Negotiating the edge

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Negotiating the edge: The rationalisation of sexual risk-taking amongst Western male sex tourists to Thailand

Abstract

Every year thousands of Western men travel to Thailand as sex tourists in order to participate in paid-for sex. Although many of these men will use condoms in order to protect themselves against sexually transmitted infections, despite the risks, others will not. By applying Steven Lyng's (1990) concept of edgework to data collected from 14 face-to-face interviews with male sex tourists in Pattaya, Thailand and 1237 online discussion board posts, this article explores the ways in which these men understood and sought to rationalise the sexual risks that they took. It argues that notions of likelihood of infection and significance of consequence underpin these behaviours, and identifies the existence of understandings of sexual risk that reject mainstream safer-sex messages and frame condomless sex as a broadly safe activity for heterosexual men. The article concludes by summarising the difficulties inherent in driving behaviour change amongst this group of men for whom sexual risks appear to be so easily rationalised away as either inconsequential or irrelevant.

Introduction

The phenomenon of sex tourism, particularly in Thailand, has been well studied (Syvertsen et al., 2015; Lim & Cheah, 2016), and yet the voluntary sexual risks that male sex tourists may choose to take have been poorly explored (Manieri et al., 2013). Steven Lyng's edgework theory (1990) hypothesises voluntary risk-taking as a reflection of the desire to test the boundary between order and disorder in one's life, and as a means of escape from an otherwise familiar and dull existence, something that Cronin et al. (2014) describe as an '*emancipation from the mundane*'. However, Lyng's theory also engages with the importance of feeling in control of the risks that one takes, with risk behaviour that may appear irrational to an outside observer perceived by the risk-taker to be well-managed. This article considers voluntary sexual risk-taking amongst heterosexual Western male sex tourists to Thailand, principally those from Europe, the United States and Australasia, as a form of edgework. In particular, it interrogates the ways in which some men conceptualise and engage with condomless sex as an acceptable practice, and explores the mechanisms that they adopt in order to feel in control of the risks that they take in doing so.

The Kingdom of Thailand is located at the centre of the Indochina peninsula in Southeast Asia, and although prostitution there is illegal, the country remains one of the most important destinations for Western male sex tourists (Williams, 2002; Mercer et al. 2007; Syvertsen et al., 2015). Bangkok, Pattaya and Phuket are amongst the most heavily frequented venues for these men (Garrick, 2005; Hobbs et al., 2011), although men are able to purchase sex throughout Thailand in venues such as bars and massage parlours, as well as from women who work directly off the street (Singh & Hart, 2007). Sexually transmitted infections (STIs) are an inherent risk to both sex workers and the men who pay them for sex, and although bacterial infections such as gonorrhoea and chlamydia are

important, it is HIV that is of greatest public health concern (Wright, 2003; Fairchild & Bayer, 2011). A survey by the United Nations Population Fund (2006) found the prevalence of HIV amongst Thai female sex workers (FSWs) in brothels to be 6.8%, although this does not necessarily paint an accurate picture of the risk. Although the Thai Government asserts that rates of HIV have been falling for several years (UNAIDS, 2015), Manopaiboon et al. (2013) suggest that the prevalence of HIV amongst venue-based (brothel and massage parlour) FSWs in Bangkok may now be almost double the UNPF's 2006 estimate. Perhaps of more concern are the many FSWs that are not venue-based but instead work informally out of bars or on the street. Although the prevalence of HIV amongst this group is notoriously difficult to pin down due to its unregulated nature, Manopaiboon et al. (2013) estimate prevalence of roughly 23%, while Nhurod et al. (2010) suggest that in some places it could be as high as 45.8%. There is also evidence these high rates of HIV may be driving an increased incidence of the infection amongst foreign male sex tourists. Rice et al. (2012) suggest that between 2002 and 2010 around 15% of new HIV cases in individuals born in the UK were acquired overseas. Of these, the largest single group were heterosexual men over 45 years of age who had been infected in Thailand, and who had reported participating in sex with a commercial sex worker; a similar pattern has also been described amongst Australian sex tourists to Thailand (Persson et al., 2014).

The correct and consistent use of condoms has been shown to be highly effective at reducing the transmission of STIs, including HIV (Hollub et al., 2011), but despite this there is evidence that some men choose not to use them. A study by Manieri et al. (2013) on Swedish sex tourist's in Thailand found that 20% of those they interviewed planned not to use a condom in their next sexual encounter with a FSW. Because this group were amongst the older men in the study (over 40), Manieri et al (2013) argue they should

have been exposed to the peak of government safer-sex messages during the 1990's. Ultimately, the authors concede that these men's decision to engage in planned condomless sex must have been driven by undisclosed factors for which they could offer no explanation. Consequently, although it is apparent that some Western men are voluntarily participating in planned condomless sex with FSWs while in Thailand, what remains uncertain are the motivations underpinning this practice, and the ways in which these men engage with the risks of acquiring STIs/HIV.

