Masculinities, ‘guy talk’ and ‘manning up’: a discourse analysis of how young men talk about sexual health

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Abstract Sexually transmitted infection testing rates among young men remain low, and their disengagement from sexual health services has been linked to enactments of masculinity that prohibit or truncate discussions of sexual health. Understanding how men align with multiple masculinities is therefore important for tailoring interventions that appropriately respond to their needs. We draw on 32 in-depth interviews with 15–24-year-old men to explore the discourses that facilitate or shut down sexual health communication with peers and sex partners. We employ a critical discourse analysis to explore how men’s conversations about sexual health are constituted by masculine hierarchies (such as the ways in which masculinities influence men’s ability to construct or challenge and contest dominant discourses about sexual health). Men’s conversations about sexual health focused primarily around their sexual encounters – something frequently referred to as ‘guy talk’. Also described were situations whereby participants employed a discourse of ‘manning up’ to (i) exert power over others with disregard for potential repercussions and (ii) deploy power to affirm and reify their own hyper-masculine identities, while using their personal (masculine) power to help others (who are subordinate in the social ordering of men). By better understanding how masculine discourses are employed by men, their sexual health needs can be advanced.

Keywords: masculinities, men’s health, sexual health, discourse analysis, STIs/HIV

Introduction

Background
Popular portrayals of discussions about sex and sexual health often depict women as talking too much (with each other) and men as talking too little (with anyone at all) (DeVore 2009). Some authors relate men’s reticence to engage in discussions about health in general to dominant masculine ideals that prescribe stoicism, independence, self-reliance and a lack of interest in self-health (Connell 1995, Courtenay 2000a, 2000b). Men are also depicted as being more likely to deny illness than engage in discussions about their health and wellbeing.
A few studies rooted in the context of men’s coping with illnesses (Oliffe et al. 2010) and chronic disease (Charmaz 1995) show that some men engage one another in meaningful conversations about their health. Most studies that have examined young men’s sexual health-related discussions focus on their communication within and about healthcare service provision situations (in patient–doctor communication) (Carlisle et al. 2006). To date, there is little empirical and theoretical literature examining men’s discussions with their peers regarding their sexual health (such as sex practices, contraception and sexually transmitted infections).

**Young men’s sexual health**

Despite decades of public health intervention, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) remain a serious health problem among young men. In 2007 in the UK men below the age of 25 accounted for 57% of all chlamydia cases (34,626 cases) at a rate of 1100 patients per 100,000 men aged 20–24 (Health Protection Agency 2009). In the USA in 2009, men between the ages of 20 and 24 experienced the highest rate of chlamydia at 1120 patients per 100,000 (compared to the national average of 409 per 100,000) (United States Centers for Disease Control 2011). In Canada, as elsewhere, young men’s STI rates are high and rising. In British Columbia (BC), Canada’s most western province, between 2000 and 2009 chlamydia rates among young men aged 15 to 24 years doubled, with 1110.4 patients per 100,000 men (compared to the BC average of 251.1 patients per 100,000) (British Columbia Centre for Disease Control 2010). Those who are racialised or economically disadvantaged as well as men who have sex with men bear the largest burden of STIs (British Columbia Centre for Disease Control 2010, United States Centers for Disease Control and Prevention 2011). In 2009 HIV incidence rates for men between the ages of 20 to 24 were significantly higher than the provincial average at 11.2 per 100,000 (compared to the provincial average of 7.6 per 100,000) (British Columbia Centre for Disease Control 2010). Moreover, the STI surveillance data indicate the potential for a significant increase of the spread of HIV among young men (Larkin et al. 2006). As a result, there is a strong public health impetus to improve young men’s sexual health outcomes.

**Men and masculinities**

Connell (1987, 1995) defined masculinity as a social and cultural structure that influences men’s identities and practices, and post-structural frameworks detail the ways in which masculine hegemony is (re)produced and constituted in men’s everyday lives through the use of discourse(s) (Wetherell and Edley 1999) and performances of gender (Butler 1990). Within these frameworks, masculinities function hierarchically, with hegemonic masculinity representing the most socially dominant masculinity. Hegemony refers to the cultural dynamics that allow a social group to sustain dominance; hegemonic masculinity is the culturally exalted gender practice that enables male dominance (Connell 1995).

