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Sex, Desire and Masturbation: An Interpretative Phenomenological Analysis of Sexual Health Education for young women

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### Abstract

British, Sex and Relationship Education has been condemned by Ofsted as 'not yet good enough' (2013:6). Previous literature would suggest this is through the absence of desire based knowledge. Other research would highlight the issue of masturbation as a construct to the improvement of the sexual health. However, as genital masturbation is often a taboo within feminine culture the current study used Interpretative Phenomenological Analysis (Smith, 1996, 1999) to assess the intrinsic values of six young women regarding their sexual health and desires. Participants ranged in sexual knowledge from undergone several years of sexual health education to limited sexual health education; forming the basis for the current national education system. Analysis of the data revealed three master themes: pleasure conflict, 'That Girl' complex and sexual discourse. A working model of sexual health needs was then proposed in order to address the hierarchy of erotic plasticity the participants showed. Ramifications of socio-political implications towards feminine desire and masturbation are detrimental to sexual health improvement.

|                  |                         |               |                     |                  |  |
|------------------|-------------------------|---------------|---------------------|------------------|--|
| <b>Key Words</b> | Sexual Health Education | Sexual Desire | Female Masturbation | Sexual Discourse | Interpretative Phenomenological Analysis |
|------------------|-------------------------|---------------|---------------------|------------------|--|

## Introduction

Sex-positivism is a movement established in the 1960's when engaging in pre-marital sex and 'free love' became sexually liberating (Escoffier, 1985). Although, some critics suggest it began earlier as it mirrors Marxist ideologies of classist dichotomy (Weis, 1998). To be sex-positive refers to the radical notion that through the celebration of individual choices of sexuality and sexual desires misogynist values will be cleared. However, as this change has not yet occurred in the 50 years since the sexual revolution, does sex-positivism have a place in a postmodern society?

Research conducted by Fine (1988) was among the first to attribute the downfall of the sexual liberation to School based sexual health education (SBSHE). Suggested are the principles that sex rhetoric provides little emphasis for adolescent females to subjectively develop sexual accountability; and in fact, 'teaches females to fear the very men, who will ultimately protect them' (Fine, 1988:32). Further, more up-to-date research by Bay-Chieng (2003) supported the idea that the sexual pedagogy of pleasure should not be so inextricably linked with danger as it conditions psychosexual and somatic gratification, with victimisation and sexual fear. Thus, in a culture Spellman (1982) observed as being gripped by 'somatophobia' (fear of the body), it would appear that the discourse of desire is needed to digress from negative sexual marginalisation.

SBSHE in England has been condemned as 'not yet good enough' as over a third of schools need improvement (Ofsted, 2013:6). However, no calls to rectify this problem have been sanctioned due to the Government perceiving that a:

...new provision would place a disproportionate burden on teachers, who would have to make and defend decisions to what constitutes "sufficient maturity" (Long, 2014:11).

Even though, some would argue teachers assess classroom maturity on a daily basis (e.g. allowing children the use of scissors), although supposedly not to the level where it is deemed appropriate to diverse education on safe sex, cunnilingus and fellatio. Nonetheless, the parental right to withdraw their child from SBSHE persists (Clause 20).

Sex and Relationship Education (SRE) in English schools constitutes of two comprehensive programmes; Science and Personal, Social and Health Education (PSHE; Rodriguez, 2011). However, neither of the two programmes emphasise 'desire' as a construct of sexual health education. Furthermore, for Academies and free schools the teaching of SBSHE is at their discretion, as they are seen as 'independent schools' (DfE, 2013: online) unrestricted by local authority. Therefore, the disparities within English sexual health programmes prevail as they are not implemented homogenously across the country.

Despite this, the clitoris is the only part of the human anatomy designed solely for sexual pleasure (Buisson and Foldès, 2009; Blechner, 2013: online) and yet the relevancy of this knowledge is not equated within SRE. Kinsey et al., (1953, 1998) reported that 64% of women in his study masturbated and of that sample 85% could

do so using clitoral stimulation rather than vaginal penetration. Begging the question as to why, if not for anatomical reasons is sexual pleasure not reported in SRE?

Increasing claims that boys should not be subjugated to female-orientated sexual health education warrant that they be placed in separate classes and taught a more male-centric approach to sexual health (Hilton, 2001). Consequently, leaving young girls to facilitate liability of pregnancy, child birth and condom use over female arousal. In agreement of which, emphasising the establishment of sexual politics in accordance to the gender roles of Biosocial theory. According to Wood and Eagly, (2002) Biosocial theory comprises both the socio-constructivist and essentialist values of observable and explanatory roles of sex-type differences, within the context of their social norms. However, feminist theory would suggest this oppresses women to anatomical factors; enforced are the conjugal and parental obligations of womanhood over the exploration of the self, a notion Foucault (1976:121) describes as the 'idle woman'. Hindering the applicability of ways in which women cope with their sexual self as they attribute a lot of their sexual agency to their partner.

