Sexual and Relationship Therapy, Vol. 16, No. 1, 2001

'Some people live out their own snuff movie': knowledge, 'safer' sex and managing desire in the city

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ABSTRACT *In the complex interweaving of sexual identities, social roles, erotic practices and fantasies, there are a number of competing discourses that surround different 'truths' of sex. Following Foucault's History of Sexuality this paper explores two of these truths, scientific knowledge of sex (Scientia sexualis) and desire grounded in the personal experience (Ars erotica). These are linked with the notion of the self-monitoring individual actor who is both an agent of his own desire, but also has been recruited into a health surveillance role of 'active patient'. Drawing on analyses from a recent study on male sexualities and genitourinary clinics, it is argued that many contemporary sexual identities are constructed through urban discourses and notions of metropolitan sexualities and forms of consumption. The city is a Leitmotif for freedom and diversity, while also the arena for management of sexual careers and identities. However, it continues to draw on metaphors of purity, contamination and danger that have characterized urban imagination.*

Introduction

This paper concerns forms of knowledge contingent to the management of male sexual desires and practice. On the one hand, these forms of knowledge relate to real-world desires, sexual careers that involve decision making and the management of sexual identities and sexual careers. On the other, the analyses concern interwoven theoretical issues that stem from Foucault's analysis of the *History of Sexuality* (1978). At the heart of that enquiry is the rejection of the hypothesis of Victorian repression but the emergence of new forms of surveillance and monitoring of sexuality and the growth in 'scientific' explanations and 'truths' of sex (*Scientia sexualis*). The growth of contemporary forms of disciplinary knowledge of sex is contrasted with erotic arts (*Ars Erotica*) as older, different forms of largely experiential knowledge. Here I draw on empirical data gained from the 'Eros

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Received for publication 22 March 2000; accepted 10 October 2000.

ISSN 1468-1994 print/ISSN 1468-1479 online/01/010015-20
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DOI: 10.1080/14681990020021539

Study' of the social construction of male sexuality in the field of genitourinary practice.

The Eros project was a qualitative case study of two genitourinary clinics in central London. It was primarily ethnographic, involving two periods of non-participant observation, semi-structured interviews with staff and gay, bisexual and heterosexual male clients in each clinic, together with analyses of documentary and historical data. It also included recruiting male readers of *Men's Health* magazine as well as analyses of the imagery of public health campaigns and other visual representations. The analyses of this thick rich data provided the elements for a new sociology of sexual health and disease, at the centre of which were recurring images and metaphors of the city. The city becomes the *Leitmotif* of the urban spaces as the social fabric of male sexual meanings and knowledge.

The narratives of many of these men seemed concerned with the refining of repetitive sexual practices, an exploration of methods and objects of desire. Foucault (1978) draws on the Greco-Roman concept of *askësis* or the individual (male) obligation to examine and refine his own sexuality and desires. There is a link to be made here between Foucault's concept of the Panoptic disciplinary power of medicine and the dissolution of the 'clinical gaze' that Armstrong (1983; 1993; 1995) proposed. Here the individual citizen is recruited into the project of governmentality through self-surveillance as an 'active patient'.

In this paper these differing types and forms of knowledge are contextualized through the men's narratives. I extend the analysis of the sexual encounter as an interpersonal event that represents both intrinsic and extrinsic elements of risk as well as pleasure. One such key element is social space, in this case the urban environment of the city and the context this provides for the management of lifestyle and opportunity for sexual encounters. I explore the experience of the male 'clients' in their management of pleasure within the dynamic context of sexual agency, where the very dangers that might crystallise desire, are simultaneously the locus of risk and the vector of contamination and disease.

Sexual truths: knowledge(s) as art and/or science?

As both a vector of disease and as social agency, sexuality has long been engaged in a discursive tension with medicine. Sexuality is an historical construct that Foucault (1978:105 ff) argues is:

> Not a furtive reality that is difficult to grasp, but a great surface network in which the stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power.

He goes on to elaborate how the Victorian 'repressive hypothesis' can be challenged. Foucault offers a working hypothesis that 19th century society did not repress sex, but on the contrary:

> it put into operation an entire machinery for producing true discourses concerning it. Not only did it speak of sex and compel everyone to do so; it set out to formulate the uniform truth of sex. As if it suspected sex of harbouring a fundamental secret. As if it needed this production of truth. As if it was essential that sex be inscribed not only in an economy of pleasure but in an ordered system of knowledge. (1978: 69)

It was four strategic unities (1978:104) through which the disciplinary 'truths' of what he termed the *Scientia sexualis* were deployed and observed. These four strategic unities were privileged objects of knowledge and key targets of sexual concern, control and power in the 19th century and arguably still today:

—the hysterical woman (a hysterization of women's bodies);
—the masturbating child (a pedagogization of children's sex);
—the Malthusian couple (a socialization of procreative behaviour);
—the perverse adult (a psychiatrization of perverse pleasure).

The family, as Panopticon, became one key site of economic surveillance, the object of a continuous pathologizing of sex through psychoanalysis, therapies, medicine, religious beliefs, education and the state. *Scientia* underpins the contemporary 'truths' of rational sexualities, health and disease, 'safer sex' and the control and regulation of bodies. *Ars erotica*, on the other hand, is not an earlier phase of the history of sex but, following Foucault (1978), it might be said that *Scientia sexualis* 'under the guise of its decent positivism has functioned to a certain extent as an *Ars Erotica*'. Foucault goes on to argue that:

> It has multiplied, intensified and even created its own intrinsic pleasures. We have at least invented a different kind of pleasure: pleasure in the truth of pleasure, the pleasure of knowing that truth, of discovering and exposing it, the fascination of seeing it and telling it, of captivating and capturing others by it, of confiding it in secret, of luring it out in the open—the specific pleasure of true discourse on pleasure. (Foucault, 1978: 71)

The emergence of the *Scientia sexualis* appeared, in Western cultures at least, to replace earlier 'procedures for producing the truth of sex' that Foucault (1978: 57 ff) identifies as the *Ars erotica*.