Masculinity theorists often position hegemonic masculinity as an idealised masculinity that is truly out of reach for most men and just barely out of reach for some men (Numer and Gahagan 2009). In other words, while hegemonic masculinity is unattainable, some men are able to align more closely with idealised masculinities (Connell and Messerschmidt 2005), whereas others fall short of these ideals, although they continue to pursue them, thereby constituting a social ordering of men. Contemporary theories of masculinity also highlight gender regimes (Connell 2011) and the social ordering of men as relational to multiple intersecting identities and subject positions, including race, ethnicity, sexual identity and socioeconomic status (Duck 2009, Robertson 2007). As a result, masculine identities can be
subordinated by virtue of their other intersecting and mutually constitutive social identities. While gay masculinities are the most conspicuous among subordinated masculinities (Connell 1995), heterosexual men embodying weak or effeminate characteristics (for example, ‘sissies’) can also be subordinated. Moreover, masculinities are contextual; depending on social or cultural contexts, normative masculine ideals valued in one social setting may be subordinated in another (for example, on a date versus in a sports game) (Creighton and Oliffe 2010, Talbot and Quayle 2010).

Regardless of their ability to fully embody and practice the hegemonic definitions of masculinity, most men nonetheless benefit from the patriarchal dividend as a result of the subordination of women and marginalised men (Connell 1995). Therefore, many men, according to Connell, embody a complicit masculinity. Dominant and normative masculinities also are terms used to relate to hegemonic masculinity. These terms have been employed by theorists to account for the disparity between hegemonic masculinity (at an overall, cultural level) and the masculinities that men experience as dominant and normative in their everyday lives. Despite being subordinated to hegemonic ideals, men who align with dominant and normative masculinities derive benefit (Coles 2009), especially in the realm of sexual practices. Many men, regardless of their alignment with dominant and normative masculinities, may align with masculine ideals that valorise (and benefit from) men’s role as a sexual pursuer.

Musculinities and men’s sexual health practices

The high and rising rates of STIs among men have been attributed to their disengagement with sexual health services (Shoveller et al. 2009), a reticence about self-help (Robertson 2007) and a lack of meaningful discussions about sexual health informed by masculine ideals (Lindberg et al. 2006, Shoveller et al. 2010). Sexually active men who avoid discussing sexual health have an increased risk of contracting an STI compared to those who discuss sexual health (as well as other health-related consequences) (Alt 2002, Brook Advisory Centres 2005, Courtenay 2000a, Pearson 2003). Recently, research has detailed how the connections between masculinities and social contexts can influence young men’s sexual health-related practices (Gautham et al. 2008, Goldenberg et al. 2008b, Shoveller and Johnson 2004, 2006, Shoveller et al. 2009, 2010). Goldenberg et al. (2008a, 2008b, 2009) described how structural conditions (for example, location and hours of STI clinics) amid hyper-masculine oil/gas worker occupations and social contexts intersect to create significant barriers for men’s engagement with STI testing services, while at the same time creating social situations that put men (and women) at an elevated risk of STIs.

Other critiques have begun to explore how aligning with dominant masculine ideals may also produce health-enhancing behaviour for men. Men whose jobs require strength and endurance (for example, firemen) may idealise a healthy body and therefore be more likely to engage in health-promoting behaviour (exercise and a healthy diet) (O’Brien et al. 2005). These healthy masculinities are typically positioned as a means to ‘preserve or restore’ another, more valued, enactment of masculinity (O’Brien et al. 2005: 1; authors’ emphasis) and these practices have also been identified in the realm of men’s sexual health practices. Hegemonic masculinity is associated with the valorisation of frequent sexual activity and sexual ‘risk-taking’ practices (such as the avoidance of condoms) (Numer and Gahagan 2009). However, some men who embrace these ideals also worry about the potentially emasculating effects of falling ill (getting STIs/HIV) (Duck 2009), revealing the complex relationships between masculinities and men’s health practices (Oliffe 2009).
Men talking about sexual health

Some studies have described how masculine performances and portrayals of masculine ideals vary according to contextual features, such as the audience (within and among men versus women) (Allen 2003, Pascoe 2007), conversational subjects (Allen 2003), historical context (across time) and socio-political milieu. Sociological analyses suggest that men’s cultural and economic capital (for example, ethnicity, social class and geopolitical contexts) can bolster or limit their capacity to embody dominant masculine ideals that may put their health at risk (for example, by discussing sexual health with their peers) (Allen 2003, Duck 2009, Shoveller et al. 2010). These approaches position men’s health-related behaviour as operating under sociocultural influences (gender norms) as well as structural-level determinants (access to capital). In the current study we examine discourses of young men’s descriptions of the social and contextual conditions that are perceived to affect sexual health communication among and by men. We pay special attention to how notions of idealised masculinity appear to influence (or not influence) young men’s discussions of their sexual health practices with their peers and sex partners.