The gender centrality of biological foundationalism conceptualises a female sexuality to anatomical differences therefore, reinventing the notion of 'penis-envy'. Psychosexual theory (Freud, 1964) highlighted that women were envious of the observable phallic member contrastingly; sex-positivism would suggest it was the envy of male sexual opportunity. In accordance to theoretical research by Muss and Schmidt (1993) into their sexual strategies theory women are regarded as having a high erotic plasticity. They digress that men and women pursue long-term relationships based on traditional gender roles. Strongly influenced within their theory is the sacredness of female purity. In light of this, due to societal pressure to not be seen as promiscuous to attract a mate the encouragement of sexual exploration is pathologised. If this truly is the case, SBSHE unintentionally through discourse of risk association, endorses the belief that women who are sexually excessive are stereotyped as undesirable.

SRE has repeatedly been criticised by academics, and supporters of the sex-positive movement (Lamb and Peterson, 2012; Barak and Fisher, 2001; Cameron-Lewis and Allen, 2013). The sex-positive movement argues for changes in current sexual education discourse to stray from teaching young people to say 'No' but, when to say 'Yes' appropriately (Baumeister, 2000). Although, previous research by Vivanco (2013) suggests that the current SRE is sufficient to reduce the risk of sexually transmitted diseases (STD), whilst improving the use of condoms. Interestingly, this is conflicted by the findings of Nwoloko et al., (2002) that young girls have a negative relationship with sexual health clinics. Despite this, recent figures from the National Statistics illuminate the drop in under 18 pregnancies (OfNS, 2014) as well as reported new cases of sexually transmitted infections (STIs: FPA, 2011). If this truly is the case, then the need for sex-positivism surely is unnecessary.

British sexual health statistics are still the highest in Europe, despite significant reductions in figures; adopted within other European countries are multi-dimensional approaches that habituate role-play, and positive reinforcement. According to previous research, the application of such methods has been successful in teaching both positive sexual imagery, and good sexual health (Mabray and Labauve, 2002; Milton et al., 2001). Implying, the affiliation with desire has positive repercussions for sexual health. In accordance to the alternative female sex response model (FSRM)

as introduced by Basson (2000) arousal and desire are fixed stages to reaching an orgasm. Without desire, sexual gratification is delayed, and in cases of women who suffer from sexual dysfunction not found at all (Lavie and Willig, 2005).

For the purpose of the current research sexual pleasure is broadly defined as the erotic satisfaction one receives from carnal activities. Constituting sexual pleasure as being the leading factor in engagement of sexual activities (Philpott, Knerr and Boydell, 2006), despite sex-negative pedagogy influence. Peterson (2010) highlighted that the inclusion of desire through insightful discussion can provoke positive repercussions for female sexual empowerment. For centuries the concept of desire has been lost in order to fulfil the socio-political implications of sexual health statistics as sanctioned by the Government (Lewis and Knijn, 2002).

An apparent lack of knowledge surrounding sexual pleasure for women establishes a self-categorisation that sex is for biological means, not enjoyment; in short mythologising the female orgasm. Research by Schuster, Bell and Kanouse (1996) developed their theory that young women progress through a 'sexual risk hierarchy' divulged by various stages of sexuality exploration. This being the case, the intensity to which sexual nirvana is attributed can be identified as a form of motivation within sexual exploration.

As illustrated by Forrest et al., (2004) a concrete understanding of in-depth information surrounding mature sexual relationships is highly coveted by adolescents. None more so than for females who seek to know more on solo masturbation. Discourse surrounding female masturbation is often lost in the academic literature, as theories of 'victimization, abuse and self-control' take prevalence (Ingham, 2005:383). Therefore, the current project intends to research into female masturbation to shed light on the under-researched topic. Even though, neurologically sexual intercourse has been implied as being 400% more physiologically stimulating than masturbation (Brody and Krüger, 2006) this still does not deter women from buying sex toys, and sexual erotica (Attwood, 2005; Styles, 2014).

Psychosomatic sexual arousal is high within women whose sexual libido is often motivated by sociocultural features. Contextual discussion that reinforces positive repertoire and practice will improve the longevity to which young women exercise safe-sex. Through the sharing of sexual experiences, techniques and tips women are positively enforcing pleasure over fear, and therefore helping each other reach a sexual nirvana. To summarise:

...mainstream culture is not going to teach us about ourselves, but when we embrace the notion of sex positivity, we teach each other (Queen, 1997: XXIV).

Contrastingly, the erudition of sex-positive SRE has been criticised for its commodification of female sexuality as it creates a promiscuous identity. Despite the intentions of liberal movements for sexual health, Glick (2000) suggests that sex-positive education reduces the vagina to a product of tradable worth and not a sexually autonomous identity. Consistent with Thorogood (2000), as she suggested that sex-positivism emphasised sex as a tool of negotiation; in essence not liberating

at all. In a sex-positive world women are encouraged to be open about their sexuality and hence, scrutiny from other bodies is often inflicted.

