Guilty Pleasures: Exploring the accounts of alcohol and sex within a sexual health service in the North East of England

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Thesis submitted for the degree of Doctor of Philosophy

Institute of Health and Society

Newcastle University

September 2018

Abstract

***Guilty Pleasures*: Exploring the accounts of alcohol and sex within a sexual health service in the North East of England**

Introduction There has been significant changes over the last few decades in alcohol consumption levels and attitudes towards sexual relationships. Research and policy on the alcohol-sex mix are dominated by young people and 'risk groups', so this thesis explores the relationship in adults aged 25+ years.

Methods: This PhD has two components, a systematic review and an ethnographic study undertaken within a sexual health service in England.

Results: Results of both the systematic review and the ethnographic study found that the alcohol-sex mix continues through the life-course and can feature at key transition points, such as divorce. Those aged 25+ years can use alcohol in sexual situations in similar ways to younger people – to increase confidence, enhance pleasure and use it as an excuse to escape and experiment.

However, results also found that similar to young people, those aged 25+ years experience similar negative outcomes, such as STIs and regret. However, this was further confounded in the ethnographic study, where for some patients attendance at the clinic highlighted a conflict between desire and morality. The clinic was more akin to a religious ceremony, where shame and guilt emerged in the search for moral recovery.

Conclusion: The traditional stereotypes of the alcohol-sex mix afforded only to the young or promiscuous is outdated. Indeed, the relationship is more cyclical with partnership status and partner-level interactions a key defining factor rather than age.

Acknowledgements

My initial thanks goes to the funders of this PhD, the former County Durham and Darlington Primary Care Trust (PCT, in particular to Anna Lynch, for encouraging me to start on this journey. Also to my current employer, Public Health England (PHE) who supported me with a six-month sabbatical to write the first draft of this thesis, without this dedicated time I simply would not have completed this PhD.

I would also like to thank those individuals who have guided me and contributed to specific elements of my study. To Fiona Beyer, Information Specialist at Newcastle University, for her expert advice with the search strategy for the systematic review and to PHE Library services for finding papers I was unable to retrieve. I would also like to thank Neil Martin, whilst he was working at Balance, the North East Alcohol Office, for his statistical wizardry when undertaking the audit within the GUM service.

Major thanks goes to my supervisors who have stuck with me through the seven years in spite of them all moving to different institutions - Professor Dorothy Newbury-Birch, Professor Tim Rapley and Dr Sally Brown. I would never have competed this study without you. Your pragmatism, support, time and direction was invaluable. I know you will all be pleased to have me finally out of your hair! Thanks also to Dr Suzanne Moffatt for agreeing to be an additional supervisor in my last year.

Thanks also to Helen Clapperton, my amazing administrator at PHE for helping with the formatting and Jen Ferguson for proof reading the whole thesis.

Thanks also to my family and friends who have encouraged me along the way. You will finally be able to call me Doctor Sullivan and I will no longer feel guilty for enjoying my weekends with you all. Siobhan, thank you for your continued support – it’s time to plan that party!

Finally, thanks to the practitioners and patients who participated in the study. Without your openness and honesty, the accounts would not have provided the rich data that has brought this thesis to life. Having a healthy sex life should not be shrouded in guilt or shame but celebrated, so I hope these findings can contribute even just in a small part to that debate.

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Chapter 1: Introduction

There has been significant changes over the last few decades in the United Kingdom in alcohol consumption levels and attitudes towards sexual relationships. In the UK, individuals aged 15+ years are consuming an average of 11.4 litres of pure alcohol a year, with an increase in the consumption of wine and spirits since 2010 (World Health Organisation, 2018). One of the main reasons proposed for such increased drinking levels is cost (Smith and Foxcroft, 2009), with alcohol now estimated to be 60% more affordable than it was in 1980 (Alcohol Concern 2017).

At the same time, findings from the most recent survey of the British National Surveys of Sexual Attitudes and Lifestyles (Mercer *et al.*, 2013) reported an increase in the number of male sexual partners over the lifetime amongst women; an increase in the proportion of women reporting at least one female sexual partner in the past five years and an expansion of heterosexual repertoires, particularly in oral and anal sex, over time. The authors conclude that the continuation of sexual activity into later life, albeit reduced frequency, emphasises that attention to sexual health and wellbeing is needed throughout the life course.

Yet young people, particularly students, have dominated research and policy on the alcohol-sex mix, with a continued focus on sexual debuts and alcohol experimentation. This has potentially neglected the phenomenon as people age. As a result, this thesis explores the accounts of alcohol and sex within a sexual health service in the North East of England.

This chapter provides a background to the study before outlining the rationale. This includes a descriptive analysis of epidemiological data on sexual health and alcohol in England, providing a context for the study. It also includes relevant results of an alcohol audit, undertaken as part of this study, amongst new patients attending a genito-urinary medicine (GUM) service. I then summarise the findings from the existing literature on the relationship between alcohol, sexual risk and sexual decision making amongst the age cohort of interest for this study. This will identify gaps as well as limitations, particularly studies on this topic undertaken within GUM settings. I then explore how the current evidence has informed national policy and

guidance in England, again identifying key gaps. At the end of the chapter, I outline the aims and objectives of the research, and an overview of this thesis.

1.1 Background

I commenced this part-time PhD in October 2011, following an eighteen-month secondment in the sexual health national policy team at the Department of Health (DH) in England, where my interest in the topic emerged. Working as a Public Health Consultant, I assessed opportunities for collaboration between the national sexual health and alcohol policy teams.

One of the key pieces of work undertaken whilst I was at DH was a national scoping exercise, which culminated in a report with key recommendations for action (Sullivan, 2010). One of the recommendations identified the gap in research, policy and practice of alcohol consumption and its link with sexual health outcomes in an older age group, in particular those aged over 25 years. Within the sexual health arena, patients aged 25+ years are anecdotally regarded by practitioners as 'older' and, unless belonging to another 'risk group', are deemed to be at lower risk of poor sexual health outcomes. In England, 'risk groups' include young heterosexuals aged 15 to 24 years, black ethnic minorities and men who have sex with men (MSM) where the impact of sexually transmitted infections (STI) remains greatest (STI Annual Report 2018, Public Health England, in press).

There is already an extensive body of literature assessing the relationship between alcohol use and sexual risk behaviour, particularly amongst 'risk groups'. Alcohol has been found to increase confidence; increase sexual arousal; enhance sexual experience; reduce inhibition, impair sexual decision making and promote sexual behaviours (George and Stoner, 2000; Sumnall *et al.*, 2006; Mullens *et al.*, 2009; Norris *et al.*, 2009; Shuper *et al.*, 2010). Some studies have also found that alcohol is associated with having multiple sexual partners (Abbey *et al.*, 2005) having unprotected sex leading to a higher risk of STIs (Zenilman *et al.*, 1994; Cooper, 2002; Cook and Clark, 2005) including HIV (Baliunas *et al.*, 2010); and having sex that is later regretted (Coleman and Cater, 2005; Bellis *et al.*, 2008; Connor *et al.*, 2015).

However, methodological limitations exist in studies assessing the relationship between alcohol and sexual risk behaviour, including sexual assault. The main reasons are the lack of standardised measures for capturing both alcohol consumption and sexual risk; use of retrospective data leading to recall bias; and study designs which can only prove association rather than causality. Assessing a direct causal pathway proves even more difficult due to individual confounding factors related to personality type such as sensation seeking, risk taking, compulsivity, arousal, alcohol expectancies (Shuper *et al.*, 2010) and situational factors (Temple *et al.*, 1993). As a result, no direct causal relationship has been proven between alcohol use and sexual risk (Abbey *et al.*, 2004; Cook and Clark, 2005) however correlation has been demonstrated (Leigh and Stall, 1993; Graves and Leigh, 1995; Cooper, 2002; Scott-Sheldon *et al.*, 2016).

As with researchers, policy makers and practitioners have also targeted their approach towards ‘risk groups’. In England, these have particularly focused on young people who experience poor sexual health outcomes, such as STIs and unplanned pregnancies. The other significant group is MSM, where the influence of alcohol, and drug use, for sexual risk increased during the onset of the AIDs epidemic in the 1980s (Stall *et al.*, 1986) and has continued thereafter (Feinstein and Newcomb, 2017).

From a public health perspective, the decision to focus on ‘risk groups’ is justified given the population level approach. However, in England there has been a 46% increase (an increase of 101, 950) in alcohol hospital admissions amongst those aged 25+ years from 2006/07-2015/16 (Public Health England, 2018a), suggesting that drinking habits formed earlier in life have continued into adulthood. Similarly, STIs in England have also seen an increase in new diagnosis of gonorrhoea, chlamydia and syphilis amongst those aged 25+ years since 2012 (Public Health England, 2018b) In one UK study, the rate of STIs in older groups (defined in this study as over 45 years) had doubled between 1996-2003, and the authors concluded that sexual risk taking was no longer just confined to the young (Bodley-Tickell *et al.*, 2008).

In terms of changes in relationships, marriages amongst opposite-sex couples have fallen by 44% (188,866) since their peak in 1972 (426,241), and in 2015 were the

lowest on record. The median duration of marriage for divorces granted to opposite-sex couples was 12 years; with the age at divorce increasing year on year since 1985; rising by more than 8 years for both men (now at 46.1 years) and women (43.7 years) (Office of National Statistics, 2015). This demonstrates that there are more people looking for a relationship in later years.

Contrary to popular belief, most adults remain sexually interested and sexually active well into later life (Nusbaum *et al.*, 2004; Mercer *et al.*, 2013). However, while there has been an increase in studies looking at sexual health in later years (Sherman *et al.*, 2005; Gott, 2006; Minichiello *et al.*, 2011), there is a risk that the changes to our sexual behaviour and alcohol consumption are viewed in isolation. As alcohol is symbolic in potentially sexual situations such as dating, and more common in encounters with new or casual partners than with regular partners (Leigh, 1999) the focus on alcohol linked to early sexual experiences has potentially neglected its use, and risks, in other key relationship transitions during the remainder of the life course.

This section has introduced some key factors, which I will explore in more detail below. The next section will provide an overview of alcohol and sexual health data in England and, where available, data for the region of study.

1.2 Epidemiological context: alcohol

This section provides an overview of alcohol data in England, including information on drinking frequency, consumption, hospital admission and deaths.

In the UK, since 2005 the Office of National Statistics (ONS) has commissioned an opinion and lifestyle survey using a randomised probability sample. Their most recent data (2016) shows that for England, in terms of drinking frequency, 57% of adults (aged 16+ years) reported drinking alcohol in the previous week, which equates to 25.3 million adults. For men, the proportion was 63% and for women it was 51%; with those aged 45-64 years being the highest age band for both men (69%) and women (60%). Furthermore, 18% of men and 13% of women exceeded the Government's previous definition of binge drinker (double the recommended daily guidelines of 8 units of alcohol for men and 6 units for women on their heaviest drinking day in the last week). When assessing heavy drinkers by

relationship status, those who defined themselves as single were higher (men 38%, women 42%) than those who were married or cohabiting (Office of National Statistics, 2017).

During 2015/16, there were 1.1 million estimated hospital admissions related to alcohol consumption (where an alcohol-related disease, injury or condition was the primary reason for hospital admission or was a secondary diagnosis). This was 4% more than in 2014/15. In the same year, there were also 6,813 deaths, which were related to the consumption of alcohol, and accounted for 1.4% of all deaths in England (NHS Digital, 2017).

The North East of England, the region of study, has the highest rates of binge drinking of all the nine English regions, with 40% of adults in 2016 exceeding the daily-recommended limits. This compares to the South East of England which has the lowest rate at 22%, against the England average of 26% (Office of National Statistics, 2017).

In terms of hospital admissions, the rate of alcohol related hospital admissions in the North East over the period 2006/7- 2015/16 amongst those aged 25+ years, increased by 26% (4,110); and the gender breakdown showed a 30% increase in females and a 24% increase in males (Public Health England, 2018a). When this is compared to the specific geographical area for the ethnographic study within the North East region, the increase show a reverse position and a much higher increase - 40% increase in females and a 50% increase in males (Balance, 2017).Finally, in 2016 the North East also had the highest rate of alcohol related deaths in England at 55.7 per 100,00 compared to the England average of 46.0 per 100,000 (Public Health England, 2017).

1.3 Epidemiological context: sexual health

This section provides an overview of sexual health data in the UK, including information on sexual attitudes, diagnosed sexually transmitted infections, conceptions and abortions.

The British National Surveys of Sexual Attitudes and Lifestyles (Natsal) are among the largest and most detailed studies of sexual behaviour in the world (Natsal, 2019). To date, three Natsal surveys have taken place: Natsal-1 carried out in 1990-1991, of 18,876 adults aged 16-59 years (Wellings *et al.*, 1994), Natsal-2 in 1999-2000, of 12,110 adults aged 16-44 years (Johnson *et al.*, 2001) and Natsal-3 in 2010-2012, of 15,162 adults aged 16-74 years (Mercer, 2013). Natsal-1 and Natsal-2 included variables linked to the relationship between alcohol and sexual behaviour. There was a reported increase between the two surveys in the proportion of people being drunk as the main reason for their first heterosexual intercourse and that heavy drinkers were more likely to report higher number of partners, and have unprotected sex with two or more partners in the last year. Male heavy drinkers were also more likely to report sexual function problems, and female heavy drinkers to use emergency contraception (Aicken *et al.*, 2011)

The third survey covered an extended age range (up to 74 years compared to 59 years and 44 years in previous surveys), allowing exploration of the interplay between aging and sexual behaviour. As highlighted above, amongst the main findings was an increase in the number of male sexual partners over a lifetime amongst women, along with an expansion of heterosexual repertoires, particularly oral and anal sex over time (Mercer *et al.*, 2013).

In terms of conceptions, binge drinking before conception has been found to be associated with increased odds of poorly timed pregnancy and unplanned pregnancy (Lundsberg *et al.*, 2018). The most recent conception data in the UK shows that between 2014 and 2015, conception rates increased for women aged 25+ years, and decreased for women aged under 25 years. The largest percentage increase in conception rates occurred among women aged 40+ years (4.1%), where the rate has more than doubled since 1990, from 6.6 to 15.1 conceptions per 1,000 women. Women aged 35 to 39 years have seen similar increases, with the conception rate also more than doubling since 1990 to 68.3 per 1,000 women. The 30 to 34 age group is the youngest for which conception rates have risen almost continuously since 1990, rising by over a third to 124.9 per 1,000 women (Office of National Statistics, 2015). Women in Britain spend about 30 years of their life needing to avert an unplanned pregnancy; with a current estimate of only 54.8% of all pregnancies

categorized as planned (Wellings, 2013). Alcohol's influence on these events across all ages requires further consideration.

Relatedly, in terms of abortion, in 2016, 60% of legal abortions in England were amongst women aged 25+ years (25% 25-29 years; 18% 30-34 years; 17% 35+ years). For women over the age of 25 years, abortion rates have seen increases in recent years. The rates for women aged 30-34 years have also increased steadily from 15.0 per 1,000 women in 2006 to 17.4 in 2016. Rates for women aged 35+ years have also increased from 6.9 per 1,000 women in 2006 to 8.1 in 2016. Additionally, repeat abortions in those aged over 25 years is higher (110,923) compared to those under 25 years (83,330), however repeat unintended pregnancy and subsequent abortion is a complex issue associated with increased age as it allows longer for exposure to pregnancy risks (Department of Health, 2017).

Given the context of increasing sexual activity, incidence of STIs in England have also increased. Below is a table of the most recent STI data (Public Health England, 2018b) which compares those under 25 years and those 25+ years, for the three most common STIs.

Table 1: Total percentage and number of Sexually Transmitted Infections (under 25 years and over 25 years) England, 2017

STI	Under 25 years (number)	25+ years (number)
Syphilis	13% (947)	86% (6,146)
Gonorrhoea	37% (16,539)	63% (28,056)
Chlamydia	63% (128,067)	36% (74, 349)

Note – does not always add to 100% due to proportion recorded as unknown

This highlights that those aged 25+ years account for the largest proportion of diagnosed cases of syphilis and gonorrhoea in England. Additionally, for HIV, those aged 25+ years accounted for 87% of all new diagnosis during 2015 (74% men), and was higher amongst the 35-49 age group (Public Health England, 2015).

In the North East of England, those under 25 years accounted for the largest proportion of diagnosed infections for chlamydia and syphilis. However, the rates for two STIs (gonorrhoea and syphilis) have shown increases in the 25+ year age group

since 2013, and increases amongst the 35+ year age group for chlamydia since 2013 (Public Health England, 2018b).

Data on attendances at specialist sexual health services in England during 2017 shows that those aged 25+ years accounted for 62% (1,370,846) of first attendances, an increase of 133% over the previous four years (Public Health England, 2018b).

Finally, during 2016/17, 39% of women accessing Emergency Hormonal Oral Contraception (EHOC) from community pharmacies in the specific area of study were also within this age group. Requests for EHOC from those aged 26-39 years have remained consistent since 2010/11. For those aged over 40, requests have decreased by 25% since they peaked in 2010/11 but still remain higher in 2016/17 than in 2005/06 (Waters, 2017).

1.4 Epidemiological context: summary

The epidemiological data has identified that binge drinking and admissions to hospital due to alcohol remains a key national issue. In the North East, this is amplified further given the region has the highest rates of all nine English regions for binge drinking, alcohol hospital admissions and alcohol related deaths. The sexual health data highlights that those aged 25+ years have an increasing number of sexual partners throughout their life course. Conceptions and abortions amongst women in older age groups has continued to increase, including repeat abortions.

The proportion of those aged 25+ years diagnosed with the most common STIs, is higher amongst this age group compared to those under 25 years, except chlamydia, though the rates of chlamydia have continued to increase in this age group. Whilst there are limitations to the data available, for example, no data on alcohol attendances, STI data that is only collected by those completing national data sets; the age data available does illustrate the increasing demand amongst an ‘older’ age cohort on health services.

This is further supported by the findings from the alcohol audit undertaken as part of this study. The results of the audit were published in a peer reviewed publication

(Sullivan *et al.*, 2017). I outline below the findings relevant to the age cohort of interest to this study.

1.5 Alcohol audit in a GUM setting

The purpose of the audit was to assess the alcohol drinking levels and delivery of alcohol screening and brief interventions (BIs) for all new patients attending a GUM service during 2012/13. The audit was undertaken in the site of the ethnographic study.

In summary, 3,390 new patients accessed the GUM clinic from April 2012 to March 2013. Forty-three per cent (n=1,463) were aged 25+ years, 54% (n=794) men and 46% (n=669) women. Eighty per cent (1169) identified as drinkers. Of those, 35% (n = 410) were positive on the Alcohol Use Disorders Identification Tool (AUDIT) (44% (n=279) males, 24% (131) females). AUDIT is recommended for use within sexual health settings in the guidelines on alcohol-use disorders: preventing harmful drinking (National Institute for Health and Care Excellence, 2010). It is a validated tool to screen the adult population for risky drinking and applied to opportunistic non-treatment seeking populations. It aims to raise awareness and provide advice on practical steps to reduce alcohol consumption and its adverse consequences (Kaner *et al.*, 2007).

Following the screening, two per cent of patients (n=22) had a score indicative of probable alcohol dependence (3% (n=16) males, 1% (n=6) females). Fifty-seven per cent (n=232) were offered a BI and 4% (n=24) of those were referred to treatment services.

There were significant differences for the whole sample (all ages) between mean AUDIT scores within key demographic groups, with males, those aged 20-24 years, students, homosexual/bisexual patients, those who identified as white ethnic origin and people living in the least deprived quintile more likely to have a higher AUDIT score.

Seventy-four per cent of those aged 25+ years (n=1,086) received a full sexual health screen for chlamydia, gonorrhoea, syphilis and HIV, and 23% of patients

(n=267) who drank alcohol were diagnosed with an STI. This was significantly higher amongst males (25%) compared to females (20%), with no significant difference amongst patients under 25 years and over 25 years (p=0.14). Logistic regression results also showed that when controlling for demographics and drinking behaviour, patients living in quintiles one to four were significantly more likely to be diagnosed with an STI compared to those living in the least deprived quintile. Finally, patients categorised as probably dependent on AUDIT (amongst all age groups) were 1.7 times more likely than low risk drinkers to be diagnosed with an STI.

The audit set out to understand the levels of alcohol consumption of patients attending GUM clinics and added to the literature, that patients attending sexual health clinics have higher levels of alcohol consumption than found in the general population, including amongst those aged 25+ years. The prevalence of alcohol drinkers in this age group who had a diagnosis of an STI certainly warrants further exploration, particularly as there was no significant difference amongst those under 25 years and over 25 years. Additionally as one of the limitations of the audit was the lack of qualitative work to assess the acceptability of alcohol screening and BIs within the service, this was incorporated into the ethnographic study and the findings will be discussed in Chapter Seven.

In the next section I discuss the main findings from the existing literature on the relationship between alcohol use, sexual risk and sexual decision making.

1.6 Research on alcohol and sexual risk

As described earlier, one of the major limitations of existing research attempting to identify the link between alcohol and sexual risk has been the varied definitions used. For the measurement of alcohol consumption, most studies use self-reported methods (Weinhardt and Carey, 2000). Some studies have assessed the relationship using non-defined measures such as frequency of drinking over a specific time period (Zenilman *et al.*, 1994; Graves and Leigh, 1995; Fergusson and Lynskey, 1996; Halpern-Felsher *et al.*, 1996; Leigh *et al.*, 2008). Others have simply captured whether alcohol was consumed or not (Ullman, 1999). Such studies acknowledge limitations of recall bias resulting in a possible underreporting. Only in studies under laboratory conditions - experimental studies - where alcohol has been administered

to participants have actual levels of alcohol been measured (Davis *et al.*, 2007; Stoner *et al.*, 2007; Stoner *et al.*, 2008; George *et al.*, 2009).

Similarly, the definitions used for sexual risk also vary. Cooper defined it as:

> *any behaviour that increases the probability of negative consequences associated with sexual contact, including AIDs or other sexually transmitted diseases (STDs) and unplanned pregnancies* (Cooper, 2002, pp101-102).

In this study, contraception was primarily focused on condom use. Others have defined it to include sexual intercourse without the use of any contraception or behaviour that was later regretted (Coleman and Cater, 2005). However, sexual risk could actually include sexual activity before the age of 16 years; sexual intercourse (vaginal and/or anal) without any form of contraception to protect from STIs and/or unplanned pregnancy (including condom, oral or injection); use of emergency contraception; having sex with casual, multiple or unknown partners; failure to discuss risk topics prior to intercourse, risk of sexual assault and regretted sexual experiences.

Study designs in this field are also varied, and found conflicting findings (Leigh and Stall, 1993). Global association studies where participants are asked about the quantity and frequency of alcohol consumption over a fixed time-period, as well as their sexual risk behaviours over the same time period have shown associations between heavy alcohol use and risky sexual behaviour (Leigh, 1990; Connor *et al.*, 2010).

Cross-sectional studies (Graves and Leigh, 1995; Bellis et al., 2008; Aicken et al., 2011) on current and/or historic alcohol use and sexual risk provide information about general patterns of behaviour and identified correlation. However, these studies are also limited, as they are unable to identify a single specific occasion of alcohol use and sexual intercourse. Controlled laboratory-based experimental studies, where alcohol is administered to some participants, and the intent to have unprotected sex is measured, is also limited as it does not measure actual risk-taking behaviour and is therefore hypothetical.

This has led some researchers to use event-led studies (Cooper *et al.*, 1994; Brown and Vanable, 2007). The event-level method refers to an in-depth examination of the characteristics of a specific behaviour occurring on a particular occasion (Weinhardt and Carey, 2000). Key findings from one event-led study was that heterosexual women and homosexual men were more likely to have unsafe sex if they were under the influence of alcohol (Trocki and Leigh, 1991). However, some of the event-led studies have also shown to be inconclusive and conflicting (Leigh and Stall, 1993; Halpern-Felsher *et al.*, 1996). Some of the event-led studies have found no direct association between drinking and condom use (Cooper, 2006); and Leigh (1999) highlighted that it did not eliminate the issue of individual-level confounding. This means that information about a single encounter does not tell us whether individuals who participate in risky behaviour are more likely to engage in unprotected sex when they are drinking than when they are not.

A systematic review (Weinhardt and Carey, 2000) of event-led studies looking at both one critical incident but also multiple-events (thus the participant acts as their own control), found only half of event-level analysis showed a significant relationship between alcohol and condom use. People who use condoms when they are sober also tend to use them when they have been drinking. The multiple-event studies have been further criticised as participants are asked to self-report and monitor their own behaviour. This method alone could have sensitized them and may not reflect their normal patterns of behaviour.

A number of alcohol studies undertaken in sexual health clinics were also identified in the literature. These studies have found that alcohol is frequently used amongst patients at a sexual health clinic (Zenilman *et al.*, 1994) with binge drinking reported as a common feature (Standerwick *et al.*, 2007; Hutton *et al.*, 2008). Sexual health patients report that being drunk led to sexual contact, unprotected sex, the reason for their attendance at the clinic (Standerwick *et al.*, 2007; Patton *et al.*, 2008; Crawford *et al.*, 2015) or sexual assault (Blume *et al.*, 2012). Binge drinkers are also more likely to be diagnosed with an STI (Zenilman *et al.*, 1994; Standerwick *et al.*, 2007).

Many of the alcohol studies in sexual health clinics also use quantitative analyses and sample patients across all age groups. These methods included the use of surveillance information, evaluating the impact of a specific alcohol intervention, or

the use of patient questionnaires to explore behaviour. Only one study identified was qualitative in design, though this was confined to African American women (Hutton *et al.*, 2015)

As my study is specifically interested in those aged 25+ years, I also scoped the literature for systematic reviews on alcohol, sexual decision making and sexual risk using the terms highlighted in Table 3. I identified eight published systematic reviews (Cook and Clark, 2005; Rehm *et al.*, 2012; Vagenas *et al.*, 2013; Lan *et al.*, 2014; Smith and Larson, 2015; Lan *et al.*, 2016; Scott-Sheldon *et al.*, 2016; Simkhada *et al.*, 2016). Three of the reviews were limited to specific countries or geographical areas. Two were undertaken by the same lead author (Lan *et al.*, 2014; Lan *et al.*, 2016), which looked at both the prevalence and interventions to tackle alcohol and sexual risk in Russia. The third looked at the association of alcohol use and sexual risk-taking in Latin America (Vagenas *et al.*, 2013). Two of the reviews focused on experimental studies, where alcohol was administered to participants and sexual intent was measured (Rehm *et al.*, 2012; Scott-Sheldon *et al.*, 2016). Two reviews focused on particular population groups, one with tourists and tourist workers (Simkhada *et al.*, 2016); the second with black women over 50 years of age (Smith and Larson, 2015). The final review looked specifically at the association between alcohol consumption and STIs, rather than all sexual risk behaviours (Cook and Clark, 2005). In summary, seven of these systematic reviews covered all age groups with only one assessing sexual risks in an older age group, though as already identified above this was limited to black women aged over 50 years. Additionally, the authors of that study combined drugs and alcohol in their analysis (Smith and Larson, 2015).

In terms of the findings from the systematic reviews, five reported an overall association between hazardous or harmful alcohol consumption and increased sexual risk behaviours (Cook and Clark, 2005; Rehm *et al.*, 2012; Vagenas *et al.*, 2013; Lan *et al.*, 2016; Simkhada *et al.*, 2016). One of the experimental studies reported that alcohol consumption was associated with greater intentions to engage in unprotected sex, particularly when sexual arousal was heightened (Scott-Sheldon *et al.*, 2016). Most concluded that the role of alcohol consumption in the transmission of HIV and other STIs may be of public health importance and recommended the need to address alcohol use and sexual health concurrently.

1.7 Proposed theories of the alcohol-sex relationship

There are two main theories proposed within the literature to explain the alcohol-sex relationship - alcohol myopia theory (AMT) and alcohol expectancy. I will briefly summarise each below, as well as highlight any potential limitations.

AMT is classed as one of the impairment theories (Steele and Josephs, 1990), where disinhibited behaviour results from an interaction of diminished cognitive capabilities and the specific cues that influence behaviour in a given situation. Steele and Josephs (1990) explain that alcohol's pharmacological properties limit an individual's capacity and therefore they only attend to the most salient information and thus become 'myopic' or 'near-sighted'. The effects of alcohol myopia occur when the inhibiting and impelling cues are in conflict. How alcohol actually affects sexual behaviour is determined by the content and relative strength of the competing cues. Whilst intoxicated, highly salient immediate cues that instigate behaviour such as sexual arousal continue to be processed, whereas complex cues such as fear of pregnancy, STIs, relationship motivation or moral values are insufficient to repress the desire for sexual gratification (Abbey *et al.*, 2006; Cooper, 2006).

Some argue that the effects of alcohol on behaviour can differ for men and women (Griffin *et al.*, 2010), though not necessarily at all stages of a relationship. Cooper and Orcutt (1997), in their study of drinking and sexual experiences on first dates found that men perceived more benefits relative to the cost of having sex on their first or most recent date, whereas women perceived more cost relative to benefits, thus creating little conflict in the cues (Cooper and Orcutt, 1997). Others have found that women's desires to establish a relationship with a man could actually outweigh responses to sexually risky or dangerous cues (Benson *et al.*, 2007). Similarly if the most salient cue is inhibitory, alcohol intoxication will also impair men's ability to be aroused (George and Stoner, 2000) or result in more cautious sexual behaviour through an increased attention to the other inhibitory risk cues.

The second theory proposed is alcohol expectancy. This theory emphasises the psychological effects of alcohol consumption on sexual risk behaviour (Scott-Sheldon *et al.*, 2016), where an individual's behaviour after drinking is influenced by pre-existing beliefs about alcohol's effects, including sexual arousal and enhanced pleasure (Leeman *et al.*, 2007). Alcohol expectancies arise as a result of a social

learning process, where individuals learrn from cultural norms of perceived appropriate behaviours whilst intoxicated (Morris and Albery, 2001).

Psychological expectations about the effects of drinking alcohol might lead an individual to engage in sexual risk-taking (Cho and Span, 2010). Those who believe that alcohol disinhibits or enhances sexual experience are more likely to drink in potentially sexual situations, with a belief that intercourse will probably happen on that occasion (Cooper, 2006). Others argue that individuals who drink more frequently/heavily are more likely to engage in sexual risk behaviour, because they use their previous experiences as an excuse to engage in such behaviour (Morris and Albery, 2001). Some studies have found that this relationship is particularly strong for individuals who are nervous or guilty about sex (Leigh, 1990).This is referred to as positive outcome and associated with an increase in consumption in such sexual situations (Leigh and Stacy, 2004). Others have found gender differences, with men endorsing stronger sex-related alcohol expectancies than women (Dermen *et al.*, 1998).

It is important to note that some have argued (Morris and Albery, 2001; Kiene *et al.*, 2008; Lac and Brack, 2018) that the two theories are not mutually exclusive and can indeed interact with each other. Morris and Albery (2001) argue that alcohol expectancies can serve as risk factors for myopic consequences as expectancies serve as mental filters that guide alcohol consumption levels. They propose a ‘dual process model’ where alcohol behaviours are a combined function of both the preconsumption and consumption stage and conclude that sexual decision-making is much more dynamic and complex.

Limitations of both theories have however been proposed. Alcohol myopia studies are mainly undertaken in laboratory conditions as it is difficult to obtain real time measures of sexual arousal within a real life setting and it also does not account for day to day in-person variation (Kiene *et al.*, 2008). Alcohol expectancies are regular measured using the Alcohol Expectancy Questionnaire (Brown *et al.*, 1980), which have been criticised for not being specific enough to assess the specific expectancies of men and women, the expectancies they have for each other, nor the ability to evaluate the relative impact of each types of expectancies on drinking behaviour (Borjesson and Dunn, 2001).

As a result some propose that there is in fact a third model to explain the association, whereby both drinking and risky sex are mutually determined by other individual or situational factors. An individual's dispositional or personality trait or attitude can impact on decisions, including sensation seeking or impulsivity (George and Stoner, 2000; Weinhardt and Carey, 2000). Situational factors such as partner type, partner alcohol consumption, partner attitude toward condom use, the quantity of alcohol consumed and cognitive state before sex are all potential moderating factors (Morris and Albery, 2001; Kiene *et al.*, 2008).

In Chapter Eight I will consider what the utility of these theories adds to this study.

1.8 Summary

The literature review has identified some of the difficulties in assessing the relationship between alcohol use and risky sexual behaviour. This is mainly due to study designs being limited in their ability to prove causation, as well as the variety of measurements used to define alcohol and sexual risk. The systematic reviews, which covered the age group of interest for this study, were also limited. Only one looked exclusively at an older age cohort; however, this was limited in its sample. The findings did include an overall association between hazardous or harmful alcohol consumption and sexual risk behaviours, including potential risk of unprotected sex and STIs. Thus, they concluded that there was a need to address alcohol use and sexual health concurrently. The alcohol studies undertaken within sexual health services, similar to those identified within the audit for this study, found that frequent alcohol use and binge drinking was common amongst their patients. Patients reported that being drunk was the reason for the sexual contact, unprotected sex or sexual assault. However, studies in these settings are also limited as the sample covers all age groups as well as dominated by quantitative study design. Finally, there are two prominent theories proposed in the literature to explain the alcohol-sex mix, AMT (pharmalogical) and alcohol expectancy (psychological). I will touch upon these theories again in the systematic review and discuss further in Chapter Eight.

I now outline how the findings from the literature have, to date, informed national policy and guidance in England.

1.9 National policy and guidelines in England

I identify below where both national policy and guidance in England mentions the relationship between alcohol and sexual health, and in particular where it explicitly references the age cohort of interest to this study. A timeline of policies and guidance can be found in Figure 1.

1.9.1 National policy and guidelines in England: Alcohol Policy

The first ever alcohol strategy for England was published in March 2004 under a Labour Government (Alcohol Harm Reduction Strategy for England, 2004). It did not make any explicit reference to the relationship between alcohol use and sexual risk taking; however, one of the population groups it did prioritise was binge drinkers. Within the strategy, binge drinkers were defined as those drinking double the recommended daily guidelines on at least one occasion in the last week. The strategy goes on to say that, binge-drinkers are those who drink to get drunk and are more likely to be aged under 25 years. They experience negative consequences as a result of their drinking behaviour, in particular health harms associated with accidents and poisoning, as well as being a victim or perpetrator of crime.

The Labour Government made a commitment to review progress of the first strategy and in 2007 this was published (Mulholland and Van Wersch, 2007). Outlined within this report were the harmful consequences of young people's drinking and for the first time it made the link between high levels of alcohol consumption and other risk factors such as teenage pregnancy. However, it did acknowledge that the nature of the relationship was not yet fully understood.

Following the establishment of a Coalition Government in 2010, they published their alcohol strategy in March 2012 (*The Government's Alcohol Strategy*, 2012). This is still the document for the current Conservative Government, though a revised strategy is expected at the end of 2018. It referred to the work underway in England to provide alcohol advice in sexual health settings.

The alcohol strategy also made reference to the report published in 2011 by the Royal College of Physicians (RCP), *Alcohol and sex: a cocktail for poor sexual health* (Royal College of Physicians, 2011). The RCP had established an Alcohol and

Sexual Health Working Party and were tasked with reviewing the evidence of the association between alcohol and sexual ill health, with particular reference to young people, and to consider the role of sexual health clinics as a setting for alcohol assessment. The working party concluded with eight recommendations including the need to train sexual health staff to deliver alcohol brief interventions; developing clear pathways to alcohol treatment services; providing information to highlight the link between alcohol consumption and sexual health outcomes, and ensuring research funding bodies have a coordinated approach to researching the interface of alcohol and sexual behaviour.

Finally, in 2016, following a three-year review, the UK Chief Medical Officers launched the low risk drinking guidelines. This included a weekly guideline on regular drinking – which was not drinking more than 14 units a week and spread over a number of days. It also provided advice on single episodes of drinking, which also referred to losing self-control, and the risk of engaging in unprotected sex, as well as a guideline on avoiding alcohol during pregnancy. These new guidelines applied the same units a week for both men and women, and therefore have implications for the previous definition of binge drinking (Department of Health, 2016).

1.9.2 National policy and guidelines in England: Sexual Health Policy

The launch of the Teenage Pregnancy Strategy in 1999 (Social Exclusion Unit, 1999), developed as part of the work of the Labour Government's approach to tackle social exclusion, highlighted the negative outcomes of alcohol related sex for teenagers. These included the increased the risk of starting sex under 16 years of age; going further sexually than intended because they were drunk; being less likely to use contraception and more likely to regret the experience.

This was shortly followed by the first ever national Sexual Health Strategy for England in 2001 (Department of Health, 2001). This also acknowledged the relationship between sexual health and alcohol, and suggested that professionals across a range of services should recognise relevant factors such as alcohol use to sexual health outcomes and be able to provide consistent information to their users.

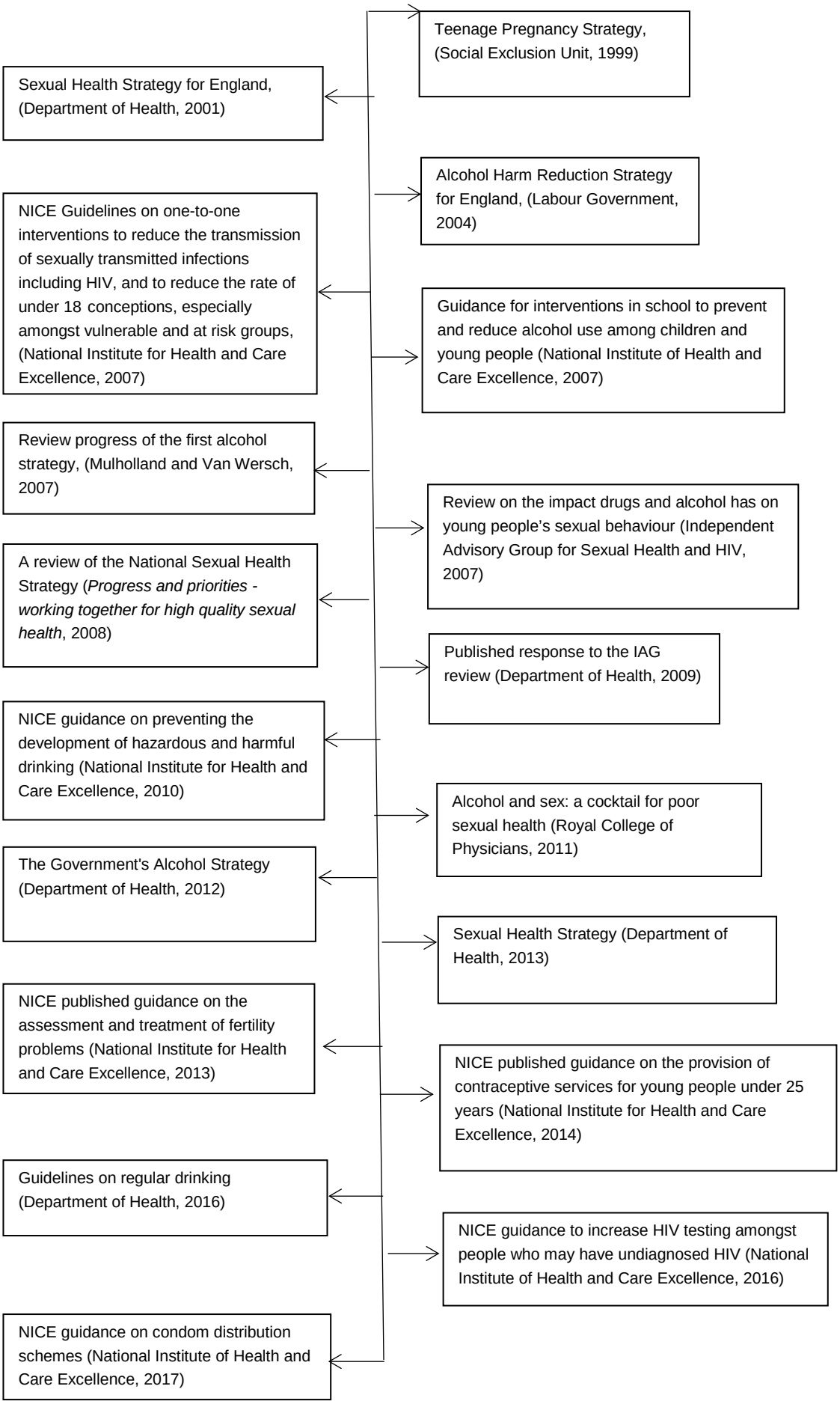
In 2007, the Independent Advisory Group on Sexual Health and HIV (IAG) published a review on the impact of drugs and alcohol on young people's sexual behaviour

(Independent Advisory Group for Sexual Health and HIV, 2007). They concluded with five recommendations including the need for a holistic assessment of young people at services to address drugs and alcohol misuse, as well as risky sexual behaviour. They also recommended that young people receive clear and factual information on the effects of drugs, alcohol and sex, and that this should form part of compulsory education. However, it was a further ten years later in 2017 that the current Conservative Government announced plans to mandate relationship and sex education in all schools in England from 2019, now delayed until 2020.

In 2008, the IAG and the Medical Foundation for Aids and Sexual Health (MedFASH) carried out a review of the National Sexual Health Strategy (*Progress and priorities - working together for high quality sexual health*, 2008). Whilst acknowledging the significant success since its publication particularly in terms of increasing access to services, reduction in teenage pregnancies and increased screening for STIs, there was still a need to integrate Government policy and to ensure sexual health was identified in other health improvement plans including alcohol. Then, in 2009 the Government published a response to the IAG review (Department of Health, 2009). It had a dedicated section on the links between alcohol and sexual health including sexual violence and identified how it was working to map sexual health to other Government priorities. Since that time, an electronic dataset for collection of data from sexual health and reproductive services includes a section on alcohol screening and brief advice. For every attendance where a patient is provided with an alcohol intervention this can be captured, however this is still not a mandated field.

A national Sexual Health Strategy under the Coalition Government was published in 2013 (Department of Health, 2013). This was a framework for Sexual Health Improvement in England, which referenced the significant changes in relationships over the past few decades as well as highlighted the different factors that can influence relationships and safe sex, including the use of alcohol. It highlighted the role of sexual health services in being able to identify users with potential alcohol problems and promoting clear referral pathways into alcohol services. The framework also acknowledged that there are different sexual health needs across the life course, with a clear ambition that all adults have access to high quality services and information so that people can remain healthy as they age. This framework is still the reference document for the current Conservative Government.

Figure 1: Timeline of policies and guidance in England (1999-2017)



1.9.3 National policy and guidelines in England: National Institute of Health and Care Excellence (NICE)

In England, NICE provides guidance, advice, quality standards and information for health, public health and social care staff so that they can commission and deliver effective and cost effective services (National Institute for Health and Care Excellence). I highlight below some of the key guidelines produced by NICE over the last decade where there is a reference between alcohol and sexual health and summarised in Figure 1.

In 2007, NICE produced guidance on one-to-one interventions to reduce the transmission of sexually transmitted infections including HIV, and to reduce the rate of under 18 conceptions, especially amongst vulnerable and at risk groups (National Institute for Health and Care Excellence, 2007). The guidance identified that the misuse of alcohol and/or substance misuse as a behaviour that increases the risk of STIs. In the same year, NICE also produced guidance for interventions in school to prevent and reduce alcohol use among children and young people (National Institute of Health and Care Excellence, 2007). The guidance recommended that alcohol education became an integral part of the national personal, social health and economic education (PSHE).

In 2010, NICE produced guidance on preventing the development of hazardous and harmful drinking (National Institute for Health and Care Excellence, 2010). One of the recommendations was for alcohol screening for young people (16-17 year olds) and adults who regularly attend GUM clinics or who repeatedly seek emergency contraception. This was further supported with the Quality Standard that was published in August 2011, with a recommendation for health and social care staff to opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of their practice.

In 2013 (updated in 2016), NICE published guidance on the assessment and treatment of fertility problems (National Institute for Health and Care Excellence, 2013). Within the guidance, it outlines lifestyle factors, including alcohol on the impact on fertility (including assisted fertility).

In 2014, NICE published guidance on the provision of contraceptive services for young people under 25 years (National Institute for Health and Care Excellence, 2014). Recommendation 4 is aimed at targeting services for socially disadvantaged young people and to offer support and referral to specialist services (including counselling) to those who may need it. For example, young people who misuse drugs or alcohol.

In 2016, NICE produced guidance to increase HIV testing amongst people who may have undiagnosed HIV (National Institute of Health and Care Excellence, 2016). This guidance was aimed at high-risk groups such as MSM, injecting drug users and for individuals who are from a high prevalence country. Within the guidance, they recommend both awareness materials and testing in venues where there may be high-risk sexual behaviour or where people of high risk gather, including nightclubs and festivals where alcohol is served.

In 2017, NICE produced guidance on condom distribution schemes. These are services providing free condoms to young people under the age of 25 years (National Institute of Health and Care Excellence, 2017). They recommend that such services should offer pathways into other services including sexual health as well as alcohol and drug services.

1.9.4 National policy and guidelines in England: summary

This section has provided an overview of the current policy and guidelines in England on alcohol and sexual health. I have demonstrated that the link between alcohol use and sexual risk has been acknowledged within national strategies and guidance, however the specific interventions or specific population groups to target remains limited to young people and risk groups.

1.10 Chapter summary

The purpose of this chapter has been to provide a rationale for the thesis. The epidemiological data I have accessed demonstrates the demand on health services for those aged 25+ years of age. This is supported by the audit undertaken as part of this current study where 35% of patients who drink alcohol attending the GUM service aged 25+ years had a positive AUDIT score, and of those who drank, 23% were diagnosed with an STI. Significantly higher amongst men than women though

not significantly different between those over and under 25 years of age. This data however is only one part of the picture and limited in understanding the needs of this specific population groups accessing these services.

I have also shared some of the limitations of existing literature, in particular how the study designs in this field to date have focused on risk groups and has been dominated by quantitative analyses. It has been recommended that qualitative research using in-depth narratives exploring the impact of alcohol on sexual risk taking could add further insight and assist in interpreting quantitative findings (Bimbi *et al.*, 2006). I have also demonstrated that the national Government policy in England has, until relatively recently, focused primarily on young people both in terms of their drinking behaviour (binge drinkers) or consequences (e.g. teenage pregnancy). The national guidance published by NICE has recognised the relationship between alcohol, unprotected sex and STIs, and although it has expanded to look at other priority groups such as MSM, the needs of the adult population, particularly those in mid to later life is minimal.

My study will therefore add knowledge to the current evidence base by exploring the factors that influence sexual decision making with an older age group, in particular the role of alcohol use. It is hoped that it will enhance understanding of this complex issue within a society where our relationship with alcohol and sex have significantly changed over the last few decades.

The next section will therefore outline the aims and objectives of the study, before outlining the structure for the rest of this thesis.

1.11 Aim and objectives

The aim of this study is to explore how the relationship between alcohol and sex is discussed and accounted for by patients (aged 25+ years) and healthcare practitioners in a sexual health service in the North East of England.

In order to answer this question it is important to carry out two components of work. A systematic review of the international literature will gain a better understanding of the research field amongst the age group of interest for this study. As identified above, the initial literature review identified that there was a gap of specific studies amongst

this age group and a systematic review within just sexual health services considered limited.

Secondly, an ethnographic study undertaken in a sexual health service to understand the views from patients and healthcare practitioners on the alcohol-sex mix and how this is discussed within the clinic. The ethnographic study will build upon the alcohol audit I led within the sexual health service described above (Section 1.5), where discussions on alcohol amongst patients had been incorporated into clinical assessments.

Given the potential novel area for the systematic review, this was undertaken concurrently with the ethnographic study with the aim of combining the results in the discussion (Chapter Eight), to undertand any overlaps and discrepancies. The aims and research questions for the systematic review and ethnography were developed independently, but both informed by the initial literature review.

Part 1: Systematic Review

The aim of this systematic review is to explore from the literature the relationship between alcohol and sexual risk, and its impact on sexual decision making, amongst adults aged 25+ years.

The review is seeking to fulfil the following research questions:

- How, why and in what context do individuals aged 25+ year use alcohol in sexual situations?
- What are the perceived outcomes of using alcohol in sexual situations amongst individuals aged 25+ years?
- What are the research gaps in the research field amongst this age group?

Part 2: Ethnographic study

The aim of the qualitative study is to explore how the relationship between alcohol and sex is discussed and accounted for by patients (aged 25+ years) and healthcare practitioners in a sexual health service in the North East of England.

The ethnographic study is seeking to fulfil the following research questions:

- How is alcohol identified and discussed in the clinical consultation of patients (aged 25+ years) attending the clinic?
- To undertake formal interviews with patients aged 25+ years to understand if, how and why they have used alcohol in sexual situations and to explore their beliefs about the alcohol-sex mix.
- How does alcohol impact on the work of healthcare practitioners at the sexual health clinic and what are the practitioners beliefs about the alcohol-sex mix?
- What are the contextual practices, informal beliefs, culture and identify within this setting?

1.12 Definitions

Throughout this thesis, there will be a number of terms used interchangeably. The definitions are highlighted below.

1.12.1 The clinic

The terms sexual health clinic, clinic and GUM will be used interchangeably. In England, a sexual health clinic or GUM offers a range of services. These include testing and treatment for STIs; provision of free condoms; provision of contraception including EHOC; pregnancy testing; HIV testing and treatment including PEP (post-exposure prophylaxis-medication that can help prevent people from developing HIV if they've been exposed to it); hepatitis B vaccinations and support for people who have been sexually assaulted. Anybody can go to a sexual health clinic, no matter their age. All services are free, completely confidential and anonymous, with all tests optional (NHS Choices).

1.12.2 Older

As indicated at the start of this chapter, as this study is particularly interested in those aged 25+ years, they will be referred to as ‘older’ throughout the thesis given this is the anecdotal definition applied by practitioners within a sexual health setting.

1.12.3 Risky Drinking

Throughout this thesis, I will use the terms risky drinking or binge drinking interchangeably. As identified above the UK Government now define binge drinking as drinking heavily over a short period of time – drinking double the recommended

guidelines (now 14 units for both men and women), on at least one occasion in the last week.

To close this chapter I describe the format for the rest of this thesis.

1.13 Overview of the thesis

Chapter Two, presents and discusses the findings from the systematic review. The review focuses specifically on the relationship between alcohol and sexual risk, and its impact on sexual decision making, for adults amongst those aged 25+ years. It seeks to identify, explain and interpret the prominent or recurring themes in all relevant literature and identify gaps in the subject field. The findings of the review will be combined with the findings of the ethnographic study and discussed in Chapter Eight.

Chapter Three, outlines the research methods used for the ethnographic study. This covers the ethical and practical framework for the fieldwork; the data collection and data analysis methods; and concludes with a discussion on the validity and reliability of the approach.

Chapter Four provides a descriptive overview of the GUM clinics and highlights some of the observations from the ethnographic fieldwork. It also introduces some of the characteristics of the patients, who were part of the ethnographic study, before introducing the three overarching themes of the study.

Chapter Five presents the findings from the first theme of the ethnographic study – *the changing norms of sex, relationships and the sexual health clinic in the UK*. This includes some of the historical changes as well as some of the transitional changes for individuals over the life course. I will discuss two significant developments, which participants believed has aided some of these changes – the internet and increased foreign travel. I also reflect how these changes have manifested within the GUM clinic.

Chapter Six presents the findings from the second theme of the ethnographic study – the *moral narrative of sex and alcohol*. This describes the moral geography of the GUM clinic within a medical arena; the narrative of the ‘moral self’ described by

patients who attend the clinic; and the moral narrative of alcohol, particularly when combined with sex.

Chapter Seven presents the findings from the final theme of the ethnographic study – *the pleasure, the shame, the guilt and the blame.* This will describe some of the benefits highlighted by participants of the alcohol-sex mix and explores how alcohol features in the sexual decision making of patients attending the GUM clinic. I will discuss the emotional responses following such decisions, which can lead to shame, guilt and blame.

Chapter Eight, is the final chapter, and combines the findings from the audit, systematic review and ethnographic study to discuss overlaps and discrepancies, before presenting the conclusions. It highlights some of the strengths and limitations of the thesis and outlines what this study adds to the existing literature. I will finally close the thesis with recommendations for practitioners, policy makers and researchers.

Chapter 2: Systematic review

This chapter presents the findings of the systematic review, which explores the relationship between alcohol and sexual risk, and its impact on sexual decision making, amongst adults aged 25+ years. The review highlights that similar to younger people, those aged 25+ years can use alcohol to facilitate sex, reduce inhibitions, increase confidence, intensify pleasure and use it as an excuse to engage in sexual behaviours some individuals may not engage in when sober. Those aged 25+ years also experience similar negative outcomes, such as unplanned pregnancy, STIs and sexual violence. Partner specific interactions emerged as a factor, as the use of alcohol prior to sexual intercourse appears to be more prevalent with non–primary partners such as casual sex partners. Additionally, age as a demographic characteristic, cannot be considered in isolation from other key factors.

Initially in this chapter, I provide the context for undertaking a systematic review, before outlining the aim and objectives of the review. I then describe the methods, which includes a description of the search strategy, the process for selecting the final studies and the method for assessing the quality of these studies. I then present the analysis and results, divided into themes, before summarising the findings. The final section discusses the limitations and strengths of the review, as well as highlight potential implications for practice and research.

2.1 Background

A systematic review uses systematic and explicit methods to identify, select, and critically appraise relevant research (Moher *et al.*, 2009); synthesising the findings from a number of studies in a transparent and replicable way. Systematic reviews are also an important vehicle for evidence-informed policy and practice, bringing the research closer to decision making (Thomas and Harden, 2008). Working as a public health practitioner within the field of interest, I wanted to ensure that the current evidence was available to inform this thesis, inform policy and serve as an aid to commissioners working in the field.

It is now recognised that policy makers and managers, (particularly working in public health) need to draw on diverse sources of evidence, not just research to inform their planning decisions (Mays *et al.*, 2005). As the topic of interest for this PhD was

emerging as a field of interest amongst policy makers (Department of Health, 2013), it was important to appraise all available evidence, including grey literature in order to avoid publication bias. Publication bias occurs when results of published studies are systematically different from results of unpublished studies (Song *et al.*, 2013).

As a result, the approach undertaken for this review has been referred to as 'knowledge support', or developmental where at an early stage of policy development, generating theories can help with the development of interventions, rather than undertaking a review to inform a specific healthcare decision (Mays *et al.*, 2005). As the overall aim of this PhD was explorative, a systematic review of the existing literature was a useful component, to inform and contextualise the study.