> In the erotic art, truth is drawn from pleasure itself, understood as a practice and accumulated as experience, pleasure is not considered in relation to an absolute law of the permitted and the forbidden, nor by reference to a criterion of unity, but first and foremost in relation to itself: it is experienced as pleasure, evaluated in its intensity, its specific quality, its duration, its reverberations in the body and the soul. Moreover this knowledge must be deflected back into the sexual practice itself, in order to shape it as though from within and amplify its effects.

Underpinning this *Ars erotica* was the (male) concern with rehearsing and refining the 'authentic' experience of sex and sexual 'truths' through *askësis*. Foucault interpreted the Greco-Roman practice of *askësis* as a model of 'ethical subjectivity'

(as opposed to the later Christian ethos of a moral, ascetic regime), that presents the potential to enjoy types of sexual pleasure not dominated by exterior law. *Askēsis* (ascesis), a Greek word meaning 'a form of questioning that requires the male citizen to reflect on his sexual weaknesses, strengths, and potentialities' (Bristow, 1997:186). As Bristow summarizes, 'the self-regulation of desires constitutes a liberating autonomy, for such *askēsis* creates a realm of freedom over which the male citizen at last maintains control'. Foucault himself identified emerging gay communities in cities, such as those in New York and the S/M 'ghetto' of San Francisco, as 'a good example of a community that has experimented with, and formed an identify around pleasure' (1989:385). It is perhaps significant that concerns in disciplines such as sociology have been primarily with validating, exploring, quantifying and describing the *Scientia* (sexualis) for example through surveys such as Wellings *et al.* (1994) and helped sustain the growth of disciplinary techniques in power/knowledge discourses. Without doubt, that has been legitimate and important, but I would suggest that the *Ars erotica*, the experience of pleasures, the meanings attached to them and the means by which they are pursued, operate in concurrent space and time.

Aligned to this concern with sexual self-surveillance is Armstrong's notion of 'the active patient' (1995). He argues that the development of the disciplinary gaze of clinical, medicine had extended by the start of the twentieth century from the hospital to the community. The individual is now recruited to turn the gaze upon him/herself, to engage in self-monitoring for signs of disease, biosocial error and medical heresy. In other words the individual citizen is recruited as a morally responsible agent of the state, the subject of governmentality.

There is a paradox here. Namely that the deployment of *Scientia sexualis* is contingent on the cultural production and reproduction of the self-observing subject. The concern with *askēsis*, the centring of pleasure on the individual body, provides a means for disciplines such as medicine or sociology and so on to penetrate hitherto 'invisible' or transgressive groups. This also extends to newly emergent identities in populations such as urban gay communities, S/M or fetish clubs, or bisexual married/partnered men. The emergence of safer sex as metanarrative would appear to illustrate this point. In other words, where identities and groups may be organized around the notion of sexual difference, paradoxically the appearance of their resistance acts to intensify the reproduction of clinical surveillance through safer sex or reflective self-help discourses. However, while this centring on the body as site of pleasure may be at the heart of discourse, there is clearly existential dissonance. Ridge *et al.* (1997: 173) make the point that gay men on the urban commercial gay scene consider this to be the only location of the metropolitan gay *community*, yet there are tensions in the ideals of a gay community and the experience of the men in the study. This is partly in the contested notions of 'community rhetoric' as liberational and embracing. However, they appear to be closer to the notion of community being more forged by legal, political and economic forces than by gay liberation *per se*. In this respect I tend also to follow the concept of the 'community' being rather more shaped by patterns of economic and sexual consumption than by ideology, where mutable social networks form and reform but which resists, processes and also internalizes wider social discourses. It

is within urban settings that these patterns of sexual consumption are perhaps most evident.

'I came to London, and then how you say? All hell broke loose!: [2] Sex, hygiene, environments and urban spaces

Particularly for the gay, rather more than the bisexual or straight men that were interviewed, identities and activities were intimately bound up in urban and especially metropolitan spaces as sites of opportunities for sex and freedom to be different. As I have already discussed elsewhere (Pryce, 1996), urban sites of erotic pleasures and performances are particularly significant in the production of social and political expressions of sexual networks and 'community'. The city is a major arena in the enactment of public sexualities, the perfect arena for the project that is identity, and the management of sexual careers (Bech, 1997; Ingram *et al.* 1997). As Weeks (1995:103) has suggested, 'social and sexual identities can only ever be relational, because without a sense of wider involvement, no identity is possible'. For Karl, a gay client at clinic B, this meant:

> It's a kind of an intimacy to being gay and being among gay people in public places and it feels that you're on one level, maybe connected to them.