Lyng's edgework theory (Lyng, 1990) offers one way of looking at this behaviour as a form of voluntary risk-taking. Originally derived from a synthesis of Marx and Mead (Lyng, 2005), edgework represents resistance to the constraints of modern life, an escape from societal control and the opportunity to achieve a heightened degree of self-determination and personal freedom. If this is the goal of edgework, the process for achieving this goal is embedded in risk-taking, and it is through voluntary participation in risky practices that valued new skills, competencies and symbolic resources are obtained that empower its practitioners. Although risk-taking has historically been viewed in terms of either rational choice (i.e. a weighing up of risk versus benefit), or else as a personality trait (i.e. some individuals are more motivated to take risks than others) edgework goes further by adding a social context to the practice (Lyng & Matthews, 2007). Edgework has been applied as a lens to explore a number of risk behaviours, either reflected in people's day-to-day lives through their employment choices (Lois, 2001; Ibáñez & Narocki, 2011; Turtiainen & Väänänen, 2012) or else amongst those who actively seek out risk through their social or recreational activities (Lyng, 1990; Lupton & Tulloch, 2002; Moran, 2011; Murphy & Patterson, 2011; Wong, 2011). Successful individuals (or those whose luck holds out) tend to perceive themselves as both individually powerful and socially connected to other risk-takers, as well as superior to those who do not take

the same risks. Lyng (2005) suggests that edgeworkers also tend to 'up the stakes' by adding more and more risk once a level of comfort has been achieved, pushing their luck further and further over time as their confidence builds. However, there is nothing intentionally self-destructive here, rather a growing sense of excitement, power and self-efficacy achieved from stepping closer and closer to the edge without 'falling off' into potentially catastrophic consequence; it is this feeling of being in control of the risks that one is taking, even if one is not, that matters most. Although edgework has been utilised in a variety of contexts, only one study has so far employed it to focus on men who pay for sex. Kong (2016) explored buying sex as edgework, as a form of resistance to normative companionate sexuality amongst Hong Kong men who have sex with FSWs in Hong Kong and mainland China. However, although this study argued persuasively for the practice as a means of escape, and as a way of developing cultural skills, it did not engage with how men address the risks of acquiring STIs. The purpose of this article is to deal specifically with that question for Western men who choose to participate in condomless sex with FSWs (Wright, 2003; Manieri et al., 2013). By employing edgework as its theoretical framework, it seeks to provide an insight into this group of men and the role that they potentially play in STI/HIV transmission both inside and outside Thailand.

Methods

Ethical approval was obtained prior to the commencement of this study. Data were drawn from two independent sources, in-depth interviews with Western male sex tourists in Thailand and online discussion boards. Interviews were conducted in Pattaya, Thailand between May and June 2014. Participants were recruited purposively by approaching approximately fifty Western men in public spaces during the daytime and explaining the

nature and purpose of the research. Those who agreed to engage in conversation were provided with an information sheet containing further details about the study, and were then asked to give written informed consent for their participation. Although most of those approached refused to participate, stating either that they were not sex tourists or else were otherwise not interested in taking part, fourteen British men aged between 37 and 71 agreed to be interviewed. No incentives or remunerations were offered to participants. Interviews were semi-structured and followed an interview schedule based on Lyng's edgework theory (Lyng, 1990) (risk awareness, risk-taking practices and concepts of empowerment and control) framed within the context of sexual risk-taking. Each interview lasted approximately forty-five minutes and was audio recorded. Interviews were then transcribed, applying pseudonyms to participants and removing all identifying information in order to protect participant confidentiality. Transcripts were encrypted and stored electronically on an external data drive, and all original audio recordings were then destroyed.

Online discussion board posts were located using a keyword search of the internet designed to identify discussion boards used by male sex tourists to Thailand. In order for the search to be as thorough as possible, independent searches were conducted using Google, Yahoo and Bing, the three most frequently used online search engines (Experian Hitwise, 2014). To be considered for inclusion, posts had to be in English, be freely available to access without the need to complete a registration process, date from no earlier than 2009 and be written by men identifying as male sex tourists to Thailand. This process sourced 1237 individual discussion board posts across seven different websites, and consisting of approximately 190,000 words. Discussion posters rarely revealed any demographic information, however those who did were predominantly over 40 years of age and living in Britain, the United States or Australia. Consent was not sought from

post authors due to the publicly available nature of the discussion boards used (Anderson & Kanuka, 2003), although all authors were provided with pseudonyms at the point of data collection. The decision was made to report all of the data presented within this article *verbatim* in order to maintain the authenticity of what these men had to say, however using direct quotes risked enabling third parties to find the original posts and usernames, potentially undermining attempts made to anonymise (Dawson, 2014). To evaluate the risk of this happening, a further internet search was conducted for each discussion board post included in the results section of this paper, but no poster was identifiable by these means. All data collected during this process were also securely stored electronically on a single encrypted data drive.

