Health risks and mediated discourse: a case study of 'AIDS in action'

Health Risks and Mediated Discourse:

A case study of 'AIDS in Action'

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INTRODUCTION

Despite years of health promotion campaigns, the wide availability of condoms, and high levels of knowledge about how to prevent transmission, HIV continues to spread. At the end of 2010, 34 million people were living with HIV worldwide (UNAIDS 2011). Sadly, the group in which the virus is spreading most quickly is the one in which it was first detected in 1982, and the one with arguably the most knowledge about preventing transmission, men who have sex with men (MSM). In the United States, between the years 2005 and 2008 the number of new diagnoses among MSM increased by 17% (CDC 2010), and in Europe the rate of transmission for MSM more than doubled in the same time period (van Griensvena et al. 2009). The same upward trend has been documented in Asia, Australasia, South America and Africa (Roehr 2010). After two decades of efforts to 'de-gay' the epidemic, circumstances have made it necessary to 're-gay' prevention efforts (Kitzinger and Peel 2005).

Many reasons have been suggested for this resurgence of HIV transmission among MSM– a growing complacency that has come as a result of new anti-retroviral treatments, the fact that this generation of gay men have not gone through the trauma of seeing their friends fall sick and die, the popularity of drugs like ecstasy in some MSM communities, and, of course, the internet, which makes meeting partners for casual sex easier than ever before. None of these explanations, however, can account for the countless episodes of unsafe sex by men who are not complacent or unaware or high on drugs, who did not meet their partners on the internet and do not display other 'risk factors', men for whom unsafe sex was more of a matter of 'one thing leading to another', like the man who told the following story at a forum on HIV in San Francisco:

> So it was a weird thing, we're using a condom but we're talking about 'yeah, I'm going to come inside you and I'm gonna fuck you without a condom', that sort of thing. And it was just really hot and very compelling and then we pull off the condom, and we're actually doing it…
>
> And you know I'm not high, I'm on no drugs. I am who I am. I know what's going on, and it's really hot, it's really compelling. He comes inside me, it's

> really brief, and it's all hitting me like 'How could I do this, what did I just do, oh my god. I just broke this intense barrier. I went on the other side'. (Cotten 1999)

This chapter is about how 'one thing leads to another' when it comes to taking risks with our health. It introduces how concepts from *mediated discourse analysis* (Norris and Jones 2005; Scollon 2001a) can help us to understand how people negotiate risky activities moment-by-moment in their everyday lives. The context in which I will be exploring this issue is unsafe sex, but the principles I will be introducing are applicable to a wide range of risk behaviors from drug abuse to participation in extreme sports (see for example Jones 2005, 2011).

The perspective on risk that I'll be taking is based on the proposition that risk is a matter of the concrete social actions that people take. At first this may seem like a rather obvious statement, but, as I will explain, the connection between risk and what people actually *do* on the level of concrete, situated actions is surprisingly under-represented in research about risk and health.

OUT OF THE SHADOW OF FRAMINGHAM

The Framingham Heart Study, initiated in 1948, represented a milestone in the way people understood the concept of risk. The study demonstrated a statistical relationship between cardiovascular disease and a range of 'risk factors' including age, obesity, smoking, and hypertension (Dawber 1980). Today much of the clinical focus in cardiology and many other medical specialties is not so much on treating diseases or conditions but on treating 'factors' (like high cholesterol) that put patients at risk for developing diseases or conditions, and mainstream preventative medicine has also come to focus on helping people to mitigate or eliminate 'risk factors'. For this we have Framingham to thank.

It was, in fact, in the Framingham Heart Study that the term 'risk factor' was coined (Kannel et al. 1964). Although the simple definition of a 'risk factor' is any variable that puts people at a higher risk for a contracting or developing a disease or condition, what actually constitutes a risk factor is quite complicated. Risk factors may involve behavior, physical characteristics, membership in a particular social or ethnic group, or external environmental factors over which people have little control (Rothstein 2003). The variety of different kinds of things associated with risk is what makes the concept of the risk factor both such a powerful tool for epidemiologists, and sometimes a difficult tool to put into practical use for clinicians and health promoters.

When it comes to behavioral risk factors like smoking and drug use, attention is increasingly being paid not just to the way behavior influences vulnerability to various diseases, but the way other factors may influence vulnerability to certain kinds of behavior. A great deal of effort, for example, has been expended to identify the variables that influence unsafe sexual behaviors of men who have sex with. Among the risk factors that have been associated with unprotected anal intercourse are: being alienated from the gay community (Herek and Glunt 1995), and being affiliated with the gay community (Flores et al. 2009); being in

a committed relationship (Elford 2001), and not being in a committed relationship (Rosenberg et al. 2011); feelings of invulnerability (Vieira De Souza et al. 1999), and a sense of the inevitability of becoming infected (Kalichman et al. 1997); meeting partners via the Internet (Benotsch et al. 2002), and lack of access to the Internet (McFarlane et al. 2005); being younger (Mansergh and Marks, 1998), and being older (Grossman 1995); being HIV positive (Halkitis and Parsons 2003), and being HIV negative (Shidlo et al. 2005).

The purpose of presenting this catalogue is not to undermine the value of such risk factors in predicating behavior among members of certain populations of gay men, but to illustrate the problems that arise when such findings are considered apart from their social contexts. in which actual unprotected anal intercourse occurs between actual people. As Berg and Grimes (2010) put it, while such factors have predictive power, they often lack the kind of 'useful explanatory power' that might come from more qualitative research which takes into account 'unique local factors associated with unsafe sex.'

