readers will believe we have left out. There will be others who think we have overplayed, or indeed underplayed, certain issues and conditions. We offer this review as a basis for discussion and further inquiry and to aid the identification of innovative projects, and not as a comprehensive survey.

We have tried to reflect the literature as it currently stands and to identify the main themes that stand out as helpful, or as barriers to our understanding of young men's health and meeting their needs.

Gender and masculinity

- We have been surprised to find how rarely gender is mentioned in both qualitative and quantitative studies. This was particularly surprising when we looked at conditions such as suicide, where statistically the incidences, methods and causes are, at least in part, gender-driven. Too often, studies appear to be unable to take into account more than one variable, so if they address age, then gender, race and other significant variables retreat into the background.
- Sometimes when gender is mentioned, it is taken as fact. With conditions such as hyperkinetic disorder and drug addiction, or groups such as rough sleepers, the gender differences are very pronounced, but this is taken as a starting point, without any analysis or exploration of the implications for causes and practice.
- When gender and masculinity are a focus of more popularist studies, too many generalisations about men are made. Such statements as 'men don't use services' and 'men don't express their feelings' or, indeed, 'boys will be boys', are all too common. This level of generalisation is inaccurate, and ignores the variations in many of the conditions and issues surrounding young men's health. We

know, for example, that many men over 25 are prepared to use phonelines for advice, and value their anonymity, while young men are more reluctant users; and that older men and men from social classes I and II are much better users of primary healthcare than men in social classes VI and V, and young men aged 15–24. Generalisations about men tend to cover up significant variations.

Gender and masculinity are complex issues, and affect different groups – and sometimes different individuals – in a variety of ways.

Recommendation

Make gender/masculinity more explicit, but also make it specific, so that it is clear which men, in which situations, with which conditions we need to concentrate on.

Definitions of men's health

- Very few attempts have been made to define men's health. In this study we have taken an Australian author's definition because, despite the growing literature, British authors have hesitated to define the territory. This has led, too often, to a definition that sees men's health as sexual health, or only covering conditions that appear to have a biological or physiological origin (such as prostate cancer). These part-definitions also often fail to include attitudinal and behavioural dimensions as gender elements.
- Kenneth Calman (former Director of Public Health) has contributed significantly to the increased attention that men's health has received in the past 7 years. He emphasised levels of risk as the defining factor in men's health, because 'men take more risks'. At the time, health was seen by the government as primarily an issue for the individual. The current government has increasingly placed health within a public health and inequalities framework. While risk remains a significant factor, as does personal decision-making, men's health needs to be placed within this new framework.
- Men's health has been accepted enthusiastically within the sexual health field and within primary healthcare. Sexual health workers, general practitioners and practice nurses, in particular, have accepted the need to develop strategies

to target and engage men. Men's health clinics, surgeries in pubs, and touch-screen technology have all been used as approaches. However, practitioners have been more reluctant to consider the implications of a man's gender on their clinical practice: how they talk to him, what assumptions they make, how a man might present symptoms, and whether his gender influences his acceptance of the diagnosis are rarely considered. A clearer definition of men's health would help identify the implications of a men's health approach.

Recommendation

A broad (inclusive) definition of men's health should be developed, to include conditions, issues and clinical practice, and to be placed within a public health and inequalities framework.

Young men's health

- Too much of the literature reflects concerns and fears about young men's risk-taking behaviours, without acknowledging the positive benefits that risk-taking can bring. A reluctance to accept that learning can emerge from experimentation, especially for certain groups of young men, suggests a more general mistrust of young men.
- Significant numbers of young men appear to take risks as part of 'proving themselves men'. This suggests that discussions and project development about and with young men need to take into account risk-taking, masculinity, and the tensions between these and young men's health.
- While peer pressure, job culture, and other factors and descriptions have been suggestions for some young men's attitudes and behaviours, the literature too often reflects the pursuit of one-dimensional causes and solutions.

Recommendations

We need to accept the complexities of adolescence, and its changing nature.

The positives of experimentation (as well as the negatives) should be acknowledged and incorporated within research, discussion, strategic thought and innovative projects.

