Phenomenologies of the *Akratic* Self: Masculinity, Regrets, and HIV among Men on Methadone

Jorge Fontdevila

ABSTRACT *This study explores the motivational bargaining processes that constitute an “act” of heterosexual HIV risk-taking by focusing on the narrative viewpoint of two men in methadone maintenance treatment programs in the Harlem section of New York City. These men reported sexual episodes with complex motivational “event grammars” that were analyzed using qualitative methods. Building on the concept of akrasia (failure to convert intentions into action), I argue that HIV risky heterosexual results from temporal displacements of instrumental rationality by two other equally relevant orientations of sexual action, namely, affectual and normative. I conclude that sexual risk occurs in the context of emotions and normative presentations of the masculine self. Consequently, a man’s risk of losing footing or consistent face vis-à-vis his female sex partner, and not the risks of HIV, becomes a priority of the sexual interaction. Sexuality is at its core social and, hence, subject to more powerful forces than personal safety or behaviorist reward.*

KEYWORDS AIDS, Akrasia, Drug use, Heterosexual, HIV risk, Masculinity, Methadone.

INTRODUCTION

Heterosexual contact is the primary source of HIV infection among women in the U.S., and at least one-third of heterosexually acquired AIDS cases in women are linked to unprotected intercourse with an infected male injecting drug user (IDU).^{1,2} Despite declining rates of HIV infection among IDUs, the association between injection drug use and AIDS cases continues to be disproportionately high.^{3,4} Ample evidence shows that IDUs have changed their needle sharing behaviors in response to the threat of AIDS. However, changing sexual risk behaviors appears to be more challenging.^{5–8} Moreover, studies among heterosexual men in methadone maintenance treatment programs (MMTPs) indicate considerable sexual HIV risk-taking, especially among those who perpetrate female partner violence.^{9,10} In this light, more studies exploring heterosexual intimate dynamics, normative expectations and gender scripts are needed to understand sexual HIV risk between opiate-involved men and their female partners. Despite research on women, few studies have examined such intimate dynamics from the heterosexual man’s perspective. This qualitative study explores the sexual narratives of two heterosexual men in MMTPs in Harlem, New York City. These men’s sexual

Dr. Fontdevila is with the Center for AIDS Prevention Studies (CAPS), University of California, San Francisco, CA, USA.

Correspondence: Jorge Fontdevila, PhD, Trayectos Study (UCSF/CAPS), 4094 4th Avenue, Suite 202, San Diego, CA 92103, USA. (E-mail: jfontdevila@sdtrayectos.org)

episodes illustrate in rich detail the motivational bargaining processes that may constitute a “heterosexual act” of HIV risk-taking.

Over two decades into the HIV/AIDS epidemic we have seen a plethora of theoretical approaches and psychosocial interventions that have had mixed effects in their attempt to minimize sexual HIV risk. Two approaches, health belief models and expected utility models, have been influential in the development of HIV behavioral theory and research. Health belief models are based on cognitive notions of individual self-efficacy and perceived vulnerability to risk.^{11–14} Most of these models work under the assumption that if individual intentions and information against HIV risk are strong enough, then protective behavior (condom use) will follow. However, many of their theoretical assumptions were originally formulated for domains other than sexual behaviors. As a result, cognitive models tend to overlook the fact that sexual practices are fundamentally shaped by the emotional meanings and power relationships in which they take place.^{15–18}

Beyond cognitive models, expected utility models do include the emotional costs associated with HIV-protective behaviors during sex, hence, taking into account “situated” rationalities in which the immediate emotional incentives of risk-taking may outweigh the more distant utilities of safer sex.^{19–23} However, even though stressing the rationality of “deviant” acts is better than depicting them as “irrational,” two problems arise in expected utility models, the first being the assumption that “situated” rationality always implies a conscious calculative orientation toward risk, a cost–benefit analysis. But when it comes to HIV risks, research shows that not only judgment of risk may be shaped unrealistically by various motivational frames but also that many risky behaviors are semiconscious and “habitual” in character.^{24–30} Second, like cognitive models, most expected utility models work under the idealized assumption that only one of the partners is able to make the decision for the couple. Again, when it comes to HIV risks, subtle power asymmetries during sexual intimacy are inextricably involved in shifting utilities as to whether or not to behave HIV safely.^{16,31}