Finally, focusing on risk factors to understand risk behavior tends to obscure the role of individual agency as it unfolds over the course of a particular event or series of events. Actors are seen as more or less at the mercy of their demographic characteristics, their environments, or their attitudes and beliefs. This erasure of the individual as agent becomes complete when the isolation of 'risk factors' is translated into the identification of 'risk groups' for whom 'one size fits all' interventions are designed.

At the other extreme are approaches that overemphasize the role of individual decision making in risk behavior, downplaying the importance of social and environmental factors. An example of this can be seen in a now famous article by systems analyst Ralph Keeney called 'Personal Decisions are the Leading Cause of Death' (2008) in which the author argues that the focus of public health be shifted from risk factors to the individual 'decisions' people take that lead to diseases For those aged from 15 to 64, Keeney writes, 'about 55% of all deaths can be attributable to personal decisions' (1345). 'The inescapable conclusion of these results', he claims, 'is that individuals have a great deal of control over their own mortality.'

Although Keeney presents his approach as a radical 'reframing', this view of the risk taker as a rational decision maker is actually at the heart of many of the most influential models of health promotion, including the 'health belief model' (Becker ed. 1974) and the 'theory of reasoned action' (Ajzen and Fishbein 1980, Fishbein et al. 1994). Of course, as both Keeney and others who subscribe to individualistic behavior change models are quick to point out, to say risk behavior is a matter of rational decision making is not to say that individuals always make rational decisions. Nevertheless, the whole notion of a decision implies a process of conscious deliberation and 'assumes that the individual recognizes that he or she has a choice and has control of this choice' (Keeney 2008: 1136). From this perspective, the best way to change behavior is to provide people with information with which they can make more 'informed' choices.

It is not hard to see the limitations of such models when faced with sexual risk behavior, not just because sex is often associated with emotion rather than reasoned decision making, but also because sex (a least the type which transmits HIV) never involves just one person, but is always a matter of 'joint decision making' or negotiation between two or more parties, which is invariably affected by a host of 'social' factors like communication and power. The most persuasive argument against such models, however, is their poor track record in predicting behavior change (Van Campenhoudt et al. 1997). Countless studies of HIV related risk have shown a wide discrepancy between knowledge and behavior (see for example O'Sullivan et al., 2006; Ratliff-Crain et al., 1999). Whatever the role played by deliberative decision-making in risk behavior, it is clear that more knowledge about HIV transmission and its dangers does not necessarily translate into safer sex. This is also true for a host of other high-risk behaviors like smoking and overeating.

This chapter aims to introduce a way of looking at risk behavior that avoids both the 'methodological individualism' of psychological models of behavior change and the environmental determinism implied by models based on 'risk factors' by focusing on the moment when psychological and environmental factors interact in the concrete observable *actions* that people take. When I speak of actions, I mean something rather different from 'behavior', which is often viewed as an abstract, essentialized phenomenon that can be considered independent of the context in which it occurs. 'Actions' – or, as I will be referring to them, *mediated actions* – are 'real-time, irreversible, one-time only' phenomena (Scollon 2001a: 5). Although it is the nature of mediated actions to produce and reproduce broader social practices (behaviors), social identities (such as group membership), and social structures, actions are best understood as taking place at particular *sites of engagement* in which particular social actors, social relationships, environmental conditions and physical circumstances come together.

From this perspective, the question is not so much 'what are the factors associated with risk behavior' as it is 'what is actually going on when somebody takes a risk'. It is a perspective that shifts our attention to the ways actions unfold under the influence of the various resources (social, psychological and material) that are available to social actors and the negotiative processes they engage in when deploying these resources.

This approach is not meant to replace either of those I discussed above, but instead to provide a way in which risk factors and mental processes can be understood in the *context* of the interaction between social actors in particular situations. Understanding the 'causes' of risk taking requires an understanding of risk as part of real-time social processes engaged in by 'real' people (Rhodes 1997, van Campenhoudt et al. 1997).

Such an approach is, of course, not without its own methodological difficulties, most central being the fact that is it hardly ever possible to observe first hand these real-time social processes, especially when it comes to things like unsafe sex. In my discussion below I rely for data on people's retrospective accounts of their sexual experiences taken from interviews and diary entries (Jones 2007,

Jones and Candlin 2003), a reliance which naturally raises a host of issues regarding objectivity, memory, and the effect of the social occasion itself on the content of accounts. Epidemiological studies of behavior, however, also rely on self-reported data gathered through questionnaires, which have an even greater potential to distort what actually occurred by forcing it into pre-determined behavioral categories. Qualitative accounts at least provide a window into the lived experiences of participants by allowing them to describe what happened in their own terms. While narrative accounts cannot be regarded as objective reflections of what actually occurred, they are reflections of how people *organize* their experiences retrospectively (Plumridge and Chetwynd, 1999), and understanding how people organize past actions can give us important insights into how they anticipate future ones.

