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Young people’s perspectives on the use of reverse discourse in web-based sexual-health interventions

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Web-based sexual-health promotion efforts often utilise reverse discourse – the acknowledgement and rejection of shame associated with stigmatised terms – both to challenge judgments about ‘risky’ behaviours (e.g., casual sex) and to appeal to young people. This study examines the use of reverse discourse in Internet-based sexual-health promotion and analyses young people’s perspectives on this approach. During in-depth interviews and focus groups with young people (aged 15–24), participants shared their perspectives on written (e.g., clinical language; colloquial language) and visual (e.g., generic, stock images; sexualised images) depictions of sexual-health topics on the websites. More explicit styles elicited negative responses from young people in terms of perceived appeal, trust and quality of websites. Negative social mores were associated with some of the more explicit portrayals of young people’s sexual lives on the websites, revealing how reverse discourse re-stigmatises young people by re-emphasising young people’s sexual activity as inherently risky or immoral. Reverse discourse was perceived to have negative effects on the saliency and credibility of online sexual-health information. We discuss the theoretical basis for the operationalisation of reverse discourse in this context, and discuss the importance of considering sociotechnical aspects of Internet-based sexual-health interventions.

Keywords: reverse discourse; young people; sexual health; Internet; intervention

Introduction

Sexually transmitted infections (STIs) are a growing public health concern, especially among young people (aged 15–24), who account for an increasingly disproportionate rate of infection. For example, rates of gonorrhoea among Canadians aged 15–19 years have almost doubled in the past decade (rising from 55.1 per 100,000 to 102.5 per 100,000 from 1999 to 2009), while rates among 20–24-year-olds have more than doubled during this time (from 66.6 per 100,000 to 145.2 per 100,000) (Public Health Agency of Canada [PHAC] 2010a). A similar dramatic increase is seen in Chlamydia rates among young Canadians (aged 15–24 years) (PHAC 2010a, 2010b).

There are compelling public-health reasons to develop novel interventions and approaches to sexual-health promotion (CATIE 2011; Moses and Elliott 2002; White et al. 2007), and web-based strategies offer promising complements to interventions delivered in person (Bailey et al. 2010; Levine 2011; Lim et al. 2012; Rietmeijer and McFarlane 2009; Rosenberger et al. 2011; Shoveller et al. 2012). As a result, increasing attention is
turning towards the Internet to reach populations at high risk for STI/HIV infection (e.g., young people, men who have sex with men). For example, in an effort to decrease the spread of infection and to increase young people’s participation in testing, the BC Center for Disease Control recently began development of an online sexual-health service programme, including web-based information and counselling resources as well as an Internet-based STI/HIV testing service.¹

This relatively nascent field of study presents new opportunities to re-conceptualise what makes for effective interventions to address the prevention and treatment of STIs and to draw on theoretical constructs developed in disciplines other than health to better understand what online approaches might be more (or less) effective. An important body of literature to be drawn on in the current paper pertains to the evidence describing various aspects of adolescents’ use of the Internet for sexual-health information (Borzekowski and Rickert 2001; Boyar, Levine, and Zensius 2011; Gray et al. 2005; Guse et al. 2012; Jones and Biddlecom 2011; Kanuga and Rosenfeld 2004). In general, much of the research in this realm focuses on usage patterns (e.g., frequency of use, topics of interest); however, new work related to other, more nuanced aspects of the ‘online experience’ is emerging (Gray et al. 2005; Jones and Biddlecom 2011). For example, it is now argued that for many young people, going online is an experience beyond mere information-seeking. Instead, it can be an extension of young people’s identities, as they negotiate online constructions of important social cues (e.g., gendered stereotypes, power dynamics within relationships, relations to peers) (Macfarlane and McPherson 2007; Mazzarella 2005; Medley-Rath and Simonds 2010). A small but growing body of research also has begun to explore other ways in which the nexus of the social and the technical aspects of web-based health interventions affects experiences with online sexual-health promotion (e.g., how features of a website affects perceived credibility, how young people identify salient online resources) (Gray et al. 2005; Jones, Biddlecom, and Hebert 2011; Simkins 2007; Wynn, Foster, and Trussell 2010).