In contrast to cognitive and expected utility models, which view human intentionality as a single and conscious decision-making center, I propose to de-center intentionality in line with notions of a multiple self.³² In addition to a cognitive dimension instrumentally gathering information and assessing risk, I contend that human agency also includes two other equally relevant orientations of action, namely affectual and normative, constituted by emotions and norms, respectively.³³ The latter orientations are not driven by individual self-interest but by emergent properties of interactional, collective orders. None of the three orientations guiding action—instrumental, normative, affectual—can be considered to be subordinate to each other. In fact, I argue that the three action orientations typically compete with each other during decision-making processes and often produce unintended outcomes that undermine the agent’s better judgment.

Akasia and Action Orientations

In the social world, actors typically undergo preference reversals (e.g., between delayed and immediate gratifications) that later, after the fact, lead to regrets about having dismissed the future. Akasia is one of the concepts from the philosophy of action that captures this pervasive human phenomenon of failing to convert original intentions into actions. Akasia occurs when an “agent sincerely believes that on balance something should be done, is offered an opportunity, is neither physically nor psychologically prevented, but fails to act accordingly.”^{34–41} During akratic

episodes, conflicting action orientations of the self emerge and shift at key interactional timings. Later these competing intentionalities do not seem consistent to the agent and create feelings of guilt or regret.

Expanding on the analytical trichotomy “rationality, emotions, and social norms as the mainsprings of action,”⁴² I characterize below the three action orientations that I argue compete to produce an akratic event of sexual HIV risk (i.e., an event after which an agent regrets not having enacted his original intentions of HIV safety). First, I define an instrumental orientation of action towards sexual HIV risks as that motivational disposition that takes into conscious consideration the most efficient means to attain the later and self-interested preference of staying healthy. According to this definition, a heterosexual man acts “instrumentally oriented” when he consistently uses condoms for vaginal and anal intercourse. If condoms are not used, he must have transparent reasons to believe his female partner is HIV seronegative and committed to his wellbeing by avoiding risky drugs and sex outside their relationship.

Second, a normative orientation of action is defined as that motivational disposition that solves collective action problems and is sustained by the meta-drives to save face rather than self-interest. According to Goffman, *face* is “the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact,” and *face-work* makes reference to “the actions taken by a person to make whatever he is doing consistent with face.”⁴³ A heterosexual man is considered to act “normatively oriented” regarding sexual HIV risks when he believes that condom use poses a threat to his masculine face. In other words, he believes that condoms are inappropriate in his relationship, and following habitual masculine scripts of sexual control and initiative, he may experience distress when condoms are requested by his female partner.

Third, an affectual orientation of action is defined as that motivational disposition that is independent of its behavioral consequences and is driven by specific affects and emotional states. In contrast to normative orientations, affectual orientations never have a clear formulation of the values motivating the action and are associated with bodily arousal. Bodily arousal is always historically situated and must not be construed as a simple physiological reflex but rather as a culturally encoded emotional or affectual state. Thus, if the notion of “uncontrollable sexual urges” is part of the local definition of what it means to be a “man,” then the experience of sexual arousal itself, its qualia and intensity, will be shaped by such ideologies of masculinity. Moreover, a man’s perceived sexual arousal will signify to himself his own manhood. A heterosexual man is considered to act “affectually oriented” in connection with sexual HIV risks when he disregards condoms for his own immediate sexual gratification, ignoring horizons of long-term wellbeing. Typically, an “affectually oriented” man indicates high rates of future time discounting during sex.⁴⁴