Whether as the 'silent community' (Delph, 1978) or as the increasingly visible pink economy in consumerist urban villages, the sequestration of the city within geographies of actual and imagined desires and metaphors is not new. However, it has emerged as a *Leitmotif* in contemporary queer writing, activism and popular gay and straight cultural imagination. Of particular relevance here is a British example—Hampstead Heath—that is a site of queer pleasure referred to by a number of men in the interviews (Bell, 1997: 81–87). Also for straight men the urban provides arenas for sex and commodification of desire and, as in Dave's stories of his addiction to seeking out prostitutes, the streets are located in a lexicon of sexual knowledge which is rarely reported except through public attempts to eradicate their 'disgrace' and *vice*.

> Dave: Well because at the time there was a good street trade going on there. I preferred to use that because I saw it as a free market. I didn't want to go into any sort of establishment, I was a bit reluctant to go into premises and stuff.
>
> Int: How did you know that 'good' street was there?
>
> Dave: Well, it's been there a long time. Also, I went to Nottingham, again those particular red-light districts were sort of legendary; Christchurch Street in Doncaster and Forest Road in Nottingham. I can't remember when I first heard of those areas, I was probably quite young, I was probably still at school. I think they featured on television in

> documentaries. So I can't honestly remember when they first came to my attention.

Such knowledge though, is transmitted as implied, tacit, seeping through the capillary levels of local knowledge and where the 'rules of engagement' have to be experienced in order to learn them. However, behind descriptions of heterosexual encounters or the notion of hegemonic gay sensibility and culture, it was quite clear from the men in the Eros study that, while the spaces of the city can be rich in potential sex, those same spaces are sites of dangers of both pleasure and self-loathing. Whether it is with paid sex or cottaging and cruising performances, the narratives of desire and sexuality are associated within a discourse of risk, precaution, danger and contagion.

Following Douglas (1966), and the concept that dangers may be seen as operating at two levels, the instrumental and the symbolic, Armstrong (1993: 393–410) has described environmental territories of the '*New Public Health*.' He identifies objects of *green* concern whereby the byproducts of economic and social activity have become ecological and social hazards around which there are new discourses of purity. However, as he also argues, the earlier anxieties of dangers located in other human bodies still operate. The sense of pollution is located in the nature of the interaction, the biological risks of infection and contamination represented in bodily exchanges, but also in the acts themselves. For example, for Andreas (a young gay Croatian man) each encounter signifies *dirt* in both the desire and the deed of sex. Interestingly, the clinic staff constructed *pollution* primarily as a symbolic contamination of professional codes of ethics and the 'clinical self'. Instrumentally, pollution is located in the medical constructions and imaging that justify the *non-touch* examination techniques, treatment and consultation practices of the *untouchable*. It is signified through the policing of the interactional boundaries of desire and practice within consultations and the potential for being discredited through insufficient management and control of desire towards the subject/client (Pryce, 2000).

Identities and sexual practices are clearly significant in the management of clients' sexual desire and disease that are explored here. More particularly, there is an emphasis on the environments and sites of sexual agency—spaces in the city, and between bodies and the construction of *safer* sexualities. These stories reveal issues and strategies whereby, even before men become 'clients', elements of their sexual and social agency refer to areas of practice subject to clinical gazes through the acquisition of and resistances to health promotion/education. Paradoxically, the increased incitement to sex, sex talk and invasion of the body through substance use, body piercing or tattoos is simultaneously concerned with older dangers such as the fear of disease and the newer rhetoric of individual responsibility for the body and body 'projects'. Such tensions and paradoxes are centred on a number of social spaces:

- The knowledge and construction of sexual disease as consequence of transgressing spatial and sanitary boundaries.

- The management of social and sexual interaction within the context of safer sex discourses.

For Joe, a young gay man, moving to London from a rural, Irish culture meant sexual and social escape:

> because there was no furtiveness about it; it was on your sleeve. So instead of being totally repressed, and whereas the sexuality was nothing, I could put my sexuality totally bare and it not cause me any aggravation.

Giulio, for whom, in the appropriate context, potential partners were approached with some confidence, also demonstrated the notion of unrestrained social interaction and sexual licence offered by the city spaces: 'I never lose time, I always go in and ask are you interested in having sex with me?'

However, contrary to that level of assertiveness, others find the rules harder to discern and play by. Hamish, a married bisexual man, comes to London as a socially safer arena to find sex. As a bisexual who only started having sex with men in his middle years, he finds the rituals of urban gay sex intimidating, esoteric and socially dangerous.

> Yesterday, for example, I just went to gay bars in London and met nobody. I felt awful. You hang around and I just feel awful doing it, because I don't meet anybody and nobody speaks to me, I haven't the guts to go up and speak to other people actually. I don't take initiatives, if someone talks to me I talk back but I don't have the courage, I don't know what to say.

For Andreas, moving from a small town in a country that had recently been communist provided a means of exploring his sexuality and the freedom to live as a gay man. However, here too the opportunities to engage in apparently unrestrained sex were limited by profound anxieties located in fears of contagion.

> I came to London, and then how you say, 'All hell broke loose'. I started experimenting with gay sex instantly, literally instantly … I don't have any kind of guilt of that sort. I really do respect people although I don't trust them, but I don't care at all what they think of me, or whether I'm called a poofter or faggot or whatever, it doesn't concern me at all. But what does concern me was that I didn't find happiness in gay sex, and I don't indulge in gay sex, I am paranoid, not only about catching HIV but about catching anything. I really would not like to catch anything.

The city is providing and enabling the management of identity and identity affiliations, which may be relatively less stigmatizing than elsewhere. However, it is also where the *other* remains dangerous, and one of its representations is disease. The risks of interpersonal contamination are at the heart of safer sex rhetoric and praxes, but despite the positive language that appears to be affirming gay identity and culture, older fears remain of the dangerous power of pollution and the orgasm.