Mosher and Vonderheide (1985) suggest that masturbation guilt is detrimental to the improvement of sexual health. Masturbation guilt is the concept that young women who are not opposed to genital stimulation are exposed to a state of remorse to not delighting in their sexual pleasures. In reference to this, Hogarth and Ingham (2009) in their research into female genital masturbation concluded that masturbation does improve the sexual self and subsequent sexual activity. However, Hogarth and Ingham (2009) do not equate as to whether masturbation does improve sexual health; a topic that Bockting and Coleman (2003) proposed is needed within female masturbation research.

The current project aims to fill the void within previous research that often overlooks female masturbation as a concept linked to sexual health. An opposing sample was chosen to express a broader opinion of participants who had undergone years of SBSHE, as well as those who had not. According to previous research female sexual pleasure will be predetermined by the SRE. If this truly is the case then women would abstain from sexual intercourse through either social deterministic biases, or through fear. Nonetheless, Interpretative Phenomenological Analysis (IPA) will be used as tool to address the internalised understandings of sexual desire, health and masturbation.

## Methodology

### Design

Qualitative methods were used to illuminate the context-specific phenomenological information. The complex matrix of human opinions is not best interpreted by standardised quantitative methods, who seek 'causal determination, prediction and generalisation of findings' (Golafshani, 2003:600). Thus, through the use of qualitative methodology an idiographic understanding of participants and how they interpret their social identity or experiences are developed (Biggerstaff & Thompson, 2008).

### Participants

Six participants were recruited based on opportunity sampling. The sample size was chosen to provide sufficient data to develop 'meaningful points of similarity and difference between participants' (Smith et al., 2009:51) without being too overwhelming for analysis. Participants were known personally to the researcher, therefore aiding in discussion of sensitive subjects. Even so, an invitation e-mail was sent to the participants that detailed the nature of the study and what their involvement would mean (see appendix 1.1).

Inclusion criteria dictated that participants were selected based on their gender, and having had experiences with SBSHE. Female participants were chosen as they were deemed appropriate to answer the current research question. Participant information can be found in table 1.1. Table 1.2 shows the SRE the women obtained. As detailed in table 1.2 the breadth of SBSHE between the participants varies, therefore, allowing for a broader phenomenological account of sexual health.

|                          |                          |         |
|--------------------------|--------------------------|---------|
| Age (Years)              | Mean                     | 20      |
|                          | Range                    | 18 – 22 |
| First Coitus Age (Years) | Mean                     | 15      |
|                          | Range                    | 13 - 18 |
| Education Level          | University Undergraduate | 5       |
|                          | A Levels                 | 1       |

| Table 1.2 – Participant SRE |   |
|-----------------------------|---|
| Pseudonym                   | SRE Information:  |
| Jessica                     | Received SBSHE from Year 6 until graduating sixth form.   |
| Louisa                      | Began SBSHE during primary school, which stopped upon enrolment at a Performing arts and technology school. |
| Rose                        | Received SBSHE from Year 6 until graduating sixth form.   |
| Sarah                       | Began SBSHE during primary school, which stopped upon enrolment at catholic school.                         |
| Francis                     | Began SBSHE during primary school, although ended subsequent to joining catholic school.                    |
| Claire                      | Received SBSHE from Year 6 until graduating sixth form.   |



### Researcher

The researcher of the current project is a twenty-one year-old female, feminist. Due to the theoretical position of the researcher, subjective bias was of chief concern when collecting and analysing the data, therefore extensive measures were taken to reduce this. In relation to the current project the researcher had SRE from year six (age: eleven), until year thirteen (age: eighteen).

### Materials and Apparatus

A thirteen question interview guide was created using theoretical and tacit knowledge of SBSHE and female desire to assess the research question (see appendix 1.5). All interviews were audio recorded using the researchers own password encrypted iPad. Upon completion of the interview all recorded data was moved from the researchers' iPad to a password protected laptop. Transcripts and recordings were then removed upon completion of the research journal.

### Procedure

#### Pilot Study

Pilot studies are regarded as a micro study 'done in preparation' (Polit et al., 2001: 467) as a technique to eradicate any methodological flaws. Illuminating the interview deficiencies before being implemented on a larger on scale will save both time and resources (NC3Rs, 2006). Participant feedback was obtained post-interview. The participant found the interview schedule comprehensible, and the topics easy to discuss. Information obtained in the pilot study was found to be extremely rich in sufficient data. Approval from the participant was gained in order to include the interview in the final analysis.

#### Data Collection

Semi-structured interviews are often characterised as being a 'conversation on purpose', this is none more so than within the context of IPA. According to the authors of IPA semi-structured interviews are preferred, due to the depth required to formulate phenomenological similarities and differences between participants (Smith, et al., 2009; Smith, 2004).