Finally, it is important to emphasize that these three action orientations are analytical abstractions (ideal types) used for intellectual clarity and are rarely found pure in the real world. Thus, for example, people take everyday risks (e.g., driving, pollution exposure) based on incomplete calculations that are much less demanding than the instrumental definition proposed above (i.e., unprotected sex only if there is absolute knowledge of a partner’s seronegativity). In fact, complex constellations of multiple action orientations are the empirical norm on the ground. An important goal of this paper is to bring such phenomenological complexity into intentional explanations of HIV risk. I have introduced the concept of akrasia and the three

action orientations. I will now proceed to sections on methods and results, where I analyze in depth two risky “event grammars” of akrasia. Finally, in the discussion I reflect on the study findings, evaluate the study limitations, and discuss implications for HIV prevention.

MATERIALS AND METHODS

Recruitment and Eligibility

Data for this analysis were collected as part of a larger multi-year study including qualitative and quantitative phases that explored the intersecting epidemics of HIV/AIDS, substance abuse, and intimate partner violence among heterosexual men on methadone. For the qualitative phase, participants were recruited from four MMTPs in Harlem, New York City, from May to July 1999. A total of 408 men agreed to participate in a 15-min screening interview. To be eligible, a participant must have (1) been 18 or older; (2) been enrolled for at least 3 months in a MMTP; (3) during the previous year, had a sexual or romantic relationship that lasted for at least 3 months with a woman whom he considered his girlfriend, wife, common-law wife, or female lover; and (4) during the previous year, perpetrated minor or severe violent acts on any female partner, as measured by the physical aggression and sexual coercion subscales of the Revised Conflicts Tactics Scale (CTS2).⁴⁵ A maximum of three female partners per participant was elicited.

Of the 408 men recruited, only one-fourth ($n = 101$) met eligibility criteria. Of those eligible, a small purposive sample of 30 men who reported high levels of HIV risk behavior and/or partner violence on the screening interview were selected for in-depth interviewing (a convenience sample of 62 men participating in 10 focus groups was also selected, and findings are reported elsewhere⁴⁶). High levels of HIV risk behavior and/or violence were operationalized as reporting (1) severe partner violence in the past year, (2) inconsistent or no condom use in the past 6 months, and/or (3) drug injecting behaviors in the past 6 months. This purposive sampling was adopted to yield rich qualitative data for the larger multi-year study on the different scenarios where HIV risk and partner abuse may intersect (e.g., condom request and partner violence; needle sharing and partner violence).

In-depth Interview Methodology and Protocol

The author conducted all 30 in-depth interviews, each lasting between 2 and 3 hours. Participants signed a consent form that detailed confidentiality procedures and their rights as research subjects. The institutional review board of the participating MMTPs approved the protocol for the study. All participants received compensation of \$25. All interviews were audio-taped.

Following a semi-structured conversational format,^{47–49} the in-depth interview instrument explored a participant’s life history, his substance abuse career, his sexual and drug-related HIV risk behaviors, a comparison between “with” and “without” condom episodes, and two abusive event narratives with a maximum of two intimate female partners. Gender and power dynamics were explored in both abusive events.

Data Analysis

“Without condom” sexual episodes where participants felt regrets after the fact (akrasia) were analyzed by the author using a modified version of grounded theory.^{50,51} First, audiotapes of in-depth interviews were transcribed verbatim.

Second, transcripts were summarized to get a sense of the “big picture,” recognizing preliminary patterns and comparisons. Third, analytical coding of the sexual episodes proceeded at two levels: open-coding or line-by-line analytical reading to identify unexpected meanings close to the “raw” data and focused-coding where priority was given to top-down research categories. A “thematic tree” with growing sub-branches was progressively created. Fourth, at any stage of the analytical process, memos capturing insights were written to clarify and integrate the various thematic findings. Fifth, in a final effort at synthesis, major thematic branches and sub-branches were linked in explanatory stories or arguments. Passages selected for this article are illustrative of important thematic findings regarding sexual akratic episodes. Qualitative analysis software QSR-NUD*IST4 was used to aid in the processing of all coding and to facilitate conceptual comparisons within the thematic tree.

