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Beyond risk and safety? Identifying shifts in sex education advice targeted at young women

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1. INTRODUCTION

This article examines sex education advice pages in *Dolly*, a popular Australian teen magazine aimed at girls aged 14-17 (Dolly 2017). Magazines such as *Dolly* are an important resource for sex education, especially for teenage girls (Arthurs and Zacharias 2006), and for topics which are absent or underdeveloped in the formal sex education curriculum (Bragg 2006, Kehily 1999a, Kehily 1999b, Hillier et al. 2010).

From a CDA perspective, it is important to analyse sex education because it has always been closely tied to ideology. Historically, sex education has reflected evolving ideas about sexuality, but also about gender, race, and social class (Nelson and Martin 2004: 2). Consequently, it has the potential to challenge the status quo when it comes to homophobia, gender inequality, and general sexual ignorance (Boynton 2006: 544). Conversely, poor sex education can adversely affect wellbeing, health and safety, and educational outcomes (Collier-Harris and Goldman 2017: 57). Sex education – whether in magazines, schools or other contexts – continues to be a significant field of exploration, given the prevalence of sexual harassment and abuse reported by women (e.g. through the #metoo movement).

Given the changes in societal attitudes towards sexuality and sexual identity that are evident in countries such as Australia, it is important to adopt a diachronic

perspective on sex education. We therefore examine sex education advice pages in *Dolly* over the last two decades (1990s vs. 2010s), to determine which discourses are present,[1] how they are constructed and negotiated linguistically, and whether they have changed over time.

To do so, this study combines corpus linguistic keyword analysis (Scott and Tribble 2006) and systemic functional linguistic appraisal analysis (Martin and White 2005). Our approach is thus positioned within corpus-based CDA (Hardt-Mautner 1995, Baker et al. 2008, Baker 2012). We first provide an overview of sex education discourses in magazines; then we introduce the data and methodology in more detail; finally, we discuss our findings.

2. SEX EDUCATION DISCOURSES IN MAGAZINES

Much work on sex education has shown how the media create and reinforce discourses around sexuality which tend to be conservative, judgmental and shaming (Attwood et al. 2015: 529). Research on magazines shows that they reinforce oppressive notions of femininity and influence what is considered normative sexual practice (Farvid and Braun 2014, McRobbie 1996, Reviere and Byerly 2013, Bachechi and Hall 2015).

These traditional discourses include 'compulsory heterosexuality', whereby heterosexuality is explicitly privileged over other forms of sexuality (Rich 1980: 632, Fine 1998). Alternative sexualities are problematised, minimised, absent or treated as 'deviant', except in the case of resources specifically targeted at queer audiences (Attwood et al. 2015, Clarke 2009, Kehily 1999a, Jackson 2005a). There is an overwhelming focus on pregnancy, involving the assumption that sex is equivalent to

penile-vaginal intercourse. There is minimal or no mention of anal or oral sex, and celibate or asexual people are also excluded (Attwood et al. 2015: 530).

Resonating with this discourse of compulsory heterosexuality are discourses which position male and female sexuality as radically different. For women, there is a discourse of 'presumed displeasure' (Bachechi and Hall 2015: 553). It is assumed that if a woman is sexually active, it is only because she feels pressure to do so (Clarke 2009, Bachechi and Hall 2015). Sex is 'marketed' to young women in relation to romance, rather than physical pleasure, and a girl's sexuality is understood and experienced in terms of romantic attachment, rather than physical desire (McRobbie 1991: 102). Masturbation is described as 'deviant' or left out altogether (Jackson 2005a, Carpenter 1998, Clarke 2009), and any mention of pleasure is outweighed by reminders of the emotional, physical, moral and/or financial consequences of sex (Jackson 2005a, Fine 1998). This is most evident in sex education's preoccupation with risk and safety, with a focus on contraception, sexually transmitted infections (STIs) and the dangers of pornography and sexting. While this information is relevant, it is often treated as the *only* relevant aspect of sex education (Jackson and Weatherall 2010: 181). This information is presented to young men as well, but it is especially used to discourage sex and desire in young women.

In contrast, sex is presented as a natural right and a strong, even irresistible, drive for young men. As well as it being the work and worry of women to avoid sex because of disease, pregnancy and the betrayal of boyfriends, they are also responsible for satisfying the sexual needs of men and for protecting themselves from male desire (Clarke 2009: 420) or against being 'used', damaged or infected (Carpenter 1998: 162, Fine 1998, Jackson 2005b). For young men, virginity is treated as something to overcome as soon as possible, while for young women it is a prize to

be offered in a committed relationship or, ideally, upon marriage (ibid: 416). Messages about piety for young women encourage abstinence and sexual restraint, placing the onus on women to control their sexuality without similarly problematising the male sex drive (Bachechi and Hall 2015: 556). Young women are responsible for saying no to unwanted sex, but the same is not expected of heterosexual men (Cameron and Kulick 2003: 39).

While some research has found that sex education discourses are becoming more progressive, these changes do not constitute a dramatic shift in content and discourses may retain an underlying anti-sex message (Carpenter 1998: 162, Clarke 2009: 425). In this article we examine whether we can identify any shifts in sex education discourses by comparing *Dolly*'s advice pages in the 1990s with the 2010s.

3. DATA AND METHODOLOGY

The data for this study consist of a corpus of advice pages from two decades: 1994 & 1995 (1990s) and 2014 & 2015 (2010s). Known as the 'Dolly Doctor' section (which existed until the end of 2016), these pages contain readers' questions which are typically answered by a medical professional, or occasionally by a celebrity or journalist. The Diachronic Dolly Doctor (DDD) Corpus contains 538 questions and answers, with a total of 1076 texts (88 476 words). The corpus design and building are described in Carr (2017). The corpus linguistic program WordSmith Tools (Scott 2017) was used to analyse the corpus.

While it is more usual for corpus linguistics to focus on patterns across texts (*inter*textual patterns), we also investigate patterns within texts (*intra*textual patterns),

by considering interactions between question and answer in the advice pages. In terms of Bednarek and Caple's (2017) topology, our study is thus situated in zones 2 and 3 (Figure 1): it focuses on language only (stays 'within-mode', is intrasemiotic), but incorporates analysis of *both* inter- and intratextual patterns. To clarify further: intertextual patterns are the patterns that hold *across* a range of texts in a corpus (we compare tendencies across texts). Intratextual patterns are the patterns that can be identified between elements *within* a text (e.g. we analyse the relationships between different textual stages). In the case of advice columns, identification of patterns in many/most of the columns ('between-text' analysis) can be combined with identification of patterns between the question/answer stages of these columns ('within-text' analysis, e.g. whether discourses in the question are repeated in the answer).