Thematic analysis (Braun & Clarke, 2006) was used to analyse the discussion board and interview data separately, an inductive process that consisted of the lead author reading the discussion board and interview data several times and then manually coding each data set prior to developing preliminary themes. Coding used the *a priori* lens of Lyng's (1990) edgework theory, and careful attention was given to men's perceptions of risk, empowerment through risk-taking and the perceived ability to control those risks that were taken. However, despite this theoretical focus, the analysis also strove to be reflexive in its interaction with the data in order to allow unexpected themes to emerge. Although Holloway and Wheeler (2010) suggest that fourteen participants is an acceptable number for qualitative studies, the authors wanted to explore the degree of saturation within the interview data (Mason, 2010; Bonde, 2013). Following further analysis of the interview transcripts, it became clear that all of the themes to emerge within the interview data did so during the first eight interviews, providing confidence that men's views had been adequately captured by the sample. A similar approach was

conducted on data drawn from the discussion board posts, which reached saturation at around post 750, just over halfway through the data set.

Once themes had been identified from within each of the data sets, all of the data were reviewed together in order to generate a more thorough understanding of the findings, and to seek areas of agreement and difference (Altrichter et al., 2008). This triangulation between the two data sets informed the synthesis of a final set of overarching themes that reflected the dominant narratives across the data.

Results

'Well you roll the dice, don't you? Sometimes you get caught out, sometimes you don't.'

Derek, 58 year old (Interview)

Three principle themes emerged from the data during analysis: 1) The ranking of STIs according to the perceived likelihood and consequence of infection; 2) The view that the benefits of practicing condomless sex outweighed any potential health consequences, and: 3) The strategies used to try to reduce the risk of acquiring an STI while still avoiding using condoms. Overall, the interview and discussion board data were in agreement, however although all of the men interviewed in Thailand participated in condomless sex with FSWs at least occasionally, a proportion of the discussion board posters stated that they always used condoms. While this is important to note, the focus of this article lies predominantly with those who choose to practice condomless sex, and in doing so seeks to understand how such men engaged with and managed their sexual risk-taking.

Ranking risk – Constructing the edge

Although the majority of the men in this study acknowledged that engaging in sexual activity with FSWs in Thailand carried some health risks for them, the perceived relevance and significance of these risks varied. Overall, men discussed three distinct types of sexual activity within their narratives – insertive oral sex, vaginal sex and anal sex – but there was a general consensus that not all these practices carried equal risk for STI transmission. Instead, the activities were presented as lying along a continuum of risk, with oral sex considered to be the lowest risk activity, and anal sex the highest (although no man admitted to personally engaging in anal sex, an act that was implicitly linked with homosexuality). The perception of oral sex as a low risk activity was such that the majority of men did not consider oral sex without a condom to be a risk behaviour at all:

'Oral sex, I don't think anybody ever, ever thinks about a condom.'

Brian, 59 year old (Interview)

Conversely, the wisdom of engaging in condomless vaginal sex with FSWs (referred to by many as 'barebacking') was more contested. Although most men considered this activity to be a higher risk for STI transmission than oral sex, the problem for them was that using a condom was far less pleasurable. This tension underpinned individual negotiations around risk that were driven by two broad considerations; firstly, the likelihood of contracting an STI from a FSW through participating in an sex without a condom, and secondly, if this occurred, what impact the STI would have on their lives. Overall, HIV was considered to be a high consequence infection but one that it was unlikely they would contract because, although few men underplayed the significance of

the disease, it was largely viewed as a homosexual problem that heterosexual men need not really fear:

'*I've got three friends what have come a cropper* (caught an STI) *doing barebacking, but I don't know one guy who's caught HIV, don't know one. It's overrated*.'

Steve, 45 year old (Interview)

The idea that HIV was only really a homosexual disease was embedded to such an extent that in one case where a heterosexual man was known by one of the participants to have acquired HIV, the transmission was blamed on secretive homosexual behaviour:

'I know a guy here… he's HIV-positive... I said to Gary, I said, "Has he ever been with blokes or ladyboys or owt (anything) *like that", he said, "Didn't you know?", "No", I said, "I didn't", "Oh yeah, he swings both ways".'*

Mark, 47 year old (Interview)

In contrast to HIV, bacterial infections such as chlamydia and gonorrhoea were viewed as relatively easy to catch, and many men openly admitted to previously contracting a bacterial STI. However, because they were easily curable via over-the-counter medication, bacterial infections were considered to be of only low consequence:

'My mate, he's still a barebacker, and he hasn't got nothing. The only worse thing he got was pissing sideways with gonorrhoea, that's all he got.'

Steve, 45 (Interview)

These beliefs around the nature of sexual risk were supported by the men's own experiences and the experiences of their peers; in fact, across all of the data, men's views about their likelihood of acquiring an STI from a FSW were guided most heavily by what had already happened to them:

> *'I barebacked over 100 women last year. Most of them street workers… I went back and tried to figure out my total. I have barebacked over 500 women in the past 7 years. Most of them in SEA* (Southeast Asia). *I have never even caught a cold from any of these girls."*
>
> Lovecat (Discussion board poster).