Case Study Participants

Given space limitations, only two participants of the sample were selected as case studies to illustrate sexual episodes of akrasia: (1) Jose (pseudonym), a 46-year-old Puerto Rican man from the Bronx who has a common-law wife, has 14 years of education, and is unemployed. He is HIV negative and has used condoms inconsistently in the past 6 months. He currently uses heroin and cocaine but does not share needles while injecting. He reports female partner violence but not severe. (2) Houston (pseudonym), a 40-year-old African American man from Harlem who reports two girlfriends, has 10 years of education, and is unemployed. He is HIV negative and has used condoms inconsistently in the past 6 months. He did not use drugs in the past 6 months. He reports mild female partner violence.

Jose and Houston were selected based on two criteria: First, their sociodemographic and behavioral characteristics followed the sample’s mean age (41.1 years, $sd = 6.2$), ethnicity/race (Latino: 43%, $n = 13$; African American: 37%, $n = 11$), mean education (11.4 years, $SD = 1.7$), unemployment (77%, $n = 23$), HIV seronegative status (77%, $n = 23$), inconsistent vaginal or anal condom use with any female partner (87%, $n = 26$), and non-severe violence with any female partner (57%, $n = 17$). Moreover, Jose was part of a significant group of men in this MMTP sample who also used heroin or cocaine (43%, $n = 13$). Second, they were selected because their sexual episodes illustrate in great detail a pattern of back and forth motivational inner-conflicts between protective and unsafe HIV choices also found among the other study participants. All participants recalled akratic episodes where they regretted relapsing into drugs or practicing risky sex. Jose and Houston reported some of the most recent (within the past year), reflexive, and multi-layered sexual narratives of akrasia.

RESULTS

Jose’s Akratic Event

In the following akratic event, Jose expressed his strong sexual attraction for his casual sex partner:

She has a hell of a fine body, and she’s very pretty; she’s only about 28. A lot of guys hit on her, but they don’t get nowhere. And when I can [have her], it gives me that ego, that ‘machismo’ thing, ... because the other guys couldn’t get any and I could.

Jose took pride in the fact that this young and beautiful woman consistently chose him over the other men in the neighborhood. Because they were not in a committed relationship, Jose and his female sex partner typically practiced safer sex. However, a week prior to the interview they checked into a motel, got high on “speedball” (cocaine and heroin mixed), and ended up having unprotected vaginal intercourse:

I was on drugs and so aroused that she had me going so ... in a feverish pitch, that I knew by the time I broke the condom [wrapper] and put it on, I wouldn't be on that high euphoria, you know. So, I went and did it [without a condom], ... I said 'the hell with it.'

Jose explained that while he was penetrating her without a condom, no thoughts of HIV risk crossed his mind. Only after reaching orgasm, it dawned on him:

After I came, and I was taking a shower or she was taking a shower, a big guilt came down [on me] ... [I prayed] 'Please, God don't let me have AIDS just for being ignorant.'

Interestingly, Jose refers to this akratic episode as “being ignorant,” using the Socratic view on *akrasia* as overall “ignorance” in the meta-sense of not knowing the rational path to the good life.⁵² Jose insisted that risky events of this type with his sex partner had only happened three times in the past six months. Normally, he left a “ready-to-use” condom on the night table so that:

When I was playing with her or kissing her, she sometimes didn't notice that with the other hand I'm putting it on. So it's like a continuous foreplay, and I use it ... [It's like a] ritual that I learned to do with time ... That's mostly the way it goes, unless like I said I'm stimulated by the drugs ...

However, in this particular sexual event, Jose was too high and aroused to follow his private meta-rule of HIV safety (i.e., a ritual that begins with readily available condoms on the night table). In consequence, he felt tremendous regrets afterwards:

I really regretted that [risky episode] because I feel like I was playing 'Russian roulette' now. And just 'cause I was [HIV] negative yesterday, I could be positive six months from now. An incubation period of a year I have to go through, and that bothers me a hell of a lot because I had control of the situation! And I had condoms in my wallet! ... So, I'm angry at myself for not using them 'cause I always do. But, she's so cute ... she had me so aroused that I said 'the hell with the condom.'