Previous research has shown that several factors appear to be related to the perceived credibility and saliency of sexual-health information and resources. For example, many young people want sexual-health education to be ‘empathetic, non-judgmental, and able to create a “safe environment” in order to facilitate the discussion of difficult subjects’ (Hilton 2003, 33) and to use relaxed and informal methods of delivery (Audrey, Holliday, and Campbell 2006; Measor 2004; Mellanby 2001; Williams and Bonner 2006). Much of the work in this area has focused on the provision of peer-led health promotion and education (Audrey, Holliday, and Campbell 2006) as an alternative to adult-led instruction. Proponents of this approach cite several advantages over more conventional, adult-led approaches, including increased credibility, empowerment, acceptability and success associated with peer-led delivery (summarized in Turner and Shepherd 1999). Such strategies reportedly draw on several important theoretical models (e.g., Social Learning Theory, Social Influences Theory) to inform peer-education initiatives (Kirby et al. 1994; Wilton, Keeble, and Doyal 1995). Within these interventions, it is suggested that learning and/or behaviour change is enhanced when the supplier of sexual-health information is perceived to share key characteristics with the recipient(s) (e.g., behaviour, experience, social status, cultural background) (Harden, Oakley, and Oliver 2001).

Although not every peer-led intervention employs reverse discourse, in some instances this thinking appears to have been extended and applied within web-based sexual-health promotion efforts, primarily via the use of reverse discourse (Foucault 1978). Reverse discourse – the acknowledgement and rejection of shame associated with stigmatised concepts – is intended both to challenge negative judgments of ‘risky’ behaviours.
Reverse discourse is a Foucauldian concept, originally developed in the context of the lesbian and gay civil rights movements (Foucault 1978). For example, over the past half century, the queer community has purposefully reclaimed expressions such as ‘fag’ and ‘dyke’ to have positive, non-judgmental connotations, although these terms were originally used as a tool of marginalisation. However, in the current analysis, we also consider reverse discourse within the broader context of Foucault’s (1978) discussions relating to discourse, power and resistance, wherein the marginalised are able to speak on their ‘own behalf, to demand that legitimacy or “naturality” be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified’ (101). Reverse discourse is a fundamentally subjective and social phenomenon, wherein dominant notions of what is sacred and what is profane are contested, in an attempt to disrupt existing power structures. This lens is applied in examining the messaging and meanings inherent in online sexual-health promotion. In particular, we focus on the acknowledgement and rejection of shame associated with behaviours (e.g., having sex outside of a monogamous partnership) that are stereotypically deemed to be negative (e.g., by virtue of their inherent risk) by ‘experts’ (i.e., those who by virtue of their health professional status shape and authorise a large part of the discourse pertaining to what is considered risky or safe behaviour). These messages are delivered using the same language and concepts that are traditionally associated with ‘unsafe’ sexual practices (e.g., having multiple sexual partners is referred to as ‘casual sex’) and, within sexual-health websites, are typically instantiated as casual/suggestive language and/or images.

Several studies have found the intersections of multiple factors (e.g., one’s gender, cultural background, sexual identity) are important influences on face-to-face communication during clinical encounters (Goldenberg et al. 2008a, 2008b; Lichtenstein 2004; Lichtenstein and Bachmann 2005; Shoveller et al. 2009, 2010). However, there is a paucity of information to illuminate how these forces might play out within online sexual-health services. For many young people, accessing sexual-health services continues to be a stigmatised activity and we suggest that it is unlikely that this will be fully resolved through web-based provision (e.g., heteronormative online spaces, online enactments of gendered stereotypes).

Within high-income countries, many young people report that the Internet is the first place they look for health information (Hesse et al. 2005). Thus, it is important to understand and respond to young people’s perspectives on online resources, particularly their perceived salience and credibility. To identify and mitigate the possibility of new online sexual-health interventions to unintentionally reinforce stigma associated with STI/HIV, or to exacerbate existing barriers to service access, we need to understand young people’s perspectives. Without accounting for these perspectives, we risk repeating many of the problems associated with conventional services (i.e., face-to-face services) (Harvey et al. 2008). Thus, we undertook a small exploratory study seeking to examine and understand young people’s perspectives on the use of reverse discourse in web-based sexual-health-promotion initiatives and to understand how it may affect their experiences accessing these resources.

**Methods**

**Recruitment**

A purposive sampling strategy was employed (Shadish, Cook, and Campbell 2002) to select a wide range of participants (aged 15–24 years), deliberately selecting those who,
by virtue of their social contexts, could share insights into the needs of a variety of young people. Recruitment efforts included posters at various ‘hang-outs’ (e.g., drop-in centres, community colleges), as well as targeted online advertisements (e.g., Craigslist, Facebook). To actualise our purposive sampling strategy, in addition to these more broad recruitment efforts, we also recruited participants from within spaces (online and otherwise) such as multicultural youth centres, low-threshold service centres for street-involved young people and list-serves for queer young people. Interested young people contacted our office by phone or email and were screened for eligibility (e.g., previously sexually active, lived in the study area, fluent in English, had considered or had undergone STI testing). As the study progressed, sampling needs were discussed by team members and adjusted according to emergent findings.