However, just as the introduction of sewers in the 19th century city rendered dirt invisible, safer sex discourses may work simply to bury those pollution anxieties beneath new sanitary systems. Particularly in post-AIDS sexualities the dangers are

minimized at the extreme by eradicating genital penetration, and through the use of mental stimulation, simulation, role play and sex implements; the new sex aesthetic appears located in the fragmented, the deconstructed and the virtual. Rob, as a self-identifying heterosexual, transvestite fetishist, argued that his practices engaged with a paradox in post-AIDS dialectic, where the fetishized desire both celebrates the body, consumption and its pleasures while minimizing unsafe contact.

> The fundamental thing about fetishism is that it's a deferred sexuality and that is why it's become more popular, really, because often there's no sexual intercourse involved—it's deferred—it's like there's maybe masturbation individually, or at home later, 'cos that's the great thing about sex you can enjoy it, you can enjoy deferred sexuality—you know you can actually tie somebody up, or S/M of some form. Later on when you're at home you can think about it and really enjoy it then, and masturbate with it and really enjoy—you know get a real direct orgasm with it then. But when you're actually doing it with the person it's a creative thing or it's to do with 'sub/dom' and all that sort of thing, and it is a deferred sexuality; and I think it's possibly one of the reasons it's become more popular because of HIV, because there is no body fluid exchanging going on.

Semen has gained new power, as opposed to the magical, life-giving and empowering fluid of the *Guardians of the Flutes* (Herdt, 1981) for some in the sexual spaces of the developed urban culture, it is now potentially dangerous, polluting and deadly (Sontag, 1989: 73). New techniques in treating semen of HIV positive men so they might safely father children emphasize this unclean danger, sanitizing it through 'semen washing' (Lasheeb *et al.*, 1997: 303). As Lupton (1994: 134) suggests, discourses of disease as *invasion* and *danger* in late modernity target the body as 'site of toxicity, contamination and catastrophe, subject to and needful of a high degree of surveillance and control'. Together with the riskiness of post-AIDS sexuality and beliefs concerning the unhygienic nature of bodily fluids and waste, the body is no longer a temple regarded as the house of God (Synnott, 1992: 85). Instead, it has become a commodified and regulated object that must be strictly monitored by its owner to prevent lapses into health-threatening behaviours. This may be partly attributable to HIV and AIDS, but might also be a signifier of wider *fin de siecle* crisis where, in the wake of postmodernism, sanitary discourses elide with notions of remote control, distance, barriers, safety. Showalter (1990) suggested that:

> In periods of cultural insecurity, when there are fears of regression and degeneration, the longing for strict border controls around the definition of gender, as well as race, class, and nationality, becomes especially intense. If the different races can be kept in their places, if the various classes can be held in their proper districts of the city, and if men and women can be fixed in their separate spheres, many hope apocalypse can be prevented and

> we can preserve a comforting sense of identity and permanence in the face of that relentless spectre of millennial change.

This would seem to provide a convincing explanation, but these conditions do not hold completely and forms of resistance and discontinuities are evident in cities like London or Manchester, metropolitan sites where renewed speculative building, gentrification and the emergence of new urban villages are coinciding with powerful political discourses around sexuality and sexual identities. However, whether it is in the pluralistic cultures of 'safe' urban ghettos, or the less diverse and sometimes more hidden communities in suburban and rural environments, there are dangers around identity and the management of desire. One central danger remains centred on the body and disease. It is therefore important to explore the genealogy of knowledge about sexually transmitted diseases for the men in the Eros study by examining their notions of safer sex and the construction of risk in dangerous desire and praxes, health and the body.

Desire with knowledge: safer sexualities and praxes

To some extent the admission of unsafe practices appeared to be seen as potentially stigmatizing too, akin to breaching a new political correctness. Like Douglas, Lupton (1994:137) suggests that condoms have become inextricably interlinked with the need to contain body fluids, reflecting society's anxiety about dirt being 'matter out of place', particularly infective matter. The focus on condoms in safer sex discourses represents both a potential to preserve the enjoyment of pleasure and, for moralists, a continuation of a decline into licentiousness echoing the late 19th century and early twentieth century eugenics and social hygiene discourses. Turner (1984: 214) asserts that the increasing emphasis placed by health promotion practitioners on the individual's responsibility for health suggests it is yet another apparatus of social regulation and control, 'masked by the language of disease'. An admission that the individual has failed to exercise due caution is a taboo that has been contravened in the canon of responsible sexual citizenship.

> Int: Would you say that your sexual activities are safe?
>
> Charles: I don't want to talk about that. I don't mind talking about sexuality in the general sense and my sexual health going for blood tests, I suppose if I had known I had been 100% safe there would have been no need for a blood test, so you can draw your own conclusions. If there can be a hurdle to our discussion, I think that possibly is a potential hurdle. Apart from the point of view of anything that you can learn from the point of view of sexual health and clinics in general I would, and possibly safer sex education to an extent, this whole attitude that we can throw a condom at a gay man and expect him to be safe, you are ignoring a whole … We all make choices in life and one of those choices, you can call it Russian Roulette, is whether you wear a condom or not

Charles had been very forthcoming and quite graphic in his description of his

sexuality and behaviour. However, he was very defensive of his 'heretical' acts of non-compliance with the rubrics of safer sex. His metaphor of 'Russian Roulette' provided an apt description of the choices underpinning risk-taking activities and sex has been commonly used in relation to disease, particularly AIDS. This may not be surprising in the light of discourse analysis where, as Bloor (1995) suggests, Foucauldian influence can be seen in the linking of discourses of power and AIDS in which:

> public discourses on AIDS have been public agendas for the policing of sexuality, the punishment of victims and the surveillance of deviants (immigrants, gays and junkies). (Bloor, 1995: 84)

What was particularly evident and striking in the conversations with many of the men here, was the extent to which *risk* and its satellites of anxiety, control, danger and desire were present as powerful components in sexual narratives. James, a heterosexual equates the 'freedom' of anonymous and frequent sex with emotional rather than physical risk. These risks were also expressed both in terms of volume as well as the sometimes anomic nature of sexual activities of the city. Marc, a young gay man explained that:

> I find it more scary being in London. I find it much more scary, I think AIDS and HIV has definitely ruined the whole sex thing completely now cause you've got to be consciously thinking about what you should or shouldn't be doing, and checking all the time ..., that's the reason why I've been going to the clinic cause the first thing I thought was 'Stephen's caught something from somebody and that's how that came about'. I definitely think it's more dangerous down here simply because of the amount of people that are here.

Sometimes risks were tangible, explicit such as in Andreas' stories of compulsion and loathing; or discrete, where risk is more pervasive, almost miasmic, but an element in an array of lifestyle and sexual choices. Risk appeared to be constructed as both a courting of dangers in public spaces through the enactment of transgressive sex or, whether in private or public, as a potential threat of damage through invasion by disease. This is consistent with the Royal Society's (cited by Bloor 1995: 96) evaluation of Mary Douglas's contribution to the analysis of risk-taking behaviour and HIV infection through her model of the grid-group. That has been criticized by Bellaby (1990) as the model fails to account for the dynamic flow of individuals from one social setting to another, and the interaction with those such as bisexual men or sex workers who may constitute hidden populations. However, as Bloor suggests:

> The implications of this approach for risk assessment and perception are revolutionary. It implies that people should select certain risks for attention to defend their preferred lifestyles and as a forensic resource to place blame on other groups ... That is, what societies choose to call risky is largely determined by social and cultural factors, not nature. (Bloor, 1995: 94)

Weighing up the balance of risk (whereby the possibility of acquiring a sexually

transmitted infection becomes a relatively minor problem when balanced against HIV) is an explicit activity located within the power relations of sex. When speaking of safer sex and the issues for him, Jamie argued that:

> I don't tend to have any problems with that, if a guy tries to screw me unprotected I stop him … cos he's tried to do something that I might not have wanted and he should have asked me if he wanted to screw me without a condom, and I would say no. Other sex I tend to do unprotected and that's a strong risk from STD, but you go and get a few tablets and it'll be gone in a week and you have the discomfort. There must be a lot of people out there with sexually transmitted diseases and the chances are higher if you go out a lot more.

For Jamie, going out a lot more included cruising on public places such as Hampstead Health, and his stories of sex in public are organized around risk and excitement. The fear of disease appears less immediate than other competing attractions, excitement and dangers:

> It's not just the Heath, I like sex outdoors and I prefer being naked, well not always as it depends on the situation. If you're outdoors and naked it's an extra buzz. Not necessarily having sex. If you're on a naturist beach its a nice feeling. Going up on the Heath it's a risk, it's dark, most of the clubs in town are dark, smoky, noisy. I thought about it once and it's a risk, something you get a thrill from, you're a bit scared, and your heart starts beating faster and you don't know who you are doing they don't have to cook you breakfast the next morning, it might be someone you know, it's just a buzz then you go.
>
> Int: You used the word risk a few times there.
>
> Jamie: [Yes] from the police, and being beaten up.

The potential for disease is less evident, calculated on the basis of relative ease of treatment, outweighed as a risk by the physiological as well as sexual excitement of the anonymous encounters he described. However, for Andreas, each anonymous encounter for sex becomes the locus of fear within a wider individual ecology of health where it is unclear whether the threat of disease is conceptualized as sexual *per se* or rather as an assault on the healthy body. The fear of disease followed him 'everywhere':

> Oh yes! Absolutely everywhere. It doesn't come to me as a huge sacrifice, not eating fatty foods and so on, it happens that I like healthy food. That what I actually like is healthy, so I do that. I don't smoke, I don't take drugs, I don't drink, I exercise. So I'm definitely not obsessed with it but I think I feel some kind of responsibility towards myself. If I can do it without going through horrendous psychological and physical torture that I should do it, and then I think well if I do all this can you imagine you can go out there and just compromise, and jeopardise, and throw away your life really. Because I'm not really scared of dying because it comes sooner or

> later. I'm not scared, I'm irritated by being ill because then you can't do this and you can't do that and it just sends me through the roof. I'm just irritated by that and with the very thought that one could get ill and deteriorate and come to a certain level that you can see, it fills me with terror.

The narrative of fear and pollution is interwoven with other wider discourses concerned with healthy living and the body project, but AIDS has helped reinvent the sexual body as arena of observation, education and individual responsibility. It is on this basis that, following Lupton (1994: 136), it can be argued that the dynamic of risk and its discourses have increasingly become 'an effective panoptic agent of surveillance and control difficult to challenge'. Such is its depth of penetration, sites of desire such as the S/M club are identified as less risky than the backroom of a pub and, as for Marc or Andreas, sex has become associated with checking and observing one for signs of contamination. Giulio, a gay Italian man, had moved to London. He was now HIV positive, and worked part-time as a 'bouncer' at an S/M club. He had proudly told me that the staff there had attended a safer sex course run by the local health authority, and now no unsafe, deviant activities were allowed in the club!