RISK AND ACTION

The theoretical framework on which this approach to risk is based is *mediated discourse analysis* (Norris and Jones 2005; Scollon 2001a, 2001b), a method of discourse analysis that focuses not so much on texts and talk as on the social actions that texts and talk make possible. Mediated discourse analysis has its roots in socio-cultural psychology, especially the work of Soviet psychologist Lev Vygotsky (1981), who attempted to explain the relationship between intramental (psychological) processes and intermental (social) processes through the concept of *mediation*. All actions, according to Vygotsky, are *mediated* through the cultural tools made available in our sociocultural environments. These tools consist of two types: There are physical tools like screwdrivers,computers and, of course, in the context of 'safer sex', condoms. And there are what Vygotsky called 'psychological tools', which he defined as 'language and gestures, sign systems, reading and writing, mnemonic techniques, works of visual art, diagrams, maps and the like.' In the context of HIV prevention, we would want to include here the language and non-verbal codes that people use to negotiate the sexual act, 'sexual scripts' (Emmers-Sommer and Allen 2005, Laumann and Gagnon 1995), 'facts' about HIV transmission, slogans and directives from media and public health materials, and advice from people like friends, teachers, counselors, and parents.

All actions are social because they depend upon our access to and mastery of these shared resources. They are individual (psychological) insofar as individuals may adapt these resources to their own purposes. Actions, then, occur at the site of what Wertsch (1994: 205) calls the 'tension between the mediational means as provided in the sociocultural setting and the unique contextualized use of these means in carrying out particular concrete actions.'

From the perspective of mediated discourse analysis, there are three important things about cultural tools that affect the kinds of actions that people can take with them. The first is that all meditational means make some actions easier and other actions more difficult. In other words cultural tools have certain *affordances* and *constraints* associated with them. The second is that the appropriation of a mediational means always constitutes on some level the appropriation of one or more *social identities*. The third is that, even within the

affordances and constraints of the mediational means available to take action, there are always opportunities for social actors to exercise *creativity* in adapting the meditational means to fit their particular circumstances and goals.

The affordances and constraints of meditational means might be inherent to the meditational means themselves (a hammer is inherently more useful for driving in nails than a screwdriver), or they might be the result of social conventions of use that have adhered to meditational means as a result of their histories within particular communities. Consider, for example, the account below (Excerpt 1) from the research diary of a 26-year-old gay man from Hong Kong in which he describes his sexual relationship with his partner:

> **Excerpt 1**
>
> When we are seized with a sudden impulse to have sex, I request him not to use a condom in order to have more intimate contact and he agrees, When he inserts his cock into my ass our sex and love are more substantial. Compared with using a condom, you can feel that sex without a condom is more exciting. Exempted from the worry of AIDS, sex is more enjoyable and exciting. When the intercourse is finished…I start to worry whether there is any probability of getting AIDS. In fact, under such romantic conditions, you don't really think about AIDS. Instead you feel safe to have sex with him because you believe he is faithful to you. (Jones and Candlin 2003: 207)

This example illustrates a fact observed in countless studies of condom use in intimate relationships (see for example Elford et al. 2001) that while condoms amplify the prevention of HIV transmission when regarded from a strictly technological perspective, in the context of actual relationships they often take on multiple complex meanings. In the situation described above, condoms are seen to *constrain* actions which may be just as important to this writer as avoiding HIV infection, actions like maximizing pleasure, establishing intimacy and expressing love.

The second important thing about cultural tools is that their appropriation always involves claims and imputations of identity. As seen in the example above, not using a condom in the context of an intimate relationship has the effect of claiming for oneself and one's partner a particular relational status, and often the ratification of relational status is one of the primary *aims* of a sexual act. A participant interviewed for a study of AIDS prevention among gay men in China (Excerpt 2, Jones 2007) similarly resisted using condoms because he felt using them would result in claiming for himself and imputing on his partner 'spoiled identities' (Goffman 1963).

> **Excerpt 2**
>
> If I like my partner.. it feels strange to use this (a condom).. it gives the feeling that you don't trust me.. you think I'm dirty.. and if you reverse it..no.. you're not dirty.. I just want to protect you.. then I'm dirty.. this is the most important reason (Jones 2007: 107)

The appropriation (or non-appropriation) of particular cultural tools does not just have the effect of communicating relational identity, but can also serve to claim or impute wider social identities. In the following quote (Excerpt 3), for example, an informant from China uses his refusal to use condoms as a way to claim heterosexual identity:

> **Excerpt 3**
>
> I only go to the fishing pond occasionally.. I'm not 'full-time'.. I've also got a girlfriend, so I'm not the same as most comrades.. right?.. so I really hate to use condoms.. and I don't need to use them. (Jones 2007: 101)

The third important thing about cultural tools is that their affordances and constraints are not determinant of the actions that can be taken with them. When we appropriate cultural tools, we always adapt them to our own purposes or, to use Bahktin's (1981: 293) words, we 'populate' them with our 'own intentions', and so it is quite common for a tool which may have been intended for one purpose to end up being adapted to a different purpose altogether. This, unfortunately, seems to have occurred with the prohibitions on unprotected anal intercourse so prevalent in public health discourse, which, have ended up making this practice *more* rather than less attractive for many gay men. As the AIDS activist and educator Eric Rofes confessed:

> Sex has taken on new meanings for me derived specifically from AIDS prevention discourse. I have found that the idea of anal sex without a condom is a great turn-on for me, and have brought this fantasy into my sex life while refusing to engage in unprotected anal sex. To make the matter a bit more heretical, I have had sex with men who are uninfected, yet who enjoy the fantasy that I am HIV positive and about to have sex with them without a condom. (Rofes 1998: 302)

What such reflections, along with the growing popularity of intentional unprotected sex ('barebacking') among certain segments of the gay population reminds us is that the relationship between discourse and behavior is often complex and unpredictable, and that it is nearly impossible to 'read off' of a particular cultural tool the actions that people will take with it in particular social situations.