In contrast to the high value attributed to knowledge gained from personal experience and peer narratives, the role of national governments, non-governmental organizations and the media in providing reliable information and advice was minor at best. Some men viewed sexual health messages from these external sources with extreme distrust, arguing that they were more about social control than protecting them from harm:

> '*Never believe what you hear on TV, it's all bullshit… the mainstream media will tell you lies like you can't believe. I never listen to them.*'
>
> Brian, 59 year old (Interview)

On occasion, this distrust even extended into questioning the nature of HIV/AIDS as a genuine disease:

‘*The dangers to normal healthy Westerners who don't do drugs, are not anal sex receivers, seem to be nearly non-existent. Studies have shown AIDs has a much higher correlation with Syphilis than with HIV, a virus that cannot be isolated and cannot be proved absolutely to exist in anyone*’

Sinbad (Discussion board poster)

Accepting risk – Crowding the edge

Although most men pushed HIV away as irrelevant, a minority of participants chose to engage more directly with the risks that they were taking, and the chance that they might acquire the virus. Where this happened, the benefits of participating in risky sexual activities were usually portrayed as being worth the potential consequences:

‘I have made my own decision. And the full sexual experience is too important as an aspect of fully living life. It's no different from choosing to eat rich, tasty food, or choosing to drive a car that is fun and exciting. Living life to the fullest is riskier than living a cloistered existence. But the richness of the experience of living it in such an enjoyable manner is worth the added risk - at least to me.’

Alphahutch (Discussion board poster)

There were dissenting voices from those who viewed condomless sex with sex workers as a dangerous, high-risk practice, and something to be neither engaged with nor encouraged:

'I hope you guys who claim to sleep bareback end up with HIV for being so stupid is all I can say. Sleep around without a condom and pay the consequences, especially sleeping with bargirls...'

Wanderer (Discussion board poster)

However, although arguments in favour of condom use were uncommon within the data, it was the narratives of older men where a positive trade-off between the risks and benefits of condomless sex was most frequently articulated. This group commonly cited their advancing years as one reason to take risks, as there was felt to be little to lose in terms of quantity of life and much to gain in quality:

'*You can't catch AIDS twice, so if you've got it you don't know for years and years… I'm 68, so if I've got, hopefully, another 20 years but I might only have 10, so why don't I have 10 good years*?'

Michael, 68 year old (Interview)

Regardless of the individual rationalisations employed by these men, what was clear across the data was that condomless sex, once sampled, was likely to be repeated. The draw was not just physical either, condomless sex was acknowledged as a risk and this risk was exciting – something to be enjoyed rather than feared:

'The problem with bareback is that it becomes addictive… For me it's not just the increased sensation but rather something psychological … I know the risks involved in all this but sadly that just seems to make it all the more exciting'

Bowlerhat (Discussion board poster)

Controlling risk – Negotiating the edge

Regardless of their stated beliefs about STIs, men's views were usually moderated by some acceptance of personal vulnerability, and although condomless sex could be thrilling, no one wanted to catch an STI if they could avoid it. As a method for trying to reduce the risks, condoms were the obvious choice and most men considered them to be a good idea in principle. However, many online posters, and all of the men interviewed in Thailand, reported engaging in paid-for sex with FSWs without using a condom, either periodically:

'*I always use a condom, always, well, sometimes*.'

Carl, 37 year old (Interview)

Or as a matter of course:

'*It's something that I don't discuss with people or people don't discuss it with me, but personally I will never use them* (condoms).'

Michael, 68 year old (Interview)

Although disliking condoms and often avoiding their use, taking risks for their own sake was rare amongst these men. Instead most sought to rationalise their way out of the problem of not using condoms by trying to reduce their sexual risks in other ways. One of the simplest risk reduction strategies involved the visual appraisal of FSWs, a commonly reported strategy requiring little effort in its practice. Women were screened according to two criteria – age and appearance. The belief, presented as perfectly logical

by several participants, was that a younger FSW might be expected to have had sex with fewer men than an older one, and therefore present a lower risk for STIs simply by virtue of her lack of years. Likewise, a subjective evaluation of a woman's physical condition was also believed to be sufficient to ascertain her sexual health status, with excessive thinness being associated with disease and underpinning any decision to use a condom:

'*This is the way I work it out, if she's fat anyway, that means she ain't got nothing. If they're skinny… wrap it up.*'

Steve, 45 year old (Interview)

Beyond physical appraisal there was also a general sense, found throughout the data, of a geography of risk whereby FSWs from different venues were considered to have different degrees of sexual risk attached to them. Women who worked in bars and massage parlours were considered to pose the least risk as the belief was that they were subject to regular sexual health testing. Non-venue FSWs – typically street-based – were considered much riskier than those who were venue-based. They were not subject to the same sexual health checks that men believed venue-based FSWs were and, as such, represented an unknown, an uncontrolled, risk. Further, it was argued that as all FSWs would prefer to work in venues rather than being out on the street, the only logical reason why a woman would not do so was that they were already carrying an STI and would fail venue health checks.

'*The girls who work on the streets, they're cheaper, they're the ones normally with sexually transmitted diseases, not the girls in the bar. The girls in the bar are checked regular.*'

Roger, 61 year old (Interview)

These two approaches, visual appraisal and venue selection, were common, practical methods through which men could gain the feeling of being in some control of sexual risk during casual sexual encounters, but there were others. Washing of the genitals with vinegar or antiseptic, both prior to and following the sexual act, was one strategy believed to kill potentially harmful organisms and allow for safer sex. Discussion around the use of barrier products, such as coconut oil, sometimes extended to include quite complex strategies designed to provide the best protection for men without the requirement for a condom:

'*For barebacking, I suggest a multi-layer defence. First rub on some silicone lube… to bond with the outer layer of skin. Wipe off the excess. Then push some thick petroleum jelly based zinc oxide ointment into the top of the urethra. That part can be done in advance, when she's not there. When the action starts, lube up with a thick layer of coconut oil on both of you*.'