Interview questions concentrate on SBSHE, and the affect this had on their sexual health, and desires. The interview schedule was created under the practices, and theoretical assumptions of IPA. Each interview lasted on average 60 minutes in order to gain a sufficient amount of rich and valid data.

Research setting was dictated by where the participant felt most comfortable as 'young women are more likely to talk about [*their*] sexuality in an environment in which they feel 'safe'' (Allen, 2003:232). Interviews were transcribed verbatim within 24 hours of the interview commencing.

#### Interpretative Phenomenological Analysis

IPA attempts to bridge the gap between the theoretical perspectives of phenomenology, hermeneutics and idiography. The researcher is then required to be mindful of the cultural, socio-political, dialectal and ideological perspective of oneself, but also the participants (Patton, 2002; Clarke, 2009; Willig, 2001). Analytic stages of IPA are part of an evolutionary and sceptical process (Smith et al., 1999) in which

each stage needs reassessment to ensure as many apparent master themes are acknowledged (Mulveen and Hepsworth, 2006). As a method of health promotion IPA has been previously acclaimed (Flowers et al., 2009) thus, in relevancy to sexual health research the consequent immersion in the data began. Transcripts were coded and themed by repeatedly checking the six transcripts. The themes coded from the interview transcript were constructed in relation to the theoretical evidence present in the introduction.

### Ethical Considerations

In accordance to the guidelines of the British Psychological Society (BPS, 2009) ethical approval was granted by MMU Psychology department. This was granted based on the information supplied in the Application for Ethical Approval Form (AEAF) and an Ethics Checklist Form (EDF; see appendices 1.7 for Ethics Forms). Detailed in the AEAF and the EDF are the five core principles of ethical research; informed consent, withdrawal rights, deception, debriefing and confidentiality.

Upon expressing an interest in the study participants received copies of the Participant Information Sheet (PIS) and consent form, to sign prior to their interview. Both forms highlight the ethical regulations of informed consent and withdrawal rights, as well as the objectives of the research (see appendix 1.2 and appendix 1.3). Although, participants were given the PIS and consent form detailing the ethical practice of this study, verbal consent was also acquired to ensure they had read, and understood their rights.

Upon completion of the interview participants were given a debriefing sheet, if further involvement was needed to address the sensitive topics within the interview participants were directed towards the MMU counselling, health and well-being service (see appendix 1.4). No deception was incurred by the current research project as participants were made aware of the research aims prior to data collection.

Confidentiality cannot be granted as the interview transcripts have been shared with the research supervisor, and quotes from the interview have been used within the research journal. Described in the debriefing form is the opportunity for the participant's to create their own unique personal pseudonym in which to remain anonymous. Further measures were taken into account in that any information shared in the interview that could be used to identify the participant (e.g. friend's names) or implement an organisation (e.g. School name) were omitted from transcription. Upon completion of the research, all copies of the interviews were destroyed.

## Analysis

Overarching patterns of meaning were derived from verbatim transcripts; from this three master themes were developed: (1) Pleasure Conflict, (2) 'That Girl' Complex, and (3) Sexual Discourse. The following extracts are illustrative of a richer and more extensive interview. Table 1.3 shows the coded themes in relevance to the frequency in which each master theme was addressed.

| Code | Master Themes       | Code                    | Sub-ordinate themes  |
|------|---------------------|-------------------------|--|
| 1.1  | Pleasure Conflict   | 1.1.1<br>1.1.2<br>1.1.3 | Partner vs. Self<br>Masturbation<br>Orgasm                                       |
| 2.1  | 'That Girl' Complex | 2.1.1<br>2.1.2<br>2.1.3 | Stigmatisation<br>Social Relationships<br>Affiliation with Sexual Health Clinics |
| 3.1  | Sexual Discourse    | 3.1.1<br>3.1.2<br>3.1.3 | Openness<br>Terminology<br>Communication Mediums                                 |

### Theme 1: Pleasure Conflict

The current theme is derivative of the exploratory reasons in which the participants engage in sexual activities. From the master theme three sub-ordinates themes were developed: Partner vs. Self, Masturbation and orgasm. However, between the six participants the opinions differ greatly.

The following extract by Louisa highlights the grounds to which the pleasure conflict of partner vs. self originates:

[ ]Sex is about both of you being pleased, being satisfied in all senses [ ] don't just assume it is about a guy. Don't give a guy a chance to do that to you; make you feel like you need him to make you feel good, you can do that in your own way. (Louisa 1025 – 1037)

Louisa is very explicative in her vocalisation of what constitutes as sexual dichotomy. Thus if unobtainable can lead to the sexual activity being stopped, for example:

I've kicked a guy out before because I wasn't enjoying it [ ] If I'm not enjoying it I'm not going to carry on. (Jessica, 225 – 227)

However, for some of the women this confidence is not always matched as Francis discloses in the subsequent extract:

Well it's not like he's not doing something I wouldn't want him to do but, it's more of a case of he knows what would make me feel better. He knows what makes him feel better. (Francis, 334 – 338)