Significant conditions

As a result of this review, we believe that there are a number of significant conditions and issues for us to consider in relation to young men's health. Those worthy of special mention are as follows.

- Accidents and resulting disabilities: gender is relatively unexplored within the literature, except in a handful of small studies looking at driving behaviour or the role of alcohol in accidents. These suggest that further (gender-based) research, analysis of collected statistics (particularly of resulting disabilities), and small-scale interventions would be of value.
- Eating disorders: the narrow definition of 'eating disorders' (anorexia nervosa and bulimia) has obscured other eating-related issues that affect young men. Masculinity may have a significant impact on young men's perceptions of their bodies (and eating disorders), and their willingness to seek help and treatment. Further, gender-based exploration and initiatives would be of value.
- Mental health, suicide and hyperkinetic disorder: all have significant gender dimensions. A gender 'blindness' exists when consideration is given to causes and treatment. Improved gender awareness would have an impact on clinical practice, and on targeting and engaging young men in terms of mental health and suicide. Small-scale projects specifically targeting young men would help determine the impact of masculinity on mental health issues.

A number of underpinning issues are identified above – in particular, risk-taking, physicality and help-seeking behaviour. These are recurrent themes in the literature, sometimes implicit, but ever present.

We suggest that these would benefit from further investigation and also provide a focus for innovative work. While risk-taking appears very often as a theme within pieces of developing practice, it rarely provides the main focus for pieces of work. A direct focus on physicality (especially in its relationship with help-seeking and communication), would also reap rewards.

The fourth theme that is ever-present in the literature and is worthy of further investigation is that of 'proving yourself a man'. There is enough to suggest that much of young men's risk-taking relates to their feelings of needing to prove themselves men. Again, a direct focus on this underpinning issue will, we believe, provide a good focus for risk-taking and risk factors.

Learning about health

What we learn about gender has a significant impact on our attitudes and behaviour towards our own and others' health. Aspects of the traditional socialisation of boys and young men clash with a healthy lifestyle, particularly in terms of risk-taking and risk factors.

- Incorporating a gender perspective within schools-based work has often enhanced the general health work (this has particularly been the case for sex education). Further initiatives within general health work will enable us to gauge how important and useful a gender perspective might be, especially in a school setting.
- Parents (particularly mothers) have been consistently named as the most influential source of information and advice on health and other matters. However, we have tended to ignore this relationship as a significant means of informing and engaging boys and young men in thinking

and reflecting on health. Young men may learn help-seeking, in particular, from their mothers (and possibly fathers), rather than through school.

- There is evidence that the more practical (and like real life) school work is, the more likely young men are to engage and learn. Health sessions need to become as practical as possible. So, for example, rather than talking about seeking help, agencies that provide help may be visited. The barriers for young men are often about 'not knowing' the agency, and a practical visit will remove this barrier, as well as possibly reducing young men's reluctance to visit and use other services.

Recommendation

A range of initiatives (such as those involving gender-aware, schools-based, parent-oriented programmes and practical sessions both in and out of school) should be set up to enable young men to learn about health.

Developing practice

To provide a broader picture of young men's health, we were also asked to 'map developing practice'. This was not in terms of quantity or of effectiveness (very few of the projects have been evaluated) – but in terms of the issues being addressed and the types of methods and approaches being used.

There are some basic difficulties in this process. The primary one is to determine what is a young men's health initiative. We have included those projects that have a specific focus on young men's health – this means that their target group is specifically young men, by design and not by default. In boys' schools, for example, most of the young offender teams, probation, and even the majority of drugs and alcohol projects work with boys and young men, but not intentionally. We have excluded projects (and sectors) unless there is a gender awareness in the approach.

We have also limited the scope to health-related projects that encompass aspects of the definition (see Introduction). This probably means that we failed to identify projects that have a lot to say about work with boys and young men. Some crime-prevention projects (such as motor bike and car initiatives) have based much of their activities on a gendered approach and an understanding of masculinity; however, we have looked for a gender awareness that may or may not permeate through the methods and approaches, but is visible and explicit.

Initially, we wanted to restrict the projects to those that were well established, but we soon realised that this would have severely restricted the number of projects detailed. We have therefore included all the projects we identified that were developing work with boys and young men.