Data collection and analysis

Data were collected using in-depth, individual interviews with 20 participants, as well as focus groups (3 groups with 4 participants per group). Interview and focus-group guides were developed and pilot tested by members of the research team. Informed consent was obtained from all participants, who were asked to also complete a brief sociodemographic questionnaire. Ethics approval was obtained from the University of British Columbia Behavioural Research Ethics Board. Upon completion of an interview or focus group, participants received a CA$25 cash honorarium. All interviews and focus groups were audio- or video-recorded, transcribed (with all identifying information removed) and transcripts were checked for accuracy. Constant comparative techniques (Strauss and Corbin 1998) informed the analysis and emergent findings were used by the research team to iteratively revise the interview and focus-group guides. Transcripts were coded and organised using NVivo 8 qualitative data software.

North American, English-language sexual-health websites (n = 15) from a variety of sources (e.g., non-profit organisations, health colleges, government-funded health initiatives) were reviewed during qualitative in-depth interviews and focus groups with participants. Through online Google queries using common search terms (e.g., ‘STI symptoms’, ‘sexual health’), team members conducted a review of existing sexual-health websites and identified and selected examples of sexual-health websites that were illustrative of the spectrum of highly ranked sites (i.e., websites that consistently rank on the first page of Google search results). Participants were asked to explore the selected websites and to comment on their overall impressions, as well as more specific aspects of the site (e.g., features they liked/disliked, features affecting their trust of the website). We also asked young people to share their perspectives on written (e.g., clinical versus colloquial language) and visual (e.g., medicalised images, sexualised images) presentations of sexual-health information on the websites, taken in isolation. Text and image sample selection included a variety of styles and included samples that could potentially be interpreted as reverse discourse by study participants. For example, to more closely examine young people’s perceptions of the effects of different presentations of similar content, efforts were made to include a wide range of text samples from the continuum of linguistic styles, while keeping the content fairly similar – for example three different examples of text seeking to normalise masturbation presented using (1) colloquial, (2) moderate and (3) clinical language. Similarly, our review identified recurring image styles within sexual-health websites – for example medicalised images of health care providers, sexualised images of young people kissing, generic images of young people smiling – about which we sought youth perspectives. While participants
were not (to our knowledge) familiar with the concept of reverse discourse, interviews were semi-structured and used open-ended questions, providing participants with opportunities to discuss the ways in which various online representations could affect their experiences accessing online sexual-health services. Identification of young people’s descriptions of reverse discourse within these websites and image/text samples was informed by our understanding of the concept of reverse discourse in the context of contemporary sexual-health messaging (e.g., identifying examples of slang, colloquialism and vernacular) and by previous analyses of enactments of reverse discourse in sexual-health messaging (Myrick 1996). Interviews were conducted in a research office or in private space made available for our use by community partners (e.g., drop-in service meeting room) and each lasted approximately 1–1.5 hours.

Results

Study participants

In total, we conducted interviews and focus groups with 12 male, 19 female and 1 transgendered young people (mean age: 20 years). Table 1 shows participants’ self-identified sociodemographic characteristics and summarises participants’ previous STI/HIV testing history.

In reviewing the sample of sexual-health websites, participants identified a variety of potentially problematic phrases and images. While there was not absolute agreement among participants as to precisely which language or imagery had a negative impact on their impressions of the websites, most participants readily identified examples of the use of sexually explicit and/or colloquial language (e.g., ‘no-strings sex’, ‘screw around’, ‘fuck friend’), which we operationalised as enactments of reverse discourse. In general, compared to their reactions to text samples, participants had less intense opinions about images, although some found more ‘sexy’ images (e.g., a photo of two young people kissing) to be an enactment of reverse discourse.

When asked to consider online sexual-health-resource developers’ motivations for utilising textual and image-based enactments of reverse discourse, nearly all participants perceived an intention by the developer to: (1) catch the user’s attention by using words or images that are more striking or explicit, (2) align content with dominant portrayals of youth culture or (3) anticipate and pre-empt young people’s discomfort or embarrassment with the sensitive nature of the topic and to mitigate this discomfort through the overt use of colloquial language and/or explicit images. For example, a headline within a popular UK-based online sexual-health resource for young people (www.thesite.org) is illustrative of these concepts: ‘Having a “fuck buddy” suits some people perfectly; recreational sex with no heavy love stuff going on. But can it work for you?’