Note that to account for his sexual risk-taking, Jose resorts in these passages to cultural narratives of sexual arousal and drug euphoria as impervious to consequences.⁴⁶ Moreover, Jose finished his narrative by expressing how much he disliked to be distracted by condoms during sex and that once he lost an erection it was hard to bring it back:

I wish I wouldn't have to use it [a condom]. I really hate using it ... It breaks the foreplay and I don't like it. The girl usually don't like the feel of it, and the way you have to put it on and the time you have to put it on, it throws off the arousal. I may be hard, [but] by the time I open the condom [wrapper] I'm soft

again ... We try [to get the erection back], sometimes it happens and sometimes it can't."

This is a sexual event of *akrasia* where two more or less "thematized" action orientations (i.e., instrumental and affectual) compete for the phenomenological floor. An action orientation is thematized when it is consciously or discursively experienced by the agent, and it is unthematized when it is part of the agent's phenomenological horizon or taken-for-granted background.^{31,53} A plausible motivational storyline may go like this (see Table 1):

Early Instrumental Phase: At the outset, Jose was driven by instrumental orientations to practice safer sex with his non-committed sex partner.

Middle Non-instrumental Phase: Soon after he and his partner got high on speedball and engaged in sexual foreplay, Jose's affectual orientations began to overshadow early instrumental orientations of HIV safety. In fact, he even forgot to implement his own instrumental strategies of "imperfect" rationality, the meta-rule of leaving condoms near by and accessible.^{28,29} In the process of discounting the future, Jose may have formed two reinforcing "motivated" beliefs concerning HIV risks, namely, that this sexual opportunity must not be missed and that it must not be ruined because of the hassle of condoms. These two beliefs are the building blocks of various accounts discussed elsewhere.⁴⁶

Late Instrumental Phase: After reaching orgasm, Jose felt tremendous regrets concerning his failure to convert safety intentions into protective actions. So much so, that he decided to get HIV tested in the following days.

To bring more texture to the event, it is plausible that affectual motivations never completely displaced normative orientations of masculine self-presentation. Recall that Jose was flattered by the fact that his partner would consistently choose him, a middle-age man, over other neighborhood men. In his own words: "It gives me that ego ... because the other guys couldn't get any." These men acted like "absent audiences," making the sexual event too male face-demanding to risk it simply because of condom interruptions and erection problems. It can be argued that Jose's cognitions and instrumental motivations concerning his future health were heavily distorted by primary affectual orientations but also by secondary normative orientations of masculine presentations to his female partner and "absent" male audiences.

Houston's Akritic Event

In the *akritic* event that follows, Houston had a friend and confidant who worked as an expensive call girl. Eventually, they became sexually intimate, but she refused to accept money from him. They always practiced safer sex until one day Houston could not get an erection:

I always used condoms, and then one day I was having this problem where I just couldn't, I couldn't get an erection. I couldn't function, and I just kept saying 'I made it up in my head.' I said 'I know what it is. It's your damn condoms. I can't use these fucking things, you know.' So she said, 'listen, I know you're a clean guy.' She had this paper. 'I just had an HIV test a couple of months ago.' She

TABLE 1. Grammar of Jose’s akratic event (read left to right then down)