I carried out an initial scoping of existing systematic reviews in 2016 using MEDLINE, and applied the thesaurus headings (highlighted in Table 3), which was developed for the review protocol. I also searched the PROSPERO database (National Institute for Health Research), in order to identify whether there were any existing reviews published or underway in this field. As the existing literature on this topic used a combination of qualitative and quantitative methods, it was important to incorporate both study types into this review as it can maximise the depth of the findings, bridge research gaps and increase their applicability to inform policy and practice (Harden, 2010). Additionally, by integrating qualitative and quantitative evidence through narrative juxtaposition, discussing diverse forms of evidence side by side, it provides a flexible approach and provides the opportunity for conceptual development (Dixon-Woods *et al.*, 2005). The results of this systematic review will be combined with the audit and epidemiological data presented in Chapter One, along with the results of the qualitative research (Chapters Four-Seven), to present new knowledge in this field of research and inform future policy and practice (presented in Chapter Eight).

As identified within Chapter One, the literature scoping that I carried out identified eight published systematic reviews on the associations between alcohol use, sexual risk and sexual decision making (Cook and Clark, 2005; Rehm *et al.*, 2012; Vagenas *et al.*, 2013; Lan *et al.*, 2014; Smith and Larson, 2015; Lan *et al.*, 2016; Scott-Sheldon *et al.*, 2016; Simkhada *et al.*, 2016). Seven of the reviews covered all age groups with only one assessing sexual risks in an 'older' age group, though was limited to black women aged over 50 years. Therefore, as no other existing

systematic review has specifically assessed the relationship between alcohol, sexual risk and sexual decision making amongst an older age group in the general population, this systematic review will seek to fill that research gap.

2.2 Aim and objectives

The aim of the systematic review is to explore the relationship between alcohol and sexual risk, and its impact on sexual decision making amongst adults aged 25+ years. As described in Chapter One, the rationale for choosing 25+ years was due to the characterisation of this group by policy makers and practitioners as 'older people', working within the sexual health arena.

The review is seeking to fulfil the following research questions.

- How, why and in what context do individuals aged 25+ years use alcohol in sexual situations?
- What are the perceived outcomes of using alcohol in sexual situations amongst individuals aged 25+ years?
- What are the gaps in the research field amongst this age group?

In Chapter Eight, I will use the findings from the review to combine with the qualitative phase of the research, in order to highlight any synergies as well as discrepancies and make recommendations for practice.

2.3 Methods

A review protocol was developed and submitted to the International Prospective Register of Systematic Reviews to avoid duplication, reduce the possibility of bias and ensure that the review can be replicated (CRD42017067422). The review used the approach suggested by the Centre for Reviews and Dissemination (CRD) at York University.

The PICO framework (Thompson *et al.*, 2012) is widely used to guide the search strategy in systematic reviews, however given its limitations to qualitative studies, an alternative tool, called SPIDER (Cooke *et al.*, 2012), was also used to help search for qualitative or mixed method studies. This was important as qualitative studies can often have creative titles. Therefore, a combination of PICO and SPIDER was applied in order to improve the effectiveness of the search strategy to encompass all

forms of study design. The search terms are presented in Table 2 and described further below.

2.3.1 Participants/Sample

In order to answer the research question, searches were initially conducted where the sample included those aged 18+ years, as it was unclear how many studies would be available. However, there were sufficient studies that included data relating to just the age group of interest (25+ years), and only these were included in the final review.

Additionally, the initial search was undertaken across all countries. However, this was further refined to exclude the African continent due to the high prevalence of HIV, which was skewing the findings.

2.3.2 Intervention/Phenomenon of Interest

Included studies included information on the role of alcohol and its link to sexual decision making and/or sexual risk. Where these variables were reported independently (i.e. sexual risk and age but not alcohol), they were excluded.

2.3.3 Design studies

All study designs except commentaries or conference abstracts were included in the review.

Table 2: PICOS/SPIDER

Participants/**S**ample	**I**ntervention/**P**henomenon of **I**nterest	**D**esign	**O**utcomes/**E**valuation	**S**etting	**R**esearch Type
Adult Heterosexual Homosexual Men who have sex with men (MSM) Women who have sex with women (WSW) Gay Lesbian Women Men Not children	Alcohol drinking Excessive alcohol consumption Binge Drinking Risky Drinking Hazardous Drinking Intoxication Drunk Booze Pissed	RCT Cohort Case-Control Cross- sectional Focus group Interviews Observation Event-led Reviews Literature reviews	*Behaviours* Sexual intercourse Sexual arousal Sexual decision making Sexual encounters risk risk -taking confidence *Physical Outcomes* Sexual Pleasure Sexually transmitted infections/diseases HIV Number of sexual partners Casual sex Unprotected/condomless sex Pregnancy Abortion/termination of pregnancy Regretted sex Rape Sexual assault	GUM clinic Sexual health clinic Contraception clinic/family planning clinic Primary care Pharmacies Sexual assault services/SARCs/Rape Crisis Centres Alcohol services Workplaces Bars	Mixed methods Qualitative Quantitative (See also design type)

2.3.4 Outcomes/evaluation

It was anticipated that the studies included in this review would report a wide variety of outcomes relevant to the study question. Key outcome measures of interest included:

- Behavioural outcomes e.g. alcohol consumption levels, sexual intercourse;
- Physical and psychological consequences e.g. STIs, pregnancy, regretted sex, sexual violence (including rape and sexual assault);
- Attitudes/beliefs/perceptions e.g. alcohol causes sexual risk, being more sexually attractive under the influence of alcohol;
- Barriers and facilitators involved in alcohol related sexual decision making e.g. confidence.

2.3.5 Setting

Studies included a range of settings including health and non-healthcare settings e.g. sexual health clinics, emergency departments, bars.

2.3.6 Inclusion criteria

- Studies published in all languages.
- Studies published between the years 2000 – 2017 (see below for rationale).
- Studies that included human participants aged 25+ years. For studies that crossed the age boundary, an age band had to be reported separately rather than simply providing a mean age.
- Studies that included alcohol use and its link with sexual health (sexual decision making, sexually transmitted infections, sexual risk).
- Peer-reviewed studies.
- Grey or unpublished literature that was not subject to peer-review.

2.3.7 Exclusion criteria

- Studies where the alcohol data could not be extracted from the findings. For example, if part of a larger study on substance misuse where the reported data was combined with drugs.
- Studies that only included individuals under 25 years.
- Studies that only focused on students. The rationale for this decision was the dominance of data amongst this population group in the existing literature.

- Studies that focused on those already diagnosed with HIV or on alcohol's role for HIV disease progression, as the review wanted to understand any risk taking and decision making amongst the general population currently undiagnosed.
- Studies that focused on specific vulnerable population groups as oppose to the general population e.g. migrants, veterans, homeless, sex workers, prisoners, those in psychiatric units, those in drug & alcohol treatment, and those with a history of sexual assault including child abuse.
- Studies from before the year 2000, so the findings were current and could account for the reported changes in drinking behaviour since that time (Foster and Ferguson, 2012).
- Studies from the African continent given the high prevalence of HIV in this area, which could potentially skew the findings.
- Conference abstracts or commentaries/opinion pieces.

2.3.8 Search strategy

The search strategy was developed with advice from an information specialist at Newcastle University. The strategy was broad in order to capture all types of sexual risk and consequences linked with the use of alcohol. It included both positive and negative consequences. Keywords were coupled with relevant MeSH/thesaurus terms, and truncated as appropriate. The following electronic databases were searched: MEDLINE, PsycINFO, EMBASE, CINAHL, SCOPUS and Web of Science. Table 3 provides the Thesaurus headings used for the key databases.

To avoid publication bias, grey literature was identified through Google, Google Scholar® and opengrey.eu. Additionally, searches were undertaken on specialist websites including: the Department of Health (England); NICE; British Association of Sexual Health and HIV, Medical Foundation for AIDs and Sexual Health (MEDFASH); British Association for Sexual Health and HIV (BASHH); AVERT (Information and education charity launched at the start of the HIV and AIDs epidemic); Centre for Disease Control and Prevention (CDC) in the USA; Alcohol Research UK; the Alcohol Learning Centre and Joseph Rowntree Foundation.

All searches were undertaken during February 2017. Therefore, studies up to and including that point are included within the review.

Table 3: Thesaurus headings and key words by databases

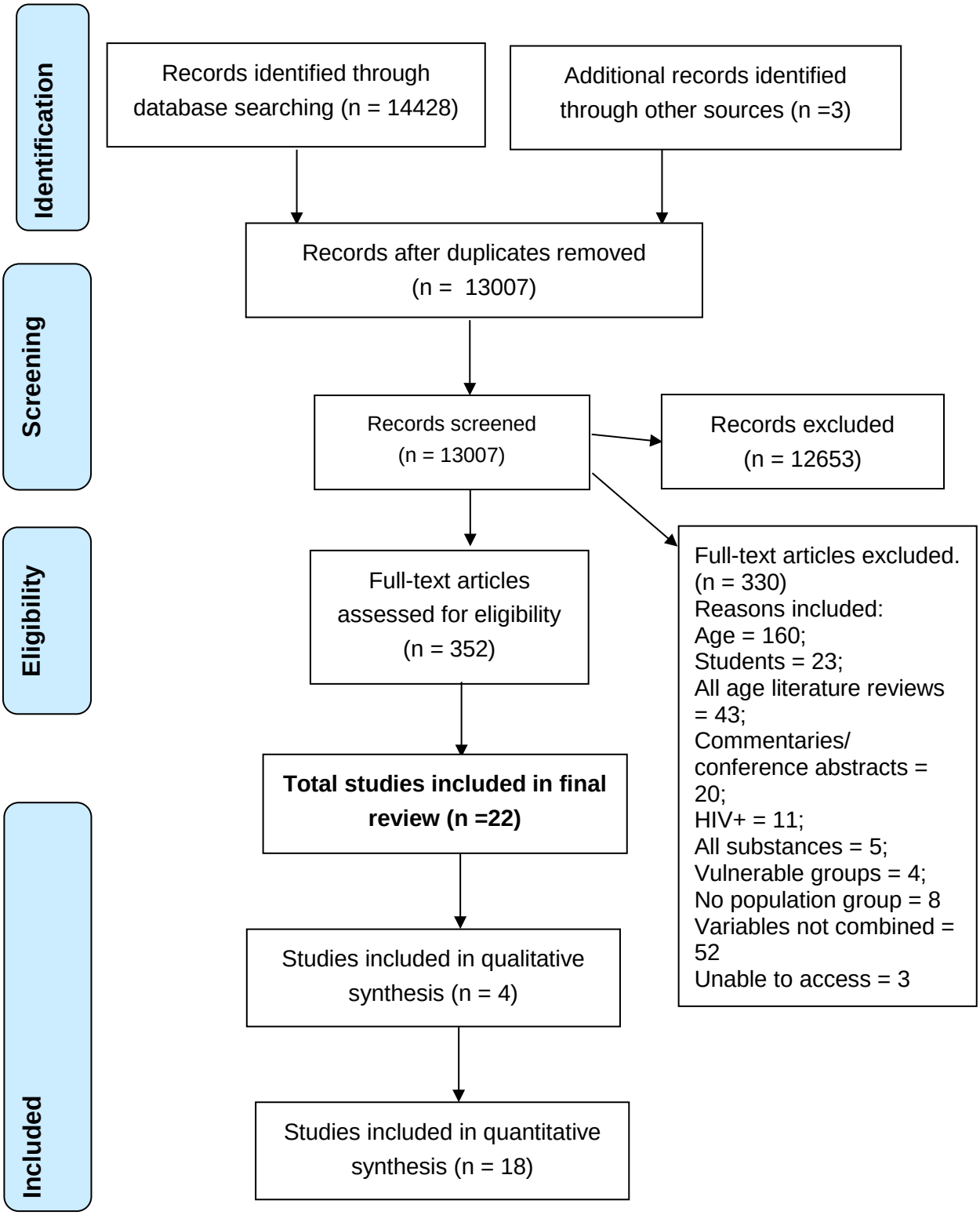
CORE CONCEPT	MEDLINE*	EMBASE*	PsycINFO*	Scopus, Web of Science and other databases
Phenomenon of Interest	exp alcohol drinking/ alcoholic Intoxication/ alcoholism/ **Key words:** alcohol consumption, drunk, risky drinking	drinking behaviour/alcohol consumption/binge drinking/alcohol intoxication/drunk sensation	alcohol drinking patterns/alcohol drinking attitudes/alcohol intoxication/binge drinking	**key words:** alcohol, alcohol drinking, binge drinking, risky drinking, alcohol intoxication.
Outcome	sexual behaviour$1/or coitus/or courtship/or extramarital relation$/or sexuality/or unsafe sex/ exp Sexually Transmitted Disease$1/ exp Sexual Partners/ Rape/ *Risk-Taking/ **Key words:** sexual decision making, sexual risk taking, sexually transmitted infections, STIs, contraception	sexual behavior$/ sexuality/sex/high risk behavior$/sexual partners **keywords:** sexual decision making, sexual health, contraception, sexually transmitted infections, sexually transmitted disease$	sexual risk taking/psychosexual behavior$/sexual intercourse/sexuality/ **keywords:** sexual behaviour, sexual decision making, sexual health, contraception, sexually transmitted infections, sexually transmitted diseases	**key words:** Sexual behaviour*, sexual decision making, sexual risk*; contraception, sexual partners, sexually transmitted infections, sexually transmitted diseases.

*MeSH, EMTREE and PsycINFO Thesaurus subject headings are presented underlined/

2.4 Data extraction and analysis

The PRISMA 2009 flowchart (Figure 2) was used as a guide throughout the review process and is reported in accordance with the PRISMA statement (PRISMA, 2013).

Figure 2: PRISMA flowchart



2.5 Study selection

As outlined above, the PRISMA guidance was used at each stage of the review process. There were three stages to the study selection. At stage one, the title and abstract of all records identified by electronic searches, including grey literature, were retrieved for relevancy and download to EndNote X7 for processing. The duplicate records were removed. All titles and abstracts were then screened in order to assess which studies met the inclusion criteria. All papers were reviewed by myself (CS). A second reviewer, Dorothy Newbury-Birch (DNB), reviewed a random sample of 20%. Discrepancies and queries were resolved between CS and DNB, erring towards inclusion if uncertain at this stage.

At stage two, full text copies of all potentially relevant papers that met criteria in stage one were retrieved. These papers were assessed according to the inclusion and exclusion criteria in order to determine eligibility. At this stage, all papers (100%), were assessed independently by both CS and DNB, with any disagreements resolved by discussion. Full text copies of three papers were unable to be retrieved despite attempts to contact the authors, and were therefore excluded (Bjekić and Vlajinac, 2000; Gebrekristos, 2011; Wegner *et al.*, 2016). Bjekić and Vlajinac (2000) assessed the relationship of alcohol use with recurring STIs in Belgrade. Gebrekristos (2011) was a dissertation on risk alcohol drinking and sexual behaviour among homosexual and bisexual men in the United States. Wegner et al, (2016) reported on the effect of alcohol on women's condom request style and men's condom use resistance tactics.

A summary of all the excluded studies detailing the reasons for exclusion is included within the PRISMA diagram above. The majority of those excluded (n=160) had no age breakdown in order to extract the relevant data pertaining to the focus of this review. Only studies that contained analysis of all the three variables were taken forward to stage three. These were: 1) alcohol, 2) sexual risk/sexual decision making and 3) age (25+ years).

At stage three, a structured excel data form was developed in order to extract information from the included studies. This included key features of each study - country of origin, date of research, aim, study design, definitions used for sexual risk

and alcohol, participant characteristics and key results. A summary of the data extraction form can be found in Table 4.

2.6 Quality assessment

As outlined by the PRISMA statement (Moher *et al.*, 2009), assessing the quality of studies is a key component of the systematic review process. Some argue that quality is an amorphous concept, though within a systematic review, the quality assessment leads to an interpretation of susceptibility to bias (Sanderson *et al.*, 2007). The key purpose of quality assessment therefore in the review is to distinguish between good and poor quality studies.

There are numerous quality assessment tools available, which have been developed for different study designs. The CASP checklist (*Critical Appraisal Skills Programme*) was used for the qualitative studies; and an adapted Newcastle – Ottowa Quality Assessment Scale (Modesti *et al.*, 2016) was used for the cross sectional studies. For the study that used a mixed methods approach (Sivaram *et al.*, 2008), the adapted Newcastle – Ottowa Assessment Scale was used, as the authors described the study as a survey.

For this review, CS and DNB assessed the methodological quality of the final included studies independently in order to reduce bias during the review process. The team then meet to discuss the findings, with any queries resolved between CS and DNB. The findings are presented in Table 5 and Table 6.

2.7 Analysis and data synthesis

As identified above, as the review question posed was exploratory and the relationship is complex due to attitudes, beliefs and perceptions, the approach taken was a thematic analysis where the evidence is summarized, explained and interpreted (Mays *et al.*, 2005). The approach adopted was to extract the relevant data relating to the study questions for all included studies against key characteristics. From this, recurring, prominent or opposing findings were then summarised under thematic headings (Dixon-Woods *et al.*, 2005) and then grouped into the final emerging themes.

2.8 Results

Figure 2 shows the PRISMA diagram displaying the number of studies excluded at each stage. From the original 14,431 studies originally identified, 22 were included in the final analysis. The data extraction form containing information on the final studies can be found in Table 4.

In summary, four of the studies were qualitative in design (Padilla *et al.*, 2012; Hutton *et al.*, 2015; Morison and Cook, 2015; Palamar *et al.*, 2016); seventeen were quantitative and one used a mixed methods approach (Sivaram *et al.*, 2008). The quantitative studies were cross sectional, using existing epidemiological data sets or administering new surveys.

The studies originated from a wide range of countries including Brazil (Rafael and de Moura, 2016); China (Luo *et al.*, 2012); Columbia (Arévalo *et al.*, 2011); Dominican Republic (Padilla *et al.*, 2012); Germany (Nicolai *et al.*, 2012); India (Sivaram *et al.*, 2008; Nayak *et al.*, 2010; Pandey *et al.*, 2012); New Zealand (Connor *et al.*, 2015; Morison and Cook, 2015); Peru (Delgado *et al.*, 2017); Spain (Folch *et al.*, 2010) and the USA (Ullman and Brecklin, 2000; Tetrault *et al.*, 2010; Wells *et al.*, 2010; Wen *et al.*, 2012; Dyer *et al.*, 2013; Thompson Jr *et al.*, 2014; Eaton *et al.*, 2015; Hutton *et al.*, 2015; Palamar *et al.*, 2016). One study (Bellis *et al.*, 2008) was undertaken in 9 cities from across the following European countries - Austria, Czech Republic, Germany, Greece, Italy, Portugal, Slovenia, Spain and the UK. The majority of studies included within the review were from the USA (n=9) followed by India (n=3).

The studies were published between the years of 2000–2017, with over half being published in the five years prior to the search being undertaken (n=13). Seven studies included men only; three of which focused on MSM (Folch *et al.*, 2010; Dyer *et al.*, 2013; Delgado *et al.*, 2017). Four of the studies included female only participants (Ullman and Brecklin, 2000; Hutton *et al.*, 2015; Morison and Cook, 2015).

Only five of the 22 studies only included those aged 25+ years, four quantitative (Ullman and Brecklin, 2000; Dyer *et al.*, 2013; Connor *et al.*, 2015; Rafael and de Moura, 2016) and one qualitative (Morison and Cook, 2015). The remainder (n=17) cut across the age boundary and therefore data had to be extracted for the age

group of focus for this systematic review. One study (Rafael and de Moura, 2016) was not in English and required translation from Spanish. A native speaking researcher based within the University undertook this translation.

As this review is specificaly interested in the concepts of sexual risk and how alcohol impacts on sexual decision making, data was extracted to look at the variety of definitions used. Table 4 provides a summary of the definitions provided by each study on alcohol consumption and sexual risk. As identified within Chapter One, one of the criticisms from the existing literature of any studies assessing the relationship or association between alcohol and sexual risk has been the lack of standardised measures used. Within the 22 studies included in this review, there were a variety of measures to define both alcohol use and sexual risk.

Alcohol use was predominantly measured in terms of frequency or quantity (or both) over a specified period e.g. day, year. Eleven studies (!!! INVALID CITATION !!! (Sivaram et al.`, 2008`; Folch et al.`, 2010`; Wells et al.`, 2010`; Arévalo et al.`, 2011`; Luo et al.`, 2012`; Dyer et al.`, 2013`; Thompson Jr et al.`, 2014`; Connor et al.`, 2015`; Eaton et al.`, 2015`; Hutton et al.`, 2015`; Delgado et al.`, 2017),) included alcohol use before or during sex (defined as a sexual risk) but did not measure the quantity and relied on self reported measures. Only three of the studies administered the standardised tool of AUDIT (Nayak *et al.*, 2010; Thompson Jr *et al.*, 2014; Hutton *et al.*, 2015) and one used a validated tool called TWEAK (Rafael and de Moura, 2016).

As well as alcohol use before or during sex, sexual risk was also defined as number of sexual partners over a given period e.g. 30 days (Bellis *et al.*, 2008; Nayak *et al.*, 2010; Arévalo *et al.*, 2011; Luo *et al.*, 2012; Connor *et al.*, 2015; Delgado *et al.*, 2017), sex without a condom (Bellis *et al.*, 2008; Sivaram *et al.*, 2008; Wen *et al.*, 2012; Connor *et al.*, 2015; Delgado *et al.*, 2017), particularly at last intercourse (Arévalo *et al.*, 2011; Delgado *et al.*, 2017) and sex with commercial sex workers (Sivaram *et al.*, 2008; Luo *et al.*, 2012; Padilla *et al.*, 2012; Wen *et al.*, 2012).

In summary, the alcohol-sex mix was described positively in terms of reducing inhibitions or anxieties with sexual partners (Connor *et al.*, 2015; Morison and Cook, 2015; Palamar *et al.*, 2016) though described negatively in terms of impaired

decision making linked with lack of condom use (Sivaram *et al.*, 2008; Arévalo *et al.*, 2011; Luo *et al.*, 2012; Padilla *et al.*, 2012; Dyer *et al.*, 2013; Connor *et al.*, 2015; Palamar *et al.*, 2016; Delgado *et al.*, 2017) regretted sex (Bellis *et al.*, 2008), in particular in terms of partner choice (Connor *et al.*, 2015; Hutton *et al.*, 2015; Palamar *et al.*, 2016), acquiring STIs (Tetrault *et al.*, 2010; Pandey *et al.*, 2012; Wen *et al.*, 2012; Connor *et al.*, 2015; Delgado *et al.*, 2017) termination of pregnancy (Connor *et al.*, 2015) and sexual violence (Ullman and Brecklin, 2000; Nayak *et al.*, 2010; Rafael and de Moura, 2016). Only two studies took a blood test from participants to screen for STIs (Luo *et al.*, 2012; Pandey *et al.*, 2012) and therefore most studies relied on self reported measures of previous STI diagnosis.

Interestingly, the theories and conclusions proposed within the studies for the alcohol-sex mix included the deliberate use to facilitate, prolong or enhance sexual experiences (Bellis *et al.*, 2008; Hutton *et al.*, 2015), including the ability to achieve orgasm (Palamar *et al.*, 2016), which supports the alcohol expectancy theory highlighted in Chapter One. In some studies there were cultural differences (Arévalo *et al.*, 2011) or gender differences highlighted (Wells *et al.*, 2010; Connor *et al.*, 2015; Palamar *et al.*, 2016), particularly for women linked with condom negotiation (Arévalo *et al.*, 2011; Morison and Cook, 2015). Partner-specific interactions also emerged as a factor, with alcohol use before sex more common amongst those who were single (Thompson Jr *et al.*, 2014), sex with casual partners (Folch *et al.*, 2010) and commercial sex workers (Sivaram *et al.*, 2008; Delgado *et al.*, 2017). Only two studies (Nicolai *et al.*, 2012; Hutton *et al.*, 2015) explicitly looked at alcohol expectancies as described in Chapter One (discussed further in section 2.13). Only one considered sexual behaviour when individuals were sober as well as under the influence of alcohol (Wells *et al.*, 2010) and only one (Palamar *et al.*, 2016) discussed the impact of alcohol on sexual functioning. These issues will be discussed in more detail in sections 2.10 - 2.15 below.

Table 4: Data extraction form for systematic review

Author, (Year of publication) [Country]	Aim(s)	Study Type/Design and Participants	Definitions of alcohol and/or sexual risk	Key Results
1. Arévalo, M.T.V., et al. (2011) [Columbia]	To establish the prevalence of risky sexual practices in Columbia and their relationship with sociodemographic characteristics in the adult population.	Quantitative - cross sectional Sample size: 25+years = 24597 (79.8% of total sample) Age: 18-69years Gender: 53.7% Women	Alcohol consumption at last sexual intercourse	The percentage of participants who consume alcohol at last sexual intercourse decreased with age. 7.1% of 25-34 year olds (n=6688), 6.3% of 35-44 year olds (n=6090), 5.2% of 45-54 year olds (n=5442) and 3.8% of 55-69 year olds (5008). This compared to 10.8% of 18-24 year olds (n=4469).
2. Bellis, M.A., et al. (2008) [Vienna, Czech Republic, Germany, Greece, Italy, Portugal, Slovenia, Spain and UK]	To understand the relationships between sex, alcohol and drug use, covering initiation into such behaviours to current use of substances to achieve sexual outcomes.	Quantitative - cross sectional survey Sample size: 1341 people Age: 16-35years (numbers only provided for 26-35years by current alcohol users =202) Gender: 51.5% Women	1. Initiation to sex 2.Strategic use of substances for sexual purposes 3. Sexual behaviour in last 12months	There was no statistically significant difference between those aged 16-25 years with those aged 26-35 years for using alcohol to enhance sensations and sexual arousal, facilitating a sexual encounter or unusual/exciting sexual activity ($p < .05$).
3. Connor, J.L., R.M. Kydd, and N.P. Dickson. (2015) [New Zealand]	Alcohol's role in sexual behaviour and outcomes among 38 year olds from a New Zealand birth cohort.	Quantitative. Sample size/Age: 936 at age 38 Gender: 50% Women	1. Self-reported alcohol use in sexual relationships. 2. Number of sexual partners, self-reported STIs ad TOPs. 3. Alcohol consumption pattern	W were twice as likely to report using alcohol to make it easier to have sex in the past year (13.9% W; 6.3% M). Unwanted consequences attributed to respondents drinking (13.5% M; 11.9% W), including regretted sex (7% M; 5.7% W); failure to use contraception when pregnancy not wanted (8.3% M; 7.1% W) and sex without a condom to protect against STIs (7.9% M; 7.6% W). There was a significant association with the involvement of alcohol amongst heavy drinkers in sex 'usually or always' for both M (aOR =5.46, 95% CI 2.26 - 13.23) and W (aOR = 12.31, 95% CI 5.16-29.37). There was a graded association of heavy drinking occasion frequency with sex that was later regretted for M and W. Heavy drinking frequency was also strongly associated with partner numbers for W.

4. Delgado, J.R., et al. (2017) [Peru]	1. Participant and partner-specific characteristics associated with alcohol use prior to intercourse. 2. Patterns of alcohol use and CAI within specific sexual partnership contexts of men who have sex with men and transgender women who have sex with men (TGW). 3. The potential impact of alcohol consumption on HIV serostatus disclosure and other alternative prevention strategies in this population.	Quantitative Sample size: 1607. Age: Mean age was 28.8years Data on those aged over 36 years provided in analysis. Gender: Men	1. Total number of sexual partners in the previous 30 days 2. Self-reported STIs 3. Type of intercourse 4. Position of intercourse 5.Condom use during sex act 6. Alcohol use before sex.	There were no statistical significant differences between those aged over 36 years and those under 35 years in alcohol use prior to sex ($p < .11$).
5. Dyer, T.P., et al. (2013) [USA]	Associations in substance use, psychological characteristics and HIV related sexual behaviours, comparing characteristics of black men who have sex with men only (BMSMO) to black men who have sex with men and women (BMSMW).	Quantitative - cross sectional and rapid HIV test. Sample size: 1429 Age: 26-47years Gender: Men Sexuality: 58% BMSMO/42% BMSMW	1. Number of drinks containing alcohol in a typical day 2. Alcohol use before or during UAI	More BMSMW reported drinking alcohol within 2 hours of unprotected anal intercourse compared to BMSMO (52.9% vs. 39.3%, $p = 0.0059$). Being BMSMW was significantly associated with increased risk of engaging in recent UAI while under the influence of alcohol (AOR: 1.45, 95% CI: 1.11-1.90).
6. Eaton, N.R.,et al. (2015) [USA]	Examined regular drinking before sex and its associated risk factors.	Quantitative. Gender: 58% women Age: 20-90+years	1. Alcohol consumption before sexual activity 2.Drinking frequency	For 30-39 year olds (17.51%), 40-49 year olds (25.39%) and for those aged over 50 years (38.41%) regularly drank before sexual activity. The odds of being a regular pre-sex drinker were significantly higher for individuals who were 50+ years (vs younger than 40 years).

7. Folch, C., et al. (2010) [Spain]	To determine the prevalence of alcohol and drug use before or during sex among MSM in Catalonia 2006, and to identify factors associated with variables of intensive alcohol and drug use.	Quantitative - cross sectional study Total sample size: 850 Age: 19-35+years. Mean was 41years Gender: Men Sexuality: 89.2% homosexual, 8.5% bisexual and 2.4% other	1. Sex practices in the last 12 months with stable and casual partners; use of condoms; self-reported HIV status and previous history of STIs. 2 Alcohol use before or during sex over the last 12months	25.6% of 26-35 year olds and 16.9% of those aged 35+ years were frequent alcohol users before or during sex. Those aged 19-25 years were significantly (OR: 1.688, 95% CI 1.16-2.45) more likely than those aged over 35 years to use alcohol before sex. For those aged 26-35, they were 1.7 times more likely (OR: 1.788, 95% CI 0.77-4.13) than those aged over 35 years but this was not significant.
8. Hutton, H.E., et al. (2015) [USA]	Explore the link between alcohol use and risky sex (Sex-Related Alcohol Expectancies) among African American Women attending an STI clinic.	Qualitative and Alcohol Use Disorders Identification Test (AUDIT). Sample size: 20 Age: 18+years Gender: Women	Sex Related Alcohol Expectancies (SRAE)	Four themes were identified from the qualitative analysis: drink for sexual desire; drink for sexual power; drink for sexual excuse; and drink for anal sex.
9. Luo, X.F., et al. (2012) [China]	Examine the prevalence and correlates of alcohol use and subsequent sexually activity as well as HIV status of adult males belonging to ethnic minorities in rural Yunnan Province.	Quantitative -cross sectional study, and blood testing. Sample size: 382 Age: 16-55years Gender: Men	1. Alcohol use: frequency & quantity 2. Sexual behaviour: number of sexual partners; sexual activity after drinking by sexual behaviour - casual/commercial sex and rate of condom use 3. Sexual activity after drinking	34.1% of 26-35 year olds, 17.9% of 36-45 year olds and 11.3% of 46-55 year olds reported sex after drinking. Those aged 26-35 years were four times more likely, (OR= 4.06, 95% CI: 1.65-10.01, p = 0.002) to have sex after drinking when compared to those aged 46-55 years. When adjusting for potential confounding variables, those aged 26 to 35 were significantly more likely (OR= 3.80, 95% CI: 1.38-10.52, p = 0.01) to have ever engaged in sex after drinking compared to those aged 46-55 years.

10. Morison, T. and C.M. Cook (2015) [New Zealand]	Explore barriers to safer heterosexual sex as perceived by midlife older New Zealand women who are re-partnering or in casual relationships.	Qualitative Sample size: 8 Gender: Women Age: 40-69 years Sexuality: Heterosexual	Relationship histories, views and experiences of safer sex behaviours and experiences of negotiating condom use in current or recent relationships	W attributed unsafe sex to alcohol intoxication. Alcohol acted as a 'social lubricant', easing re-entry into dating. Normalising the link between unsafe sexual practices and intoxication.
11. Nayak, M.B., R.A. Korcha, and V. Benegal (2010) [India]	Systematically exam associations between diverse alcohol patterns, including hazardous alcohol use with HIV risk behaviours in a population sample of adult men in Karnataka. Critically evaluating the unique contribution of alcohol use to HIV risk related behaviours.	Quantitative. Total sample size: 1137 Gender: Men Age: 16-49years	1. HIV Risk behaviour: 2 or more sexual partners and/or perpetration of partner physical violence in the last year 2. Alcohol use: Quantity and frequency. AUDIT also carried out	Amongst current drinkers, 24.2% of 30-39 year olds and 13.7% of 40-49 year olds had at least one HIV risk behaviour over the past year. Men 30-39 years were more likely to report HIV risk behaviours (COR 1.89, $p < .02$) compared to those 16-29 years. No significant difference between those 40-49 years and those 16-29 years. Multivariate analyses (between hazardous alcohol use and HIV risk behaviour amongst current drinkers), found that those 30-49 years were more likely to have HIV risk related behaviours than those 16-29 years, though this was only significant amongst those aged 30-39 years ($p =0.04$).
12. Nicolai, J., M. (2012) [Germany]	To investigate the relationship between alcohol expectancies and alcohol use in a community sample as a function of age and gender.	Quantitative. Total sample: 6467 Age: 18-59 years Gender: 54% women	Alcohol expectancies: Drinking behaviour: Frequency and quantity	Expectancies related to sexual enhancement were significant predictors merely among those aged 18-23 years ($p =0.05$) and for 50-59 year old women ($p =0.04$).
13. Padilla, M.B., V. Guilamo-Ramos, and R. Godbole. (2012) [Dominican Republic]	Alcohol consumption and sexual risk behaviour analysed in the context of culture and economy in the Caribbean tourism spaces.	Qualitative Sample size: 32 Age: 18-50	1. Alcohol use 2. Sexual practices including transactional sex	Alcohol and sex are intertwined (one implies the other); women's sexuality was a primary component of the alcohol consumption experience. Sex & alcohol was a desire of tourists, alcohol venues offered sex and eroticism. Tourists behave differently on holiday than they do at home.

14. Palamar, J.J., et al. (2016) [USA]	Compare psychosocial and physical sexual experiences related to alcohol and marijuana use among adults.	Qualitative Sample size: 24 Age: Mean age 27.4years Gender: 50% women	Sexual activity with another individual that can result in orgasm	12 themes were identified in the qualitative analysis: Self-perception attractiveness; sociability and loss of social inhibitions; Facilitation of social connection with others; partner choice; feelings after sex; regret; general adverse effects; dose effects; sensations of body and sex organs; length and intensity of sex; sexual dysfunction; orgasm and sexual behaviours.
15. Pandey, A., et al. (2012) [India]	To examine the correlates of alcohol use and its association with STI among adult men in India.	Quantitative and laboratory testing to ascertain STI. Sample size: 6579 Age: 20-49years Gender: Women	1. Consumption of alcohol 2. STI: lab result of one of STIs	For those aged 26-30, STI prevalence amongst alcohol consumers was 2.5%. Those 31-35 years it was 3%; those 36+ years it was 4.5%. Adjusted OR found no significant difference amongst the different age groups of having an STI.
16. Rafael RMR, Moura ATMS. (2016) [Brazil]	To analyse the association between use of alcohol and partner violence.	Quantitative - cross sectional Sample size: 476 Gender: Women	1.Alcohol: TWEAK (Tolerance, Worried, Eye-opener, Amnesia and K/C Cutdown) 2.Sexual Violence	Alcohol misuse by women was significantly associated with sexual violence OR=2,1 (95%CI=1,2/3,8) (p=0,014); logistic regression analysis: adjusted OR= 2,2 (95%CI=1,2/4,1) (p =0,008).
17. Tetrault, J.M., et al.(2010) [USA]	To determine the prevalence of substance use in patients diagnosed with STIs in a community dwelling population.	Quantitative Total sample: 54,533 (those aged 26+years = 18,542) Age: 12+years Gender: 51.7% women	1. Alcohol: Past year alcohol abuse/dependence. 2. Sexual risk: Self-reported STIs in the past year.	The adjusted associations between STI and alcohol use found no significant difference between age groups. However, for those classified as binge drinkers, those 26-34 years were 1.8 times (95% CI: 1.6-2.0) more likely than those 35+ years to have an STI. For those classed as heavy drinkers, those 26-34 years were 1.2 times (95% CI: 0.9-1.5) more likely than those 35+ years to have an STI. Those who were 26-34years who were alcohol dependent were 1.7 (95% CI: 1.2-2.3) more likely than those 35+ years to have an STI.

18. Sivram, S. et al. (2008) [India]	To explore the determinants of risky sexual behaviour among male alcohol users.	Mixed Methods Total sample size: 1196. Gender: Men Age 18-40 years (71% were 25+ years, n=846)	1. Risky sex: Sexual behaviour, relationship with the sexual partners, number of times they had used condoms. 2. Alcohol: Frequency of alcohol use in sexual encounters, frequency and quantity of alcohol use during wine shop visits.	Quantitative: Those 18-24 years were significantly more likely than those 25+ years to have unprotected sex amongst patrons of wine shops in Chennai. Qualitative: Alcohol was consumed as individuals planned for sex and as part of foreplay, particularly with a sex worker. However non-sexual factors motivated alcohol use e.g. social exclusion.
19. Thompson Jr, R.G., et al.(2014) [USA]	Examined whether relationship status and AUD (Alcohol Use Disorder) increased the likelihood of regularly drinking alcohol before sex.	Quantitative. Gender: 58% women Age: 20-90+years	1. Regularly drinking alcohol before sex 2. Relationship status 3.Alcohol use disorders	Prevalence of drinking alcohol prior to sexual intercourse - 17.51% of 30-39 years; 25.39% of 40-49 years and 38.41% of those aged 50+years. Percentages increased with age. After adjusting for control variables, those aged 18-49 years were significantly less likely to drink prior to sexual activity than those aged 50 years (OR 95% CI: 18-29 = 0.36, 30-39 = 0.42 and 40-49 = 0.65).
20. Ullman, S.E. and L.R. Brecklin.(2000) [USA]	Examining alcohol's role in sexual assaults.	Quantitative Study sample: 163 Age: 26-86 years Gender: women	1.Sexual assault - characteristics of the sexual assault experience and frequency 2.Victim drinking	Two thirds of women were not drinking prior to the assault, whereas 62.3% of attackers were drinking according to their victims reports. Offenders who were strangers to the victims were more common in attacks where victims were drinking prior to the attack than in attacks where victims were not drinking. Offender and victim drinking prior to the assault were significantly positively associated with each other.

21. Wells, B.E., et al.(2010) [USA]	Assessing patterns of drinking and sexual activity among young adults who frequent nightclubs.	Quantitative. Sample size: 308 (141/45.8% 25-29 years) Age: 18-29 years Gender: 54.2% men Sexual Identify: 90.3% heterosexual/9.7% gay, lesbian or bisexual	1. Recent drinking: Quantity and frequency 2.Sexual risk: Recent sober sexual activity, recent sexual activity after drinking and perceived sexual risk	For those 25-29 years: 82% had sex while inebriated; 63.6% had sex after drinking and 20.2% had less safe during sex as a result of drinking. Those aged 18-24 years were significantly more likely to engage in less safe behaviour after drinking (P =0.011) than those aged 25-29. There was no significant differences amongst the age groups for 'sex while not inebriated' and 'sex after drinking'.
22. Wen, X.J., L. Balluz, and M. Town. (2008) [USA]	To examine the differences (if any) in HIV risk behaviours of 18-64 year old binge drinkers versus non binge drinkers in the US population, and to assess the association between HIV risk behaviours in bingers and the frequency of binge drinking episodes during the 30 days prior to the survey.	Quantitative - cross sectional. Sample size: 281,303 Age: 18-64years Gender: 61.3% women	1. Sexual behaviours: Being treated for STIs, given or received money for drugs in exchange for sex and having anal sex without a condom. 2.Binge drinking: Quantity and frequency	Across all demographic characteristics, the HIV risk behaviours were consistently higher among the bingers compared to the non-bingers. HIV risk behaviours amongst binge drinkers; 8.2% of those 25-34 years; 4.2% of those 35-44 years; 3.5% of those 45-54 years and 2.5% amongst those 55-64 years. Decreasing with age.

Key: W=women; M=men; OR = Odds Ratio; aOR =Adjusted Odds Ratio

2.9 Quality assessment results

The results of the quality assessment can be found in Table 5 for the qualitative studies (Padilla *et al.*, 2012; Hutton *et al.*, 2015; Morison and Cook, 2015; Palamar *et al.*, 2016) and Table 6 for the 18 cross sectional studies. Although there is not an official rating system by CASP for the qualitative studies, the strength of the papers is based on the number of 'Yes' results obtained. The results of the assessment of the qualitative studies in this review (Table 5) showed that there were two strong studies (Hutton *et al.*, 2015; Morison and Cook, 2015), though neither provided an adequate description of the relationship between the researcher and participants. Two studies were assessed as medium quality as they did not adequately consider the ethical issues or confirm that they had ethical approval for the study (Padilla *et al.*, 2012; Palamar *et al.*, 2016). Additionally, one paper did not have a clear statement about the aims of their research (Padilla *et al.*, 2012). Although the CASP checklist requires the assessor to consider whether or not it is worth continuing if the statement of aims is not a 'Yes'; on this occasion the reviewers agreed to continue as the other key indicator on the appropriateness of the methodology, was felt to be appropriate, so the study was included in the final analysis.

Table 6 contains the results from the quality assessment of the cross sectional studies. The adapted Newcastle–Ottowa Quality Assessment Scale (Modesti *et al.*, 2016) has a star rated system across three areas – Selection (maximum 5 stars), Comparability (maximum 2 stars) and Outcome (maximum 3 stars), with a maximum of 10 stars available. The aim is to compare the quality of the studies against each other. Of the 18 studies assessed, no studies obtained all 10 stars. There were 9 strong studies, scoring 9 (Pandey *et al.*, 2012) or 8 (Sivaram *et al.*, 2008; Nayak *et al.*, 2010; Nicolai *et al.*, 2012; Dyer *et al.*, 2013; Thompson Jr *et al.*, 2014; Connor *et al.*, 2015; Eaton *et al.*, 2015; Delgado *et al.*, 2017). Four studies scored 7 (Ullman and Brecklin, 2000; Wells *et al.*, 2010; Luo *et al.*, 2012; Wen *et al.*, 2012) and one 6 (Tetrault *et al.*, 2010) so assessed as medium quality. With the remaining four studies each scoring 5 (Bellis *et al.*, 2008; Folch *et al.*, 2010; Arévalo *et al.*, 2011; Rafael and de Moura, 2016) and therefore assessed as low quality.

To summarise, there were a number of key limitations of the studies included within this review. First, two studies did not acknowledge any limitations to their study, despite containing them (Arévalo *et al.*, 2011; Padilla *et al.*, 2012). Second, the

findings from eleven studies may not generalizable due to the sampling technique or sample size used (Bellis *et al.*, 2008; Sivaram *et al.*, 2008; Folch *et al.*, 2010; Tetrault *et al.*, 2010; Padilla *et al.*, 2012; Wen *et al.*, 2012; Dyer *et al.*, 2013; Hutton *et al.*, 2015; Morison and Cook, 2015; Palamar *et al.*, 2016; Delgado *et al.*, 2017). Third, all studies had an element of self-reported behaviour, which would be subject to recall bias. Even with the use of AUDIT (Saunders *et al.*, 1993), a validated tool, still relies on the participant being truthful in their reporting. Additionally, given that alcohol use and sexual behaviour are sensitive personal topics, there could in fact be deliberate concealment (Luo *et al.*, 2012), or social desirability bias (Wen *et al.*, 2012; Morison and Cook, 2015). This may even lead to gender differences in willingness to disclose or recall specific outcomes e.g. women are more likely to remember a termination of pregnancy given its significance (Connor *et al.*, 2015).

Fourth, five studies also used secondary analysis of data; where the original data collected, although may be relevant, was collected for a different purpose (Ullman and Brecklin, 2000; Arévalo *et al.*, 2011; Nicolai *et al.*, 2012; Pandey *et al.*, 2012; Delgado *et al.*, 2017). For example, Ullman and Brecklin (2000) used data from a national survey of women's drinking and life experiences, which only included a single-item screening question on sexual assault, therefore respondents may have interpreted the question differently.

Finally, as eighteen of the studies were cross-sectional and four were qualitative, the findings simply highlight associations and do not establish causation.

Table 5: Quality Assessment of Qualitative Studies using CASP (*Critical Appraisal Skills Programme*)

	Hutton et al, (2015)	Morison and Cook (2015)	Padilla et al, (2012)	Palamar et al, (2016)
Was there a clear statement of the aims of the research?	Yes	Yes	No	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	Unsure	No	Yes	Unsure
Have ethical issues been taken into consideration?	Yes	Yes	No	No
Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	Yes	Yes
Value of the research?	Yes	Yes	Yes	Yes

Table 6: Quality Assessment of cross-sectional studies using an adapted version of the Newcastle-Ottowa Scale (Modesti *et al.*, 2016)

	SELECTION				COMPARIBILITY	OUTCOME		TOTAL
	Representativeness of the sample?	Sample Size	Non respondents /Response rate	Ascertainment of the exposure	The subjects in different outcome groups are comparable, based on the study design or analysis. Confounding factors are controlled	Assessment of the outcome	Statistical test	Total Score (from a possible 10)
MAXIMUM NUMBER	1	1	1	2	2	2	1	10
Arévalo, M.T.V., et al.(2011)	1	1	0	0	1	1	1	5
Bellis, M.A., et al. (2008)	0	0	0	2	1	1	1	5
Connor, J.L., R.M. Kydd, and N.P. Dickson. (2015)	1	1	1	1	2	1	1	8
Delgado, J.R., et al. (2017)	1	1	1	1	2	1	1	8
Dyer, T.P., et al. (2013)	1	1	0	2	2	1	1	8
Eaton, N.R.,et al. (2015)	1	1	1	2	1	1	1	8
Folch, C., et al. (2010)	1	0	0	1	1	1	1	5
Luo, X.F., et al. (2012)	1	1	1	1	1	1	1	7

Nayak, M.B., R.A. Korcha, and V. Benegal. (2010)	1	1	1	1	2	1	1	8
Nicolai, J., M. Moshagen, and R. Demmel (2012).	1	1	1	1	2	1	1	8
Pandey, A., et al. (2012)	1	1	0	2	2	2	1	9
Rafael RMR, Moura ATMS. (2016)	0	0	0	2	1	1	1	5
Sivram, S et al. (2007)	1	1	1	1	2	1	1	8
Tetrault, J.M., et al. (2010)	1	1	0	1	1	1	1	6
Thompson Jr, R.G., et al. (2014)	1	1	1	2	1	1	1	8
Ullman, S.E. and L.R. Brecklin.(2000)	1	1	1	1	1	1	1	7
Wells, B.E., et al. (2010)	1	1	1	1	1	1	1	7
Wen, X.J., L. Balluz, and M. Town. (2008)	1	1	1	1	1	1	1	7

2.10 Results of the thematic synthesis

As described above, following the data extraction, I analysed the twenty two included studies using a thematic synthesis. The key results from each study related to the age group of interest were extracted and summarised. I then grouped these results by similarities (e.g. alcohol-sexual risk increases with age), and placed under key headings. These are presented below as overarching themes. Where studies were assessed as low quality this is highlighted below.

2.11 Demographic inequalities

Whilst age, in particular adults 25+ years, was a key focus for this review, interest in other demographic characteristics amongst this age group was also one of the three objectives of the review. These demographic characteristics in fact highlighted particularly inequalities experienced by different population groups within the age group of interest for this review. These included gender, sexual orientation and ethnicity/cultural differences. I will discuss each one in turn below.

2.11.1 Gender

In their sample, Arévalo et al (2010), found that a higher proportion of men (9.9%) consumed alcohol at last sexual intercourse compared to women (3.9%); and 45.6% of men had two or more sexual partners in the last 30 days compared to 28.3% of women. This study was assessed as low quality so should be viewed with caution. However, other studies which were assessed as strong also highlighted gender differences which were particularly significant for women. Conner et al, (2015) also found gender differences in the context of pre-sex drinking. Their results found that it was women who reported being more strongly affected by alcohol in sexual situations, though heavy drinking and multiple sex partners was also higher amongst men.

Morison and Cook (2015) found that midlife women, aged 40-69 years, were ambivalent about prioritising safer sex; were more inclined to align their use of condoms with men's preferences and concluded that negotiating safer sex was aligned to gender roles and societal expectations of femininity. This is supported within the existing literature that women's initiation of condom use risks feminine identity, as it could signal sexual desire; with the symbolic meaning of condoms often

associated with promiscuity (Cook, 2012). This was confounded for women if their long-term goal was associated with the chances of a relationship or romance.

Morison and Cook (2015) found that alcohol provided the confidence to become sexually assertive in the bedroom, particularly where self-confidence is low. This was supported by Hutton (2015), where women may seek power through alcohol in order to become equal to men, yet can place themselves at risk when they become impaired by it effects.

Further discussion about gender disparities is included in the other themes below.

2.11.2 Sexual orientation

Three studies had a particularly focus on MSM (Folch *et al.*, 2010; Dyer *et al.*, 2013; Delgado *et al.*, 2017), including those who self-identified as homosexual, transgender, bisexual or heterosexual. Two of these studies (Delgado *et al.*, 2017) (Dyer *et al.*, 2013) were classified as high quality and one (Folch *et al.*, 2010) as low quality indicating that the results of this study should be viewed with caution.

Dyer et al (2013) focused on the difference between black men who have sex with men only (BMSMO) and black men who have sex with men and women (BMSMW). They found that BMSMW were more likely than BMSMO to engage in unprotected anal intercourse while under the influence of alcohol. Interestingly, BMSMW were more likely to be the insertive partner when having sex with other men, a sexual practice that may mitigate some of the infection risk.

Delagado et al, (2017) found that a high proportion of men in their study would engage in sexual intercourse without any prior knowledge of their partners HIV serostatus; though condomless anal intercourse (CAI) occurred more frequently where the partners HIV serostatus was known, infected or uninfected. They concluded that partner specific interactions (primary, casual, commercial sex, anonymous), can shape both the alcohol consumption and the sexual risk behaviour as has already been identified above.

Folch et al (2010) found a high prevalence of alcohol and drug use before or during sex among MSM in Catalonia, though their findings showed that those aged 19-25

years were significantly more likely than those aged over 35 years to use alcohol before sex.

There were no studies included within the review that looked only at women who identified as gay, lesbian or bisexual.

2.11.3 Ethnicity and cultural differences

As the included studies spanned across four continents, cultural norms were an important consideration when making any conclusions about the alcohol-sex relationship. Four studies were undertaken in Asia, three exclusively with men in India and one exclusively with men in China. Of these studies, the three studies undertaken in India were assessed as strong (Sivaram *et al.*, 2008; Nayak *et al.*, 2010; Pandey *et al.*, 2012) and the one undertaken in China was assed as medium quality (Luo *et al.*, 2012).

In India, there has been reported increase in pre-marital sex amongst young men and women; a practice traditionally viewed as morally unacceptable (Sharma, 2001). Pandey et al (2012) found that alcohol consumption increased with age, with men over the age of 25 years more likely to consume alcohol than those under 25 years. However, the STI prevalence was higher amongst those who consumed alcohol, regardless of sociodemographic factors such as age. This was echoed by Nayak et al (2010), who found that those aged 30-49 years were more likely to have HIV risk related behaviours than those aged 16-29 years; though the severity of alcohol misuse showed a linear relationship with HIV risk related behaviours.

Sivram et al (2008) found that among male alcohol users, unprotected sex was more common among those who used alcohol before sex and who did not have a regular source of income, thus adding an additional sociodemographic dimension to explain the relationship.

Luo et al (2012) looked at the prevalence and correlates of alcohol use and subsequent sexual activity amongst adult males in China and found that ethnic minorities were severely affected by alcohol use (and drug use) and HIV. This perhaps highlights that social exclusion is a factor in fuelling such a high prevalence of alcohol use (Sivaram *et al.*, 2008). Sex after alcohol and low rate of condom use,

highlights a structural inequality, which has perhaps received very little public health attention to date.

2.12 Alcohol and Sex – the lifelong cocktail?

Alcohol consumption is now a socially acceptable behaviour across many parts of the world. In fact, in some parts of the world, alcohol and sex are so intertwined that one almost implies the other (Padilla *et al.*, 2012). Consumption of alcohol, either before or during sexual encounters, particularly the most recent sexual intercourse, was a common feature within the studies for this review, particularly amongst those studies assesses as strong and medium for quality (Sivaram *et al.*, 2008; Wells *et al.*, 2010; Luo *et al.*, 2012; Dyer *et al.*, 2013; Thompson Jr *et al.*, 2014; Connor *et al.*, 2015; Eaton *et al.*, 2015; Hutton *et al.*, 2015; Delgado *et al.*, 2017).

Additionally, some studies found that the combination of alcohol intoxication and unsafe sex was in some cases normalised (Morison and Cook, 2015; Palamar *et al.*, 2016), with some individuals making it a lifetime behaviour (Luo *et al.*, 2012). Within this review, those papers assessed as strong or medium quality found that alcohol consumption was prominent in sexual relationships with new or casual partners (Sivaram *et al.*, 2008; Luo *et al.*, 2012; Morison and Cook, 2015; Delgado *et al.*, 2017); commercial sex workers (Sivaram *et al.*, 2008; Luo *et al.*, 2012; Padilla *et al.*, 2012; Delgado *et al.*, 2017); and anonymous partners (Delgado *et al.*, 2017).

For those studies that compared the different behaviours by age, the following papers assessed as strong or medium reported that the relationship between alcohol and sex decreased with age (Sivaram *et al.*, 2008; Tetrault *et al.*, 2010; Wells *et al.*, 2010; Luo *et al.*, 2012; Wen *et al.*, 2012). Whereas other studies found there was no significant differences between age groups in alcohol use prior to sex or facilitating a sexual encounter (Bellis *et al.*, 2008; Delgado *et al.*, 2017), or indeed of having an STI (Tetrault *et al.*, 2010; Pandey *et al.*, 2012). However, the study by Bellis et al (2008), was assessed as low quality so needs to be considered with caution.

For three of the studies (all quality assessed as strong), being older was one of the demographic correlates for engaging in alcohol consumption before sex (Nayak *et al.*, 2010; Thompson Jr *et al.*, 2014; Eaton *et al.*, 2015). Thomson et al (2014) found that those aged over 50 years were more likely to drink prior to sex than those aged

18-49 years. This echoed findings from Eaton et al (2015), where the odds of being a regular pre-sex drinker were significantly higher for those aged 50+ years than those under 40 years. Nayak et al (2010) also found that those aged 30-39 years were more likely to report HIV-risk related behaviours than those aged 16-29 years.

