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The Intersection of Desire, Drugs, and Unsafe Sexual Practices:
An Ethnographic Study of the Gay Circuit Party Subculture

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THE INTERSECTION OF DESIRE, DRUGS, AND UNSAFE SEXUAL PRACTICES: AN ETHNOGRAPHIC STUDY OF THE GAY CIRCUIT PARTY SUBCULTURE

By
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Thesis Submitted to
The Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements for the
Degree of Doctorate of Philosophy in Nursing

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Ottawa, Ontario

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Your file Votre référence
ISBN: 978-0-494-52337-7
Our file Notre référence
ISBN: 978-0-494-52337-7

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Abstract

At present, HIV rates within the population of men who have sex with men continue to rise despite increased resources being dedicated to stopping this trend. Previous research has indicated that drug use, particularly within the context of gay circuit parties (GCP), may be a central factor in this rise in HIV rates. Further research has revealed that one reason for this phenomenon is that much of the research that has been undertaken to-date ignores the role of desire. In fact, an in-depth review of previously undertaken research that aimed to understand men's motivations for sexual practices revealed a strong, uncritical reliance, on the assumption that individuals are inherently driven to act in *healthy* ways. In response, this research project undertook an ethnographic study of GCPs, and engaged in direct observation, surveying, and interviewing guided by a poststructuralist perspective. The goal was to challenge mainstream assumptions about health, drug use, unprotected sex, and GCP party attendance. To accomplish this, a theoretical framework was developed drawing primarily on the work of Deleuze and Guattari, and supported by the theoretical work by Bataille, Foucault, Grosz, and Lupton. After this groundwork was laid, two days worth of direct GCP attendance was undertaken, followed by the administration of 209 auto-administered surveys, and the completion of 17, hour-long, formal interviews. The major findings of this study are (1) that desire is not necessarily a reaction to previous negative situations as is posited by psychoanalysis, and drawn upon by mainstream sexual health researchers, and (2) that drug use and GCP attendance do not cause individuals to engage in unsafe sexual practices, but rather, that individuals use drugs and attend GCPs with the pre-established goal of engaging in unsafe practices. In this way, drugs and GCPs become mechanisms that are used to allow individuals to indulge in their desires, not causes of what they desire. Therefore, the findings of this research indicate that GCPs should be capitalized on as important sites of health promotion work for nurses, and that this work should not be based on the conjecture that drug use or unsafe sex is irrational or deviant, but rather, that its use follows the dictates of desire.

Acknowledgements

I would like to thank my supervisor, Dr. Dave Holmes, for his invaluable assistance and guidance that he provided over the course of my studies. Without his help, the outcome of this project would have been impossible. His guidance and mentorship has helped me develop my theoretical, methodological, and critical thinking skills tremendously. In addition, I would like to thank my co-supervisor, Dr. Kirsten Woodend whose assistance greatly helped me advance my understanding of complex public health issues. Furthermore, I am indebted to my doctoral thesis committee members, Drs. Meryn Stuart, Michael Orsini, and Christine McPherson who also provided assistance throughout this process. I would also like to thank my mother, Frances O'Byrne, for persevering and assisting me greatly throughout the duration of the editing process. Lastly, I would like to thank my closest friends, Marie-Eve Béland, Toomas Emery and Ethan van den Berg, Chris van Galder, Craig Owen, and Elissa Biasone, in addition to my brothers James and Matt Owen, for their understanding of my absence during this process, for their discussions which helped me further my comprehension of my own research topic, for their provision of support and motivation at times when they knew that I needed it most, and for their patience during endless hours of book shopping and reading.