Cakey_Joe (Discussion board poster)

The prophylactic use of the antibiotic azithromycin, which was widely available from pharmacists, was also suggested as a protective measure against bacterial STIs, seen as the greatest risk by most men and far more likely than HIV to be caught:

'I know lads over here who, who buy the tablets, right, and they take them before they go out at night... Zithromax, cure for anything... They take tablets and they go out. They might have a dose but they've took the tablets already… '

Derek, 58 year old retired (Interview)

The availability of control strategies such as these, irrational or not, was very empowering for men, permitting condoms to be avoided with relative confidence. Most were relatively easy to use and they could be mixed-and-matched as required in order to add further confidence. As the majority of these methods were developed and utilised by other sex tourists, they were also trusted implicitly, far more than the safer-sex messages targeted at them from external sources.

Discussion

When laying out his theory, Lyng (1990) describes edgework as any voluntary risk-taking activity that permits an individual to seize control over their lives, and one in which failure to meet the challenge may lead to death or serious injury. In line with this, and possibly because the theory originally emerged from Lyng's experience of free-fall parachute jumping, the majority of studies that have engaged with edgework have focused on individuals actively seeking out risk through their participation in dangerous employment or leisure activities. One might therefore argue that these men chase sexual risk for similar reasons, flirting with disaster as a means of escaping the mundane; however, for the men in this study this did not appear to be the case. Although male sex tourists to Thailand may be looking to escape from their ordinary lives, at least temporarily, these men were not seeking risk for its own sake. Rather they were looking to engage in pleasurable, authentic sex that for them was only incidentally associated with risk.

Although the men in this study largely accepted that there were some risks associated with practicing condomless sex with FSWs, they also felt to some degree in control of

the risks that they took; edgework theory does not require that this control be real, only that it be perceived to be real by its practitioners (Lyng, 1995; Laurendeau, 2006). Across the data, men possessed a complex and overlapping system of objectively flawed control strategies – some conceptual, others practical – that they believed reduced the risks to their health of engaging in condomless sex. The first of these was an implicit system of ranking of disease that essentially divided STIs into two groups, with HIV on one side and bacterial infections, primarily gonorrhoea and chlamydia, on the other. Men were aware that HIV was a very serious infection but they were able to construct the disease as essentially a homosexual problem, and so one that they were insulated from by virtue of their heterosexuality. In this way they were able to transfer both the risk and responsibility away from themselves, a belief that largely ignored the very real risk of heterosexual transmission (Delpech, 2013). In the minds of most of these men, this made HIV a high consequence but unlikely disease, one that would be catastrophic if caught but with very little risk of that actually happening to them. In addition to this general distancing of HIV as a disease of the 'other', there was also a degree of fatalism expressed by some men about the consequences of the infection if they should happen to contract it. For these men, using condoms meant forsaking sexual pleasure now in return for a consequence that was far off in the future, or which they might not live long enough to see. This tendency to value the now over the future is acknowledged elsewhere in the literature (Taylor et al., 2003; Gwandure & Mayekiso, 2012; Doyle, 2013), but is a detachment from edgework theory. This perhaps stems from Lyng originally developing his ideas around extreme sports where the cause and consequence of getting things wrong (injury or death) occur in a rapid temporal sequence, for example jumping out of a plane and hitting the ground. By pushing potential negative outcomes far into the future, older men in particular felt liberated to engage in the condomless sex that they enjoyed. In this

sense, their approaching mortality may be seen, ironically, as their escape route (perhaps for Lyng their parachute) away from meaningful consequence.

In contrast to HIV, the men in this study were all familiar with the risks of bacterial STIs, with many reporting having contracted them at some point in the past. Although men felt vulnerable to these infections, treatment with antibiotics was considered quick and easy; bacterial STIs were seen as a likely outcome on condomless sex with an FSW, but of low consequence. Figure 1 illustrates this concept of the categorization of disease by risk and consequence as a visual representation of the way in which the men rationalised their engagement in condomless sex.