2.13 Expectancies and the excuses

As described in Chapter One, one of psychological theories proposed within the literature for the alcohol-sex relationship is alcohol expectancies. Alcohol expectancies or more specifically, sex related alcohol expectancies (SRAEs) are when an individual's behaviour after drinking is influenced by pre-existing beliefs about the physiological, emotional and behavioural effects of alcohol consumption on sexual behaviour (Hutton *et al.*, 2015; Scott-Sheldon *et al.*, 2016). Two of the studies assessed as strong in this review specificially discussed alcohol expectancies.

Nicolai et al (2012) undertook a national probability sample survey amongst 18-59 year olds in Germany in order to assess patterns across age and gender. They found a linear trend toward the weaker endorsement of positive and negative alcohol expectancies with increasing age in both males and females. The positive association between expectancies related to sexual enhancement and alcohol use only held for younger respondents. However, Hutton et al (2015) in their qualitative study of sex-related alcohol expectancies amongst African American women attending an STI clinic found that every participant believed that alcohol increased their sex drive and therefore increased the likelihood of engaging in and deriving pleasure from sex, including riskier sexual activities.

Bellis et al (2008) found that 12.4% of the 26-35 year olds in their study reported using alcohol to help to have unusual or exciting sexual activity, although this study was quality assessed as low it was supported in other studies. Unusual or exciting behaviour was labelled as being 'adventurous' or 'kinky' (Palamar *et al.*, 2016). Alcohol enabled individuals to partake in sexual positions such as anal sex, which would otherwise be uncomfortable or painful, and unlikely to happen sober (Hutton *et al.*, 2015).

Palamar et al (2016) also found that sex with alcohol was casual, and less emotional. For some participants it helped to prolong sex; others reported that they enjoyed

aggressive, primal and intense sex with alcohol. Whereas for others it also could have a negative impact on maintaining an erection and impacted on achieving orgasm for both men and women.

It is well documented in the literature that alcohol is an effective formula for loosening inhibitions (Stoner *et al.*, 2007). Within this review, studies assessed as strong or medium found that alcohol was used as a social lubricant (Palamar *et al.*, 2016) to help with re-entry into the dating scene with new partners (Morison and Cook, 2015), and provided a sense of power to be 'bold' or 'invincible' (Hutton *et al.*, 2015). Conner et al, (2015) found that women were twice as likely compared to men to have used alcohol to make it easier to have sex with a new partner. However, in other studies this was not confined to females. Palamar et al (2016) found that both men and women felt more attractive and sociable after using alcohol. For men, alcohol provided the liquid courage to make them feel more attractive, numbing insecurities and be up for 'doing anything'. Sivaram et al (2008) also found that males required alcohol to provide courage as they planned for sex, and was a key part of foreplay, particularly with sex workers.

Sex workers were also a particular feature of the study by Padilla et al (2012) linked to sex or romance tourism (discussed in more detail in Chapter Five). Given the rise in affordable foreign travel over the past few decades, male and female tourists can also have sex expectations from this period of abandonment or escapism, being able to travel to new environments with different normative systems and controls. In their study, in the holiday resort of Sousa in the Dominican Republic, staff (mainly women) were employed as bartenders and waitresses but often served double roles as sex workers. Thus, the alcohol venue functioned as an informal brothel, a place to purchase drinks but also offered the joint commodities of eroticism and sex.

Regret, shame and embarrassment were common negative emotions following alcohol related sex amongst both men and women (Palamar *et al.*, 2016). It is well documented that alcohol serves as a useful scapegoat to the other causes of post drinking sexual activity (George and Stoner, 2000). Within this review amongst those studies quality assessed as strong or medium, alcohol was blamed for loss of control or impaired memory loss, particularly the next morning. Regretted sexual experiences included poor partner choice, as it altered the perception of the partner

attractiveness; unprotected sex (Hutton *et al.*, 2015; Palamar *et al.*, 2016), particularly amongst heavy drinking women (Connor *et al.*, 2015); or to provide cover for engaging in sex that was considered taboo (Hutton *et al.*, 2015). Blaming alcohol was a useful way to dissociate from the behaviour, particularly for women, as it also helped to protect reputational damage. This notion of blame and sexual double standard will be discussed further in Chapters Seven and Eight.

2.14 Unwanted consequences

As well as the negative emotions, there are often a number of unwanted consequences resulting from alcohol related sex. Within this review, amongst studies quality assessed as strong or medium, these consequences were similar to those already identified within the literature amongst young people. These included unprotected sex (sex without a condom), (Connor *et al.*, 2015), including insertive and receptive anal intercourse (Delgado *et al.*, 2017); acquiring STIs (Pandey *et al.*, 2012; Connor *et al.*, 2015); unwanted pregnancies (Connor *et al.*, 2015); regretted sexual experiences (Connor *et al.*, 2015; Hutton *et al.*, 2015; Palamar *et al.*, 2016) and sexual violence (Ullman and Brecklin, 2000).

The study by Connor et al (2015) was one of the five studies, which just focused on the specific age group of interest for this review. Their research with men and women aged 26-38 years, found that heavy drinking patterns were associated with having more sexual partners; regretted sex (mainly linked to poor partner choice); contracting STIs and pregnancy terminations. However, failure to use contraception was more commonly reported by heavy drinking men.

Heavy drinking, or even alcohol misuse, was an important factor in four studies assessed as strong or medium quality. It was found that those with an alcohol use disorder were significantly more likely to drink alcohol prior to sex (Thompson Jr *et al.*, 2014); have a diagnosis of an STI (Tetrault *et al.*, 2010); or where their drinking patterns increased their HIV-risk behaviour (Nayak *et al.*, 2010; Wen *et al.*, 2012). This echoed findings of the alcohol audit discussed in Chapter One, where patients categorised as probable alcohol dependent were 1.7 times more likely than low risk drinkers to be diagnosed with an STI.

As is the case with young people, there is also a perception amongst older age groups that condoms reduce sexual pleasure, and interrupts the activity particularly with new sexual partners. In their study, Morison and Cook (2015) found that the condom characteristics – smell, taste and feel, prevented women from using them. Additionally, participants assumed that they could judge the risk of the individual by how they looked or by their personality type and therefore a condom was not necessary.

This echoes existing literature on familiarity and attractiveness, referred to as social projection bias, where individuals expect similarities between ourselves and similar others. Thus, if an individual believes they are low risk, then someone perceived as similar would also be low risk (absent of STIs), therefore a condom is not warranted (Zawacki *et al.*, 2009). This will be discussed in more detail in Chapter Seven. Palamar et al (2016) concluded that alcohol impaired judgement and impacted on the 'hasty decisions' particularly with regard to condom use in order to fulfil immediate desires.

Two of the studies within this review focused specifically on the impact of alcohol on sexual violence (Ullman and Brecklin, 2000; Rafael and de Moura, 2016) and one other highlighted the issue of non-consensual sex, particularly anal sex when under the influence of alcohol (Hutton *et al.*, 2015). The aforementioned studies both had a focus on those aged 25+ years. One assessed the relationship between alcohol and all violence between intimate partners (Rafael and de Moura, 2016) whereas the other just focused on sexual assault (Ullman and Brecklin, 2000).

Rafeal et al (2016) found statistically significant associations between the use of alcohol by women and the co-occurrence of intimate violence including sexual violence, however this study was assessed as low quality so should be viewed with caution. Ullman and Brecklin (2000) reported that alcohol use is commonly present in sexual assault incidents. They found that offender pre-assault drinking was associated with more stranger assaults, more victim injury and greater offender aggression. Victim pre-assault drinking was also related to more stranger assaults, victim heavy episodic drinking and more offender pre-assault drinking. They concluded that a victim's drinking might be more strongly related to risk of rape completion rather than aggression or physical force, as offenders would be able to

complete rape without the need for additional physical force. Additionally, offender aggression was related to more victim injury in cases without offender pre-assault drinking. So the use of violence and pre-assault drinking by offenders are separate strategies for committing sexual assault; thus are independent tactics used by perpetrators.

2.15 Summary

Adults engage in sex throughout adulthood and into later life (Mercer *et al.*, 2013). This current review has highlighted that the alcohol-sex relationship does not stop at adolescence, but can continue throughout life. Although there were mixed results in this review as to whether the relationship increases or decreases with age; the use of alcohol prior to intercourse was still a feature amongst those aged 25+ years.

This review found that alcohol can be used to facilitate sex, reduce inhibitions, increase confidence, intensify pleasure or be used as an excuse to engage in sexual behaviours that individuals may not engage in when they were sober. Venues serving alcohol provide the perfect opportunity for the alcohol-sex mix. From the wine shops of India (Sivaram *et al.*, 2008) to the tourist bars of the Dominican Republic, sex can be a part of the alcohol consumption experience, and can indeed be consumed together (Padilla *et al.*, 2012).

However, as already reported in studies amongst young people or adolescents (Abbey *et al.*, 2005; Coleman and Cater, 2005; Cook and Clark, 2005) this review highlighted that those aged 25+ years can suffer similar outcomes experienced by the younger age groups. Alcohol can impair judgement and lead to unwanted consequences such as unplanned pregnancy, STIs and sexual violence. The aftermath can lead to feelings of regret (particularly with regard partner choice), shame and embarrassment. One positive finding however, was that in the study by Bellis et al (2008) those over 26 years reported that they were more likely to seek an STI test than younger persons. However, for many who may have never have used such a facility, it could simply add a further veil of shame.

Whilst not all pre-sex drinking is problematic, particularly in monogamous sexual relationships (Eaton *et al.*, 2015), this review has found that alcohol was primarily used with non–primary sexual partners including casual partners, anonymous

partners and sex workers. Therefore protection in a perceived monogamous relationship can still be problematic. As will be discussed in more detail in Chapter Five, relationships have been re-defined and the goal of maintaining one monogamous partner for life has shifted. As a result, pre-marital sex, extra marital sex or re-entering relationships following a long period of monogamy can lead some individuals to be naive about sexual risks. As concluded by Delgado et al (2017) these partner-level interactions are key in assessing risk.

This review has also highlighted the need to look at a number of demographic characteristics linked with this age group rather than just looking at age in isolation. It has highlighted specific issues linked to gender roles, sexual orientation and ethnicity/cultural differences. Tackling the alcohol sex relationship in older age groups therefore requires stratification for specific groups, particularly for women, MSM and ethnic minorities.

Finally, the included studies used a variety of definitions in their measures of alcohol use and sexual risk, and how this impacts on sexual decisions. Alcohol use was predominantly measured in terms of frequency or quantity (or both). The definition of sexual risk included alcohol prior to sexual intercourse, number of sexual partners, sex without a condom and sex with commercial sex workers. All studies had an element of self-reported behaviour which would be subject to recall bias, or indeed individuals may have chosen to deliberately conceal behaviour for fear of judgement or shame. Only one study assessed sexual behaviour when sober (Wells *et al.*, 2010) and therefore it is difficult to draw firm conclusions about alcohol related sexual behaviour when sober sexual practices was not captured. Additionally, only one study (Palamar *et al.*, 2016) considered the issue of alcohol on sexual functioning, particularly maintaining an erection, something which may be more important to individuals than definitions of sexual risk applied within the majority of studies.

2.16 Strengths and limitations of the review

I begin by outlining the strengths of the review before highlighting any potential limitations.

The key strength of this review has been the comprehensive search undertaken to seek studies from across four continents, available in all languages and include both

published and unpublished studies. Although only five papers reported specifically on the age group of interest, extracting data from a further seventeen papers, helped to add to the richness of the findings. Additionally, as far as I am aware, this is the first systematic review to look specifically at the alcohol-sex relationship in an older age group (25+ years), regardless of gender or sexual orientation.

One of the strengths has also been the pooling of data from both quantitative and qualitative studies. By following the steps outlined in the PRISMA statement as a guideline (Moher *et al.*, 2009), I have been careful in my judgement at each stage of the review process. This was supported by having a second reviewer, to ensure that decisions and interpretations were undertaken independently. I have also taken steps to ensure that the extracted data was consistent across all study types using a data matrix (Pawson, 2002), rather than simply capturing a summary or abstract of each study. Additionally, I have appraised the quality of each study using relevant checklists, again undertaken independently by the two reviewers. Of the 22 studies included within the review, only four studies were assessed as low quality (Bellis *et al.*, 2008; Folch *et al.*, 2010; Arévalo *et al.*, 2011; Rafael and de Moura, 2016), so we can be relatively confident in the findings of the remaining eighteen.

However, some may argue that the approach to synthesising the data will have still been subject to potential biases. In particular, it has been proposed that qualitative research is not generalizable and specific to a particular context, therefore it has been important not to de-contextualise the findings (Campbell *et al.*, 2003). I have therefore been transparent about the methods I adopted (Mays *et al.*, 2005), and thus it has the potential for it to be replicated in the future.

However, given the limited number of studies that just focused on the age range of interest, and the need to extract the data from the seventeen studies which was only relevant to the research question, I acknowledge that this may have resulted in limitations. The data extraction in narrative reviews is always something of a compromise (Pawson, 2002) and there are well documented limitations of thematic analysis (Dixon-Woods *et al.*, 2005). However, I hope the findings are sensitive to the studies included and has some utility to practitioners and researchers.

2.17 Conclusion

Sexual activity accompanied by alcohol is not exclusive to young people. Individuals may continue to experiment with alcohol and sex throughout their life or at key transition points during the life course. There may be some benefits of the alcohol-sex relationship for older adults including enhanced pleasure and increased confidence. However, similar to that experienced by young people, it can impair sexual decision making and may simply result in unwanted outcomes. Additionally, caution should be heeded when considering age as a demographic characteristic in the alcohol-sex relationship, and should not be viewed in isolation from other characteristics including partner level interactions.

2.18 Implications for policy and practice

First, interventions aimed at promoting safer sex, need to include all age groups and where possible stratify by gender, sexuality and ethnicity. Public health has prioritised the sexual health needs of young people, which should reap rewards in the future, but leaves a gap amongst the current adult population who perhaps still view condoms as a contraception measure rather than an aid to prevent STIs. Additionally, practitioners need to explore how partnership characteristics might influence drinking before sex. This is particularly significant amongst those who are single or unmarried (Thompson Jr *et al.*, 2014; Eaton *et al.*, 2015); those who engage in casual sex (Sivaram *et al.*, 2008; Delgado *et al.*, 2017); and those who pay for sex (Sivaram *et al.*, 2008; Delgado *et al.*, 2017).

Second, education on negotiation of condom use needs to extend beyond the classroom and into primary healthcare settings. Morison and Cook (2015) found that GPs were not initiating discussions with mid-life patients on sexual health. This could be a double edged sword as patients are often embarrassed to raise concerns, particularly if the practitioner is young, but equally health professionals often do not want to discuss sexual health for fear of causing offence (Gott, 2001).

Third, some argue (Bellis *et al.*, 2008; Pandey *et al.*, 2012; Thompson Jr *et al.*, 2014) that there need to be strategies to integrate alcohol risk reduction into STI/HIV programmes and vice versa, particularly amongst groups such as high-risk women (Hutton *et al.*, 2015). This may be possible amongst primary care staff who undertake screening and brief interventions; so it follows that screening and interventions for

STIs and alcohol use could easily be linked (Tetrault *et al.*, 2010). Thus tackling them in the way that individuals experience them – part of the same process (Bellis *et al.*, 2008).

Finally, alcohol related sexual violence and non-consented sexual activities emerged during this review. Drinking by both victims and offenders is a risky behaviour that requires prevention efforts, particularly when the parties do not know each other well, given the severity of stranger assaults (Ullman and Brecklin, 2000).

2.19 Implications for research

First, as outlined at the beginning of this review, there are a wealth of studies assessing the relationship between alcohol and sexual behaviour amongst young people, particularly students. However, the results of this review have demonstrated that there needs to be a greater focus on the alcohol-sex relationship into adulthood given the similarity of outcomes experienced in later life.

Second, of the twenty-two studies included, only five focused solely on an 'older' age group. In future, any quantitative studies that do cover a wide age span should at least report the differences by age bands rather than simply providing a mean. Additionally, of those five dedicated studies on the 'older' age group, one included men only, more specifically MSM (Dyer *et al.*, 2013); and four included women only (Ullman and Brecklin, 2000; Connor *et al.*, 2015; Morison and Cook, 2015; Rafael and de Moura, 2016).

In terms of outcomes, two of the five studies focused on sexual violence (Ullman and Brecklin, 2000; Rafael and de Moura, 2016). Therefore, it is important that future research considers the alcohol-sex relationship amongst both sexes, addresses all sexual health outcomes and seeks to understand any specific differences by a range of demographic characteristics including age and sexual orientation.

Third, there were only four qualitative studies within this review. Two focused solely on the views of women (Hutton *et al.*, 2015; Morison and Cook, 2015). The other two did include men and women, but one focused solely on tourism workers (Padilla *et al.*, 2012). The final study compared the sexual experiences of people using both alcohol and marijuana, rather than just those who used alcohol (Palamar *et al.*,

2016). Therefore, qualitative research in this field amongst this age group remains limited.

Fourth, of all the twenty-two studies, only one recruited participants from within a sexual health setting (Hutton *et al.*, 2015). This study was carried out in New Zealand and, although qualitative by design and assessed as high quality, as indicated above only included women.

Finally, none of the studies included within this review were exclusively undertaken in the UK. One study, (Bellis *et al.*, 2008) included a UK city as one of its nine sites and this was assessed as low quality. However, as outlined in Chapter One, given the increasing levels of alcohol consumption and STIs in the UK, any association in the UK warrants further exploration.

Some of these research gaps have helped to inform this PhD, which will focus solely on the alcohol-sex relationship in an older age demographic; will include both sexes regardless of age and sexual orientation; be undertaken within a sexual health service and will add to the very limited literature within the UK.

2.20 Chapter summary

The chapter has presented the findings from the systematic review, which explored the relationship between alcohol and sexual risk, and its impact on sexual decision making amongst adults aged 25+ years. From the twenty-two studies included in the final analysis, four themes emerged.

The first theme identified that age needs to be considered alongside other demographic characteristics, particularly in terms of addressing inequalities. The second theme linked the interplay of alcohol and sex throughout life, albeit not always at the same level as experienced by young people and highlighted the importance of the partner level interaction. The third theme highlighted the expectancies and excuses used to provide the moral framework for undertaking such risks. The final theme of unwanted consequences was very similar to that experienced and evidenced in the literature by those under 25 years. Therefore, sexual activity accompanied by alcohol is not exclusive to young people. Individuals

may continue to experiment with alcohol and sex throughout their life or at key transition points during the life course.

These findings will be combined with the qualitative results of this study and discussed further in the final chapter (Chapter Eight). The next chapter will outline the research methods used for the qualitative phase of this thesis.

Chapter 3. Research Methods

This chapter outlines the research methods used for the qualitative element of the study. I outline the aims and objectives of the qualitative study followed by the ethical and practical framework for the fieldwork. I then explain the data collection methods adopted and the approach taken to data analysis. I finally discuss the validity and reliability of the study.

I also spend some time in this chapter describing the outcome of the preparatory work undertaken during the pilot phase. I cannot underestimate how important this was for my own thinking in the design of the study and in my development as a researcher. I believe it was this preparatory time that led to the success of the recruitment; secured my ability as a researcher to be embedded within the service; and ensured that I considered the issues of rigour throughout the study rather than post-hoc.

As with the systematic review a qualitative research protocol was developed, which was used as a reference document throughout the study.

3.1 Aim and objectives

3.1.1 Aim

The aim of the qualitative study is to explore how the relationship between alcohol and sex is discussed and accounted for by patients (aged 25+ years) and healthcare practitioners in a sexual health service in the North East of England.

3.1.2 Research questions

- How is alcohol identified and discussed in the clinical consultation of patients (aged 25+ years) attending the clinic?
- To undertake formal interviews with patients aged 25+ years to understand if, how and why they have used alcohol in sexual situations, as well as explore their beliefs about the alcohol-sex mix.
- How does alcohol impact on the work of healthcare practitioners at the sexual health clinic and what are their beliefs about the alcohol-sex mix?
- What are the contextual practices, informal beliefs, culture and identify within this setting?

3.2 Ethical and practical framework

NHS patients and staff were recruited to this study and therefore approval was sought and approved from the National Research and Ethics (NRES) Committee North East - Newcastle and North Tyneside 2 - 13/NE/0352, IRAS project ID: 137734.

As stated above, I could have left this section to a brief summary however I learnt some key lessons through the process which l believe are worth sharing. As mentioned in Chapter One, the GUM clinic is an anonymous service dealing with a sensitive subject matter. I initially concentrated a lot of effort on the ethical considerations for patients to consent, and how I would approach the topic within the interviews. This was perhaps at the expense of considering some of the very practical considerations of undertaking research within this setting. I have outlined some of these below.

Following the initial submission of the relevant paperwork through IRAS in November 2013, the committee requested some clarifications and minor amendments to the study design. My original proposal was to observe patients under 25 years as well as those aged over 25 years. This was to observe any variations in practice for different age groups and individuals at different life stages e.g. students, divorcees. I had always planned to only interview patients aged 25+ years. Following discussion, it was agreed that observation of patients under 25 years should be removed from the study so that only those aged 25+ years would be observed. In hindsight, I believe my original proposal was too ambitious. As I was a sole researcher undertaking both the interviews and the observations, I had not fully considered how I would deal with the clinics and interviews running in parallel. Therefore, there was a risk of potentially missing the consultations with those patients aged 25+ years, which was the focus of the study, yet formed the smallest proportion of patients accessing the clinic. Amendments were made to the protocol and final approval was received in March 2014.

Similarly, the relevant paperwork was also submitted to the research and governance committee at the NHS Trust where the research was carried out. The final approval and letter of access was received in May 2014 (Study Ref: MED 288 2013).

3.2.1 Pilot process

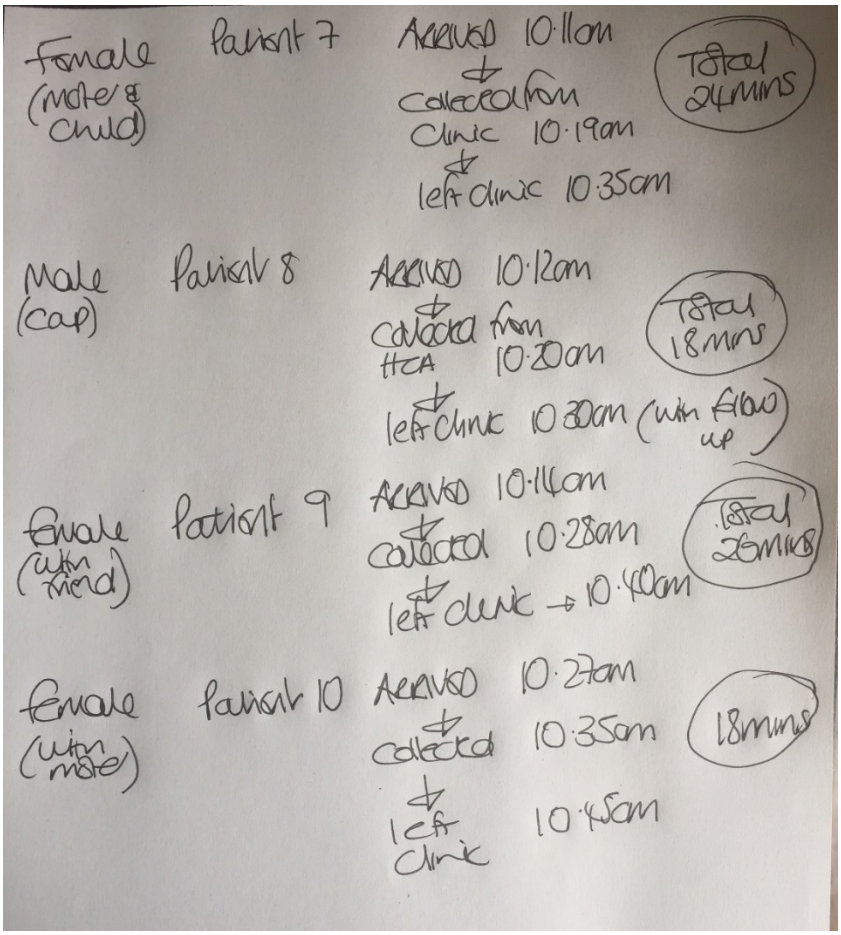
Following the ethical and governance approvals, a pilot process was undertaken during July 2014. This was part of the planning process as I was keen to gain feedback from participants on the draft Participant Information Leaflets (PIL) and consent forms, as well as to refine the patient pathway in order to optimise participation.

As a result of the pilot, two minor and three major amendments were submitted to IRAS. The minor amendments included altering the PIL to include the revised Trust details as the Patient Advice and Liaison Service (PALS) had been disbanded. I also amended the length of time on the PIL for the patient interviews (See Appendix 1 and Appendix 2 for the patient and practitioner PILs).

As part of the pilot, I timed the patient journey from entering to leaving the clinic (See Figure 3). As the average length of time of a patient's journey in the clinic was only 20 minutes, it was unreasonable and unlikely that patients would give up a significant amount of additional time for the interviews. Fortunately, the interviews undertaken during the pilot averaged only 10.04 minutes so by altering the length of time on the draft PIL from 30 minutes to 'approximately 10 -15 minutes' it was hoped this would reduce any barriers for patient participation.

The approval for the minor amendments was received on 29th August 2014.

Figure 3: Extract from field notes on times of patient journeys



With regard to the major amendments, firstly, feedback from the practitioners was that they, as staff participants, would like to have the option to consent to participate in the research on the same day of the team briefings rather than waiting 24 hours which is seen as best practice. This was for logistical reasons given that many of the staff work part-time and operate across the three sites (See Appendix 3 and Appendix 4 for the patient and practitioner consent forms).

Secondly, I had not considered the need for additional inclusion and exclusion criteria for patients who are not sexually active. While the service is a sexual health service, I had not considered those patients who are not sexually active but have symptoms that require the expertise of a sexual health physician e.g. genital dermatology. Therefore it was appropriate to exclude patients who are not sexually active given the research was specifically interested in sexual decision making.

Finally, the third major amendment related to a change in the study design. During the pilot phase, I had numerous conversations with the team members including the

receptionists. Originally, in discussion with the Consultants and clinic manager it had been agreed that the reception staff could hand the leaflet to those patients eligible to participate in the study when they arrived in the clinic. The receptionist would seek their interest in participation in the research. If there was a positive response, then I would obtain consent at this point. However, during the pilot phase it was suggested by the receptionists that it was best for the Healthcare Assistant (HCA) rather than the receptionist to ask the patient if they would like to participate in the research, once they had escorted them from the waiting room into the clinic room. The main reasons were:

- The patient was too overwhelmed when first entering the service to consent at reception, particularly new patients.
- It provided additional time whilst in the waiting room for the patient to fully read the PIL and comprehend the research.
- Once the HCA escorted the patient into the clinic room, it provided a more confidential space to discuss the research.
- There was a natural pause within the patient journey between the HCA interaction with the patient and a member of the clinical team attending for the consent to be obtained. Therefore, once the HCA had completed their duties and requested whether the patient would like to participate in the research, they informed me once they left the room. It was at this stage that I would enter to obtain consent prior to the clinician arriving.

Support for the major amendments was approved on 11th September 2014.

Additionally some other practical tools to support the team included the development of a script for the reception staff when handing out the PIL to patients, and at the start of each clinic identifying the date of birth of those patients eligible (aged 25+ years) so that the staff could easily identify participants from patient records. As a result of this approach, the reception staff would then attach the leaflet onto the front of the medical notes for those patients attending a booked clinic as a prompt to mention the research.

3.3 Methods

An ethnographic approach was used. Ethnography usually involves features of studying people (and their accounts) in everyday contexts; gathering data from a range of sources; focusing on a few cases or a single setting to facilitate in-depth study and analysing data by providing descriptions, interpreting meanings and generating theories (Hammersley and Atkinson, 2007).

Ethnography in healthcare research is often overlooked and undervalued yet can provide valuable insights into beliefs and practices (Savage, 2000) and can reach aspects of complex behaviours and attitudes that quantitative methods cannot (Pope and Mays, 1995). As described by Long et al (2008) hospitals are also places of discovery, creating moments of truth and rites of passage, which is a staple site of inquiry for ethnography (Long *et al.*, 2008). The sexual health clinic was certainly a place of revelation, a confessional box to share secrets, a crossroads for some relationships and a place to uncover some complex behaviours and beliefs regarding sex and alcohol.

Additionally, undertaking qualitative research within sexual health services can complement some of the quantitative studies of STIs, by providing insights into complex social behavioural research with difficult to access populations (Power, 2002). However, I was aware that I would be intruding into the most private experiences of patients' lives. I therefore utilised some of the general strategies for tackling sensitive issues (Elam and Fenton, 2003). The setting itself was by its very nature a place where the patient had already made the step to talk about this sensitive topic in a confidential space. It is defined as a place where they were less likely to be judged given they do not even have to disclose their identity.

Identifying the most appropriate space within the clinic for qualitative interviews with patients was also key. The health advisors room, normally used for counselling conversations, was chosen. These rooms had a more relaxed environment with low seating rather than a sterile clinical room. Additionally, as the interviews took place at the end of the patient journey, the patient was often more relieved once the clinical assessment, diagnosis and treatment was completed.

My approach as a participant observer required me to establish and maintain a relationship with the practitioners (social actors); undertaking the study within the clinic as the ‘natural environment’ with a clear purpose of observing and describing the social actions; interacting with both the practitioners and patients. I participated in every day ceremonies and rituals (including the tea making) and learning their language (e.g. not using the name of the patient, as it was an anonymous service, but describing a patient as the disease to be treated) in order to understand the meaning of their actions (Gobo, 2011).

As qualitative research uses a naturalistic approach that seeks to understand phenomena in context specific settings, I decided to focus on three qualitative research methods which are dominant within the naturalist paradigm (Golafshani, 2003). Observations in the clinical consultation as part of the initial assessment of the patients; semi-structured interviews with patients and practitioners; and general observations within the service. By combining these approaches, I wanted to collect data from multiple perspectives and triangulate where possible, particularly comparing and contrasting between and within practitioners’ and patients’ accounts. I will outline the approach to each method below.

3.3.1 Observations of the clinical consultation

I decided to observe the clinical consultation between the clinician and patient to witness the talk within this space. As described above, as one of the key features of ethnographic work is to study the everyday contexts rather than conditions created by the researcher, it was important for me to collect data within this context specific natural setting (Hammersley and Atkinson, 2007)

For the patient, I was particularly interested to hear how they articulated the purpose of their visit and the language or meaning they used in their narrative. Following discussion with the clinicians, it was felt that any recording equipment within the consultation would be obtrusive so I just noted key words (descriptive and reflective thoughts) in my field diary, which I later expanded upon and married to the individual interview transcripts.

For the clinician, I was particularly interested in how they (or if they) discussed alcohol and/or any other risks with the patient and how they delivered any advice. This patient/clinician relationship is key to the success of healthcare so it was useful to get a better understanding of this dynamic (Goodson and Vassar, 2011) reaping benefit not just to clinical practice but also policy makers. I left the consultation prior to any physical examination taking place.

3.3.2 Audio-recorded interviews with patients and practitioners

I decided to undertake one to one semi-structured interviews with patients to explore in more depth an understanding of both their sexual activity and alcohol behaviours. Semi-structured interviews are especially suited to explore attitudes and behaviours associated with sexual health (Dixon-Woods *et al.*, 2001). The interviews allowed me to understand the phenomenon in the context as it emerged, as well as insights into the cultural frames people used to make sense of those experiences (Miller and Glasner, 2011). Given the nature of the topic, the individual personal histories and the need to capture this information in a timely (and time constrained) way, semi-structured interviews were deemed a preferred method.

Equally, for the practitioners, I was keen to explore in some depth their personal and professional views on the topic. The semi-structured interviews built on some of the more informal interactions within the clinic. It also allowed me to obtain views from a sample of the clinical team as opposed to just the consultants (the gatekeepers) who may have been more dominant within focus groups.

The interviews utilised skills from my professional coaching training, applying active listening skills; probing the interviewee (Silverman, 2011) and repeating the narrative back to the participant as a way of validating the meaning and testing hypothesis.

3.3.3 General notes of observations

As well as drafting the clinical assessments observation notes within the field note diary, I also used it to draft descriptive notes of the interactions between the practitioners and between practitioners and patients. These were key points (often just a few words/phrases) of the informal talk, as well as jotting down issues arising

on that day. Following each clinic, I made notes in my diary, expanding on the key words and adding in my own analytical thoughts, feelings and reflections.

This ethnographic method meant becoming immersed for short periods in the clinic, in order to establish a direct relationship with the practitioners. This included working across two different sites, observing twenty-three different clinics and undertaking approximately 131 hours of ethnographic work. Whilst I could have spent one block period to undertake the fieldwork, the value of returning at different points throughout the year was a useful way for me to concurrently collect data, analyse, reflect and revisit emerging concepts each time I visited.

There were however a number of challenges that needed overcoming. Firstly, the staff numbers on duty for any given clinic were actually quite small (e.g. one doctor, two nurses, two healthcare assistants and one receptionist). As most staff members were part-time, this meant a different team on any clinic day. I therefore needed to renegotiate access on a recurrent basis (Hammersley and Atkinson, 2007); identifying the facilitators (and gatekeepers) at each clinic, re-establishing relationships and reinforcing the process at the start of each clinic.

Secondly, as the clinic spaces themselves were very small and I was simply observing the interaction, I was keen not to be in the eye line of either the practitioner or patient. In some of the smaller clinic rooms, I perched on a windowsill or stood in corners of the room; in the larger rooms, I sat on a stool. At times, either the practitioners (who were used to having students observe) or the patient, tried to engage me in the discussions. I was conscious of the impact of my role on the participants so tried not to engage in such discussions.

3.4 Sample and strategy

The study was undertaken within a GUM service in a NHS Foundation Trust in the North East of England. The GUM service operates across three sites; however, the study was only undertaken across two sites, which were within the geographical area. This was a pragmatic decision due to staff shortages at the third site, the time constraints to complete the study as well as the need to develop the rapport with individuals and teams.

The description of the clinics is contained within Chapter Four, however in summary the two sites serve different populations (one a large university city and the other a market town serving a large rural population) so I felt this provided good variation in the sample of clients who would access the service.

Open-access (named *Q and wait*) and booked appointment clinics were observed at both sites. At site one, 2/8 clinics were open access and at site two, only 1/6 clinics was open access. Open access clinics operate on a ‘first come first served’ basis, normally for individuals who believe they require immediate assessment. As a generalisation, staff members informed me that these open access clinics were often utilised by a younger client group (under 25s) though I was keen to observe open access and booked clinics at both sites. The inclusion and exclusion criteria are listed below.

3.4.1 Inclusion criteria

- Patients aged 25+ years attending the GUM clinics within the identified geographic area of study.
- Practitioners working within the GUM clinics within the identified geographic area of study.
- Patients who are sexually active.
- Willingness to participate in the study.

3.4.2 Exclusion criteria

- Patients and practitioners not in the geographic area/clinic of study.
- Patients aged under 25 years.
- Patients who are not sexually active.
- Patients assessed by practitioners as not suitable e.g. not having mental capacity, clients who were receiving clinical examination following acute rape.

3.5 Recruitment and consent

3.5.1 Practitioners

All members of the clinical team (twenty five in total) within the sexual health service were invited to participate in the study. I initially held meetings in May 2014 with the senior team to discuss the project. Liaising with the clinic managers, I then arranged to meet with the wider group of staff over lunch breaks to introduce the research. Written consent from practitioners participating in the pilot phase was obtained following the ethical approval. For the majority of practitioners, consent was obtained after the pilot phase following the major amendments from ethics. The consent from the clinical team had therefore been received in advance of the clinics where patient consent was obtained.

Whilst overt access to the clinic and the practitioners was relatively easy due to my existing relationships (discussed below) with the Consultant team who were the gatekeepers to the study (Silverman, 2011), not all parts of the clinic were equally open to observation and not everyone was willing to participate (Hammersley and Atkinson, 2007)

One staff member did not initially consent. They worked across both sites and I agreed to work with the clinic managers to ensure only those clinics where the practitioners consented were observed. Interestingly, a few months into the study the practitioner contacted me and asked if I still required more patients for the study. As a result, the practitioner then consented to participate and identified two patients who consented for interview only. Whilst the practitioner consented to participate, I did not observe any of their clinical assessments. Although I stressed that the observations in the consultation were not about assessing practice, I was not sure if the practitioner, who was a more junior member of the team, felt comfortable with this approach.

Some practitioners who agreed to participate in the study were also invited to be interviewed. Purposive sampling was used to identify members of the team to be interviewed. Purposive sampling requires the researcher to think critically about the population interested in and chose the sample carefully on that basis (Silverman, 2011). I was interested in hearing perspectives from the different professional groups

working across the two sites so the interviews were held with a mix of consultants, nurses and HCAs (See Table 7).

Table 7: Sample of practitioners interviewed

Clinic 1	**Clinic 2**
Consultant 1 Consultant 2	Consultant 1
Nurse 1 Nurse 2	Nurse 3 Nurse 4
Healthcare Assistant 1	Healthcare Assistant 2 Healthcare Assistant 3

The average length of time the practitioners had been working at the clinic was 11 years, ranging from 2-23 years, so I was confident that they would be able to reflect on any significant changes they had witnessed within the clinic. They were approached directly by me via email to request an interview. It was entirely voluntary, there was no pressure exerted from their employer (who had no vested interest in the research) or myself. Following discussions with the clinical team, it was agreed to undertake the interviews after or before the clinic, or at a convenient time for the practitioner in order not to have any impact on service delivery. All of those approached agreed to be interviewed.

A topic guide for the interviews with the practitioners (Appendix 5) was developed. In summary, it covered the changes in the clinic over time, their beliefs about sexual decision making and the inter-relationship between alcohol and sexual risk.

3.5.2 Patients

Both ‘open-access’ (*Q and wait*) and ‘booked appointment’ clinics were observed. Given both the nature of clinical work and observational methods, I did not know in

advance which consultations with patients would be observed. I spent time during the preparatory phase developing the patient pathway with input from the consultant team, and revised it during the pilot phase (See Figure 4 and description below of the pathway). This was important for me to understand the operational flow of the clinic and helped me to reflect on the study design and my role as a researcher within this setting. Given the anonymous nature of the service, it was not possible to contact the patient in advance of the clinic to seek consent or to follow up after the observation and/or interview.

A topic guide for the interviews with patients (see Appendix 6), was developed. In summary, it covered the reason for their attendance; their previous use of sexual health services; their influences on sexual decision making and their views on the alcohol and sexual risk relationship.

3.5.3 Patient Pathway

On arrival, the patient registers with the receptionist and is provided with a registration form and confidentiality statement that the patient completes whilst sitting in the waiting room. On discussion with the clinical team, this was agreed as the most appropriate stage of the patient journey to share the PIL. As demographic details are provided, the receptionist was able to identify those patients aged 25+ years who would be eligible for the study.

As indicated above, initially this was also going to be the stage within the patient journey to obtain consent from the patient to participate in the research. However, following the pilot process, the receptionist simply requested that the patient read the leaflet whilst they were in the waiting room and informed the patient that the HCA would discuss it with them in the clinic.

The HCA escorted the patient from the waiting room and into either a male or female clinic room to confirm patient details, discuss symptoms and complete the alcohol screening tool.

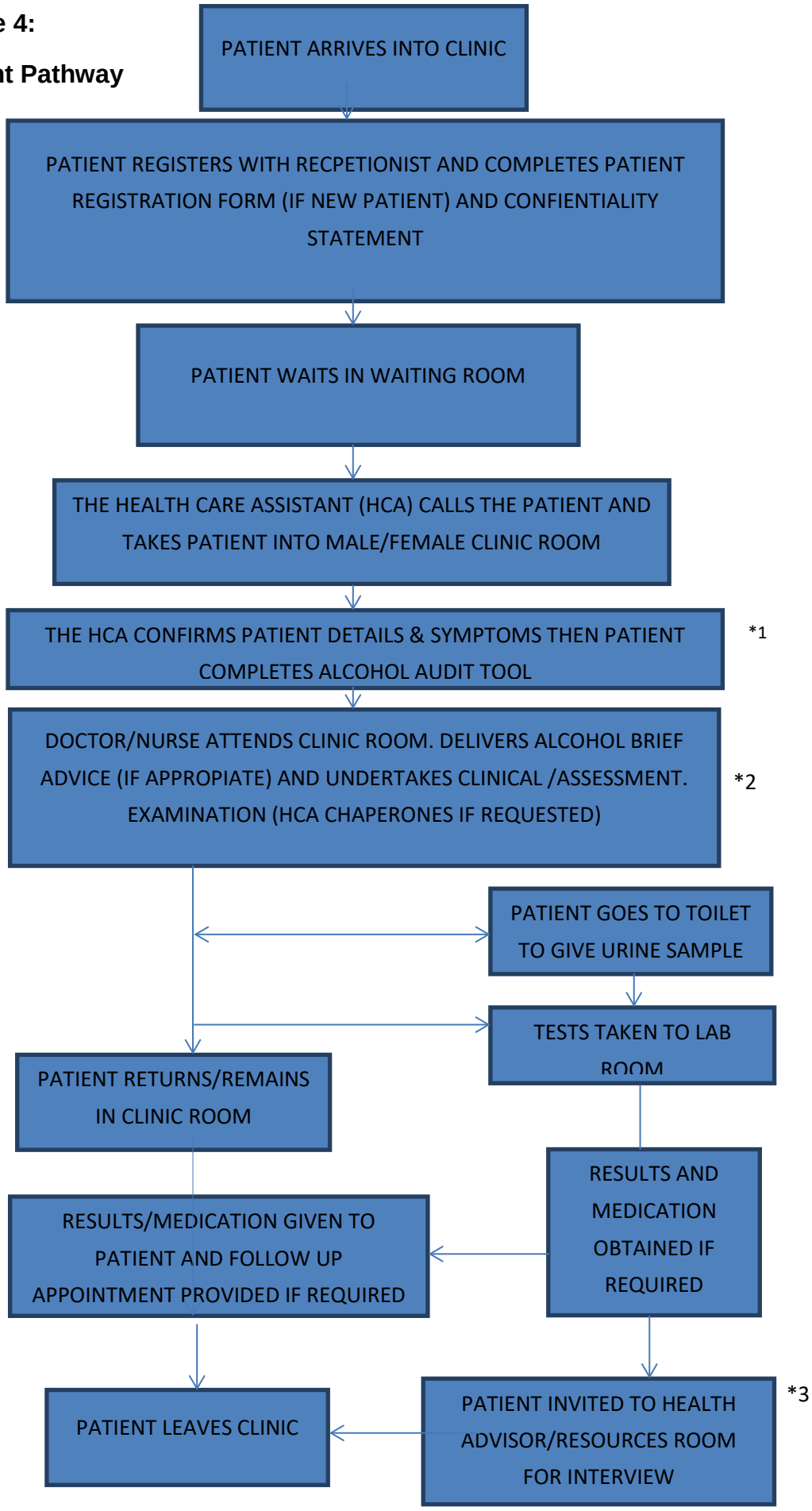
If the patient informed the HCA that they were willing to participate, I entered the clinic room to discuss the research and obtain consent before the clinician arrived.

The patient consent form and patient information leaflet were tested for the educational level of a 16 year old using an online Simplified Measure Of Gobbledygook (SMOG) test (Readability Formula, 2017). The consent form contained contact details of the researcher if a patient who had initially consented then wished to withdraw from the study.

If the patient agreed to be interviewed, once their consultation ended they were directed by the clinician into the health advisors room (or resource room) for me to carry out the interview. This was after the patient had received any physical examination and/or treatment where required.

Figure 4:

Patient Pathway



3.6 Data collection

Following the changes identified by the pilot phase, the fieldwork commenced in November 2014 and was completed in December 2015.

Where the patient consented to either ‘observation only’ or ‘observation and interview’, I observed the clinician-patient interactions, adding notes into my field diary which were later added to the front of the transcripts for each patient. Additionally, although not originally anticipated, a further three patients were interviewed without observation of the clinical assessment and identified to me by the clinician following their treatment.

The formal interviews with both the practitioners and patients were audio recorded and transcribed verbatim. Once I received the transcripts back I checked them against the original recordings and made amendments where required. The interviews with patients lasted between 3.23 minutes and 26.08 minutes with a median time of 10.40 minutes. The interviews with practitioners lasted between 20.47 minutes and 62.37 minutes, with a median time of 26.02 minutes.

In total:

- I spent two days (one at each site) to familiarise myself with the clinics and worked with the clinical team on an initial draft of the patient pathway. This helped me to identify appropriate points where I could seek consent and identify the space to undertake the interviews. It also provided time to form the relationships with the wider group of practitioners.
- I spent two days (one at each site – four clinics) as part of the pilot phase to seek feedback on the PIL, consent form and make amendments to the patient pathway.
- I observed 23 clinics: 17 booked clinics and 6 open access, (Site 1:10 booked and 4 open access clinics; Site 2: 6 booked and 3 open access clinics). Total hours of ethnographic work was around 131 hours - 106 hours of clinic time plus 25 hours of non-clinic time (including lunch breaks, where I would integrate with the teams in the staff room).
- The number of patient observations and interviews undertaken within one clinic ranged from 0-4.

- I attended on other more convenient times to carry out 10 practitioner interviews (5 from each clinic site).
- I carried out 19 patient ‘observations and interviews’, 4 ‘observations only’ and ‘3 interviews only’. The total number of patients were 26.

My observations of the clinic contained within my field note diary were also typed and used for the data analysis along with local documentary sources (e.g. clinic timetable, health information leaflets) which will be used to present a narrative of the clinic outlined in Chapter Four.

3.7 Data management

As soon as audio-recordings of interviews transferred to secure locations, they were permanently deleted from the recording devices. All audio-recordings were transcribed verbatim, and carefully anonymised. Each participant was allocated a unique identification number e.g. Patient 1. To aid with the thesis, these will now be presented as PT for patient and HW for practitioner/health care worker.

3.8 Data analysis

I, like I am sure many others before me, have struggled to give a neat label to the qualitative analysis applied to my research. Reading and attendance at qualitative research lectures provided an overview of the different methodologies for qualitative data analysis e.g. Thematic Analysis, Interpretative Phenomenological Analysis and Constructivist Grounded Theory, Framework Analysis. Rather than strictly following a pre-guided methodology, I drew on a number of specific methods, or steps, from these different methodological approaches. For example, all the approaches outlined above describe a process of closely reading the data and describe coding the data in an ordered, systematic way, moving from smaller codes to over-arching codes. Following methods from grounded theory, I engaged in an iterative process of data collection and coding, with prior codes, creating new areas of data collection to focus on. Also, from grounded theory, I focused on writing about my ideas and writing about my codes.

In taking a more pragmatic approach, it could be argued that I have lost the core conceptual and theoretical elements that shape how to understand the data. It is important to note that the same core methods (or steps) of grounded theory have, over time, been used to support research taking different ontological and epistemological positions, with the initial early work (Glaser and Strauss, 1967) moving from positivism to symbolic interactionism and the later work of people like (Charmaz, 2014), highlighting ways to use them in terms of more constructivist, constructionist, work. Similarly, thematic analysis was initially generated in an era of more positivistic work, and over time, has been applied in a variety of ways, ranging from naïve positivism, to more post-positivistic work as well as the range of more constructivist approaches. What is important are the specific conceptual assumptions and approaches you work with when analyzing the data. As I outline below, (section 3.9.8), my work is embedded in the more pragmatic position of subtle realism.

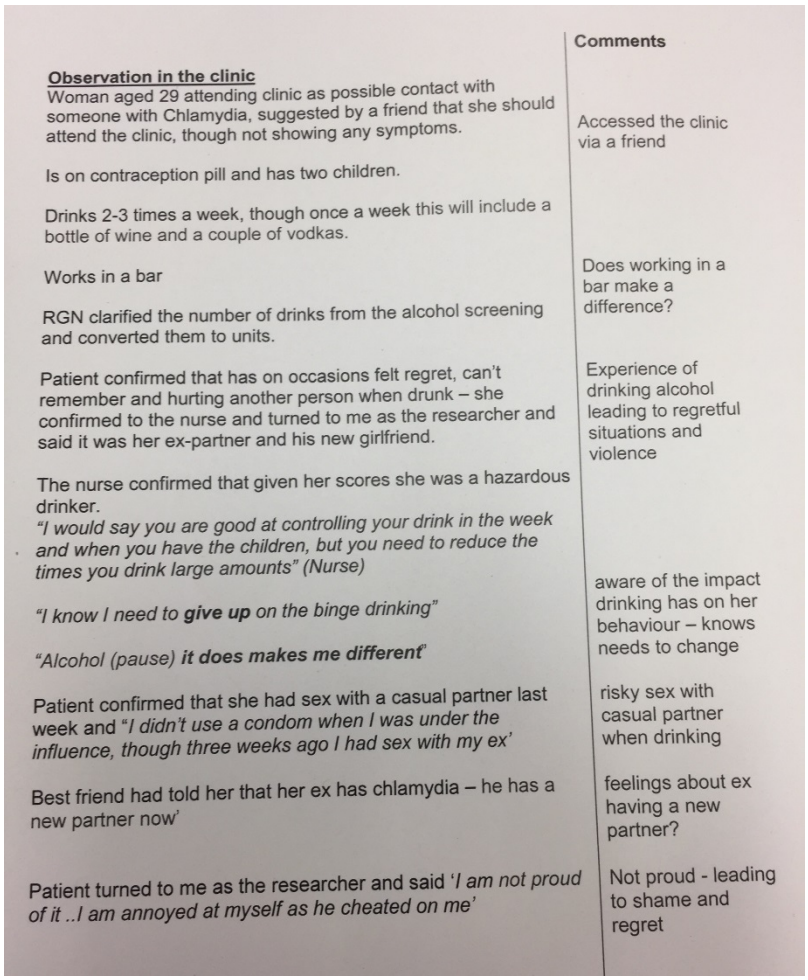
As someone who is systematic but with a creative mind, I was keen to use paper and pens as oppose to a specialised software for the analysis. This was an important process as it allowed me to write thoughts and link concepts between participants using notes and memos. The analysis required me to move back and forth between the data, refining and testing through further data collection. This sequential iterative analysis, although time-consuming, is considered advantageous as it allows the researcher to go back and refine questions, develop hypotheses and pursue emerging avenues of inquiry (Pope *et al.*, 2000).

Each step took me a stage closer, moving from describing the issues to finally (Step 10) after a period of absence, returning to the data to make the conceptual leap (Rapley, 2011, p.286) of identifying the core themes and understanding the story behind the data. I have outlined below the steps which took me on my iterative analytical journey (Rapley, 2011):

1. I checked the transcripts against the original recordings and made amendments where required (including the removal of any identifiable information).
2. I familiarized myself with the dataset – reading (and re-reading) the transcripts, handwriting any specific comments in a column on the right hand side of the transcript and highlighting key words or phrases.

3. I inserted the observational notes from the fieldwork diary to the front of the transcripts, added my reflections at the end of the transcript. These were typed into a word document and saved (See Figure 5 for an example).
4. I generated initial sub-codes and comments from the first three transcripts and shared these with my supervisory team as a way of checking the coding to ensure I had not missed anything.
5. I used the initial sub-codes to refine the interview topic guide and test emerging findings during further interviews with both patients and practitioners. For example, the ideas behind the code '*alcohol used as a crutch to cope with relationship breakdown'* was discussed with other patient participants.
6. I continued to review and expand the sub-codes as a result of further data collection and analysis. Constantly interrogating the data, refining and renaming throughout the process, removing where appropriate

Figure 5: Example of observation notes and comments



	Comments
Observation in the clinic Woman aged 29 attending clinic as possible contact with someone with Chlamydia, suggested by a friend that she should attend the clinic, though not showing any symptoms.	Accessed the clinic via a friend
Is on contraception pill and has two children.	
Drinks 2-3 times a week, though once a week this will include a bottle of wine and a couple of vodkas.	
Works in a bar	Does working in a bar make a difference?
RGN clarified the number of drinks from the alcohol screening and converted them to units.	
Patient confirmed that has on occasions felt regret, can't remember and hurting another person when drunk – she confirmed to the nurse and turned to me as the researcher and said it was her ex-partner and his new girlfriend.	Experience of drinking alcohol leading to regretful situations and violence
The nurse confirmed that given her scores she was a hazardous drinker. *"I would say you are good at controlling your drink in the week and when you have the children, but you need to reduce the times you drink large amounts" (Nurse)*	
*"I know I need to **give up** on the binge drinking"*	aware of the impact drinking has on her behaviour – knows needs to change
*"Alcohol (pause) **it does makes me different**"*	
Patient confirmed that she had sex with a casual partner last week and "*I didn't use a condom when I was under the influence, though three weeks ago I had sex with my ex'*	risky sex with casual partner when drinking
Best friend had told her that her ex has chlamydia – he has a new partner now'	feelings about ex having a new partner?
Patient turned to me as the researcher and said '*I am not proud of it ..I am annoyed at myself as he cheated on me'*	Not proud - leading to shame and regret

7. I then used the sub-codes to create overarching codes (separately for patients and practitioners), clustering together by linking patterns and relationships. Each sub-code was then numbered and each code was colour coded. The example of sub codes and codes for practitioners and patients are highlighted in Tables 8 and 9.