And so the first set of questions that mediated discourse analysts ask when it comes to risk behavior are: What is the relationship between the cultural tools available to people to avoid risk and the actions they are able to take? What is the relationship between these actions and the way people enact social identity in the context of particular relationships or particular communities? And, how do people adapt cultural tools to their own purposes?

SYNTAGMS, PARADIGMS AND THE 'FUNNEL OF COMMITMENT'

In many of the accounts of unsafe sex I have collected, however, participants are much less clear about their reasons for not using condoms. Rather than reflecting on the affordances and constraints of the tools available to them or on the claims and imputations of social identity associated with these tools, participants explained episodes of unsafe sex as simply as a matter of 'one thing leading to another'. Individuals may plan to refrain from unsafe sex or initiate sexual contact with the intention of using a condom only to be swept up in a chain of actions. In other words, what seemed to drive risk behavior was the sense of 'momentum' associated with the behavior itself. Scollon (2001b) calls this sense of 'momentum' 'the funnel of commitment'.

Sex, like all complex activities, is not a matter of discrete actions that can be considered separately, but is rather made up of *chains* of mediated actions, each following the other in predictable patterns based on all sorts of factors, including human biology, social convention, and the environment. Like language, these chains of mediated actions can be analyzed both syntagmatically and paradigmatically, both as a matter of 'one thing leading to another', and as a matter of behavioral *paradigms* or 'social practices' that over time have come to be conventionalized in particular social groups.

In analyzing accounts of unsafe sex syntagmatically, two things become apparent. First, people often arrange the actions in their accounts of unsafe sex in a ways that each action is portrayed as creating the conditions for or 'inviting' subsequent actions, and providing evidence as to how the previous actions have been interpreted by partners, not very different from the relationship of 'conditional relevance' that conversation analysts (Sacks 1966, Schegloff 1968) have pointed out between utterances in conversations. Second, in assigning agency for these sequential actions, people often alternate responsibility for the actions between themselves and the other person so that the responsibility for unsafe sex is shared.

Both of these tendencies can be seen in the example below (Excerpt 4, Jones and Candlin 2003) in which the author of a diary entry relates an episode of unprotected anal intercourse between himself an 'Mr. A', a new acquaintance. As illustrated by the way I have arranged the sentences of the story into different columns, the account consists of sequential actions arranged in pairs, much like a conversation, each action by one particular actor portrayed as arising from the previous action of his partner, and as validating the meanings assigned to previous actions. Furthermore, agency for actions alternates between the narrator and his partner, Mr A.

Excerpt 4

(insert excerpt 4 here)

Analyses of such an account from the behavior change school of health communication would likely focus on the 'commentary' given by the storyteller (arranged above in the far left column) and conclude that it was primarily the storyteller's thoughts and feelings (for example, 'I felt so high that I didn't care')

that drove this episode of unsafe sex. Mediated discourse analysis, while not discounting the role of thoughts and feelings, would focus more on the actions themselves and note the ways the storyteller makes himself accountable for these actions by arranging them in an orderly fashion, each action acting as a motivation for subsequent actions.

At the same time, the way people organize chains of actions is not just a matter of responding to previous actions. We also organize our actions with reference to socially recognized practices or 'scripts' (Emmers-Sommer and Allen 2005). Sexual encounters are more than just chains of actions: they are 'types' of activities, paradigms, and different sorts of paradigms allow certain elements to be introduced into them and don't allow other elements. The activity of 'making love' for example, as I noted above (see analysis of Excerpt 1), is a paradigm which resists the introduction of the element of a condom, whereas a casual sexual encounter in a bathhouse might more readily allow for such an element.

What Scollon (2001b) means by the 'funnel of commitment' is that the chains of action we engage in *themselves* play a role in our ability to resist or interrupt them. He gives the example of buying a cup of coffee, noting that the further along we progress in this chain of actions: entering the coffee shop, choosing a product, placing our order, paying, and accepting the coffee from the server, the harder it becomes to change or reverse this chain of actions. This is because of the dual force of the syntagmatic and the paradigmatic dimensions of the activity, the syntagmatic dimension driving the activity forward through the power of one action to constrain the kinds of actions that can follow it, and the paradigmatic dimension driving the activity forward by virtue of the expectations participants share about how this activity should be carried out. The same reasoning can be applied to a sexual encounter in which discrete actions 'open up slots' (Schegloff 1968) for subsequent actions and broader scripts about things like sex, love, and desire seem to push people into particular roles and particular actions.

From this perspective, rather than asking why a particular individual did or did not use a condom in a particular sexual encounter we might more productively ask: At what points in this encounter did using a condom become either more or less possible, and how was this affected by partners' shared expectations about how 'one thing follows another' in certain kinds of sexual encounters and certain kinds of relationships. The value of this way of thinking is that it gives researchers, counselors and those who engage in risk behavior themselves a way to analyze what happened that avoids the fatalism implied in narratives of lost control ('I just couldn't help myself') and the self-blame implied in narratives of personal responsibility ('I should have known better'). It is a way of thinking that also has great practical value in helping people plan how future chains of actions can be altered and future expectations can be negotiated between partners in ways that unsafe sex can be avoided.

ACTIONS, PRACTICES, AND 'RISK GROUPS'

It is not enough, of course, from the point of view of public health, to confine our analysis to individual episodes of risk without asking how the chains of actions leading up to risky behavior come to constitute recognized social practices within certain communities. What are the mechanisms by which practices like 'safe sex' or 'barebacking' come to be regarded as 'community practices' (Watney 1990) in ways that they affect the paradigmatic dimension of people's actual sexual encounters?