Methods

This study draws on methods from critical discourse analysis (CDA) – an analytic method chosen to explore the social processes that (re)produce and reflect knowledge and power relations through discourses (Fairclough 2003), rather than exclusively on the specific grammatical and linguistic use of language (Galasinski 2008, Hodges et al. 2008). CDA explores the ways in which social structures and practices constitute how specific topics (such as sexual health) are discussed (or not discussed) (Chouliaraki and Fairclough 1999). CDA positions social structures (such as masculinities and the social ordering of men and women) as systems of social relations that do not produce equilibrium but that are instead ‘characterized by dominance, exploitation, struggle, oppression and power’ (Johnstone 2008: 28). We used a CDA approach to investigate men’s discourses about sexual health and how they are concomitantly constituted and (re)produced through broader social structures (for example, those related to hegemonic masculinity) (Fairclough 1985). This approach positions the speakers (the young men) as both affected by and engaging in social practices related to the generation of masculine norms, while showing how their discourses constitute/reflect their taken-for-granted knowledge base and the transpiring of social actions and interactions (Fairclough 1985, Johnstone 2008). By employing this analytic framework, the power distributions between and across socially dominant and subordinate groups (for example, within the social hierarchy of men) were explored. Specifically, we drew on Connell’s masculinities framework (1995) to explore how men’s conversations about sexual health are constituted by hierarchical masculine discourses and how these hierarchies influence men’s ability to either construct or contest dominant discourses.

Study setting

The young men were recruited to the study in Metro Vancouver, Canada. Vancouver is located on Canada’s southwest Pacific coast and has a population of 2,116,581 people with approximately 215,000 men aged 15 to 24 years (Statistics Canada 2007). Approximately 40 per cent of Vancouver’s population are first-generation immigrants (Statistics Canada 2007).
Recruitment and study sample
Using posters at youth STI clinics, bus stops and community centres, men 15–24 years old of various ethnicities, sexual identities and ages were recruited to participate in individual, semi-structured, in-depth interviews. Participants were also recruited from online advertisements (including Facebook). We employed a variety of recruitment strategies to reach a diverse group of men (those who have and have not had the opportunity to engage with sexual health services) to enhance the diversity of experiences presented in our study. Interested participants telephoned or e-mailed the research office and were screened for eligibility. Eligible participants were those who indicated that they were English-speaking men (aged 15–24 years old) and had previously been sexually active (with another person). We used a purposive sampling strategy to select a variety of men across age, ethnicity and sexual orientation. Ethics approval was obtained from the University of British Columbia. Participants under the age of 19 did not require a parent’s/guardian’s assent and all participants provided their informed consent.

Interviews
Each interview lasted 1 to 1.5 hours and took place in a private setting (in research offices). During the interviews, the participants were asked to describe the situations in which they engage in conversation or discussion about sexual health with their peers and sex partners. The interview questions addressed a variety of topics that might arise in conversations with peers and sex partners, including STI testing, sexual practices and contraception. In order to better understand how their conversations played out, we asked the participants to describe the social contexts in which these conversations took place (such as the location, comfort levels, topics, tone of conversations and reactions of their peers and sex partners). All participants were offered a CDN$25 honorarium and the opportunity to ‘member check’ their transcripts.

Data analysis
Interviews were transcribed, checked for accuracy and uploaded to NVivo8 for coding. The interview data were coded and the codes were compared to identify broad themes across the interviews (ten Have 1995), paying special attention to men’s discourses about the sexual health discussions they have with peers and sex partners. The masculinities literature was consulted to develop conceptual themes and to identify coherent patterns within and across the data (Sandelowski 1995). As data collection and analysis continued, coding occurred iteratively within and across the interviews to test emergent ideas about the connections between concepts and to identify new themes. The texts (that is, the men’s interview transcripts) were analysed to explore subverting and contesting discourses (Fairclough 2003) by asking: What dominant discourses do men employ when talking about sexual health with peers and sex partners? What are the specific ways that men either appropriate and construct or resist and challenge dominant masculine sexual discourses?

Findings
In total, we interviewed 32 men (average age: 20.5 years). Seven men were recruited from clinical (youth clinics) and six men from non-clinical sites (community centres and colleges) using posters and 19 men from online social networking sites (such as Facebook). All participants had previously had sex (oral, anal or vaginal, or all three). See Table 1 for the characteristics of the participants.
The conceptual findings are divided into two thematic sections that exemplify the discourses men employ to talk about sexual health: (i) guy talk and (ii) manning up. We use quotes from participants to illustrate these themes and to further contextualise how they described the discussions that they have with peers and sex partners about sexual health.