Chapter One – Overview and Introduction

"They talk of my drinking, but never my thirst."
Scottish Proverb

Introduction

As revealed by this Scottish proverb, it is time to move beyond analyses (and psycho-analyses) of drinking, and, instead, to reflect on the motivations and experiences of thirst: the thirst of desire, the thirst of drug use, and the thirst of unsafe sex. However, the impetus for this exploration was not, as Freud might propose, an underlying psychological or emotional deficit. Nor did an intellectual lacuna prompt the inception of this project. On the contrary, a chance immersion in a surreal fantasyland of sex, space, music, movement, and bodies started it all. It was desire that reached out and formed connections, fuelled curiosity, and led toward the discovery that this fantasyland was a gay circuit party (GCP). Much like the GCP itself – recreated each time through unique combinations of visual, environmental, and sound elements never experienced before, and lasting from hours to days – the description provided here may, perhaps, reconstruct itself within the mind of the reader; and the feelings, sensations, emotions, and mysteries generated by this description might broaden the readers understanding until, and beyond, its last sentence. Perhaps the reader will be transported by these sensations, and shown new, different potential perspectives, thus enabling new emotions to provide a fresh approach to a phenomenon that is possibly beyond current "structuralist" public health understanding.

To commence this exploration, this chapter describes the problems which impact on this research process as the intersection of desire, drugs, and unsafe sexual practices in a specific environment – the GCP. After which, the objectives and the research questions are presented, followed by an explanation of the epistemological stance that guides the entire project. The theoretical framework is presented in chapter two. In chapter three, a review of

the pertinent literature is presented; chapter four explains the research methodology, and chapter five presents the research results. Chapter six contains the discussion, and finally, chapter seven concludes this dissertation.

Research Problem

Defined as multi-day gatherings of tens of thousands of gay and bisexual men in diverse venues that incorporate intricate light shows, unique dress codes, live disc jockeys, and various other live performances, the GCP subculture has grown in popularity over recent years, and although GCPs are generally held with the purpose of HIV/AIDS education and prevention, unprotected anonymous sex and drug use does occur within these settings.[1-4] Due to the seemingly paradoxical existence of unprotected anonymous sex and drug use in parties designed for HIV/AIDS awareness, research has begun to question the relationship between these items, only to find that not only do such practices occur within these venues, but also that drug use within GCPs may be a cause of recent increases in chlamydia, gonorrhea, syphilis, and HIV rates among males who have sex with males (MSM) (please see chapter three for an in-depth presentation of these increases).[2,6,7] The reasons that researchers have begun to presume that GCPs could be responsible for a significant proportion of new sexually transmitted infection (STI)/HIV infections are as follows: (1) research suggests that the all-night, high-energy nature of these parties may promote increased drug use; (2) drug use has been associated with decreased condom use, increased receptive anal sex, and increases in numbers of sexual partners; and (3) current HIV statistics illustrate that MSM have the highest HIV infection incidence rates in Canada.[2,3-6,8-11]

One example of practices being undertaken within GCPs that may illustrate the sequence that leads toward exacerbated STI/HIV transmission occurs when partygoers mix methamphetamine hydrochloride (crystal meth) with phosphodiesterase (PD-5) inhibitors

(sildenafil, vardenafil, tadalafil), a combination which reportedly produces increases in sexual drive and duration and corresponding decreases in pain perception and physical fatigue.[12] It is precisely this combination of drugs that provides the necessary physical and psychological requirements for counteracting the erectile dysfunction caused by the sole use of party drugs (such as, crystal meth, ecstasy, ketamine, and gamma-hydroxybutyrate) to allow for "sexual marathons" where individuals engage in sexual activities over artificially extended periods of time with one or more partners.[13] This practice of combining crystal meth and PD-5 inhibitors can also result in a decreased awareness of skin deterioration and skin abrasions caused by prolonged sexual activity, thus further increasing the transmission probabilities for STIs/HIV.[12,14,15]