Primary action orientation	Original cognition	Emotion	Motivated cognition	Face-work	HIV-related behavior
1. Instrumental	My sex partner and I are in a non-committed sexual relationship, hence I must protect myself	Relief/content	Not applicable	Basic maintenance	Condoms ready in wallet
2. Affectual	I am really high on drugs and extremely sexually aroused	Euphoric and aroused	The present must not be missed because the future is uncertain if I put on a condom I may lose full erection and miss this opportunity	Basic maintenance	Not putting on a condom
3. Instrumental	I have taken HIV risks, hence I may lose my life	Regrets/guilt	Not applicable	Basic maintenance	Getting HIV tested

said ‘everything is okay.’ So she said, ‘I’m just going to see if I can get it up for you and I’ll come,’ and I let her do all the sex on me without the condom, but at the moment it was a bad choice. That’s why I keep telling you [that] I keep going to the hospital. I’m afraid of that. I’m afraid. And then while she was doing it, I didn’t actually penetrate her. She took the head of my penis and she was rubbing it all over her vagina, and it didn’t have a condom on! ... I know a little bit about AIDS ... I know that you can contract it from the secretion of the girl’s vagina and that it don’t actually mean that you got to penetrate. The way she was rubbing it could have just got in the head of my penis. Oh, well, I don’t want to go there ‘cause I’m scared as hell of that one. But I actually let her proceed to ... proceed to give me oral sex without a condom, and I let her do it ...

Once he regained full erection during oral sex stimulation, he proceeded to have protected vaginal sex. Soon, however, he decided to take off the condom, rationalizing at that point that extra risk-taking would be inconsequential because he had already engaged in risky penis–vagina rubbing:

Once I got an erection [through oral sex], she put a condom on, and we had [vaginal] sex. And I didn’t enjoy it with the condom because I had had her without the condom. So I kept saying to myself ‘man, I’m ... I don’t do this ... I went one step, maybe if I go another step further, I mean, it ain’t going ... what the hell is going to happen now?’ So I took the damn thing [condom] off and I penetrated her.

Finally, after orgasm, Houston felt terrible regrets:

I enjoyed it at the time, but as soon as I reached that climax, this cold, cold ... I can’t explain ... this cold clammy feeling came over me, and she knew something was wrong because of the way I was looking. So she told me ‘listen, everything is okay ... we’ll never do it again. Don’t let it ruin your day.’ But I am just saying to myself ‘how the hell did I get caught up in that situation where I got that stupid like that. This woman is a goddamn call girl!’

This is a rich akratic event where the three motivational orientations (instrumental, normative, and affectual), via switches and overlaps, compete for the phenomenological floor. It is also a complex event where “transitional” instrumental orientations attempt to “reassess” health risks halfway into the episode. A plausible motivational storyline may go like this (see Table 2):

Early Instrumental Phase: At the outset, instrumental orientations guided Houston to use condoms with his “call girl” friend because he assumed she had had sex with multiple clients.

First Non-instrumental Phase: As soon as he experienced erection problems, normative orientations of masculine self-presentation overrode instrumental orientations. Regardless of the “true” reasons why he was losing his erection (“I made it up in my head”), Houston scapegoated the condom. Later, in another passage, he reported feeling embarrassed while losing his erection in the presence of his “call girl” friend, indicating that at this stage he was mostly driven by normative orientations to save masculine face. Throughout his arduous masculine face-work to recover full erection, Houston formed two “motivated” beliefs: a questionable belief that his partner was in fact HIV seronegative (however, an HIV test a “couple of

TABLE 2. Grammar of Houston's akratic event (read left to right then down)

Primary action orientation	Original cognition	Emotion	Motivated cognition	Face-work	HIV-related behavior
1. Instrumental	My sex partner is a sex worker, hence I must protect myself	Relief/content	Not applicable	Basic maintenance	Putting on a condom
2. Normative	This condom appears to impair my erection, hence it threatens my masculine image	Shame/embarrassment	It is reassuring that my sex partner is HIV seronegative as she claims Rubbing unprotected genitals is questionable but acceptable HIV risk level for this occasion	Performing arduous face-work following scripts and rituals of masculine self-presentation to recover erection and save face	Taking off a condom
3. Instrumental	I have regained full erection, and my partner is still a sex worker, hence I must protect myself	Relief/content	Not applicable	Basic maintenance	Putting on a condom
4. Affectual	I am really sexually aroused, and this condom prevents me from feeling full pleasure	Frustration/stress	I already engaged in HIV risks by bare rubbing, hence now any extra risks are inconsequential The present must not be missed because the future is uncertain	Basic maintenance	Taking off a condom
5. Instrumental	I have taken HIV risks, hence I may lose my life	Regrets/guilt	Not applicable	Basic maintenance	Getting HIV tested

months ago” does not guarantee seronegativity) and a belief that penis–vagina bare rubbing, though troublesome posed, acceptable health risks for this masculine face-threatening occasion.