Approach and methods

For mapping developing practice, a number of organisations and publications were used as starting points, including:

- the Health Development Agency's publication *Young People's Health Network*
- the Health Action Zone internet network (accessed via HDA)

- the Department of Health
- our own networks at Working With Men
- the Men's Health Forum, *Men's Health Directory*.

Other projects were identified and contacted from this base. Once initial contact was made, a telephone questionnaire was completed, and the following information collected for each project:

contact details; aims and objectives; details of setting(s); main target groups (around identity, eg age, ethnicity, sexuality or need, locality); main health issues; method used (especially targeting); working assumptions (around masculinity, men's roles, etc.); any evaluated details; sources of funding; major gaps in your service; future development plans and support needs of staff.

- Forty-one projects were identified. These projects suggested that working with boys and young men was a very young field. Only 10 of the projects had been in existence for more than 4 years, and a further eight between 2 and 4 years. This meant that 56% (23) were less than 2 years old.
- Funding sources varied, but the most common were:
 - Health Authorities 11
 - Health Action Zones 9
 - Youth Services 7
(including the National Youth Agency)
 - Charitable Trusts 5
- Most projects had at least one funder. Interestingly, most of the projects had been funded because they *did not know* the client group, not because they had substantial experience of working with boys and young men. This suggested that most projects were experimental and innovative in nature.
- While projects often had very broad target age groups (Parkhouse, 12–21; Lads' Room, 12–25), when we asked about those young men who attended services and projects, the majority of projects were much more specific, with 14–16 years being most common.
- When we asked about methods, most projects said that they primarily offered either individual or small group work.

- Both male and female workers were involved in about equal numbers. While a number of projects spoke to us about the importance of 'male role models', this was not necessarily reflected in project staffing. This concurs with our own view that not only males should be involved in developing this work. Projects also mentioned the common involvement of part-time workers and volunteers.
- Given both the experimental nature of this work, and the primary funding sources, we were surprised to find that only one in five of the projects had an external evaluation in place at the time we spoke to them. A further three (school-based) projects came under Ofsted, leaving nine projects saying that they would be carrying out an 'internal' evaluation, and more than half with no evaluation plans.
- Many of the very young projects (less than 2 years) told us they were still struggling to recruit and/or engage young men. Only a very small number of the established projects (more than 4 years) had built up sufficient local momentum and reputation not to have to worry about recruitment and engagement. While the quality and appropriateness of services will ensure that projects become established and used, given some young men's reluctance to use services, it may take time (more than some funders expect) to build the momentum that projects such as 42nd Street (in Manchester) have managed.
- Many of the projects said they were seen within their locality as specialists to whom other agencies referred young men. However, they often described themselves as isolated from mainstream provisions because of their specialist tag. Apart from a few notable exceptions (such as Dorset), isolation was the norm.
- Projects reflected a diverse range of settings, although the most common (nine sexual health; nine diversion and offending projects) were predictable. Maybe more of a surprise was that we found only one project within primary healthcare; only three in schools; and no Internet-based projects, despite the enthusiasm that so many have shown for this as a method of gaining access to young men.

In our conversations with projects, we were particularly interested in two themes – first, what projects thought young men would respond to; and second, why projects thought their service worked.

There are enormous limitations in this level of opinion-gathering: who we spoke to; how much they wanted to

project a thriving, effective project; and how they felt about their projects on that day may all have had a bearing on the response we received. We offer these responses as a discussion base for the two significant questions noted above.