Based on the findings of these previous research projects, which correlate drug use and risky sexual practices, one governmental strategy has been to recently restrict the purchase of the over-the-counter medications required to produce crystal meth (such as, pseudoephedrine). However, this intervention has already been thwarted by numerous websites and books that provide simple and accurate instructions for making these recently restricted chemicals (see Fester[16]). In addition, as a second problem, such interventions are designed on the unchallenged assumption that drug use causes risky sexual practices, as demonstrated by health interventions that address the use of the drugs as the major predisposing factor in risky sexual practices, even when there is only limited evidence available to demonstrate this link.[17] This means that health departments have been basing their interventions on current public health research that almost exclusively relies on classical epidemiological methods which correlate individuals with sexual practices, focusing primarily on statistical associations between demographic and behavioural variables, such as, age, gender, sexual orientation, a particular sexual practice, and/or location with items, such as, drug type and usage, number of partners, length of sexual contact, and condom use. Based on the findings of research projects employing such limited classical

epidemiological methods, many public health interventions seem to have been undertaken with the premise that, if individuals are made aware of health risks, or if the demographic-behavioural or behavioural-behavioural correlates are addressed through properly designed prevention strategies, then individuals will inevitably make healthy choices.[18,19] Yet, despite these campaigns, STI/HIV rates continue to rise (as evidenced by the steady increase in HIV incidence and prevalence rates over the last decade) and it has been acknowledged that within the GCP subculture, when public health officials undertake safer sex health initiatives, some GCP participants seem, neither to listen to the information, nor to follow the interventions.[3]

When GCP participants ignore such public health campaigns, sexual health nurses face the dual, and possibly conflicting, responsibilities of disseminating health promotion messages while simultaneously respecting patient choices. This ethical struggle is intensified by the fact that, current sexual health strategies are a bricolage, and are based on epistemological conclusions/correlations that give little attention to the individual's subjective experiences of desire. In consequence, current health strategies may not respect patient choices – for example, when nurses counsel patients to use condoms as dictated by public health agencies (see PHAC[20]). By engaging in such counselling practices, nurses disregard previous research on desire, such as, that by Holmes and Warner,[21] which identified that a large number of both HIV sero-positive and HIV sero-negative gay and bisexual men are fully aware that mainstream public health discourses deem their actions as risky, but nevertheless continue to engage in them. In addition, research on drug use has shown that individuals whose sexual practices put them at higher risk for acquiring HIV are also more likely to become crystal meth users. In one such study by Halkitis, Shrem, & Martin,[22] it was found that crystal meth did not cause risky sexual practices, but rather, that MSM who engaged in risky sexual practices regardless of drug use were attracted to crystal meth.

Furthermore, it is important to emphasize that while society in general considers drug use to be a problem, it still remains only one concern among many. Thus, the reaction to drug use in North American may be disproportionately strong when compared to other competing societal issues. For example, even in the case of different subgroups of drug use (which in this context includes alcohol), an excessive amount of attention has been given to crystal meth, resulting in frequent governmental and media agencies addressing and discussing this one drug. Unfortunately, a caveat is attached to this *demonization* of crystal meth: if first time users do not experience some of the severe negative side effects that have been vividly portrayed in the media, may they become disillusioned with the veracity of the public health message and, believing such messages to be fuelled by anti-drug propaganda, continue using this drug?

It is the premise here that GCP participants' disregard public health initiatives because of the aforementioned problems of statistical correlations, which are devoid of theoretical exploration combined with inaccurate depictions of the negative elements of drug use. In such cases, by relying almost exclusively on axiomatic statistical associations, researchers disregard the influence of desire when it intersects with drugs and sexually charged spaces, thus leaving significant gaps in both empirical research and current scientific knowledge.[23,24] Ultimately, individuals may ignore current public health campaigns because these interventions fail to address the sequence of *desire, drug culture, and health* as it relates to the GCP subculture, and therefore may overlook the determining aspects of the psychosocial needs of these individuals.[23,25-28] Consequently, research should be undertaken to understand the links between the GCP subculture, drug use, and unsafe sexual practices, thereby eliminating a gap in nursing and public health literature. In accord with the principles of health promotion and illness prevention,[29] nurses are in an excellent position to undertake such research and design population-specific strategies that address the significance of drug use in relation to the rising rates of STIs/HIV.