One participant theorised that these techniques were used on sexual-health websites ‘because a lot of people would relate to that language and sort of use it already. So it’s common, so they would know what it means’ (Justin, aged 17). Often, young people’s initial responses to reverse discourse presentations focused on the perceived intentions of the website creators (i.e., health care organisations directing the creation of the site). Implicit in many of these reflections was a perceived lack of authenticity. As one young woman told us: ‘It seems like they are trying to like fit in. I know it sounds ridiculous, but like fit in with the reader’ (Coral, aged 18). Like many young people in the study, Coral sensed that the creators of the website were attempting to resonate with young people by using their language. Ultimately, these efforts had the opposite effect: participants sensed that the authors of this content were not, in fact, their peers, but were instead ‘outsiders’
(i.e., sexual-health intervention developers). Instead of seeming authentic, inauthenticity emerged, as young people perceived the youthful messaging style as feigned.

Table 1. Participants’ self-reported sociodemographic characteristics and self-reported STI testing history.

<table>
<thead>
<tr>
<th>Age group</th>
<th>N = 32 (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–19 years</td>
<td>15 (47)</td>
</tr>
<tr>
<td>20–24 years</td>
<td>17 (53)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19 (59)</td>
</tr>
<tr>
<td>Male</td>
<td>12 (38)</td>
</tr>
<tr>
<td>Transgender (F)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Ethnicity (self-identified)</td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>4 (13)</td>
</tr>
<tr>
<td>East Asian/Southeast Asian</td>
<td>6 (19)</td>
</tr>
<tr>
<td>Euro-Canadian</td>
<td>19 (59)</td>
</tr>
<tr>
<td>South Asian</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>22 (69)</td>
</tr>
<tr>
<td>Other</td>
<td>10 (31)</td>
</tr>
<tr>
<td>Length of stay in Vancouver</td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>4 (13)</td>
</tr>
<tr>
<td>1–5 years</td>
<td>9 (28)</td>
</tr>
<tr>
<td>6–10 years</td>
<td>3 (9)</td>
</tr>
<tr>
<td>11–15 years</td>
<td>3 (9)</td>
</tr>
<tr>
<td>&gt; 15 years/entire life</td>
<td>13 (41)</td>
</tr>
<tr>
<td>Living arrangement</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>2 (6)</td>
</tr>
<tr>
<td>University residence</td>
<td>5 (16)</td>
</tr>
<tr>
<td>With friends/roommates</td>
<td>6 (19)</td>
</tr>
<tr>
<td>With partner/spouse</td>
<td>2 (6)</td>
</tr>
<tr>
<td>With parents/family</td>
<td>12 (38)</td>
</tr>
<tr>
<td>Shelter/transition house/street</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Lesbian</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Gay</td>
<td>4 (13)</td>
</tr>
<tr>
<td>Straight</td>
<td>23 (72)</td>
</tr>
<tr>
<td>Two-spirit</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Current sexual activity</td>
<td></td>
</tr>
<tr>
<td>Not currently sexually active</td>
<td>7 (22)</td>
</tr>
<tr>
<td>With one partner</td>
<td>22 (69)</td>
</tr>
<tr>
<td>With more than one partner</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Tested previously</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>10 (31)</td>
</tr>
<tr>
<td>Yes</td>
<td>22 (69)</td>
</tr>
<tr>
<td>Last tested (n = 22)</td>
<td></td>
</tr>
<tr>
<td>Within 1 month</td>
<td>5 (16)</td>
</tr>
<tr>
<td>Within 6 months</td>
<td>10 (31)</td>
</tr>
<tr>
<td>Within 1 year</td>
<td>3 (9)</td>
</tr>
<tr>
<td>1 year or more</td>
<td>4 (13)</td>
</tr>
</tbody>
</table>

Note: *Percentages may not add up to 0 due to rounding.
Saliency and credibility

More explicit content elicited negative responses from young people in terms of perceived appeal, trust and quality of these websites. Participants told us that when sifting through the abundance of sexual-health information on the Internet, they undertake a complex process of identifying information that is personally salient or relevant to their needs. For many, reverse discourse detracted from this saliency. For example, many young people valued a professional, straightforward approach to the delivery of sexual-health content. As one woman explained:

Like, when you are looking for an answer you want someone who sounds like they know what they are talking about, not somebody that sounds like the person you are drinking with. (Sarah, aged 21)

While acknowledging that particular words or phrases might catch young people’s attention or be seen as humorous, most participants suggested that they would not perceive information presented in this way to be ‘worth’ processing. For many participants, delivering sexual-health information without an appropriate level of seriousness effectively rendered the message as being without value. As Natasha, aged 23, described:

It will make you laugh. But at the same time, like you are probably not gonna remember anything you read from it, because it doesn’t go into your brain as something serious.