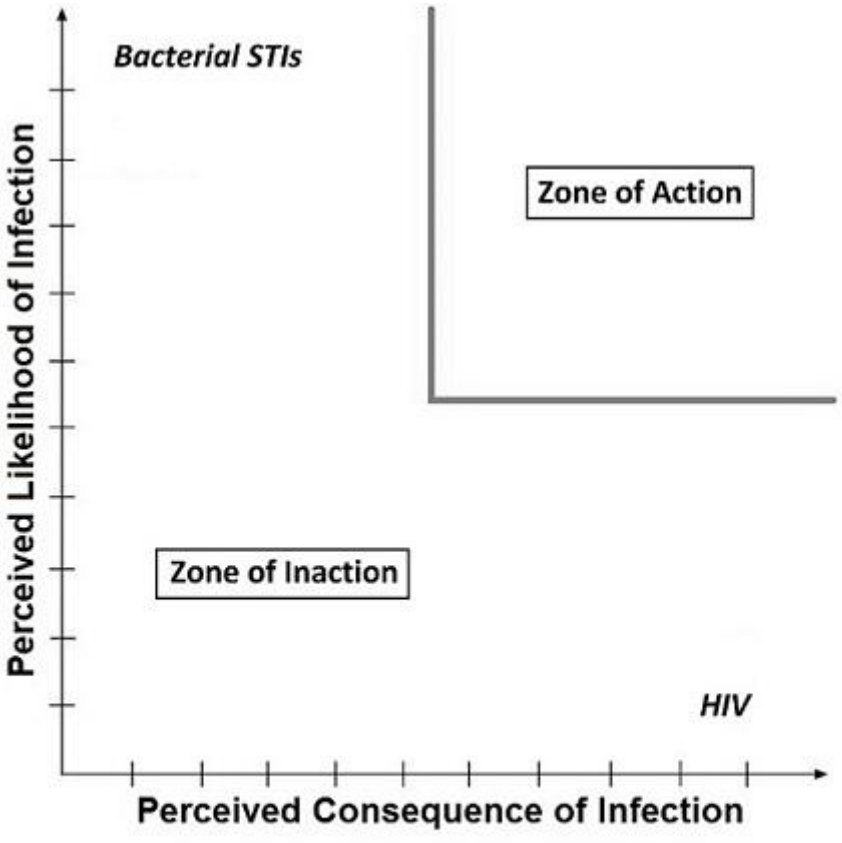

Figure 1. Zone of Inaction – The relationship between the perceived likelihood and the perceived consequence of sexually transmitted infections on condom use.

Here the zone of inaction represents the situation where either the perceived likelihood of contracting an STI, or its subsequent consequence, are considered to be low. Where condomless sex is the preferred option, men may decide that it is not necessary to use a condom because bacterial infections, although likely, are easily cured and therefore of little consequence. Conversely, while HIV may be viewed as a far more serious infection, heterosexual men may consider it unlikely that they will contract the virus, particularly in circumstances where HIV is framed primarily as a disease of homosexual men. The model theorises that only by increasing the perceived consequence of bacterial infections, or else increasing the perceived likelihood of contracting HIV, would men move into the zone of action and become more likely to use condoms. As with all models, the map simplifies the territory and some men considered all STIs to be both high risk and high consequence infections, ranked them differently or feared pregnancy over infection, and other viral STIs, such as herpes, were not discussed at all. However, overall the model is representative of the stated beliefs of the majority of the men in this study for not using condoms.

Beyond these conceptual methods of risk minimization, most of the men in this study also adopted practical strategies that they believed provided them with additional protection from contracting STIs. The selection of sexual partners based on age, physical appearance or venue was a commonly used strategy – older, thin, sick-looking FSWs and those operating as non-venue-based freelancers were considered a risk, although young healthy looking, bar or brothel-based FSWs were not really viewed as being risky at all. For many men, this represented a very easy way to minimise their perceived risks, requiring no greater effort than simply picking the right woman from the right geographical space. Men's primary focus on preventing bacterial infections was reflected in other practices too, including genital washing and the prophylactic use of antibiotics

for bacterial STIs. Regardless of the actual risk of viral STIs, including HIV, these methods were commonly considered appropriate to the predominantly bacterial risks that these men believed that they faced.

The knowledge that underpinned these practices was derived heavily from the men's own experiences and the experiences of their friends and peers. However, alongside this there were other messages too, messages that came from outside their community. Men were aware of public health campaigns, both from the West and from within Thailand, that warned them of the risks of HIV in particular, and told them to use condoms. The problem with these messages was two-fold. Firstly, they did not tally with the men's own experiences; they warned of HIV and yet none of the men knew of any firmly heterosexual man who had caught it. Secondly, they came from outside the sex tourist community and there was a very strong feeling of 'us' and 'them' across the data whereby anyone who was outside the group ultimately did not have their interests at heart; governments and other agencies wanted to control their behaviour and stop them from doing what they wanted to. Consequently, information that came to them via mainstream media (outsider information), whether it be part of a health promotion campaign or simply a news story, was often distrusted as having ulterior motives (Ford et al., 2013; Eaton et al., 2015). Instead, men trusted what they knew or what they heard from other sex tourists (insider information), either directly through conversation or via the internet. The message here, and one that was felt to be true by the majority of participants, was that condomless sex with carefully selected FSWs was broadly safe for HIV. If there had been narratives circulating from men who admitted catching HIV from condomless sex with FSWs then this would have provided the sort of first-hand insider evidence that the sex tourist community would be more likely to trust, however there

were none reported. This does not mean that no men were contracting the disease heterosexually, only that if they were, they were not sharing their stories.