In addition, it is important that nurses undertake research in this field because compounded with the burden placed on the nurses who deal first hand with GCP participants is the fact that, historically, the majority of non-classical-epidemiological research on such environments has been conducted by individuals from outside the discipline of nursing, thus resulting in a very limited amount of applicable nursing-specific information being available to inform practice. Currently, the majority of the literature addressing GCP-related phenomena comes from newspapers, police reports, and emergency department records, as well as epidemiological, sociological, and anthropological studies. As a direct result, the interventions, counselling, and resources provided by nurses are a haphazard transfer of sociological findings to health interventions. While these sources each provide a unique contribution to the body of knowledge surrounding GCPs, there is a knowledge gap as it pertains to health care research, more specifically, in the theoretical/philosophical aspects of statistically apparent trends. Moreover, as stated by Fox,[30] sociological research approaches the topic of health issues, in this case GCPs, as a social phenomenon. Fox[30] continues that as a sociologist, he is "not in a position to make informed clinical judgments as to the efficacy of or problems with any particular intervention" (p. 134). In consequence, nurses must address the health outcomes related to GCP attendance without the support of appropriate research in fields other than those dealing directly with sexual health and drug use.

For example, the use of recreational drugs has been linked to a large number of other health concerns[31-34] which have resulted in a 20% increase in young adults requiring expensive and heroic lifesaving measures in emergency departments across Australia, Europe and North America.[32,35-37] Furthermore, the use of recreational drugs has been linked to a myriad of problems occurring both during and after the withdrawal phase. With drugs such as ecstasy or crystal meth, psychological symptoms such as depression, anxiety, paranoia, irritation, and unsociable behaviour have been reported,[7,36,38-40] as well as

long-term impairments of cognitive abilities such as visual and verbal memory.[7,41-43] Therefore, this problem is of the utmost relevance because overwhelming evidence links GCP practices with mental, physical, and sexual health concerns (for more information, please review the effects related to specific drugs outlined in chapter three). At this point, it becomes obvious that GCPs should be a major concern and a necessary topic for study within the field of nursing research to provide nurses working in a variety of health care settings with sufficient, relevant, and applicable knowledge to guide their nursing care.

Research Objectives

1. To understand the motivations of MSM who use drugs and engage in risky sexual practices within the GCP subculture.
2. To understand how the GCP environment affects drug usage and sexual practices.

Research Questions

1. What are the motivations and expectations of MSM who attend GCPs?
   a. What degree and type of risk do those who attend GCPs perceive?
   b. What are the attitudes of GCP attendees regarding health?
2. How do desire, drugs, and the environment of the GCP intersect to produce the social phenomenon of the GCP and its associated health concerns?

Epistemological Stance

This project will address the above research questions and objectives within the paradigm of critical theory as defined by Guba and Lincoln,[44] and more precisely, from a poststructuralist perspective. The main aspect of this paradigm is that reality is discursively constructed: that all things remain *in potentia* until given form by an *observer* who operates within a variety of discourses. Unlike free flowing water that is frozen, but may be thawed

into its original form, within this paradigm *reality* cannot be returned to its primordial state. Thus, the process of locating reality within a particular time/space context not only changes the substance of this reality, but is also moulded by established social, political, cultural, economic, ethnic, and gender values brought to the research by the researcher.[45-47] In other words, the researcher and the research process are inextricable factors in the research results.