> Guilio: I'm impressed and amazed by how many men still basically get fucked without a condom. It's happened to me, someone has said I want to get fucked by you and I say 'I don't have a condom' and they say 'it doesn't matter' and I say 'No, I won't do it'. It's not just for transmission of HIV it's for thousands of other reasons. In this kind of gay sexual environment more than others I think there is, people are much more ready to take on the risk of unsafe sex which is interesting. I think you should do research and see where HIV is more likely to be transmitted. It's more in a sort of way in the rough scene.
>
> Int: More likely to be in the 'rough' scene?
>
> Guilio: I think so. Or in people who are used to going in to bars and clubs where there is a dark room and they could have sex … But the very interesting thing is that I have been practising unsafe sex with my boyfriend, the second person I was involved in a relationship with in England was HIV positive as well and it happened that we had unsafe sex knowing that he was HIV positive. So it was a risk that I took on.

Having already acquired HIV through unsafe sex, his stories are interwoven with issues of discretion management, control and danger. Obviously the identification of boundaries is an important element in the strategic management of the body and desire and the notion of the *educated* body is pivotal in a number of narratives here. At its heart is the assumption that, from the experience of learning how to negotiate and manage sexual encounters, personal pleasure is maximized, together with an educated understanding of the techniques of controlling or at least knowing the

limits of pleasure. Gary, a bisexual man in his 20s, was concerned with sexual boundary maintenance.

> Int: Where do you draw the line?
>
> Gary: I don't want to be physically damaged. The line is obviously my pain threshold, and obviously everyone's is different. I don't approve of blood being drawn from a health point of view, definitely not, nor any of the toilet oriented activities even in an S/M context. I would draw the line at piss, blood and shit … that sums it up.

He makes an interesting distinction here between those things that he would not want, i.e. physical damage, and those sources of pollution of which he does not *approve*. Like Guilio, an experienced S/M practitioner, Joe, who is not into S/M, emphasized the importance of trust in the management of boundaries.

> Int: If you had vanilla as point zero and extreme S/M as point 10 where do you put yourself?
>
> Joe: Because of my history I put myself at about 1 or 2 basically speaking because I would have to trust somebody before I let them tie me up or I tied someone else up. I wouldn't let any bastard hit me. I'm not into abuse, I don't think. I don't know I haven't explored that side of my personality yet.

Despite the assertion that he is not 'into abuse', the conditional note emphasizes the potential for change, that the body and the management of its pleasures are mutable and open to learning. The notion that the self is concerned with the project of exploring and mapping its desires appeared to be common among the men I interviewed—a contemporary *askësis*. This has implications for both the responses to activities that challenge existing concepts of self and identity, and also for the responsibility as a self-observing subject for the self as sexual health educator. Sometimes, the strategies relied on highly essentializing rationales.

> Jamie: I've been out with people and I've thought this guy doesn't *smell clean* there's maybe something wrong with this guy and nothing has happened, I've had no symptoms or anything; if I don't feel comfortable with what I'm doing then I'll stop. Usually it's too late with STD but I don't go to somebody else … I switch off basically.

Like a nervous deer or a hunting dog on the trail of pheromones, Jamie could be deterred on the basis of scent alone from having sex with a new contact!

Akin to these numerous strategies for the management of potential dangerous boundaries of socio-psychological spaces is the growing use of the internet to provide a matrix of 'safe' sexualities. Giulio is increasingly using it and the virtual opportunities for him to extend his social networks are greatly enlarged. For him the internet was primarily for chatting and meeting men, not for cybersex. Giulio had earlier emphasized the safe credentials of well policed S/M activities. Its deferred elements make the internet an understandable and compatible mode of socializing

where sex may be a virtual or 'real' bodily process or outcome. In the management of boundaries between the biological or the 'virtual' presence, cyberspace is 'cleaner', offering choices whether to subsequently meet up in the flesh. It is this management of the flesh to which I now turn.

I see myself as a work in progress [3] body projects, identities and the active patient

Continuing his theme of the development of the aesthetic, inscribed urban body, Rob, who identified as a heterosexual, transvestite fetishist, argued that the possibilities for pleasure and the body's boundaries are limitless.

> I still think there's many possibilities that I haven't even tried yet you know, sexuality is so incredibly complicated and varied there's no limit to what you can do with it, where it can lead you, and it can lead some people into a very bad way of life, but for myself it's not, it's all very harmonious with my working life and my spiritual life, there's no question of that.

However, these bodily boundaries are limitless only in the sense that they are subject to highly contextualized negotiations (Davies *et al.*, 1994) as well as physical constraints. The body for many of these men provided opportunities for the exploration of pleasure but, for all of them, it (the body) was constantly observed. Within a generalized awareness of the importance of safer sex and the use of condoms, the observation was conducted through eyes that were subject to some distortion! Echoing and reinterpreting Foucault's (1978) notion of 'perverse pleasure' number of these men, like Giulio, had unprotected sex with someone they knew was HIV positive, or were experiencing bodily pleasure so intensely that safety was secondary. For Gary, safer sex decisions are contextual.

> I always, well 99.9% of the time use a condom with women because I suppose its deeply ingrained about the pregnancy issues. With men I mostly do and I recognize the importance of safer sex, but I'm afraid for my sins I'm a human being. There are occasions when I'm blitzed on one thing or another.