The problem with traditional ways of regarding risk groups from an epidemiological perspective is that people are defined in terms of traits (such as age, ethnicity and sexual orientation) rather than by the actions that they take together. In such approaches, even 'behaviors' are treated as traits rather than as phenomena. Mediated discourse analysts, on the other hand, define communities based on what people actually *do* together. Communities are communities *of practice* (Lave and Wenger 1991), or, as Scollon (2001a) calls them, *nexus of practice*.

Of course just because people engage in the same social actions does not make them into a community; all of the gay men who engage in unsafe sex do not constitute a community in the same way 'barebackers' might. What separates groups of people who happen to engage in similar actions using similar cultural tools (what Wertsch (1998) calls 'implicit communities') from 'communities of practice' in which shared expectations about actions come to be regarded as emblems of group membership is what mediated discourse analysts call the 'technologization of practice' (Scollon 2001a, Jones 2002. The technologization of practice is the mechanism by which social actions themselves come to be regarded as cultural tools, which can be lifted out of their social contexts and appropriated into new contexts.

Like the mechanisms that drive social actions described above, the mechanisms that drive the technologization of social practices have both 'bottom-up' and 'top down' dimensions. On the one hand it is a matter of active processes of 'imagining' (Anderson, 1991) by members of particular groups accomplished through the circulation of texts and other semiotic tools. In the early days of the HIV epidemic among gay men, for example, texts like Michael Callen's 1983 pamphlet 'How to Have Sex in an Epidemic' helped gay men to see condom use in ways that affirmed rather than threatened the sex-positive values of the community. Similarly, websites, parties, and pornographic videos extolling the joys of 'barebacking' help men who engage in this practice to regard it as something more than just an individual proclivity. Sometimes the technologization of social practices can serve strategic purposes for communities, serving to distinguish them from other communities or to make them seem more 'normal'. In my analysis of unsafe sexual practices among Chinese MSM (Jones 2007), for example, I argued that one reason condom use had not been successfully technologized as a community practice is because it makes it harder for gay communities to portray themselves as conforming to traditional Chinese norms of sexual morality.

The circulation of texts and other semiotic tools, however, is not enough to drive the technologization of practice. If this were so, then the 'top down' approaches

of most health promotion would be much more successful than they actually are. The technologization of practices also takes place through the moment by moment claims and imputations of identity that occur in the kinds of situated sexual encounters I described above. In this regard, social practices come to be technologized in a kind of cyclical process by which sequences of actions are submerged into the habitus of individual members and then passed on to new members in subsequent encounters. Scollon (2001a), for example, shows how the social practice of 'handing' arises in the habitus of a child through the gradual accumulation of actions taken with family members over the course of several months, and my own analysis of gay men's narratives of early sexual encounters (Jones 2008) shows how habits of unsafe sex develop in individuals through the moment by moment negotiation of sexual encounters with other community members over time. In that study I relate the following story told by a gay man in Hong Kong:

> When I was studying at F3 or 4[1] I read a magazine article which mentioned about a homosexual got arrested because of his indecent behavior in the public toilet in Jordan. The article also reported on all the public toilets in Hong Kong which were very popular among gay people. After reading the article I could hardly wait and decided to go to the toilet in Shamshuipo on Saturday in the same week.
>
> I arrived there at 6pm, it took me quite a while to get there because I was unfamiliar with that area. I felt scared and excited. Scared because there might be bad guys, triad people, cops and I was only a 14-15 young man, you couldn't tell what others might think. Excited because of the unknown situation: I could meet a late teenager or someone at his early 20s, someone athletic with a sexy body.
>
> When I got there. I saw some men at the cubicles, some were at the urinal. I walked to the washing basin and started washing my hands and looked at the mirror as what the article described about how gay men cruise in the toilet.
>
> I saw a man in his 20s, he looked at me in the mirror and signaled us to leave together. I followed him. I was very nervous and also because it was my first time, I didn't really choose. When we were outside, this gay started to me questions about my name, age and my work... I said to myself that he really had lots to say.
>
> We walked into a small park where there was a toilet. He went in first to check if there were other people around. He then took us in a cubicle and started to undress me and kissed me. He even used his mouth... I was very excited then that I ejaculated in his mouth.
>
> Before we parted, he talked to me sincerely for a while: 'The gay circle is very complicated that you need to be careful. Police may come in at any time; play safe and use a condom, don't get an STD...' He gave me his telephone number then left.

> On my way home, I was still recalling what had just happened. I asked myself if he would get AIDS because he had sucked my dick. But I didn't think he would.
>
> I kept wishing that I would have more similar experiences in the future. I want the thrill, the excitement. Since then, whenever I have time, I would look and cruise around. (Jones 2008: 251-2)

In this account we have both of the dimensions I mentioned working to technologize the practice of 'cruising around'. On the one hand it is technologized through the circulation of texts like newspaper articles and advice from older gay men to younger gay men. On the other hand, it is constituted through the moment-by-moment negotiation of discrete social actions such as gazing, signaling, following and making certain uses of public spaces like toilet cubicles.

What is important to note in this example is that these two dimensions of the technologization of social practice are not always complementary: sometimes they exist in contradictory relationships. In this example, the way the older man characterizes sexual practices in his advice ('play safe'), for instance, contradicts the arguably unsafe practices the two partners have just engaged in.

The challenge of mediated discourse orientated approaches to health communication is to come to a clearer understanding of how risk behaviors develop both for individual and for the communities of which they are a part through attention to *both* broader processes of community practices, and to the discursive negotiation of actions and identities in *situated* social encounters.