As one component of this reality, the rules and regulations that govern and define the discipline of nursing have been structured with the same values to produce its *truths*, truths that need to be challenged since believing and promoting them, without critique, propagates an oppression solidified into the structure of the profession.[48,49] As an example, when dealing with desire, drugs, and sexual practices (some of society's most fundamental truths),[50] it is necessary to employ an approach that challenges the foundations on which those *truths* are built. Thus, pluralism (rejection of singularity and the celebration of difference) combined with deconstruction (the critical debate of knowledge and its sources) can be employed to broaden the scope of sexual health nursing practice. From this perspective, the distinction between ontology and epistemology blurs, requiring that these two concepts be discussed together.[44]

Within critical theory, epistemology is a dynamic process. The *one* (the observer, or knowledge developer) and the o*ther* (the one who is observed, or about whom knowledge is developed) are interactively linked; that is, the values of the o*ne* inevitably influence the o*ther* and vice versa.[44] Thus, knowledge is imposed: after a particular perspective achieves supremacy, it is maintained by an array of social functions, and is likely to be included in all ensuing research. However, everything known is based on the total possible relations between clients, nurses, and researchers, relations which are not absolute truths, but dynamic, ideologically linked processes. By recognizing the imposed still-frame construction of reality (ontology), that is, by acknowledging that results arise from the interactions

between, and the pre-existing values of, both the investigators and their cases (that the *one* and the *other* inevitably interact), researchers are in an excellent position to challenge old, and create new knowledge (epistemology).[44,51,52]

As previously stated, statistical correlations about STI rates, at-risk populations, and locations where transmission may be likely to occur already exist. Unfortunately, a disregard for the role of desire in the context of drug use and risky sexual practices has created a research gap in this area. To address this gap, research within the critical theory paradigm could perhaps add a new dimension to public health nursing as it relates to understanding the intrapersonal and inter-subjective aspects of sexual practices. Moreover, since HIV transmission has no absolute behavioural or objective markers, and because "self-report is the only current viable technology for assessing HIV risk"[15] (p. 153), current epidemiological data is not sufficient for creating public health initiatives. The sequence of *risk*, *desire*, and *drug use* is highly subjective and, therefore, requires the critical theory paradigm of inquiry to provide an alternative grounding for the qualitative analysis of individuals and their practices as subjective and interactive.[6,28]

Inquiry within this paradigm promotes pluralism and rejects the notion of one meta-truth, thus allowing new research to provide alternative and additional, rather than new and absolute, means for re-evaluating sexual practices and drug use. This paradigmatic lens promotes a condition, a state of mind and of being, rather than a particular worldview. In addition, the theoretical perspectives included in this position provide support for nonlinear thinking, *multivocality*,[44] and alternative ways of understanding prevention. By employing such in-depth and deconstructive analyses of the political implications of knowledge development and inter-textual relationships between objects, this perspective is in direct contrast to the concept of a signified, aesthetic/critical approach to scholarship, and thus, could assist researchers in expanding beyond traditional questions by enabling them to refocus in new and revealing ways. Finally, it could create a closer relationship between the

sciences and the arts as well as between literary and empirical modes of analysis and (re)presentations.[53,54]

Such an approach would allow an interactive and qualitatively driven research project, and locate the researcher far from the taken-for-granted assumptions propagated by current public health discourses, such as, the "imperative of health" (please refer to Chapter Two for more information).[18] A critical ethnographic design[55] might provide information about the desires of individuals who engage in risky sexual practices and use drugs, and might position human desire as integral to effective public health campaigns. Because both drug use and risky sexual practices occur within the context of GCPs, such environments create an ideal space for moving beyond strict statistical models of nursing research by qualitatively analysing the interpersonal factors, such as, desire through a poststructuralist, theoretical framework derived from the works of Deleuze and Guattari.[45,46]

The current moralistic/authoritarian conceptualization of sexual practices by public health discourse that prescribe, and proscribes, sexual practices, is potentially a major part of the research problem regarding STIs, drug use, and sexual practices. Consequently, the goal here is to undertake a project that has, as part of its strategy, a more inclusive sexual health discourse. This reframing would impel health care professionals to understand that not all individuals are concerned with their health.[19,56] By widening the philosophical perspective regarding sexual health, it is hoped that this research might ultimately result in the provision of more appropriate and effective services to individuals who engage in risky sexual practices. A poststructuralist approach, informed by the theoretical works of Bataille,[57] Deleuze & Guattari,[45,46] Foucault,[58-61] Grosz,[62,63] and Lupton,[18,19] will permit an alternative theoretical understanding of sexual practices which are currently identified as deviant by mainstream society. In this way, all attributes of the GCP can be incorporated into the total conception of desire, drugs and unsafe sexual practices to create population

sensitive health initiatives for individuals who are deemed non-conformist by current public health discourses.