Therein lies the paradox of danger and desire, 'rational' choice and pleasure. Characterizing this as 'relapse' from more or less constant self-surveillance is perhaps too reductive a view, and suggests an over-deterministic sense of sex. Gary is demonstrating the tension between the *Ars erotica*, through succumbing to pleasure at the expense of the external 'law' of the metanarrative of safer sex on the one hand. On the other, the internalization of the 'active' patient mode, where not effectively defending against threat to health is constructed as failure, *bad* sexual and social citizenship. His 'sin' is compounded by his reluctant identification as an (opportunistic) bisexual, which thereby places him at the cusp of differing practices, 'reliability' and perceptions of risk. Boulton & Fitzpatrick (1996: 3ff), for example, discuss how bisexual men construct danger, and like Gary suggest that condom use with women is primarily as contraception, whereas with male partners it represents

'safer sex'. Gary's acknowledgement of substance use also highlights the double locus of anal sex and the compromising of levels of discretion where recreational drugs such as poppers (amyl nitrate), ecstasy, speed (amphetamine) cannabis, cocaine, as well as other injectable drugs are used. Similarly, Joe well illustrates these inconsistencies where he engaged in occasional drug binges.

> I did ecstasy beyond belief, I loved it. I can't say I'm never going to do it again. But I did ecstasy, speed, a bit of cocaine. I never smoked hash, I think that's the most disgusting drug ever for some reason, that's it really. But my ecstasy abuse was unbelievable. The last time I went out I did 11 E's in one day!

However, he is now subjecting himself to diet and exercise regimes within the wider health-driven social concern with the body. This body project has specific gains for him, he is now 'a changed person' having lost weight, cut his hair short, stopped smoking and drinking and decreased his social activity in the club scene. He has moved from being 'a fat lump who's an opinionated twat, now I'm just a loud mouthed twat', and the pay-off was an increased opportunity to be promiscuous … 'I had a summer of sex'. Defining where the boundaries of promiscuous sex are located is problematic on one level.

> Int: Where do you draw the line?
>
> Joe: That's a good question, I don't know. I haven't been in a situation where I have had to draw the line—yet. The thing is, extreme S/M, I'm not into it and I've never met anyone who is. I also don't have the right look of somebody to go for that I don't think. Mind you what is the right look? Because the type of sex I indulge in … there is not a lot of S/M I can do and I haven't practised S/M with anybody, I don't trust anybody enough to do it. I suppose I could explore it with a partner but it's not in my top 20 of things to do next week type of thing. I suppose deep down I'm looking for the love romance side of things, not quite vanilla. With the sex I want the relationship and the communication and if I'm not going to get the communication and the relationship I will just have the sex; so I'm just pure animalistic without any type of communication. So I'm quite clinical with sex, I just have to get it out of the way.

Joe's reference to 'the look' is incidentally interesting in that it raises a number of questions around whether sexual preferences are determined by the ability of that individual to assume an appearance that coincides with a particular sexual aesthetic. In other words, is one excluded from S/M performances solely on the basis of the inability to look the part? Clearly some looks, by definition have to be worked for, like the 'Muscle Mary'. However, the body focus of hegemonic gay and increasingly, heterosexual masculinities are contingent on its plasticity and potential for sculpting. For Joe, his body re-mould enabled increased anonymous sexual activity subject to rigorous safer sex rubrics in which he identified himself as an activist, acting as a sexual health education resource through the display and use of safer sex videos.

> I got the videos because I was dead interested in what they were going to say about it and also I got them so I could put them on my shelf so that if people came round it was visible and then when my parents came to stay they were there visible as well. It's there to make people aware that I am safer sex-oriented. Most people will not ask, they don't want to know what you do with your sex life. So I put them there for two reasons, some friends of mine are quite shy so they can borrow them but it also puts people at ease—'yeah that's sensible, considering you do stuff like that'.
>
> Int: It's signifying your position?
>
> Joe: It's signifying my position and it's there available.

In a sense Joe represents the dual aspect of the model I have proposed. On the one hand he is concerned with self-examining *askēsis*, within a sexual praxis that remains, like his body, a project in progress. However, it is thoroughly saturated in the deployment of the disciplinary narratives of safer sex. He is the 'active' patient. The obligations are twofold. One is central to health promotion and the widespread social injunction to the individual to take responsibility for his/her own health through dietary and other ascetic regimens. Nested within this, the other more specific element is the particular reflection and monitoring of sexual health and practices. However, like the experience of many men explored here, sex education was often a haphazard serendipity acquired through adolescence. As adults, their sexual health knowledge often remained ill-focused, irrelevant, ignored or learnt through interpersonal experience rather than official routes.

> Int: Are you learning as much from your partner as you do from gay literature?
>
> Damien: Well I don't pick up gay papers and don't go to bars and most of my friends don't have much money so we don't go clubbing or gay places. I've learnt nothing from the gay press. My partner bought me the Peter Tatchell book on Safer Sex. But that is just another one of his 'great to be gay' things and you could pick up more from a couple of leaflets. I suppose with my age I have been brought up in the generation who knew about AIDS. Older people say they are sorry for my generation.

For many, men's sexual health promotion was sought out only in response to need, while for others education was simply acquired through experience and a synthesis of information gathered, like David by being 'a man of many summers'. Some educational strategies appeared to be insufficiently robust. However, for straight men, such as Richard, the availability of sexual opportunities and sexual health information generally, paradoxically presented problems:

> Society condemns masturbation by women, that's why you have to keep in line … but then I read an article in *Cosmopolitan* about women and masturbation and I thought 'Oh My God! Not my girlfriend!'. My problem

> is that I just think about it too much. Most men would just get on with it or feel the guilt and learn from it.