1. Young men responded when:

- *They were desperate.* A number of projects told us that young men came forward when their fear of the issue they confronted was greater than their fear of appearing inadequate or 'less than a man'. Projects were often dealing with young men who had left difficulties to a point where they had become preoccupations.
- *Access was easy or easier.* Phone lines, drop-ins and contact through an activity base all provided young men with relatively easy access, or a form where they could do very little and lose little 'face'. Projects such as Alive and Kicking (CEDC, Coventry) and Twilight Football (Wolverhampton) use an activity base as an access point, and add services and themes on top of this (much like the social education model used in traditional youth club work).
- *Identity was involved.* Many of the projects that targeted specific groups of young men (African–Caribbean young men in particular) did not have some of the targeting difficulties reported by other projects. Identity, culture, community base and common experience of racism were often significant factors in young men's use of projects. Some of the projects targeting gay young men, who have traditionally relied on common identity, isolation and experience of homophobia, reported that recruitment was still a problem.
- *We are advocates for young men.* Where projects were strongly supportive of the young men, they responded. This was fine for those projects that gave advice, or were prepared to go with young men to places where they were nervous (such as clinics) or to support their views (about school or parents), but this was more problematic if projects were more challenging of young men's attitudes or behaviour.
- *They have to be here.* Young offenders' and schools' projects, where there was either a level of coercion, or little choice about attendance, found that young men would attend but not necessarily engage. Coercion, not surprisingly, often led to resistance and reluctance to engage, and projects found this was the biggest barrier for their projects to deal with.

2. Projects worked when:

- *They had a positive approach* towards the young men they were working with. This often meant they were enthusiastic about young men, looking for individual qualities rather than 'group-based' problem behaviour.
- *Project workers looked past disruptive behaviour* and 'under' presenting problems. Whereas too often workers are distracted by some young men's disruptive behaviour, many of these project workers ask 'why would they be doing that?'
- *Projects were based on young men's needs*. This usually meant that workers started with issues and activities that they knew young men would respond to. Issues that they identified with, that were directly related to their lives and were practical, were some of the themes that made projects interesting and relevant.
- *Both male and female staff were positive and enthusiastic* about young men and their lives. This appeared to be much more important to young men than the gender of the worker.
- *An awareness of masculinity and gender* permeated the project at a number of different levels. At least four levels were identified:
 - level 1: where applications to funders highlighted the need to address gender and masculinity within the project; this was often because the funders themselves had highlighted it as a priority
 - level 2: where an understanding of gender and masculinity was used to improve the targeting of young men – projects talked about young men's difficulties in seeking help: 'we have to go to the places they already go and we offer a drop-in, because we think these young men will find appointments difficult'
 - level 3: where clear boundaries, positive approaches and appropriate setting were used to engage young men
 - level 4: where methods and practice were developed to incorporate an understanding of masculinity and gender, for example, in reflecting on the effects of peer pressure on group work – when young men will respond on their own and when in a group, what creates safety for groups of young men, and whether 'banter' has to be a part of developing work?

Many of the projects reached level 3, but level 4 remained relatively unexplored.

- *Project workers understood the motivation young men had* to get involved, and respond to what they had to offer. Condoms (and other freebies), explicit 'deals' (activities for discussions), because they related to their futures, because no one else would talk (or listen) to them about an issue; in short, because they understood what was on offer and wanted it.
- *They had been there long enough*. An implication of some young men's reluctance to use services is that there may be a gap between young men knowing about a service and then using it. Some men will use a service only when they have heard it is 'ok' from a mate or from someone else whose opinion they trust, and this takes time.
- *They are part of a broader strategy*. If projects rely on referrals from other agencies, they have to have credibility not only with young men, but also with these agencies. Lloyd (2001; *What Works with Fathers? Working With Men*, London), in a review of fathers' projects, found that agencies were too often protective of those fathers they liked, and were reluctant to refer them to other agencies, while some fathers' projects would be offered 'the dad from hell'. Some of the fathers' projects would have a reputation of being anti-women (because they were supportive of men); others would be seen as too radical. Projects have to ensure that their services are known, and that they are integrated within the local project base.
- *They accepted there was no quick fix*. Recent interest in identifying initiatives with very broad appeal (such as healthcare in pubs, information on websites and peer education) have wanted simplistic answers to what we know is a complex series of questions. Projects worked when they accepted that there were no 'quick fixes', and that a variety of responses are required for a range of individuals who share a gender.

These points are not offered as guidelines for new projects to follow, but do provide some useful starting points for projects to consider. A more in-depth analysis of 'what works?' in boys and young men's projects is in preparation.

*Trefor Lloyd
Working With Men*

Appendix 1: Accidents and resulting disabilities

Road traffic accidents

Road traffic accidents 1997

	Age			
	10–14	15–19	20–29	30–39
Males	71	355	629	415
Females	33	100	147	92

Source: DETR (1998) *Road Accidents, GB, 1997. The Casualty Report*. Department of the Environment, Transport and the Regions, State Office.