For women like Francis exploratory sexual behaviours are often attributed to their sexual partners rather than themselves. Therefore, they have no established arousal outside of partner-based stimulation:

When I'm not with someone it's like my sex drive disappears. (Claire, 205 – 207)

For other women this view is then developed into terms of an inability to become sexually aroused without a partner:

I know it sounds stupid but, I don't think I can. When everyone used to say in Year 10, year 11 'Girls all finger themselves' I was like, 'no they don't'. Well not me. I don't think I can to be honest [ ] I've got my boyfriend now; I don't need to do things like that. (Sarah, 270 – 280)

Often leading sexual desires to be repressed:

I just have to get on with it and go and wash the dishes or something. (Francis, 319 – 322)

Contrastingly, the following extract by Jessica highlights that masturbation is perceived as a psychosomatic release:

It's more like a release [ ] I wouldn't spend hours over it [ ] I'll masturbate whenever I want [ ] It's either I go masturbate, or I'll go sleep with someone. (Jessica, 627 – 643)

Jessica identified masturbation as having little time restraints and as measure of coping with stress and sexual arousal, reflective of male masturbation. Even though, half the participants repeatedly confirmed masturbation as unnecessary, a strong desire on the contrary was suggested alongside it:

To me it's like a private members club that I want to join but I can't. Well not yet. I want to be able to do it because, if I know how to get myself off then I know a guy can do it for me. Like, to be able to orgasm on my own or with a partner, the thought of it makes me so happy [ ] I guess I was never in pursuit of it until I started having sex and missing the point of it. (Claire, 527 – 541)

The previous extract highlights the pressure women put on their selves in order to be able to orgasm. The perception of female masturbation and orgasms are then attributed to certain women. Claire also addresses the notion that masturbation can be used to mirror sexual desires with a partner. However, it also suggests that women often go into sexual relationships not expecting to be sexually gratified.

## Theme 2: 'That Girl' Complex

The second theme revolves around three sub-ordinate themes; stigmatisation, social relationships and affiliation with sexual health clinics. This means the participants make sense of their sexual behaviours by assessing their sexual patterns, and evaluating the implications this has on their self-concept.

The notion of 'That Girl' refers to the prejudice towards promiscuous women; characterised as being of ill sexual health, and undesirable in terms of future relationships thus, more emphasis is placed on being in a committed monogamous relationship. For three of the participants this has high prevalence to their construct of desire, sexual health and their sexual self:

I guess it's a case of I'm scared to be that girl. Like, no one wants to be that girl. The kind of girl who gets laughed at behind her back because she sleeps around and can't hold down a stable relationship. Like I said, I won't sleep

with someone unless they're my boyfriend or something. I just feel safer that way. (Claire, 461 – 467)

However, Claire does later comment that:

I don't feel like I know what I like, it's like I've spent so long trying to work out what they'll want so they don't leave me, or whatever, and them be like 'She was shit in bed'. I'd rather not be that girl either. (Claire, 485 – 489)

In these two extracts Claire illustrates the stigmatisation of sexual identity, in relation to formation of a committed relationship. Negative feedback and prejudice is largely discouraged in terms of being a suitable partner both, characteristically and sexually. In the following extract Sarah discusses a similar notion.

Although once you're in that clinic, everyone looks at you like you're a slag or something like you're going to have an abortion. Well that's what I thought anyway. I was sweating and everything. (Sarah, 653 – 657)

Repeatedly, the idea of visiting a sexual health clinic is associated with negativity. Half of the participants interviewed described the stigma attached to being seen in a sexual health clinic, to which they perceived themselves as being type-cast in a derogatory manner. From this a strong sense of avoidance was placed on going to sexual health clinics alone:

I think the last time I got checked out was; 2012. Wow! 2012. I didn't even realise it was that long. I guess that just shows how much I put it off. (Claire, 331-334)

Despite this, the comparison is still made that they have more endearing qualities than other women:

More proud to not be like those girls [ ] If I had friends like them I don't think I would want to be associated with them. Whereas, I know to me when I do give that to someone it means a lot more than just sleeping with someone. (Francis, 371 – 374)

Reinforcement of their beliefs is then equated in terms of superiority, and a perception that their sexual relationships have a deeper context. However, for the remaining three participants these justifications appear unwarranted. The following extract from Rose describes her sex life as going through a 'wild period' (120). This refers to engagement with a multitude of sexual partners over a short space of time. For Rose, Louisa and Jessica this is often established alongside good relationships with sexual health clinics. The following extract from Jessica describes how frequently she visits sexual health clinics:

.... I get tested all the time, like every 6 months ... Depending on how many partners I've had, or what's changed...it's a sense of security for my-self... (Jessica, 371 – 378)

This opinion is shared between the three participants. The amount of sexual partners is then justified by having no negative repercussions (e.g. STI's). Therefore, any stigmatization attached to their sexual behaviours has been rendered irrelevant, as they do not perceive their sexual identity as unsafe.