Although this study throws some light on the ways in which Western male sex tourists appear to rationalise their engagement in condomless sex with FSWs, it suffers from a number of limitations. Its findings relate only to the 14 men who were interviewed in Pattaya, and to 1237 English language discussion board posts, and so it would be unreasonable to suggest that this study offers anything more than a brief insight into some of the ways in which these men engage with sexual risk. Future research should seek to broaden this to engage with men of different ages and nationalities across other major sex tourist destinations such as Angeles City in the Philippines and San José in Costa Rica. Additionally, expanding the focus of this research to include men who have sex with male and transgender sex workers would also help to develop a fuller understanding of risk-taking behaviours by male sex tourists, which could help to better inform public policy and health promotion practice in relation to this liminal but important group of men.

Conclusions

Some, perhaps many, Western men who travel to Thailand each year are choosing to engage in condomless sex with FSWs despite the risks of contracting an STI. Lyng (1990) considers voluntary risk-taking to be a goal in itself, providing both excitement and a sense of escaping the confines of modern life, but for the men in this study sexual risk was an unfortunate hazard rather than an objective. There was never any sense that men enjoyed gambling with the chance of acquiring an STI, it was simply that many did not want to use condoms. By ranking diseases according to likelihood and consequence, and practicing a diverse and eclectic range of locally derived risk control strategies, many

men were able to feel in control of the risks and so were unable to see any real imperative to use a condom. Overall, edgework theory provided a good explanation of the way in which these men engaged with sexual risk-taking, although edgework here was much more about dealing with risk than with seeking it; risk could not be avoided but it could be managed.

From a public health perspective, STIs are a concern for both male sex tourists and FSWs, however the majority of sexual health promotion efforts in Thailand rely primarily on empowering FSWs to protect themselves by insisting on condoms (Treerutkuarkul, 2010). This places the women in an untenable position because the money, and therefore the power to decide whether a condom will be used or not, ultimately lies with men. Instead, health promotion practitioners and policy makers need to be able to communicate the risks of condomless heterosexual sex in ways that better connect with the lived experience of these men, and which are derived from a source that they can trust. Employing narratives drawn from the direct experience of men either who have suffered a serious health consequence from a bacterial or viral STI, or who have contracted HIV heterosexually, might have the potential to better impact on the accepted wisdom of sexual risk-taking in this setting. Although there would undoubtedly be both practical and ethical implications in adopting such an approach, without taking some form of targeted action it seems unlikely that there will be any change in these men's worldview and to their subsequent sexual risk-taking behaviours.

References

Anderson, T. & Kanuka H. (2003). *E-Research: Methods, strategies and issues*. Boston: Pearson.

Bonde, D. (2013). Qualitative interviews: When enough is enough. Retrieved March 11 2016, from http://www.researchbydesign.com.au/media/RBD-WhitePaper-Margin-of-Error.pdf.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Methods in Psychology, 3*, 77-101.

Cronin, J. M., McCarthy, M. & Collins, A. (2014). Creeping edgework: Carnivalesque consumption and the social experience of health risk. *Sociology of Health & Illness, 36*, 1467-9566.

Delpech, V. (2013). The HIV epidemic: global and UK trends. *Medicine,* 41, 417-419.

Doyle, J. R. (2013). Survey of time preference, delay discounting models. *Judgment and Decision Making, 8*, 116-135.

Eaton, L. A., Driffin, D. D., Kegler, C., Smith, H., Conway-Washington, C., White, D. & Cherry, C. (2015). The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. *American Journal of Public Health, 105*, e75-e82.

Fairchild, A. L. & Bayer, R. (2011). HIV surveillance, public health, and clinical medicine - Will the walls come tumbling down? *New England Journal of Medicine, 365*, 685-687.

Ford, C. L., Wallace, S. P., Newman, P. A., Lee, S. J. & Cunningham, W. E. (2013). Belief in AIDS-related conspiracy theories and mistrust in the Government: Relationship with HIV testing among at-risk older adults. *Gerontologist, 53*, 973-984.

Garrick, D. (2005). Excuses, excuses: Rationalisations of western sex tourists in Thailand. *Current Issues in Tourism, 8,* 497-509.

Gwandure, C. & Mayekiso, T. (2012). Internal versus external control of reinforcement in health risk and HIV and AIDS prevention. *Journal of Applied Social Psychology, 42,* 1599-1624.

Hobbs, J., Pattalung, P. N. & Chandler, R. C. (2011). Advertising Phuket's nightlife on the internet: A case study of double binds and hegemonic masculinity in Sex Tourism. *Sojourn, 26,* 80-104.

Holloway, I. & Wheeler, S. (2010). *Qualitative research in nursing and health care*. Winchester: Wiley-Blackwell.

Hollub, A., Reece, M., Herbenick, D., Hensel, D. & Middlestadt, S. (2011). College students and condom attitude: Validation of the multi-factor attitude toward condoms scale (MFACS). *Journal of American College Health, 59,* 708-714.

Ibáñez, M. & Narocki, C. (2011). Occupational risk and masculinity: The case of the construction industry in Spain. *Journal of Workplace Rights, 16,* 195-217.

Kong, T. S. K. (2016). Buying sex as edgework: Hong Kong male clients in commercial sex. *British Journal of Criminology, 56,* 105-122.

Laurendeau, J. (2006). "He didn't go in doing a skydive": Sustaining the illusion of control in an edgework activity. *Sociological Perspectives, 49,* 583-606.