‘Guy talk’

We asked participants to describe the situations in which they were able to discuss their sexual health with peers. Most participants explained that their discussions about sex typically consisted of descriptions about their sexual encounters (whom they had sex with and what sex acts they engaged in) and several participants referred to this as guy talk. Few said they had ever talked about sexual health-related issues (such as STI testing or condom negotiation). As Milo, a straight 19-year-old East Asian man, explained, when he and his friends talk about sex, it is:

just guy talk, I guess. Whatever. Like, if I had sex with a girl last night, I’ll like call my buddies and be like ‘Yo, last night was fun!’ and he’d be like ‘Oh what’d you do?’ Stuff like that. But we don’t really talk in terms of like sexual health [emphasis added to indicate Milo’s voice inflection], like getting STI tests.

As the inflection in Milo’s voice indicates, sexual health was frequently described by participants as a side issue that distracted from or diluted the details of their discussions about sexual conquest and pleasure. In this way, the men in our study discursively emphasised masculine sexual performance (that is, discussions about who did what to whom is afforded priority during discussions). This discourse also positions sexual health discussions as tied to help-seeking behaviour (getting STI testing) – a subject not conventionally included in guy talk. As a result, notions of idealised masculinity are discursively linked to sexual prowess and virility and, inversely, discussions about health or illness are associated with notions of weakness (feminine stereotypes), thereby constituting a discourse that precludes discussions about sexual health or illness.
Some participants explained that gay men can more freely or openly engage in conversations about sexual health (for example, because they are assumed to ‘talk about sex all the time’). Although our data revealed a more complex set of practices, the gay men in this study were more likely to describe having talked about sexual health, but only with their gay friends. As Bill, a 22-year-old Euro-Canadian gay man, said:

For gay guys like me, my best resources are my gay best friends. Gay guys talk about sex all the time. Sometimes it’s just, you know, a story ... But if you want advice on something, you’re probably going to get it. Because somebody probably experienced the same thing.

Conversations about sexual health among gay men were also aligned to a dominant masculine discourse around men’s talk relating to sexual performance where descriptions of sexual acts and partners are used to signal virile gay masculinities, marking hierarchies within those masculinities. Several gay participants also acknowledged that heterosexual men tend to focus their guy talk primarily on their sexual encounters (but with women), relying on the use of humour and derogatory remarks to relay their stories. As Bill, the aforementioned 22-year-old gay man, acknowledged:

It’s like they [heterosexual men] just make fun. It’s not sexual health ... My best friend is straight and I hang out with straight guys all the time. When they start talking about sex, I slowly turn myself off ... I don’t want to hear them talking about pussy ... Girls are gross ... I don’t want to hear a string of short stories about their ‘times with women’. And, then, they’ll come up with some kind of gay, orgy fantasy. And, I’m just like [pause]: ‘I don’t even dream about that shit!’ Where do they come up with these things?

Talking about sexual encounters (including fantasies about gay sexual encounters) in ways that reify hyper-masculinity tended to dominate participants’ accounts (even in groups that include a mix of gay and straight men). Revealed here is an example of how patriarchal power can be (re)produced by a set of ritualistic masculine practices (hyper-sexualised hegemonic ideals) which can also be operationalised by (heterosexual) men’s discourses to include the subordinated ‘other’.

Some men described experiencing negative social repercussions if they discussed sexual health. By breaking the taboo, those who broached the topic of sexual health with their men peers were frequently subjected to ridicule. For example, Christopher, a Black 17-year-old straight man, expressed frustration with the teasing he was subjected to by peers after he tried to discuss sexual health. Christopher explained that he has since avoided talking about sexual health, for fear of further mocking:

Well ... [talking about sexual health] with guys, no, because I don’t know where the conversation is going. I don’t want it to be that I’m going to ask an intelligent question, and at the end of it, I’m being made fun of for being a virgin or something silly like that ... It’s going to be twisted around and then I hear from the next girl I’m trying to date that she thinks I’m gay or that I might have an STD.