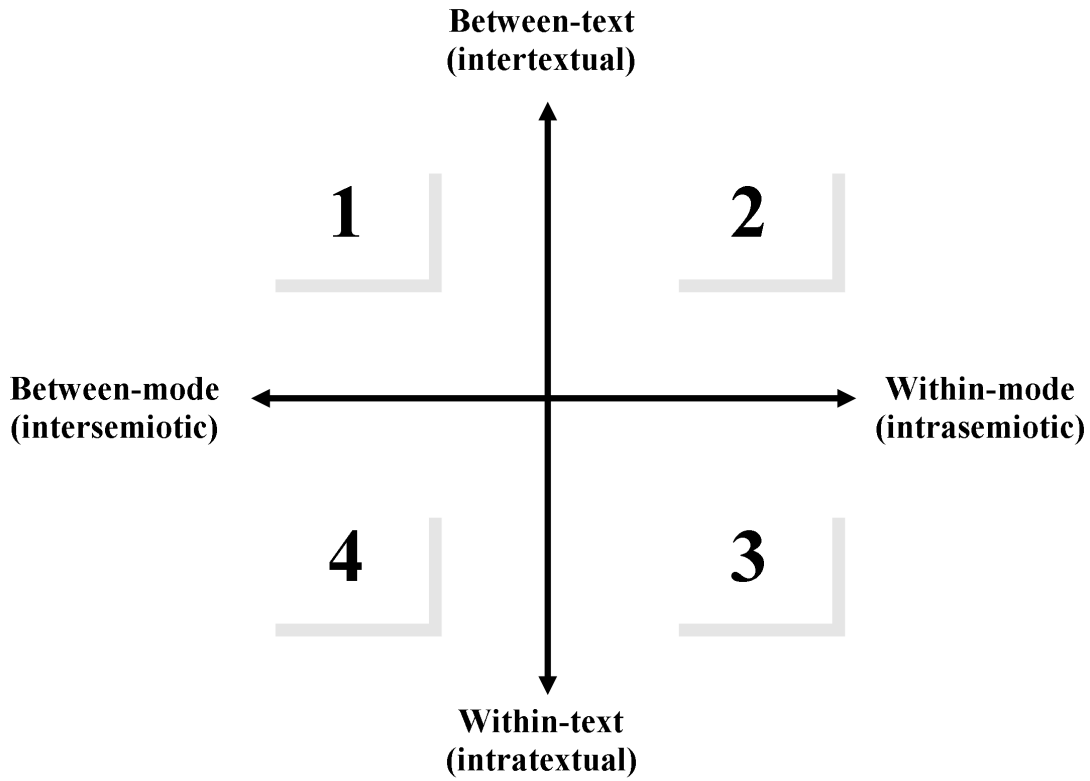

Figure 1 Situating the research

More specifically, our starting point is keyword analysis (Scott and Tribble 2006). This allows a comparison of two datasets, which is useful for our diachronic focus. Keyword analysis identifies words that are unusually frequent in one corpus (the study corpus) compared to a second corpus (the reference corpus). By using one decade of the DDD corpus as the study corpus and the other decade as the reference corpus, we can highlight thematic differences between the 1990s and 2010s data. For greater insight, we used each corpus once as study corpus and once as reference corpus.

This thematic analysis of keywords is complemented by analysis of appraisal. Appraisal is an interpersonal discourse semantic system concerned with how writers/speakers adopt stances towards the things they talk about and the people they communicate with (Martin and White 2005). When we appraise things, we construct our world in a particular way, tabling shared values, tastes and normative assessments (ibid: 1). Appraisal is thus a useful way into understanding discourses.

Appraisal has three sub-systems: attitude, engagement and graduation. Attitude is concerned with mapping feelings, and is divided into three further systems: affect, judgment and appreciation. Affect deals with resources for construing emotional reactions (e.g. *cheerful, upset*), judgment involves resources for assessing people's character and behaviour (e.g. *honest, selfish*), and appreciation is concerned with evaluations of things, including semiotic and natural phenomena (e.g. *captivating, tedious*) (ibid: 51-56). In this article we mainly analyse <u>inscribed</u> attitude, i.e. explicitly evaluative lexis, which is 'largely fixed and stable across a wide range of contexts' such as *coward, beautiful* (White 2006: 39). In contrast, <u>invoked</u> attitudes are realised by text that is understood as attitudinal, but does not carry positive or

negative value of itself and independently of its co-text (ibid). In some cases, the distinction between inscribed and invoked attitude is difficult to determine; indeed, Bednarek (2006: 45-48) includes the distinction as one of several *clines* that are relevant to evaluation.

Attitude is the main focus of this article, but the engagement system is partially drawn upon where relevant. Engagement is concerned with resources which allow a speaker/writer to position themselves in relation to alternative voices. We will introduce the relevant choices below. (Graduation options, not analysed in this article, are concerned with how attitudes are graded, in terms of how strong or weak and how sharply demarcated they are.)

The majority of appraisal analysis to date can be classified as 'manual' discourse analysis rather than applying corpus linguistic or computational methods (but see e.g. Taboada and Grieve 2004; Whitelaw et al. 2005; Bednarek 2008a, 2009; Hunston 2011). Since both approaches ('manual' and corpus) have their advantages and disadvantages in relation to the analysis of evaluative language (Hunston 2011: 21-24, passim), we used a combination of both methods: We started with keywords analysis to pinpoint words worthy of further investigation but returned to the full context (question-and-answer pair) for qualitative analysis. A keyword is a word which is unusually frequent in one corpus compared to a second corpus, i.e. a word is 'key' if it appears more often than would be expected (Scott 2017b). The keywords analysis enabled automatic, empirical, and statistical identification of differences between decades in terms of word frequency, with concordancing allowing analysis of how these words are used in their co-text, particularly in relation to the surrounding evaluative lexis. These corpus methods were complemented by manually analysing the full texts (question-and-answer pairs), which meant that we could consider the

wider co-text, identifying intratextual patterns across question and answer (c.f. Figure 1 above).

By 'cross-pollinat[ing]' corpus linguistics and CDA in this way we are able to analyse larger quantities of data without sacrificing the 'micro-level nuances' of discourse analysis (Baker et al. 2008: 274, Hunt 2015: 267). Discourses are considered here as ways of constructing the world, including through language (see note 1). In addition, we find it useful to distinguish between 'dominant' discourses and 'subordinate' discourses: 'Dominant' here means those discourses which are authoritative and commonly established (Harvey 2013: 50), while 'subordinate' discourses are non-mainstream (Baker 2010: 125).