Table 8: Creating sub-codes and codes for practitioners

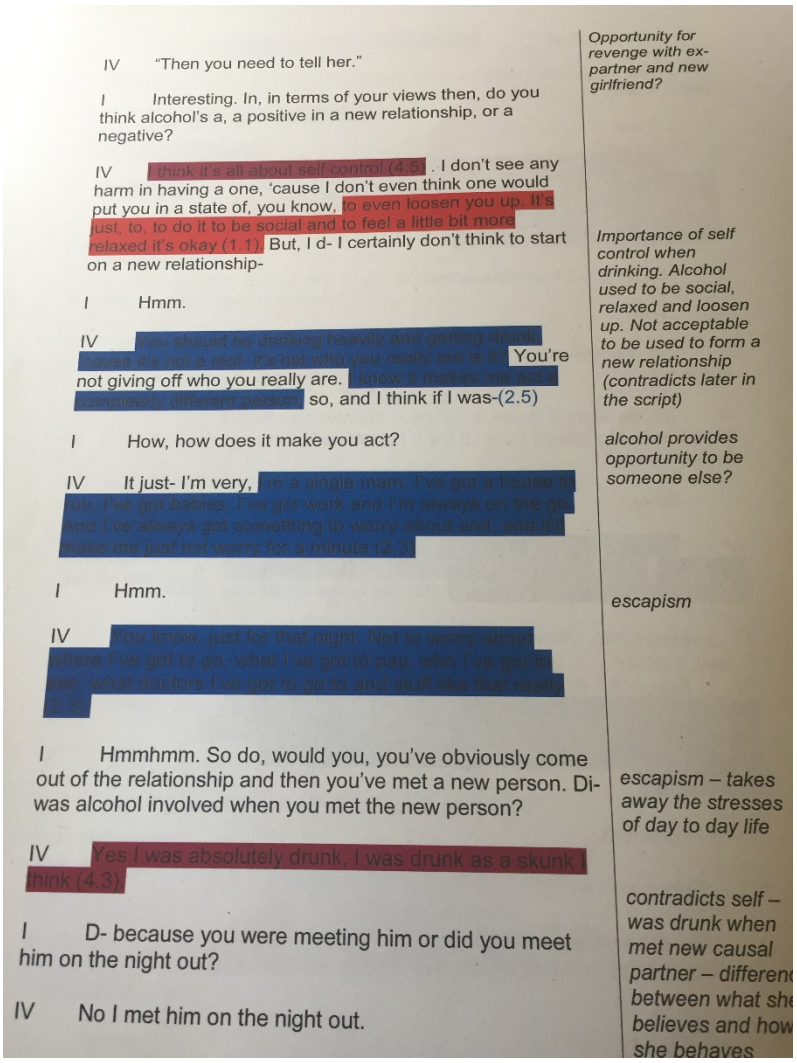
Practitioners	
Changing Norms	**Groups/Reasons for Access Clinic**
1. Acceptability and accessibility of the Clinic 1.1. Increased Awareness 1.2. Stigma 1.3. Location 1.4. Variety of services 1.5. Increased demand 1.6. Friends and family 2. Role of Internet 2.1. Dating 2.2. STI Information 2.3. Pornography and confidentiality 3. Use of Alcohol 3.1. Culture 3.2. Passion 3.3. Age 3.4. Sexual performance 3.5. Relaxant 3.6. Screening 3.7. Confidence 3.8. Excuse 3.9. Sexual Assault 3.10. Breakdown of relationships 4. Use of Drugs 5. Relationships 5.1. Dating 5.2. Marriage 5.3. Unfaithful 5.4. Casual sex 5.5. Long term 6. Attitudes towards sex & GUM 6.1 First sexual experiences 6.2 Contraception 6.3 Sexual pleasure 7. Infections 8. Peer pressure	1. Demographic profile 2. Young People and students 3. Casual Sex 4. Changing relationships through lifecourse 5. Gender 6. Sexual Assault 7. Holiday makers 8. Infidelity 9. Gay Men 10. Regular users 11. Bouncers, swingers and sex workers

Table 9: Creating sub-codes and codes for patients

1. Confidence	2. Circumstances	3. Consequences	4. Contradictions
1.1 Self Esteem 1.2 Body image 1.3 Dutch courage 1.4 Loose inhibitions 1.5 Negotiation of condom use 1.6 Increase sexual pleasure	2.1 Internet 2.2 Infidelity 2.3 Escapism 2.4 Socialising 2.5 In control 2.6 Alcohol addiction 2.7 Older and wiser 2.8 Sexual needs and desires 2.9 Youth 2.10 Cultural differences/norms	3.1 Shame 3.2 Regret 3.3 Attendance at SH Clinic 3.4 Emergency contraception 3.5 Violence 3.6 Sexual performance 3.7 Unprotected sex	4.1 Age 4.2 Gender 4.3 Alcohol use 4.4 Control 4.5 ‘Self’ and ‘others’ 4.6 Relationship status

8. I then systematically colour coded and numbered all of the transcripts (including the observational data) using the refined codes and sub-codes; again separately for patients and practitioners (See Figure 6).

Figure 6: Example of applying coding to transcripts



IV "Then you need to tell her."

I Interesting. In, in terms of your views then, do you think alcohol's a, a positive in a new relationship, or a negative?

IV I think it's all about self control (4.5) . I don't see any harm in having a one, 'cause I don't even think one would put you in a state of, you know, to even loosen you up. It's just, to, to do it to be social and to feel a little bit more relaxed it's okay (1.1). But, I d- I certainly don't think to start on a new relationship-

I Hmm.

IV You should be drinking heavily and getting drunk because it's not a real- it's not who you really are is it? You're not giving off who you really are. I know it makes me into a completely different person so, and I think if I was-(2.5)

I How, how does it make you act?

IV It just- I'm very, I'm a single mam, I've got a house to run, I've got babies, I've got work and I'm always on the go and I've always got something to worry about and, and it'll make me just not worry for a minute (2.3)

I Hmm.

IV You know, just for that night. Not to worry about where I've got to go, what I've got to pay, who I've got to see, what doctors I've got to go to and stuff like that really (2.3)

I Hmmhmm. So do, would you, you've obviously come out of the relationship and then you've met a new person. Di- was alcohol involved when you met the new person?

IV Yes I was absolutely drunk, I was drunk as a skunk I think (4.3).

I D- because you were meeting him or did you meet him on the night out?

IV No I met him on the night out.

Opportunity for revenge with ex-partner and new girlfriend?

Importance of self control when drinking. Alcohol used to be social, relaxed and loosen up. Not acceptable to be used to form a new relationship (contradicts later in the script)

alcohol provides opportunity to be someone else?

escapism

escapism – takes away the stresses of day to day life

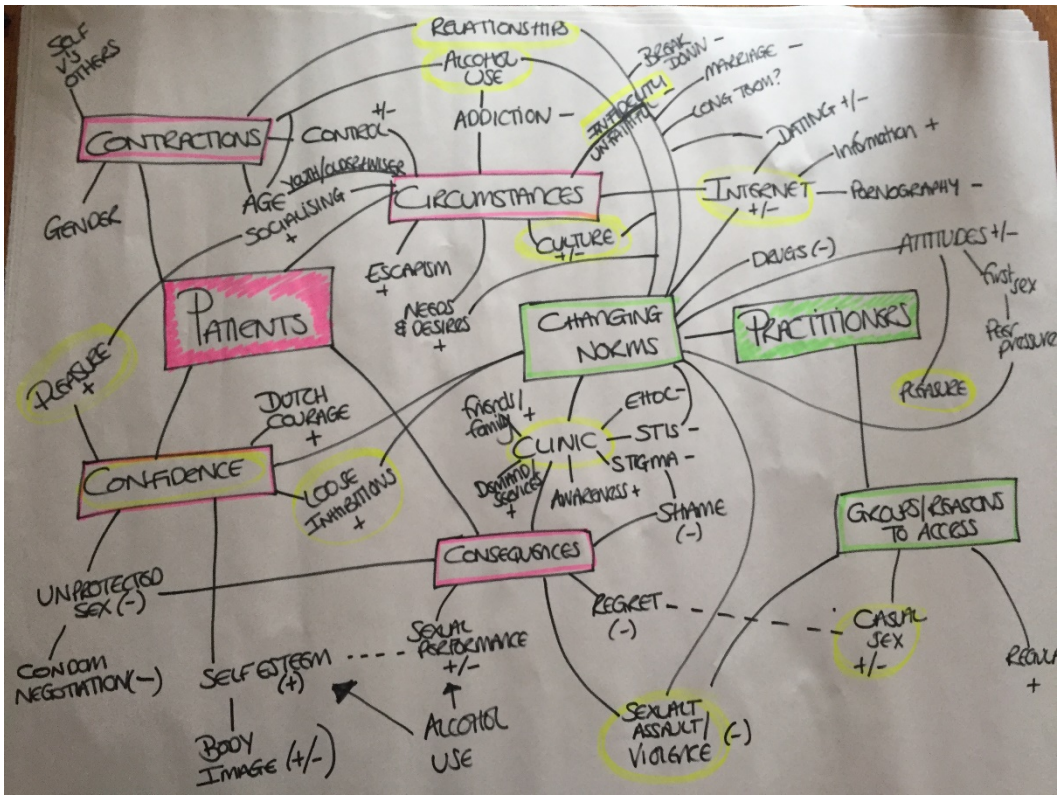
contradicts self – was drunk when met new causal partner – differen between what sh believes and how she behaves

9. I then extracted the data from all the transcripts against each of the codes and for the first time began the process of describing my findings. This process of writing as described by Rapley (2011) formed part of the analysis process, as I found myself not only attempting to explain and justify my ideas, but also helped me to develop them. The writing was undertaken separately for both patients and practitioners.
10. I spent some time away from the data and then returned to it by re-reading all of the transcripts again; noting down my thoughts and feelings. I also re-read my notes on the clinic, patients and practitioners. This was all undertaken

without looking at the sub-codes and codes. It was at this point, that the story behind the data began to emerge – the changes in how individuals were describing their needs from sex and relationships; the struggle between the emotions of desire and guilt and finally how this manifested in the 'morality' of the behaviours and narratives presented.

11. As a form of validation, I crosschecked the codes and sub-codes between practitioners and patients to confirm the final themes (See Figure 7). The final themes are introduced in Chapter Four, and a discussion on each is discussed in more detail in Chapters Five-Seven.

Figure 7: Crosschecking sub-codes and codes between patients and practitioners



3.9 Validity and reliability

There is much debate in the literature on the use of the terms 'validity and reliability' and its application to qualitative research (Golafshani, 2003; Rolfe, 2006). As the terms are rooted in a positivist perspective some argue that their use should be redefined for a naturalist approach (Golafshani, 2003).

I however concur with the arguments proposed by (Morse *et al.*, 2002) that the concepts of reliability and validity are overarching constructs that can be used appropriately in all scientific paradigms (Morse *et al.*, 2002). Put simply, validity and reliability is how the researcher applies rigour to the study and articulates this within the findings. Morse at al. (2002) go further to lay the responsibility of this process at the researcher, believing it should be applied throughout the inquiry, not just at the end by the views of external reviewers. I agree, and believe my accounts thus far have demonstrated the verification strategies I have used to shape and direct the research during its development.

I will outline below how I have applied such strategies, amended from Morse et al. (2002), throughout my study. This was in my ambition to become a good qualitative researcher; cognoscente of my role to consider the validity and reliability of the research, however they are defined, in order to achieve rigour.

3.9.1 Methodological coherence

As the study aim was explorative, the combined qualitative methods chosen were designed to match the study question in order to explore the phenomenon of interest –'*alcohol based sexual risk and sexual decision making'* by data triangulation from multiple perspectives. I have outlined earlier the importance of the preparatory phase (including the pilot) which required amendments to the methods and sampling frame which although delayed the start of the study, alterations to the protocol and further ethical approval, I believe demonstrates my flexibility and fundamental drive to meet the aim of the research.

3.9.2 Concurrent practice

I have also described my approach to the analysis as being iterative as opposed to linear. Initially analysing the first three transcripts (Step 4) and sharing the draft findings with the supervisory team allowed me the opportunity to 'stand back', look at the data in different ways and validate my emerging concepts. I continued to refine the process by collecting and analysing the data concurrently. This practice also allowed me to move from the creation of sub-codes to the creation of codes by connecting within and between data. The need to move from the micro to the macro

analysis led me to the conceptual leap (Rapley, 2011) and I validated such a leap through further cross-checking of the data (Step 11).

3.9.3 The Sample

Qualitative research can produce a significant amount of data. The sample size for this study, collecting data from two sites, undertaking interviews (n=10 practitioners and n=26 patients), 131 hours of observations, provided a rich amount of data.

The journeys that led many of the patients to the clinic may have differed (which added to the richness of the data) and individuals did not share the same demographic characteristics. However, the beliefs, feelings and reflections were surprisingly similar. Many of the initial sub-codes generated were replicated throughout the interviews, which provided me with confidence in the analysis and emerging themes. This was further supported by the identification of deviant cases, (mainly extremes such as 'the addict'), which helped provide a greater understanding of the phenomena and added to the strength to my claims. However, as will be discussed in Chapters Seven and Eight, the cultural impact of the geographic area of study does not make all aspects of my findings generalizable, and cultural context is a caveat.

3.9.4 The context of the setting

As described previously in Chapter One, researching the relationship between alcohol and sexual risk taking amongst an 'older' population was always going to be challenging. Early discussion with the supervisory team considered the merits of finding participants in other settings e.g. bars, though we recognised that these would also be subject to their own limitations. I was also aware of the limitations of this setting i.e. the patient participants in the GUM service were only the ones who sought help at this setting for their symptoms or as a result of unprotected sexual activity.

Additionally, Silverman (2011) argues that what people claim in interviews does not have a stable relationship with how they behave in naturally occurring situations. Whilst the consultation within the GUM clinic was a 'naturally occurring situation', I was conscious that the 'stories' portrayed to the practitioners may have been shrouded in a morally acceptable narrative. Undertaking the research within the GUM service however did provide the opportunity for the patients to share reflective

accounts in an anonymous space; capture data in a timely manner, which would have been difficult to obtain in other settings, and provided qualitative data from a setting relatively under researched using qualitative approaches.

3.9.5 Practitioner awareness of the subject

As the practitioners were aware of the topic of research, I was concerned that they may be more influenced within the clinical consultation to ask patients about their alcohol use. At first, they were conscious of my presence as a researcher. However, after a few visits to the clinic they began to see me as part of the duty team (as described below). I later felt reassured about this, particularly on the occasions when the practitioners did not even ask the patient about their alcohol use or look at their alcohol score within the consultation.

3.9.6 Replicability

Reliability also deals with replicability; whether other researchers could have repeated the same research project and come up with the same results, interpretation or claims (Silverman, 2011). I believe that the description above provides a transparent account of the data collection and data analysis methods utilised, which could be replicated by others. The research is therefore repeatable. I have also tried to remain objective and critical when handing the data (Silverman, 2011), ensuring transcripts were transcribed verbatim and rechecked the audio recordings to listen for data such as pauses and laughter as well as noting the body language within my field note diary.

3.9.7 Practitioner as researcher

The practice of ethnography … requires careful attention to issues of identity and social status and the role of the researcher in the generation of the data (Allen, 2004)

There is much debate within the literature on the advantages and disadvantages of researcher insider-outsider status. I will outline below the position of my role as a researcher for this study. I will demonstrate how I utilised the benefits of my role as a researcher ‘in the middle’ (Breen, 2007) to maximise some of the advantages, whilst remaining cognoscente, through my practice of reflexivity, of the impact of my role on the research.

When I commenced the study, I had worked for six years as a Public Health Consultant in the region of study and had a particular interest in sexual health and alcohol. I worked in public health policy roles in the geographic area of study, as well as nationally at DH. As a result, I was known to the GUM Consultants, though had never actually worked as an 'insider' within a GUM clinic. As a result I was conscious that my professional role meant that I was straddling two worlds and would perhaps undertake this research with a certain way of seeing (Silverman, 2011). The advantages of my prior experience was that I was familiar with the environment of GUM clinics; I was able to converse in the dialogue without the need for translation and had an acute understanding of some of the challenges faced by the service. This common ground increased my trustworthy status and facilitated rapport (Ayça and Aykan, 2010), as well as allowed me to probe and ask more meaningful questions in the limited time available in very busy clinics.

On a very practical perspective, I was keen to distinguish my role as a researcher from practitioner. This included wearing more informal dress than I would wear in my practice role; using only my University email address when contacting the practitioners; not being drawn into discussions about policy or funding and introducing myself as 'Claire the researcher'. Additionally, as I had no clinical training, my 'outsider' role meant there was no ethical dilemmas of being drawn into clinical practice during busy periods as experienced by other 'insider' researchers. Nor would I miss significant behaviours or rituals, perhaps normalised for insiders.

My introduction into the clinic was through the existing relationships with the Consultants who provided immediate access to the study sites. I was aware that the hierarchical position of the Consultants (and my own role as a Consultant) may have influenced the other practitioners to participate in the study, however I was very clear to stress in the team briefings that consent to participate was voluntary. I was also fortunate that research and audit were a fundamental practice in this GUM service. During the period of my study, the clinical team were involved in a trial for an alternative treatment of genital warts and the enhanced surveillance of gonorrhoea. Therefore, my role in the clinic as a researcher was not alien, though the method of qualitative research was perhaps more novel.

At first, all practitioners were curious and perhaps a little suspicious, but this did not prevent them from sharing their opinions and stories (discussed in Chapter Four). All practitioners approached for interview agreed to participate, and in fact, some were surprised that I would be interested in their views. I was flexible in order to fit with their work patterns, all of which I believe led to an increasing level of trust and respect. This was demonstrated when my name was added to the monthly staff rota and I gradually became an accepted member of the 'hub' team (see Chapter Four).

3.9.8 Philosophical perspective

Following my pragmatic relationship to applying methods, I also drew on Hammersley's (1992) more pragmatic philosophical position of 'subtle realism'(Hammersley, 1992). Subtle realism attempts to manage the tensions between more realist/positivistic approaches – that can assume the possibility of an objective reality or form of knowledge – and more relativist/constructivist or constructionist approaches – that can assume such objectivity cannot exist, but rather knowledge of the world is embedded in social, historical and cultural norms. Subtle realism seeks to manage some of differences between realism and relativism which could otherwise undermine the findings of qualitative research studies. Hammersley (1992, p 52) outlines that;

This subtle realism retains from naïve realism the idea that research investigates independent, knowable phenomena. But it breaks with it in denying that we have direct access to those phenomena, in accepting that we must always rely on cultural assumptions, and in denying that our aim is to reproduce social phenomena in some way that is uniquely appropriate to them. Obversely, subtle realism shares with skepticism and relativism a recognition that all knowledge is based on assumptions and purposes and is a human construction, but rejects these positions' abandonment of the regulative ideal of independent and knowable phenomena. Perhaps most important of all, subtle realism is distinct from both naïve realism and relativism in its rejection of the notion that knowledge must be defined as beliefs whose validity is known with certainty.

So, my work is an attempt to represent reality rather than to attain a single truth (Mays and Pope, 2000) to offer an analysis that you can be reasonably confident about. Some may argue that my role (and values) as a practitioner could not be

distinguished from my role as a researcher. Having former knowledge of the topic could have influenced my data collection. It could have also influenced my interpretation of the data. I acknowledge that if another researcher was undertaking the study they may have presented some different aspects of situations and experiences I analysed. Indeed my claims may be later disputed by others. Following subtle realism, while we cannot be entirely certain of the knowledge claims I make in this thesis, we can make judgements about their accuracy and value. We can gain confidence through engaging with the evidence I provide as well as through asking questions about the plausibility and credibility of the claims I make, and the assumptions on which it has been based. Through this chapter, I have described the methods applied throughout the research to achieve rigour and thus improve the credibility of my findings and clearly outlined my position. The final method I adopted to further demonstrate the credibility of my work was one of reflexivity.

Reflexivity acknowledges that researchers will be shaped by their socio-historical locations, including their values and interests (Hammersley and Atkinson, 2007). My interest in the topic of research was borne out of my professional practice role and I was aware at the start that this may lead to focus on specific issues. I attempted to mitigate this through continually writing personal notes, regular dialogue with my supervisory team and triangulation of the data. My self-reflexivity drove a consciousness in both my data collection and data analysis (Greene, 2014).

I monitored the impact of my roles as both practitioner and researcher, attempting to suspend previous assumptions and beliefs. I believe I was able to critically observe and at times exploit some of the advantages open to ‘insiders’. My ability to work as the ‘researcher in the middle’ made it easier to keep questioning the research material, because I was neither inside or outside (Breen, 2007). Burns et al. (2012) advocate that qualitative researchers should avoid the tendency to be one thing or another, in favour of occupying a space where we can draw on our multi-layered identify, in order to facilitate familiarity whilst maintaining the degree of distance (Burns *et al.*, 2012). I concur, and believe my dual identity should not detract from the findings but enhance their validity. However, I hope I have provided sufficient evidence to provide the reader with confidence in my claims (Angen, 2000) and contribute new knowledge in the field of study relevant to both academics and

practitioners. My final judgement will simply come from those who decide whether it has contributed any useful knowledge at all.

3.10 Chapter summary

In summary, my intention with this chapter was to provide an honest description and clear account of the process undertaken from the design, ethical and practical considerations through to data collection and data analysis. I believe as a researcher I have been '*open, authentic, honest and deeply interested in the research participants … committed to accurately and adequately representing their experience'* (Dwyer and Buckle, 2009)(p59).

I have shared some of the key learning and in depth reflection on the ways in which the research data has influenced the research process (Savage, 2006), particularly the preparation for fieldwork and my growth as a researcher in my pursuit for rigour. I believe I have been sympathetic to the aim of the study, providing novel data for this under researched cohort in sexual health and in a setting, which is rarely selected as a field for qualitative research.

The next chapter provides an overview of the findings, including a detailed description of the clinics, a summary of some of the common features of the patients and introduce the final themes.

Chapter 4. Findings - overview of the clinics and the patients

This chapter provides a descriptive overview of the two clinics and introduces some of the characteristics of the patients encountered as part of the ethnographic study. The clinic information is based on the observational data from the field work diary and artefacts collated during the study. The patient information describes some of their common features, and background to the journeys which brought them to the clinic. This section is based on observations and interviews, supplemented by the reflections from the practitioners obtained through informal conversations and interviews. I close the chapter with a summary of the developing themes before introducing them individually in Chapters Five to Seven.

4.1 A description of the GUM clinics

In order to retain the identity of the clinic, I have not referenced the council websites used to ascertain the statistics of the geographical area of study, instead I simply refer to them as Source 1 and Source 2.

4.1.1 Clinic one

Clinic one is based within a large university hospital in a city centre. Over half of the residents of the city are students, with the permanent resident population having roughly the same age balance as for the rest of the County. The County is in the top 30% most deprived authorities across England (Source 1).

Within the hospital, all departments are located off a large corridor that runs around the building at each level. The large corridor is painted blue, artwork adorns the walls and seating is sporadically located as ‘rest areas’ along the route. Signs are located on the ceiling to help patients navigate around the hospital.

At the entrance to the GUM service there is a door with a number of push buttons in order to gain access to the clinic. The door is locked when the clinic is not in operation, though also remains closed when the service is open to the public.
On the days when the open access (Q and wait) clinics are operating there is often a long queue in the main corridor of anxious patients waiting for the door to be unlocked. Once the appointments for the open access clinic are filled, the doors are locked again. Those patients not successful at securing an appointment for the clinic

are required to book into the next available clinic. The open access clinics mainly consist of young people (16-25 years). The practitioners suggested that this was because it is easier for them to wait than book an appointment in advance. The alternative suggestion provided was that the sexual risks they engage in result in them having to deal with the consequences quickly e.g. access to emergency contraception.

See Figure 8 for the layout of the clinic (not to scale). On entering the clinic, the reception is on the left hand side. The receptionists are in a room behind a glass panel where they greet the patients. To the right of the window is the waiting room with a small number of chairs. A colourful notice board contains a range of health information and contact details for others relevant services. It is also used to promote key sexual health dates in the calendar e.g. World Aids Day. The notice board also acts as a partition to the rest of the clinic.

Continuing past the waiting area, there is a long corridor with a number of examination rooms, offices for doctors and nurses, the staff room and toilets. The toilets include a hatch for urine specimens to be passed through to the diagnostic room. Off to the right of the corridor is where the diagnostic room is located; it contains microscopes, a medical fridge and supplies in coloured containers.
In the centre of the corridor is a large desk, which would have previously been a nurses' station. This large desk is the 'hub' of the service and where coordination between the professionals takes place. Behind it stands the large medicine cupboard which is always locked. It is at the large desk where the receptionist drops off the file for each patient once they have 'checked in' to the clinic.

Within this clinic it is the Healthcare Assistant (HCA) who collects the patients from the waiting room and escorts them to the relevant clinic room – gender specific because of the different examination beds required for men and women, thus the rooms vary in size. Patients are greeted by their first name only, or whichever name they provide to the receptionist, in order to maintain confidentiality.

Once the patient is in the clinic room, the HCA confirms the demographic information and symptoms or purpose of the visit. The HCA also provides the alcohol screening tool for the patient to complete. The HCA leaves the room and places the notes back

into the tray on the ‘nurse’s station’ for an appropriate member of the clinical team to attend – doctor or nurse depending on the complexity of the symptoms or case.

The clinician then enters the clinic room and undertakes the appropriate assessment and investigations in order to diagnose and treat the patient. Following treatment, and if required, a health advisor will provide advice and counselling in the dedicated resource room which contains lower, soft seats, and free condoms.

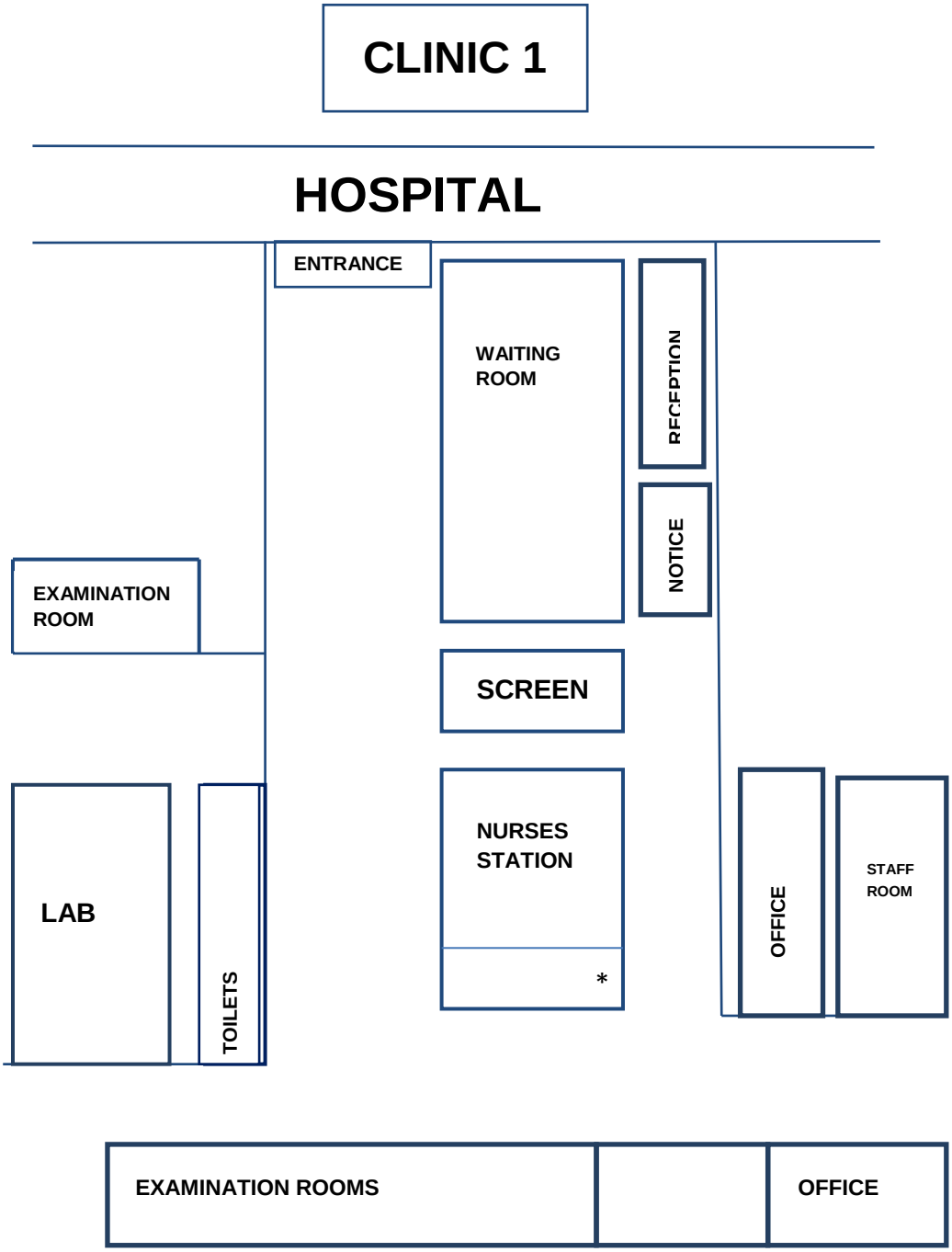
There are two permanent consultants working at this clinic, both of whom undertake work in other sites for at risk groups – one in a prison and another at a HIV clinic in the regional centre. Two doctors (one specialising in contraception), three nurses and three HCAs rotate in the clinics throughout the week. Additionally a psychologist attends the clinic once a week to support patients and their partners who are HIV positive.

Practitioners at this clinic regularly raised the issue of staff shortages. This was exacerbated during the fieldwork by the fact that part time staff - particularly those who had reduced their hours on progression to their retirement, were having to work more hours to ensure all of the clinics were covered. On a couple of occasions I arrived to find that agency or locum staff were working in the clinic that day, so had to explain the research and where appropriate secure their consent to participate. Additionally, as one of the consultants from the third site (not covered by this research) was on maternity leave, the workload was shared amongst the consultant/doctor team to cover across the three sites. A new doctor and a new HCA were recruited to the service whilst I was undertaking the fieldwork.

This is a busy service. The practitioners come and go regularly from the nurse’s station (hub) throughout the clinic. The clinicians often go back to their own offices between seeing patients to complete the electronic records of patients.

As well as the ‘hub’, the informal space of the staff room remained a focal point through the course of the fieldwork. Not only was this an area for the practitioners to come together to have lunch and refreshments, but it was used in a professional context to discuss issues regarding the service, particularly on the transition between morning and afternoon clinics.

Figure 8: Layout of clinic one



*** = CONGREGATION AREA**

4.1.2 Clinic two

Clinic two is situated in a market town serving a large rural area with around a quarter of this area's population classified as living in the 10% most deprived nationally (Source 2).

Clinic two is in an old hospital outbuilding, located on the opposite side of the road to the main building. On driving up to the car park for the clinic you notice the staff 'social club' is housed in a more modern building. For over ten years the clinic has been promised a move to the main hospital site; however another service has always taken priority. It suggests the value of the sexual service within the organisation, as well as perhaps the context of sex and sexual health within the community – something that is hidden away and out of sight.

The outbuilding was going to be demolished but protected birds were found to be nesting in the roof so this was put on hold. In the winter months the clinic is very cold and the practitioners have to put electric heaters into the rooms. In the summer months it is ants that frequent the clinic and the pest control officer becomes a 'regular attender'.

One enters the building through a main glass door into a reception area (See Figure 9 for layout, not to size). A set of chairs are in the foyer next to the main reception desk. This area is very rarely used and looks desolate. A number of other services are delivered from this building but rarely do you see patients, implying it may simply be a staff base for other services. The GUM clinic is situated on the right hand side as you enter through the glass doors. The clinic only opens for parts of each day, either as an open access clinic or for pre-booked appointments. A locked key code is on the main door, this is predominantly for security reasons but it also gives a first impression that something potentially 'secret' or 'restricted' happens behind the door. The door also remains closed during hours of operation.

On entering the clinic, it feels a bright and warm. It is a long and thin space. So different to the pale walls and unloved environment of the foyer. The notice boards are filled with information about other services including the alcohol services; details on where to get free condoms and posters explaining the different STIs. The practitioners have filled the space with plants and the local radio station plays loudly

which I realise is also there to provide an additional layer for maintaining confidentiality.

The patient enters the clinic to be greeted by the receptionist on the left hand side who sits behind a large open desk, with no glass screen. As the clinic has recently transferred to electronic records, the space behind the receptionist now contains empty filing cabinets once filled with a numerical filing system. An orange screen divides the receptionist desk from the waiting room.

On arrival the patient is provided with a range of information that they need to complete before seeing a practitioner. They are asked to complete this in the waiting room. This includes a consent form as well as a laminated copy of the alcohol screening tool for the patient to complete prior to being invited into the clinic room. Previously (and how it operates in the other site), the HCA would meet and greet the patient, take them to a room and confirm their demographics and symptoms. This no longer happens at this site as the electronic system is now completed by the nurse or doctor.

The waiting room contains a small number of seats. The radio is located on top of a pile of magazines. There are mainly women's magazines, previously belonging to the practitioners, the majority of whom are female.

A number of rooms run off the main area – offices for the nurses and doctors as well as a health advisors room with the low seating to counsel clients, which also doubles up as an office for the nurses. The examination rooms (also separate ones for men and women) run along the end of the waiting room and along a corridor. On the corridor is the 'hub' of the clinic – the largest room which contains the microscopes and medicines, for analysing the swabs and ensuring access to immediate free treatment. This treatment also means a patient does not need to attend a pharmacy if they require medication or indeed pay for prescriptions. This prevents any further embarrassment for patients.

The staff room is at the end of the corridor, though is akin to a large cupboard for staff to hang their coats, leave their bags and make tea. It holds a couple of chairs but is not really used as a staff room as it is simply not big enough. Any staff

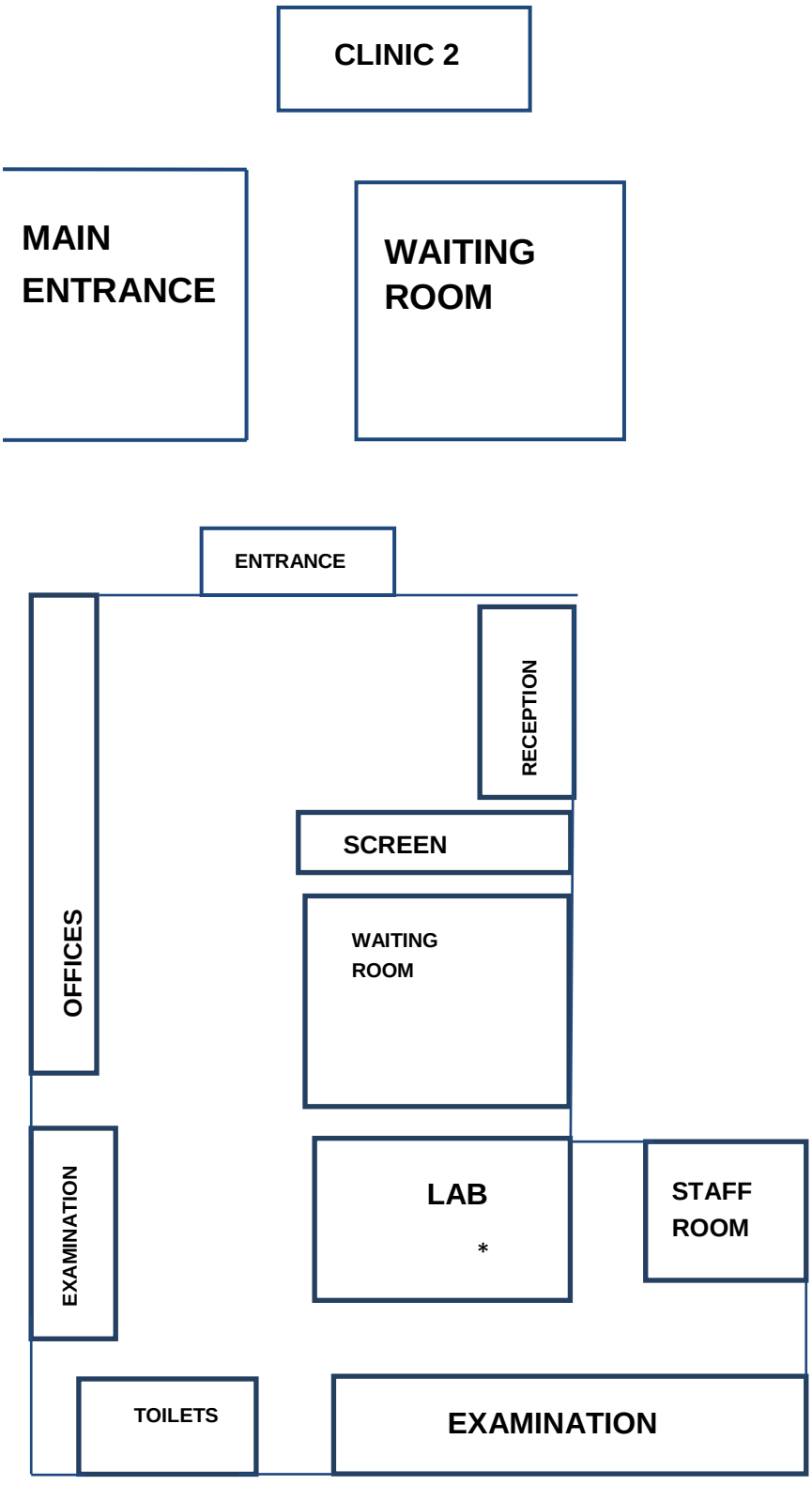
development sessions are actually held in the patient waiting area given it is the largest space in the clinic.

Most of the practitioners at the clinic work part-time which suits the time slots of opening. There is one consultant based at the clinic, two other doctors deliver sessions but their main base is elsewhere. There are three nurses, one of which is the lead nurse and two HCAs. The HCAs are talkative and have both worked at the clinic for eight years. Their main role now is to prepare the rooms, keep supplies stocked, act as a chaperone as well as take blood and urine samples. Given the hospital laboratory is in the main site, sometimes the HCAs carry the swabs across the road for further testing. The nurses are more reserved and provide a calmness to the clinic. All but one practitioner is female. All practitioners congregate in the lab room (which also doubles up as a nurse's station). The waiting room is monitored from here too.

On the bottom corridor are two further notice boards. One contains the Hospital Trust information on standards and training. The other has details of the results from the monthly patient's survey and how they scored against other departments. Rated as 'outstanding' by the patients.

It is obvious the team do not get a lot of other visitors apart from trainees on placement and of course the pest control man. I am met with curiosity and within a short period of time, given the interest that I show in their work, I am seen as one of the team. I hang about in the lab room (hub) too which, with hindsight, I realise how soon I became accepted in their space too.

Figure 9: Layout of clinic two



*** = CONGREGATION AREA**

4.2 Observations from both clinics

4.2.1 The 'Hub'

As described above, like many clinical areas, both clinics had a 'hub' which was the focal point for information to be shared between practitioners. These, like other hospital conversations were important conduits for clinical information flow (Long *et al.*, 2007). When a clinic was in operation, practitioners moved between the clinical rooms, the laboratory and their individual offices passing each other at the 'hub' to discuss patient progress or to seek advice from colleagues. These brief encounters demonstrated high quality engagement in the briefest time, utilising momentary time slots to good effect (Crawford and Brown, 2011). This was amplified when couples attended the clinic together but were seen separately; the hub space became essential for cross-checking symptoms and diagnosis to plan care for both parties. This communication was informal yet effective and complemented the clinic environment which was fast moving.

As well as the clinical information, the hub was also the congregation point to share more practical information such as rotas, discuss supplies and reflections on the day. This was often led by the clinic managers who were also the lead nurses.

In clinic two, as the hub was in the laboratory it also became the space for informal education or 'on the job' training. During the fieldwork, I met student nurses who were encouraged, along with existing staff, to learn from clinicians. They would observe the consultations, view samples down the microscope and be encouraged to discuss cases.

As the teams on duty for each clinic were relatively small (n=4-6 practitioners), there was no observable professional hierarchy to the team, despite clinical experience. I regularly witnessed discussions and debates between practitioners, including reception staff. This was mainly linked to the day to day operation of the clinic. Opinion was regularly sought from junior members on key decisions such as when to close the clinic. The practitioners were positive in the informal discussions and interviews about their approach, 'we all work together as a team' (HW8). This way of working may have been as a result of the length of service of many practitioners within the clinics, who were able to make such judgements based on their extensive experience.

There were however two subtle details which distinguished the difference in hierarchy – the uniforms and the allocated office space. The HCAs and nurses wore traditional nurse's uniforms, albeit each a different colour in order distinguish grade; doctors and consultant grade staff wore their own clothing. This informal dress, as oppose to a traditional white coat, created a more relaxed feel within the clinic. In terms of office space, consultants had individual offices, nurses shared office space and HCAs did not have an office at all.

The hubs were also used for social conversations and chats (Long *et al.*, 2007) about the lives of the practitioners, again not distinct by professional boundary. These non-work interactions proved to be a powerful way of building a collective identity at work (Finn *et al.*, 2010). Updates on children and holidays were exchanged, with apparent genuine interest. This sense of 'team' was also displayed by the birthday lists that were in the staff rooms; the photos of team 'nights out' which decorated the notice boards and the regular collections for special occasions. The two sites did not come together for these occasions even though they were part of the same service.

The teams displayed some of the key features of effective teams – mutual trust not driven by hierarchy but an appreciation of the skills of each member; closed-loop communication to improve patient safety; and a shared mental model where everyone's role in the team was clear so the patient journey was seamless (Weller *et al.*, 2014).

4.2.2 The secrecy of the clinic

The most striking observation from both clinics, and highlighted in the descriptions above, was how the sexual health clinic operated within a medical environment yet contained this additional layer of secrecy, demonstrated by the closed doors with locked keypads. Additionally there was a lack of explicit signage to identify it was a sexual health service, and ensured only those who knew the medical terminology (GUM) would understand its purpose.

Foucault (1978) in his seminal work on the history of sexuality described the introduction of sexual health care into the medical establishment as a way of sex being managed (Foucault, 1978)(p.24). This management of sex appeared to still be

in place as it was in the Victorian era, and was reinforced once inside the clinic when, for some patients, the confessional nature of the consultation emerged. Foucault (1978) describes the 'sinful' nature of sex being associated with the burden of guilt and the confession being the general standard of governing the production of the true discourse on sex. He argues that the confession itself allows the confessor to be exonerated, redeemed and purified with the clinician acting as the authority who prescribes and intervenes in order to judge, punish, forgive, console and reconcile (p61). The confession itself is a valued technique for producing truth and therefore it can provide the space for expression of individual secrets. I observed the discourse of the confession where sex was spoken publicly in a clinical environment, not to cast judgement, punishment or even forgiveness by the clinician, but a place where sex was 'administered' and treated. I will explore the confessional nature of the consultation in more detail in Chapter Seven, in particular the role of the patient in sharing their secrets and the role of the practitioner in eliciting truth.

Additionally, in Chapter Five, I discuss how the clinic has tried to adapt to remove some of the barriers for individuals to access the service. However, I will demonstrate that the stigma associated with the clinic and indeed STIs continues to remain. Goffman (1963) in his work on stigma, argues that such an attribute leaves individuals feeling weak or tainted, falling short of the individual they ought to be, and in particular concerned how they will be received by others (Goffman, 1963). This will be discussed in more detail in Chapters 5-7, in particular how being at the clinic has an impact on social identity.

4.2.3 A non-judgemental service with a repertoire of stories

The underlying value base of the sexual health clinic,was like the rest of the NHS steeped in confidentiality but reinforced here due to the anonymity of the service. Again the anonynimity creating another aspect of secrecy. I witnessed this 'non-judgemental' approach in the consultations with patients. The practitioners reflected in their accounts about what being a non-judgemental service actually meant in practice as explained below,

Even though we are non-judgemental doesn't mean we are not shocked (HW1).

Nurses and doctors therefore discussed ‘non-judgemental’ in the context of ‘shock’ where nothing the patients told them really surprised them anymore. The practitioners felt that some patients would deliberately attempt to shock them and reflected how it was important to ‘have a kind of poker face of not being shocked what you hear’ (HW5).

These atrocity stories were often recounted and over time became folklore of the clinic (Allen, 2001). As described by Allen (2001) these repertoire of tales define the group identity and have an occupational boundary. However, within the GUM clinic the tales belonged to the whole group and perhaps helped to distinguish themselves from other hospital departments.

Additionally, as experienced by Allen (2001) , the stories were also recounted for my benefit too. I felt the purpose of the storytelling was a way of initiating me to become an insider or perhaps was to simply shock me also.

4.2.4 The language of the clinic

It was not surprising that this service, like many others, had its own shared language. The clinic was essentially a culture within a larger culture of a hospital. This language was another layer of group identity.

When describing patients during the course of the clinic, the norm from practitioners was to describe the patient in the context of the infection they had or the infection of the person they had been in contact with e.g. ‘chlamydia in room one’. Whilst this helped with anonymity, it also depersonalised the healthcare discussions.

New sexual terms also emerged throughout my time at the clinic and clearly developed regularly amongst the local community. Two new terms explained to me were:

- Mars barring – inserting a mars bar into a woman’s vagina then passing around for people to take a bite.
- Snowballing – passing girls around a group of male friends in a circle to carry out different sex acts with each (a form of sexual exploitation).

4.2.5 Pride in the quality of service delivered

During discussions with the practitioners in their team meetings about the research, they were keen for me to ask for feedback from the patients about their experience of the service. This was easy to incorporate into my interview schedule as they had feedback cards for patients to complete. The service had a target to capture at least 50 feedback cards each month and was important to demonstrate to the rest of the organisation the quality of their service. The results of the patient feedback was visible at both sites on the notice boards. The feedback also contained comments from the senior managers in the organisation, though I wondered how many senior managers had actually visited.

The feedback from patients was always very positive, mainly due to the way they were treated by the practitioners (non-judgemental) and all stated how they would return or recommend the service to friends. At one of the sites, patients also empathised with the practitioners based in the run-down building, having to operate under such difficult conditions.

4.2.6 Frustrations within the clinics

As well as the staffing shortages highlighted earlier there were two other frustrations shared by practitioners. Firstly, during the fieldwork, a new IT system had been introduced into the service. The aim was for the service to become completely electronic and paperless. Initially this caused significant disruption and delays as patient details had to be transferred onto the new IT system and hence caused backlogs in clinics. This initially had a direct impact on the study for those patients who had consented to both an observation and interview but were unable to stay due to work or family commitments.

Additionally, during the period of the study in clinic two, the HCA no longer escorted the patient into the room to check demographic details but the clinician checked this on the computer. As a result it was the clinician who requested if the patient wanted to participate in the study. I would then have to seek consent before the consultation began.

The new IT system also meant that the eye contact between the patient and clinician was interrupted by the computer. This seemed an intrusive barrier given the

practitioner was collecting very personal information as part of the assessment e.g. numbers of previous sexual partners, sexual activity linked to paid sex.

Secondly, it was difficult to predict in advance of any clinic whether patients would agree to participate in the research or not. On a couple of occasions at the clinic no one consented to participate. One of these was when there was a patient who had recently been raped and another with learning difficulties. However more often than not it was due to a high volume of patients who did not attend (DNA) for their appointment. High DNAs were frustrating to the practitioners particularly when they felt they had to turn away patients due to full clinic lists. This was amplified by the fact that the patient is sent a text reminder in advance about their appointment.

4.2.7 Increasing drug use amongst patients

One of the more emerging features that was witnessed whilst I was undertaking the research was the increase in drug use amongst some of their clients. Practitioners acknowledged that the largest substance used was still alcohol, but they were surprised at the increasing use of recreational drug use amongst some of their patients. Practitioners described these patients as functioning drug users as opposed to addicts.

During the fieldwork, the issue of ‘chemsex’ was emerging nationally and was also raised by one of the participants locally. Chemsex is a term commonly used by gay men and MSM to describe the use of certain drugs in a sexual context. Chemsex usually involves using one or more of three drugs – Crystal Methamphetamine, Mephedrone and GHB, to enable, enhance and prolong sexual interactions; improving sexual performance and experiences by increasing arousal, stamina and pleasure (Winstock, 2015). This will be discussed further in Chapter Five.

4.2.8 Summary

This section has provided a description of the clinics and a glimpse into the lives of the clinics and the practitioners. From the observations and interviews I was able to identify the shared norms across both sites. These included the success of the teamwork; the role of the environment and specifically the ‘hubs’ as a way of enhancing communication and staff development. The common language and

shared ‘atrocity stories’ also defined their group identity, though I suspect not only defines the identity of these clinics but many GUM clinics across the country. Though both clinics had their individual challenges, particularly linked to workforce, IT and premises, this did not detract from the pride and quality in the service; so valued by the patients. In the next section I introduce the patients I met as part of the fieldwork and share some of their common features.

4.3 Characteristics of patients

During the course of the study, I observed 23 patients in clinical rooms, interviewed 22 (19 patients ‘observed and interviewed’; 3 ‘interviews only’ and 4 ‘observations only’). Appendix 7 provides an anonymised summary of each patient, with their individual journey that led them to the clinic. Table 10 below provides a breakdown of the total sample demographics, including relationship status and purpose of the visit.

During the interviews and discussions with the practitioners they explained the types of patients that attended the clinic and how this had changed over time (discussed in more detail in Chapter Five). On the demographic profile of patients who accessed the clinic, there was general agreement amongst practitioners that it was young people ‘probably between the ages of 17 and 30’ (HW7) who use the clinic more regularly, matching the age group of attendees and diagnosed infections seen within the clinic (Public Health England, 2017).

As clinic one is located in a university city it was unsurprising that the student population were identified as a specific sub group within the younger age group:-

> I would say under 25s, definitely students. We’ve got a big university here (HW1).

The practitioners explained that the demand for the service increased during term time and was quieter during holiday periods.

> A lot more people just coming up for check-ups. When the term starts we get a lot of people. Then when the term finishes we don’t get so many (HW9).

Other periods of the year were also identified for students when both alcohol drinking and the need for sexual health services also reduced – implying an association.

> The students drink a lot more regularly, but there will be times, during exams, when they have nothing (HW10).

In terms of a gender profile, this was described by the practitioners as an even split given that most HIV positive patients using the clinic were men and with the expansion of the contraception clinic this was mainly accessed by women. As these groups of patients would be classed as ‘regular attenders’, they would not be identified by the publically available data which focuses on those attending the clinic for the first time. This data on first attendances actually demonstrates that it is more women than than men who attend these clinics - Clinic 1: 56% Female, 44% Male and Clinic 2: 61% Female, 39% Male (Public Health England, 2017). However, it was generally felt by the practitioners that it was women who were more comfortable accessing the sexual health service as it was felt that ‘women are better at seeking healthcare anyway’ (HW10).

Table 10: Sampling profile of patients

Observations/Interviews

PATIENTS	OBSERVATIONS	OBSERVATIONS ONLY	INTERVIEWS
26	23	4	22

Gender

MEN	WOMEN
16	10

Age

20's	30's	40's	50's
9	10	5	2

Sexuality

HETEROSEXUAL	HOMOSEXUAL/BISEXUAL
21	5

Relationship Status

SINGLE	IN A RELATIONSHIP/ MARRIED	SINGLE/DIVORCED/ CASUAL	CASUAL SEX	RELATIONSHIP/ DIVORCED
5	14	2	3	2

Purpose of Visit

SYMPTOMS	REGULAR CHECK-UP	SCREENING	CONTRACEPTION	FOLLOW-UP TREATMENT
8	1	6	3	5

Other Factors

HIV POSITIVE	ALCOHOL/DRUG DEPENDENCE
2	2

Practitioners raised the role of vulnerable or unusual clients who accessed their service. At clinic two they identified some particular vulnerable clients - rough sleepers and members of the travelling community. One woman from the local travelling community always attended with a male partner. The practitioners were trying to persuade the woman to use contraception, as she had previously had a number of unwanted pregnancies. The practitioners informed me that they needed to keep a trusting relationship with vulnerable patients so that they would keep returning.

The practitioners were also aware of venues locally where 'swingers' attended – these were people who engaged in group sex or the swapping of sexual partners. The practitioner who informed me about these clients explained how normalised these sexual establishments had become but I wondered whether this 'normalising' had also become part of the normalising amongst practitioners too.

The practitioners also supported a number of sex workers in the clinic. For example, one client worked in a sex show in another country and another in a pole dancing venue which also offered additional sexual experiences for customers.

Young people (including students) and more vulnerable patients, such as sex workers, were not a focus of this research, however of the patients I observed and interviewed there were five categories of patients encountered. They included those who had participated in casual sex; those who attended as a result of sex outside of a relationship (either themselves or their partner); those who attended on a more regular basis for screening and/or treatment; those who were asymptomatic; and those who were attending for other services provided by the clinic such as dermatology. I have used below the terminology that was used by the practioners within the clinic to describe these categories of patients – 'casuals', 'unfaithful' or 'cheaters', 'regulars', 'worried well' and 'others'.

Amongst the patients who participated in this study, alcohol emerged as a key feature in the categories of 'casuals', 'unfaithful/cheaters' and 'regulars', the latter specifically for MSM. Alcohol was not a key feature in the categories of 'worried well' or 'others'. Interestingly, there was an absence of a category term used by practitioners explicitly about alcohol, apart from one case of a patient who was in

alcohol treatment when the practitioner informed me that he was a ‘drinker’ as well as a ‘regular’. However, the association of alcohol was perhaps implicit in the definitions used by practitioners of ‘casuals’, ‘unfaithful’/’cheaters’ and ‘regulars’. The assumptions about alcohol and its links with sexual risk amongst these categories perhaps held particular stereotypes or judgements. The use of stereotypes, both by practitioners and patients will be discussed in more detail in Chapters Seven and Eight.

Some patients could have been allocated into more than one category, however I use the more prominent characteristics of the patients for their current categorisation. Within the descriptions below I also incorporate comments from practioners too.

4.3.1 Casuals

The practitioners shared that over the last decade they had witnessed an increasing number of patients who attended the clinic who engaged in casual sex, referred to as ‘casuals’. Practitioners explained how they expected students to engage in casual sex as part of this period of experimentation, along with experimentation with alcohol. However the practitioners also shared how they had witnessed more casual sex amongst all age groups.

Casual sex was viewed by the practitioners as sexual activity often with no emotional attachment. Casuals could have one or concurrent partners, and in many instances were just one-off occasions. Some patients had ‘friends with benefits’ who they would see more regularly.

There were five patients I interviewed who were in the casuals category, three men and two women. Three were observed and interviewed, one interviewed only and the other observed only. I have highlighted an example of a male and a female below.

Example 1

Patient 2 was a single mum in her twenties. Following a long-term relationship of many years with the father of her children, their relationship ended due to his infidelity. She mentioned that she had casual sex relationships now, and although using oral contraception, often did not use condoms, particularly when drinking alcohol. Her attendance at the clinic was due to unprotected sex with her ex-partner. As a result, she was concerned that an STI may have been transmitted to a new casual sex partner who she saw once a week.

Example 2

Patient 14 was a heterosexual man in his thirties who had been previously treated for alcohol dependency. He explained he regularly had unprotected casual sex with 'one night stands', particularly when drunk. After the 'one night stands' he would attend the clinic for regular check-ups, but he was always clear which he said made him more blasé. After his most recent encounter he had contracted an STI.