Road deaths: percentage of accidental deaths 1997

	Age			
	10–14	15–19	20–29	30–39
Males	62	76	54	45
Females	77	69	63	38

Source: DETR (1998) *Road Accidents, GB, 1997. The Casualty Report*. Department of the Environment, Transport and the Regions, State Office.

Fatal road accidents by mode of travel, 1995–97 (rate per billion passenger kilometres)

	Motor-cyclist	Cyclist	Pedestrian	Car driver	Car passenger
Males	112	49	58	3	4
Females	53	35	32	2	2

Source: DETR (1998) *Road Accidents, GB, 1997. The Casualty Report*. Department of the Environment, Transport and the Regions, State Office.

Serious road accidents by mode of travel, 1995–97 (rate per billion passenger kilometres)

	Motor-cyclist	Cyclist	Pedestrian	Car driver	Car passenger
Males	1358	845	589	34	43
Females	1235	720	361	48	33

Source: DETR (1998) *Road Accidents, GB, 1997. The Casualty Report*. Department of the Environment, Transport and the Regions, State Office.

All other accidents

All accidental deaths (numbers)

	Age			
	10–14	15–19	20–29	30–39
Males	115	467	1,155	928
Females	43	145	235	243

Source: Prescott-Clarke, P. and Primatesta, P., eds (1998) *Health Survey for England: The Health of Young People, 95–97*. Department of Health, London.

Annual major accidents per 100 persons

	Age				
	2–4	5–9	10–14	15–19	20–24
males	29	24	37	42	42
females	21	18	26	26	21

Source: Prescott-Clarke, P. and Primatesta, P., eds (1998) *Health Survey for England: The Health of Young People, 95–97*. Department of Health, London.

Annual minor accidents per 100 persons

	Age				
	2–4	5–9	10–14	15–19	20–24
males	147	153	294	435	341
females	83	112	202	204	182

Source: Prescott-Clarke, P. and Primatesta, P., eds (1998) *Health Survey for England: The Health of Young People, 95–97*. Department of Health, London.

Deaths from accidental injuries and poisoning, England and Wales, 15–19 years, 1992

Cause	Male	Female	Total
Transport accidents	376	110	486
Accidental poisoning	24	14	38
Accidental falls	13	6	19
Fire and flames	1	5	6
Accidental drowning	24	2	26
Inhalation	13	2	15
Others	9	3	12
Total	460	142	602

Source: Hibert, J. (1996) Injuries to adolescents. In: Macfarlane, A. (ed.). *Adolescent Medicine*. Royal College of Physicians, London.

**Sporting accidents resulting in attendance at A & E
(1.08 million)**

Football	408,000
Rugby	78,000
Roller-skating, roller-blading or skateboarding	31,000
Cricket	22,000
Ice-skating	18,000
Swimming	16,000
Hockey	15,000

Source: DTI (2000) *Home and Leisure Accident Report. Summary of 1998 Data*. Department for Trade and Industry, London.

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Deaths from non-transport accidents that occurred in the home, England and Wales, 1997/98

Age	Males	Females	Total
10–14	24	7	31
15–19	72	27	99
20–24	167	31	198

Source: DTI (2000) *Home and Leisure Accident Report. Summary of 1998 Data*. Department for Trade and Industry, London.

Smoking

Cigarette-smoking status for 16–24-year-old men and women, 1994 and 1998

	1994		1998	
	Men (%)	Women (%)	Men (%)	Women (%)
Current smokers:				
<10 per day	12	11	19	17
10–19 per day	16	16	14	18
20+ per day	8	7	6	4
Total current smokers	36	34	36	29
Ex-regular smokers	6	9	4	6
Never or occasional	57	57	57	55

Sources: ONS (1994) *General Household Survey*. Office of National Statistics, London.

Rainford, L. *et al.* (2000) *Health in England 1998: Investigating the Links between Social Inequalities and Health*. Office for National Statistics/Health Education Authority, London.