Young people often suggested that there is a ‘time and a place’ for sexual topics to be discussed in a casual or humorous way, but that the use of reverse discourse in an online sexual-health resource was not necessarily the most appropriate or effective means of health communication. Some were more direct – they told us that reverse discourses that challenge conventional norms about young people’s sexual behaviour are inappropriate in an online context – many preferring instead to discuss such things with friends. As Sarah, aged 21, explained:

They are trying really hard to sound sort of like the friend you would talk to. If you are gonna go online, I mean that’s why you have friends. Like if you were gonna talk to your friend, you wouldn’t go to a website, you know what I mean?

Furthermore, the use of reverse discourse often had a detrimental impact on the perceived credibility of a website. Participants told us they valued a professional approach to online sexual-health information provision and that reverse discourse negated this. For example, Elisa, aged 18, told us:

If I was reading this on a website I would probably leave the website right away because it doesn’t seem like it’s something that a very credible source would use at all. Like the ‘f’ word, ‘heavy love stuff’, like once again that doesn’t seem very serious at all. Like, I know what it means but not something that I would probably continue reading.

Participants particularly objected to the use of reverse discourse enacted as slang within sexual-health websites. One young woman, Bridgette, aged 17, told us that the way a website ‘talks’ has significant effect on how well she trusts it as a source of information and that the use of a colloquialism detracts from the trustworthiness of online sexual-health messaging. For example, in response to the use of the word ‘cum’, she told us the website was ‘not too trustworthy. I don’t know it just sounds silly. To me anyhow, it just seems like some teens talking.’

Social context

Many participants acknowledged that enactments of reverse discourse on a sexual-health website could potentially be a deterrent for some young people, depending on their current
social context (e.g., living situation, sexual identity disclosure status). For example, Vidia, a 17-year-old young woman, suggested that, for young people from more conservative or religious backgrounds, enactments of reverse discourse in this area could be off-putting – for these young people, sexualised images on sexual-health websites (e.g., images of young people kissing):


could be somewhat offensive. Like they wanna learn about sex but they don’t wanna see people going at it. Like they didn’t search for porn or like sexy movies, they searched for facts.

As a young woman who identified as a lesbian, Vidia acknowledged that for many, engaging in same-sex sexual interactions can be laced with stigma and shame, making it even more difficult to seek relevant sexual-health resources. She suggested that this might motivate some (e.g., young people who identify as lesbian, gay, bisexual or transgendered) to visit websites that were absent of any risqué content. She suggested that, to avoid creating additional barriers for this demographic, online sexual-health resources should avoid ‘big pictures of people making out, or having the words “sex” super, super big. Basically don’t make it super crude or risqué, or intimidating.’

In addition, the use of reverse discourse also appeared to be differentially perceived by young people depending on their cultural or ethnic background. Participants stressed the importance of young people’s relationships with cultural norms as being influences on how reverse discourse would be perceived. For example, for a young person who is unfamiliar with contemporary lingo, slang or idioms associated with sexual-health topics, the more nuanced aspects of this language could be lost in an online context that used frequent examples of reverse discourse and/or employed slang or colloquialisms. As one young woman explained:

You need to be fluent in English, and kind of be born in the Western world to understand that. And I think that a lot of my immigrant friends would not. (Ramona, aged 19)

Reinforcing stigma

Many participants reacted negatively to seeing youth sexual behavior presented in what they perceived to be a callous or crude manner and tended to have negative associations with such depictions. For example, upon reviewing website content that discussed the implications of casual sex, using colloquial terms (‘fuck buddy’), one participant, Jane, aged 16, told us: ‘It’s so offensive. I think it’s like you’re just a “fuck buddy”, you’re nothing else to that person. There are so many other ways you could describe it.’

Some participants told us that casual depictions of young people’s sexual behaviour do not align with their own construction of sex. In response to one website’s references to ‘recreational sex’, Olivia, aged 19, told us that: ‘It’s not a good message [to send]. It’s more serious. You shouldn’t be viewing it this way.’ Many other participants agreed that, to them, sex was a serious topic and deserved to be discussed in a respectful way. One young man, Trevor, aged 20, told us:

I don’t think [these terms] should be included in a site talking about something so serious. It’s funny, now, to talk about these sites [in this interview], but like, if you were actually looking for information . . .