### Theme 3: Sexual Discourse

The final master theme is constructed of three subordinate themes; openness, terminology and communication mediums. Sexual discourse refers to the manner in which the participants feel talking about sexual interaction is appropriate, what words they use and how they do it. The following extract highlights the willingness Sarah feels in which to speak about sexual activity.

...‘Shut up, I don’t want to speak about it’. I mean it physically knocks me sick, the fact that they’re speaking about it because, I don’t like speaking about it to anyone ... I don’t even go out to the shops to buy tampons or anything. I have to get one of my mates to do it. It knocks me sick, I swear to god. (Sarah, 61 – 67)

Sarah has very strongly deep rooted her inability to talk about sex related topics thus hindering the buying of essential sexual health related products. Often overemphasised for the participants who share this perspective is their lack of socio-cultural influences regarding sex and sexual health:

I mean your friends talk about sex; they don’t talk about sexual health (Francis, 221 – 225)

Francis later comments on how the lack of discussion makes her feel:

It makes the subject closed off its like taboo. How do you know what you can ask your friends, and what you can’t ask your friends if no one talks about it? (Francis, 235 – 238)

It appears sexual health is not spoken about within social circles, despite related sub-topics (e.g. sex, pornography or child-birth) frequently appearing in the media. Consequently leading to women having a very limited knowledge basis of sexual health, as the following extract highlights:

...you know what I don’t even know if you can get [STI’s] orally or, whether it is just through sex. Like, do you touch someone and it happens? Or, do they have to ejaculate? I just wouldn’t know how you would catch it. (Francis, 795 – 800)

However, this view is not shared by all the participants, as Louisa explains:

I think as I’ve become more confident in myself. I cope by talking about it. I talk about it still with my girl mates. Even if they don’t do it themselves, or have never done it I kind of say it in a way that I do it, there’s nothing wrong with it. (Louisa, 1016 – 1025)

Open discussion is then sanctioned as a means of a solution to a sexual problem, allowing women to touch on both issues of sexual pleasure and sexual health. Although, it appears that this notion is both hindered and facilitated by the terminology currently available:

Well I feel potentially like its bit gender-centric. Like, I feel that everything about sexual language is aimed at the male. (Rose, 322 – 324)

The previous extract highlighted the notion that sexual language is largely associated with male connotations. This is expressed in the interviews in terms of expletives however, the use of which is not always unjustified:

I think women and men should use the same terminology to describe their desires. What we do, and what men do it's all connected, all the same. Why should it be any different? (Jessica, 472 – 476)

For Louisa, Jessica and, Claire expletive language was used as way to highlight the differences in sexual relationships:

[ ] they do describe the situation better; the rawness of sex, and the animalistic passion behind it. I mean like in comparison to 'making love' - I mean who actually makes love anymore? (Claire, 611 – 615)

Suggesting, that within its sexual context the use of such language is not derogatory but descriptive. However, for the remaining participants the repeated use of medical terminology was highlighted as sexual discourse:

[ ] the pill it's not even called the pill it's called Microgynon, or something. I don't know. I mean the implant isn't even called the implant it's called IUD. (Francis, 601 – 607)

Proposing participants who use clinical linguistics are unaccustomed to the dialect of sex-slang, and find comfort in expressing opinions in a scientific manner. All of the participants address the notion of indirect communication through mobile phones as a way of 'testing the water' (Claire, 168 – 169) before truly vocalising their sexual desires which are often much more robust:

I love being tied up and bitten but, I'd never say that to someone I'd just met. (Claire, 170 – 172)

In conclusion, the participant's opinions differ greatly between those who masturbate, and those who abstain. A distinct lack of sexual knowledge discourages open discussion, and implicates stigmatisation of both sexual behaviours, and health clinics. Masturbation, thus, encourages sexual health through positive relationships with the self that can be applied to partners, peers and clinicians. In absence of which, a prominence is placed on the partner to be the provider of both sound sexual health and, sexual pleasure.

## Discussion

Participants negatively viewed the observable factors towards sexual health; in alignment with essentialist theory the factors of observable and explanatory are detrimental to the construct of behaviours (Gelman, 2004). The current research recognised the development of negative stigmatisation forwent the personal and relational meaning of sexual health, contrary to the belief of the women who engaged in regular masturbation. Thus, the current research supports the work of Mosher and Vonderheide (1985) that masturbation guilt is a deterrent for sexual health. Although, the current research proposes this is due to the formation of

cognitive biases towards the attribution of partner role in their sexual health, and not purely the absence of masturbation as Mosher and Vonderheide (1985) suggest.