Chapter Two – Theoretical Framework

"Theory is not so much to be applied, as [it is] to be used"
Grosz[63]

Introduction

While analysing the problem of increased STI rates in an era when public health initiatives advocate, not only illness prevention, but also health promotion, the significance of the role that desire plays in sexual practices is overlooked in both public health literature and public health campaigns. Due to the complexity of the concept of desire, a variety of theoretical perspectives have been drawn upon to construct a more multi-perspective approach to understanding this concept. The goal of using the works of multiple theorists (all who follow a poststructuralist perspective) is to create a more robust understanding of the concept of desire than any one theory alone can provide. As a result, this project applies the works of Gilles Deleuze and Felix Guattari,[45,46] and relates their concept of desire to the topic of sexual health as a consequence of sexual practices; their interconnected concepts of *becoming* and the *Body without Organs* (*BwO*) is addressed to supplement this ideation of desire. The ideas of Georges Bataille[57] on eroticism, death, and the forbidden are also drawn upon. Following this, Elisabeth Grosz's[62,63] work in analysing the effects of an architectural environment on behaviour is presented. Michel Foucault's[58-61] work on sexuality and power relations is also discussed, followed by a discussion of Deborah Lupton's[18] ideation of risk. Finally, the concept of the GCP as a culmination of the ideas of *becoming*, the *BwO*, architecture, and risk is presented. This chapter focuses strictly on the theoretical framework which guided the data collection, analysis, and discussion.

Deleuze and Guattari

Desire

The poststructuralist work of Deleuze and Guattari[45,46] on desire provides an alternative (contra-psychoanalytic) explanation of the sexual practices that are currently labelled as non-compliant, or resistant. To explain this understanding of desire, it is essential to identify the difference between Deleuze and Guattari's[45,46] conceptualization and the traditional psychoanalytic definition (see Freud[64-69]).

Within a Deleuzo-Guattarian context,[45,46] desire is neither a reaction to a deficiency, nor a response to a missing item. According to Deleuze and Guattari,[45,46] desire is a positive force which drives individuals to reach out and create connections with other entities, whether animate or inanimate. It constitutes positive forces and affirmations, and displays who we are and who we want to be. These authors[45,46] define desire as a productive process which creates a series of connections, investments, and intensified states within and between bodies and objects without reference to an exterior trigger or agency; desire produces intensities. According to Patton,[52] it is implicated in all social and political processes, and life itself should be considered a condition of immanent desire.[49]

In contrast to the above, from the psychoanalytic perspective, desire appears as a response to a constructed restriction (law). For Freud[65] this is the Oedipal complex that develops when the father forbids access to the mother as a sexual object; this externally imposed prohibition enforces restrictions on impulse, and in doing so creates desires. For example, for psychoanalysts, the state of needing to appease a basic drive, such as, hunger can be constructed as arising from a negative impetus. However, while proscription may trigger desire in some individuals at certain times, according to Deleuze and Guattari,[45,46] desire precedes the law and not all actions occur as the result of interdiction. Returning to the example of hunger, once this physiological need has been satisfied, a continuation of the act of eating is propelled by the desire to achieve/maintain an impulse (a state of

pleasure or displeasure) as opposed to the psychoanalytical view that eating beyond the point of need is the result of an additional lack within the over-eater's psyche (e.g., dysthymic disorder).