APPLICATIONS AND CONCLUSION

In this chapter I have outlined how the principles of mediated discourse analysis can be applied to the analysis of risky behavior in ways that take us beyond the methodological individualism and environmental determinism of more traditional approaches. Simply giving people more information or belittling their risk behavior as 'irrational' is not very useful in helping them to change their behavior. An approach informed by mediated discourse analysis does not begin with the assumption that people's 'risky' behaviors are necessarily a result of 'deficiencies' in knowledge. Rather, it considers how behaviors arise from the ways individuals in actual interaction negotiate what they are *doing* using the discursive resources available to them, and also how these behaviors often have their own 'local logic', sometimes functioning as strategies for individuals or groups to accomplish important social goals.

The most important aspect of this approach, however, is its potential to inform interventions in which risk-takers can be made more aware of the moment-by moment-unfolding of their risk behavior through producing narratives, role plays, videos and other artifacts of their experiences (see for example Jones 1997; Jones et al. 1998). The outcomes of such reflective accounts of risk can be an understanding of how certain tools might either constrain or amplify the avoidance of risk or how small alterations in behavior near the beginning of a

'funnel of commitment' can make a difference between risk and safety. Such reflective approaches to health behavior have already shown themselves effective in areas like drug abuse, exercise, diet and diabetes management (Frost and Smith 2003 Goetz 2010, Jones et al. 1998)

The principles laid out in this chapter argue for health promotion strategies that operate at the intersection between actions and the meanings through which these actions are apprehended and experienced, understanding the phenomenology of sexual experience rather than merely classifying actions to be condoned or prohibited. As Race (2003: 370) puts it, health promoters must 'attune themselves to the protective agency of individuals, the contexts in which embodied practice is worked out, and the concerns and systems of value that mediate practice'.

REFERENCES

Ajzen, I., and Fishbein, M. (1980) *Understanding Attitudes and Predicting Social Behavior*, New Jersey: Prentice-Hall.

Anderson, B. (1991) *Imagined Communities*, London: Verso.

Bakhtin, M. M. (1981) *The Dialogic imagination: Four Essays* (C. Emerson & M. Holquist, Trans.), Austin: University of Texas Press.

Becker M.H. (ed) (1974) 'The health belief model and personal health behavior', *Health Education Monographs 2*: 324-508.

Benotsch, E.G., Kalichman, S. and Cage, M. (2002) 'Men who have met sex partners via the Internet: Prevalence, predictors, and implications for HIV prevention', *Archives of Sexual Behavior 31* (2): 177-83.

Berg, R.C. and Grimes, R. (2010) 'Do traditional risk factors predict whether men who have sex with men engage in unprotected anal intercourse? The need for locally based research to guide interventions', *Health 15* (5): 517-531.

Callen, M. (1983) *How to Have Sex in an Epidemic*, New York: News From The Front Publications.

CDC (2010) 'HIV among gay, bisexual and other men who have sex with men (MSM)', Atlanta: Center for Disease Control and Prevention.

Cotten, P., Lustre, N., Schimel, S., Thomas, R., & Wagner, K. (1999, May 8) 'Speaking out about sex in silent spaces', Paper presented at the The Rubberless Fuck, UC Berkeley.

Dawber, T. (1980) *The Framingham Study: The Epidemiology of Atherosclerotic Disease*, Cambridge, Mass.: Harvard University Press.

Elford, J., Bolding, G., Maguire, M., & Sherr, L. (2001) 'Gay men, risk and relationships', *AIDS, 15*: 1053–1055.

Emmers-Sommer, T.M. and Allen, M. (2005) *Safer Sex in Personal Relationships: The Role of Sexual Scripts in HIV Infection and Prevention*. Mahwah, NJ: Lawrence Erlbaum.

Fishbein, M., Middlestadt, S.E., and Hitchcock, P.J. (1994) 'Using information to change sexually transmitted disease related behaviors', In R.J. DiClemente and J.L. Peterson (eds) *Preventing AIDS: Theories and Methods of Behavioral Interventions* (pp. 61-78). New York: Plenum Press.

Flores, S.A., Mansergh, G., Marks, G., Guzman, R. and Colfa, G. (2009) 'Gay identity-related factors and sexual risk among men who have sex with men in San Francisco', *AIDS Education and Prevention*, 21(2), 91–103.

Frost, J. H., & Smith, B. K. (2003) 'Visualizing health: Imagery in diabetes education' Paper presented at the Designing For User Experiences Conference, June 5-7, San Francisco.

Goetz, T. (2010) *The Decision Tree: Taking Control of your Health in a New Era of Personalized Medicine*, New York: Rodale.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*, London: Penguin.

Grossman, A.H. (1995) 'At risk, infected, and invisible: Older gay men and HIV/AIDS', *Journal of the Association of Nurses in AIDS Care*, 6 (6): 13-19.

Halkitis, P.N. and Parsons, J.T. (2003) 'Intentional unsafe sex (barebacking) among HIV-positive gay men who seek sexual partners on the Internet', *AIDS Care,* 15 (3): 367-78.

Herek, G. M., and Glunt, E. K. (1995) 'Identity and community among gay and bisexual men in the AIDS era: Preliminary findings from the Sacramento Men's Health Study', In G.M. Herek and B. Greene (eds) *Aids, Identity, and Community* Vol. 2 (pp. 55-84), Thousand Oaks, CA: Sage.