Clearly, for the men here, whether gay, straight or bisexual, age and experience had a significant impact on knowledge gained through praxis. Defining sexual health might also revolve around whether knowing someone who has experience of disease changes attitudes or behaviour. These associations between sexual behaviour and the contextual dynamics of risk have been widely reported elsewhere. Fitzpatrick, Boulton & Hart (1989: 132ff) suggest that in British studies at that time, there was no conclusive evidence to suggest that associations existed between levels of knowledge, perceptions of risk and behavioural change. Since then numerous reports have analysed changes in sexual behaviour, perceptions of risk and incidence of HIV transmission (Davies *et al.*, 1994; Davies, 1999; McKeganey & Barnard, 1996; Parker & Coxon, 1996; Ridge *et al.*, 1994, 1997). The individual actor's commentary on risk and danger may indicate reflections on the 'haphazard' irrationality and 'luck' element of sexual encounters. Damien, for example, was concerned with the maintenance of control and surveillance to ensure:

> A healthy sex life and making sure everything is fine. But I'm not sure what that means either, but I was with people with HIV the other day and it made me realise how lucky I am, it's not worth the risk. My friend found out about this guy with whom he'd had penetrative sex, with a condom, and he went back to America. My friend just heard that he'd died of AIDS! He must have had it when they were together. Some people are living out their own snuff movie.

However, this thorough internalization of the active patient role as exemplar of the expansion of knowledge/power discourses also generates resistance to the *Scientia sexualis*. Foucault (1978) argued that sexuality was increasingly socially controlled through the discourses of *Scientia sexualis*; it therefore paved the way for resistances:

> it also established the preconditions for a 'reverse' discourse: homosexuality began to speak on its own behalf, to demand that its legitimacy or 'naturality' be acknowledged, often in the same vocabulary and using the same categories by which it was medically disqualified. (Foucault, 1978:58)

Charles has already demonstrated this through his resistance to safer sex, but resistance may also be seen in the instrumental manipulation of clinical services to provide management of both sexual and economic other outcomes. His educated use of services provides an illustration of the active patient-as-resistance. He appears to be such a model, informed and aware of risks, observing himself for signs of disease, albeit he practices unsafe sex at times. However, charles had another desire, that of attaining insurance cover with least risk of being 'outed'. He achieved the result of gaining insurance cover, but despite this display of rationalizing strategy there remains the second discretionary level. By this I mean the pre- and post-test counselling provided a kind of psychological 'insurance' in the event of a positive test result!

Conclusions

This paper has concerned the strategies used by men to manage the complex, multidimensional boundaries between the self and the *other*. I have discussed the development of the model of the sexual actor whose agency encompasses the twin processes of *Arserotica* and the 'active patient'. The process of *askësis* also serves to provide both a mode of observation and an injunction to monitor the interpenetration of sexual and health practices. I have suggested that this process may also be characterized as being both symbolic and instrumental in terms of the actions and meaning that are attendant on the search for sexual pleasure and the management of the limits at the margins of pleasure and danger. Sexual identities are largely constructed through urban iconographies and discourses. These challenge and contest 'traditional' sex and gender roles and the city provides the potential for varieties of sexual consumption. Most powerfully, the metaphorical spaces of the city are the arenas where such tensions are evident and may be clearly identified between the strategic management of desire and restraint, health and disease. These are also constructed in terms of varying notions of risk. It is clear, however, that following the literature such sources and modes of information must be nuanced to reflect the flux of contemporary sexual and social categories and identities to avoid the over-deterministic models that have dominated health promotion. The metanarrative of safer sex presents both a potential for eroticising performance, while also creating the grounds for 'heresy'. For example, during the research I came across a leaflet inviting men to join an unofficial, self-help group for men 'addicted to unsafe sex'. Clearly, 10 years before, unsafe sex was 'normal', but now had been pathologized as a new compulsive disorder! This leads, in Foucauldian fashion to the invention of new medicalized categories of pathology, ripe for its disciplinary gaze, with the development of unsafe sex addiction.

The model of the 'active patient' also illustrate how this might both further the penetration of the clinical gaze into the myriad erotic interpersonal spaces of the erotic city while also providing a means of resistance to the same gaze. The instrumental use of medicine may be an element in decisions like Charles' of whether to use the clinic for purposes other than simply the treatment of infection. The various constructions of danger and risk explored here, together with the strategies by which they are managed in everyday life, are critical. The urbanized experiences of sexual agency, practices and the meanings that the actor attaches to danger, pollution, identity, performance, interpersonal relationships, pleasure, desire and the body, are continuous with the experience of clinic attendance. Central to the universe of meanings are sometimes competing discourses of purity and danger, restraint and availability in which the representations of sexuality and sexual identities now stem from urban constructions of lifestyle and consumption. These are reproduced not only in the imagery, languages and performativity of the city streets, but also in the new cosmopolitan virtual public spaces for erotic activities of cyberspace. This is where further research is required for, whether the individual actor is located in the city or rural arena, the postmodern diversity of sexual identities and practice have become more fluid and contested. Having now codified these within a predominantly urban imagination, it remains to be seen how sexual

desires may be rehearsed in the new architecture of cyberspace before being managed in the social and embodied world.

Notes

[1] Damien, client, Clinic B.
[2] Andreas, *Men's Health* magazine respondent.
[3] Joe, client at Clinic A.

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