4. FINDINGS

4.1 Thematic differences between the decades

A keyword analysis highlights the differences between the two decades of the DDD corpus. To maximise the data that could be used to make diachronic comparisons, the p-value was set to 0.05,[2] thus retrieving more keywords. The keywords for each decade are shown in Table 1, with keywords of interest in bold (see Appendices 1 and 2 for further details). The low raw frequencies (< 70 occurrences) made it possible to examine each instance in its co-text. We used WordSmith's Concord tool to do so, since we are interested in the meanings of these words as they are used in the advice columns.

Sub-corpus	**Keywords (sorted by keyness)**

1990s	***clinic***, ***planning***, ***stds***,[3] *guys,* ***std***,[3] ***pregnant***, *problem,* ***pill***, ***condom***, *local, mother, boyfriend's, although, form, caused,* ***sexually***, ***penis***, *face, occur, cream, loss, friend's, fact*
2010s	*GP, au* [from web addresses that end in .au], ***anxiety***, *online,* (*stis*),[3] *kids,* ***down***, *org,* ***thoughts***, *com, check,* (*sti*),[3] *issues, helpline, self, dating, here, helpful, listen, wondering, boobs, felt, call, e* [from e.g.], *experiencing, shaving, hear, line, chat,* ***angry***, ***depression***, *themselves, encourage, scary,* ***upset***, *options, conscious, open,* ***happy***, *actually, stay, chest, example, checked, issue, tough, handle, negative, differently, conversation, pressure, late, stand, saying*

Table 1 Keywords in the 1990s sub-corpus and the 2010s sub-corpus, sorted by log likelihood

Once concordance lines are examined to identify the use of these keywords, it is possible to classify them into two themes (or 'fields' in systemic functional linguistic terms, e.g. Martin 1992). The 1990s keywords tend to relate to sexual health: *clinic*, *planning* (*Family Planning Clinic*), *STDs, STD, pregnant, pill* (*contraceptive pill*, *morning-after pill*), *condom, sexually* and *penis*. Conversely, the 2010s keywords tend to relate to emotions and mental health: The keywords *anxiety, depression* and *thoughts* relate to issues of mental health (e.g. *thoughts of self-harm and suicide*; *unhealthy thoughts*). Interestingly, the concordancing showed that *down, angry, upset* and *happy* are also used in the co-text of references to mental health. For example:

(1) If you're consistently **down** and experiencing other symptoms of depression... reach out for help. (2014_2_A14)[4]

(2) I have had a condition called Dermatillomania (compulsive skin-picking) for as long as I can remember... I always feel **angry** and depressed, and I never really want to leave the house anymore. (2014_9_Q10)

(3) This year, my depression got really bad and I felt hopeless, stupid and **upset**, and I started harming myself. (2015_6_Q3)

This suggests a preoccupation with sexual health in the 1990s which has shifted over time to a preoccupation with mental health and emotions more generally in the 2010s. This finding reflects a change in attitudes in the 'real' world. The HIV/AIDS epidemic of the 1980s created an urgent concern over HIV transmission. Towards the end of the twentieth century, as rates of unintended pregnancy and sexually transmitted diseases started to rise, this shifted towards a concern with the risk of STDs more broadly, as well as contraception (Harvey 2013). The data from the mid-1990s reflects the concern with sexual health, particularly risk and safety, which characterised this period.

In contrast, the 2010s data reflect a change towards a concern with mental health. Until the 1990s, mental illness was thought to be 'rare, even impossible' in children and teenagers (Mondimore 2002: 1), and issues of mental health in adolescents have historically been under-recognised and dismissed (Weller and Weller 2000: S10). Now, however, the stigma around mental health is decreasing, and both medical professionals and broader society recognise the legitimacy of mental health concerns in young people (Sartorius 2007, Harvey 2013: 36). Further, rates of psychological distress among young people are on the rise, with one in three (32%)

Australians aged 12-25 now reporting high or very high levels of psychological distress; more than three times the rate in 2007 (9%) (Headspace 2018). Correspondingly, the 2010s sub-corpus reflects this change in attitudes, with mental health becoming more of a concern. Arguably, this shift is broadly a positive finding. The stigma surrounding mental health creates a considerable barrier for accessing professional help (Barney et al. 2006, Gulliver et al. 2010). The emerging preoccupation with mental health in the 2010s suggests that this stigma has lessened over time, with young people now more aware of mental health issues and more comfortable inquiring about these concerns than in the 1990s. Having highlighted this thematic difference, we now examine the corresponding discourses associated with sexual and mental health.

4.2 The 1990s sub-corpus: discourses of sexual health

In order to understand the discourses around sexual health in the 1990s, we took a closer look at the sexual health keywords by returning to the original question-and-answer pair. After examining every instance of *clinic, planning, STDs, STD, pregnant, pill, condom*, *sexually* and *penis* in a total of 111 texts, two discourses were identified. The first of these discourses, and by far the most frequent in the 1990s sub-corpus, is a discourse of risk and safety. This is best exemplified through the keywords *condom, pregnant, STDs* and *STD*, which occur in 61 of the texts concerning sexual health (55%).[5]

We examined the explicitly evaluative lexis that co-occurs with these words, which provides evidence for how they are evaluated, and how they contribute to the

discourse of risk and safety (keywords underlined, inscribed attitude in bold; -/+ signify negative/positive attitude):

(4) I'm **worried** [-affect] I may be pregnant. (1994_2_Q6)

(5) I **want** [+affect] to get the pill to eliminate any **risk** [-appreciation] of getting pregnant.

(6) You are **at risk** [-judgment] of catching an STD. (1994_Sp_A12)

(7) I've heard that if you use spermicidal cream with a condom it helps make sex **safer** [+appreciation]. (1994_6_Q9)

In Examples 4-7, *STD* and *pregnant* occur with negative evaluations (4-6), while *condom* occurs with positive evaluation (7). Using a *condom* (with spermicidal cream) helps make sex *safer* [+], while being *pregnant* and *catching an STD* are evaluated negatively as a *risk* [-] and something to be *worried* [-] about.[6] While only a small number of examples are given here, many more instances of this evaluative construction can be found in the 1990s sub-corpus.