Christopher’s explanation reveals the masculine discourses and codes that filter, censor and govern men’s sexual health talk. At risk in the moment and in the aftermath of such disclosures are gossip and rumour, invoking a subordinate (gay) or suspect (diseased) masculine status. As a result, Christopher said that he had learned to avoid discussing sexual
health – a strategy rooted in silence, thereby prioritising the avoidance of potentially emasculating ridicule and damaging rumour. Christopher’s explanation also demonstrates the ways in which discourses that prioritise heterosexual desire and essentialise masculine talk as strong and confident can create barriers for men engaging in discussions about sexual health. In fact, for several participants, our interview provided the first opportunity to discuss and reflect on issues related to their sexual health. Christopher explained that the primary reason for participating in the study was to have the opportunity to confidentially discuss and learn more about sexual health issues.

Several participants explained that conversations about condom and contraception negotiation were particularly difficult to have with sex partners because issues of trust and fidelity would inevitably arise. As a result, participants explained that they avoided these discussions, thereby deferring to their partners the responsibility of initiating relevant conversations and action(s). For example, Johan, a straight 22-year-old Euro-Canadian man who was not monogamous, explained that, while his preference was to use condoms, he often felt uncomfortable discussing this topic with sex partners:

I just find myself not making good decisions around it [using condoms] more often than I’m comfortable with. It – the pleasure is definitely a huge part of it. I think another part of it might be that I – I don’t like talking about ... It is just ... [pause] Like, I don’t want to stop to necessarily bring it up – like if I bring it up, it’s like, almost like ... Talking about condoms is almost like discussing having sex, and like ... you know, if it’s just happening, then like, I don’t wanna feel like I am having to discuss it. ... I really do appreciate it when girls bring it up ... because yeah, just, it takes that pressure off a bit.

Here, the participant positions sex as being substantially a realm of non-rational experience that is also valued because it does not involve everyday types of thinking. Related to this, negotiating safe sex through condom use is positioned as more likely to emerge from the female partner as a by-product of feminised virtues that value health more than sexual pleasure. As a result, initiating this conversation might reveal Johan as being concerned about safety rather than spontaneity and pleasure. While acknowledging that he should care about condom use, Johan’s silence renders him complicit in sustaining dominant masculine discourses around pleasure, hedonism and giving into his sexual needs. This discourse reveals the gendered power relations that place Johan in a position where he leaves it to his female partners to take care of sexual health decision-making.

A few men explained that, although it was difficult, they occasionally engaged in discussions about sexual health with their peers and/or sex partners (for example, STI symptoms or testing; notifying sex partners of potential infections). When asked how these conversations ‘played out’, participants explained that humour was the lynchpin to engaging in such discussions – especially when they had talked with male peers. When asked to describe how he discussed sexual health with his friends, Tyler, a 23-year-old straight Euro-Canadian, explained:

Tyler: Once in a while one of my friends will get with somebody very questionable and we’ll kind of poke him and prod him to go get, go get tested. [Chuckles] That does happen sometimes.
Interviewer: What do you mean by ‘questionable’?
Tyler: Um, well, first of all, someone we don’t know. Someone we may have heard that sleeps around. Somebody who insists on not using protection.
Interviewer: Okay. And how does the ‘poking and prodding’ go?
Tyler: Usually we tease him and tell him he probably has AIDS. It really gets him going.

By employing teasing humour in these conversations, the friend is encouraged to seek STI testing, while Tyler (and the wider group) implicitly disclaim they really care about their friend’s sexual health. Teasing humour can serve to prompt men to reflect upon, and perhaps recognise and reconsider ‘risky’ sexual practices, while not explicitly challenging key hyper-masculine performance indicators (sexual pleasure and conquest).

A few participants explained that they were able to discuss sexual health in a more serious way, but only with friends that they trusted deeply. Jameel, a straight 21-year-old man of Middle-Eastern ancestry, described how he discussed STI symptoms with his closest friends:

It depends on the background of the guys first of all and how long you’ve known the friends for. Like, I usually can’t talk to a friend that I’ve just met on campus for, like, a month or two. Usually I can’t talk about that with him. But I usually prefer to talk to my male guys that I’ve known for 6, 7 years that I’ve known like my brothers. So I just talk to them with my concerns and they usually come up with some advice and they’re usually, like, if I am concerned with some symptoms or if I’m just paranoid they tell me: ‘Hey, just calm down and go get tested. Don’t worry about it and hopefully it’s nothing serious.

For Jameel discussions about STI symptoms (and the like) could only be conducted with friends that he trusted ‘like brothers’. Jameel’s explanation reveals how deviating from the discourses constituted by guy talk (such as asking for advice or help about his sexual health) can only take place when specific criteria are met (with friends that he trusts while he is ‘paranoid’).