Action orientations do not easily override each other. Instead, this study argues that during motivational transitions there is often rapid switching back and forth between competing orientations. In the first half of this akratic event, we find that (1) on the normative orientation dimension, Houston remained without condoms to regain full erection and save masculine face, but (2) on the instrumental orientation dimension, he avoided unprotected vaginal penetration to minimize HIV risks. It is likely that at this stage, rapid theme versus horizon switches between instrumental (HIV-protective) and normative (masculine face-saving) phenomenological relevances were taking place. At certain junctures, troubled Houston may have experienced co-existing but contradictory reasons or motives for acting the way he was acting.

Transitional Instrumental Phase: During oral sex stimulation, Houston regained full erection, saving masculine face. He put a condom back on, allowing for instrumental forms to re-orient his sexual actions once again.

Second Non-instrumental Phase: However, soon enough he became frustrated because he was not feeling the depths of pleasure he had just experienced when he was having oral and vaginal rubbing sex. Houston was probably so sexually aroused at this point that affectual orientations were shaping another “motivated” belief in him, namely, the “wishful” perception that “penetrative” risks were now negligible because he had already engaged in “rubbing” risks. However, it should be noted that, regarding unprotected sex, a “penetrative” event is independent and more serious than a “rubbing” event. Eventually, affectual orientations of sexual arousal overthrew instrumental orientations of HIV safety. Houston took the condom off and proceeded to climax. Whether Houston discounted preference for the future in full knowledge of the risks involved (preference reversal) or simply minimized perception of risks (wishful thinking), it is hard to evaluate.³⁰ However, Houston’s post hoc hedonistic account reported above—“I went one step (rubbing), maybe if I go one step further (penetration) ... it ain’t going [to make a difference]”—points to distorting risk perception rather than discounting the future.

Late Instrumental Phase: Right after orgasm and coming down from his sexual high, Houston began to feel agonizing regrets or guilt because he realized he failed not once but twice to act on his original intention, namely, to engage in protected intercourse with his sex partner who happened to work in the sex industry. In other words, Houston had experienced full circle two articulated episodes of akrasia. To placate his lingering anxiety, Houston now in the context of late instrumental orientations of action went to get HIV tested. At least for this risky event, test results consistently came back negative.

DISCUSSION

Jose’s and Houston’s fascinating post hoc accounts of sexual risk reveal “motivational bargaining” processes that are experienced by phenomenological selves at crucial interactional junctures of the heterosexual act. These processes

seem to follow ritualized “event grammars” that consist of successive action orientations that suddenly become relevant, take over, and then surrender the phenomenological floor, they become focused for a while and then fade away, only to come back later. And at the end there is always regret. The dialectics of sexual HIV risk and protection open contradictory spaces where social presentations of the self, in particular the masculine self, become thematized and challenged. When that happens, a man must deploy arduous face-work to restore “gender common-sense.” The event becomes not so much about the pragmatics of sex, but rather about the meta-pragmatics of reestablishing a proper interactional footing vis-à-vis his female sex partner.⁵⁴ Simply put, men and women in sexual encounters “work hard” at creating a sense of interactional success towards each other.^{55,56} In the process, HIV may be the least of their concerns.