The appraisal analysis also showed that the words *condom, pregnant* and *STD/s* frequently occur together, as in example (8):

(8) It's certainly **important** [+appreciation] when you decide to have sex that you take measures to prevent yourself from becoming pregnant and catching an STD. Using a spermicidal cream combined with a condom will help protect you from both of these things. (1994_6_A9)

Here, *important* is an inscribed attitude, which has scope over and affects the subsequent co-text. It is clear that *prevent* and *protect* are to be read as positive in this phase of text (invoked attitude). The semantics of these verbs are also relevant: if something *prevents* or *protects* you from something else, the subject of the verb is often evaluated positively and the object is evaluated negatively. When the terms *condom, pregnant* and *STD/s* occur together, condoms *protect* against and help *prevent* pregnancy and disease. Thus, the verbs *prevent/protect* simultaneously reinforce the positive evaluation of condoms and the negative evaluation of STDs.

The corpus linguistic concepts of semantic prosody and semantic preference are also relevant here. Both concepts, the relationship between them, and the scope of their definitions have been hotly debated (e.g. Partington 2004, Whitsitt 2005, Hunston 2007, Bednarek 2008b), a debate we cannot go into here. Broadly following Sinclair (2004: 142), we define *semantic preference* as the co-occurrence of a word with a set of semantically related words – words that come from specific lexical fields or semantic categories (e.g. words referring to sizes; emotions; sport; risk/safety). We use the term *semantic prosody* (Louw 1993) to refer to what Bednarek (2008b) calls *POS/NEG collocation* – the co-occurrence of a word with a set of *attitudinal* words or phrases (words that are positive or negative). This can be regarded as a special case of semantic preference (Partington 2004: 149), with a difference in generality: 'It is a question of how open-ended the list of collocates is: it might be possible to list all words in English for quantities and sizes, but not for "unpleasant things"' (Stubbs 2001: 66).

An analysis of all texts containing *condom, pregnant* and *STD/s* reveals repeated co-occurrence with the semantic category of risk and safety: examples include *risk, prevent, prevention, avoid, protect against, protect (yourself) from,*

protective, protection, safe and *safer*. Many of these co-occurring words are also at least implicitly attitudinal (negative or positive). This phenomenon could hence be considered a case of both semantic preference (co-occurrence with words from the semantic category of risk/safety) *and* semantic prosody (co-occurrence with attitudinally negative/positive words). While all four word forms have a semantic preference for words relating to risk/safety, *condom* has a positive semantic prosody and *pregnant, STD* and *STDs* have a negative semantic prosody. Arguably, the common semantic preference of these words is an important resource for the construction of the discourse of risk and safety.

Another important resource for this discourse is engagement, specifically concur formulations. Concurring is defined as a (heteroglossic) formulation which overtly announces that the speaker/writer and their audience are in agreement (Martin and White 2005: 122). This is used when referring to condoms, for example:

(9) If you make the decision to have sex, there are several things you should do to make it enjoyable and not painful. First, **of course**, use a condom. (1995_8_A6)

(10) Use a water-based lubricant, like KY Lubricating Jelly (as well as a condom, **of course**). (1994_11_A10)

In Examples 9 and 10, the concur formulation *of course* positions the audience as sharing the writer's view that condoms are an assumed and essential part of having sex. Significant here is the fact that these texts have two distinct audiences: the advice seeker (questioner) and advice giver (answerer) converse directly with one another in the advice column. However, they both also have the magazine's readership as their

wider audience. Therefore, the use of concurring resources in ***of course****, use a condom* assumes agreement not only between the questioner and answerer, but between these writers and the much larger audience who will read their correspondence. In this way, the discourse of risk and safety is constructed as a shared position not only for the immediate interlocutor but also for the wider readership of the magazine. We have presented just two typical examples, but this construction occurs frequently in the 1990s sub-corpus. Notably, Examples 9 and 10 also both contain imperatives: ***use*** *a condom* and ***use*** *a water-based lubricant*. Imperatives are monoglossic in that they do not reference, or allow for the possibility of, alternative actions (Martin and White 2005: 111). The monoglossic imperative, in combination with concur formulations, positions the advice as shared and obvious.

Broadly, then, the analysis demonstrates that condoms are evaluated positively while pregnancy and STDs are evaluated negatively in the 1990s sub-corpus. This is unsurprising in the context of a magazine aimed at young women. However, this analysis also reveals a larger discourse around risk and safety: condoms are not just good but something *safe* which offers *protection*, and pregnancy and STDs are not just bad but a *risk* and something to *prevent*.

This discourse of risk and safety is by far the most prominent sexual health discourse in the 1990s sub-corpus, demonstrated by its occurrence in 55% of sexual health texts. However, there are a small number of texts which demonstrate a subordinate discourse of pleasure, primarily in relation to masturbation. While *masturbate* and *masturbation* were not identified as keywords in the 1990s sub-corpus, texts relating to masturbation do appear when examining words like *sexually* (e.g. *sexually aroused*), which is a keyword. In these texts, masturbation is evaluated very positively:

(11) Masturbation is the **natural** [invoked +appreciation] way to find this [how your body works and how you **like** [+affect] to be touched] out, while providing a **safe** [+appreciation] outlet for your sexual urges. (1994_4_A7)

(12) Some people say that it [masturbation] can have a **positive** [+appreciation] influence on your life by reducing any built up sexual **tensions** [-affect]. (1994_4_A10)

In Examples 11 and 12, masturbation is described as *natural* [+], as providing a *safe outlet* [+] and having *a positive influence on your life* [+]. In addition to providing positive evaluations of masturbation, the texts also refute negative evaluations. This can be seen in the interaction between questions and answers, where the question provides a negative evaluation and this is refuted in the answer. This is done using further engagement resources, specifically disclaim formulations. Disclaim formulations are heteroglossic, meaning they acknowledge viewpoints of external voices. However, when disclaiming, a writer cites an alternative position only so it can be directly rejected or replaced (Martin and White 2005: 118). The answerer opens up the dialogic space, but only to acknowledge and reject the view expressed in the question. For example (attitudes in bold, disclaim underlined):

(13)

> *I am a **healthy*** [+judgment] *and **athletic*** [invoked +judgment] *12-year-old girl. For the past eight months I've been masturbating regularly… Will masturbating affect my health* [invoked -judgment] *or slow me down when I'm running, jumping and sprinting* [invoked -judgment]]*?*
>
> Masturbation is…a **harmless** [+appreciation] activity with no medical or health **consequences** [invoked +appreciation]. Masturbating will certainly not **decrease your performance** in sport [invoked +appreciation]… (1994_4_Q&A10)

In Example 13,[7] the questioner asks whether masturbating will *affect my health* (-) or *slow me down* (-) in sport. The answerer uses disclaiming formulations (*no*, *not*) along with a concur formulation (*certainly*) to reject and replace the negative evaluations. As a resource for heteroglossia, disclaiming does open up the dialogic space. However, disclaim formulations are the most contractive of the heteroglossic resources. That is, they allow an alternative position to be acknowledged – that masturbation *does* have health consequences and could affect sports performance – but only so that this position can be rejected. All of the texts relating to masturbation reflect the same patterns of evaluation in the answer: masturbation is evaluated positively, and any negative evaluations are rejected.