*Manning up: talking about STIs and health*

While most of the men in our study employed guy talk to filter out or govern discussions around sexual health and illness, some men described situations in which they engaged in a different kind of discourse, which several described and discursively positioned as a social practice that required ample courage. Jameel said that he would feel the need to talk with his friends about the experience of getting tested for an STI (albeit *after* he was treated and cured):

As time goes on, I think things tend to be less intense; so, I would actually let them know after a while that ‘Yeah, I’ve been diagnosed with that like several months ago; but, I’m getting treated or I’m under some kind of treatment’, and then would actually let them know. But at the instance, I don’t think I would be able to. I wouldn’t have the courage to tell them, yeah.

Like Jameel, most participants indicated that they would need time to muster the courage to break with masculine discourses around stoicism, invulnerability and the denial of illness, and several of the participants used the term ‘manning up’ to describe this process. Preparing to man up and speak more openly about sexual health problems (STIs) with friends and peers emerged as an important theme during the interviews, although most of the interview participants indicated that their first instinct would be to align with a masculine discourse where themes of autonomy and self-reliance trump the urge to talk with or seek the counsel...
or support of others. The process of manning up was most frequently invoked as a discourse when the study participants described situations where they had engaged in discussions with male friends about having had an STI.

Participants also positioned the strength and courage to man up as residing in particular actions. Zachary, a gay 22-year-old Euro-Canadian explained that when he had tested positive for STIs he had notified his sex partners directly rather than ask the health department to contact them (in BC clients have the option to do either):

My sexual partners, I don’t exactly know very well. I always try to keep ... I always try to contact them if I ever do come down with something. That’s hard. But they have that service available here where you can just give the clinic the phone numbers of the people and they’ll call, which is kinda good. But, I mean, really you should man up and tell them yourself.

Zachary’s characterisation of notifying his sex partners himself as an act of manning up seemingly contravenes dominant masculine discourses in which men deny illness and do not advise other men about sexual health. However, by manning up, Zachary repositions what it means to take responsibility for others’ sexual health by emphasising his decisive, honourable actions aimed at doing the principled and perhaps protective thing. Notifying sex partners (which in Zachary’s story is positioned as virtuous) is characterised as something that ‘real men’ have the power and control to do for greater good, with a reckless disregard for the implications and potential repercussions on their own masculine status. In privileging and performing this version of manning up, participants were complicit in sustaining a specific set of masculine ideals. They discursively positioned real men as dominant and capable, facing up to a problem for which they might be held responsible, amid steely resolve to withstand any potential conflict or estrangement (such as being blamed for the STI by sex partners). As Tyler, a 23-year-old straight guy, confirmed:

Tyler: Straight up. No. No e-mail, no doctor calling them.
Interviewer: So you wouldn’t prefer the doctor or nurse to call your sex partners?
Tyler: Hell no. No. Go tell them yourself. Quit being a pussy ... I think you should call them yourself. Really, I think you should implicate yourself. I think you should put it right out there, yeah. Uh, ‘I had sex with you. Um, if it wasn’t protected, I may have given you something’. Own up to it.

In being required by the state (that is, public health surveillance systems) to account for sexual illness, Tyler and Zachary’s explanations reveal the multiple considerations they face in deciding whether or not to inform their partners about the possibility of STI transmission. Tyler and Zachary reject the option of deferring responsibility to a public health nurse (in which they could remain anonymous to their partners – or, at the very least, distanced from their reactions) and instead take-up ‘manly’ discourses related to integrity and responsibility. In doing so, Tyler and Zachary position the partner notification process as a situation in which they must preserve their masculine identities.

Other forms of manning up emerged during the interviews, whereby feminine ideals (like caring and helping) were reshaped in more subtle ways to reflect masculine ideals (such as taking charge or being strong). Cody, a 23-year-old straight Aboriginal man, explained how he had helped his young cousin who was experiencing STI symptoms:
My little cousin, man, he had chlamydia and VD [gonorrhoea] and it was bad, man. It was Christmas time. I’m driving around looking for a clinic to get him fixed, man. That’s the pain he was in. Yeah, gonorrhoea, man, it fuckin’ hurt him. It’s like, ‘Aw, dude, man’. I found a doctor’s office that was open and they gave him the pills ... He was 16! He was 16 when he caught both of those diseases, man. Like the dude was in pain, man! ... He was like, ‘Yeah, I have something ...’. And I told him, yo, man, I just got rid of chlamydia myself. There’s pills for it, man’.