From this sexual frameworks are formed on the presence of a partner consequently, little emphasis is placed on the self as a construct of sexual identity. Therefore, the current project also illuminates further research into the topic of sexual dysfunction. Lavie and Willig (2005) attribute female sexual dysfunction with somatic and psychological aspects of the sexual disorder; although they cease to acknowledge a root cause. The current research established that the women who expressed similar patterns of sexual oppression did so in perception sexual arousal was inevitable. Mirroring the applicability of the alternative FSRM (Basson, 2000) as the absence of desire authenticated the belief that sexual pleasure was unobtainable.

The current research proposes that female sexuality is symbolic of context, and not a development of commodification as Glick (2000) and Thornton (2000) suggest. In alignment with Context theory sexual health and desires are influenced greatly by the context-specific experiences thus, generalisations of sexuality are limited. For the participants who affiliated sexual pleasure as a product of empowerment used their life-experiences and knowledge as a tool for the sexual liberation of others. Contrastingly, this does differ with the participants who accentuate being in a committed relationship before engaging in sexual intercourse with their partner. A transaction between the two parties is then negotiated as emotional attachment in reward for sexual relations; challenging the research by Allen (2003) that the notion for young women to be 'in love' is outdated.

Frameworks of both the Sexual Strategies theory, and the Biosocial theory advised that sexual well-being is influenced considerably by gender roles and the attraction of partners. The implications of such understanding have been perceived in the current sample as a high aversion to sexual practice, discussion and health clinics. Suggesting SRE that does not enforce desire pressurises young women to attain sexual fulfilment in their relationship status, rather through satisfaction. Interestingly, the expression of these views stemmed largely from the participants who had a reduced SBSHE; for this reason it is acceptable to consider the possibility that establishment of sexual values is not based on definitive knowledge but, through a process of socialisation. Cultivation of such values maintains the work by Bem (1981) into the Gender Schema theory, where the development of roles is done so through cultural norms of gender.

Stigmatisations upheld within the current research towards the promiscuous woman are emblematic of socio-political sanctions towards feminine sexual health. The institutionalisation of monogamous relationships within SRE implement the behaviour and desires of sexually liberal women is chastised. However, censorship of desires is not found in male sexual desires. Research by Nzanzi et al., (2009) amalgamated male promiscuity with maturity where the ranking of sexual partners preconditioned the passage to manliness. Postmodernist gender roles are thus conflicted, between developing liberal values of sexuality over the collective consciousness of societal enforcement of institutionalised norms.

The current research does not propose that masturbation is the definitive cause for good sexual health as the matrix of sexual relations cannot be explained so deterministically. However, findings from the current research suggest that women