Some participants commented that rather than dispelling the stigma associated with young people’s sexual behavior, the use of reverse discourse had the potential to exacerbate conceptions of young people’s sexual behaviour as inherently risky or immoral. Enactments of reverse discourse that endeavor to dispel shame associated with stigmatised concepts invoked a boomerang effect, serving instead to re-stigmatise. For example, one young woman, Aimee, aged 24, told us:
Potential benefits

A few young people in our study, especially those who described themselves as relatively well informed and comfortable with sexual-health topics, acknowledged the potential role and benefit of reverse discourse in online sexual-health resources. For these young people, reverse discourse offered safe spaces within which to explore sexual-health topics, with a sex-positive agenda and a non-judgmental approach:

To me, it sounds like someone is actually interested in and passionate about the topic of sexual health and wants to convey that to people reading it. (Lira, aged 24)

While these participants were amenable to the use of reverse discourse in sexual-health promotion, they often recognised that this might not work well for all young people. For example, when asked about seeing more explicit content on a website, Daniel, aged 23, told us: ‘Personally I don’t mind, but I know some people that would.’ During a focus group, a participant pointed out that as a relatively empowered and privileged university student he felt receptive to enactments of reverse discourse, but that other young people may be differentially positioned in terms of their willingness and capacity to uptake information presented in this way. For example, Trevor, aged 20, explained that while the use of reverse discourse may be effective for youth who occupy social positions that allow them to be receptive to this strategy, it may inadvertently create barriers to access for other young people. He acknowledged that, as a university student, he was likely to have been exposed to a wide variety of sexual-health information and thus was more likely to be receptive to reverse discourse approaches. However, he asks:

What about for a group that don’t know any information. Like we probably know a larger chunk than a lot of kids who don’t go to university, and haven’t graduated high school.

As Trevor suggested, for these young people, enactments of reverse discourse would likely be less accessible.

Discussion

These findings reveal how, despite the best intentions, the use of reverse discourse can have undesired and unpredicted effects on young people’s perceptions of online sexual-health promotion efforts. While, for some, enactments of reverse discourse can have neutral or even positive effects on their experiences with web-based sexual-health resources (e.g., by conveying an engaged tone to the reader), these approaches did not resonate with many of the participants in our study. In fact, often the opposite effect was achieved – many perceived these approaches as artificial and/or exaggerated representations of young people’s own discourses pertaining to sexual health. Reverse discourse also was perceived to have negative effects on the saliency and credibility of online sexual-health information. Participants in our study suggested that negative social mores were associated with more explicit portrayals of young people’s sexual lives on the websites, revealing how reverse discourse potentially re-stigmatises youth by re-emphasising young people’s sexual activity as inherently risky or immoral. This research illuminates the importance of considering these and other socio-technical aspects of Internet-based sexual-health interventions.

Health promotion efforts should be informed by both evidence and theory (Barak and Fisher 2001, 2003; Crosby and Noar 2010; Green 2000). However, the theoretical and
empirical foundations underpinning the use of reverse discourse in online sexual-health promotion are unclear. Some ways in which reverse discourse has been employed within sexual-health promotion interventions include peer-delivered information that aims to be relatable to young people, use their own language and break down communication barriers about a stigmatised topic. While these approaches have been enthusiastically promoted (World Health Organization 1991) and are informed by behavioural theories (e.g., Social Learning Theory), the evidence for their effectiveness remains inconclusive (Harden, Oakley, and Oliver 2001; Turner and Shepherd 1999). Faced with the growing reality that ‘scientists’ are not the sole contributors of so-called ‘expert’ health information on the Internet (Richardson 2005), young people are understandably apprehensive consumers of health information, turning to clues left within the text of online health spaces (e.g., tone, word choice) in order to determine credibility and expertise (Locher 2006; Locher and Hoffmann 2006). Within this context, the creators of sexual-health websites must be especially careful to attend to the linguistic nuances of constructing a credible, online, advice-giving resource (Locher 2010; Richardson 2003) in order to capture both the attention and the trust of young health-information-seekers.