So far we have identified two discourses of sexual health in the 1990s. In line with previous findings (cf. section 2), the discourse of risk and safety remains by far the most dominant discourse. This discourse is used to discourage sexual activity, emphasising the dangers of sex while downplaying desire and the positive aspects of sexuality. However, the discourse of pleasure, while much less frequent, is arguably

more positive. It directly contradicts the discourse of 'presumed displeasure' for young women, moving from treating sexual activity as painful or dangerous to something enjoyable.

Above, the examples given for the discourse of pleasure have centred around masturbation, where the discourse of risk and safety does not feature because the risks of pregnancy and STDs do not apply. However, when the discourse of pleasure is used in relation to other sexual activities which *do* come with these risks, we can see how these two discourses interact. For example:

(14)

> *I've heard how **painful*** [-appreciation] *sex is for the first time. I don't think I'm big enough. I have had guys finger me but they only use one finger. Trying to find out for myself, I found two fingers won't fit. Is there a way to fix this?*
>
> If you make the decision to have sex, there are several things you should do to make it **enjoyable** [+appreciation] and **not painful** [+appreciation]. First, of course, use a condom. This not only helps prevent pregnancy but also protects you from sexually transmitted **diseases** [invoked -appreciation]. Secondly, **pain** [-appreciation] during intercourse is generally caused because the girl is not sufficiently aroused. So make sure you spend time being sexually stimulated before you have intercourse; take it slowly, don't hurry. Finally, using a water-based lubricant like K-Y Lubricating Jelly can also help. Don't use an oil-based lubricant like Vaseline as it might **damage** [-appreciation] the condom. If you follow these guidelines you'll find that your vagina will be large enough to receive your boyfriend's penis and you will **enjoy** [+affect] your first-time sex together. (1995_8_Q&A6)

In Example 14, the answerer begins by stating that sex should be *enjoyable* [+] *and not painful* [+]. The discourse of pleasure is thus introduced from the first inscribed attitude. However, this is followed by the advice *first, of course, use a condom* (again using the monoglossic imperative). This cites the discourse of risk and safety through mention of condoms, which have a semantic preference for risk and safety. This is further reinforced with *of course* (concur), which assumes that the writer and their

audience are in agreement on this position. While the answerer goes on to give advice about how to make sex pleasurable, the discourse of risk and safety continues to be used. The answerer advises to *use a water-based lubricant* to make sex more enjoyable, but this is followed by a further invocation of the discourse of risk and safety with the mention of condoms in *don't use an oil-based lubricant like Vaseline as it might damage* [-] *the condom*.

Example 12 illustrates that the discourse of pleasure and the discourse of risk and safety can co-occur. Indeed, it makes explicit that safety is part of what makes sex enjoyable: *there a **several things** you can do to make sex enjoyable… **first**… use a condom*. In this way, the discourse of risk and safety is dominant not only because it is much more frequent and pervasive in the corpus, but also because it is considered a necessary part of the discourse of pleasure when the sexual activity comes with risk (i.e. oral, anal and vaginal sex rather than masturbation).

In this section we have identified not only the dominant, or most frequent and widespread discourse of risk and safety, but we have also pinpointed the less prominent, subordinate discourse of pleasure. In addition to offering a more rounded and comprehensive picture of sexual health discourses, this illustrates that dominant discourses and subordinate discourses do not sit equally side-by-side, but instead interact and even compete with one another. As we will see below, the same is also true for mental health discourses in the 2010s sub-corpus.

4.3 The 2010s sub-corpus: discourses of mental health

As suggested in section 4.1, the keywords for the 2010s sub-corpus concern emotions and mental health (see examples 1-3). In this section, we provide further examples

which highlight how these words contribute to mental health discourses. Analysis of all texts containing these keywords revealed that they frequently co-occur with terms such as *symptoms, disorder, diagnose, (school) counsellor* and *assessment*, as well as referrals to Australian mental health services such as *Headspace* and *Beyondblue*. For example (keywords underlined; medical terms in bold):

(15) I am a relatively happy person, but every now and then I experience **symptoms** of depression. (2014_10_Q1)

(16) It's important that you seek help for your **symptoms** of depression, especially to discuss your thoughts of self-harm and suicide. (2014_9_A5)

(17) Three of my closest friends keep suggesting I may have a mild anxiety **disorder**. (2014_2_Q12)

These keywords thus have a semantic preference for terms relating to medicine.[8] This is a principle resource for constructing a medicalising discourse of mental health, which privileges descriptions of psychological distress in clinical terms (Harvey 2012: 371). This discourse involves constructing emotional turmoil as an illness, something which can be 'diagnosed' and is manifested by 'symptoms' (Bennett et al. 2003, cited in Harvey 2013: 156).

Importantly, a medicalising discourse does not necessarily entail that a mental illness has been diagnosed. Rather it is the tendency to describe emotional turmoil in diagnostic or clinical terms rather than as an ordinary experience. There are texts in the 2010s sub-corpus where someone has, in fact, been diagnosed with a mental illness, as in *I've been diagnosed with social anxiety* (2015_5_Q11). In these cases, the formulation of psychological distress in medical terms is based on an actual

clinical interaction. But most texts on mental health do not include a formal diagnosis, including texts which refer to *anxiety* and *depression*. Rather, they reflect a self-diagnosis on the part of the questioner or a suggested diagnosis on the part of the answerer. That is, most descriptions of mental illness refer to medical terms such as *diagnosis* and *symptoms* because of a choice to use a medicalising discourse, rather than because of a clinical interaction in real life which warrants this language.