Nevertheless, it is necessary to remember that the application of the term, desire, within a Deleuzo-Guattarian[45,46] perspective excludes physiological needs. By applying this perspective to the spectrum of human sexuality (but not as it relates to procreation), one could re-conceptualize desire as a positive, driving force which temporarily defines objects (individuals) and locates them spatially, cognitively, emotionally, and behaviourally. According to Deleuze and Guattari,[45,46] popular literature and thought commonly portray desires as resulting from inadequacies in other domains of life and as something in need of being withheld, controlled, and dominated by the self. Such is the case when mainstream public health discourse promotes both restricting sexual contact and accepting sexual frustration as the norm – behaviours that Freud would have identified as leading to hysteria.[70] It should be noted here, that in this context, the traditional definition of hysteria is being expanded beyond its original focus on women. In this case, the resultant physical symptoms associated with hysteria are deemed acceptable consequences, while relieving this tension is considered dangerous, uncivilized, and risky if not done as directed by health experts. This disquisition serves to limit the body, and forbid desires that are contrary to public health imperatives. If the enactment of such prohibited desires does occur, they are scrutinized. To date, many health authorities (researchers and clinicians) have relied on the assumption that consciously seeking health is rational and logical, to the point that they feel justified in mandating that personal choices be congruent with current health standards and that individuals must practice self-mastery.[18] Thus, by seeking to maximize health and quality of life, individuals must control themselves.

Moreover, it is important to nuance that Freud[64] developed his psychoanalytic perspective by observing the characteristics of individuals who functioned solely within

prescribed and proscribing Western social mores. In effect, such a context eradicates any understanding of desire, which may deviate from those resulting from perceived deficits, thus making Freud's descriptions accurate in relation to Western social thought, but not in relation to desire itself.[71] In fact, by failing to define positive desire, the social apparatus, in effect, effaces it. That is, by failing to provide it with a name and a language to describe it, and by restricting the definition of desire to a result stemming from a lack in one's life, positive desire is removed from open discussion and ultimately from consciousness. In contrast, the Deleuzo-Guattarian[45,46] perspective challenges the naturalness of the Freudian definitions, positioning Freud's[64-69] work as a description and creation of the internal processes of many individuals within Western cultures.

Figure 2.1 illustrates the Deleuzo-Guattarian[45,46] concept of desire as an infinite number of lines radiating out from the subject (S). These lines are not the result of a lack or need; they define and create the subject through interaction at the moment that one (or several) of the lines materializes through action and thought. Desires spread out in every direction, including opposing ones, propelled by the subject's wish to move forward rather than due to an inadequacy within the subject.

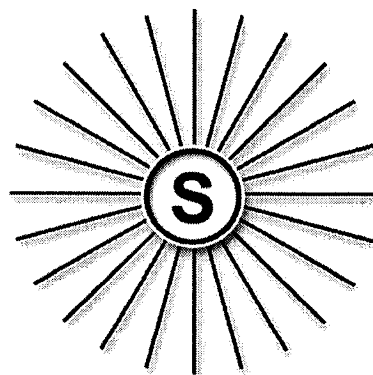


Figure 2.1: Desire

Stratification

The second postulation of importance drawn from Deleuze and Guattari[45,46] is their concept of stratification, which is useful for analyzing the problem of restriction and the dichotomization of behaviour. To situate this concept, it is essential to return to their interpretations of space and place. A *space* is any area that is *smooth*, that is, without differentiation; a *place* is a *striated* space, that is, a regulated, differentiated setting. To illustrate the difference between them, descriptions of the desert and the city will be compared.