Here, Cody disregards the discursive conventions of guy talk and reveals his chlamydia diagnosis in order to empathise with his young cousin. This discourse also positions Cody as a fixer – a man who is strong and wise enough to take charge and handle the problem. Emphasising his capacity to man up in a crisis, Cody also told us that his best friend had recently come out as homosexual. He explained that he was able to support his friend through this process because he knew how to behave in difficult situations (pointing out that he had been hardened up by his difficult previous life experiences). Cody described himself as someone that others could rely on in difficult moments, especially in those circumstances requiring ‘straight up’ actions:

Just, everybody just thinks I’m cool, man. I’m a good guy to hang out with, like. I’m straight up, there’s no fuckin’ lying or anything. I’m straight, man, and you know? If I don’t like someone in the fuckin’ crowd, I’ll fuckin’ tell ‘em straight, ‘Yo man, you know, you’re being an asshole, man, you know? Like, fuck, no one likes you’ ... Plus I stick up for my friends ... I’ve seen some fucked up things, man. Especially for my age, too, man. I can’t believe all the shit, but hey man, out of the fast style, the lifestyles. I’ve done a lot of things in my life and probably will do more.

Cody’s discourse demonstrates a complex packaging of dominant masculinity to distil particular virtues in what it means to be a real man. He takes pride in being a man strong enough to transcend heterosexist stereotypes (embracing his friend as a homosexual man). Cody also takes risks both in and around adopting behaviour associated with feminised traits (by caring about others and accepting and defending gay men); but, rather than having his masculinity questioned, he deploys a discourse that ultimately bolsters his ubiquitous hyper-masculinity. Whereas for ‘weaker’ men, these situations would present dangerous and emasculating risks, for Cody these performances are catalysed to elevate his masculine status.

Discussion

Dominant masculine discourses produce and govern the ways in which knowledge about sexual health can (and cannot) be discussed (Foucault 1978). By exploring men’s discourses about sexual health we can better understand how their discussions of sexual health are discursively constituted, constructed and changed (Hammersley 2003). For the men in this study, discussions about sexual health revolved primarily around their sexual encounters. Previous work suggests that the ways in which men talk about sexual health draws on and (re)produces idealised masculine expectations (what it means to be a ‘real’ man). As Flood (2008) explains, men’s homosocial discussions about sex are often the medium in which male bonding is enacted and internal pecking orders of the masculine hierarchy are (re)enforced.
Most men in this study employed what Korobov (2005, 2008) terms ‘ironic teasing humour’, which is used to neither cancel out an expression of concern for other men, nor explicitly disavow concern about a male friend’s sexual health. As Korobov explains, this equivocation makes it difficult to determine if men are complying with or resisting dominant masculine discourses; however, based on the current findings, it is clear that men can both comply with and resist these discourses, depending on their social contexts (in a research interview versus among male peers). Nonetheless, the focus on men’s sexual exploits through the use of humour reproduces group solidarity among men, thereby reconstituting a shared purchase on patriarchal power in which women and other men are often dominated and marginalised (through the use of discourse).

The process of manning up stems – in part – from within the realm of a liberal notion of accountability of individuals to the state, in which the emphasis on regulation and maintenance of control (for example, through the use of epidemiological surveillance) is realised by-and-large through voluntary – rather than forced or coercive – means (for example, men agreeing to conduct sex partner notification, even though the situation is potentially shameful) (Lupton 1999, Rosenfeld and Faircloth 2006). As men alter their masculine identities through the process of manning up, they concurrently (re)align their practices with that of a responsible citizen – that is, one who is ill or at risk and therefore requires a different set of (masculine) generative dispositions related to state-driven accountability. Similar to those of Watson (2000) and Robertson (2007), our findings reveal how masculinities can be reconstituted as masculine virtues in response to the demands of good health citizenship in individual social contexts.

‘Manning up’ also represents a discourse that men use to break the silence and move beyond prescribed ‘guy talk’ in order to engage in action-oriented discussions to: (i) deploy power over others with disregard for the potential repercussions; and (ii) deploy power to others in ways that reify features of their hyper-masculine identity while concomitantly assisting those occupying subordinate masculinities. Manning up by deploying power over others emphasises the masculine power of the speaker/performer (being tough enough to say anything) and their embodiment of idealised masculinity. For example, the use of manning up serves to position some men as being strong enough not to need to worry or care about the repercussions of partner notification – a form of damage control to preserving masculinity (O’Brien et al. 2005). Manning up is also enacted by using one’s personal power (power derived from one’s hyper-masculine status) to help others. While deploying power may permit some men to disrupt some aspects of hegemonic masculinity (by permitting them to care for others), its use is not intended to disrupt the hegemony completely. Rather, this form of manning up has a symbiotic relationship with idealised features of the dominant male (such as the fixer). Both of these manning up techniques rely on men’s ability to use masculine discourses that position themselves at the top of masculine hierarchies, which suggests that those who do not (or cannot) man up are, in fact, subordinate (and, therefore, unable to attain the status of real men). By reconfiguring and reproducing notions of hegemonic masculinity, manning up remains an option viable only for some men (those who have attained a relative idealised masculine status).