Jones, R.H. (1997) 'College students responses to AIDS education: a sociolingusitc approach', In Ho, B. (ed) *Buliding New Hope Together: Proceedings of the Hong Kong AIDS Conference 1996* (pp. 107-119), Hong Kong: HK Advisory Council on AIDS.

Jones, R.H. (2002) 'Mediated action and sexual risk: Discourses of sexuality and AIDS in the People's Republic of China', Unpublished PhD. Dissertation. Macquarie University, Sydney, Australia.

Jones, R.H. (2005) 'Mediated addiction: The drug discourses of Hong Kong youth', *Health, Risk and Society*, 7 (1): 25-45.

Jones, R.H. (2007) 'Imagined comrades and imaginary protections: Identity, community and sexual risk among men who have sex with men in China', *Journal of Homosexuality*, 53 (3): 83-115.

Jones, R.H. (2008) 'Good sex and bad karma: Discourse and the historical body'. In V.K. Bhatia, J. Flowerdew and R. Jones (eds) *Advances in Discourse Studies* (pp. 245-57), London: Routledge.

Jones, R.H. (2011) Discourse, technology and bodies without organs. In C. Thurlow and K. Mroczek (eds) *Language in the New Media* (pp. 321-39), Oxford: Oxford University Press.

Jones, R.H. and Candlin, C.N. (2003) 'Constructing risk across timescales and trajectories: gay men's stories of sexual encounters', *Health, Risk and Society,* 5 (2): 199-213.

Jones, R., Lin, A. and Tsang, W. (1998) 'Empowering at-risk teens in drug education', A paper presented at the 'Working Together for Better Health' International Conference on Health Promotion (sponsored by WHO), Cardiff, September 23-25.

Kalichman, S. C., Kelly, J. A., Morgan, M., & Rompa, D. (1997) 'Fatalism, current life satisfaction, and risk for HIV infection among gay and bisexual men', *Journal of Consulting and Clinical Psychology,* 65: 542–546.

Kannel, W.B., Dawber, T.R., Friedman, G.D., Glennon, W.E. and McNamara, P.M. (1964) 'Risk factors in coronary heart disease: An evaluation of several serum lipids as predictors of coronary heart disease; the Framingham study', *Annals of Internal Medicine,* 61: 888–899.

Keeney, R.L. (2008) 'Personal decisions are the leading cause of death', *Operations Research,* 56 (6) 1225-1347.

Kitzinger, C. and Peel, E. (2005) 'The de-gaying and re-gaying of AIDS: contested homophobias in lesbian and gay awareness training', *Discourse and Society,* 16 (2): 173-197.

Lave, J. and W, E. (1991) *Situated Learning: Legitimate Peripheral Participation*, Cambridge: Cambridge University Press.

Laumann, E. and Gagnon, J. H. (1995) 'A sociological perspective on sexual action', In R. Parker and J. Gagnon (eds), *Conceiving Sexuality: Approaches to Sex Research in a Post-Modern World*. New York: Routedge.

Mansergh G, and Marks G. (1998) 'Age and risk of HIV infection in men who have sex with men', *AIDS,* 12: 1119–1128.

McFarlane, M, Kachur, R., Klausner, J.D., Roland, E. and Cohn, M. (2005) 'Internet-based health promotion and disease control in the 8 cities: Successes, barriers and future plans', *Sexually Transmitted Diseases*, 32 (10):S60–S64.

Norris, S. and Jones, R. (eds) (2005) *Discourse in Action: Introducing Mediated Discourse Analysis*, London: Routledge.

O'Sullivan L. F., Udell W., Patel V. L. (2006) 'Young urban adults' heterosexual risk encounters and perceived risk and safety: A structured diary study', *Journal of Sex Research*, 43 (4): 343-351.

Plumridge E. and Chetwynd, J. (1999) 'Identity and the social construction of risk: injecting drug use', *Sociology of Health and Illness,* 21:329–343.

Race, K.D. (2003) 'Revaluation of risk among gay men', *AIDS Education and Prevention,* 15 (4): 369-381.

Ratliff-Crain, J., Donald, K.M., Dalton, J. (1999) 'Knowledge, beliefs, peer norms, and past behaviors as correlates of risky sexual behaviors among college students', *Psychology and Health,* 14 (4): 625-641.

Roehr, B. (2010, February 25) 'Closeted calamity: the hidden HIV epidemic of men who have sex with men', *Scientific American*, February 25. Retrieved January 16, 2012 from http://www.scientificamerican.com/article.cfm?id=closeted-calamity-the-hidden-hiv-epidemic.

Rhodes, T. (1997) 'Risk theory in epidemic times: sex, drugs and the social organization of "risk behavior"', *Sociology of Health and Illness,* 19 (2): 208-27.

Rofes, E. (1998) *Dry Bones Breathe: Gay Men Creating Post-AIDS Identities and Culture*, New York: The Haworth Press.

Rosenberg, E.S., Sullivan, P.S., DiNenno, E.A., Salazar, L.F. and Sanchez, T.H. (2011) 'Number of casual male sexual partners and associated factors among men who have sex with men: Results from the National HIV Behavioral Surveillance system', *BMC Public Health,* 11 189-98.

Rothstein, W.G. (2003) *Public Health and the Risk Factor: A History of an Uneven Medical Revolution*, Rochester, NY: Rochester University Press.

Sacks, H. (1966) 'The search for help: No one to turn to', Unpublished doctoral dissertation, University of California, Berkeley

Schegloff, E. (1968) 'Sequencing in conversational openings', *American Anthropologist,* 70: 1075-1095.