Lim, S. J. & Cheah, S. X. (2016). Risky pleasures. *SAGE Open,* 6(2).

Lois, J. (2001). Peaks and valleys: The gendered emotional culture of edgework. *Gender and Society, 15,* 381-406.

Lupton, D. & Tulloch, J. (2002). 'Risk is part of your life': Risk epistemologies among a group of Australians. *Sociology, 36,* 317-33.

Lyng, S. (1990). Edgework: A social psychological analysis of voluntary risk taking. *American Journal of Sociology, 95*, 851-886.

Lyng, S. (2005). *Edgework: The sociology of risk-taking*. London: Routledge.

Lyng, S. & Matthews, R. (2007). Risk, edgework and masculinities. In K. Hannah-Moffat & P. O'Malley, *Gendered Risks*. Milton Park: Routledge-Cavendish,.

Manieri, M., Svensson, H. & Stafstrom, M. (2013). Sex tourist risk behaviour - An on-site survey among Swedish men buying sex in Thailand. *Scandinavian Journal of Public Health, 41*, 392-397.

Manopaiboon, C., Prybylski, D., Subhachaturas, W., Tanpradech, S., Suksripanic, O., Siangphoe, U. & Whitehead, S. J. (2013). Unexpectedly high HIV prevalence among female sex workers in Bangkok, Thailand in a respondent-driven sampling survey. *International Journal of STD & AIDS, 24*, 34-8.

Mason, M. (2010). Sample size and saturation in PHD studies using qualitative interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*. Retrieved April 7 2016, from http://www.qualitative-research.net/index.php/fqs/article/view/1428/3027.

Mercer, C. H., Fenton, K. A., Wellings, K., Copas, A. J., Erens, B. & Johnson, A. M. (2007). Sex partner acquisition while overseas: results from a British national probability survey. *Sexually Transmitted Infections, 83*, 517-522.

Moran, K. (2011). (Young) Men behaving badly: dangerous masculinities and risk of drowning in aquatic leisure activities. *Annals of Leisure Research, 14*, 260-272.

Murphy, S. & Patterson, M. (2011). Motorcycling edgework: A practice theory perspective. *Journal of Marketing Management, 27*, 1322-1340.

Nhurod, P., Bollen, L. J. M., Smutraprapoot, P., Suksripanich, O., Siangphoe, U., Lolekha, R., Manomaipiboon, P., Nandavisai, C., Anekvorapong, R., Supawitkul, S.,

Subhachaturas, W., Akarasewi, P. & Fox, K. K. (2010). Access to HIV testing for sex workers in Bangkok, Thailand: a high prevalence of HIV among street-based sex workers. *The Southeast Asian Journal of Tropical Medicine and Public Health, 41*, 153-62.

Persson, A., Brown, G., McDonald, A. & Körner, H. (2014). Transmission and Prevention of HIV Among Heterosexual Populations in Australia. *AIDS Education & Prevention, 26*, 245-255.

Rice, B., Gilbart, V. I., Lawrence, J., Smith, R., Kall, M. & Delpech, V. (2012). Safe travels? HIV transmission among Britons travelling abroad. *HIV Medicine, 13*, 315-317.

Singh, J. P. & Hart, S. A. (2007). Sex workers and cultural policy: Mapping the issues and actors in Thailand. *Review of Policy Research, 24*, 155-173.

Syvertsen, J. L., Bazzi,, A. R., Martinez, G., Rangel, M. G., Ulibarri, M. D., Fergus, K. B., Amaro, H. & Strathdee, S. A. (2015). Love, trust, and HIV risk among female sex workers and their intimate male partners. *American Journal of Public Health, 105*, 1667-1674.

Taylor, S. E., Kemeny, M. E., Schneider, S. G. & Aspinwall, L. G. (1993). Coping with the threat of AIDS. In J. B. Pryor & G. D. Reeder, *The Social Psychology of HIV Infection*. New Jersey: Lawrence Erlbaum.

Treerutkuarkul, A. 2010. Thailand's new condom crusade. *Bulletin of the World Health Organization, 88*, 404-405.

Turtiainen, J. & Väänänen, A. (2012). Men of steel?: The masculinity of metal industry workers in Finland after World War II. *Journal of Social History, 46*, 449-472.

UNAIDS (2015). *Thailand AIDS Progress Report 2015*. Retrieved March 22 2017, from http://www.unaids.org/sites/default/files/country/documents/THA_narrative_report_2015.pdf.

United Nations Population Fund. (2006). *HIV Prevention for Girls and Young Women, Report Card: Thailand*. Retrieved March 15 2014, from http://www.unfpa.org/hiv/docs/report-cards/thailand2.pdf.

Williams, W. L. (2002). Endangered relations: Negotiating sex and AIDS in Thailand. *American Ethnologist, 29*, 1016-1017.

Wong, L. P. (2011). Socio-demographic and behavioural characteristics of illegal motorcycle street racers in Malaysia. *BMC Public Health, 11*, 446.

Wright, E. R. (2003). Travel, tourism, and HIV risk among older adults. *Journal of Acquired Immune Deficiency Syndromes, 33*, S233–S237.