Alcohol combined with unprotected sex was a feature in four of the five casual sex patients interviewed. Patient 18, was the deviant case. She was not from the UK and was attending for emergency contraception following a failure in condom use. Alcohol was not a factor in her sexual encounter and she was very clear that alcohol would never be combined with sex or dating for her, for fear of choosing the wrong partner. 'I mean, if I want to meet someone, I want to, er, not to be drunk. (*Laughter*) but to be sober' (PT 18).

4.3.2 Unfaithful/cheaters

Of particular significance, the practitioners shared their observation about the increase in patients who were unfaithful whilst abroad (discussed in more detail in Chapter Five) or whilst away with friends on weekends in the UK. The practitioners recounted many occasions where it was as a result of drunken behaviour on a stag or hen party, goaded by friends when drunk.

There were three patients interviewed who were in this unfaithful category. Two I observed and interviewed, and one I interviewed only. All were men but only two had

been the unfaithful partner, having sex with somone else whilst away from their partner for a weekend. I highlight two examples below:

Example 3

Patient 26 was a man in his thirties and had been unfaithful to his female partner on a recent weekend away. He explained he had a drunken (unprotected) homosexual experience and was keen to get checked at the clinic, not only for his own reassurance but for the benefit of his female partner. He explained that when he was younger he had oral sex with a man. He stated this was the first time he had been unfaithful to his partner and had not considered the consequences of STIs, particularly HIV until he attended the clinic that day.

Example 4

Patient 21 was a heterosexual man in his thirties, who had been married for many years. He was returning to the clinic for follow up tests following a recent 'one night stand' of drunken unprotected sex while he was abroad.

Practioners explained that the guilt as a result of the infidelity was a growing proportion of patients attending the service. 'I think it's mostly infidelity and the regret that I've seen' (HW7). This infidelity was apparent for both men and women, albeit that 'It is perhaps more with men but it certainly happens both ways' (HW9).

> On a Monday morning they'd come in and say they'd had unprotected sex on a Friday, or they're in a relationship and they'd had a casual, and they can't have sex with their wife or their husband because they need this sorting (HW1).

For the patient who had unprotected receptive anal intercourse with men, arrived into the clinic on a Monday and was prescribed PEP (post exposure prophylaxis) treatment. This meant he would need to have protected sex with his female partner, something he knew he would be unable to keep from her as they also did not use condoms.

An unfaithful patient may continue to have unprotected sex with their main partner but be unaware that they have contracted an STI. The clinic encourages patients to

bring along their partners for screening (called contact tracing) to ensure they have also not contracted an STI. Many arrive embarrassed and ashamed.

The girlfriend of Patient 17 had been diagnosed with chlamydia so he was in the clinic to also receive a screen and treatment. He explained that this may have been caught prior to the start of their relatively new relationship so assured himself that she had not been unfaithful.

4.3.3 Regulars

Gay men, or more specifically MSM, are identified nationally (Public Health England, 2016) and identified by the practitioners locally, as a particularly risk group in terms of STIs and risk taking behaviour. The practitioners felt that the risk taking was more prevalent amongst younger gay men who are experimenting with their sexuality. As a result, meeting sexual partners in a bar or club meant it was also associated with alcohol consumption and increasingly for some, drug use.

> I think there is a big drinking culture among gay men ‘cause they’ve got a lot of clubs and that. The ones that come to clinic, there’s a few elderly ones but there is some younger ones who use alcohol as well for confidence in meeting people (HW6).

But equally, the practitioners were keen to stress this risk also meant that gay men are also more informed than perhaps those who are heterosexual; such a stereotype therefore can often be misleading.

> gay men get tarred with a heavy brush ... there’s a whole load of them who are in stable, monogamous relationships like there are heterosexuals (HW3).

Thus, gay men can be proactive in their sexual health screening and do not have such a stigma of using the sexual health services as perhaps heterosexual clients.

> gay men, they tend to use the services. They come early, sort of, when you first, sort of, erm, come out and start with sexual partners; the health advisor speaks to them and tells them about regular screening at least checking for HIV yearly and things like that. I think they become, “Right,” well it’s part of their lifestyle so

they then will come along and then make use of that, err, the, the service (HW7).

In support of the practitioners view, a gay male couple were two of the patients I 'observed and interviewed'. They attended together for their annual check.

Example 5

Patient 8 and Patient 9 were a gay male couple who had been together for over a year. They attended the clinic together (though seen separately) to receive their annual screen and Hepatitis B Booster. They acknowledged that their attendance at the clinic was a normalised part of looking after their health.

From the observations and interviews there were eight patients I have categorised as 'regulars', six men and two women. Four of the six men were homosexual. I observed and interviewed five patients, interviewed two without observation and observed one. The regulars came for sexual health check-ups, part of ongoing treatment e.g. genital warts or to manage their long-term condition e.g. HIV.

Patient 7 was a regular attender at the clinic for the treatment of genital warts. However, whilst comfortable to access the clinic she had been unable to change her sexual behaviour to prevent STIs due to her inability to negotiate condom use.

Example 6

Patient 7 was a single heterosexual woman in her thirties. She had been a regular attender at the clinic for treatment of genital warts which kept re-occurring in spite of not having sex for a while. She had used the clinic previously for emergency contraception. She admitted she rarely used condoms with sexual partners and finds it difficult to ask a man to use a condom.

Gender is an important aspect when considering the issue of male condom use. Some researchers have found that women may not have the skills to be able to negotiate safe sex and find it even more difficult to discuss with a partner in advance (Cook, 2012). I will discuss the issue of condom negotiation further in Chapter Seven.

Practitioners referred to a number of **'**regulars' of the clinic who are sexual health aware and keen to have regular checks particularly if they change partners or who require ongoing treatment and care.

> you do get people that come for a range of different things, whether it be follow-up for contraception, whether it be your more long-term conditions, like HIV, your wart patients (HW5).

Patient 20, was attending for his regular HIV check, but confirmed he had always been a regular user of sexual health clinics.

Example 7

Patient 20 was HIV positive and in his thirties. He had been in his current relationship for a number of years. He attends the clinic every six months but was also a regular user of sexual health clinics when he was younger. His previous long-term partner was also HIV positive. He explained that he contracted HIV from his ex-partner when they were both drunk.

The practitioners enjoyed getting to know some of the regulars, particularly as so many of their patients never returned to the clinic again.

4.3.4 The worried well

Practitioners explained that many patients arrive at the clinic anxious, even when they don't have any symptoms. Within the literature this categorisation of patient is often referred to as the 'worried well' and was a term used within the clinic. Within sexual health, the 'worried well' emerged during the AIDs epidemic where individuals would perceive themselves to be at high risk, irrespective of their proximity to those who were high-risk and showed no signs of AIDs related illness (Miller, 1986; Harowski, 1987).

Practitioners believed that for some patients they attend to simply gain reassurance or reprieve, particularly if they are feeling guilt or regret. There were two female patients interviewed who were categorised as 'worried well'. One was convinced she had been 'let down' by her new partner, as this was what she had come to expect, and the other was convinced she had contracted HIV.

Example 8

Patient 1 was a woman in her forties who, following a long-term marriage, had re-partnered on two different occasions. In the relationship after her marriage, she had contracted genital warts from the new partner and the relationship ended. This led her to a position of helplessness – losing faith and losing interest in ever meeting a new partner. However she had recently formed a new relationship of a few months. She arrived at the clinic fearing that she had genital warts again. This turned out not to be the case but the sense of doubt was still with her. She explained that alcohol was not a big part of her life, though following the alcohol screen the practitioner advised her she was drinking too much.

Example 9

Patient 6 was a single mum in her forties. She had been married on two separate occasions. On both occasions her partners were unfaithful. This led to a reduction in confidence. In order to increase her self-esteem she started to have casual sex with new partners whom she met through internet dating. She stated she used condoms at first but subsequently stopped after the first few times. Alcohol was not a big factor for her as she felt her confidence boost was met by losing weight and 'getting dressed up' to meet people. She was embarrassed about her recent sexual behaviour and was now convinced that she had contracted HIV even though she had previously tested negative. The guilt and regret were palpable.

This lack of confidence, guilt and regret was a recurring theme throughout the interviews with both patients and practitioners and emerged as a major theme which will be discussed in detail in Chapter Seven.

4.3.5 Others

There were eight patients who were allocated into the 'others' category. Four were men and four were female. The other services they were accessing included contraception (3 female patients), urology (3 male patients), treatment of genital conditions not classed as STIs (1 female) and genital dermatology (1 male). The practioners echoed existing literature that the delivery of these and other services, such as cervical screening, act as an important route into the GUM clinic as it can also provide a legitimate opportunity to raise questions about sexual health (Dixon-

Woods *et al.*, 2001). Six of the eight patients were observed and interviewed; two were just observed. I have provided two examples below.

Example 10

Patient 4 was a heterosexual male in his fifties. He was attending the clinic with a burning sensation when urinating and a tender foreskin. He had been married twice before and was in his current relationship of five years. He had used a sexual health clinic previously when he had a sexual relationship with the 'lady in-between the wives' who had helped to increase his sexual confidence but then later discovered she had been unfaithful to him.

Example 11

Patient 11 was a heterosexual female in her thirties. She had been in a relationship for a number of years and was planning to get married. She had recently attended the clinic due to a recurring bacterial infection. She preferred to come to the clinic rather than her GP. A friend had introduced her to the clinic when her previous partner had been unfaithful and she required a check-up.

The decision by Patient 11 to use the GUM service over her own GP concurs with other studies where patients may prefer to discuss their sexual health needs in an anonymous and accessible service which does not risk the relationship with the GP(Dixon-Woods *et al.*, 2001; Fernando and Clutterbuck, 2008)). There is also a perception that GPs lack the knowledge to discuss sexuality, particularly for older age groups (Haesler *et al.*, 2016) or lack expertise on sexual health (Llewellyn *et al.*, 2012).

This section has provided a summary of the typology of patients who attend the clinic. As well as young people (including students) and vulnerable clients, the practitioners believed that the typology of patients is probably similar in other GUM settings. They also believed that patients might move through the typologies depending on their individual circumstances and changes throughout their lifecourse. This was demonstrated when the practitioners explained that students experiment with alcohol and casual sex, something the practitioners considered acceptable. As well as their assumptions about increased sexual risk following a relationship breakdown, regardless of age. Given that alcohol featured in the typologies of

‘casuals’, ‘unfaithful/cheater’ and ‘regulars’ amongst patients within this study, it also highlighted that age was perhaps not as significant as relationship status when considering the alcohol-sex mix. This will be discussed in more detail in Chapters Five and Eight.

Patients interviewed who had been to the service previously expressed that once they had been through the doors of the clinic, it was easier to return. Given the shift in the reduction of stigma amongst younger people attending sexual health services (see Chapter Five), there may be an increasing growth in ‘regulars’ to the clinic in future, who will perhaps just view their attendance as part of looking after their general healthcare.

The next section introduces the final themes before discussing them in more detail in Chapters Five to Seven.

4.4 The development of themes

As described in Chapter Three, and highlighted in some of the findings above, the emerging codes for patients included alcohol use to increase confidence; the circumstances or journeys which led to the attendance at the clinic; the consequences of behaviours often linked with shame and regret; and finally the contradictions within the accounts. When cross-checked against the codes for practitioners, linked to the changing norms of sex and relationships, and how this had changed practice within the clinic, the following overarching themes emerged.

1. <u>The changing norms of sex, relationships and the sexual health clinic.</u> This first theme, presented in Chapter Five, provides the contextual narrative that emerged during this study. It highlights the changing norms of sex and relationships from a historical perspective in terms of changes over time, as well as changes for individuals over a lifecourse; including the alcohol-sex mix. There were two relatively recent developments identified in the data, which has accelerated some these changes – the internet and sex tourism. This will highlight the expectations of sexual behaviour over the life course and at key transition points, and reflect what this means for a sexually active ‘older’ adult.

2. The moral narrative of sex and alcohol. The second theme, presented in Chapter Six, builds upon the contextual framework identified within the first theme, but focus on the what actually happens when an individual becomes a sexual health patient within the clinic. I consider the language used by participants within a medical environment. I discuss how for some patients the clinical consultation became shrouded in a moral narrative,regarding their sexual behaviour and alcohol use. In particular, I explore the role of some patients in the search for recovery of the 'moral self', who were not like 'others' who deserved to be there.

3. The pleasure, the shame, the guilt and the blame. This final theme, presented in Chapter Seven, brings to life the emotions behind the language used within the clinic. This builds on the moral narrative to understand the feelings of shame, guilt and regret which emerged in the previous two chapters. I then discuss how these feelings ultimately manifests in the apportionment of blame, including the role of alcohol as a legitimate scapegoat. It also considers how in this search for blame, some norms and stereotypes have perhaps not changed over time inspite of the historical changes identified in Chapter Five.

4.5 Chapter summary

In summary, this chapter has provided an overview of the clinics, highlighting some of the common features and ways of working within the GUM clinics – language, anonymity, 'atrocity stories' and teamwork. I have also introduced the common characteristics and typology of the patients who attend the clinic – casuals, unfaithful/cheaters, regulars, the worried well and others who attend to access other services.

The next chapter introduces the first theme of the changing norms of sex, relationships and the sexual health clinic. This looks at the historical changes of sex and relationships over time in the UK and how this was reported within the clinic. It also explores the changes to the definition of sexual relationships and how key sexual transition points during the life course are combined with alcohol.

Chapter 5: The changing norms of sex, relationships and the sexual health clinic

This is the first of the three empirical chapters. In this chapter, I discuss some of the contextual changes to sexual relationships, including the views of marriage, monogamy, concurrent partnerships and casual sex. In particular, I explore how within this study it was casual sexual encounters which were mainly associated with alcohol, and for MSM, casual sex was also combined with both alcohol and drug use.

I argue that relationships are for many, no longer linear and that the alcohol-sex mix can continue throughout the life course. I demonstrate this by describing the journeys for those re-entering relationships following key transitions such as separation, divorce or bereavement.

I go on to discuss two significant developments, highlighted in particular by practitioners which they perceive has aided the changes to sexual relationships - sex related internet use and sex tourism. I share some of the positives and negatives from these developments that emerged during the study, as well as explain how these changes have manifested within the clinic.

I end the chapter by sharing the expectations of sexual behaviour at key sexual transition points during the lifecourse. Practitioners and patients reflect on sexual decision making in early adulthood to decisions made in mid to later life. This highlights some of the barriers that a sexually active ‘older’ generation may experience. I argue that whilst sexual relationships may have changed over time, for ‘older’ patients, there continues to be a stigma associated with sex, relationships and the sexual health clinic.

5.1 Redefining relationships

Throughout the interviews and observations, participants discussed sexuality through the construct of relationship status; be it single, having casual sex, being in a long-term relationship or married. As already highlighted in Chapter One, the significance of marriage in the UK has changed over the past few decades and this also arose during the interviews.

> a lot of people don't get married these days … go back 20 years, 25, 30 years, everybody courted, then got married, then had kids (HW1).

Marriage was perhaps still viewed as the most socially approved context for sexual activity even amongst some practitioners, and this was amplified within the clinic due to the integration of family planning services alongside the GUM service. Family planning clinics, now renamed CASH (contraception and sexual health), still hold their traditional label, which continues to be utilised by patients and practitioners alike. Hence, for participants in this study, sex is still linked to procreation.

For those who are married, there is perhaps still a societal expectation that they will remain monogamous and any extra marital sex continues to carry a level of stigma. Yet, as initially outlined in Chapter Four, practitioners described a small number of patients who were married but who also enjoyed sexual relationships outside of their marriage.

> It's quite acceptable to have casual friends as some of them call them … and we've had people in admitting that they have another partner. They are married and they have somebody else who is their sexual contact out of marriage (HW2).

For one married patient, he explained the reasons behind his need for casual friendships as his 'sex drive are sky-high up here, and my wife doesn't need that much' (PT21). The casual friendships were a means of meeting those physical needs. His attendance at the clinic was due to a casual sexual relationship where he 'did not use a condom at first'. The sex took place after consuming alcohol.

> When you do it without a protection, that's when alcohols involved, especially, you know you got a wife and er, you come back home (PT 21).

Although he stated he did not regret the sex, he did regret having to attend the clinic.

> For the first time actually, now, I see, erm, the value of marriage through my own eyes and through my own understanding … I saw that sex for, for erm, just sex' sake … there is no feeling in the background (PT21).

For him, having to explain his actions to his wife was publically embarrassing, as she also had to attend the clinic for a sexual health screen. He believed this recent experience helped him put greater value on the emotional element of his marriage, as oppose to the purely physical relationship with a 'casual friend', so perhaps the disclosure to his wife of his infidelity was the most regretful.

However concurrent partnerships arose not only during marriage, as one other patient explained he was 'happy going about with a few different people' (PT16) at any one time. Following his recent relationship break up, he was contemplating whether he would now be with 'one partner or more partners, just depends what comes along' (PT16). Therefore was again open to the concept of concurrent partnerships.

As well as concurrent partnerships, it was accepted by all of the participants that individuals no longer have one relationship throughout the life course but 'multiple relationships over a time' (HW2). As explained, this was often at key transitional stages within relationships,

> They've come out of a monogamous, you know, relationship whether it's through death of a partner or through a divorce or whatever, and then they're, sort of, now into that, err, arena where they're meeting somebody new and then they're endeavouring to start on a new relationship (HW6).

Participants described how social attitudes to having a number of partners during the life course had changed 'had more of a stigma, if you went from partner to partner' (HW8). However, all participants felt that these norms have now changed and no longer carry the same level of stigma,

> I don't think you should have any shame about it really. I think if you want to go out and just be careful, then there's no harm in it, there's no shame (PT2).

The practitioners spoke of ‘older’ patients who were starting to date again after the end of a marriage or long-term relationship, but had not practised safe sex (protected), and were now required to consider the risks of STIs and pregnancy,

> You’ll find that they may’ve had sex with somebody younger, as a casual, or somebody they have seen for a short period of time, and they’ll say, they’ve never heard of the GUM clinic, they’ve never thought of using condoms, they’ve been in a long-term relationship for years they wouldn’t think of it (HW1).

For some patients, the period following the breakdown of a long-term relationship can also mean a time to ‘have fun’ and ‘go mad’ as explained by this patient, ‘I’d been in one relationship for that long I was just like, “I’m free!” (PT15). For some, however this freedom was shortlived. For practitioners shared how so many of their ‘older’ patients had ‘gone of the rails’ and started on a ’bad path’, ‘gone wild and they’ve had a few partners, two, three or half a dozen’ (HW3). Some patients also reflected their embarrassment of moving from monogamy to a period of having multiple sex partners; this embarrassment was mainly felt by female participants within the study,

> Cause I’d never had, you know, I could count on one hand the amount of sexual partners I’d had. I mean I’ve been married twice, but ten years each time and that’s it. Erm, so yeah, sort of did that and thought, “Oh my God,” and horrified at myself (PT6).

This ‘horror’ and the short lived period was perhaps as a result of having to deal with the consequences of their behaviour, particularly linked with reputational damage. In the case of this patient, the consequence was having to attend the sexual health clinic,

> I’m divorced and I’m older and I can do what I like. But you only do that and end up, from my point of view, you only do that and end up here (PT6).

This study has found that the former expectation by society of a linear relationship journey, starting with courtship and ending in a monogamous marriage has perhaps shifted. As a result, the definition of what constitutes a long-term relationship has also changed,

> What classes to them as a long-term relationship may not class to us as a long-term relationship. So when somebody says, “Oh I’ve been with my partner ages”, and I go, “So how long is that?” And they go, “Nine months”, and you think, well that’s a new relationship in my eyes, you’re just learning to get to know each other (HW1).

This view by the practitioner of the period required to become familiar with someone, differed from her own personal expectations.

The relationship journey has been redefined, and participants discussed how there had also been changes in the speed at which it develops. This manifested in the changes to what was traditionally viewed as the period of dating or courtship. Dating was previously part of the journey on the route to long-term relationships and more specifically marriage,

> The girl and boy, now, holding hands, then they kiss, then holding the boob, and then take it from there (HW8).

Instead, casual sex, referred to as a ‘casual’ within the clinic, is now a recognised form of a sexual relationship. For many participants within the study it is viewed as a key part of the ‘dating’ experience. Casual sex is defined as non-committed, one-off or brief sexual encounters, but in fact even casual sex has nuances (Wentland and Reissing, 2011). Wentland and Reissing (2011) described four types of casual sex including; ‘one-night stands’, ‘booty calls’, ‘fuck buddies’ and ‘friends with benefits’. Each defined by their frequency of contact, type of contact and the amount of emotional disclosure. Each fulfil a specific need and as one patient noted, ‘it fulfils its purpose’ (PT20).

Sometimes casual sex is planned and sometimes unplanned, as identified by one practitioner when recounting a recent discussion with a patient, ‘I’ve never had sex with me friend before, but we were drunk and I was using his shoulder to cry on’ (HW1). These moments then also transform the more traditional notions of friendship too.

However, many participants believe that the overriding ‘in the moment’ drive is simply linked to excitement and pleasure ‘as long as you do take the right precautions then enjoy yourself’ (PT15). Pleasure will be discussed in more detail in Chapter Seven, but for the patients within this study, the pleasure narrative seemed more rooted in the feelings of desirability as they aged, particularly amongst female patients.

When patients attend the clinic, the practitioners undertake a sexual history assessment, which includes the disclosure of the number of sexual partners. Practitioners shared that patients felt no shame in sharing this information, ‘They are quite happy to tell you all this and some of them go into quite detail with you’ (HW2), some are even quite proud, ‘I think the worst I’ve written is 50’ (HW1).

The association of alcohol with casual sex, in particular one night stands was a key feature in the study. As one patient noted,

> I’ll hold my hands up, more often than not, any sort of intercourse has come from the majority of the time, casual, after I’ve had a drink (PT15).

Having ‘a drink’, albeit referred to here as a single drink, seems to imply that the two are correlated, particularly with a ‘casual’. Practitioners also referred to ‘drink’ in relation to casual sex,

> I think a lot of people now, it’s out, have a drink, meet someone, and that’s it. End up either chatting to them and if it’s not sex the first night, but pretty, pretty soon after (HW6).

Sex was considered by particpants as part of the drinking experience, and expectations about sex following a ‘drink’ is perhaps, for many, an implicit part of any new sexual relationship. This section has demonstrated how participants believed relationships have changed over time and the number of sexual partners over the life course has increased for many. This is not just acceptable but expected. In their interviews, some of the practitioners continued to hold a more traditional view of dating and relationships. Some also held stereotypical views, particularly of casual sex, and also alcohol-related sex amongst MSM. I focus on MSM in more detail next.

5.2 Men who have sex with men

The literature on alcohol and sexual risk behaviours amongst the Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex (LGBTQ+) community has predominantly focused on MSM. As indicated in Chapter One, there is now over thirty years of research in this field which emerged during the 1980s as part of the HIV/AIDs epidemic. However, the association of alcohol and risky sex in MSM populations is complex. The relationship is contested for a number of reasons.

Firstly, the interaction of alcohol with other drugs, also considered a feature of the socio-cultural life of gay men (Mullens *et al.*, 2009; Pollock *et al.*, 2012) often makes it difficult to distinguish the correlation of each substance. Secondly, the desire for sex leading to the drinking rather than vice-versa (Bolton *et al.*, 1992). Finally, the need to account for relationship status, as alcohol use prior to unsafe sex is more common in encounters involving casual partners rather than stable partners (Vanable *et al.*, 2004).

MSM were identified by practitioners as a particular high risk group accessing the GUM service, and were known to participate in risky sex where alcohol featured - ‘use saunas, gay bars and parties’ (HW5), where alcohol is often available. These settings can provide opportunities for both heavy drinking and sexual risk taking. This was explained by one of the identified gay patients,

> Gay men are so much more promiscuous and there’s alcohol involved in all of the decisions that they make. Because as soon as we’re single we’re out on the gay scene and we’re predators, we’re out there, we’re hunting for another partner or just a sexual partner. And that’s always surrounded by alcohol, I don’t know many gay men that don’t drink unless they’ve been called alcoholics and then they stop. And that’s the only time I know gay men to stop drinking (PT20).

This patient describes this process as more akin to animal behaviour as ‘predators’ to find a sexual partner to mate with, reaffirming the promiscuous stereotype driven by the need for sex as oppose to a relationship. Alcohol is key feature of this drive, with this patient inferring that all gay men use alcohol as part of that hunt. However, for one MSM patient, the use of alcohol also helped him to explore his sexuality,

> I've always been sort of curious about … I suppose bi-curious would be the word, erm, I think when I was probably about 20 I sort of engaged in a bit of sort of oral sex, but that was it really until this Friday and I stayed in this hotel. Erm, it turned out the hotel was actually … were kind of owned by a, a gay bar … and I wasn't too bothered about that ... I think I went to this function and then went back to the hotel and decided to go for another drink in the bar and sort of got talking to a couple of guys and one thing led to another (PT26).

When asked about whether this homosexual encounter would have happened without alcohol, the patient was very clear it would have not. The patient explained that he was not fully aware of the impact of unprotected anal intercourse on his HIV risk and also that of his heterosexual partner.

Another patient who identified as gay also confirmed that alcohol provided the confidence to enter the gay scene for the first time too, therefore was viewed positively,

> Having the confidence to be able to enter into those kind of situations or those kind of bars … alcohol helped me completely (PT20).

As identified earlier, the link between alcohol and drugs for MSM has also witnessed a shift in the UK, a term originally coined by MSM on apps as 'chemsex'(Hegazi *et al.*, 2016). This focus on drugs as opposed to alcohol is in order to enhance pleasure and prolong sexual functioning (Mullens *et al.*, 2009). Unlike drugs, the effect of alcohol is on sexual performance 'loss of erection mainly, and … that's probably it. I mean that's quite a big one though, it's quite big if it happens it's all over' (PT20). So using drugs to enhance performance is for some, a preferred option for some within the MSM community.

> Drugs is a massive thing in the gay scene. My ex-partner is now an, a crystal meth addict, and he's lost his job, he's lost his whole life. But he goes to these sex parties and he does it, there's all sorts of stuff like that going on (PT20).

As this patient described, drugs are integral at ‘chemsex’ parties. These parties can last up to 48 hours, however, whilst in the short term it can actually help with sexual performance; the longer term impact can be far more devastating.

When looking at the different age groups amongst MSM, practitioners considered older gay men as more aware of sexual risks compared to younger gay men. This was linked to the knowledge obtained from the former HIV/AIDs prevention campaigns in the 1980s.

> The younger [gay] generation, they don’t seem to really care very much, they’re not very much aware what the implications of what could occur, of what could happen (HW8).

One participant was HIV positive and had acquired HIV when he was younger. The Consultant later confirmed that he had struggled with his HIV status and had initially used alcohol to cope or come to terms with this condition. As a result, he had decided to withdraw from social media and the socio-cultural life of the gay scene. He now concentrated on work, had not had a relationship for a number of years and stated he now had his alcohol use ‘under control’ (PT3).

Over the last decade however the ability to meet new sexual partners, in particular casual sex partners, has actually moved beyond the bars and into the home. One of the key developments that has facilitated this is the use of the internet and mobile technology. Sex related internet use will be the focus of the next section, not just for MSM but people of all age groups and sexual orientation.

5.3 Sex related internet use

In 2017, 89% of adults in the UK had recently used the internet, 90% of men and 88% of women (Office of National Statistics, 2017). In terms of access, 73% of adults accessed the internet ‘on the go’ using a mobile phone or smartphone, more than double the 2011 rate of 36% (Office of National Statistics, 2017). This expanse of internet usage and mobile applications (apps) has perhaps become a game changer in the pursuit of finding love; seeking new sexual partners; purchasing erotic products in private (e.g. videos, sex toys); access to pornography to aide masturbation;

provision of sexual health information and access to online tests for detecting STIs. As one practitioner explained,

> I think people obviously have at their fingertips now, much more information, which doesn't necessarily need to have been obtained face-to-face (HW4).

Practitioners described that this additional layer of anonymity rather than a 'face to face' contact with professionals had certainly reduced barriers to access sexual health services. Researchers have already identified anonymity and access as two of the five benefits of sexually related internet use, described as the 'quin-A engine'. The other three include acceptability, affordability and approximation (Ross *et al.*, 2007). For patients attending the GUM clinic, most of these benefits were also highlighted, and I will provide examples below.

The practitioners were particularly positive about the use of the internet for individuals to access information about STIs. Whilst this access did not directly translate to reducing the demand for their service, patients were more informed on arrival to the service.

Practitioners felt that for some patients, as attending a clinic was a stigmatising experience, access to testing and treatment through the internet e.g. chlamydia, helped to reduce barriers 'it's a lot easier now for people to be able to do that without having to pluck up courage to come in' (HW4).

However, they also highlighted some reservations around safety and online privacy in the context of the exchange of sexually explicit images between sexual partners via the internet. As one practitioner explained,

> We always try and persuade people not to disclose things 'cause, you know, your best friend next week might be your- you know, your worst enemy and slap on Facebook that you've got the clap (HW4).

The practitioners felt they had a key role to educate patients about the risks of using the internet with one practitioner mentioning the need for training on an 'internet safety course' (HW2) to support their role.

Pornography was raised as a specific issue by the practitioners, as explained below.

> What they're seeing on the internet, they think that's kind of normal, and what they all should be doing, with the things like anal sex, and even simple things like girls being totally shaved (HW5).

The practitioners described that this access to pornography had the ability to raise unrealistic expectations of sex and sexuality; normalising aspects of body image and sexual acts that was considered more aligned to ‘porn stars’ than real life.

Managing expectations however was most notable in the discussions on the role of internet dating websites and apps. The practitioners shared their views from their interactions with patients, ‘the only way they’re going to find somebody is on the internet’ (HW1). This was seen as particularly important for those who are ‘middle aged’, who perhaps did not have a large circle of single friends; had busy lives with work and family commitments that prevented them from meeting someone quickly.

Meeting a partner through traditional routes, such as forming relationships at work or through hobbies was viewed by participants as time consuming. Internet dating sites and apps were viewed as a way to expedite the process. Both patients and practitioners discussed the expanse of such sites in a negative tone, ‘there’s some serious ones, there’s some nice ones, and there’s some seedy ones isn’t there … which are really, all they’re looking for is sex’ (PT8). The implication of their use as simply a way of using people for sex and other things, as opposed to a place to find a relationship was recounted by participants and described by the patient below,

> People I know who have been on the dating websites, erm, and seem to have got a couple of psychopaths and narcissists who’ve used them, tried to use them as a meal ticket (PT23).

The main concern was being clear about the expectations when using such sites. For some patients they had a genuine interest to meet someone in order to form a longer-term relationship, but found it difficult to meet someone compatible ‘I did a bit of internet dating but they were all weird’ (PT7) and thus ended in disappointment.

Such disappointment was compounded when it was felt that people were not honest on their ‘profile pages’, as described by one patient,

> In person, he was completely different. I really prefer to meet people in person. The first impression you get in person is totally not the same as the first impression you get with a dating app (PT18)

This need to be ‘a bit more genuine’ was explained to be linked to finding the right site for you. One patient explained, that if you were after a relationship ‘I’d suggest you pay a little bit for it’ (PT15) as the free sites were deemed more ‘unsafe’. Safety was twofold - the risk of contracting STIs and of personal safety. Practitioners explained, this was confounded for those re-entering the sexual arena in later life;

> Patients who are leaving long-term relationships and often are less clued up in terms of safer sex, having come out of long-term relationships and putting themselves at risk and meeting people on the internet, which is a biggie now in terms of Facebook (HW4).

The risks of personal safety and sexual violence was raised by both practitioners and patients, with one patient expressing real concern for the welfare of her friend,

> My best friend, and she’s single and she’s on PlentyOfFish. And, erm, she has two or three dates a week, and they’ll go for a coffee or a meal, but she always invites them back to her house (PT11).

Going ‘back to her house’ implies sex. As it was at her invitation, it suggests that she was initiating the encounters which her friend (who was in a long term relationship) struggled to comprehend. However, one practitioner did raise the issue of violence and sexual violence as a direct result of meeting strangers through internet dating,

> I’ve had a couple of people who’ve come in … they’ve been badly treated, and it’s because they’ve met people off the internet. You’re on that cusp of, “Have you informed the police, have they done this to other people, is it getting worse over the time that they’ve been doing it, and is there other people out there at risk?” (HW1).

The contact between the practitioners at the GUM service and the police has reportedly increased over the last decade and I return to the theme of sexual violence in the next section. For now, I want to discuss the issue of anonymity and its connection with internet dating or mobile apps.

For the computer or phone screen, rather than the face-to-face contact, can also provide the opportunity to be anonymous. For some patients, they explained that it helped to increase confidence to engage in sexual chat that would be difficult to undertake face to face. This was particularly the case for one patient who explained he was so shy, even with alcohol, he found it difficult to meet someone; however 'In the last three years, it's all been through the internet' (PT12). He was a deviant case in terms of the use of alcohol to increase confidence, as for him it offered no benefit to his confidence. For most participants who had tried internet dating, alcohol also helped to gain confidence as 'you can still have a glass of wine and be quite confident when you're typing away' (HW6). As a result, for one patient she 'liked the texting and the chatting more than the, the meet' (PT6) as it made her feel desirable following the breakdown of her marriage.

I will now return to the issue of accessibility and its relationship to the use of dating or 'hook up' apps. Tinder, mentioned by the patient below, was initially introduced as a dating app for heterosexuals but has also been referred to as a sex or 'hook up' app (Sumter *et al.*, 2017)). Hook up refers to a single or ongoing sexual activity between individuals not in a committed relationship (Wentland and Reissing, 2011) and some of these sites use geosocial networking as a way of identifying others in your geographical proximity for sex. Therefore, the motivation is not to meet with a longer-term relationship goal but to meet someone for casual sex.

> I met them on Tinder. It was a joke just to see what it is and how it works and stuff. Er, I would have never imagined to meet someone to have, to really have a relationship with. And I don't think that it's a good way to meet people (PT18).

This patient reports that she was encouraged by her friends to try the app, so she did it as 'a joke', thus with no expectation of meeting someone for a long-term relationship.

Apps which make use of a mobile devices geolocation was considered by practitioners and MSM participants as a fundamental part of their social identity,

> So Grindr's massive, Grindr's massive … I mean, you know, again nearly everybody I know is on it' (PT20).

Grindr was launched in 2009 geared towards gay and bisexual men, designed to help them meet other men in their area. MSM patients viewed the use of these mobile apps as a benefit for meeting sexual partners with no further expectations. However, the practitioners felt it reinforced the stereotype regarding the promiscuous behaviour of gay men, driven by sex rather than forming a relationship,

> I didn't know until quite recently that gay men actually have apps on their phone which means they know when there is another gay man around because it beeps or something. We have had people in here who have come in for a check-up and they have literally met somebody on the street through these apps and gone off and had sex. Nothing to do with alcohol; alcohol is not involved …The one I am thinking of had rung in the middle of the afternoon, he had literally met this man locally and gone off and had sex. He rang us and he said, "I have had a risk 20 minutes ago" (HW9).

The ability to meet someone for sex, and as indicated by this practitioner without the need to meet for 'a drink', has altered the immediacy of the casual sex encounter for groups of all sexual orientation. Such spontaneity may not even provide the time to consider the use of condoms.

As well as sexual risks linked to STIs, another negative impact which featured in the data, and touched upon above, was the relationship between alcohol and sexual assault, and how this has manifested within the clinic. This will be discussed in more detail next.

5.4 Sexual assault

Sexual assault includes sexual harassment, sexual coercion, attempted rape, rape, child abuse and exhibitionism and the terms sexual assault and sexual violence refer to any type of sexual contact that is not freely consented to by one of the persons involved (Davis *et al.*, 2013). Based on aggregated data from the annual crime survey for England and Wales (2009-12), females are much more likely than males to have reported being a victim of a sexual offence. Overall 2.5% of females and 0.4% of males had reported experiencing some form of sexual offence in the previous 12 months (Ministry of Justice *et al.*, 2013).

Additionally, it is estimated that approximately half of all sexual assaults are associated with alcohol, for the perpetrator, victim or both (Abbey *et al.*, 2004; Lorenz and Ullman, 2016). This has been supported by a UK based study into sexual assault and alcohol use in attendees at a GUM clinic (Blume *et al.*, 2012). In their study, Blume et al (2012) also found that over half of victims had been drinking prior to the assault with the majority believing that alcohol contributed to the assault.

Women who are heavy drinkers may also be at higher risk of sexual assault and targeted by perpetrators (Abbey *et al.*, 2004). This was supported by one of the patients who worked in a bar. She witnessed men deliberately targeting women who were drunk,

> I see it every day. If there's a really, really beautiful girl who is, you know, absolutely beautiful but she's not drunk, even though she's the person they like, they'll choose the drunker one 'cause the, the chances are they will get further. Even if they're the one they didn't actually want to be with, they'll always choose the drunker ones (PT2).

Practitioners shared that the clinic has seen an increasing number of sexual assault cases; victims require sexual health screening and prophylaxis (preventive treatment) for STIs including HIV. As a result, practitioners explained how they had provided an outreach clinic at the local Sexual Assault Referral Centre (SARC). More recently, victims of sexual assault preferred to be seen at the hospital based GUM clinic alongside other patients rather than return to the SARC. The practitioners shared that

they find the sexual assault cases challenging, particularly when the victim is unable to remember what happened,

> they woke up without their knickers on, they woke up in somebody's house they didn't know … some of them don't even know whether they've had sex or not "I don't know whether I had sex or not", that's what they say (HW2).

This inability to remember was more often explained by alcohol. The practitioners encourage patients to report to the police, 'but trying to get them to go to the police is still, still really difficult, and a lot of people if it's been after alcohol, they just want to forget it' (HW1). The patients are often too embarrassed particularly if they cannot recall events, for fear they may be judged for being drunk. As one practitioner explains, it is still important for them to take any forensic evidence in case a patient does decide to go the police,

> They woke up in his bed or they can't remember consenting to anything which is a whole new issue and we have to try, obviously unless there's solid evidence but we used to just, erm, take the swabs in and just keep them as what we call the chain of evidence ... It doesn't happen that often where they do pursue anything, especially if I think deep down they are thinking, you know, "I don't know what happened because I was drunk (HW2).

This indicates that the level of alcohol related sexual assaults amongst GUM clients is potentially much higher than the amount reported to the police. Alcohol was reported as a key feature in these assaults, but it carries a level of blame that makes it difficult for victims to report.

Most of the discussion about sexual assault by practitioners was regarding female victims, but as evidenced in the national data, men can also be a victim. In the following instance described by one practitioner, the patient did not want to speak to the police as the assailant was in fact his male partner,

> Very few men tell you, but we have recently had a few men that have been sexually assaulted … a guy came in last month and he was sexually assaulted by his partner, and two of his partner's friends (HW1).

This impact of sexual assault, in particular alcohol related sexual assault on patients attending the clinic was described by the practitioners to have increased over time, particularly by those who had worked at the clinic for many years, and it was felt they are significantly under reported to the police. These cases do not just affect the victims, but also the practitioners. Sexual assault of course does not just happen at home, but can also happen abroad. The next section will discuss the second significant development highlighted within the data on sexual behaviour, and in particular casual sex - the growth of sex tourism.

5.5 The growth of sex tourism

Over the past few decades there has been a significant increase in affordable foreign travel. There is evidence that tourists may behave differently abroad than they do at home which some describe as a climate of abandon or escapism (Padilla *et al.*, 2012). Some may also travel with the intention of having sex (Bellis *et al.*, 2004).

The Natsal-3 survey found that 9.7% of men and 2.6% of women amongst those aged 35-74 years in their sample has reported at least one sexual partner whilst overseas in the last 5 years; with a strong association for men in this age group who pay for sex (Tanton *et al.*, 2016). In terms of sexual health, evidence in the literature reports a higher incidence and prevalence of STIs amongst people who holiday abroad; a greater likelihood of multiple sex partners and an inconsistent use of condoms (Arvidson *et al.*, 1997; Downing *et al.*, 2010; Vivancos *et al.*, 2010; Simkhada *et al.*, 2016).

In this study, one of the noticeable changes over the years highlighted by the practitioners was the increase in ‘holiday makers’ attending the clinic.

> I do see plenty of women in their 30s and 40s who go off to Turkey, and probably aren't in a relationship here at the moment, but will go off and have sex, usually after alcohol. It's probably something like they don't drink very much here; it's just that when they're away, it's different (HW10).

As identified within the literature, the holiday is a time to be ‘different’ where you can alter not just drinking behaviour but your sexual adventure, ‘I used to live abroad … I did quite a lot of things after I’d had a drink, I’d put myself at risk when going with somebody’ (PT10).

This ‘risk’ for patients attending the clinic was mainly linked to their lack of condom use and in the end ‘they've panicked after they've had that bit of passion on holiday, which is good on them. But obviously, they need to know the risks’ (HW7). As a result for one patient, he contracted an STI, ‘I caught chlamydia when I was in Canada, I was drunk and jumped into bed with the first girl’ (PT22).

There were mainly two stereotypical groups of patients discussed by practitioners who participated in casual travel sex: women who had a ‘holiday romance’ and men on stag parties who ended up ‘sleeping with prostitutes’ (HW2). This very definition portrayed the gender differences held by practitioners of women seeking love and men seeking transactional sex.

> We see a lot of women, actually, who go on holiday and end up having a one-night stand, often with a Turkish waiter. It happens loads (HW10).

One patient in this study also went travelling following the breakdown of her relationship and explained that she had a number of casual sexual partners whilst travelling and had contracted an STI.

> PT15: I went travelling and it felt like you were back at kind of university again … it was exciting and it was fun
>
> Interviewer: So did you have a number of sexual encounters when you when you were travelling?
>
> PT15: Erm, I think I had five throughout a year and half, erm, one, one of them in Australia I was, erm, casual, and then another guy near the end I met up with … and unfortunately is the one who I think the warts come off.

The ‘excitement’ and ‘fun’ can often override the need to use a condom. As one practitioner explained,

> They are on holiday, they probably had a few drinks, they meet somebody, they go and have sex. It is not pre thought out. They don’t use a condom because they haven’t got one. It is all just very spontaneous (HW9).

This ‘spontaneity’ is again linked with alcohol and lack of preparation for a sexual encounter. Participants described how alcohol plays a key factor in casual sex abroad; in fact sex and alcohol are inextricably linked to the tourism economy in some parts of the world. As identified in Chapter Two, some bars and nightclubs operate as informal sex establishments, with workers employed to form sexual relationships with tourists (Padilla *et al.*, 2012).

Not only has alcohol ‘massively affected their decision making’ (HW4) but on some occasions led to sexual assault,

> We see women coming back from mainly Spain, Turkey, either they’ve been sexually assaulted when they’re out there, or they’d been, had a new boyfriend for the fortnight they were there and then they’ve come back and realised (HW1).

Having a ‘boyfriend for the fortnight’, again reinforces the gender stereotype that women are looking for romance. Yet for male holiday makers, very often ‘they’ve been to stag weekends … and they’ve had a brief encounter abroad’ (HW7). By their very nature, these stag weekends include alcohol where men are expected to participate in games and pranks,

> They set themselves up for things or they set their mates up for something that they later sincerely regret. We have had cases where people have been set up with prostitutes and they have been drunk so they have gone along with it. They realise in the cold light of day they have done something very, very foolish and are very worried for the next three or four months until all their tests come back (HW9).

The ‘cold light of day’ is actually the longer term impact when they return home. For those who are in a relationship at home, ‘they come back, and they just cannot live with themselves’ (HW10). Because some of the STI results (in particular HIV) are not reactive until months later, this can lead to immense regret and worry for the patient, particularly as they are unable to have unprotected sex with their long-term partner for risk of passing on an STI.

> They go away, they go to Spain, I could name you two or three patients to whom that has happened. They have been the bane of our lives because they have been on the phone, they have been in the clinic day after day after day worried until they get the all clear (HW9).

The practitioners coin these demanding patients as suffering from ‘guilty penis syndrome’ and will be discussed further in Chapter Seven. The practitioners also explained that for some, the experience has not actually deterred them and they become regular attenders, frustrating the practitioners, who feel these patients have not amended their behaviour.

I have described above how the transitions and developments have changed the norms of sex and relationships presented in the clinic, however I now consider in more detail the expectations of sexual behavior at key sexual transition points during the lifecourse. I initially discuss early sexual behaviours, and although not a focus of the study, I demonstrate that for some patients behaviours formed in early life can continue or inform behaviours in later life.

5.6 Transitions during the lifecourse: Coming of age

Early adulthood is a time during which both sexual exploration and alcohol experimentation takes place. Evidence shows that those whose first experiences occurs under the influence of alcohol are less likely to have planned for contraception (Weinhardt and Carey, 2000). Additionally, alcohol use before the age of 16 years is associated with sexual initiation before that age too; with young people more likely to regret having sex after alcohol use and less likely to seek an STI test (Bellis *et al.*, 2008).

Interestingly, the practitioners commented on the reduction of school aged young people into their clinic, ‘I’ve seen a decline, when I first started they were coming from school, 13s, 14s and I think it’s been noticed by everyone that we have a lot less and they’re more over 18’ (HW6).

The practitioners believed that this was due to an increasing number of people who delay in first sex ‘maybe 19 or 20, who’ve not had sex yet. So I think there are more who are waiting’ (HW10).

As one of the sites was located within a university city, the practitioners frequently discussed students. Although being a student is not the focus of this study, the acceptable expectations during this period amongst practitioners is an important context when discussing their beliefs and expectations in later life.

> I think it's kind of expected a lot now ... I'm at uni, but that's what you do’ (HW5).

Most practitioners made the link between alcohol and sex for the student population and believed one implied the other. Specifically sexual risk whilst under the influence of alcohol and in particular the link with the availability of cheap alcohol ‘especially the student bar ‘cause it’s cheaper, isn’t it?’ (HW7) and pre-loading with bottles of spirits prior to a night out.

> I think a lot of them, they go to a pub or something and get really drunk, and then just end up having sex. I don't think they go with that intention. I think it's a consequence, rather than, "I'm going out tonight with the intention of having sex with someone." I think it's usually the other way around (HW10).

For students, this ‘intention’ (or not) to have sex is one aspect of their approach to sexual decision making. The other is how they assess potential risks through indirect cues such as appearance or knowing their friends (familiarity). This will be further explored in Chapter Seven for patients within this study, as if these negotiation skills are not acquired early in life it can also impact in adult life.

Within the interviews, patients reflected back on their own early sexual and alcohol experiences**.** The link between alcohol and sex was associated with fun and

excitement during an earlier part of their life when they had more sexual partners. They recognised it as a time where they took more risks as explained by this patient,

> I was a right bugger when I was young, I was really bad. Wanted to be the cool girl and I used to do, no, I wouldn't say sleep around but there were like three girls and three blokes and we were always like, sounds awful doesn't it, but it was the teenage thing where you'd swap boyfriends every few months. So, er, I was quite promiscuous (PT7).

For this patient having sex was a way of fitting in with her peers. When she reflected back in the interview she was embarrassed when describing her behaviours. Other patients were also embarrassed at the risks they took when they were younger, including losing their virginity at a very young age,

> I lost ma virginity when I was 12 … and I was, that was very, very wrong of me doing that … Like, like ma little nephew, he's 12-year-old now and I'm like, "That's wrong. It's just totally, totally wrong" (PT22).

Being able to identify with his nephew, this patient was able to see how 'wrong' this was, and felt embarrassed.

For some of these patients alcohol also featured in this new experience as a way of giving increasing confidence and drinking 'for the fun of it' (PT2). Some patients believed that 'it's just part of growing up really' (P22). Starting to experiment with sex, sexuality and of course alcohol and 'I think that's quite a natural process' (PT21) and a time when you are 'more curious and inquisitive' (PT19).

However, for one deviant case, being younger did not provide the opportunity for such experimentation due to the rise at that time of HIV/AIDs,

> My generation were … becoming sexually active, erm, very early '80s, right at the beginning of the '80s, just at the time that all the scaremongering with AIDS was beginning. Erm, so … my personal decision was, not that I ever got the chance, not to be promiscuous (PT23).

Not having the opportunity to participate in norms awarded to previous generations was disappointing and although he stated this was a personal decision, it also had a great influence amongst his peer group.

When asked within the interviews about the role that peer pressure now played for patients attending the service I received a dichotomous response from practitioners. Those that worked in the more affluent town centre where a lot of patients were also university students responded that ‘I’ve never picked up any peer pressure up’ (P7). Whereas those who worked in the other clinic identified peer pressure as a particular issue for young people. This pressure came in the form of pressure from new partners to have sex as ‘that's what's expected after the first date’ (P5) and pressure from peers to drink alcohol and to have sex in order to fit in with the crowd.

> peer pressure is still a biggie with the young people because, you know, we have- we have them coming in, they don’t really wanna have sex but they think people will, will think that they’re stupid if they don’t (HW4).

The practitioners raised issues about consent and explained how they reinforced messages about ‘delay’ until the person is ready to have sex, attempting to abolish the myth that all their friends are having sex ‘actually, they probably haven't, if that's what they're telling you’ (HW5). Additionally, the practitioners were keen to stress the positive aspects of a healthy sex life to their patients reinforcing that sex should be something ‘that you are meant to enjoy, rather than it being maybe just sort of a duty’ (HW5).

This section has highlighted findings from this study on sexual decision making in early adulthood. Whilst these decisions may be more informed, the role that alcohol plays in these decisions continues to feature. Participants shared how experimentation with sex and alcohol are rooted in rites of passage on the journey of ‘growing up’. These are expectations, which are acceptable and normalised by the participants. The next section explores how expectations of sex and alcohol manifest in the period of ‘growing older’, and how the ‘younger self’ is a precursor to the ‘older self’.

5.7 Transitions during the lifecourse: Older and wiser

As identified in Chapter One, there has been a growth in the literature on sexuality and ageing, with a particular focus on those aged over 50 years (Nusbaum *et al.*, 2004; Gott, 2006; Minichiello *et al.*, 2011; Nash *et al.*, 2015). A common misconception about older adults is that they do not engage in sexual intercourse or sexual behaviour, indeed they have been traditionally viewed as asexual (Nash *et al.*, 2015). The 'baby boom' generation of the 1960s and 1970s changed attitudes to sexuality (Morison and Cook, 2015) and it has been proposed that as they age they will not conform to the stereotype of the 'sexless older person' (Gott, 2001). This is evident by the thriving market of online dating sites for those in later life e.g. https://www.ourtime.co.uk; https://www.seniorsinglesnear.me; https://www.postcodeseniors.com.

However, research shows that older people who enter new sexual relationships are also less likely to seek information about the new partner's sexual history or negotiate condom use, for fear it may compromise the relationship. Additionally, condoms are still viewed as primarily a contraceptive measure, which impacts on pleasure (Morison and Cook, 2015) and their use to prevent STIs is not always considered.

Some patients in this study reflected how age and previous experiences had made them 'a bit wiser and a bit more sensible' (PT15). They explained how they now preferred to get to know the person before they entered a relationship and in the case of this man in his fifties, he was clear that he would be using condoms, at least at the start of a new relationship.

> Vetted sounds a bit clinical but I've already checked the person at the, you know, I already have a pretty good idea of, or very good idea, of the person beforehand and initially I'm going to be using condoms as well (PT23).

Being 'older and wiser' also meant that for some they were careful in terms of contraception and proactively having a sexual health screen to check for STIs. Some of this stemmed from the lessons of their younger days 'it's because I wasn't bothered when I was younger, but whereas I'm older now, I want to look after myself

a bit more' (PT16). Looking after themselves was seeing sexual health as part of their general wellbeing.

The reflections from some of the patients in this study was that as they aged, their sexual desires turned more into their desires to find something more stable 'and something more constant rather than something that's just going to be a one night stand type … that's going to be influenced by alcohol probably' (PT8).

However, the practitioners did not always share the same reflections and explained how they were seeing an increase in older clients into the clinic, where alcohol featured,

> We also now are seeing a lot of older- and by older I mean, sort of, the over-40s. The ones that previously wouldn't have been deemed high-risk, you know, erm, in terms of STI risk (HW4).

Examples, discussed further in Chapter Seven, were presented of mainly 'older' women who perhaps had not had sex for some time, who were presented with sexual opportunities whilst they were drinking alcohol that they later went on to regret. As a result, some patients end up attending the GUM clinic.

Practitioners felt that older patients often feel embarrassed to be at the clinic, as they view the service primarily for a younger clientele.

> "Well I'm a bit old for this." And you think that's what they're saying to you and you think, "Well actually nobody's too old for- to have sex or anything." So I think they have a little bit of an embarrassment about that (HW7).

Being 'a bit old' was probably more about attending the clinic rather than having sex. During the fieldwork I found no evidence of promotional work by the clinic to target their services at an older age group or any information material on STIs which presented images of older people.

This section has focused on the positive changes in society to acknowledge that older people do indeed have sexual needs and enjoy sexual relationships into mid-

later life. However, this acknowledgement has not translated into sexual health promotion aimed at this age group. In the final section I discuss how the clinic has however changed in order to respond to some of the changes discussed in the chapter in its journey to normalise the sexual health clinic. Again, this highlights the difference between the 'younger' and the 'older' generation.

5.8 Changing role of the clinic

All practitioners highlighted the increased awareness and changing attitudes towards the sexual health clinic. As one noted, 'people are much, erm, less bothered about, you know, about, about coming in' (HW4). The younger patients, those defined as up to 25 years by practitioners, are seen as 'pretty relaxed' and 'not bothered' (P6). This shift in attitude is marked and articulated within the interviews as a reduction in stigma.

However, it was explained that whilst this reduction in stigma was apparent amongst the younger generation, the stigma amongst 'older' patients is perhaps tied to the historical legacy; the legacy of past cultural narratives towards sex, STIs and the sexual health clinic. STIs are still stigmatising conditions 'there's such a bad stigma with STIs, especially ones like this [genital warts] … and I cannot bring myself to tell because I think it's that stigma' (PT15). This stigma however was not just associated with the clinic but the STI and the sexual behaviour itself as explained by this practitioner,

> I think that it had a stigma years ago, and I think they just thought that it was just a sexual health clinic, and that you came if you had, you know, like, herpes, gonorrhoea, er, and, and you're just one of these people that were just sleeping about and just catching anything (HW8).

The 'people' that attended the clinic were assumed to be more promiscuous and therefore patients did not want to associate their behaviour as being the same as 'others'. However, the shift in awareness of the role of the clinic, a view particularly held by young people, was seen as a positive change. Not only do they have a greater understanding but this has also led to better access witnessed by the increasing demand.

Practitioners at both sites reported how the demand for the services had increased ‘we are inundated usually with people wanting to be in’ (HW2). This increase was as a result of expansion in service provision, particularly linked with the integration to deliver contraception services, delivering HIV treatment more locally, as well as providing more flexible opening times to accommodate people’s lives.