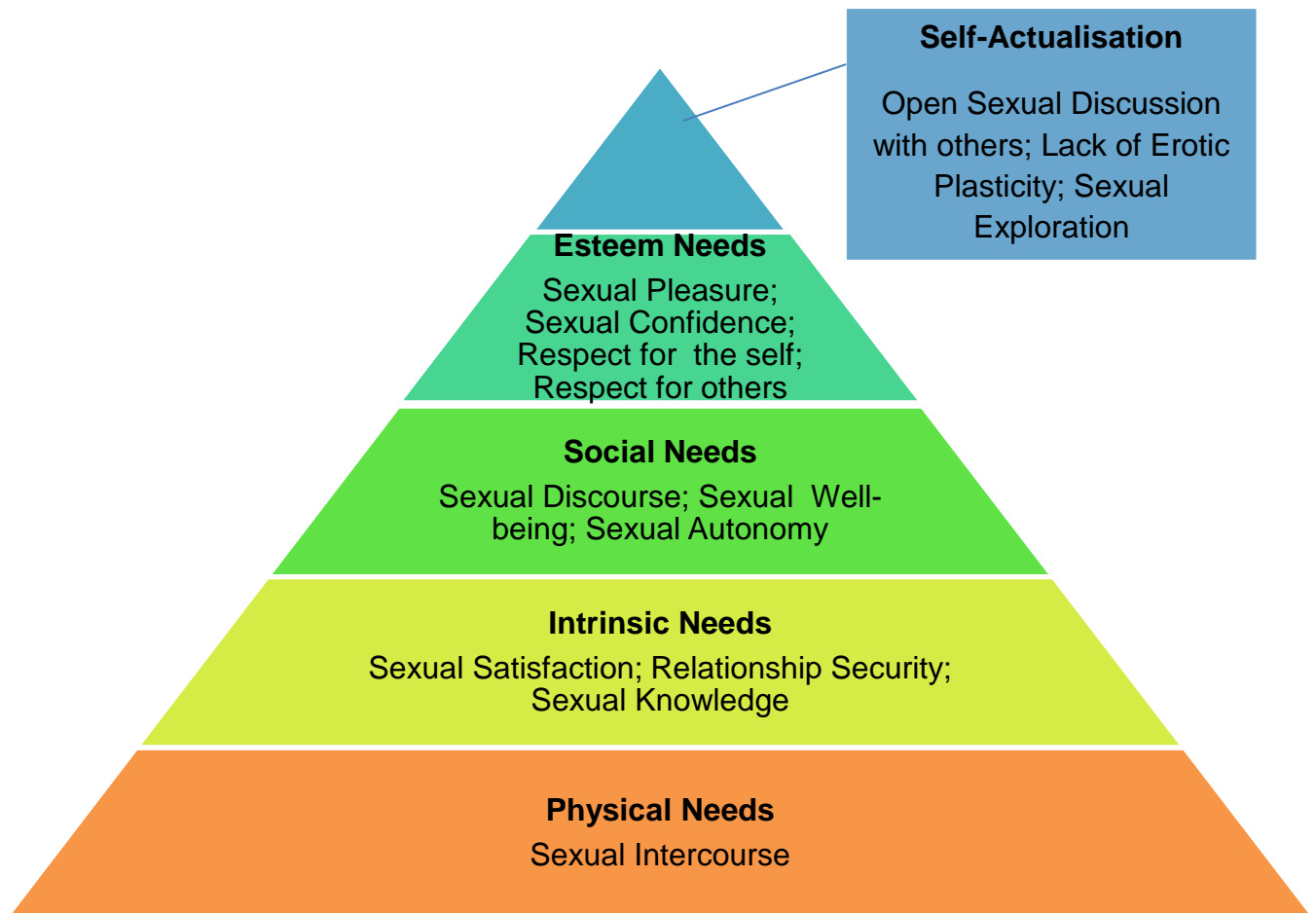


who masturbate are motivated by the pursuit of sexual pleasure in order to negotiate negative stereotypes. Stigmatisation of sexual health clinics was unrecognised when frequent relationships with sexual health clinics were established; abetting the open discussion of sexual health topics with both peers and institutions. Developing the previous research proposed by Hogarth and Ingham (2009) into masturbation.

Even though, the results of the present research support claims made by Fine (1988) that a discourse of desire is needed in SRE; the equivocation that the absence of desire, and pleasure knowledge is perceived negatively for the young women. The majority of young women in the present study who had SRE established positive sexual roles and values despite a supposed sex-negative pedagogy. However, arguably the young women who had a reduced SRE expressed the characteristics in of 'anti-sex' as Fine (1988) suggested. Therefore, in-keeping with the results of Kohler et al., (2008) whereby, adolescents are more likely to be at sexual risk, if they are not taught SRE. However, as the two participants who viewed sex in such a way were raised in Catholic schools, the notion thereby as to the degree of facilitation religion had as a precursor to sexual norms in a secular society.

Proposed from the current research is a model of sexual health and pleasure that comprises components from the aforementioned sexual risk hierarchy (Schuster, Bell and Kanouse, 1996) and the FSRM (Basson, 2000). Encompassing the components of Maslow's hierarchy of social needs (Poston, 2009) the proposed model deliberates the psychological and somatic well-being of the participants' sexual health and pleasure to motivational factors. Addressed in figure 1.1 is the working model of the proposed sexual needs hierarchy although, further research is needed to truly authenticate the proposed model.

Figure 1.1 - Hierarchy of Sexual Needs



Constructionists often criticise the use of IPA, as it does not account for the analysis of discourse (Eatough and Smith, 2006; Brocki and Wearden, 2006). Due to the confinement of the word count superfluous themes (e.g. pornography) had to be excluded from the research project. Furthermore, future research should seek to illuminate the context of SRE in relation to other sexualities.

New societal trends to sell one's virginity through online auctions has become financially engrossing with figures reaching into the hundreds of thousands (Hancill, 2014: online; Moye, 2012: online); arising the question is sex becoming increasingly commoditised?

Conceptualisations of emic feminine sexuality stigmatise sexual agency through unification of prejudicial vernacular and institutionalised ideologies. Through critical SRE that contains an enhanced knowledge of masturbation and contextual discussion is it possible for the re-socialisation of female sexuality and consequent improvement of sexual health.

## Reflexivity

Reflexivity in qualitative research aligns the 'methodological rigor with a critically disciplined subjectivity, decentring not only the sedimentations of the analyst but (reflexively) those of the field itself' (Macbeth, 2001:39). Consequently, allowing for the egocentrism of academic work to be denoted for its altruistic applications.

Increasingly prevalent was the underlined questions towards one's own sexual desire in light of the sensitive nature of masturbation, and sexual health. In such I too have not had the most sexually sound history, thus certain emotional implications may have impacted the data analysis. However, as IPA 'is both dependent on, and complicated by, the researcher's own conceptions' (Smith, 1996: 264) one's phenomenological and philosophical stance was heeded.

Nonetheless, I felt conflicted towards the use of IPA within the current research. Although, not on the grounds of its suitability (that was always certain) but, on my own ability to use such a profound method. Methodologically, the use of semi-structured interviews was critical in the exploration of the research question however, one's experience as an interviewer was unsettling. Although due to the comprehensiveness of 'Interpretative Phenomenological Analysis: Theory, Research and Method' (Smith et al., 2009) this anxiety was eradicated.

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