While the medicalising discourse of mental health is common in the 2010s, it is not the only option for describing psychological distress. Such descriptions may occur without a medicalising discourse, as in Example 18:

(18) I had a BF [boyfriend] and I was **so happy** [+affect], then we broke up and I can't stop thinking about him and feeling **down** [-affect]. When I do have an OK day, my fam[ily]'s arguing makes me feel **like crap** [-affect] again. What can I do to stop feeling **so down** [-affect]? (2014_4_Q2)

In Example 18, the questioner describes their emotional turmoil following a break up using a series of inscribed negative affects. The medicalising discourse is absent from this question, although there is an implied evaluation of negative emotions as undesirable, indicated by *what can I do to **stop** feeling so down?*

For the answers, if the medicalising discourse is absent we can identify another, competing discourse: a normalising discourse. This discourse normalises experiences of emotional turmoil, treating them as 'everyday and unavoidable' human experiences (Moynihan et al. 2002, cited in Harvey 2012: 371). While there are only a few examples in the data, repeated intertextual patterns reveal how this is constructed

through the use of the terms *common*, *all* and inclusive first-person plural pronouns as the Emoter (Bednarek 2008a: 154) of negative emotions. For example:

(19) **We all** feel nervous [-affect] and insecure [-affect] occasionally… Anxiety is **very common** and something **we all** experience. (2014_3_A1)

(20) **We** can **all** feel anxious [-affect] for different reasons. (2015_5_A2)

(21) It's **common** for it to take a while to adjust to a new situation like this [feeling like you don't fit in [-affect] at a new school]. (2014_9_A2)

In Examples 19-21, negative emotions such as feeling *nervous, insecure, anxious* and *like you don't fit in* are described as ***common*** and *something **we all** experience*. By describing these feelings as everyday and ordinary experiences rather than as something requiring a medical explanation, the answer normalises the emotions expressed.

Bringing together analysis of *inter*textual patterns (across the analysed texts) with analysis of *intra*textual patterning (between the question/answer stages), an important question regarding the medicalising discourse is the identity of the person introducing it: Is it the questioner (young person) or the answerer (professional)? In his study of an online advice column, Harvey (2012) proposes that the medicalising discourse of mental health is produced by health advisors and that this then becomes a template for young people to use in their own formulations (2012: 372). For the DDD corpus, we would therefore expect the medicalising discourse to primarily occur in the answers, since these are largely written by medical professionals. In fact, while this discourse is present in the answers, this is almost always in response to it being present in the corresponding question. The overwhelming pattern for texts using a

medicalising discourse is for the question to introduce this discourse and the answer to *re*produce it. For example:

(22)

*Three of my closest friends keep suggesting I may have a mild **anxiety disorder**. During exams, I have breakdowns and I don't sleep well during the school term. I constantly worry about my math marks even though I have the top marks in my year, and just sitting a normal math test can leave me gasping for breath. I don't want to talk to my mum as she doesn't care about this type of thing and thinks I'm a drama queen, and I can't tell my dad as I don't live with him and only see him once a month. Are my friends right, do I have an **anxiety disorder**? If so, what should I do?*

From the **symptoms** you're describing, it seems you're prone to **anxiety**. When a person experiences **anxiety**, typically there's a physical component. Worrying and catastrophic thoughts (e.g. "I'm going to fail") trigger a release of chemicals and hormones in the body, producing a "fight or flight" response. This reaction is often characterised by fast, shallow breathing, increased heart rate, dizziness, nausea, butterflies and tensing of muscles. To counteract these **symptoms**, take calm, deep breaths. Inhale slowly through your nose, then slowly exhale through your mouth. As you breathe out, say the word "relax" and consciously release any tension in your muscles. Repeat this often through the day and, if you're restless, at night. Identify any **anxiety**-provoking self-talk (e.g. "I'll never get through this") and counteract it with helpful coping statements (e.g. "Just take it one step at a time"). A healthy lifestyle including exercise, a balanced diet and less caffeine can help reduce overall stress. Relaxation techniques such as yoga and meditation are also beneficial. For more **anxiety** advice, check out reachout.com or see your **counsellor** or **GP**. (2014_2_Q&A12)

In Example 22, the question opens with a medicalising discourse: *Three of my closest friends keep suggesting I may have a mild* ***anxiety disorder***. As the hyperTheme (a higher level Theme which functions as a 'topic sentence' for a phase of discourse, Martin and Rose 2003: 177), this frames the description that follows as potential realisations, or symptoms, of that *disorder*: *I have breakdowns, I don't sleep well* and *I constantly worry about my math marks.* The answer similarly contains a medicalising discourse through repeated use of the term *symptoms,* which are also elaborated as a list: *fast, shallow breathing, increased heart rate… and tensing of muscles*. Thus, in Example 22, we see that the medicalising discourse is first produced in the question and then reproduced, or <u>mirrored</u> in the answer.

In contrast, if the question does <u>not</u> use a medicalising discourse, then the answer is unlikely to either. This can be seen in Example 23, where the question describes negative emotions (in bold), and the answer responds with a normalising discourse (underlined; inscribed attitude elsewhere in the answer not analysed):

(23)

*I'm always **nervous*** [-affect] *when I go to out-of-school activities. I get **shy*** [-affect] *and don't talk much. I feel **insecure*** [-affect] *and fat! I **don't like*** [-affect] *being social and try to get out of things. I don't know what's wrong. Help!*

We all feel **nervous** [-affect] and **insecure** [-affect] occasionally, so don't be too hard on yourself. But if you want to feel more confident, talk back to yourself about the negative thoughts you're having. If your friends put themselves down, what would you say to them? Say that to yourself. However, if you feel panicky often and can't bring these feelings under control easily, you might be experiencing anxiety. **Anxiety** [-affect] is very common and something we all experience**.** If these feelings cause you to avoid situations and stop you from participating in activities, there are things you can do to help stop it. Talk to a trusted adult or contact Beyondblue on 1300 224 636. (2014_3_Q&A1)

In Example 21, the questioner expresses their emotional turmoil with inscribed negative affect (*nervous, shy, insecure, don't like*). Rather than employing a medicalising discourse they use ordinary, everyday terms to express their emotions. In response, the answerer uses a normalising discourse, framing the questioner's feelings as common: ***we all*** *feel nervous and insecure occasionally* and *anxiety is **very common** and something **we all** experience*. At the end, the answerer hints at a medicalising discourse by suggesting that they *contact Beyondblue* (a mental health organisation). However, this is introduced with the conditional; ***if*** *these feelings cause*

you to avoid situations…, framing psychological support as optional, and indicating that a medical basis for their distress is just one possibility. The answerer makes no reference to diagnosis, symptoms, or any of the other features of a medicalising discourse. In Example 22, a medicalising discourse in the question leads to the same discourse being produced in the answer. In Example 23, its absence in the question leads to its absence in the answer, leaving room for a normalising discourse.