> We’re definitely busier … because when I started this clinic was only open three sessions a week. Erm, we were the first to provide an integrated- you know the Monday morning trial thing which worked really well. And now obviously we’re open, erm, six times a week, erm, with later appointments. We introduced earlier, sort of, pre-school, pre-work appointments (HW4).

In the past there would have been peaks and troughs throughout the year but as one practitioner reported in the clinic within the large university city, they no longer have a ‘lull in the summer holidays, we don’t anymore, we’re continually booked’ (HW1). Shorter waiting times have played a key part in managing the demand and increasing the accessibility of the clinic ‘I think we all feel that the longer people wait for an appointment, the less likely they are to turn up’. (HW10). Increased investment and access though the introduction of national waiting time targets was felt to have helped manage demand significantly,

> The way the clinic works now with walk-ins and the 48 hour access it’s loads better, loads better than the time when we’ve had four and six weeks wait (HW1).

This reduction in waiting times also needed to accommodate those patients who are increasingly using the clinic as a more preventative measure, ‘I would always get checked out, every three to six months, just to make sure that I am all right’ (PT22), rather than waiting until they were symptomatic.

> I think one positive thing is that we get lots of people who come in, they're absolutely fine, but they decide they should come and have a check-up

> as a positive thing, if they're changing partner or something. That is a positive thing (HW10).

Again this positive behaviour was noted by the practitioners as particularly evident amongst the younger generation, who were viewed as much more sexual health aware ‘and they see it as just looking after their general health’ (HW6) and more comfortable accessing the service. STIs also form part of their vocabulary ‘I mean Chlamydia and stuff it's, it's, it's so common to them, it's a common word’ (HW2) and it no longer holds the stigma that was held by previous generations.

The role played by family and friends was also seen as important in terms of the changing norms of the clinic. One practitioner noted how generations of families were now using the service ‘their son or daughter has recommended- sometimes we’re getting grandparents in as well’ (HW4). Where for others, groups of friends attended the clinic together.

> There’s a lot more people now just coming because they want a screen, coming because their friends are coming so they thought they’d come at the same time (HW1).

On the one hand being able to attend with their friends provided a normalisation of the use of the sexual health clinic, but on the other hand also provided support to each other too.

Practitioners commented that whilst things had progressed over time, there was still this element of stigma attached to the clinic which was most notable amongst older patients who feel humiliated at having to come and afraid of judgements by others, ‘I hope nobody sees me here’ (HW10) and ‘someone might see her walking through the doors’ (HW2). Aas will be discussed in detail in Chapter Six, having an STI meant that they are still viewed like ‘others’ who were morally bad.

> It's more sort of older generations that have kind of the stigma of coming down, and they're probably a little bit more reluctant to come, or a little bit more embarrassed, maybe, than the younger ones (HW5).

Once older patients had been to the clinic however, the practitioners felt that patients had a sense of relief and acceptability of the clinic once they leave ‘I think people are a lot happier’ (HW9). Despite working hard to redefine the image of sexual health medicine and increasing access, the legacy of shame still resonates, most notably embodied in the name people attach to the clinic.

> We're still, probably, known by a lot of people as the clap clinic. Erm, I don't know if that'll ever go away, but we are trying (HW5).

As identified earlier, the clinic has responded to the changing needs of patients, though has still some way to go in terms of the targeted approach to make the service accessible for all groups, particularly older clients.

5.9 Chapter summary

This chapter has highlighted the changing norms linked with sexual relationships, which many participants felt were no longer linear. Casual, concurrent, and multiple sex partnerships were decribed as replacing courtship and having a monogamous partner for life. Casual sex in particular appeared to have a strong association with alcohol, not just for the young, but also for individuals throughout the lifecourse. For MSM, both alcohol and drugs feature with casual sex partners, and indeed the findings highlighted their feature in ‘predatory’ sexual behaviour.

The participants highlighted the role of the internet as aiding some of the changes, and can be argued as a game changer in the shifting the norms of sex and relationships. Access to sexual health information considered a benefit by practitioners, though for those re-entering new sexual relationships later in life, it was considered that their sexual health literacy remains limited.

Use of dating websites and mobile apps was considered to span the demographic profile – age, gender and sexual orientation. For some, the anonymity of the interaction can help to increase confidence and desirability. However, it can also raise unrealistic expectations and increase the risk of STIs. Hook up apps were

considered a vehicle for sex rather than a search for a relationship; amongst MSM their use helped to reinforce the stereotypes of promiscuity.

Practitioners believed the growth in sex tourism had in turn increased demand to the clinic. Holidays can provide the opportunity to escape and engage in casual sex abroad. Whether this was in search for romance or transactional sex, for some patients the combination with alcohol during this period of escapism led to spontaneity but also to regret and guilt. These emotions will be explored in more detail in Chapter Seven. However, personal safety, in particular sexual assault, was identified as a potential outcome by practitioners from the alcohol-sex mix, at home and abroad. The findings highlight the underreporting of alcohol related sexual assault amongst GUM patients and the impact seen within the clinic.

Key transition points at the start of a sexual career and in later life, seems to be subject to expectations and stereotypes. The sexual health clinic has tried to redefine its role within this historical and life course transition; and even expanded its services to make it more accessible. However, the findings suggest that there remains a stigma tied to the historical legacy of sex, STIs and the clinic, which appear to be more notable by those in mid-later life than those under 25 years. The sexual health practitioners have a key role in shifting this stigma so the next chapter moves beyond the wider context of sex and relationships, to look at what happens when an individual becomes a patient and enters the medical world of the sexual health clinic.

Chapter 6: The moral narrative of sex and alcohol

The previous chapter discussed the reported changes to sex and relationships, over time, and changes that can affect individuals over the life course. I argued that in the context of these changes, sexual stigma continues to feature amongst those in mid to later life. I proposed that sexual health practitioners have a role in helping to reduce this stigma. Therefore, this chapter looks at the journey when a sexually active 'older' person becomes a patient within the sexual health clinic.

I discuss the impact of the sexual health service being located within a clinical environment, and argue that its position continues to medicalise sex. I describe the moral narrative used within the consultation and its alignment to another establishment – the Church. Some patients within this study presented their 'moral self' to the practitioner and sought forgiveness for any immorality. The patients distinguished their 'good self' from their 'bad self'; constructing a narrative that had a clear demarcation between 'self' and 'others'.

I close the chapter by discussing the moral narrative of alcohol, and return to the language of self, in the guise of self-control. I discuss how some patients use alcohol deliberately to enhance pleasure, escape and experiment sexually. I also discuss how participants view the discussion of alcohol within the sexual health clinic, and explore the acceptability of such a narrative within this space.

6.1 The moral geography of the GUM Clinic

The language of sexual science was transformed in previous centuries from a sole focus of error or sin, with sexual health being legitimately located within the medical sphere (Pryce, 2000). However, as previously described in Chapter Five, given its association with sex and STIs, the GUM clinic is still considered by some individuals to be 'dirty'. This study highlighted that the GUM clinic retains a level of stigma or immorality, not necessarily experienced by any other clinical service. I observed that sex, a private and socio-cultural issue, is laminated into a traditional empathetic medical arena, when the consequences of poor sexual decision making requires treatment.

Chapter Four highlighted the differences between the two clinics, in particular the importance of their locations in helping to reduce the stigma. For clinic one, being integrated into the main hospital 'just on a corridor with everybody else' (HW1), afforded it the same moral geography as experienced by other clinical services, as explained by the practitioner below,

> Being in a hospital does make a difference. In one sense it is sort of not exactly a prestige but you are more accepted as a mainstream healthcare provider rather than just a little clinic sat in the middle of nowhere in a grotty health centre somewhere. Even if you are providing the same care (HW9).

Many sexual health clinics are still located within 'grotty' buildings, demonstrated by the description of the second clinic (see Chapter Four). However, prior to their relocation into the main hospital, practitioners working in clinic one also reflected on their former building. It was a 'shady little shack' (HW2) where 'people would walk up with hoods up in the summer because they didn't want to come in' (HW1). This description highlights how some patients had to undertake a different kind of walk of shame, due to their 'shady' sexual activity. The problems they presented with did not, at that time, warrant being co-located alongside other types of patients.

Sexual health services now integrated into 'mainstream healthcare' aim to be more accessible and acceptable for patients. However, whilst this 'cover' can provide the sympathy and anonymity awarded to other patients in the hospital, having to wait in a queue in the corridor for the clinic to open was sometimes problematic, as explained by this patient,

> With people going in, visiting wards and it's a bit embarrassing when they look at you … it's outside, it's embarrassing, when people's looking at you (PT25).

This comparison between the 'morally acceptable' sick and the GUM patient, highlighted the level of perceived judgement by 'others'; particularly if their attendance was considered to be more self-inflicted, preventable or avoidable.

The importance of bringing sexual health in from the sidelines of the medical specialities was a key driver amongst the practitioners, who wanted equal status with their medical colleagues,

> There still is some stigma, and, I hate to say it, but some of is, with my health professional colleagues, within other specialties. Y'know, er, walking down the corridor with consultant colleagues saying something along the lines of, "how do you feel about going in there," or, "I wouldn't want to have to go in there," or, y'know, something crass along those lines. And no conception of what we're doing (HW4).

There was still a lack of understanding about what actually went on behind those closed doors within the hospital, amongst patients, as well as some clinicians. The attempt to shift the moral geography has been planned through the range of other services now offered at the clinics, as 'people are coming for other things that aren't necessarily STIs' (HW3). The practitioners were proud of the range of services that were now available at the clinic, and of the specialism they had built up within their practice to deal with cases that are more complex. In particular, they discussed the increased use by women to access contraception, and the HIV patients who receive treatment more locally rather than having to travel to more specialist centres further afield. Additionally, as explained by this practitioner,

> We've also introduced, which we've been doing this morning, the monthly combined genital dermatology clinic which I think has, has provided a really good MDT approach with access to the pain clinic (HW4).

This MDT (multi-disciplinary team) approach was a way of breaking down barriers between medical specialities', in this case gynaecology and dermatology. As such, through new and additional services, the practitioners have started to reframe the narrative of sexual health care and challenge the professional stigma held by some of their colleagues. Once inside the space of the clinic however, a different type of narrative emerged, which brought with it further moral work.

6.2 The confessional box

From my observations within the clinic, there was a particular moral narrative that had similarities to a religious ceremony rather than a clinical consultation. For some patients once in the clinical room, they became the sinner, atoning for their sins, seeking forgiveness and redemption from the clinician. As described by one practitioner,

> Because they think, "She'll think I'm terrible if I went and had sex with somebody I didn't know." Maybe they have to have a reason. I don't know. It's possible that they feel, "Actually, it kind of wasn't my fault. I wouldn't normally do that." Because they come in and they apologise. They say, "I'm really sorry. You must think I'm terrible." (HW10).

I observed the clinic transformed into a confessional box, where the confessor, whose very attendance at the clinic seemed to be a symbol of their moral recovery, was prepared to seek the appropriate punishment in order to repair their moral identity.

Similar to the policing of sex in the eighteenth century, some believe that this ceremonial ritual of the clinic is still concerned with policing, with much of the professional performance driven by the need for containment (Pryce, 2000). From a public protection perspective, this is understandable in order to reduce the spread of infection. However some argue that clinicians make moral judgements within the consultation particularly when telling people not to have sex in order to protect those who could contract an STI (Dunphy, 2017).

However, as previously described in Chapter Four, the non-judgmental public approach witnessed within this study by the practitioners was a noticeable feature. The positioning of the chairs in the clinic, allowed the practitioner to face the patients without the interruption of the desk; this meant they could lean-in and listen intently. Their body language and facial expressions displayed empathy and understanding, nodding and smiling when the patient sought their reassurance. The tone of their voice was not one aligned to negative moral judgement, but rather of enacting care and support. They regularly checked whether the patient understood the next steps in their care, or to clarify a condition ‘shall I explain the causes of VB?’ (HW3).

From the observations, I became aware of the roles of the clinicians as the 'expert' or 'counsellor'. I observed the clinicians engage with patients in a carefully skilled way to bring a sense of normalization to their accounts,

> 'you're probably just drinking a bit too much … I sometimes don't count how much I drink either, have you thought about cutting down? (HW1).

Within this study, it was the patients rather than the practitioners that introduced the moral discourse within the clinical consultations. Patients readily presented accounts, excuses and justifications, in order to demonstrate their moral worth,

> 'I didn't intend to have sex … decided to go for another drink in the bar ... It was a real, a real drunken state (PT26).

For this patient, the intention was important to articulate, and the justification was his level of intoxication. During the interview he stated that he regreted the sexual experience, though the contrition seemed more linked to the increased risk of contracting an STI and as a result having to disclose his homosexual tendencies to his heterosexual partner.

For other patients, they wanted to express their own disappointment with themselves at the start of the consultation prior to any potential judgement by others - 'I am not proud of it … I am annoyed at myself' (PT2) and 'I know it shouldn't have happened' (PT25) so demonstrating their ability to be self-reflective.

Scott and Lyman (1968) explain the difference between justifications and excuses as; '*Justifications are accounts in which one accepts responsibility for the act in question, but denies the pejorative quality associated with it. Excuses are accounts in which one admits that the act in question is bad, wrong or inappropriate but denies full responsibility'* (Scott and Lyman, 1968)(p47).

Practitioners were aware that patients would present an account of self, 'they tell us what they think we want to hear' (HW5). However, being intoxicated prior to the

sexual encounter appeared to be a legitimised norm within the clinic, amongst patients and practitioners,

> It is spontaneous, and alcohol plays a big part, its normal (HW9).

The practitioners used their experience and counselling skills to navigate the truth,. as explained by this practitioner,

> They've had their eyes opened because they have to speak it, what they've done. A lot of people are quite shocked and they feel really bad (HW1).

In this way, the practitioner enables them to reflect on their behavior, to reflect on their actions and consequences. This act of speaking 'truth' was the confessional nature of the consultation, whether patients genuinely regreted the sexual act itself was unclear, as only one patient stated he did not regret it.

I observed the clinicians within the consultations eliciting facts, sticking closely to their pre-defined script. They did not collude in the emotional moral discourse of the patient, but danced around it in order that they could diagnose and treat. One patient (PT6), who was convinced she had contracted HIV, just requested that specific test, however the practitioner advised how important it was to screen for other STIs not just HIV, but did not pressure the patient when she declined the other tests.

For those patients that received a negative diagnosis, this, rather than clinician was the savior. For those who had a positive diagnosis it was the treatment that became their salvation.

> I feel quite reassured now actually … it's going to be a bit of a process over Christmas, which, erm, is not ideal (PT26).

For this patient receiving post-exposure prophylaxis (antiretroviral medicines to prevent infection) helped with his fear of aquiring HIV, and was relieved that the course of treatment was relatively short term, compared to the alternative of a life-long condition.

It was only on the occasions where those who were diagnosed with more longer-term condition or where they needed to share their ‘immorality’ with someone close, (including their partner or sexual contacts), that the burden seemed to continue to weigh heavy as they left the clinic. It was on these occasions, when the clinician, in order to reduce the spread of infection, advised that the patients share with close contacts. This was significant as the patients had to deal with wider consequences rather than just treating an STI. As reflected by this married man, who was the patient who stated he did not regret the sex, was advised by the practitioner to bring his wife for testing, it was only when he had to ‘confess’ to his wife that he had been unfaithful did the impact emerge,

> It was really something stupid … I’ve never cheated on my wife before … my wife now knows about it, and that’s why we are here for tests (PT21).

The role of the practitioner within this context then was one of promoting healthism, being the ‘expert’ on sexual illness who can guide the patients and advise how to practice safe sex. This practice brings into being the notion of self-care, which will be discussed further below.

This section has introduced the moral geography of the GUM clinic. I have demonstrated that on the one hand, whilst the sexual health clinic has entered the medical arena, its moral worth as equal to other clinical specialties has been recognised. Yet on the other hand, the clinic continues to retain the level of stigma, reinforced by the wider medical profession. The sexual health practitioners have attempted to reduce the stigma amongst their peers, but the secrecy of the moral space continues. Once inside the clinical space, I have likened the consultation to a religious ceremony, with some patients seeking forgiveness for their ills. Within this study, the practitioners focused on eliciting the truth, in order to treat rather than forgive, but part of that treatment is tied to taking on responsibility for care of the self. This section also introduced the issue of the moral self, and in the next section, I explore this in more detail.

6.3 The moral self

The moral self is defined as a complex system of self-defining moral attributes involving moral beliefs, orientations, dispositions, and cognitive and affective capacities that engage regulatory focus toward moral behaviour (Jennings *et al.*, 2015). Foucault's work on governmentality defined government as an activity that is not limited to the state politics alone, but includes a wide range of control techniques including 'control of the self or others', or more precisely the 'conduct of conduct' (Lemke, 2001). Such self-governing capabilities include personal responsibility and taking control of our undertakings, defined by Foucault as 'technologies of the self'(Foucault, 1985). These technologies of 'self', refer to the practices by which individuals represent to themselves, and to others, their own ethical self-understanding.(Oster and Cheek, 2008) used Foucault's work on governmentality as a framework in their study on governing the contagious body by patients with genital herpes. One of the features they considered in the ethical government of self was ontology – where the behavior of a person is concerned with moral conduct (Oster and Cheek, 2008).

The articulation of the moral self within the consultations and interviews was a key feature within this study. As the researcher, I became conscious of how the narrative unfolded between the practitioner and patient, with stories of hidden meanings and unsaid truths. This included the motive of pleasure and the social acceptability of the alcohol-sex mix to achieve this. However, the attendance at the clinic shifted between social acceptability to one of problematic morality.

It was important for some of the patients in this study to demonstrate how their moral actions did not align, on this occasion, to their usual moral conduct.

> We had sex without a condom, it's not something I'd habitually do or I have ever really done, I was very drunk at the time, it's not something I would have done sober (PT26).

Some patients recounted the stories that led them to the clinic as soon as they arrived - to the receptionist, the HCA and then the clinician, trying to influence all of the practitioners along their journey in the clinic. As explained by this practitioner,

> They say “I didn’t drink very much. I normally wouldn’t have been out of control at that stage” … they are mortified, or, “It’s not really like me, I wouldn’t normally do that” (HW4).

However, there were many contradictions within the narratives. This was two-fold, firstly when describing the beliefs and behaviours of the moral self. Secondly, and perhaps more significantly, was when patients were describing the differences between self and others. I will discuss the contradiction of ‘self’ first then discuss ‘self’ versus ‘others’ next.

Patients described the changes in any risk taking behavior of self being justified by changes expected with age. As already discussed in Chapter Five, being ‘young and daft’ (PT25), the belief was that it was acceptable and part of the norm to ‘get absolutely mortal drunk’ (PT2), explore sexuality and take some sexual risks, particularly as this period of life is defined by experimentation. However, all patients believed that ‘you do grow up a lot’ (PT25), with an agreed social norm that you will ‘settle down’ and become ‘wiser and a bit more sensible’ (PT15).

For many, their attendance at the clinic was described by both practitioners and patients as simply due to ‘a moment of madness’ (PT26), and not their normal or expected behaviour. The concept of risk, in particular sexual risk was explored in the interviews with patients. Some felt their sexual risks had wider consequences, not just with the sexual relationships, ‘I thought I had HIV … I have my kids, and a 15 year mortgage’ (PT6). Thus the confession again was linked not just to having an STI but the impact on commitments and the identify of being a working mother.

Another patient, who had received treatment for alcohol dependency shared the impact of his sexual risk taking. Now sober, he was keen to explain the significant difference between his ‘drunken self’ and his ‘sober self’,

> During that time of drunkenness and drinking and taking drugs and things, I was out doing a lot of very self-destructive, reckless behaviour, you know, entirely the opposite of the character I am sober, the exact opposite in every way. I could list a hundred things that's different. It's like Jekyll and Hyde, you know, but I'm not that person sober. (PT14).

The description of the Jekyll and Hyde fictional characters was a way of demonstrating the extremes of his alter ego and confirm the true identify of himself now sober. These parallels of ‘good self’ and ‘bad self’, was often described in the context of ‘self’ versus ‘others’.

6.4 Self versus others

This distinction between self and others was the most fascinating dialogue that emerged during the interviews and consultations. Jordan et al (2011) found that when individuals recall their immoral behaviour, they would report a stronger tendency of their moral identities to others in order to protect their image (Jordan *et al.*, 2011). This was particularly true of the patients within this study who often resisted being at the clinic for it was a place for others as described by this practitioner,

> They wouldn’t have dared to come across a clinic like this, because that was only for “those sorts of people”. I’ve come along but “I’m not one of those that should be coming to the clinic” (HW3).

Most patients were keen to explain in some depth the difference between the behaviours of those sorts of people and themselves, thus falling short of the moral identity and standards that defined them, ‘I’m not that type of person, I’ve never gone out and thought I’ll get drunk and try and pull‘ (PT17). They were morally good and ‘that type’ were judged by society as morally bad.

Interestingly, such a narrative emerged for both men, ‘I’m a good boy me’ (PT12), and women,

> I’ve never been what I would call loose. That’s why I have a really hard time with why I’m here to be honest. Don’t judge other people for it, but it’s not who I am (PT2).

This patient was keen to demonstrate that she was not promiscuous, and wanted to dissociate herself from those who may be judged by others as such. Additionally,

some patients also highlighted the distinction of the types of sexual behaviour that warranted most judgement,

> It wasn't a one night stand; I'd had a few dates with the three guys that I'd slept with. It's still bad I suppose, but not a one night stand type (PT6).

Thus on the ladder of sexual immorality, having a 'one night stand' was considered more 'immoral' than having multiple sexual partners over a short period of time. Any changes to this were described in the context of an exception, where it was not the fault of the individual but, as will be discussed in more detail in Chapter Seven, the alcohol.

The 'good' and 'bad' self were therefore two different identities. On entering the clinic, most patients presented their 'good self', unaffected by alcohol, with the aim of redeeming their identity.

When patients did recognise that their behaviour was not alcohol's fault but was the act of self, it was important to seek reassurance from the experts, that their behaviour or sexual decisions was relative to the behaviour of others as explained by this patient,

> Having talked to other people and the nurses, they said that's quite a common thing, that people do quite a lot more than I'd actually done (PT6).

Describing the behaviour as 'common' normalized it, and allowed the patient to reassess their level of moral self. Patients were also keen to provide their own examples of sexual decisions or actions by others as a useful way of distinguishing from their own moral code.

> Can you imagine being on a night out and having too much to drink and then just a bloke says, "Do you wanna come back to mine?" And anything can happen, can't it? You don't know where that person's been. When people have had a drink and they're quite willing to go back to someones house … I can't quite get my head around it (PT11).

This patient talked about others in the language of those people, yet this example was in the context of her friend, a social group she belonged to, but she was keen to distinguish a higher level of moral code from her peers.

Other patients contradicted their own beliefs and behaviours, as described by this patient, who later confirmed in the interview that she would alter her own behaviour if she had a ‘night away from the kids’ too.

> Its people that, you know, they’ve got a night off from the kids or from work they come in and they’ll sit with their back up and their leg crossed. Every girl after a couple of wines doesn’t care anymore, the legs will be open. I watch them leave with different people (PT2).

The practitioners also described how they would find patients to be scathing sometimes of others in order to justify their own behaviour,

> They are quite judgemental, because there is still this perception that, "If I haven't had many partners, I shouldn't get an infection. I'm not one of those people who sleeps around much. How come I've got this when all those other people are having sex with lots of people? I'm not like that” (HW10).

However, this judgement of others may have been simply a means of portraying a more acceptable moral account of their identity to the practitioner in their search for forgiveness. This judgement of ‘others’ was particularly evident amongst the female patients within the study. Whatever the rationale, the contradictions in accounts continued into other areas, and I will close this section by describing the contradictions on relationship status, which may have also been part of the sacrifice required in their quest for moral salvation.

6.5 Contradictions about relationships

One of the contradictions that emerged during the interviews with patients was their desire to be in a relationship. A couple of patients were flippant about their current relationship or sex life, ‘You know I’d rather have a cup of coffee and a cigarette if I’m honest’ (PT2); when in fact, this patient later acknowledged that ‘I have a pretty hard

time dealing with being single' (PT2). Most patients, male and female, did acknowledge this desire to be in a relationship rather than single 'it's always about having a relationship for me' (PT20).

The contradictions from one single mum to commit to remain single following her attendance at the clinic, 'I will remain celibate and a single mum, 'cause I can't be doing with all of this' (PT6) later shared that she was actually seeking a partner through internet dating. Two patients (one male and one female) in the study, struggled with their visible diagnosis and therefore did not proactively seek a new sexual partner for fear of rejection.

As discussed in Chapter Five, alcohol can be used to increase confidence, reduce inhibitions and help tackle nerves with a new sexual encounter. One patient, when describing how she had used alcohol to facilitate sexual encounters, contradicted herself within the interview at different stages. Initially she was adamant 'you shouldn't start a new relationship drinking heavily, because it's not who you really are is it?' (PT2). Then later in the interview, when asked if she had been drinking when she met her new partner she confirmed 'I was absolutely drunk, I was drunk as a skunk' (PT2).

Finally, practitioners also explained how couples who attend the clinic together, but are seen separately regularly contradict each other. 'That happens quite a lot. One story in one room and a totally different story in the other room' (HW5). Often the practitioners are required to triangulate the stories, yet retain individual patient confidentiality and collude in the protection of the self.

This section has highlighted how patients accounted for their actions and presence at the clinic. For many, the sober, moral self attended the clinic in an attempt to protect their moral identity. Their narrative distinguished between the good self and the bad self, and compared self with others, others who deserved to be there. There were many contradictions in their dialogue when trying to present their moral self. The next section will explore in more detail the moral narrative attached to alcohol, by introducing the aspect of self-governance, as well as to understand the relevance of discussing alcohol use within the clinic.

6.6 The moral narrative of alcohol

The temperance movement in Western societies in the nineteenth century highlighted the moral ills of alcohol and how it was rooted in social, moral and physical decay (Bell *et al.*, 2011), particularly amongst the lower working classes or more specifically amongst a minority of 'deviants'. Measures to control and discipline alcohol consumption arise from this period as does the re-emergence of the medicalized term 'addiction' (Coveney and Bunton, 2003). Some argue that the state used indirect techniques for leading and controlling individuals through the strategy of 'responsibility' (Lemke, 2001). As a result, there was a shift in the West to governance through self-care, self-control, risk management and choice, ensuring that the moderation of alcohol (along with sexual behaviour) remained at the door of the 'moral self' rather than the state. Valverde (1998) illustrates this self-governance through the work of Alcoholics Anonymous (AA); whose main focus is not the governance of alcohol itself but what she terms as the governance of the soul (Valverde, 1998).

Similar to the discussion above between 'self and others'(Monk and Heim, 2014), in their systematic review of alcohol norms, discussed the theory of social comparison process. They found people compare to alike others in order to judge what is appropriate. However, in the alcohol literature a sense of cognitive dissonance is proposed, whereby individuals believe one's own consumption is different from the normative or typical consumption thus ending in a norm misperception (Monk and Heim, 2014).

As already identified in Chapter Five, for patients in this study, re-entering the dating scene, alcohol consumption and alcohol serving venues were often part of that journey. Their levels of alcohol consumption, similar to the levels of sexual risk taking, also changed at key points or transitions in people's lives. For some they had reduced their drinking consumption as they aged due to their changing personal circumstances, whereas others made a conscious decision to reduce their intake.

Patients discussed their alcohol intake in the context of their ability to remain 'in control' of their situation. However, there were also a number of contradictions regarding their ability to remain 'in control' when the alcohol-sex mix combined. One patient described how alcohol had been such a key part of his life and 'it hasn't really

got me into a lot of trouble' (PT20); yet had contracted HIV following unprotected sex with his HIV positive ex-partner whilst under the influence of alcohol. He later went on to say 'I'm not daft really, in a careless way sexually' (PT20).

Whilst another patient stated that 'lately I'm not drinking and stuff and it's because of things like this … I know I need to give up on the binge drinking' (PT2), later confirmed that she 'would never not have a drink before I went on a date, never, I would have two, two vodkas I'd say, well, three maybe' (PT2).

Having self-control, so taking responsibility over their levels of alcohol consumption, and hence their sexual decisions, was discussed by all of the patients. Those that acknowledged in the interview that they had taken sexual risks; either in their past or more recently, also acknowledged that these decisions were aligned to their general risk taking behaviour in life. However again there were contradictions to these accounts,

> But I wouldn't call myself a risk taker. I'd call myself actually very risk averse really (PT26).

This patient, a male in a heterosexual relationship, had been away and had sexual encounters with gay men without using condoms, yet described himself as risk averse. Whereas another patient who admitted to being a risk taker, framed it within the context of levels of stupidity rather than risk.

> Life's too short to worry and over think on things because it's just- it does no one any good. Erm, so I'm quite spontaneous and I would- yeah, people might class that as a risk taker, I'd never do anything stupid, too stupid if you know what I mean? (PT15).

Spontaneity and levels of stupidity were the guides for self-control for this patient, who was receiving treatment for warts following unprotected sex, though was afraid to tell her new partner. There were two other areas discussed for the rationale for consciously drinking (and sex); these were escapism and sexual experimentation and will be discussed next.

6.7 Escapism

One of the motives for alcohol consumption is that people drink alcohol to cope; this motive is used to escape, avoid or regulate unpleasant emotions (Abbey *et al.*, 1993). Alcohol use as a form of escapism emerged as a theme within the interviews for a number of patients. From travelling abroad to escape the breakdown of a relationship, to drinking excessive quantities of alcohol to block out problems at home, were all seen as forms of escapism from 'real life'**,**

> If people are using alcohol heavily then there's normally something behind that, they're self-medicating or escaping (PT23).

Alcohol was used as a form of self-medication and a key part of the recovery process in the breakdown of relationships (See Chapter Seven). It often helped people by taking away pain or forgetting troubles, even for just a short period of time, as explained by this patient,

> I think its just like an escape from real life really. I love me life, don't get us wrong, I'm a happy person. But life's hard, it's tough and sometimes yeah, I know drink will make us forget about it … I'm a single mam, I've got a house to run, I've got babies, I've got work and I'm always on the go. And I've always got something to worry about and, and it'll make me just not worry for a minute (PT2).

Moral licensing, where an individual can relax their moral strivings, in the case for this patient being a 'good mother', and engage in less moral behaviour (Jordan *et al.*, 2011) was particularly apparent within this study amongst the single mothers. Being able to forget life when it's 'tough', was viewed as a positive attribute of alcohol amongst some patients. The amnesic qualities of alcohol helped to provide an excuse for some patients not only to forget, but also to become 'someone else' and even experiment, and this will be considered next.

6.8 Sexual experimentation

Alcohol was positively described by patients as providing the confidence to explore sexuality and, in some cases, become 'someone else'. This was specifically in relation to sexual experimentation, as explained by this patient,

> When you start exploring like different sexual positions, it was easier to do them after a couple of drinks as opposed to when your sober, there's all sorts you can do (PT11).

Alcohol provided the courage to participate in sex acts that were considered not possible when sober. Both male and female patients recognised this. As described by one male patient,

> It was like I was somebody new; I wasn't me, almost like ... If I were making love I was actually, "This can't be me", you know. It's like going from sort of the fourth division to playing for Man United, you know, and she seemed to bring out things in me I didn't even know were there (PT4).

This football analogy meant that alcohol and the casual sex partner provided him with the ability to increase his sexual performance. However some experiments, perhaps considered more 'deviant' and, as discussed in Chapter Two, required alcohol to be brave enough to try,

> There was one occasion where we were experimenting and we shared a bottle of wine before we did it. And I thought 'yeah, I'll definitely need a drink before we try this' (PT15).

This specifically related to anal sex, with wine helping to numb or dull the pain or indeed being used as an excuse to participate in a sex act considered taboo. Yet this was not the only sex act that was considered socially unacceptable. One male patient described how he wanted to engage in wife swapping (swinging) but that his partner was more reluctant,

> I am really open to so many different things, but it also depends on your partner. If my wife would be open for those things I would. I'm quite open to try different things and take risks (PT21).

He acknowledged that there were potential risks associated with such behaviour; however, these risks were considered more reputational than physical.

Reputational risk was also experienced by another male patient who, following a binge-drinking episode with friends, ended up in a 'threesome',

> When you're drunk you, you tend to think outside the box … ma other friend was there, male friend was there and we ended up having sex with all the three of us and I got up the next day and I was like, "What the hell are you doing?" but it was because alcohol was involved (PT22).

The deliberate or consequential use of alcohol provided the courage, or excuse, for some patients to experiment in sex acts with regular and non-regular partners. As some of the experiments are considered socially unacceptable, then it was easy to blame alcohol in the aftermath. This blame will be discussed in more detail in Chapter Seven, but for the next section, I explore how the participants felt about discussing their alcohol consumption within a sexual health clinic.

6.9 Discussing alcohol within the clinic

All patients interviewed were asked about practitioners discussing their alcohol use within the sexual health clinic. All of them were happy for the alcohol screening and discussions (BIs) to be undertaken and were not 'bothered', a term which arose frequently.

> It doesn't bother, no, no, no, it doesn't bother me one bit, I don't mind. I'll chat about anything. It's part of life, everybody's life, everybody usually drinks (PT8).

Most attendees at the clinic were alcohol drinkers so patients easily identified the inter-relationship between sexual health and alcohol, and the importance of

discussing the relationship within this setting rather than anywhere else, ‘to be honest, I'd rather it happened in here’ (PT12).

Though others mentioned the need for similar discussions in other healthcare settings, ‘I think they should ask more times, maybe in the GP or something like that, yes’ (PT9). For one patient who had previously received treatment for drug and alcohol misuse, he highlighted the potential role of the service to treat any underlying issues, which may have led them to the clinic,

> I think it's necessary … I mean, it's an obvious thing to investigate, and if you're not investigating it, you're just treating the symptoms rather than the cause the whole time, aren't you? (PT14).

However, for some patients, they saw the alcohol screening as a way of identifying those who are dependent (addicts) as oppose to hazardous drinkers. Discussing alcohol within the clinic was acceptable, as it was not an issue for them but for others,

> No, because I’m not alcoholic, I don’t- I’m not really a big drinker at all so it doesn’t- no it doesn’t bother me (PT17).

Two patients raised concerns that it may lead to them being judged for their drinking behaviour, as they didn’t want to be labelled an addict. As a result, one identified that friends had lied when completing the form for fear of judgement by the practitioners,

> I do think people lie, and erm, I know I spoken to some friends who’ve come through and said, “Did you have to fill in that alcohol thing?” And I’m like, “Yeah.” And, “Were you truthful?” I went, “Well yeah.” Erm, and then they were like, “I wasn’t.” And I’m like, “They’re not going to judge you” (PT15).

This was supported by the practitioners, who also thought that returning patients, rather than new patients, might not be truthful in order not to avoid the discussion again with the healthcare practitioner about their alcohol use.

As well as the patients, views from the practitioners were also sought on how they felt about alcohol screening, which had now been delivered in the service for a number of years. They concurred with the patients that they were happy with undertaking the screening and delivering the BIs, seeing it as part of their routine practice and ‘acceptable within the clinic’ (P10). This helped by ‘having a standardised tool’ (HW3). The tool helped the practitioners introduce the topic of alcohol and helped to normalize the screening within the clinic for all patients.

> I think with having the tool to discuss it is, is it's just helped so much because just everybody can talk about it and “It's a question we’ve got to ask you”. Mm I use that phrase as well myself when I'm handing them the alcohol AUDIT sheet, erm, I, kind of, play it down a little bit so it's not a big thing. “While you are waiting we’ve got to ask everybody if they’ll fill in one of these forms, would you mind?” and I’ll leave it at that, unless they need some help filling it in (HW2).

The practitioners shared examples within the interviews of the reactions and dialogue with some of their patients once the screening was complete. How their individual score alone is used to raise awareness and explore reasons for the drinking behavior,

> Some people look at it and they go, "Oh, crikey. I didn't realise I was as bad as that." They've kind of done their own brief intervention, really, just by seeing that score (P10).

This approach of integrating the screening into the consultation was generally felt to be part of the repertoire of the sexual health practitioners,

> I just bring it into general conversation. You know, “Oh right. Alcohol- oh you’ve done your score, right. Oh what do you think of that?” Just ask them what they think about it first … if they’re in a high score category then I explore it a little bit more, “Is there any reason?” And then sometimes it comes out (HW7).

However, one new doctor was employed into the service during the period of the fieldwork and was the only practitioner to raise concerns about asking patients about

their drug, alcohol and tobacco use. She felt like she was ‘telling the patient off’ and did not want to affect her relationship with the patients.

The other practitioners informed me that on an odd occasion, patients found being asked about these lifestyle issues irrelevant so would refuse to answer the assessment questions, but that this was very rare,

> Not really because we ask them about smoking and drugs as well. It is one of the questions we ask. It is just a routine question (HW9).

The GUM service was regarded as having a unique position compared to other settings to be able to ask sensitive questions,

> we are probably in a more privileged place, because people come here expecting to be asked funny questions, and to be quite personal and sensitive. Erm, so I think the fact that you've asked somebody, you know, when did they have sex? "What sort of sex did you have?" and things like that, I think if you've done that, alcohol's, erm, not really, I think, erm, much compared to that. Erm, so I, I don't think it has affected the relationship (HW5).

This practitioner believed that asking questions about alcohol use was easy compared to asking about the details of an individual’s sexual behaviour.

However, one of their biggest challenges raised by the practitioners was delivering advice against the backdrop of an excessive binge drinking culture,

> I get a lot of people who are in the mid-ranges… You have a brief chat with them and they go, "That's fine," and they think their drinking is completely acceptable, because that's what everybody else does … and they just don't think there's anything wrong with that at all, and wouldn't dream of changing it. So I think the guidelines about safe drinking bear no relation to what the population think is deemed to be okay (HW10).

As outlined in Chapter One, binge drinking levels in the area of study was significantly higher than the England average, so as mentioned by this practitioner

they were concerned about reinforcing the national drinking guidelines when the local population doubted their accuracy.

For one of the practitioners, this difference was particularly significant amongst the student population, where the practitioner did not feel the tool was sensitive enough to account for different life stages and any intervention would be fruitless,

> I must confess for the students, I, I would probably ignore a score of 14 or something like that. Y'know, the fact that they've been pissed a few times this term and they've felt a bit sorry for themselves and, uh, they can't quite remember what happened, y'know, what am, what am I gonna do? I'm never gonna get them to go to the alcohol services. Because they don't perceive that it's a problem (HW3).

This therefore highlighted a particular population group and perhaps discriminatory approach to the way the BIs were being delivered.

This section has introduced the moral responsibility attached to alcohol drinking. Alcohol was viewed as inextricably linked to sexual experiences, and for many patients their levels of consumption varied as partnership status changed throughout their life. As a result, for many the relationship appears to be cyclical rather than age dependent. The 'self' emerged again for many patients when discussing alcohol, but this was in terms of self-control rather than their moral self. Alcohol was legitimatised as a form of moral licensing when the patients wanted to escape or experiment sexually. Discussing alcohol within the clinic was acceptable for both patients and practitioners, and indeed the sexual health clinic was considered to be an appropriate place for such discussions given the links between the two. However, similar to sexual behavior, the patients were keen to distinguish their alcohol drinking behavior between self and others, who required such an intervention.

6.10 Chapter summary

This chapter discussed the moral geography of the GUM clinic. A key finding is that whilst some GUM clinics have reaped the benefit of their relocation from a 'shady shack' to the environment of a hospital; the sexual health service, having claim to

such a ‘prestigious’ position, is problematic. This is evidenced by the continued stigma attached by patients and the wider medical profession. I would argue that having the sexual health service located within a clinical arena continues to medicalize sex. Whilst I previously considered the role of the sexual health practitioners in reducing the stigma of the service, the location alone could actually be a potential barrier to the changing norms of sex and sexual health discussed in Chapter Five.

For some patients when they enter the clinical consultation, a more ceremonial ritual began. The clinical consultation between patient and clinician was a confessional space where the ‘sinner’ shared their secrets and sought forgiveness. Unlike other studies, I found it was the patients who introduced the moral narrative into the clinic rather than the practitioners. This moral narrative was perhaps for fear of judgement, but mainly as a form of self-initiated repair for any moral damage of ‘self’. For most patients who experienced contrition, it was the fear of potentially contracting an STI but more significant was the additional ‘confession’ required to inform their primary partners.

Others have witnessed sexual health practitioners engage in a moral judgement in response to the sin shared by the patient. Whilst I also found that practitioners undertake moral work, this was primarily driven by the need to search for truth in order to treat and protect others. Practitioners operated as skilled counsellors, providing a pastoral role to provide assurance. However, I am not arguing that clinicians are not morally challenged, and as has been discussed in Chapter Four, they were still shocked from some of the atrocity stories. Indeed, the private accounts told by the practitioners were often very different to their public performance within the consultation.

As part of the moral narrative, some patients also made a distinction between the good self and the bad self. The good (sober) self, attended the clinic. Yet some accounts were littered with contradictions and excuses for their behaviour. Sometimes patients admitted that they deliberately used alcohol to increase sexual pleasure, escape and experiment but overall, alcohol was the main culprit to their spoilt identity. For some of the patients, their very attendance at the clinic was the

consequence of their immoral behavior, and a diagnosis of an STI or indeed resorting to celibacy (even temporarily), was a justifiable punishment in their moral recovery.

The moral accounts of alcohol drinking were also governed through the application of self, in particular self-control. Patients and practitioners believed that discussing alcohol within the service was appropriate given the links between alcohol and risky sex, though this was not age dependant. Again, when discussing alcohol, many patients were keen to delineate the drinking behaviours of self versus others, particularly alcoholics who required such an intervention. Practitioners also discriminated certain population groups who would require an alcohol intervention, and this highlighted the need to raise more awareness of the purpose of alcohol screening and the harms of more regular use for patients attending the clinic.

The next chapter goes beyond the language used within the clinic to look closer at some of the emotions alluded to within this and the previous chapter. In particular, it focuses on the feelings of shame, guilt and regret. I also discuss how these feelings can ultimately manifest in the apportionment of blame. This builds upon the legitimate and social acceptability of alcohol identified in this chapter but also considers how in the search for blame, some norms and stereotypes have continued to remain.

Chapter 7: The pleasure, the shame, the guilt and the blame

This final empirical chapter discusses some of the feelings that emerged in the previous chapter – pleasure, shame, guilt and blame - but considers how the moral language was used to overlay the feelings by patients within the clinic.

I begin by discussing the sexual benefits of alcohol use, including how it can be used to increase confidence, reduce inhibitions and enhance pleasure. I argue that the absence of pleasure narrative within the sexual health service remains a significant gap.

I then explore how alcohol affects sexual decision making, in particular sexual arousal on condom use. This highlights particular gender stereotypes, which I argue have not evolved over time. I then explain how for some patients the consequences of some sexual encounters and unprotected sex, can lead to feelings of shame, guilt and regret. I build upon the moral narrative discussed in Chapter Six, by exploring how some patients use excuses to cover for their actions. The excuses include how alcohol is legitimately used in the apportionment of blame.

7.1 Sexual benefits of alcohol use

For the majority of patients, when asked specifically for their view of the alcohol-sex relationship, it was considered an integral part of the social fabric in the UK and especially in their 'part of the world'. Socialising was synonymous with alcohol, as described by this patient,

> I sit in the house every night with me children, or I'm at work. So if I have a night off, I'm gonna go out and I'm gonna socialise. And socialising does just involve alcohol really, you can pretend it doesn't but it, it will (PT2).

Having 'a night off' from the mundane activities of day-to-day life provides a sense of freedom. As 'socialising' involves alcohol, this means it often takes place in a bar or a club. The venue not only provides the perfect location to meet friends and consume alcohol, but also has the added benefit of potentially meeting a new sexual partner.

Patients overwhelmingly highlighted alcohol's ability to increase confidence in sexual situations. Thus, alcohol was positioned in the context of a positive outcome as opposed to a negative association, the very opposite of the relationship that is often portrayed within the media and national policy. Most patients talked about alcohol increasing confidence and deliberately using it to increase self-esteem, particularly if their former relationship had made them 'feel crap after I was divorced' (PT6). It was only female patients that verbalised the word 'self-esteem' and this boost in confidence enabled them to feel wanted again, particularly if their former partner had been unfaithful.

Patients explained that when first meeting a new partner, alcohol provided the 'dutch courage' (PT4) to be able to chat or flirt with someone, particularly if the individual felt they had lost their confidence. Alcohol could make a person feel 'brave, very brave with alcohol' (HW6). One patient shared how she used alcohol to garner the courage she needed to approach someone she was attracted to,

> And I liked him and he was talking to us, and then for some reason, I don't know why, I just thought, "I daren't talk to him, he's gorgeous." So I drank more knowing that I could be a bit more, "Hiya, yeah I'm all right thanks." You know, 'cause it does loosen us up (PT2).

Alcohol's ability to 'loosen' people up in order to get the confidence to speak to an attractive person was regularly described by the patients; helping the individual feel more relaxed and 'lose your inhibitions a bit' (PT4). The patients used the terms 'dumbing', 'losing' and 'getting rid of' inhibitions and again framed this positively within the interviews. Alcohol was described as a very effective formula for loosening sexual inhibitions. One male patient however believed 'it works more for girls rather than for, for, for men. I think girls got more of a blockage and they loosen themselves up with alcohol' (PT21), I will return to gender differences later in this chapter.

Most patients also described how they would use alcohol prior to going on the first date 'because of nerves I would purposefully have a few drinks on the first time I was going to go for it' (PT7). For this patient, the 'few drinks' transpired to be a number of vodkas, and 'going for it' not only referred to consciously drinking prior to the date, but the conscious decision to have sex too. However, not all patients believed that

alcohol was sufficient to gain the confidence to approach someone they found attractive. One deviant case was someone who was very shy and felt that alcohol made no difference in helping him to meet someone,

> To be honest, I'm the shyest person you'll ever meet in your life and I probably won't talk to you, ever. It's that simple ... And if someone starts talking to me, then I'll do it. If not, then nothing happens. Basically, I can stand there all night and look at people, and say, "Yeah, she's nice," and then I'll still not talk to her (PT12).

The practitioners informed me that this patient had genital warts. This had an impact on his self-confidence, and with members of the opposite sex. His fear of rejection was increased by having such a visible STI.

Other patients identified self-consciousness too but this was mainly linked to body image. Alcohol was used to gain confidence to overcome concerns about ‘body confidence issues’ (PT2) including being naked with a sexual partner, though again this was only highlighted amongst female patients,

> I'm paranoid about my body, but when I've had a drink I don't really care (PT11).

This patient was in a long-term relationship of a number of years with her partner, so the fear of judgement was not with a new partner. Alcohol seemed to be the only way she could be very comfortable when naked with her partner.

7.2 Pleasure

Most studies have focused on the negative aspects of alcohol and sex, though some argue it should not be just understood in a reductionist term. The pleasures of sex extend beyond the interaction itself to feelings of satisfaction, providing psychological benefits of being sexually aroused and coming close to another human being (Pedersen *et al.*, 2017). Folklore and general population belief is that alcohol contains aphrodisiac qualities and researchers have accepted that the pursuit of pleasure is one of the most obvious explanations of alcohol use (George and Stoner, 2000).

Within this study, alcohol was also linked to enhancing sexual pleasure. This included providing the confidence to experiment sexually (as discussed in Chapter Six); having sex ‘quite soon’ after meeting someone and providing a relaxant to help patients who experience problems during intercourse. For one patient alcohol also helped with the duration of sex,

> I liked to get a little bit drunk, especially with a new girl, simply because I could do sex for longer (PT21).

This patient was the only one who identified that alcohol helped him perform as other male patients, and the practitioners, raised the issue about the impact of alcohol on male sexual performance, as ‘if you’re too drunk you don’t get an erection’ (HW9). However, further clarification was provided by another male patient,

> If you can control the amount you're drinking, just have a bottle of wine, it can, it can- what's the word I'm looking for? Er, it can enhance … the experience, to a degree … make it a bit more fun (PT14).

The patient’s ability to remain in ‘control’ was linked to the quantity of alcohol consumed, an important factor in sexual performance.The practitioners discussed how alcohol could be used to help some patients who struggled with sex, both ‘physical or psychological problems’ (HW10),

> The women that we see and the, sort of, the painful vulva type conditions. That’s often helpful to get them out of that vicious circle of, “It’s going to hurt so I’ll tense up so I’ll anticipate it so it will hurt,” and it’s a self-fulfilling prophecy. It’s one of the things we do say to them, erm, to make it, sort of, pleasurable again (HW4).

The only positive aspect presented by practitioners of the alcohol-sex mix was recommending its use as a relaxant so that sex could be more pleasurable. Though again, the practitioners confirmed that it was mainly women who would raise these concerns within the clinic.

When asked if they thought they had a role in promoting pleasure within the clinic, most practitioners stated that it was not something they would raise routinely, and 'I don't feel as if I have any training to answer their questions' (HW9). The sexual health clinic was there to simply deal with sexual ill health rather than all aspects of sexual health, including pleasure.

> We tend to just see the downside … because we're probably viewed as dealing with the problems … We should be promoting that everyone has a right to a good sexual health life shouldn't we? (HW10).

This absence of a pleasure discourse from practice, research and policy will be discussed again in the next chapter.

This section has described the positive aspects of the alcohol-sex mix used by participants. Socialising, particularly in bars, was a way of combining the alcohol-sex mix. Alcohol's relaxant quality was useful in potentially flirting and dating situations. It could introduce or enhance sexual pleasure, so long as the quantity consumed did not affect sexual performance. Practitioners reflected on their role in promoting pleasure and recognised they had limited experience in this space.

The next section looks at the direct effect of alcohol's role in sexual decision making; the decision regarding partner choice and whether or not to use protection.

7.3 Alcohol's role in sexual decision making

As alcohol is thought to interfere with judgement and impair decision making, some suggest that its use in conjunction with sexual activity might increase the probability that risky behaviour will occur (Leigh, 2002). As alcohol is also a key component of most dating activities, it can also intensify this impairment in sexual decision making (Noel *et al.*, 2014). Within this study, practitioners reflected that when alcohol was involved the 'decision making goes out of the window' (HW4). They confirmed that the majority of patients attending the clinic are there because of poor sexual decision making where alcohol has been a factor.

Patients also reflected on the decision making process once alcohol was involved,

> I don't sleep around at all. You know, I'm really not that interested in sex, but as soon as there's drink involved, then anyone's fair game, you know (PT14).

For this patient being ‘fair game’ meant that it did not matter whether he liked the person or not, so long as they were ‘up for it’. Alcohol helped to seize the opportunity when it arose. For many, the drive was linked to opportunity but more prominently to sexual desire as explained by this practitioner,

> You are not really thinking quite as rationally as you normally do. Sorry to be crude but the sort of adage that when a man has got an erection his brain is in his penis not in his head would appear to be – a lot of men say it is true. That they get to that point where the desire takes over from any kind of rational thought. There comes a point with females as well although it is not probably quite so quick. I think the same thing probably happens (HW9).

The desire taking over rational behaviour when alcohol is involved was not always viewed negatively by participants. It was when the irrational behaviour led to unprotected sex, as a consequence of being ‘in the moment’ that it became an issue,

> You kind of lose the plot and that’s, that’s dangerous because, you know, sex itself is, is not bad. But, you know, when you do it without a protection, that’s when it’s er, more things (PT21).

The ‘danger’ related specifically to unwanted pregnancy and STIs, though ‘the more things’ for this patient may have also been linked to infidelity and regret, which will be explored further later.

Practitioners discussed the improved public knowledge and access to contraception, in particular condom use as opposed to ‘the pill’, which was traditionally associated as a method for preventing pregnancy. However, for patients attending the clinic this increased knowledge and access did not always translate into practice, particularly if alcohol was involved.

> On one occasion, after some drink, I did just think “What the hell, if she gets pregnant, she gets pregnant and if she doesn’t, she doesn’t” (PT4).

The immediacy of fulfilling the sexual desire meant that any consequences would need to be dealt with later. This held for both heterosexuals and homosexuals. One patient confirmed that ‘the reason I’m HIV positive is because my ex-boyfriend, we were really drunk and that’s when it happened’ (PT20).

Finally, there is perhaps a misconception that alcohol enhances everyday sexual experiences. This was echoed by a couple of patients who ended up having ‘pretty crappy sex’ (PT23) and it ‘wasn’t that good anyway’ (PT15).

Some patients actually reflected back on the poor sexual experiences where alcohol was involved, particularly in their formative years. This meant that as they aged, they were more aware of their sexual needs and for some it ‘just keeps getting better. Erm, well, that’s, well, for me it does’ (PT23) and ‘I’m more sexually active now’ (PT11). Being sexually confident and being able to ‘make the decision that I was going to have sex with somebody’ (PT7) meant that many enjoyed a healthy sex life, with both long-term and casual partners with or without alcohol.

The next section looks at the issue of condom intention, condom use and the role of sexual arousal in these ‘in the moment’ decisions.

7.4 Condom intention, condom negotiation and sexual arousal

One of the factors considered extensively in the literature and featured within this study was the issue of condom use. Alcohol is strongly associated with increased desire to have sex with a new or casual partner and decreased discussion of risks prior to intercourse, but it is inconsistently associated with condom use (Cooper, 2002).

Gender and age are important demographic characteristics when considering the issue of sexual decision making linked to condom use. It is proposed that women’s initiation of condom use involves risk, including risk to feminine identity as it could

signal sexual desire (Cook, 2012). Cook (2012), goes on to discuss the symbolic meaning of condoms as being associated with casual sex and promiscuity, therefore raising the topic of condom use might interpret the request as a negative character assessment. This is compounded if the woman has strong relationship goals, as negotiating condom use as it could threaten a potential relationship (Zawacki *et al.*, 2009).

Within this study, the issue of negotiating condom use only arose in discussion with female patients. This was raised in the context of having the confidence to request that a man use a condom to protect from both pregnancy and STIs. For some women, this did not change over time or was a particular issue with alcohol; it was simply that the confidence to negotiate condom use did not feature or develop as they matured.

One patient explained she was afraid to discuss it at all and hence would 'very rarely use condoms, like I would want to but I wouldn't dare say it' (PT7). Instead, she would provide an excuse as to why they needed to use a condom,

> You know I still think, find it like a bit awkward, yeah ... I make up like, I make up an ex- like I tell them I'm not on the pill now when I am 'cause I've got to like think of like an, it's like you feel guilty almost for, for saying it, yeah (PT7).