In this light, I argue that a significant amount of heterosexual HIV transmission occurs in the context of interactional threats to the masculine self and other gender rituals. Put another way, the risks of losing footing or consistent masculine face, and not the deadly risks of HIV, are likely to become a phenomenological priority of the sexual interaction. In short, it can be argued that sexuality is crucial to the institutional accomplishment of gender and hence, subject to more powerful forces than personal safety or hedonistic reward. Rather than being a private affair, heterosexual intimacy may be construed as a ritualized “social event” where men and women are pulled in many different and intransitive directions according to competing preferences of their multiple selves and their sense of gender accountability to one another. For many heterosexual men, the social risks of losing masculine face before a female partner, including embarrassment and humiliation, are very much prioritized over long-run HIV risks. In this sense, condoms can be threatening to a man because condoms may challenge “naturalized” narratives of masculine heterosexuality, including control and initiative.^{57–59}

Limitations of the Study

Convenience sampling procedures and small sample size render these qualitative data not generalizable. In-depth data were collected via self-report with all its concomitant problems. The author does not claim propositional truth of what “really” went on in the various behavioral and accounting claims but simply “post hoc” rationalizations of action from the point of view of the study participants. Thus, for example, the “true” motivational reason why Houston scapegoats a condom for his failed erection is unattainable with in-depth interview methodology. However, the fact that he perceives the condom as the cause of his failure to perform sexually, that is, to live up to his masculine self-image, is highly consequential for HIV prevention research.

The analysis presented here does not focus on the relationship between akratic risk-taking and partner violence. It simply shows how heterosexual men in MMTPs may account for their unprotected sexual behaviors at the phenomenological level. Although Jose and Houston did report instances of minor abuse with their main partners, the sexual narratives analyzed here took place with casual partners in the absence of any physical or sexual violence. Further comparative analyses should explore how different contexts of severe partner violence alter akratic rituals and categories, including masculine face-loss and repair.

Finally, the complex interactions among race, class, and masculinity are beyond the scope of this article. It has been argued that among some working-class or

minority men with little access to material resources, “protest” hypermasculine presentations of self may become important signifiers of local power and status.^{60,61} However, the relative impact of protest masculinities on shaping Jose’s and Houston’s akratic episodes cannot be established with data from this analysis. Further comparative analyses of HIV risky events across different types of masculinities—hegemonic, marginalized, protest, subordinated—may shed insight into the effects of race and class on heterosexual motivational bargaining.⁶¹

Implications for HIV Prevention

Almost three decades of HIV prevention research have shown that no single intervention approach by itself effectively controls the spread of HIV/AIDS.^{62,63} In addition to psychosocial⁸ and community-level⁶⁴ interventions, I argue that HIV prevention among heterosexual men with drug-using histories must target the interactional level of gender. Through the concept of akrasia, this study has shown that subtle interactional threats to presentations of the masculine self can prevent a man from practicing safer sex. The take-home message of this study’s findings is that selves are inconsistent in their sexual encounters and that, despite their strong intentions as individuals, at some juncture they will feel more accountable to complex framings of face-to-face interactional performances, in this case gender performances. The sexual akratic events analyzed here underscore the primacy of the “interactional order” over individual cognition.^{65,66}

This study has at least two implications for HIV prevention. First, people must be made fully aware that they have a multiple self with competing interests and that these interests will surface when least expected. Therefore, enacting some interests (masculinity, pleasure) over others (health) is not a human failure but part of powerful phenomenological forces working at the interactional level. Such forces need to be articulated, made explicit, and harnessed through imperfect tactics, such as meta-rules and pre-commitment strategies (e.g., learn to detect chains of cues that lead to risky encounters, expect shifting orientations during sexual events and enact protocols of engagement accordingly).

Second, short of structural change, “local” gender and masculinity discourses and practices must be made fully reflexive within intervention efforts, including power relations and ritualized presentations during sexual performances. By having men and women reflect on the volatile features of their multiple selves in sexual action, masculinity and gender may be demystified. In the spirit of Giddens’ dictum that “the possibility of intimacy means the promise of democracy,”⁶⁷ patriarchal reproduction should not be a concern in the bed. As long as societies are unable to decouple the erotic domain from patriarchy and the asymmetric reproduction of masculinity, HIV prevention efforts among heterosexual populations will be an uphill battle.

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