# Safer Sex: Passionate Escapism versus Rational Thought

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# Introduction

Current social marketing practice emphasises the use of theory, this being one of the benchmark criteria used by the UK’s National Social Marketing Centre to define good social marketing practice. Such theories include the Theory of Planned Behaviour (Ajzen, 1991), the Health Belief Model (Hochbaum et al., 1952; Rosenstock, 1966; Rosenstock et al. 1988) or the Transtheoretical Model of Change (Prochaska et al., 1991). These first two theories suggest that man acts as *Homo economicus,* using rational decision making based upon expected outcomes i.e. value-expectancy types of theory. The third model suggests that behaviour change follows predictable patterns, enabling us to plan stepwise interventions.

Recent collaborative research between the University of the West of England, Stockport Primary Care Trust and the UK’s National Social Marketing Centre took a qualitative approach to investigate decision making processes for condom use and chlamydia testing amongst heterosexual young people aged 16-24 from a relatively deprived area. This paper draws contrasts between common theoretical models used in social marketing and the apparently haphazard decision making used by these young people in relation to sexual health. It goes on to suggest how social marketers can best influence decision making for topics such as sexual health, where influences such as emotion, peer pressure, alcohol and drugs and self-esteem combine to undermine rational decision making models.

# Method

Sexually active young men and women, aged 16-24, were recruited in Spring 2008 using convenience sampling in local pubs, shops and streets of the Brinnington area of Stockport. Snowball sampling was then used to achieve a quota of 28 participants, 14 of each gender, representing ages across the range required. Incentives were offered to each participant. Each attended a semi-structured interview, one-to-one with a trained healthcare worker, which was audio-recorded and later transcribed for analysis. All participants also attended one of four focus groups: one each for males and females aged 20 or under, and one each for males and females aged over 20.

The moderator’s guide was developed by the researcher at the University of the West of England, to probe key themes such as general lifestyle, attitudes and behaviour related to sex and the opposite sex, and attitudes and behaviour related to safe sexual practices. Interviews and focus groups were used to compare responses to sexual health issues alone and in groups. Both interviews and focus groups were analysed by the researcher and a report compiled for Stockport PCT with recommendations for social marketing strategy.

# Results

All 28 participants took part in both interviews and focus groups. Knowledge of sexually transmitted infections (STIs) was high across the sample, and attributable to sexual health services in the area. School sex education was less successful because of exclusion, absence and rejection of environment. Practical barriers such as knowledge of how to use condoms and ease of procurement were low. Emotional barriers such as embarrassment in procuring condoms and fear of condoms splitting were also not as influential as suspected.

The most influential source of knowledge about sex was friends: there was low perceived use of condoms by peers and high perceived barriers to condom use, but chlamydia testing was seen as more acceptable. Indeed, the high uptake of chlamydia testing resulted was directly linked to low condom use, with frequent testing seen as sufficient protection from the long-term effects of chlamydia. Other infections were not perceived as a threat.

Rates of STI infection amongst peers was routinely *over* estimated, yet participants perceived low personal vulnerability to infection. This phenomenon has been observed, especially amongst young people, across a range of social marketing issues by researchers within this university, such as dangerous driving and sun protection. Such perceived invincibility is a significant barrier to social marketing campaigns for this age group.

Barriers to condom use included the perceptions that condoms ‘ruin the moment’, result in lack of sensation, smell and feel distasteful and that they are primarily for use as contraception rather than contra-infection. Motivationstowards condom use were less pronounced than the barriers, but include protection from infection (if this is perceived as a threat e.g. if do not know a partner or their history), prevention of regret about unprotected sex, or because a partner insists on condom use.

All the above barriers and motivations were, however, largely discounted at the actual moment where condom use is decided. Condom use was rarely discussed between casual partners, and often not considered by either in the throes of passion and under the influence of alcohol and/or drugs after a night out. Many participants (mostly female) expressed regret about not using condoms, despite their best intentions.

The relationship between the genders discouraged communication, and encouraged a confrontational approach to sex and relationships. This has led to a culture of blame, where each gender considers the other responsible for perpetuating STI infections.

# Conclusions and Public Policy Implications

The results of this research show that education is not enough to improve sexual health: despite high awareness and high perceived rates of infection, few precautions were taken. Campaigns to change social norms are indicated yet have shown low rates of success across other social marketing issues.

One of the most promising avenues is the role of women as gatekeepers: they have higher perceived threat from STIs in terms of fertility, and also express more regret associated with emotional vulnerability and sex.

The evidence backs up some theories such as the Theory of Planned Behaviour, while undermining others such as the Health Belief Model and the Transtheoretical Model of Change. Theory related to challenging perceived personal invulnerability (despite precursors associated with the Health Belief Model) needs to be developed and this study has led us to make suggestions. However the actual circumstances under which casual sex takes place, i.e. under the influence of alcohol and/or drugs and passion, may undermine such rational measures. This effort to embrace escapism and independence is unlikely to sit well with controlling and ‘safe’ interventions, encouraging us to look at more sexy and fun ways of introducing condom use. This also suggests that interventions near the time and place of casual sex may be required to trigger the desired behavioural response, or, more promisingly, that the antecedents of unsafe sex should be addressed, i.e. the use of alcohol and drugs.

## References

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