The patient explained 'the heat of the moment' you 'just think "Oh it'll be alright" (PT7). This patient described herself as a risk taker in life, participating in extreme sports. Her personality of 'sensation seeking' and impulsivity were perhaps more of a driver.

Once transitioned into a new relationship, many patients also described how they may use condoms at the start but would stop after a while. For one patient, her decision to stop using a condom was a symbol of her commitment in a new relationship. However, she later discovered her new partner had been an injecting drug user who had spent time in prison, and thus it increased her fear of contracting HIV or Hepatitis, 'I'm back because the partner that I thought that I'd had turned out not to be who I thought he was' (PT6). This was also reflected by the practitioners,

that many patients are too trusting and rush into the ‘commitment’, defined as stopping using condoms, until they uncover more about their new partner,

> And then they think they might have the right person then all these skeletons come out the wardrobe about this other person and then you start to think, “I don’t know how I ever walked into that.” And it’s that kind of situation that a lot of people find themselves in (HW7).

Practitioners shared their frustrations regarding the lack of condom use for the ‘in the moment’ actions. The intention or use of condoms often contradicted within the consultations, ‘some people will say, “I definitely used a condom’ (HW1), even though they had an STI. Whereas others still felt the need to provide an ‘excuse’ to the practitioner,

> ‘The condom split’, it sounds a lot better from some people than, “Oh yeah I had a one-night stand last night and we didn’t use anything. I was mortal, you know, didn’t use nothing” (HW1).

These phrases such as ‘split condom’ became a regular story within the clinic and during the fieldwork I also heard it, ‘we had this accident with the condom’ (PT18) and ‘the condom broke’ (PT5). One practitioner likened this excuse to a child’s description of ‘the dog eating your homework’ (HW4). Jokingly, the practitioners informed me that if there were as many faults in condoms then the manufactures would have gone out of business by now.

As sex is often a ‘spontaneous’ act, one practitioner stated ‘I really honestly don’t think that there is a great deal of thought that goes into it’ (HW9), which was supported by a male patient ‘you have a few drinks and you just take your brain out and put it on the side (PT4), thus demonstrating the lack of preparation and planning. If the man or woman has condoms with them, the condom application was simply considered an interruption in the sexual experience. One patient acknowledged this, ‘I didn’t think about it, I didn’t care. The next day I thought “Oh my god!” (PT2). For this patient, she admitted that the impact of alcohol on her sexual arousal and context of the situation had affected her decision making.

For those who do admit that they did not use a condom, they did not anticipate that ‘they’ could contract an STI, ‘they don’t expect to. It is okay for them to do it and they won’t catch anything’ (HW9). Many perceive that,

> If I haven't had many partners, I shouldn't get an infection. I'm not one of those people who sleeps around much. How come I've got this when all those other people are having sex with lots of people? I'm not like that (HW10).

Therefore contracting an STI was considered what ‘those people’ get as a result of being more promiscuous, as discussed in the previous chapter, the difference between ‘self’ and ‘others’.

7.5 Familiarity and attractiveness

Research on sexual risk appraisal has shown that increased familiarity encourages judgements that the person is low risk. As explained in Chapter Two, this is via social projection bias, a tendency to expect similarities between others and ourselves. Familiarity with a potential partner can act as a situational cue that the partner is low in sexual risk and therefore a condom is not warranted (Zawacki *et al.*, 2009).

After drinking, women may be less likely to focus on a man’s sexual risk and more likely to focus on the pleasure of the interaction (Purdie *et al.*, 2011). Equally some men may be more concerned with gaining greater sexual pleasure than prevention of STIs (East *et al.*, 2011). Men are less likely to discuss the risks of intercourse or use a condom with women they perceive to be physically attractive only doing so when the potential partner is less attractive (Kruse and Fromme, 2005).

This description of assessing partner risk emerged in this study also, as one practitioner explained,

> I think people still think you can tell, by looking at someone, that they're alright. You think, "Well, are they going to have a 'C' stamped on their head, or 'HIV' stamped on them?" People still judge people just by looking at them (HW10).

For many STIs there are ‘visible’ and ‘invisible’ symptoms. The advancements in some treatment regimens means that it is even more difficult to assess risk as explained by this patient, ‘You don’t even know if someone’s got AIDS or HIV, because of the medication, you couldn’t even tell’ (PT22). I will return to this notion of the visible and invisible STIs later.

Within this study, the physical attractiveness was not as significant as the drive to fulfil the desire to have sex after drinking – ‘you get drunk and … you get horny’ (PT22). Desire or sexual arousal is heightened that sex with anyone, being ‘a little bit less picky if I’ve had a drink’ (PT16) was part of the narrative for some patients. The impact of ‘beer goggles’ allowed patients to take the risk of having unprotected sex, but also with someone who they were not particularly attracted to. Many reflected on their past drunken sex experiences within the interviews and shared their shame and regret, ‘I would never have slept with the people I’d slept with over the past two years if I hadn’t have been drinking’ (PT2).

This section has highlighted how alcohol can blur the decision making process in the choices of sexual partners and whether or not condoms are used. The desire to have sex often overrides any other decisions, dealing with any consequences in the aftermath. The excuses used within the clinic by patients for not using condoms has also become folklore along with the other 'atrocity' stories described in Chapter Four. The next section considers the emotional shift in the aftermath, from desire to shame, regret, guilt and blame.

7.6 Shame

Shame or self-disgust is a negative emotion characterised by intense discomfort, feelings of exposure, inadequacy and worthlessness, and a desire to hide (Balfe *et al.*, 2010). As explained in Chapter Five, the stigma attached to the GUM clinic meant that for many patients, their attendance was often shrouded in a veil of shame and embarrassment.

Both male and female patients discussed the shame of having to attend the clinic, particularly if they had never visited a sexual health clinic previously ‘you only do that

and end up here once and feel like that' (PT6). This patient had visited for the first time following a series of casual sex relationships following her divorce,

> I came for a test 18 months ago, and I had gone out a few times and I had had two or three, erm, sleeping with guys, which I'd never done in my whole life. Erm, and was horrified at myself after all of that and came for all the tests and everything (PT6).

The patient was 'horrified' at sleeping with a number of casual partners and struggled within the consultation and interview to reconcile her behaviour given it was not what was 'expected' of a mother with a professional role. As a result of corporate identities being breached, many patients felt more comfortable speaking to the practitioners about their sexual activity, feeling too ashamed to share with friends or partners,

> He doesn't know about the warts, which is hard. And I cannot bring myself to tell him because I think it's that stigma, he'll just think it's like a dirty thing I think (PT15).

This patient uses the word 'dirty' to describe the STI, but perhaps 'dirty' has more connotations of her being judged for having sex with other men. Additionally, as this STI affects appearance unlike other 'invisible' STIs such as Chlamydia, the visibility of the STI appears 'dirty'.

For others however, the shame is linked to having the sexual behaviour being made more public as described by this patient,

> In a small town, everybody is there, so you can't escape what you do because everybody knows ya, everybody knows what you've done. If they don't someone's gonna tell you as soon as you walk in (PT2).

This additional shame of 'everybody' knowing your personal business however did not always deter people from making poor decisions and thus led to guilt and regret.

7.7 Guilt and regret

Guilt is an emotion that is similar to shame, though it arises in response to an undesirable behaviour rather than in response to an undesirable self (Balfe *et al.*, 2010). As one practitioner explained ‘It's pretty rare to get a regretted one-off, if there's not been alcohol involved’ (HW10). The ‘morning after’ was often cited as the time when the impact of the decision took effect, once the individual had ‘sobered up’. One patient shared that ‘I’d say maybes like five times I’ve woke up and thought “Oh god. No” (PT2). Demonstrating that the behaviour, for her, had not changed over time.

For others however, the single occasion was sufficient to ensure this would not happen again,

> I've tortured myself, lying in bed awake for- all night thinking, "Oh my God, what have I done? What have I done?" And just, like, feelings of guilt and regret. And, you know, you cannot undo things (PT14).

The guilt and regret is described by this patient as ‘mental torture’, a psychological response on this occasion. Practitioners raised some of the psychological and physical responses to guilt they witnessed within the clinic. They had even given it a diagnosis,

> ‘Guilty Penis Syndrome’, where there’s nothing to see but they scrub themselves ’til they’re raw. Penis goes red, it hurts when they pee, so they come in and they’re in and out every week and they test and they re-test and they re-test (HW4).

This ‘diagnosis’ was raised by a number of practitioners and they confirmed this was predominant amongst a small number of middle-aged men who had cheated on their long-term partner and struggled to come to terms with their actions,

> Just cannot get the guilt out of their heads. We've had one, he must have attended 30 times. He comes every few days. We've actually referred him for some psychological therapy. The more people keep testing, it just reinforces it. I'm like, "Don't do any more tests. We're just reinforcing that we think there

might be something." He's fine, but he's in absolute mess, because he's got a partner, and he thinks he's going to pass something on to her (HW10).

This level of physical and psychological consequence of the guilt meant they were unable to function within their relationship and the service could provide no more help for them.

As explained in the previous chapter, some patients regularly tried to reframe their narrative in order to justify their behaviour, mainly through the formation of excuses or cover stories, wanting to present images of themselves that are consistent with the norms of their social group. They reprieved themselves by questioning their decisions and of course were keen to demonstrate the benefit of hindsight,

> wish I had now ‘cause then I wouldn’t ... I’d be sitting in here with a blimin liquid nitrogen in an awkward place (PT7).

For many patients in the study, being at the clinic was viewed as punishment enough, putting the experience down to alcohol, as one patient eloquently described, he was left with ‘booze depression and booze guilt’ (P22).

Not surprisingly, given the purpose of the clinic, the reason people were attending was to check out symptoms, though the practitioners confirmed that as well as not skilled to discuss pleasure they ‘don’t tend to ask about regret either’ (HW3). For the patient who had sex with her ‘cheating ex-partner’ it was bitter sweet; whilst she was ‘not proud of it, I’m annoyed at myself as he cheated on me’ (PT2) it was an opportunity to gain revenge. However, in the aftermath she had two levels of regret – regret for sleeping with her ex-partner who had left her for another woman and regret of potentially passing on an STI to her new casual partner,

> Because I have been seeing somebody who I do like, and then ridiculously slept with me ex ‘cause we have a- I don’t know, hard time. I, I try and let him go, but he still keeps pulling me back in, which is what I think … I like this other new boy, I obviously don’t wanna be giving him something ‘cause that would just be horrible (PT2).

This patient struggled to come to terms with the breakdown in her relationship having been rejected from her ex-partner, which impacted her ability to ‘move on’. This issue of alcohol role in the breakdown of relationships will be discussed again at the end of this chapter.

However, for some, the regret had a longer lasting impact than a breakdown of a relationship. For those who were diagnosed with warts, HPV or HIV needed to consider the long-term treatment regime and stigma attached to those conditions too, as described by this patient,

> I've got to live with the consequences of the actions. And I was, you know, haunted by the thought that I'd be stuck with this for the rest of my life (PT14).

For many patients having to live with the emotions of guilt and regret soon led to the need to identify the source of the blame.

7.8 Blame

A few of the practitioners reflected on the reasons why people react in such a way within the clinic. Whether they are afraid of being judged, are ashamed or are simply in shock, ‘we find that the more that they protest about being here, is because they’re frightened to believe themselves of what they’ve done’ (HW1).

The issue of who, or what, to apportion blame for the regretted sexual experience was fascinating to hear. The most notable and unsurprising perpetrator was of course ‘alcohol’, as explained by this patient,

> I know I, I definitely just slept with him and didn’t use anything ... because I’d had too much drink, I wouldn’t have done it if I hadn’t have been drinking (PT2).

The account often told to the practitioners, is that it is more socially acceptable to ‘blame the alcohol’ (HW2) rather than acknowledge it was their own actions for fear of ‘looking bad’ (HW5). Thus they provide an account that is morally and publicly acceptable.

As explained in Chapter One, there are three theories proposed within the literature to explain the alcohol-sex behaviour: alcohol myopia theory (AMT); alcohol expectancies; and the 'third variable'. Individuals may engage in risk taking they would not do sober as the pharmacological properties can affect an individuals judgement and indeed provide a legitimate excuse for the behaviour. This was raised regularly within the study,

> You wouldn't have sex with somebody you'd just met if you were sober during the day, whereas if you've had a drink, then you seem to think it's okay (PT10).

As described by one patient who had unprotected sex after drinking, 'I still knew in the back of my head what was going on' (PT15) but the sexual arousal was a competing cue that trumped the decision to use a condom.

For many of the participants (patients and practitioners), they considered that the drinking leads to the sexual encounters rather than any prior considerations of the desire to have sex,

> I think a lot of them, they go to a pub or something and get really drunk, and then just end up having sex. I don't think they go with that intention. I think it's a consequence, rather than, "I'm going out tonight with the intention of having sex with someone." I think it's usually the other way around (HW10).

The issue of intent is also linked to the likelihood of whether or not a woman carries condoms. However, Cooper (2006) believes that the intention or desire to have sex may precede or cause drinking rather than the reverse and therefore posits this reverse causal explanation on the relationship. This was demonstrated by one patient who explained that she was 'purposively meeting in the pub and was going to end up having sex that night' (PT15). Thus, the drive for sex led her to the pub where she could drink alcohol.

Some practitioners on the other hand were less clear,

> We ask everybody about alcohol, erm, we know that there's quite a few of them where alcohol's been involved with sex. And whether it was a sorta kinda pre-

> destined, you know, “I think I’m gonna try and have sex now so I’ll get a little bit pissed so I can then go and find somebody,” or whether they get pissed and find somebody (HW3).

Therefore this practitioner thought that it was either the alcohol or the sex that was the primary driver, though this varied by each individual and links to the third model linked with individual factors such as sensation seeking. As has already been described above for one patient who participated in extreme sports and was also willing to take risks in relation to condom use, individual factors were a key consideration.

The following section considers the other culprit within the blame domain linked to the ‘other’ party and highlights some fundamental gendered stereotypes.

7.9 Gender: slag & stud

As well as blaming the alcohol, the other perpetrator of course was the ‘other’ party as illustrated by the practitioner below,

> One of the things which does amuse me and I have said this a lot of times to people, is that you get a bloke who comes in who admits to having lots of relationships. The minute he gets something he calls that person a slag. They immediately say, “It is the other person’s fault.” Even though they themselves have had multiple partners. As long as they don’t get anything it is alright but as soon as they get something then that person is a slag (HW9).

‘The slag’ is a derogatory term used to describe women and the assumption is that the other party, in this case the woman, has been promiscuous and ‘sleeping around’ without using protection, hence the man has now contracted an STI.

> The boys are usually the ones who blame the girls. It's the same when they, if they are diagnosed with something it's, it's never their fault, it's always “She must have done that, she must have given me it” and, you know, well, well the nurses had have to somehow say, you know, “Well how do you know that you didn't have it first and you gave it to her?” (HW2).

All practitioners discussed this blaming and stereotyping by male patients for contracting STIs as commonplace. However, the practitioners reinforced gender stereotypes too. This was mainly in their belief that men blamed women, but also in their experience, men were more likely to 'brag' about the number of sexual encounters they have, 'guys just have to make themselves up, big themselves up a little bit (HW2). This was particularly in front of their friends as explained by this practitioner,

> We see a lot of lads who come in, you know, cocky as anything with their friends who, erm, "When did you last have sex?" "Who with?" "I dunno. A random, I was out on the piss" (HW4).

Not knowing whom they had sex with, a 'random', seemed to provide pride in the conquest. This was considered 'bravado' amongst the practitioners, particularly when they were accompanied by friends and were 'blasé' about their attendance at the clinic, as explained by this patient,

> From all accounts from what the doctor's told me I'm quite potent, you know, my sperm ... It don't take much and we're away (PT4).

One patient was keen to acknowledge that women have sexual desires 'we all have needs evidenced this. Like, as long as you take the right precautions then enjoy yourself' (PT15) but still struggled with being seen at the clinic 'you never want to bump into anybody you know when you come to this – like to clinic' (PT15). Other female patients reinforced this gender divide,

> Boys - it doesn't matter to them. Erm, the majority of them don't, they see it as an act and that's what they do, it doesn't matter who with. Girls are a lot more reserved' (PT15).

This carried on through to the stigma of having an STI, where for males it was simply 'not a big deal to them' (PT2) and highlighted by one male patient who explained within his consultation that 'I had Herpes but its chilled now' (PT5). Within the study it

was mainly women who were more regretful if they had casual sex without using protection, fearing not just about the STI or pregnancy but also the reputational cost.

These gender stereotypes and gender roles in sexual practices however were not the only cultural norm that arose during the study. The next section discusses the cultural norms linked to geography.

7.10 Geographic cultural norms

As indicated at the start of this chapter, socialisation in the UK is inextricably linked with alcohol, and within the area of study binge drinking is also a normalised. In this study, three patients were either visiting or living in the UK from other European Countries. One of these patients felt that the ‘fucking British are not able to talk with you if they are not drunk!’ (PT18).

Their reflections on the local drinking culture provided a useful comparison from the cultural norms from where they originated. As noticed by this patient,

> they are faster drinkers, so if you are with somebody they, and, and also when you are on a table, or something like that, sharing some drinks, they buy a drink for you even if you didn’t finish that. Probably something cultural, I don’t know, but in Spain it’s not like that. You have to take your time with something like that. So probably in an hour, er, you drink in the UK five pints, and in Spain you will drink three or something like that. So yeah, it’s different (PT9).

This volume of alcohol and speed at which it is consumed clearly puts pressure on others to drink, particularly if you are drinking as part of a ‘round’ with a group of friends. The other feature raised was the group dynamics of drinking,

> What I observed is that women and men go out separately - most of the time. And then they start interacting when they start getting drunk. I never noticed this idea of going out separately and then starting to interact (PT18).

These noticeable ‘drinking and mating’ behaviours between groups of men and women, though not necessarily generalizable elsewhere, were seen locally as a

normalised ritual, though not explicitly acknowledged by those who originated from the local area.

Group drinking, particularly on a Friday and Saturday evening was a recognised tradition by the practitioners, dating back to the Industrial past where ‘pay day’ was an opportunity to binge drink.

> I think the norm if you like for most people is that they have quite a bit to drink on a weekend and they don’t drink the rest of the week. They might have too much at the weekend but they probably don’t drink Monday to Friday. That is probably what most people do. That is the normal pattern (HW9).

Following the Industrial decline, these norms have been retained and now includes women. The group drinking culture however means that instead of frequenting one bar, people ‘literally go from bar to bar ‘til you fall over’ (HW4).

One other patient, who was British Asian, explained how difficult it was growing up in the local culture where alcohol was such a key part of growing up and experimenting. This was particularly challenging coming from a family that did not drink alcohol.

> And with being Asian as well, parents have, kind of, I wouldn't sa- what do you say? It's, it's, it's a culture thing. Like … we weren't allowed to have that, kind of, go out and-get drunk and go out nightclubbing. And you're not allowed to have boyfriends. My friends used to be drinking in the bus stops or out with their false IDs on a weekend. I wasn't allowed to do any of that (PT11).

This drinking culture then is part of the transition to adulthood, with young people securing their ‘false IDs’ in order to be able to participate in this local ritual.

This section has discussed the feelings of shame, regret, guilt and blame experienced by patients within the clinic. Words such as dirty, horrified and haunted were regularly used to describe the consequences of such actions. Alcohol was regularly used as the main culprit, though blaming 'others' helped to mitigate responsibility. This blame held specific gender and cultural stereotypes amongst patients and practitioners - women being 'slags' and men 'studs'. The British culture

of excessive alcohol consumption and drinking in packs meant that ‘mating' was driven by alcohol. For some patients, alcohol was used intentionally to gain the confidence to have sex whilst for others alcohol allowed the desire to take over the rational 'self'. Either way, the consequences could have a longer lasting effect. This included impacting on social identity, having to live with a stigmatised condition or (as will be discussed in the final section) how for some was a key part of the breakdown of relationships.

7.11 The role of alcohol in the breakdown of relationships

Just as alcohol is part of the social fabric in the UK, using it as part of the process to form relationships, it can be a key part of the end of relationships too as described by this practitioner,

> Coming out of that relationship, if there is a bit of a, a grieving process and things going on, and they're maybe using the alcohol as a way of trying to forget, or, you know, just to kind of move on. But they may be using sex as a- not- again, probably not for the pleasure thing, but just for something to kind of fill that void of not having that close relationship with the previous partner (HW5).

Alcohol is used as a way to ‘forget’, and having sex with others during this grief period was described by partipants as an accepted way to help with the recovery process. Helping to ‘get over the other one that you’ve just lost’ (PT19) and to take away the pain for just that short period, thus ‘using it as a crutch’ (HW4). When confident enough, re-entering the ‘social’ scene again, alcohol helped with any ‘opportunity’ to meet a new partner,

> it was like a new lease of life when, when I ended up with him … when you’re getting attention off other people and going out on dates and they’re really nice, it was different, it was exciting (PT15).

While this recovery journey was described as purposeful and exciting, those on recovery from alcohol addiction had a very different type of journey. Two patients

within the study had received treatment for their alcohol misuse. Both discussed how their addiction had a major impact on their relationships, as described below,

> for the last couple of years I've been heavily under the influence of alcohol. It's cost me a lot, my driving license, car, business, house, family, all sort of things (PT14).

Losing everything had come at a huge ‘cost’ and now sober this patient reflected how his drinking (and drug use) had destroyed his relationship. This was mainly because he was regularly unfaithful when under the influence of alcohol ‘We were continuously arguing and breaking up, and then I would always go away and drink and go away and fraternise’ (PT14).

Both patients were now in recovery from their alcohol addiction and discussed how they could now see the benefits of relationships ‘being sober, er, there is much more pleasure involved in it’ (PT21). So for them sex without alcohol brought a new type of sexual pleasure.

7.12 Chapter summary

This chapter has presented both the positive and negative outcomes of alcohol sexual encounters. All participants considered alcohol as being synonymous with socialising, and venues such as bars are a perfect location for the alcohol-sex mix to occur. Alcohol is viewed as an asset in order to increase confidence and self-esteem, including being naked with a partner. This was particularly of note amongst females patients.

Narratives of using alcohol for sexual pleasure overshadowed the more traditional narratives of how consuming too much alcohol could negatively affect sexual performance. Participants described how it can enhance sexual pleasure and as described in Chapter Six, it can be used intentionally to increase confidence to experiment sexually. The practitioners believed that alcohol only possessed one positive quality in supporting sexual pleasure. This was amongst a minority of patients who experienced problems during intercourse, including painful sex. Hence, sex was again associated with illness and medicalised. The practitioners recognised

that they did not have the reputation or skills to be a promoter of good sexual health or indeed discuss pleasure. The service remains a sexual ill health service, and reinforces the medicalisation of sexual health.

All participants discussed how alcohol was a factor in the sexual decision making process and how alcohol can impair the rational thought process. For some patients previous experiences, beliefs and attitudes (sex related alcohol expectancies) influenced their current sexual decisions including condom use. However sexual arousal was an important element in understanding the influences of alcohol based sex decisions particularly when it trumped any other cues (alcohol myopia). This was apparent for three areas. The judgement to use condoms; the assessment as to whether someone is low risk based on their appearance; and the belief that they were immune from any risk. This resulted in a plethora of excuses used within the clinic for the lack of condom use.

Being aroused often motivated the risk not to use condoms and the condom application was an unwanted interruption. As identified within the existing literature, condoms were a symbol of trust and requesting a sexual partner to use them was a sign of mistrust. Early into a new relationship, the decision to stop using them was also symbolic of a commitment to monogamy.

As discussed in the previous chapters many patients who attended the clinic experienced shame, though predominantly this was amongst female attendees. This was stigma for attending the clinic but also shame about their sexual behaviour. Guilt then emerged. For some men, the guilt can manifest into a psychological diagnosis labelled by the practitioners of a ‘Guilty Penis Syndrome’, where they are unable to function within their relationship due to their guilt. For some patients it also meant they had to deal with long-term conditions such as HIV.

As described in Chapter Six, some patients presented a moral self into the clinic, demonstrating their behaviour was out of character and justify their reasons. There were two culprits to blame – alcohol and ‘the other person’. Alcohol was used as an excuse for socially unacceptable behaviour. The ‘other person’ was laden with gendered stereotypes.

Geographical norms also highlighted a particular behaviour within the area of study. This links to the binge drinking culture highlighted in Chapter One. The area was characterised by the volume of drinking, speed of drinking and cultural norm of drinking with groups of friends before interacting in the ‘mating game’.

However, alcohol did not just feature in the formation of a new relationship but also played a key part in the breakdown of relationships. This was twofold; for those who misused alcohol it was the cause of the breakdown. For those who were newly separated, it was a useful aid in the recovery process.

The final chapter (Chapter Eight) draws on the key findings from the audit, the systematic review as well as the empirical chapters. It builds upon some of the key recurrent themes highlighted throughout this thesis - the ‘problematisation’ of sex (and alcohol) and the stereotypes which continue to be reinforced in the alcohol-sex mix.

Chapter 8: Discussion and conclusion

This final chapter presents the key findings linked to the original aim of the study - exploring how the relationship between alcohol and sex is discussed and accounted for by patients (aged 25+ years) and healthcare practitioners in a sexual health service in the North East of England.

The key findings include how for some, the alcohol-sex mix can continue through the life course and can feature at key transition points, such as divorce.

Those aged 25+ years may use alcohol in sexual situations in similar ways to younger people, and can experience similar negative outcomes. For many, meeting new sexual partners continues through life, and partnership status or partner level interaction emerged as a key defining factor for the alcohol-sex mix, rather than age. This study found that finding sexual partners, in particular casual sex partners, via the internet, mobile apps and through holidays abroad are now more common.

Both the systematic review and ethnographic study found that alcohol can be used by some individuals to increase confidence, act as the moral license to escape and engage in sex considered socially unacceptable. However, for some individuals conflict arose in the aftermath when the feelings of sexual desire turned to feelings of shame, guilt and regret. Within the ethnographic study, the shame included attending the sexual health clinic; viewed by some as a healthcare institution preserved for the morally sick. For some patients this moral discourse of the clinical consultation was akin to a religious ceremony where the patient, the ‘sinner’, confessed for their moral lapse in their search for the recovery of the ‘moral self’. Some patients were keen to distinguish between ‘self’ and ‘others’; others who were more deserving to be there.

I discuss these key findings in more detail below, identifying what these findings add to the literature. I discuss two recurrent findings from this study, the ‘problematisation’ of sex, alcohol and pleasure and the issue of stereotypes and stereotyping. I identify the implications of these findings for policy, practice and further research. I finally close the chapter by describing the strengths and limitations of the study, before concluding this thesis.

8.1 Discussion of key findings

I begin by recapping on the relevant findings from the audit undertaken in the GUM service (Chapter One), the systematic review (Chapter Two) and the empirical study (Chapters Four to Seven). I combine the findings to identify areas of overlap and discrepancies, and discuss what the findings contribute to the existing literature.

The audit found that levels of alcohol consumption amongst patients attending a GUM service was higher than found in the general population, including amongst those aged 25+years (Sullivan *et al.*, 2017). The increased levels of alcohol use amongst sexual health patients is well documented in the literature (Zenilman *et al.*, 1994; Standerwick *et al.*, 2007; Crawford *et al.*, 2015), though this study provides more specific information on those aged 25+ years.

The interviews undertaken as part of the empirical study explored the views from patients and practitioners about discussing alcohol use within a sexual health clinic. All participants interviewed (10 practitioners and 22 patients) believed that discussing alcohol within this setting was both acceptable and necessary, particularly for 'those who needed it'. Whilst the findings identified some issues about the purpose and effectiveness of alcohol brief interventions amongst different population groups (e.g. students, dependent drinkers), the sexual health clinic was considered by participants to be in a unique position to discuss alcohol use with attendees. The alcohol audit found that alcohol screening is embedded within routine practice within the sexual health clinic, evidenced by the fact that 90% of new patients were screened, which is far greater than in other healthcare settings (O'Donnell *et al.*, 2014). So, this setting adds to the literature on the potential range of healthcare settings for alcohol screening and brief interventions (Derges *et al.*, 2017).

The systematic review highlighted four key themes. The expectancies and excuses; the lifelong cocktail of alcohol and sex; the unwanted consequences; and the need to account for other demographic inequalities, not just age, when considering the relationship between alcohol and sex. The review found that the relationship between alcohol and sex can continue through the life course, and adds to the existing systematic reviews in the alcohol-sex field (Cook and Clark, 2005; Rehm *et al.*, 2012; Lan *et al.*, 2014; Lan *et al.*, 2016; Scott-Sheldon *et al.*, 2016; Simkhada *et al.*, 2016).

However, this systematic review was unique in that it focused on just those 25+ years, rather than amongst all age groups.

The review found that those aged 25+ years can use alcohol in sexual situations in similar ways as that experienced by younger people. Consumption of alcohol prior to sex was a common feature; helping to increase confidence (Connor *et al.*, 2015; Hutton *et al.*, 2015; Palamar *et al.*, 2016), particularly when re-entering the dating scene (Morison and Cook, 2015). The review also found that those aged 25+ years can also experience similar negative outcomes as experienced by younger people. These included contracting STIs (Pandey *et al.*, 2012), unwanted pregnancies (Connor *et al.*, 2015), regretted sexual experiences (Hutton *et al.*, 2015; Palamar *et al.*, 2016), and sexual violence (Ullman and Brecklin, 2000; Rafael and de Moura, 2016).

The evidence as to whether alcohol use prior to sexual intercourse increased (Nayak *et al.*, 2010; Thompson Jr *et al.*, 2014; Eaton *et al.*, 2015), decreased (Tetrault *et al.*, 2010; Wells *et al.*, 2010; Wen *et al.*, 2012) or remained the same with increasing age (Bellis *et al.*, 2008; Delgado *et al.*, 2017), reported mixed results. However, alcohol prior to sex remained a dominant theme within the review amongst this age group.

As well as other demographic factors, partnership status or partner level interactions emerged as a key feature in understanding the alcohol-sex relationship. This is important, particularly when considering the sexual literacy for those re-entering the dating scene after a period of absence. Alcohol was mainly consumed with non-primary partners, in particular casual sex partners (Sivaram *et al.*, 2008; Folch *et al.*, 2010; Luo *et al.*, 2012; Morison and Cook, 2015), anonymous partners (Delgado *et al.*, 2017) and with sex workers (Padilla *et al.*, 2012). The alcohol-sex mix was not a reported issue amongst monogamous partners, however, it highlighted that a perceived monogamous relationship did not always guarantee the protection if one partner participated in sex outside of that relationship. Finally, the review found that bars and clubs were ideal venues to consume alcohol, but also to facilitate new sexual partnerships, by combining the alcohol-sex mix in one location (Sivaram *et al.*, 2008; Padilla *et al.*, 2012).

The empirical research identified three overarching themes. Firstly, the changing norms of sex, relationships and the sexual health clinic. Participants discussed how relationships are now more fluid, with a shift away from monogamous life-long partnerships to casual, concurrent and multiple sex partners over the life course and featuring in particular at key transition points e.g. following separation, divorce. The fingings of the empirical study echoed the findings from the systematic review that alcohol can feature in new sexual partnerships throughout the life course. In particular, participants considered casual sex partnerships as an acceptable norm, no longer confined to the young. This provides an added dimension to the literature on sex in midlife and older adults (Carpenter *et al.*, 2006; Gott, 2006; Nash *et al.*, 2015), with casual sex now considered a legitimate partnership option.

Additionally, the empirical study added to the evidence identified in the systematic review on the method for meeting a new sexual partner. With the expansion of internet dating sites and mobile apps, it has enabled people of all age groups to meet new sexual partners though different fora; thus shifting the emphasis beyond the alcohol serving venues of bars and clubs. The existing literature has identified that internet dating is a proxy risk for acquiring STIs, particularly for MSM (Elford *et al.*, 2001; Mettey *et al.*, 2003), yet this study has found that it is potentially confounded for those re-entering the dating scene.

The practitioners reported an increasing growth in patients who attend the clinic following unprotected sex whilst abroad or during weekends away with friends. This was mainly reported amongst those who participated in ‘hen’ and ‘stag’ parties. This finding adds to the growing literature on tourism and sex tourism (Simkhada *et al.*, 2016; Yang *et al.*, 2017). I concur with the findings that these numbers are likely to increase, so sexual health should be part of health advice for all travellers regardless of age (Tanton *et al.*, 2016).

The second theme was articulated in a moral narrative and was the subject of the next empirical chapter – the moral discourse of sex and alcohol. This theme was not a significant feature in the systematic review, and therefore adds to the literature amongst this age group. It highlighted the moral geography of the GUM clinic itself, where although sexual health was now medicalised, it still required to justify its position in the healthcare arena, alongside other morally acceptable services.

For some patients once inside the clinic, the space transformed into a ceremonial occasion and the consultation room became a confessional box. This finding adds to the literature on the sexual health clinic being a moral occasion (Pryce, 2000; Holmes and O'Byrne, 2006; Cook, 2014). The patient (the confessor), sought not just diagnosis and treatment, but forgiveness for their ‘sin’. For many patients the ‘sin’ was not necessarily linked to the sexual experience itself, but for having to attend the clinic and the potential stigma of acquiring an STI. However, more significantly the contrition appeared stronger if the patient, as a result of a diagnosis or treatment regime, had to also confess to their partner. The remorse was a feature amongst both men and women.

Within the clinical consultation, the clinician used their expertise to guide the patient in search for the ‘truth’. However, unlike other studies (Foucault, 1978), the search for ‘truth’ by the practitioners was not explicitly to cast moral judgement, or even to forgive, but to treat and protect others. This balance between casting a moral judgement (perceived or actual) and protection of others raises a key challenge for sexual health practitioners, which I will return to later.

Some patients described their accounts in a moral narrative and ensured they presented their sober ‘moral self’ in the clinic. They distinguished between their ‘good self’ and their ‘bad self’ and compared their moral conduct against the conduct of ‘others’. For these ‘others’ were more deserving of their visit to the clinic. This adds to the moral discourse literature, with the need for individuals to align with social acceptability (Rhodes and Cusick, 2002; Jordan *et al.*, 2011) but highlights the added stigma felt by sexually active ‘older’ patients attending the clinic.

The moral accounts from some participants in this study contained contradictions and excuses, with alcohol being the main culprit to what Goffman (1963) would describe as ‘spoilt identity’. Similar as found in other studies (Dunphy, 2017) for some patients, having an STI was seen as part of the punishment for their lapse in moral conduct; for others sexual exile was a justified step in their moral recovery.

The final theme from the empirical study was around the pleasure, the shame, the guilt and the blame. Pleasure is limited in the sexual health and alcohol literature

(Coveney and Bunton, 2003; O'Malley and Valverde, 2004) but also seemed absent from the dialogue within the clinic, unless it was ironically associated with pain. This study found that drunken sex can be pleasurable, not just for young people, but 'older' adults too.

There were many benefits cited in the empirical study for the alcohol-sex mix, which adds to the existing literature in the field amongst this age group (Connor *et al.*, 2015; Hutton *et al.*, 2015; Palamar *et al.*, 2016). This included using it intentionally to gain confidence, referred to in this study as 'dutch courage', tackling nerves prior to a date or making it easier to have sex with a new partner. It also allowed some individuals to escape from mundane life or to 'become someone else'. Similar to the findings within the systematic review, it was used by some as an 'excuse' or 'moral license' to engage in sex considered socially unacceptable and risky (Bellis *et al.*, 2008; Hutton *et al.*, 2015).

The findings from both the systematic review and the empirical study supported the two main alcohol-sex theories described in Chapter One. The AMT theory, where alcohol's pharmacological properties limit an individual's capacity and only highly salient immediate cues continue to be processed, was particularly demonstrated in relation to sexual arousal. Within the systematic review alcohol was blamed for loss of control, impaired memory loss, partner choice, unprotected sex (Connor *et al.*, 2015; Hutton *et al.*, 2015) and ability to maintain an erection (Palamar *et al.*, 2016). This was also supported within the empirical study, however more notable findings included that for some participants, their moral values were insufficient to repress the desire for sexual gratification, and hence, as described above, led to alcohol being blamed for behaviour which many believed would not have occurred sober. A feature which was highlighted amongst men, women, heterosexuals and homosexuals.

There was also evidence in both the systematic review and empirical study to support the alcohol expectancy model. Two studies within the review specifically looked at sex related alcohol expectancies, Nicolai et al (2012), in their study amongst 18-59 year olds, found that the association between expectancies relating to sexual enhancement only held for younger participants in their study. However, Hutton et al (2015), found that every participant believed alcohol increased sex drive, pleasure and participation in riskier sexual activities perhaps considered taboo. This was supported within the empirical study, amongst both men and women, where

alcohol expectancies was associated with pleasure, escapism and sexual experimentation.

Some studies have found that alcohol expectancies are particularly strong for individuals who are nervous about sex (Leigh, 1990). Patients within the empirical study overwhelmingly highlighted alcohol's ability to increase confidence in sexual situations. This included increasing self esteem, 'dutch courage', losing inhibitions, tackling nerves before a date and being naked with a partner.

However, as identified within Chapter One, some have argued (Morris and Albery, 2001; Kiene *et al.*, 2008; Lac and Brack, 2018) that the two theories are not mutually exclusive and can indeed interact with each other. Evidence from this study highlighted contradictions as to whether it was the alcohol that led to the sexual encounter or the motivation for sex and a relationship that led individuals to such places as bars. Additionally, as highlighted previously both theories are limited in accounting for other modifying factors such as personality type (e.g. sensation seeking), and the situational factors such as partner type (e.g. casual sex), both of which were found in the empirical study. Additionally, this study has also found that the theories are also limited in accounting for changes over time, where both pharmacological effects and psychological expectancies may change with age. Given that the alcohol-sex theoretical research is dominated by young people and students (Griffin *et al.*, 2010), and rarely looks at differences by age, ethnicity (Borjesson and Dunn, 2001) or sexual orientation, this study has highlighted the gap in this field.

As well as the limitations in the theories, I now want to turn to the limitations of the definitions used within research. The definition of sexual risk in the systematic review included alcohol use before or during sex, number of sexual partners, sex without a condom (and thus an increased risk of STIs) and sex with commercial sex workers. In the empirical study sexual risk also included unprotected sex, in particular lack of condom use and having sex with casual or multiple partners. Unlike the systematic review, it did not identify the consumption of alcohol when engaging with commercial sex workers by patients, though it was raised by the practitioners when discussing patients who have sex abroad. However, sexual risk in the empirical study, also included more nuanced aspects as defined by the participants - attendance at the clinic, reputational damage and sexual functioning.

If using alcohol in sexual situations, patients explained that there needed to be a level of ‘self-control’; however when the control is compromised, both male patients and practitioners identified how it can affect sexual performance, in particular maintaining an erection. Interestingly, sexual functioning was only raised in one of the included studies within the systematic review so highlights the importance of understanding how individuals define sexual risk, which is much broader than sex without a condom.

One of the unexpected findings that emerged during the study was the role of alcohol in relationship breakdown. The impact of alcohol misuse on relationships breakdown already features in the literature (Boden *et al.*, 2013), however, its use as a ‘crutch’ in the aftermath of the relationship linked with sexual risk, perhaps requires further attention.

The old adage of the ‘split condom’ was a common excuse provided by patients within the clinic for any unprotected sexual encounter. As already identified within the literature (Cook, 2012) and the sytematic review, for females, lack of condom negotiation skills and the symbolic meaning of the condom also emerged. For some women within the ethnographic study, the lack of condom negotiation skills was not just about age, it was simply that the confidence to negotiate a condom did not feature when they were young, or develop as they matured and adds to the existing literature wher people follow their usual pattern of condom use, regardless of alcohol (Leigh *et al.*, 2008). For others, similar as has been found in younger females (Abbey *et al.*, 2006; Marston and King, 2006), the condom was linked to a perceived lack of trust, and therefore a conscious decision to stop using condoms was a symbol of monogamous commitment. This adds to the existing literature amongst midlife women, where condoms may threaten a long term relationship (Neundorfer *et al.*, 2005; Sherman *et al.*, 2005).

For some patients in this study, in the aftermath of the ‘spontaneous’ decision, desire led to feelings of shame, guilt and regret. Shame for having to attend a sexual health clinic in the first place, but more so if diagnosed with a stigmatised infection. Stigma of attending the sexual health clinic is already documented in the literature (Sauer *et al.*, 2013), and therefore the findings of this study highlight the added shame for

‘older’ patients. Additionally, the empirical study highlighted the distinction between ‘visible and ‘invisible’ STIs. Those patients who had ‘visible’ symptoms felt more stigmatised or ‘dirty’ when meeting a new partner. This adds a more nuanced dimension to the existing literature on the stigma of STIs (Sauer *et al.*, 2013).

For many patients, the emotional feeling of guilt then appeared if the sexual encounter was regretted. However, regret was also not discussed by the practitioners within the clinical consultation. In private, the practitioners applied the psychological diagnosis of the ‘guilty penis syndrome’ to describe some men who struggled with the guilt from their infidelity. Although this does not feature within the published literature, it is a well-used informal diagnosis used by the sexual health practitioners.

Alcohol was regularly cited as the main culprit for regretted experiences however, if a patient contracted an STI, the blame was also aimed at the ‘other’ sexual partner. By blaming the ‘other’, the patients could then potentially hold onto the moral position of being blameless.

As was found in the systematic review, the negative consequences of the alcohol-sex encounter - STIs, regretted sex, sexual assault and unplanned pregnancy, were also identified by the participants in this study. However, the level of alcohol related sexual assaults amongst GUM clients was perceived by practitioners to be far higher than that reported to the police, which echoes existing research undertaken in sexual health clinics in the UK (Blume *et al.*, 2012). Practitioners encourage patients to report but their reluctance was often due to the association with alcohol, and subsequent fear of judgment from another ‘authoritarian’.

In summary, the key findings from this study has found similar issues amongst an older age group (25+ years) than that experienced and well documented amongst a younger age group (Abbey *et al.*, 2005; Cook and Clark, 2005). This includes how alcohol is consumed sometimes intentionally, in new sexual relationships for pleasure; and how it is often ‘blamed’ for any negative consequences. Although being young is a legitimate time to experiment, particularly with alcohol and sex, there is perhaps still a societal expectation that this period is time limited. However, this study has found that the alcohol-sex relationship is more cyclical, with partnership status being the key defining factor rather than age. It therefore highlights

some prominent areas for practitioners, policy makers and researchers, which I will discuss in the following sections.

8.2 The 'problematisation' of sex, alcohol and pleasure

Some have argued that the 'problematisation' of pleasure needs closer examination (Coveney and Bunton, 2003). The findings from this study has found that alcohol and sex, and the combination of the two, in policy and practice are 'problematised' against the backdrop of pleasure. The pleasure narrative is largely ignored or where it does exist it is encoded as risk (O'Malley and Valverde, 2004). Some patients within this study were willing to accept a level of risk, particularly in the heat of the moment. Notably at times, the risk itself was even the source of the pleasure.

Coveney and Bunton (2003), go on to describe carnal pleasure as 'pleasure that is often unanticipated, arising out of nowhere but calling for attention and gratification' (p168). Within this study, the speed and sometimes extreme behaviours to fulfil carnal pleasures were found in the speed of meeting new sexual partners: of engaging in anonymous sexual encounters (particularly helped through geo-location mobile apps) and levels of alcohol consumption leading to drunkenness and memory lapse. Although alcohol consumption levels in the geographical area of study may have some local cultural significance, this drive for immediate gratification needs to be further understood. Some argue that carnal pleasure needs to be balanced against the public health disciplined pleasure, which is promoted in terms of moderation and restraint (Coveney and Bunton, 2003).

The practitioners acknowledged that the sexual health clinic was in fact a sexual illness service, which was there to treat the physical symptoms not to proactively discuss pleasure. The only occasions where pleasure or more specifically lack of pleasure were discussed were in a few instances of 'problematized' painful sex with women. The practitioners recognised that they ignored pleasure by focusing on the risks and problems. This was compounded as sex then continues to be associated with morality.

The moral space and moral discourse that emerged in the empirical study, placed sex and the medicalisation of sex alongside other diseases. Some argue that health

and disease have always been moral concepts; thus by having sex located within the sphere of medicine, and therefore illness, it is seen as a deviance (Crawford, 1980). Others go as far as to argue that the clinic needs to be sanitized to ensure it does not get contaminated by the erotic (Pryce, 2000). As pleasure is trivialized against this backdrop of disease or deviance, practitioners are also ignoring its fundamental role as a key deciding factor in the application of condoms and hence protected sex.

However, others argue that the harm reduction approach undertaken by the practitioners, in the case of this study - safe sex, contact tracing and alcohol brief interventions, is non-moralised (Race, 2008). Harm reduction approaches do not stigmatize the activity or the person per se, but help individuals to define their own problems and set their own reform goals, albeit in a version of culturally specific social norms (Valverde, 1998). This harm reduction approach was witnessed within the 'confessional' space of the clinic, where some patients viewed their own conduct and attendance as a moral failing; the practitioner guided and counselled the patient, without publically casting moral judgement.

There are therefore four key areas for practitioners and policy makers to consider. First, how to integrate the pleasures of sex, the pleasures from alcohol, and indeed the pleasures of them combined, into the patient-practitioner dialogue. This will require a significant cultural shift away from simply focusing on risks and harms. This study identified that practitioners did not have the confidence or skills to engage in a pleasure narrative. Specific training and resources are required for healthcare practitioners, not just sexual health clinicians, who are perhaps uncomfortable when broaching the topic of pleasure (Mitchell *et al.*, 2017). This can be supported by ensuring public health strategies (national and local) and social marketing planning includes the narrative of pleasure.

Second, the systematic review and empirical study found that individuals can have numerous sexual partnerships over the life course. Key transition points such as divorce, separation and bereavement, are critical periods for individuals. This study found that for some individuals, alcohol was used as a form of coping during these difficult periods. Alcohol was also used by some 'as a crutch' following the ending of a relationship, to increase self-esteem and for 'dutch courage' when re-entering the dating scene again. Yet, as many have described, beginning to date again entails

revisiting behaviours which may be rusty and incompatible to the current sexual environment (Rich, 2001). Health professionals, in particular primary care professionals, and other wider public health roles such as counsellors, need to have the skills and the confidence to discuss sex and alcohol use with 'older' patients who may have experienced the ending of a relationship or who may be considering re-entering new relationships. This will ensure they are able to support and equip patients with the skills or new knowledge for this transition phase where the alcohol-sex mix may reappear. This will also need to include discussing condom use with women beyond reproductive age.

Third, it may be time to reassess the moral space of sexual health in a medical arena altogether. Whilst this may not be palatable amongst some sexual health clinicians who enjoy the alliance alongside other medical specialties in a hospital space, it may have far greater benefit for patients if it was located within other community settings. As identified in Chapter Four, the secrecy of the clinic and labelling of patients by their diagnosis rather than their name reinforces the morality of sex and sexual illness.

Finally, sexual health clinicians need to be aware of their biomedical approach in their search for 'truth'. Whilst their drive is both harm reduction and protection of others, some have proposed that the focus on the biomedical perspective overlooks the meaning and significance of symptoms and diagnosis of STIs for individuals (Mapp *et al.*, 2017). The moral discourse of the consultation highlighted within this study may require clinicians to recognise that the very attendance of some 'older' patients at the clinic, is a moral failure leading to shame, guilt and regret. Practitioners should acknowledge such emotions as part of the consultation, not to collude or judge, but as part of their role in providing reassurance. This could build upon their non-judgmental approach, by focusing on the benefits rather than just the harms, and normalising the attendance of 'older' clients within the clinic.

8.3 The stereotypes

One of the interesting features of this study, ironically set against a backdrop of delivering a 'non-judgemental service', was one of stereotypes. Stereotypes littered the ethnographic study and I want to reflect on some of these now.

The practitioners discussed patients using a range of stereotypes, arguably influenced by epidemiological data and years of experience working at the clinic. These were specifically amongst at risk groups, such as young people, students and MSM. However, it appeared that practitioners viewed these groups with a more favourable and acceptable level of risk than others who were perhaps considered more low risk. These stereotypes were mainly associated with culture or identity – practitioners viewed MSM as having a more 'promiscuous' lifestyles and believed young people enjoy a period of experimentation. This was demonstrated for example, when the alcohol-screening tool was adapted by the practitioners to account for the identity of being a student, an approach which is not evidence based. As a result, practitioners need to be aware of their own beliefs and unconscious bias, which might simply reinforce these stereotypes. They may also miss opportunities to identify hazardous and harmful drinkers amongst other groups, and as identified within this study, people who are single, regardless of age.

Many patients also held particular stereotypes linked to the population groups who accessed the sexual health service. They felt the clinic was only for young people or 'those' whose sexual deviance required it. As described in Chapter Four, I did not locate any marketing material or information leaflets aimed at an older age group. This has been found in other studies where older persons are frequently left out or invisible in STI campaigns (Minichiello *et al.*, 2011). The annual sexual health campaign delivered by the Family Planning Association (FPA) in England during 2015 did focus on pleasure, including highlighting sexual wellbeing as you get older, with tips for enjoying sex into later life (FPA, 2015). However, policy makers and practitioners need to develop and use such materials to target information and increase awareness of a sexually active 'older' age group. Sexual health clinicians should also engage with older clients to understand how they could make the service more attractive and accessible for them.

However, by far the greatest stereotype that emerged within the study was linked to gender. This was apparent amongst both practitioners and patients, and I want to discuss this in more detail next.

The audit undertaken within the sexual health clinic, found that men were significantly more likely to have a higher AUDIT score, indicating risky drinking, compared to females. Of those who consumed alcohol, men were also significantly more likely to be diagnosed with an STI compared to women. The systematic review also identified gender differences. Risky sexual practices, both number of partners and unprotected sex more common in men than women with heavy drinking and multiple sex partners higher amongst men too (Connor *et al.*, 2015).

Gender differences also arose in the empirical study; for example, practitioners and female patients felt that when men were diagnosed with an STI it was considered 'not a big deal', whereas women were shamed and stigmatised. Gender stereotypes also became particularly evident in the dialogue of blame. Both practitioners and patients highlighted, and indeed reinforced, some of the gender stereotypes. Men bragging about their number of sexual partners and seeking transactional sex. This builds upon existing literature, (mainly amongst young men), where men can exaggerate how many women thy have 'hooked' up with, in order to increase their prestige amongst their peers (Fisher, 2009).

Women were viewed by practitioners as more emotional, seeking romance, embarrassed to be at the clinic, regretful if they had sex without using protection, fearful not just about the physical consequences but the reputational cost too. The moral burden was particularly significant for those who were single mothers, and is supported in the existing literature of further gendered moralities (May, 2008). This again highlights that the definition of sexual risk used by researchers and policy makers perhaps needs to be broader and encompass emotional as well as physical measures too. Some have argued that the sexual scripts of women highlight issues of passivity, receptivity and monogamy as socially accepted roles (Hinchliff and Gott, 2008), and this sexual double standard is still a moral code that continues to restrict a women's sexual freedom. As identified above casual sex is an accepted norm amongst 'older' adults, yet this study adds to the existing literature that it continues to be a contradictory terrain, for women, who struggle to escape from its derogatory meanings (Farvid *et al.*, 2017).

The quantitative and qualitative data highlights the continued tension between gender, sex and sexual outcomes. Practitioners need to be conscious of their own

beliefs, not perpetuate these stereotypes, and reflect on any service delivery that reinforces such stereotypes. Practitioners have a key role in helping to challenge the societal norm of women as ‘slags’ and men as ‘studs’, and shift such sexist discourse (Farvid *et al.*, 2017). Additionally, there is a key role for policy makers and practitioners to scrutinise the data so that they target interventions and social marketing towards heterosexual men, not just MSM, to tackle some of the poor alcohol and sexual health outcomes they experience, and in so doing rebalance the stereotypes.

As the focus of this study was on those aged 25+years, there needs to be a societal shift in attitudes to sexuality and ageing (Gott, 2006). These stereotypes are beginning to change and, as discussed by practitioners within the clinic, they have witnessed an increase in patients 40+ years requiring sexual health advice and treatment. The practitioners viewed this positively, but their attendance was often reactive rather than proactive. The reactive role of the clinic meant that sexual health advice was often too late. The practitioners acknowledged that they needed to take a more proactive role with ‘older’ adults and promote that everyone has a right to a healthy sex life. As discussed earlier, this will require policy makers and commissioners to make explicit the preventative role of the sexual health clinics throughout the life course and shift the medicalised discourse of the clinic from a sexual ill health service completely.

As well as practitioners making services more accessible for older age groups in order to reduce stigma, new developments in sexual health practice are shifting the focus away from face-to-face consultations, and more towards the home environment for testing e.g. chlamydia screening, HIV home sampling, and online consultations. These non-traditional methods of service delivery will help to reduce service-access barriers caused by a sexual health consultation (Holmes and O'Byrne, 2006), but again needs to be targeted at different age groups and not just focused on at risk groups.

As identified within Chapter Two, some argue (Bellis *et al.*, 2008; Hutton *et al.*, 2008; Pandey *et al.*, 2012; Thompson Jr *et al.*, 2014) that sexual health and alcohol interventions require more integration given that they are regularly experienced together. Integrated services or as a minimum clear referral pathways are essential.

The alcohol audit undertaken as part of his study confirmed that alcohol screening and brief advice has become part of routine practice in this sexual health service, and whilst further work is required to assess the efficacy within this setting (Crawford *et al.*, 2015), particularly amongst different population groups, using an evidence-based tool as part of the clinical assessment was regarded as positive amongst practitioners.

8.4 Strengths of this study

As far as I am aware, this is the first study of its kind to explore the relationship between alcohol and sex exclusively with this age group, regardless of sexual orientation or gender. The major strength of this study was the ability to seek personal accounts from 'older' patients and practitioners within this setting. As described in Chapters One and Two, research within this setting rarely benefits from a qualitative study design. The opportunity to work with both patients and practitioners added to the richness of the findings.

Research on the associations between alcohol and sex has tended to focus on a younger age group or other 'risk groups'. The findings therefore add to the limited qualitative literature on the associations between alcohol and sex for this older age cohort (Morison and Cook, 2015). Although this was a small study, it should provide a useful insight into the experiences of a sexually active 'older' age group who may use alcohol 'as a tool' in their formation or dissolution of sexual relationships.

Second, as far as I am aware the systematic review was also the first to look specifically at the alcohol-sex relationship in an older age group (25+ years) rather than just focusing on 'at risk' groups. The review also highlighted the lack of studies undertaken within the UK amongst this age group, and therefore, the findings now adds to the limited literature for this age group undertaken within the UK (Bellis *et al.*, 2008).