Scollon, R. (2001a) *Mediated Discourse: The Nexus of Practice*, London: Routledge.

Scollon, Ron (2001b) 'Action and text: Toward an integrated understanding of

the place of text in social (inter)action', In R. Wodak and M. Meyer (eds) *Methods in Critical Discourse Analysis* (pp. 139-83), London: Sage.

Shidlo, A., Yi, H. and Dalit, B. (2005) 'Attitudes towards unprotected anal intercourse: Assessing HIV-negative gay or bisexual men', *Journal of Gay and Lesbian Psychotherapy.* 9 (3-4): 107-128.

UNAIDS (2011) *Global HIV/AIDS Response: Progress Report*. Geneva: UNAIDS.

van Campenhoudt, L. Cohen, M., Guizzardi, G. and Hausser, D. (eds) (1997) *Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research,* London: Taylor and Francis.

van Griensvena, F., de Lind van Wijngaardenc, J. W., Barald, S. and Gruliche, A. (2009) 'The global epidemic of HIV infection among men who have sex with men', *Current Opinion in HIV and AIDS,* 4: 300-307.

Vieira De Souza, C.T., Bastos, F.I., Lowndes, C.M., Landman Szwarcwald, C., Moreira Dos Santos, E., Ayres De Castilhl, E., and Stumoller, F. (1999) 'Perception of vulnerability to HIV infection in a cohort of homosexual/bisexual men in Rio de Janeiro, Brazil', *AIDS,* 11 (5): 567-79.

Vygotsky, L.S. (1981) 'The instrumental method in psychology', In J.V. Wertsch (ed) *The Concept of Activity in Soviet Psychology* (pp. 134-143), Armonk, NY: M.E. Sharpe.

Watney, S. (1990) 'Safer sex as community practice', In P. Aggleton, P. Davis and G. Hart (eds.) *AIDS: Individual, Cultural and Policy Dimensions* (pp. 19-33), London: The Falmer Press.

Wertsch, J.V. (1994) 'The primacy of mediated action in sociocultural studies', *Mind, Culture and Activity,* 1 (4): 202-208.

Wertsch, J.V. (1998) 'Vygotsky and Bakhtin on community', Unpublished manuscript, St. Louis, MO: Washington University.

Further Readings

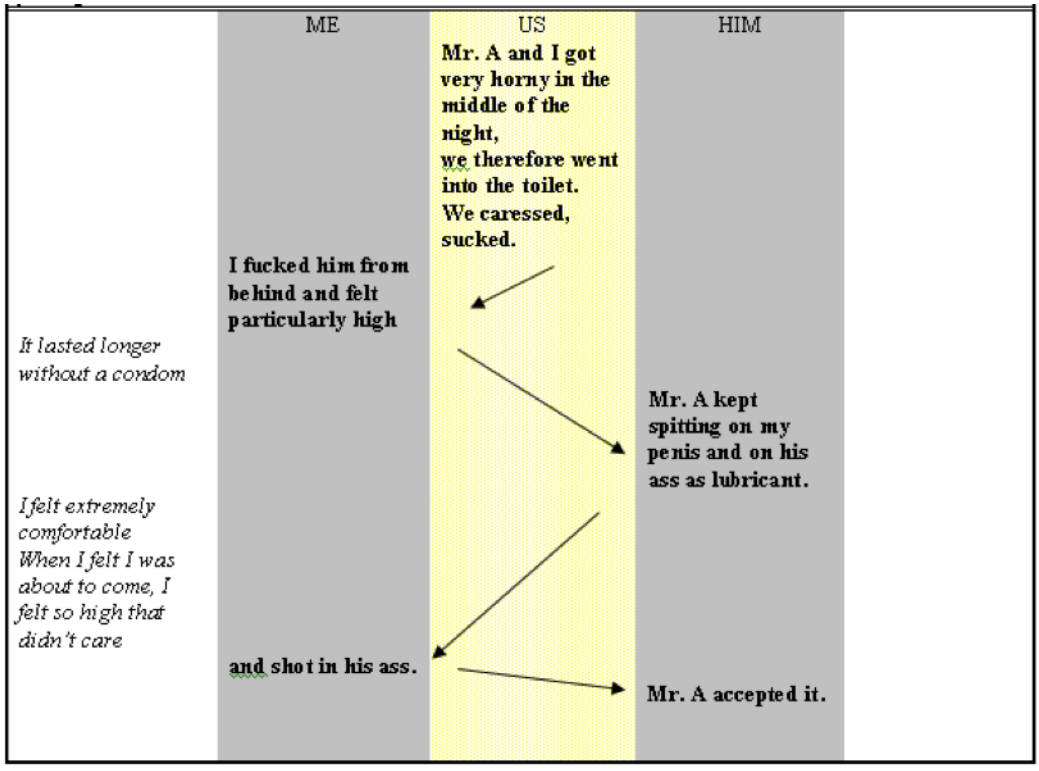
Jones, R. H. (2013) *Health and Risk Communication: An Applied Linguistics Approach*. London: Routledge.

Norris, S. and Jones, R.H. (eds) *Discourse in Action: Introducing Mediated Discourse Analysis*. London: Routledge.

Related Topics

Health Promotion, HIV/AIDS, Mediated Discourse Analysis, Risk,

Excerpt 4



From Jones and Candlin (2003:206)

[1] F3 and F4 refer to Form 3 and Form 4, level of secondary education in Hong Kong which students normally engage in at ages 14 and 15 respectively.