This mirroring of discourses between the question and answer accounts for most of the mental health texts analysed. However, there are some instances where the discourse of the question and answer differs. Specifically, there are some examples where the medicalising discourse is absent in the question and is instead introduced in the answer. This is always done using engagement resources which are dialogically expansive, specifically <u>entertain</u> formulations. Entertaining is defined as a formulation where the writer/speaker indicates that their position is just one of several possible options (Martin and White 2005: 104). For example:

(24) I **can't say** whether you might also have depression or anxiety…or whether there might be something else going on... You **might** also want to talk with a professional…you **could** see your GP, look for a Headspace service, or talk to a teacher or school counsellor. (2015_12_A2)

(25) The school counsellor **may** be a good person to talk to. (2014_9_A2)

In Examples 24 and 25, the modal auxiliaries *may*, *might* and *could* open up the dialogic space, indicating that there are a range of viewpoints available. Specifically, the answerer suggests that the emotional turmoil could have a medical basis, but also indicate that their position is just one of several alternatives. Rather than stating that

the questioner's emotions have a clinical explanation, the answerer only entertains this possibility in *you **might** also want to talk with a professional*, *you **could** see your GP* and *the school counsellor **may** be a good person to talk to*. Similarly, in Example 24 the answerer recognises that their view is one among a series of alternative positions (***I can't say** whether*). This grounds their proposition in their own individual subjectivity and makes space for other viewpoints. In sum, where the discourse of mental health differs between the question and answer, the answerer is careful to introduce a new discourse with engagement resources which open up the dialogic space, thereby recognising that there are alternative positions.

In conclusion, while the preoccupation with mental health in the 2010s is broadly a positive finding (see section 4.1), the prevalence of the medicalising discourse of mental health is cause for concern. It reflects an increasing trend of psychiatrisation, not only for the emotional turmoil experienced by adolescents but for all 'problems of living' (Rose 2006: 476). This trend applies proto-professional labels to emotional states that could be seen as normal rather than pathological, and encourages the 'treatment' of an 'illness' where there is none (Harvey 2012: 360; Lewis 1967b as cited in Rose 2006: 482). Although substantially less common in the data, the normalising discourse is a positive alternative to this trend. In addition, medical professionals are cautious in their use of the medicalising discourse. It is primarily used in the answer only where it has first been produced in the question, or it is absent from both. Where the discourse is not mirrored, that is, where it is introduced in the answer rather than the question, the professionals indicate that the medical explanation is just one of several alternative positions.

5. CONCLUSION

Exploring magazine advice column discourses helps understand the messages in sex education that are widely disseminated through mass media and how this might change over time. This study has discovered a shift from a preoccupation with sexual health in the 1990s to a preoccupation with mental health in the 2010s, with associated dominant and subordinate discourses. We detected both recurring tendencies *across* advice columns and identified patterns *within* advice columns (between the question and answer stages).

To some extent, the found discourses are reproductions of problematic discourses that have been identified previously. The discourse of risk and safety focuses on the dangers of unwanted pregnancy and disease, treating sex and sexuality as problematic, while the medicalising discourse of mental health treats emotional states as pathological rather than normal where this may not be warranted. However, each of these discourses is complemented by a more positive subordinate discourse. For the 1990s, the dominant discourse of risk and safety treats sexual activity as dangerous, while the subordinate discourse of pleasure treats it as enjoyable. For the 2010s, the dominant medicalising discourse of mental health frames psychological distress in clinical terms, while the subordinate normalising discourse treats it as a part of everyday human experience. In both cases, the subordinate discourses, while less frequent, are arguably more positive, suggesting that sex education discourses may be gradually becoming more progressive. Importantly, while CDA tends to highlight negative or problematic discourses, it is important to also highlight neutral or positive discourses in order to gain 'a full picture of representation' (Baker 2012: 255; see Martin 2004 on Positive Discourse Analysis).

As well as identifying these sex education discourses, we have illustrated how they are constructed linguistically. This is essential to understanding how discourses are changed or maintained. For example, the normalising discourse of mental health – which is a counterpoint to the medicalising discourse – can be constructed by using first-person plural pronouns with inscribed negative affect (e.g. *we all feel nervous*…).

This study is limited in that it analysed the discourses of the 1990s and 2010s individually and not comparatively. That is, we analysed the sexual health discourses only in the 1990s and the mental health discourses only in the 2010s. In studying how discourses in sex education have changed over time, ideally this investigation would have looked at *both* sexual and mental health discourses in *both* decades. Such a comparison would reveal whether they have changed qualitatively as well as quantitatively, or whether they have remained the same but are constructed using different linguistic resources. In addition, it is necessary to analyse in more detail other discourses (e.g. around virginity) in terms of both similarity and difference. The analysis of sex education discourses in products targeting boys would also be vital for a comprehensive picture.

In conclusion, this article has shown that some discourses may be becoming more progressive, but other, conservative discourses still endure. For example, the subordinate discourse of pleasure treats sexual activity as enjoyable for young women rather than reproducing the conservative discourse of 'presumed displeasure'. But the dominant, enduring discourse of risk and safety foregrounds the dangers of sex and simultaneously backgrounds non-heterosexual sex through its focus on pregnancy. We argue that analysis of discourses in sex education and how they are linguistically constructed is crucial to understanding young people's experiences on a range of

issues, including sexuality, gender equality, and mental health stigma. Such analysis can help us move towards better understanding how language can be used to expand the space for inclusion, and to challenge the status quo. This in turn may have a positive flow-on effect on our sexual encounters and how we are treated by society, which has the potential to benefit everyone.