It is also worth examining use of reverse discourse in this area from a Foucaultian perspective. While the adoption of such an approach is an attempt to operationalise a reverse discourse, ultimately, these are the strategies used by intervention planners to achieve public health goals (e.g., decreasing the spread of sexually transmitted infections; lowering teen pregnancy rates). Reverse discourses are meant to contest dominant notions of what/who is compliant and what/who is rebellious, wherein existing power structures are disrupted. However, rather than being subversive in nature, these strategies may not be a reflection of young people’s sexual empowerment beginning to speak for itself, nor a young sexuality demanding the legitimation of its own ‘naturality’, as described by Foucault (1978). Shoveller and Johnson (2006) describe the shift from adult- to peer-led models of sexual-health education over the past two decades and argue that the adoption of young people as the voices advocating for safe choices constitutes a perpetuation of the sex-as-risk discourse of adult ‘experts’, rather than an empowering experience.

Furthermore, by consistently juxtaposing enactments (or, rather, interpretations) of ‘young’ culture with traditional risk discourse, it serves to re-stigmatise young people’s sexual behaviour as inherently risky (Fortenberry 2003). Stigma is a socially constructed concept and, according to Goffman’s (1963) foundational work on the subject, can be associated with physical attributes (e.g., a sexually transmitted infection), moral attributes (e.g., engaging in risky behaviour) or ‘tribal’ affiliation. Nack (2002) extends this concept of tribe beyond familial/ethnic associations in the context of sexual behaviour norms attributed to a particular group. Young people represent a socially distinct group, and an understanding of their own identities as sexual beings is informed by many of the morals that are entrenched in negative social constructs of young people’s sexuality (e.g., stigmatisation of certain sexual behaviours as ‘risky’ or immoral). Normative conceptions of young people’s sexual behaviour shape their views of the tribe of sexually active young people to which they belong (or will belong) and we risk exacerbating stigma associated with young people (especially those who are sexually active). Greaves et al. (2010) describes the ‘internalised stigma’ resulting from ‘developed processes of self-stigmatisation and secondary deviant identities’ (527). Often, the context that would inspire a young man or woman to seek online sexual-health services might already render likely the harbouring of some internalised stigma (e.g., about behaviour they suspect may be risky). Those experiencing anxiety related to prior sexual behaviour who encounter reverse discourse in web-based sexual-health resources may interpret it as a reification
of their suspicions. In this regard, enactments of reverse discourse potentially serve to augment internalised stigma (that a young person may already be experiencing). For many, stigma (both internal and external) represents a significant barrier to accessing conventional sexual-health services and information (Fortenberry et al. 2002; Lichtenstein 2003; Lichtenstein and Bachmann 2005; Rusch et al. 2008; Shoveller et al. 2009). Thus, it is imperative that novel, online approaches attend to and avoid possible sources of stigma within web-based interventions (Wayal et al. 2011).

Furthermore, by framing young people’s sexuality in this way, health-promotion efforts risk oversimplifying young people’s sexual behaviour/experiences – a complex, multifaceted aspect of their lives. Schalet (2004) describes the ‘dramatisation of adolescent sexuality’, highlighting internal conflicts between ‘impulse and cognition’ – two paradigms that ‘limit us in our ability to conceptualise and promote’ positive adolescent sexuality (15). Conventional social norms reinforce these as contradictory states – sexually, young people are either informed and in-control or uninformed and risky (Shoveller and Johnson 2006). Both paradigms equate sex with risk and assume that the best way to promote healthy sexuality among young people is by stressing its inherent risks (Schalet 2011). In some ways, the use of reverse discourse in online sexual-health promotion may unintentionally re-emphasise this dichotomy (e.g., by consistent ‘representations’ of young people’s sexual culture in the context of risk). Instead, efforts should focus on sharing important information with young people pertaining to their sexual health without buttressing this misleading, reductionist perspective.

There are several limitations to the current study. As researchers, our interpretation of reverse discourse is based on a theoretical sensitivity to the concept, one with which the participants in our study were not (to our knowledge) familiar. Thus, we strove to offer examples of reverse discourse (according to our own lens), as well as other text and images, allowing participants to draw on their own understandings and reactions, without imposing our own perceptions on the discussions. Furthermore, while showing text and image samples out of context provides the opportunity to examine youth’s perspectives on specific aspects of a site in isolation, in reality, text and images are situated within (and are inseparable from) the context of the entire website. By asking youth to review some website content in situ, as well as asking them to discuss text/image samples taken in isolation, we strove to achieve a balance between the two scenarios.