Alcohol

Alcohol consumption for 16–24-year-old men and women

Consumption (units)	Percentage
Men	
Non-drinker	9
<1	3
1–10	31
11–21	20
22–35	14
36–50	9
51+	14
Women	
Non-drinker	8
<1	9
1–7	30
8–14	19
15–25	19
26–35	7
36+	8

Source: Rainford, L. *et al.* (2000) *Health in England 1998: Investigating the Links between Social Inequalities and Health*. Office for National Statistics/Health Education Authority, London.

Young adult mean weekly alcohol consumption by age and gender, 1993–97

	1993	1997
Males 16–17	9.4	14.1
Males 18–19	17.7	23.0
Females 16–17	5.5	7.9
Females 18–19	8.6	12.3

Source: Prescott-Clarke, P. and Primatesta, P., eds (1998) *Health Survey for England: The Health of Young People, 95–97*. Department of Health, London.

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Suicide

Change in male suicide by age, 1974–90 (rate per million population)

	Age							
	Average	15–24	25–34	35–44	45–54	55–64	65–74	75+
1974	95	58	106	114	154	159	188	221
1990	121	117	160	171	164	139	136	194
% \pm	+27	+102	+51	+50	+6.5	-13	-28	-12

Source: Kelly, S. and Bunting, J. (1998) Trends in suicide in England and Wales, 1982–96. *Population Trends*, Summer 1998.

Suicide by social class, England and Wales (rate per 100,000)

Social class	1970–72	1991–93
I	16	13
II	13	14
IV	18	23
V	32	47
Average	15	22

Source: Kelly, S. and Bunting, J. (1998) Trends in suicide in England and Wales, 1982–96. *Population Trends*, Summer 1998.

Mental health

Psychiatric disorders (percentage) among young people aged 16–29 living at home in Great Britain, 1993

Type of disorder	Age		
	16–19	20–24	25–29
Males			
Any neurotic disorder	7.0	12.0	12.0
Functional psychoses	0.3	0.5	0.5
Alcohol dependency	11.0	18.0	12.0
Drug dependency	8.0	11.0	3.0
Females			
Any neurotic disorder	19.0	21.0	18.0
Functional psychoses	0	0	0.7
Alcohol dependency	7.0	4.0	3.0
Drug dependency	6.0	3.0	2.0

Source: Melzer, H. *et al.* (1995) *The Prevalence of Psychiatric Morbidity amongst Adults Living in Private Households*. OPCS Survey of Psychiatric Morbidity in Great Britain: Report 1. Stationery Office, London.

Appendix 2: Practice mapping

The following 41 projects were identified in the practice mapping. Descriptions of these can be found in Lloyd, T., Forrest, S. and Davidson, N. *Boys' and Young Men's Health: Practice Examples*. Working With Men/Health Development Agency, London.

Alive & Kicking
African Families Support Service
Barnardos Young Men's Project
Blackpool Young Gay Men's Group
Boys and Young Men's Sexual Health Team (Derby)
Bread Youth Project
Brook Young Male Sexual Health Clinic
CALM (Campaign Against Living Miserably)
Canonbury Project
Clay Partnership
Community Response to Persistent Young Offenders
Dads R Us (Lancaster Farms)
Developing Work with Young Men (Lancashire)
Dorset Interagency Suicide Prevention Plan
Enigma
From Boyhood to Manhood Foundation
Gateshead and South Tyneside HIV/Sexual Health Promotion Service
Health of Men – The Lad's Room
Hospital Youth Work Team
Hounslow Youth Counselling Service
LADS Project (Learning and Development Skills)
LEAP Confronting Conflict
Let's Get Serious
Loudmouth Educational Theatre Company
Mancroft Advice Project (MAP)
New Bridge
NOBLINE
Parkhouse Project
Peer Health Education Project
Running the Risk
Sexual Responsibility for Young Men in Schools
Soft Touch Community Arts Co-operative Ltd – The 'Hyped' Project
Supporting Young Dads
STRIDES
Twilight Football League
Wiseguys Project (Signpost)
Young Fathers Group (Cornwall)
Young Men's Health Promotion Roadshow
Young Men's Residential
Young People's Health Project (Birmingham)
42nd Street

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