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Appendices

Appendix 1

Keywords in the 1990s sorted by log-likelihood (reference corpus: 2010s), including raw frequency, normalised frequency (per 100,000 words), number of texts, percentage of texts, and log-likelihood (LL)

1990s sub-corpus						
Rank	**Keyword**	**Freq.**	**N. Freq.**	**Texts**	**% Texts**	**LL**
1	clinic	37	82.1	35	5.4	32.9
2	planning	33	73.2	32	4.9	32.0
3	stds	21	46.6	19	2.9	28.3
4	guys	68	150.9	54	8.3	27.5
5	std	18	39.9	16	2.5	24.3
6	pregnant	42	93.2	33	5.1	24.1
7	problem	65	144.2	60	9.2	23.4
8	pill	41	91.0	26	4.0	23.1
9	condom	33	73.2	23	3.5	22.1
10	local	33	73.2	32	4.9	22.1
11	mother	20	44.4	16	2.5	20.4
12	boyfriend's	19	42.2	18	2.8	19.1
13	although	37	82.1	35	5.4	15.5
14	form	20	44.4	18	2.8	13.4
15	caused	26	57.7	22	3.4	12.7

16	sexually	33	73.2	27	4.1	12.1
17	penis	25	55.5	20	3.1	11.8
18	face	32	71.0	28	4.3	11.3
19	occur	17	37.7	17	2.6	10.3
20	cream	21	46.6	17	2.6	8.3
21	loss	17	37.7	16	2.5	6.5
22	friend's	18	39.9	16	2.5	5.8
23	fact	18	39.9	16	2.5	5.8

Appendix 2

Keywords in the 2010s sorted by log-likelihood (reference corpus: 1990s), including raw frequency, normalised frequency (per 100,000 words), number of texts, percentage of texts, and log-likelihood (LL)

2010s sub-corpus						
Rank	**Keyword**	**Freq.**	**N. Freq.**	**Texts**	**% Texts**	**LL**
1	gp	36	82.9	31	7.3	38.3
2	au	18	41.5	14	3.3	25.6
3	anxiety	28	64.5	17	4.0	24.2
4	online	15	34.6	12	2.8	21.4
5	stis	15	34.6	10	2.4	21.4
6	kids	14	32.3	14	3.3	19.9
7	down	58	133.6	51	12.0	19.4
8	org	13	29.9	11	2.6	18.5
9	thoughts	20	46.1	18	4.2	17.8
10	com	12	27.6	10	2.4	17.1
11	check	36	82.9	30	7.1	16.6
12	sti	11	25.3	10	2.4	15.7
13	issues	11	25.3	10	2.4	15.7
14	helpline	10	23.0	10	2.4	14.2
15	self	37	85.2	34	8.0	12.9
16	dating	16	36.9	16	3.8	12.9

17	here	13	29.9	12	2.8	12.7
18	helpful	13	29.9	12	2.8	12.7
19	listen	18	41.5	18	4.2	12.5
20	wondering	15	34.6	14	3.3	11.8
21	boobs	12	27.6	11	2.6	11.4
22	felt	17	39.2	16	3.8	11.4
23	call	17	39.2	16	3.8	11.4
24	e	19	43.8	10	2.4	11.2
25	experiencing	19	43.8	17	4.0	11.2
26	shaving	21	48.4	15	3.5	11.2
27	hear	11	25.3	11	2.6	10.1
28	line	13	29.9	12	2.8	9.4
29	chat	13	29.9	13	3.1	9.4
30	angry	13	29.9	13	3.1	9.4
31	depression	15	34.6	13	3.1	9.2
32	themselves	15	34.6	12	2.8	9.2
33	encourage	15	34.6	14	3.3	9.2
34	scary	10	23.0	10	2.4	8.9
35	upset	20	46.1	18	4.2	8.5
36	options	12	27.6	10	2.4	8.3
37	conscious	18	41.5	17	4.0	8.3
38	open	14	32.3	14	3.3	8.1
39	happy	17	39.2	17	4.0	7.4
40	actually	17	39.2	17	4.0	7.4

41	stay	15	34.6	13	3.1	7.2
42	chest	11	25.3	10	2.4	7.2
43	example	13	29.9	13	3.1	7.1
44	checked	16	36.9	15	3.5	6.5
45	issue	14	32.3	11	2.6	6.3
46	tough	14	32.3	12	2.8	6.3
47	handle	10	23.0	10	2.4	6.1
48	negative	10	23.0	10	2.4	6.1
49	differently	10	23.0	10	2.4	6.1
50	conversation	15	34.6	15	3.5	5.6
51	pressure	13	29.9	12	2.8	5.4
52	late	11	25.3	10	2.4	5.2
53	stand	12	27.6	10	2.4	4.5
54	saying	12	27.6	11	2.6	4.5

[1] We use the term *discourses* in the Foucauldian sense of 'practices that systematically form the objects of which they speak' (Foucault 1972: 49).

[2] The p-value indicates the amount of confidence that a result is not due to chance. A p-value of 0.05 is the highest p-value at which the risk of error is considered acceptable (Scott 2017b).

[3] The keyness of *STD* (sexually transmitted disease) in the 1990s and *STI* (sexually transmitted infection) in the 2010s reflects a change in naming convention that began in the 1980s because 'disease' implies obvious symptoms, but many sexually transmitted viruses and bacteria cause no symptoms, only 'infection' (STDs/STIs 2017). Today they can be considered 'synonymous and interchangeable' (Hunter Handsfield 2015: 169). Taking this into account, we used the Log-likelihood

and effect size calculator (2017) to determine that *STD/STDs/sexually transmitted disease* is key in the 1990s, but *STI/STIs/sexually transmitted infection* is not key in the 2010s (hence in brackets).

[4] Throughout this article, file IDs are included when giving examples. For example, 2012_2_A14 is the fourteenth answer from the second (February) issue of 2012. File IDs beginning with 1994_Sp refer to the 1994 'Special edition' titled 'Make it Happen'.

[5] We focus here only on those word forms which are key in the 1990s sub-corpus, and we therefore exclude related word forms such as *condoms* and *pregnancy*. However, these forms overwhelmingly occur in the same texts as the keywords (e.g. *condom* and *condoms* are likely to appear in the same texts), and thus very few texts are overlooked in this analysis. Note that *STD* and *STDs* contain the word *disease,* which Martin and White (2005: 67) analyse as invoked attitude.

[6] In Example 2, *risk* is treated as a thing and therefore [-appreciation], while in Example 3, *at risk* is [-judgment] since the appraised is a person in ***you*** *are at risk*. In Example 4, *safer* is classified as [+appreciation]; even though *using spermicidal cream with a condom* is a behaviour, suggesting [+judgment], *safer* is treated as [+appreciation] since it directly appraises *sex* (a thing, though this could be 'double coded' as inscribed appreciation/invoked judgment – see Carr 2017).

[7] Attitudes are coded as positive or negative based on the overall construction: *health consequences* is [invoked -appreciation], but ***no*** *health consequences* is [invoked +appreciation].

[8] While we do not focus on the grammatical relations between the co-occurring words here, these are also relevant: for example, the medicalising discourse is constructed not only because *depression* occurs in proximity to a word from the medical field (*symptoms*), but because of the head-postmodifier or Focus-Thing relation (*symptoms of depression*). In Hao's (2015) discourse semantic terms, *symptoms* are a 'dimension' of *depression*.