In addition, our sample was composed of young people who volunteered to participate in a research study about sexual health and, thus, were likely to have a moderate-to-high comfort level with such topics (which provides an interesting juxtaposition to the largely negative reactions to the use of reverse discourse). In fact, in many ways we were surprised by participants’ (often strong) reactions to online representations of reverse discourse, given the strong theoretical basis for informal, peer-voiced approaches. Rather than lending credence and/or contesting contemporary conceptualisations regarding young people’s sexuality, web-based enactments of reverse discourse within sexual-health resources had several unintended, negative effects. Acknowledging that there are tradeoffs between conveying accurate information and avoiding overly clinical language, online sexual-health resources should strike a balance and convey informative content that resonates with the audiences. While the importance of adopting non-judgmental approaches resonates widely, such approaches need not necessarily employ reverse discourse in their linguistic instantiations. The findings of this study suggest closer examination of communication strategies employed by sexual-health websites may offer an illuminating complement to the current study (e.g., a systematic content analysis of existing web-based sexual-health resources), building on important previous work.
examining the use of reverse discourse in sexual-health messaging (Myrick 1996). While these findings are not meant to be generalisable to all young people, nor to all online interventions, they represent a starting point from which to examine, question and, perhaps, reassess the use of reverse discourse in promoting sexual health to young people online.

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Note
1. Internet-based testing for STI/HIV is relatively new within the realm of sexual-health services and typically involves an online risk-assessment questionnaire, a downloadable laboratory requisition (or a mail-order testing kit), and online provision of test results. For examples, please visit www.gettestedwhynot.ca or www.iwanthekit.org

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Résumé

Les efforts de promotion de la santé sexuelle sur les sites web emploient souvent le discours inversé – la reconnaissance et le rejet de la honte associée à des concepts stigmatisés – à la fois pour remettre en cause les jugements sur les comportements « à risques » (par ex. les rapports sexuels occasionnels) et attirer les jeunes. Cette étude examine le recours au discours inversé pour la promotion de la santé sexuelle sur les sites web et analyse les points de vue des jeunes sur cette approche. Lors d’entretiens en profondeur et de groupes de discussion thématique avec des jeunes âgés de 15 à 24 ans, ceux-ci ont exprimé leurs opinions sur des descriptions par écrit (par ex. langage clinique; langage courant) et visuelles (par ex. images génériques, images d’archives; images sexualisées) des sujets relatifs à la santé sexuelle sur les sites web. Les descriptions les plus explicites ont provoqué des réactions négatives, motivées par les perceptions des jeunes sur l’attractivité, la fiabilité et la qualité des sites web. Les mœurs sociales négatives étaient associées à certaines des descriptions les plus explicites de la vie sexuelle des jeunes sur les sites web, ce qui a révélé comment le discours inversé peut à nouveau être stigmatisant vis-à-vis des jeunes, en soulignant une fois de plus les aspects intrinsèquement « à risque » ou immoraux de leur activité sexuelle. Le discours inversé était perçu comme ayant un impact négatif sur l’importance et sur la crédibilité de l’information sur la santé sexuelle en ligne. Nous discutons de la base théorique de la mise en œuvre du discours inversé dans ce contexte, ainsi que de l’importance de la prise en compte des aspects sociotechniques des interventions pour la santé sexuelle sur Internet.

Resumen

En las iniciativas en Internet para fomentar la salud sexual muchas veces se utilizan discursos invertidos – el reconocimiento y el rechazo de la vergüenza asociada a los términos de estigma – tanto para cuestionar las opiniones sobre conductas de “riesgo” (p. ej., sexo casual) como para atraer a los jóvenes. En este estudio analizamos cómo se utilizan los discursos invertidos en Internet para fomentar la salud sexual y estudiamos qué opinan los jóvenes de este planteamiento. En entrevistas exhaustivas y charlas en grupo con jóvenes (con edades entre 15 y 24 años), los participantes aportaron sus opiniones sobre descripciones escritas (p. ej., lenguaje clínico; lenguaje coloquial) y descripciones visuales (p. ej., imágenes genéricas o de archivo; imágenes sexualizadas) de temas de salud sexual en sitios web. Los estilos más explícitos generaron respuestas negativas por parte de los jóvenes en lo que respecta al atractivo, la fiabilidad y la calidad percibidos de los sitios web. Algunos de los retratos más explícitos de las vidas sexuales de los jóvenes en los sitios web fueron asociados a costumbres sociales negativas, lo que indica el modo en que los discursos invertidos vuelven a estigmatizar a los jóvenes al recalcar sus actividades sexuales como una conducta intrínsecamente de riesgo o inmoral. Se percibió que el discurso invertido tenía efectos negativos en la importancia y la credibilidad de la información sobre la salud sexual en Internet. Examinamos la base teórica de la aplicación del discurso invertido en este contexto y analizamos qué importancia tiene considerar los aspectos sociotécnicos de los programas de salud sexual en los sitios de la red.