What men cannot say about their sexual health also operates as a mechanism of power relations (Foucault 1978): in breaking these ‘rules’ (by talking about STI/HIV testing or condom negotiation) men might be teased or mocked and have their masculinity questioned. As a result, for many of the participants, discussions about sexual health are neither possible nor desirable. Moreover, the practice of relying on female sex partners to take care of sexual health decision-making highlights how some men consider taking care of
sexual health as feminine terrain. While there was some evidence of frustration with the silences imposed by the limits of guy talk, men described only a few conditions (by using humour and manning up) under which silence can be broken while protecting or bolstering their masculine status.

The current study has several strengths and limitations. Describing the contextual and social conditions that affect men’s discussions about sexual health must also account for diversity within the broad social category: ‘men’ (Numer and Gahagan 2009). Masculine hierarchies represent complex social milieus that are not separate from other social identities (socioeconomic status or racialised bodies) (Connell 1995). While the current analysis offers some insights into these social and cultural forces we were unable to fully address other important issues. There are several limitations to the study design, including its vulnerability to sampling and selection biases, as well as the relatively small sample size. While the findings are not claimed to be generalisable to all men’s discussions about sexual health, we identified several ways in which men employ various discourses to resist, accommodate or transform masculine discourses as they engage in discussions (or remain silent about) sexual health.

While these findings provide support for theories suggesting that men’s health is at risk if they align themselves with or interact with hegemonic masculinity, they also reveal instances in which hegemonic masculine discourses produce opportunities for more socially just outcomes (for example, manning up, in which power is exerted in order to help others). These social interactions represent instances in which hegemonic masculinity is disrupted, then reinstated through performances to preserve or restore another, more valued, enactment of masculinity (O’Brien et al. 2005). Indeed, hegemony, as argued by Howson (2006), is unlikely to be de-gendered, but may represent a potential for overcoming, redistributing (and reinstating) a more socially just hegemony. As Howson argues, by focusing on the negativity of hegemonic masculinity, instead of the potential for ‘progressive equivalential unity’ in gender relations, theorists will ‘ensure that the politics of gender continues to operate conceptually around the mutual exclusivity of hegemony and social justice’ (2006: 6–7). By examining situations in which men (and their families, peers and service providers) can socially reconfigure notions of hegemonic masculinity related to their sexual health, theorists will also better understand the ways in which more socially just systems of hegemony can be produced (Howson 2006).

These findings highlight situations in which more socially just forms of masculinity are discursively manifested (through manning up); however, they do not fully explicate the mechanisms through which social practices and relations derived from hegemonic masculinity interact with interventions in ways that might enhance or detract from men’s (and women’s) sexual health. For example, interventions that seek to reconfigure dominant masculine discourses (such as advertising campaigns suggesting young men should man up and take care of one’s self and others) may inadvertently reproduce narrow gender role definitions (stereotypes about men as being sexually irresponsible) or contribute to the (re)production of masculine patriarchal hegemony (Larkin et al. 2006). As a result, interventions must take a careful, nuanced approach that focuses on better understanding the intended as well as the unintended consequences related to young men’s sexual health interventions that attempt to produce more socially just masculinities. Through analysing how masculine hierarchies influence men’s ability either to construct or to contest dominant discourses, theorists and interventionists can work together to inform and contribute to pathways toward more equitable gender relations.
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Notes

1 While women aged 15 to 24 experience higher rates of STIs, such as genital chlamydia, these disparities have largely been attributed to asymptomatic cases in heterosexual men who have not been tested and therefore not treated, or who are treated for their symptoms but not tested (and therefore remain unreported in the surveillance data) (British Columbia Centre for Disease Control 2010).

2 The term ‘racialised’ is used as a preferred option to the term ‘visible minority’, which is a term used by Statistics Canada to define persons, other than Aboriginal peoples, who are ‘non-Caucasian in race or non-white in colour’ (Statistics Canada 2008).

References

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