Finally, my role as researcher 'in the middle', allowed me access and acceptability within the clinic, as well as to undertake a sensitive topic of research. Additionally, as I am employed by an arms-length body of the Department of Health (England), the

opportunity to translate the findings and influence policy and (sexual health and alcohol) practice should now be realised.

8.5 Limitations of this study

As with all research, there are a number of limitations to this study and I will highlight these in turn next.

First, some may question the rationale for choosing the 25+ age group as cut off to describe 'older' adults. As highlighted in Chapter One, this age group was selected due to the definition applied within the sexual health arena for the age group of lower risk. Those aged under 25 years are still regarded at higher risk of STIs and most of the literature on the associations between alcohol and sex are still focused towards this age group (Abbey *et al.*, 2005; Coleman and Cater, 2005). However, I acknowledge that the 25+ age range is very broad, and I believe this has resulted in limitations within the ethnographic study. Whilst I was able to observe and interview patients in their late 20s, 30s, 40s and 50s, the oldest patient participant was only 54 years. Therefore, the findings are perhaps more applicable to 'midlife adults' as I was not able to confirm if the alcohol-sex relationship continues into 'later life'. A pragmatic decision was taken at the start of the study to recruit all patients aged 25+ years, particularly given the small numbers of patients aged 50+ years accessing the clinic. However, in hindsight, I would have at least amended my selection criteria to recruit an equal sample size from each age decade.

Second, the study was undertaken in one service in the North East of England, with the interviews capturing views at one point in time, so not generalisable. As outlined in Chapter One, and discussed by patients not from the geographical area of study, alcohol consumption levels and the use of alcohol in the 'mating' behaviour of local residents was a cultural norm, which may not be applicable elsewhere.

Third, as described in Chapter Three, undertaking the study within a sexual health setting (GUM), only captured those patients whose symptoms led them to seek help at this setting, as oppose to another setting such as primary care. Indeed, it also did not capture the views from those who may practice sober unprotected sex. Many have argued that undertaking alcohol research in non-alcohol related contexts is

problematic (Monk and Heim, 2014), but given the very private nature of the research it was impossible to seek views directly following sexual intercourse. However, I acknowledge that both the setting and those who self-selected to participate were perhaps more comfortable in discussing alcohol and sex, than those who did not agree to participate. Again, in hindsight it would have been helpful to have captured the demographic details of those patients who declined to participate, in order to understand any comparison.

Fourth, neither the systematic review nor the empirical study included women who identified as gay or bisexual (sexual minority women – SMW). Yet there is evidence that single SMW are significantly more likely than heterosexual women to be heavy or hazardous drinkers (Drabble *et al.*, 2005), particularly those who are single or in non-cohabiting relationships (Veldhuis *et al.*, 2017). Similar to heterosexual women, research on the impact of their alcohol use with sexual risk remains limited to young people (Patel *et al.*, 2013) and may benefit from further research.

Finally, I was working in the field as a sole researcher and as described in Chapter Three, I am also a practising public health consultant. This may have resulted in the findings been biased, or my vision skewed towards a certain way of seeing (Silverman, 2011). Although I applied strategies to prevent bias, I acknowledge that it may have occurred.

8.6 Implications for future research

This study has identified a number of opportunities for further research, some quite practical, others that have arisen due to gaps within this research design or following the findings from this research.

First, given the limited studies available for the systematic review, any future studies looking at the association of alcohol and sex that do cover a broad age spectrum, should at least report the differences by age bands rather than simply providing a mean age. This would allow more data to contribute to any future systematic reviews in this field.

Second, as one of the limitations of this study was the lack of participants aged 50+years, dedicated research should explore the alcohol–sex relationship in later life. Although there is a growing amount of work on sexual intimacy in older age (Nusbaum *et al.*, 2004; Gott, 2006), its link with alcohol remains limited.

Third, given the stigma experienced by patients in physically attending a sexual health clinic and, as described above, with the shift to more self-testing and online support to remove the barrier of face to face consultations (Aicken *et al.*, 2016) evaluating the impact of these new methods should explore the impact amongst all age groups and not just focus on young people.

Fourth, drug use emerged as a feature within this study amongst the age group of interest. Heath et al. (2012) in their review of alcohol and substance use amongst MSM over 50 years of age, found that they were more likely to engage in risky sexual activities compared to younger MSM, trading off safe sex in order to fulfil desires (Heath *et al.*, 2012). Further research should investigate the impact of both drugs and alcohol within this age group, regardless of sexual orientation. More specifically, chemsex arose as an emerging factor within the empirical study. Although chemsex and associated research (Turner *et al.*, 2015; Hegazi *et al.*, 2016) is relatively new, as more data becomes available, a focus on age, partnership status as well as geography (major cities) may provide a greater understanding of this phenomenon.

Fifth, this study identified the cross-cultural differences of the alcohol-sex relationship. Whilst the empirical research identified this difference amongst other European patients, the systematic review specifically identified the experiences of ethnic minority men. Therefore, cultural norms and ethnicity should also be considered as a factor in this field of research; particularly amongst ethnic minority women who are absent from research and may be unaware of their sexual risks from their perceived monogamous partner.

Finally, the need to account for partner level interactions and partnership status was a key feature of both the systematic review and the qualitative study, this echoes findings from others studies where partnership type provides a better understanding of STI risk rather than partnership numbers (Mercer *et al.*, 2017). As observed within this study health practitioners who carry out sexual health screening request

information on the number of sexual partners and ask about alcohol use. However, health practitioners undertaking alcohol screening may not systematically ask about sexual partners or partnership status. As partnership status is a key factor in alcohol use, all health practitioners should consider changes in frequency of alcohol use with any partnership changes.

8.7 Conclusion

The aim of this study was to explore how the relationship between alcohol and sex is discussed and accounted for by patients (aged 25+ years) and healthcare practitioners in a sexual health service in the North East of England.

The main findings of the alcohol audit were that patients who attend sexual health clinics have a higher level of alcohol consumption than found in the local population, including amongst those aged 25+ years (Sullivan *et al.*, 2017).

The systematic review and empirical study found that for many the relationship between alcohol and sex continues through the life course and features at key transition points, notably divorce, separation and bereavement. Those aged 25+ years, may use alcohol in sexual situations in similar ways as that experienced by younger people; to facilitate sex; reduce inhibitions; for ‘dutch courage’ and to enhance sexual pleasure. Those aged 25+ years can also experience similar negative outcomes to young people – ‘visible’ and ‘invisible’ STIs, unplanned pregnancy, regretted sexual experiences, non-consented sex and sexual violence.

As a result the traditional stereotypes of the alcohol-sex mix being only confined to the young or those who are ‘promiscuous’ needs to shift. This study has found that the alcohol-sex mix is more cyclical rather than age dependent. Existing evidence in the UK has found that partnership formation continues throughout the life course (Mercer *et al.*, 2013), and partnership status or partner level interaction is a key defining factor for the alcohol-sex mix rather than age.

Similar to young people, for some people alcohol provides the excuse or moral license to engage in sex considered socially unacceptable, participate in risky sex (mainly unprotected sex), to escape and experiment. Within this study meeting new

sexual partners, in particular casual sex partners, via the internet, mobile apps and via holidays abroad were now more common. For some participants these encounters often led to drunken sex, but in the aftermath, it also led to feelings of shame, guilt and regret.

The shame included attending the sexual health clinic, a place considered only for the young or the sexually deviant. For some patients the moral discourse of the clinical consultation was akin to a religious ceremony. The patient, the ‘sinner’, confessed for their moral lapse in their search for their recovery of the ‘moral self’. They were not like ‘others’ who deserved to be there. The clinician operated as the ‘authoritarian’ and ‘expert’, navigating the discussion in the search for ‘truth’ in order to treat and protect others.

Sexual health commissioners and practitioners have a key role in ensuring services are promoted, accessible and attractive for ‘older’ age groups. In so doing, they also need to reconsider their role in promoting pleasure, as well as challenging the entrenched gender stereotypes that exist, and perhaps even reinforce. This needs to be emphasised, and sexual health services positioned wholly within a medicalised discourse perhaps reconsidered.

The policy and practice approach to sexual health has focused so much on the containment of disease, that it has largely ignored the social context of sex and alcohol. Part of the definition of public health as ‘the science and art of promoting and protecting health and well-being’ (Faculty of Public Health, 2017), requires practitioners and policy makers to achieve a better balance between promotion and protection. Instead of just viewing sexual health and alcohol in terms of disease, risk and deviance, the time has come for public health and Government policy to be bolder about the narrative of pleasure, and acknowledge that this occurs across the life course.

Glossary

AIDs – acquired immunodeficiency syndrome

AMT – alcohol myopia theory

Apps – mobile applications

ARHA – alcohol related hospital admissions

AUDIT – Alcohol Use Disorders Identification Tool

BIs – brief interventions

CAI – condomless anal intercourse

CASH – contraception and sexual health

CASP – critical appraisal skills programme

CQUIN – Commissioning for Quality and Innovation

CRD – Centre for Reviews and Dissemination

DH – Department of Health

DNA – did not attend

EHOC – emergency hormonal oral contraception

GP – general practitioner

GUM – genito-urinary medicine

HCA – healthcare assistant

HIV – human immunodeficiency virus

HW – healthcare worker/practitioner

IAG – Independent Advisory Group on Sexual Health and HIV

LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex

MDT – Multi-disciplinary team

MedFASH – Medical Foundation for Aids and Sexual Health

MSM – men who have sex with men

Natsal – National Surveys of Sexual Attitudes and Lifestyle

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

ONS - Office of National Statistics

PEP – post-exposure prophylaxis

PHE – Public Health England

PIL – patient information leaflet

PT - patient

RCP – Royal College of Physicians

SARC – sexual assault referral centre

SRAE – sex related alcohol expectancies

STI – sexually transmitted Infection

Appendices

Appendix 1: Participant Information Sheet (Patient)

Research Study: To explore factors that influence sexual decisions in those aged 25years and over.

Chief Investigator: Claire Sullivan

What is the purpose of the study?

This research will explore the factors that influence sexual decisions. In particular the role alcohol plays, if any. You have been invited to take part in this study as I am keen to hear views from patients aged 25years and over attending sexual health services. The reason behind this decision is because there is little research on this topic amongst this age group.

What will happen if I agree to take part?

If you decide to take part the researcher will sit in for your appointment but will not be present for any further tests. The researcher will be taking notes but will not be recording the appointment. None of your personal details will be identified.

If you agree to be observed but not agreed to be interviewed **your involvement in the research will end after the appointment, there is no follow up**.

What will happen if I agree to be interviewed?

If you decide to take part for the interview, the researcher will carry the interview once you have completed your tests and received any treatment today. The interview should last approximately 10-15 minutes. Once completed, **your involvement in the research will end; there is no follow up**. The interview will be tape recorded but none of your personal details will be identified. The recording will then be typed so that I can analyse the results.

Do I have to take part?

Taking part in the research is entirely voluntary: it is up to you to decide whether to join the study. If you agree to take part you will sign the consent form. You are free to withdraw at any time, without providing a reason.

What are the possible disadvantages and risks of taking part?

There are no risks for you as a result of taking part in this study. The only possible disadvantage if you agree to be interviewed is that you are giving up some of your time. I understand that you might find talking about your sex life uncomfortable but must stress the confidential nature of our discussions and your right to withdraw from the study at any point.

What are the possible benefits of taking part?

Taking part in this interview will offer you the chance to share your views on this subject and to know that your views are being listened to. You will be contributing to research and understanding in this area.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time. Information I have already collected with your consent will be destroyed.

Will my taking part in this study be kept confidential?

Yes. All information about you will be handled in confidence. The interview data will be kept confidential and reported without your name attached. Any direct quotes will be given to a general patient e.g. "Patient A". The information collected will be stored securely in a locked filing cabinet at the University, computers will be password protected. The interviews will be recorded and typed up in line with the Newcastle University's code of conduct for research. The interviews will be destroyed ten years after publication of the study's findings.

What will happen if the researcher identifies any significant issues (e.g. harmful behaviour and/or substandard clinical practice)

If the researcher identifies any significant issues in relation to your care or has concerns for your safety she will inform the Clinical Director. If you become distressed during the course of the interview the researcher will support you to access relevant support services.

What will happen to the results of the research study?

This research will be used as a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and presentations at conferences will also be produced.

Who are the researchers and who is funding the research?

The research forms the basis of a PhD funded by the former NHS County Durham and Darlington Primary Care Trust. Claire Sullivan will be the Chief Investigator on this research study and will be supervised by a group of experienced academics based at Newcastle University and Durham University.

Who has reviewed this study?

The research has been reviewed by the Research Ethics Committee, independent of the University. This is in order to protect your interests.

What if I want to complain?

If you want to complain about the study or how you were treated, a complaint should be made within 7 working days to Dorothy Newbury-Birch, the supervisor of the research at:

Institute of Health and Society

Newcastle University

Room 3.77 Baddiley-Clark Building

Richardson Road

Newcastle Upon Tyne

NE2 4AX

Tel: 0191 2228500

e-mail: dorothy.newbury-birch@newcastle.ac.uk

Alternatively you can contact:

Lynne Williams

Research & Development Research Governance

Darlington Memorial Hospital

Hollyhurst Road

Darlington

DL3 6HX

Tel: 01325 743737

Fax: 01325 743768

e-mail: lynne.williams@cddft.nhs.uk

How can I get further information?

If you would like any further information, please do not hesitate to contact me:

Claire Sullivan

Institute of Health and Society

Newcastle University

Room 3.77 Baddiley-Clark Building

Richardson Road

Newcastle Upon Tyne

NE2 4AX

Tel: 0191 2228500 Email: c.sullivan@newcastle.ac.uk

Thank you for taking time to read this leaflet.

Appendix 2: Participant Information Sheet (Practitioner)

Research Study: To explore the factors that influence sexual decisions in those aged 25 years and over.

Chief Investigator: Claire Sullivan

What is the purpose of the study?

This research will explore the factors which influence sexual decision making, in particular the contribution alcohol plays (if any) amongst those aged 25years and over. You have been invited to take part in this study as I am particularly interested in hearing your views about the role you feel alcohol plays as a factor in sexual decision-making and sexual risk, particularly amongst the patients who access your clinic.

What will happen if I agree to take part?

If you decide to take part, the researcher will observe the clinical consultation but only once consent has been sought from the patient also. The researcher will be taking hand written notes but will not be recording the consultation. The researcher will not be present for any physical examination of the patient.

What will happen if I agree to be interviewed?

If you are agree to be interviewed, a single (one-to-one) interview will take place at a convenient time that suits you. The researcher will conduct the interview in a face-to-face situation. The interview should last no longer than one hour. **Once completed, your involvement in the research will end**. There is no longer term follow up. The interview will be audio-recorded but none of your personal details will be identified. The recording will then be transcribed so that I can analyse the results.

Do I have to take part?

Taking part in the research is entirely voluntary: it is up to you to decide whether to join the study. If you agree to participate please sign the consent form. You are free to withdraw at any time, without providing a reason.

What are the possible disadvantages and risks of taking part?

No risks are envisaged for you as a result of taking part in this study. The only possible disadvantage is that you are giving up some of your time to take part in the interview.

What are the possible benefits of taking part?

Taking part in this interview will offer you the opportunity to share your views on this subject and to know that your views are being listened to and contributing to research and understanding in this field.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time. Information we have already collected with your consent will be destroyed.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The interview data will be kept confidential and reported anonymously. Any direct quotation will be attributed to a practitioner only (e.g. "Practitioner A"). The information collected will be stored securely in locked university offices, computers will be password protected. The interviews will be recorded and transcribed in line with the Newcastle University's code of conduct for research, the interview transcripts will be destroyed ten years after publication of the study's findings

What will happen if the researcher identifies any significant issues (e.g. harmful behaviour and/or substandard clinical practice)?

If the researcher identifies any significant issues in relation to patient care or has concerns for the patient's safety she will inform the Clinical Director. If you or the patient becomes distressed during the course of the interview the researcher will provide support to access relevant services.

What will happen to the results of the research study?

This research will be used as a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced.

Who are the researchers and who is funding the research?

The research forms the basis of a PhD funded by the former NHS County Durham and Darlington Primary Care Trust. Claire Sullivan will be the Chief Investigator on this research study and will be supervised by a group of experienced academics and practitioners based at Newcastle University and Durham University.

Who has reviewed this study?

The research has been reviewed by the Research Ethics Committee, independent of the University, to protect your interests.

What if I want to complain?

If you want to complain about the study or how you were treated, a complaint should be made within 7 working days to Dorothy Newbury-Birch at the address below.

How can I get further information?

If you would like any further information, please do not hesitate to contact me:

Claire Sullivan

Institute of Health and Society

Newcastle University

Room 3.77 Baddiley-Clark Building

Richardson Road

Newcastle Upon Tyne

NE2 4AX

Tel: 0191 2228500 Email: c.sullivan@newcastle.ac.uk

Thank you for taking time to read this leaflet.

Appendix 3: Patient Consent Form

Study Title Exploring the role alcohol plays as a factor in sexual decision making with patients (aged 25 years and over) and staff at a sexual health clinic in the North East of England.

Chief Investigator: Claire Sullivan

Participant Consent Form - Patient

Number ___

Please initial the appropriate boxes:

I have read and understood the project information sheet. I have had the opportunity to ask questions about the research. I am happy with the answers I have been given.	
I understand that taking part is voluntary. I can withdraw from the study at any time, without giving reason.	
I understand that my details will not be shared with people outside the project.	
I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I understand that the information collected will be stored in a locked filing cabinet and computer files will be password protected.	
I consent to the researcher sitting in on my appointment. I understand that the researcher will be taking notes. I give permission for direct quotes to be used in the study report or publications. I understand that the researcher will leave the room if I need to have tests.	
I consent to have a tape recorded interviewed. I give permission for direct quotes to be used in the study report or publications.	
I understand that anything I say in the interview will be confidential. The only time the researcher will break this is if she has concerns for my safety.	

I understand that if any disclosures are made during the interview that suggest malpractice, misconduct, or that someone is in danger of harm, the researcher has a duty to share this information with the Clinical Director.	
I have read and understood the information and I agree to take part in this study.	

_____	_____	_____
Name of Participant	*Signature*	*Date*
_____	_____	_____
Name of Researcher	*Signature*	*Date*

(One copy for participant, one for health records and one for research file)

Contact details for researcher is you wish to withdraw from the study – c.sullivan@newcastle.ac.uk or Tel: 0191 2228500

Appendix 4: Practitioner Consent Form

Study Title: Exploring the role alcohol plays as a factor in sexual decision making with patients (aged 25 years and over) and staff at a sexual health clinic in the North East of England.

Chief Investigator: Claire Sullivan

Participant Consent Form- Practitioner

Please initial the appropriate boxes:

I have read and understood the project information sheet and have had the opportunity to ask questions. I am happy with the answers I have been given.	
I understand that my taking part is voluntary and I can withdraw from the study at any time, without giving reason.	
I understand that my personal details will not be revealed to people outside the project.	
I understand that the confidentiality of the information collected will be maintained, it will be stored securely in locked university offices and computer files will be password protected.	
I consent to the researcher observing the consultation so long as the patient has provided consent. I understand that the researcher will be taking notes during the course of the consultation. I acknowledge that anonymous direct quotes may be used in the study report. I understand that the researcher will leave if I the patient is to receive a physical examination.	
If I am invited for interview I consent to the use of audio taping for the interview and understand the possible use of anonymous direct quotes in the study report.	
I understand that if any disclosures are made during the interview that suggest malpractice, misconduct, or that someone is in danger of harm, the researcher has a duty to share this information with the Clinical Director.	
I have read and understood the information and I agree to take part in this study.	

_____	_____	_____
Name of Participant	*Signature*	*Date*
_____	_____	_____
Name of Researcher	*Signature*	*Date*

(One copy for participant and one for research file)

Contact details for researcher is you wish to withdraw from the study – c.sullivan@newcastle.ac.uk or Tel: 0191 2228500

Appendix 5: Topic Guide for interviews with practitioners

Introduction

Notes to Interviewer

Interviewer to:

Introduce myself and thank participant for agreeing to talk to me.

Provide them with the research information sheet.

Explain that I am a PhD research student based at Newcastle University. I am carrying out a doctoral research project to explore the relationship between alcohol and sex, in particular sexual-risk and the impact of alcohol on sexual decision-making.

Explain that they have been invited to take part in this study because I am keen to get their view as a practitioner working in the field of sexual health whether they believe that alcohol plays a role in sexual risk taking and sexual decision making.

Advise participant that the interview should last approximately 1 hour.

Confidentiality and consent

Explain that:

They will not be identified in the report.

I would prefer to record the interview as this helps us to capture exactly what is said. Ask if they are comfortable with that.

Ensure consent form is signed.

Ask if they have any questions before I start.

Interview Schedule

Section 1: **Background**

- What is your role and responsibilities within the clinic?
- How long have you worked at the clinic?

Section 2: **The patients they see in the clinic**

- demographics – what changes have you seen over time?
- what's your view of patients use of sexual health services now - stigma/ease of access/types of users?
- does this differ for different client groups e.g. young women, students, gay men?

Section 3: What are your **beliefs** about the factors that people take into account before they make the decision to have sex? (e.g. peer pressure, sexual need/desires, opportunity)

Section 4: **What are your views about the use of alcohol in sexual decision making**

- how does it manifest in attendees at the clinic? What are the consequences you see e.g. EHOC, pregnancy, shame?
- has there been a change in what you have seen/heard in the clinic connected to alcohol over the years?
- do you believe there are positives in the role of alcohol with sex e.g. sexual pleasure, confidence?
- do you believe there are any negatives in the role of alcohol with sex e.g. regret, non-consensual sex, increase risk of STIs?
- do you believe alcohol is used as an excuse for sexual risk-taking?
- do you believe alcohol is used to manage life e.g. to cope with relationship breakdowns, escapism?

Section 5: **Beliefs about the inter-relationship between alcohol and sexual risk & sexual decision making.**

- Do you believe it varies with different groups and at different life stages- do you have any examples?
- Do you see any contradictions with clients e.g. peoples beliefs vs their behaviours, 'self' and 'others'?

Section 6: **Asking about alcohol in the consultation**

- You ask all new patients to complete the alcohol screening tool - do you feel this helps to raise the issue about alcohol?
- Who do you feel would raise the fact that alcohol was a factor in the consultation – the patient or the practitioner?
- Do you believe that asking about alcohol in a sexual health setting is appropriate/are you comfortable asking about it?
- Do you feel it affects the clinical relationship with the patient?

End of interview

That completes my questions. Before we finish:

Do you have any questions?

Is there anything you would like to add? Is there anything you feel we didn't talk about that is relevant?

Finally:

Thank participant for their time. Remind them how material will be used:

- Once I have completed the interviews with practitioners, the findings will be analysed to identify key issues / research themes.
- The findings of this research will be used as a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated.
- All quotes / opinions will be anonymised – any direct quotation will be attributed to general job title only (e.g. "Practitioner A").

Appendix 6: Topic guide for interviews with patients

Introduction

Notes to Interviewer

Interviewer to:

- Introduce myself and thank participant for agreeing to talk to me.
- Explain that I am a PhD research student based at Newcastle University. I am carrying out a doctoral research project to explore the factors that contribute to sexual decision-making.
- Explain that they have been invited to take part in this study because there is a lack of research amongst this age group.
- Advise participant that the interview should last approximately 30minutes.

Confidentiality and consent

Explain that:

- They will not be identified in the report.
- I would prefer to record the interview as this helps us to capture exactly what is said. Ask if they are comfortable with that.
- Ask if they have any questions before I start.

Interview Schedule

Section 1: Please can you provide me with some background about yourself? (demographics- age, sexuality, occupation, are you in a relationship at the moment?)

Section 2: What was the reason for your attendance at the clinic today? (e.g. symptoms, general health check, unprotected sex, condom split, emergency contraception etc:)

Section 3: Have you been to the clinic previously?

- was it for similar reasons?
- do you regularly attend or was it a one off reason?

Section 4: What do you think influences your sexual decision making/reasons for having sex? (e.g. peer pressure, meet someone new, got drunk, experimenting, sexual desires)

- do you believe that has changed over time?

Section 5: What do you believe is the relationship between alcohol and sex?

- What are the positives? e.g. enhances sexual pleasure
- What are the negatives? e.g. regret, non-consensual sex?
- Have you used alcohol intentionally to facilitate a sexual encounter or when going on a date?
- Do you feel that alcohol had a part to play for the reason for your attendance today- was it the reason you had sex?
- Do you regret it?
- Would you have had sex in that situation without alcohol?
- Are there other times that you would have not had sex if you hadn't been under the influence of alcohol?

Section 6: How would you define risk? (would you take risks – if so what type of risks?)

Section 7: How do you feel being asked about alcohol by the sexual health practitioner? (appropriate/expected, not appropriate to be asked when coming to get treatment for something else?)

End of interview

That completes my questions. Before we finish:

Do you have any questions?

Is there anything you would like to add? Is there anything you feel we didn't talk about that is relevant?

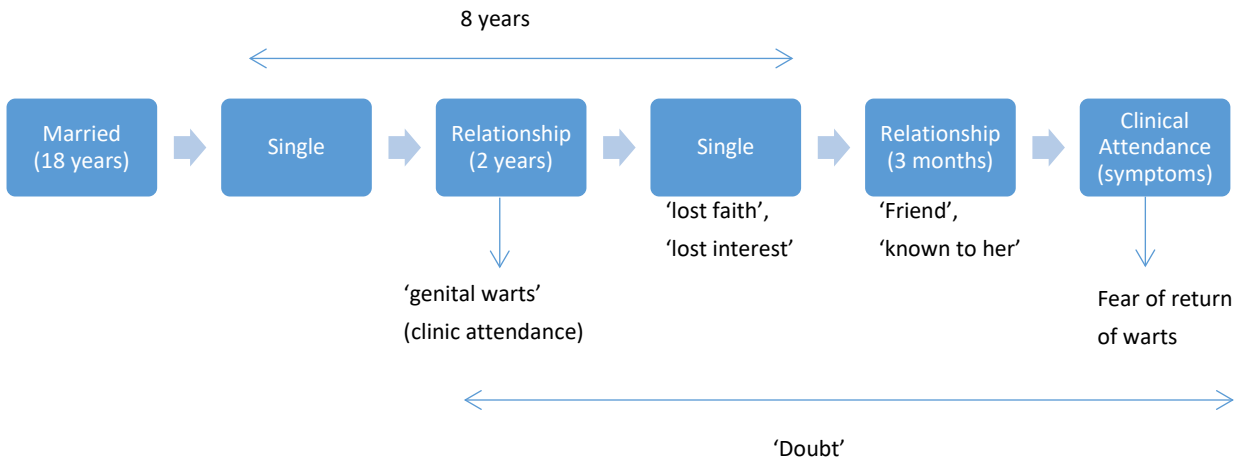
Finally:

Thank participant for their time. Remind them how material will be used:

- Once I have completed the interviews, the findings will be analysed to identify key issues / research themes.
- The findings of this research will be used as a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. A summary of the findings will be available from the researcher if you are interested (contact details are on the information sheet).
- All quotes / opinions will be anonymised – any direct quotation will be attributed to general patient (e.g. "Patient A").
- Ensure I have the consent form.

Appendix 7: Patient Journeys

Patient 1



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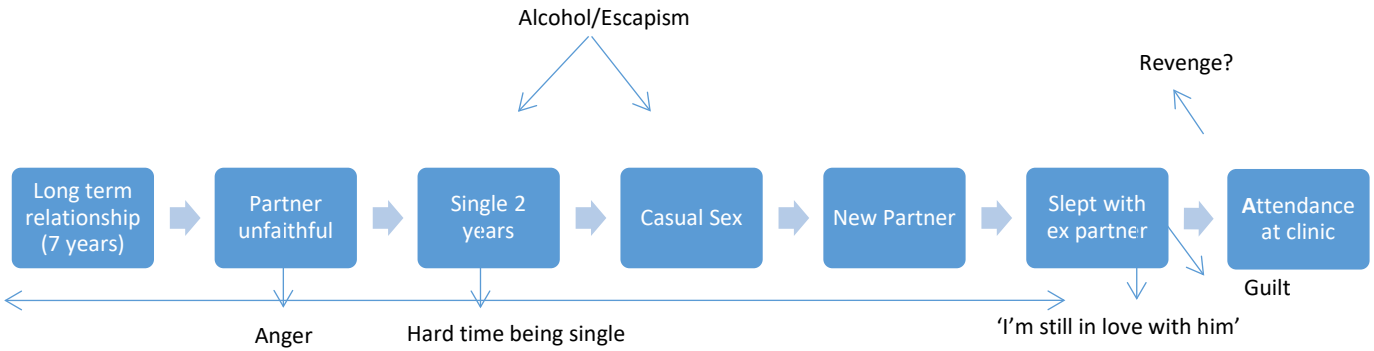
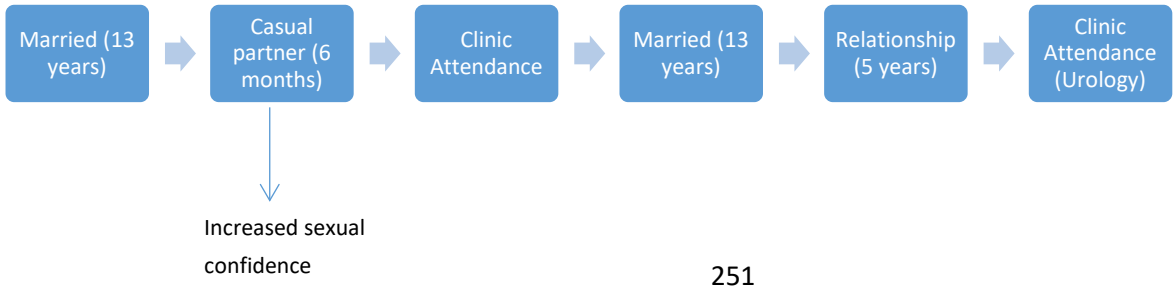
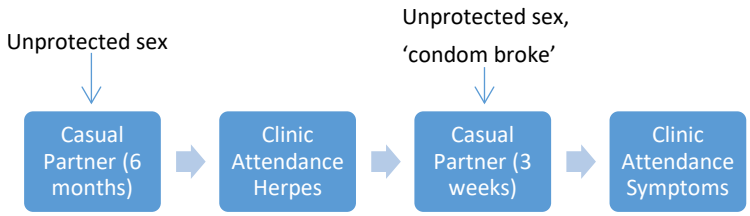


Patient 3 (O)

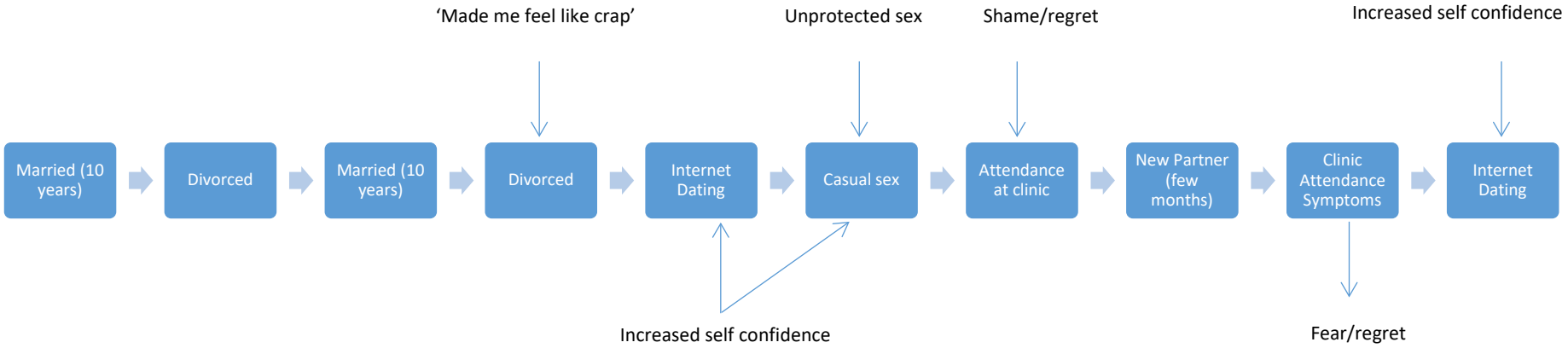
Patient 4



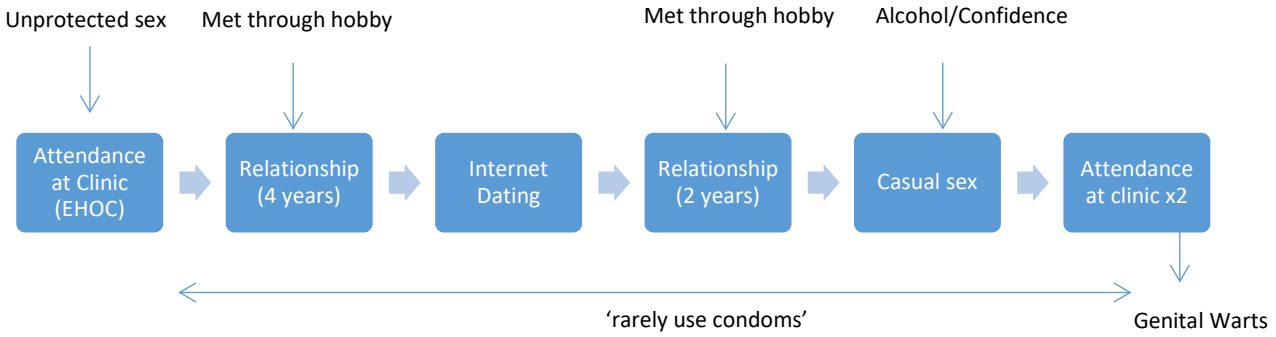
Patient 5



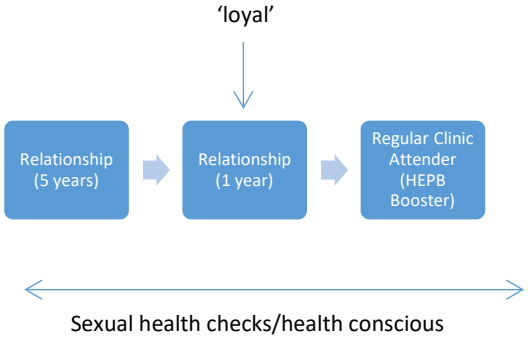
Patient 6



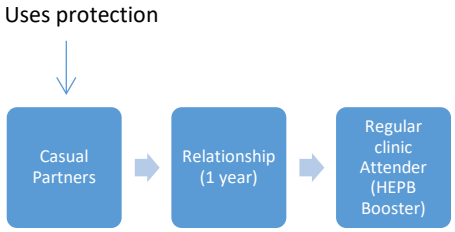
Patient 7



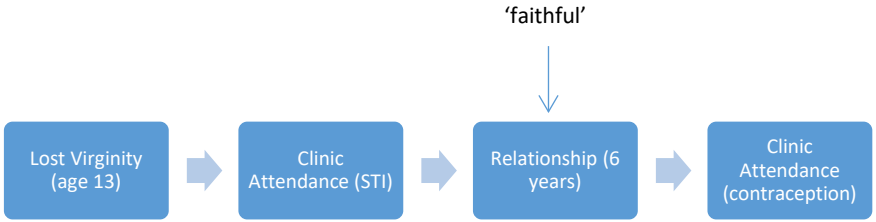
Patient 8



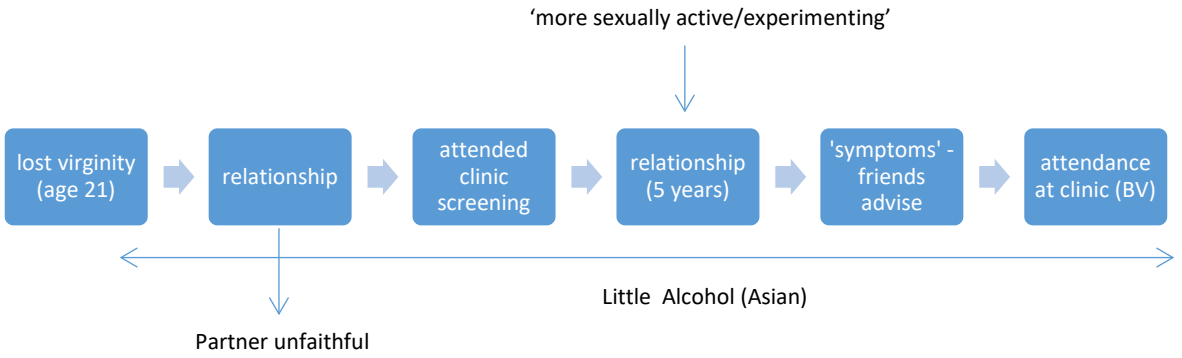
Patient 9



Patient 10



Patient 11



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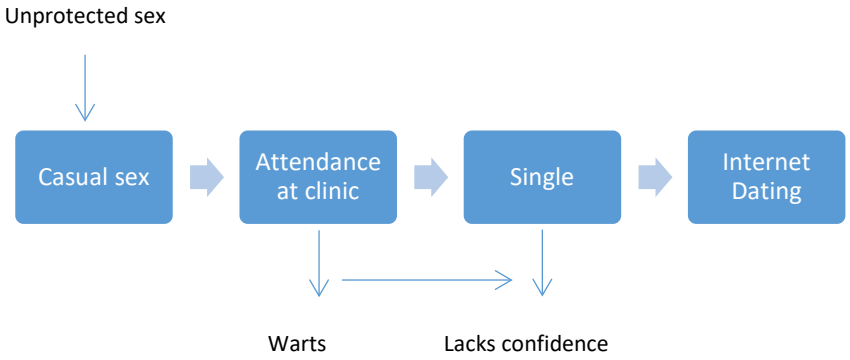

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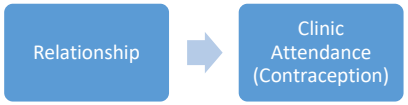
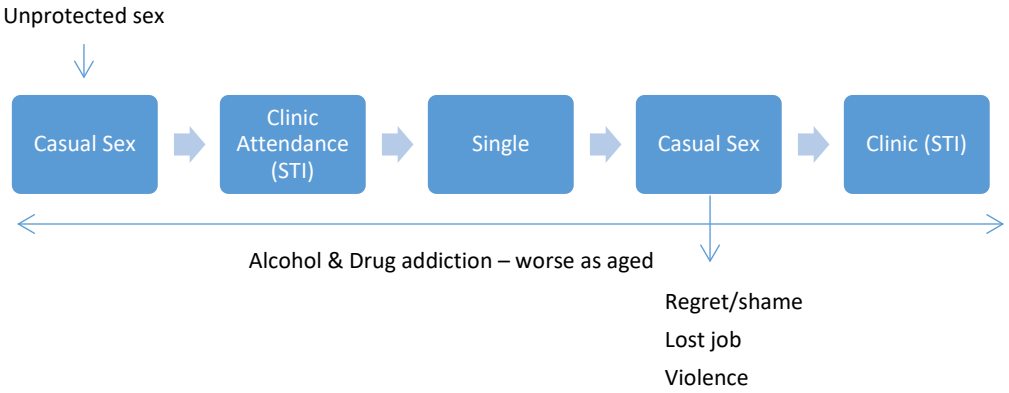
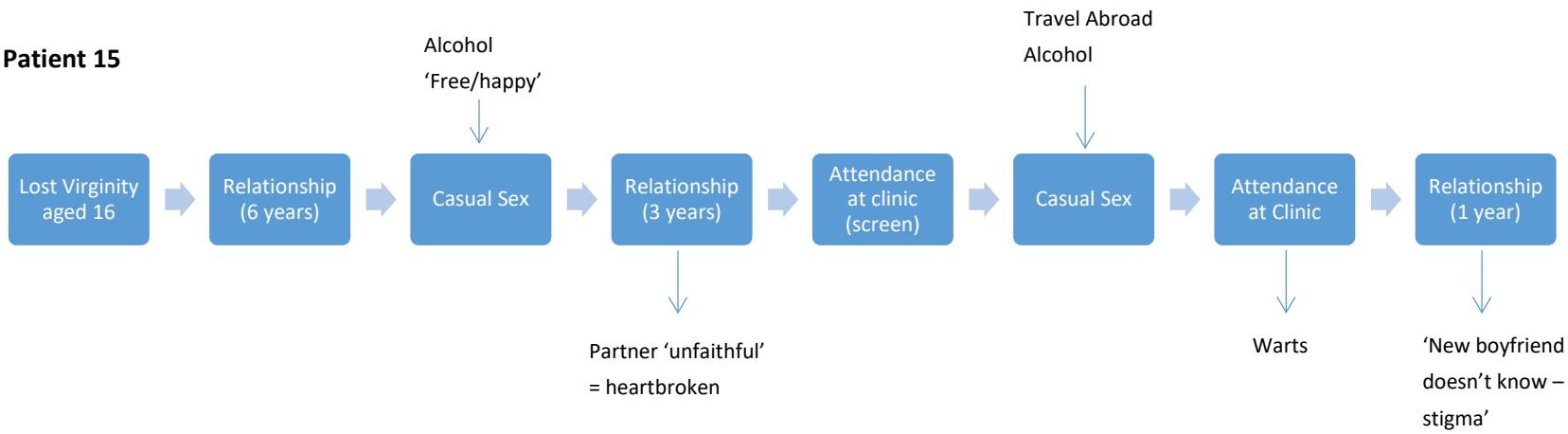


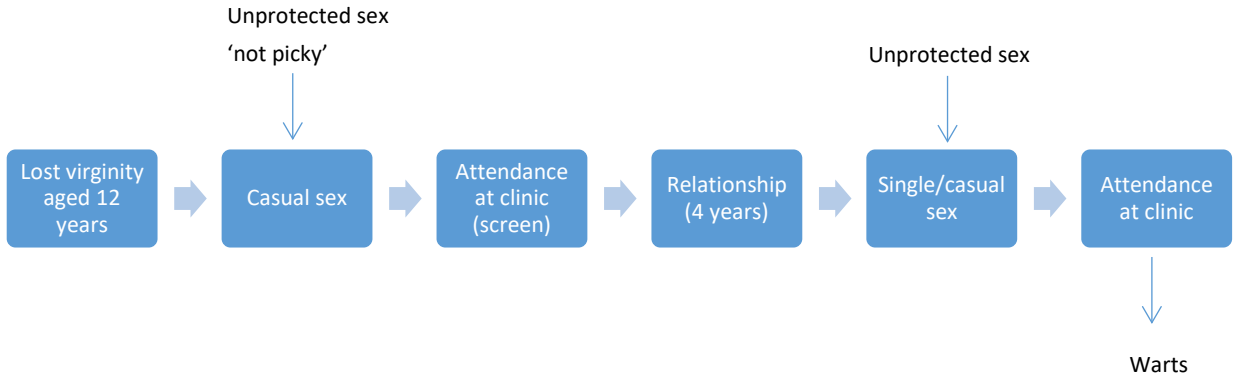
Patient 14



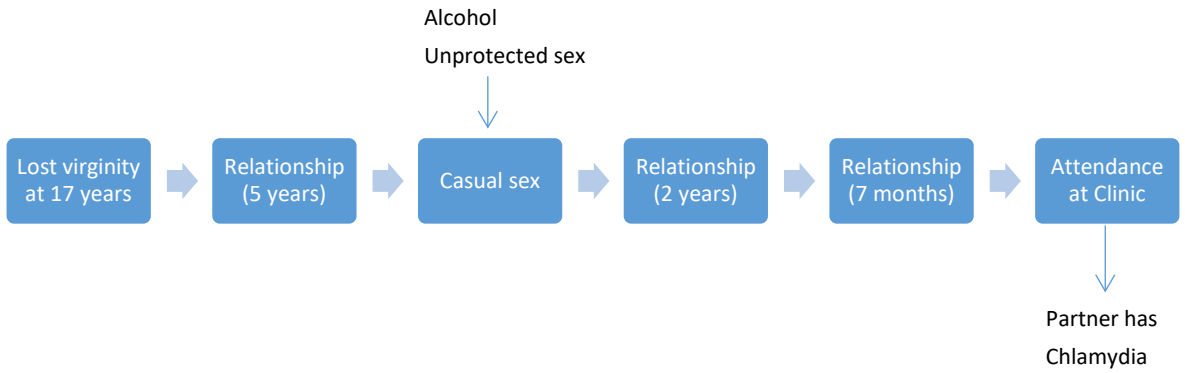
Patient 15



Patient 16



Patient 17



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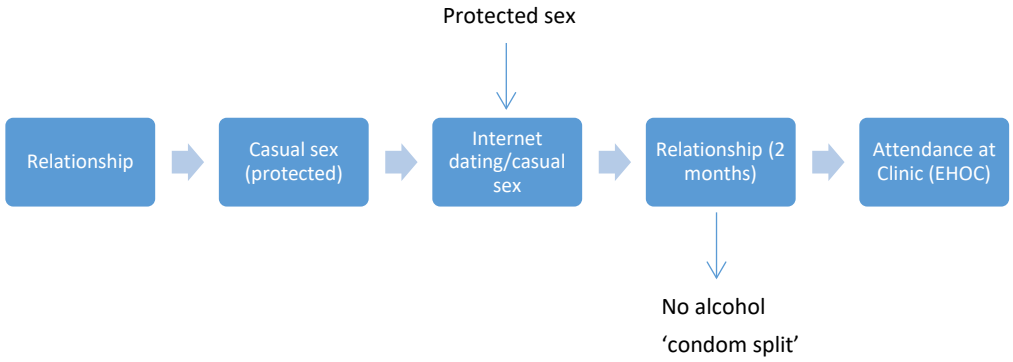

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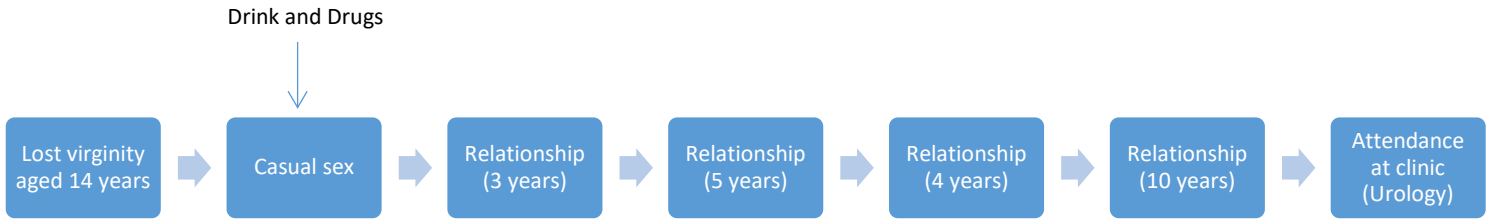

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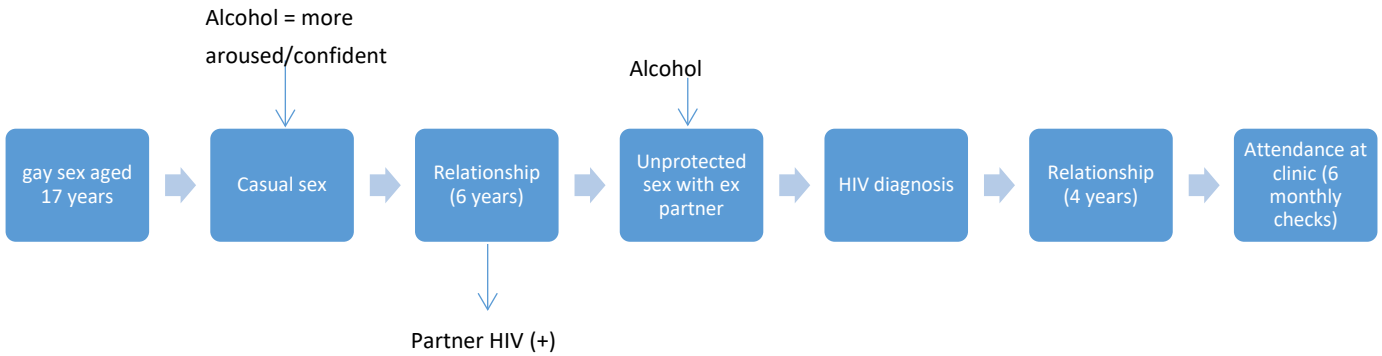
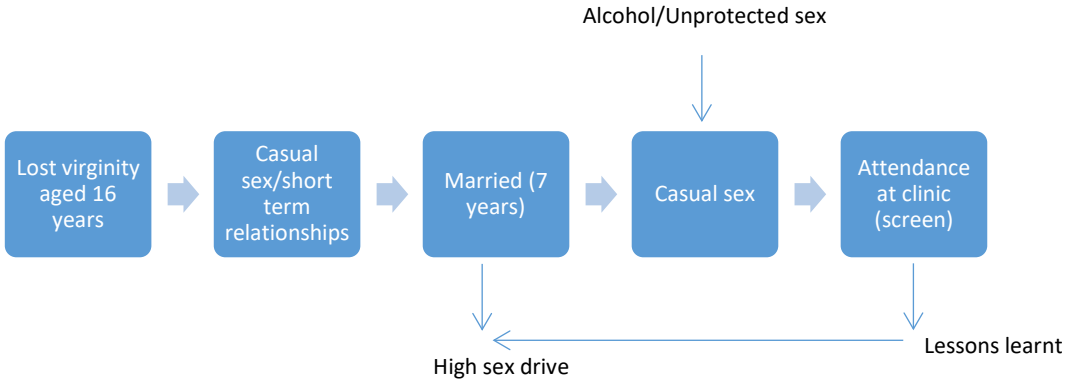


Patient 21



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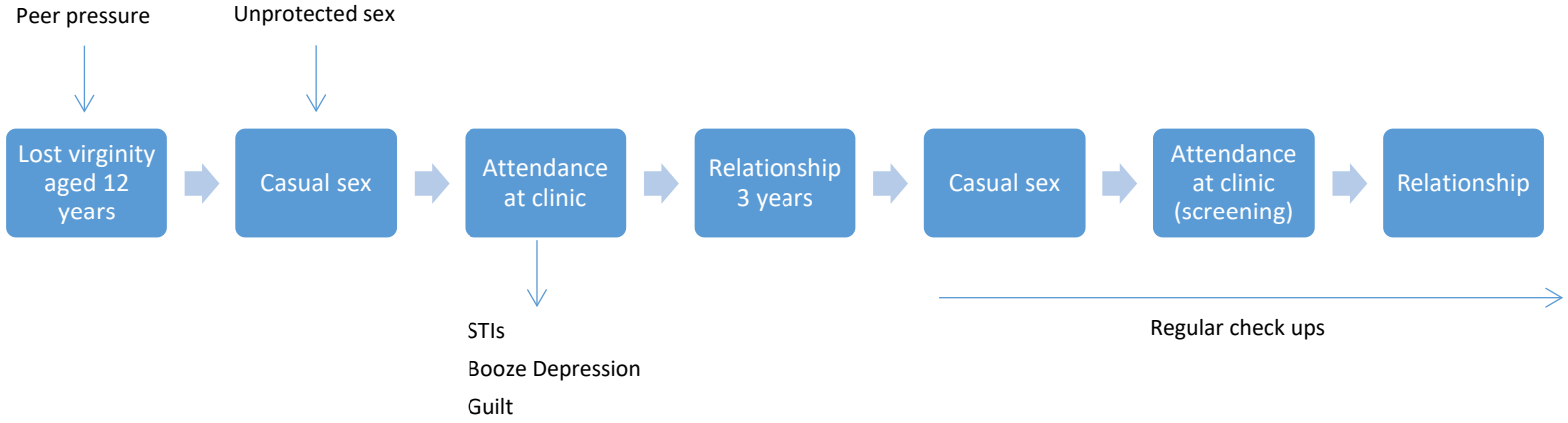

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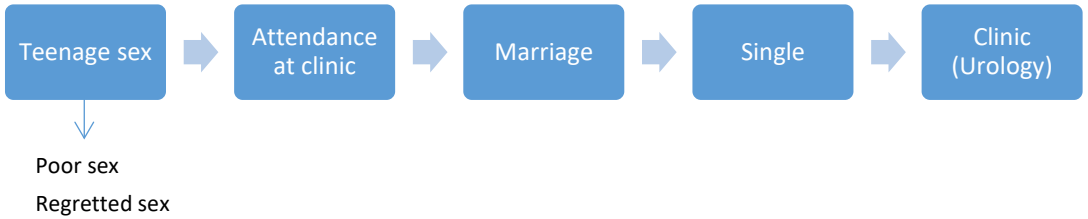
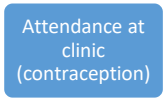


Patient 24 (O)



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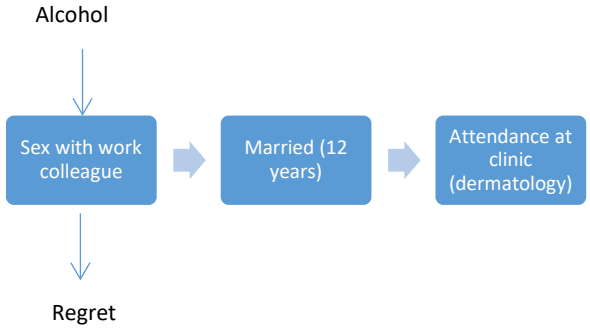
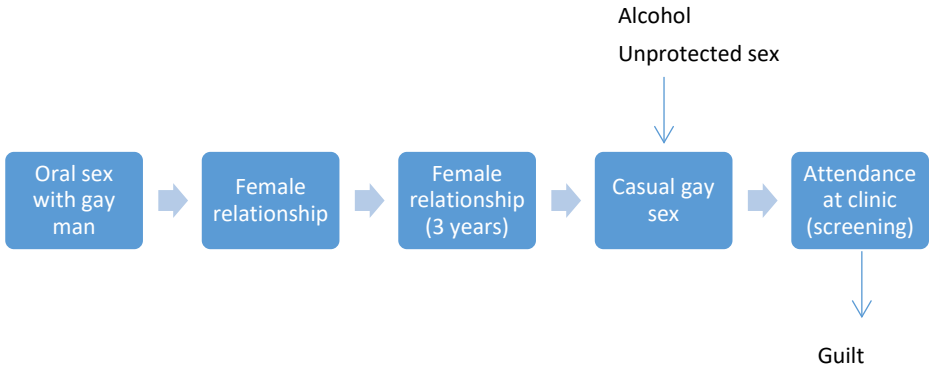


Patient 26


Alcohol
Unprotected sex
Oral sex with gay man
Female relationship
Female relationship (3 years)
Casual gay sex
Attendance at clinic (screening)
Guilt

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