The desert is a *smooth space*, a continuous landscape where sand is blown from one dune to become part of the next. There are no breaks in the desert landscape; there are no ninety-degree angles. There is only continuity and fluidity. However, it is not continuousness alone that makes the desert a *smooth space*; restriction also determines *space* versus *place*. An individual can inhabit or explore the desert, and may traverse the landscape in a limitless number of directions: the *smooth space* is occupied without being mapped, without being *striated*.[45,46] It is the infiniteness of the desert and the possibility that one can go anywhere that makes it *smooth.*

On the other hand, the city is a non-continuous, or fragmented, landscape. There are many breaks in it; there are many ninety-degree angles. The city can exist only within the confines of its walls, or outermost roads. It is segmented – by roads, by zoning bylaws, by speed limits, by designated locations for activities such as drinking alcohol, smoking, sporting activities, etc. – thus making it a *place*.[49] In opposition to *smooth space*, which is occupied without being mapped, *striated space* (*place*) is defined prior to being occupied:[45,46] territorial mapping precedes habitation. Segmentation and stratification transform a *space* into a *place*. Before the city arose, the landscape where the city now stands was infinite; the city imposed *striation*, and the *smooth space* that once existed became the *place* of an urban centre.

However, *striation* (i.e., stratification) is not limited to geography. Stratification can occur in many realms, including those of thought, knowledge, and action – examples of race, class, and object/subject separation are readily available. In the *smooth space*, behavioural possibilities are unlimited; in the *striated place,* they are evaluated and classified according to the values of the dominant group and its, often, hegemonic discourses. Traversing the city often necessitates taking pre-established routes that do not correspond precisely with a sought-after direction. For example, travelling northeast usually involves taking a north road followed by an east road, or vice versa. In a similar way, dominant discourses on safer sex restrict many paths (behaviours), and prohibit the freedom of sexual preferences by progressively stratifying all areas of sexuality. This limitation is created and enforced everywhere, from academia to clinical practice. Figure 2.2 illustrates one example of a stratification process.

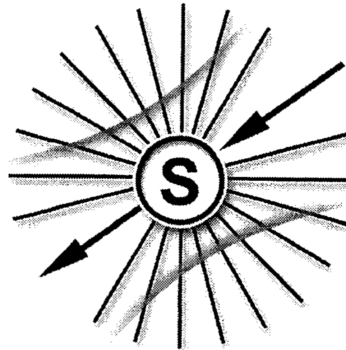


Figure 2.2: Stratification

In figure 2.2, the large arrows represent the ideal practice that individuals must undertake according to the prevailing beliefs – for example, always using condoms, or eschewing multiple partners. As can be seen, the central line has transformed from being one line among many, to being *the* line. Simultaneously, many lines that previously had been eligible alternatives are prohibited; only pre-determined linear transformation within a restricted scope is acceptable. Thus, stratification is the process of locating and fixing objects to

particular sets of coordinates from which they are not allowed to stray without experiencing negative consequences.

Furthermore, the consequences of straying from one's spatial location are not necessarily temporary or limited to the offence, but rather, may produce repercussions of varying severity. For example, according to Foucault,[60] in Ancient Greece, to hold a position of power, individuals had to have led their lives in strict adherence to the highest level of their society's behavioural norms. If these norms were not respected, the individual was shunned socially, and legally barred from many career options. Foucault[60] explains:

> An individual who had prostituted himself was debarred from holding any magistracy in the city or abroad, be it elective or conferred by lot. Further, he could not address the council or the assembly, even though he were 'the most eloquent orator in Athens.' ... What was hard for Athenians to accept – and this is the feeling that Aeschines tries to play upon in the speech against Timarchus – was not that they might be governed by someone who loved boys, or who as a youth was loved by a man; but that they might come under the authority of a leader who once identified with the role of pleasure object for others. (pp 217-19)

This idea that one's past should determine one's future (as is described in the above quotation in relation to one's sexual comportment) is also a common theme in classical literature. In *Les Misérables,* Victor Hugo[72] argues that the notion of one's past being the best predictor of one's future still pervades society. In this novel, a criminal, Jean Valjean, changes his behaviour to become a highly respected citizen. However, the chief of police, Javert, is unable to see Jean Valjean as anything other than the criminal he once was, and tries throughout the book to remove him from his new status. Because Javert represents a rigid social system that cannot accommodate contradictions, Javert feels that he has no alternative but to commit suicide when he begins to recognize that his judgment of Valjean was wrong. The following quotation exemplifies this:

> Jean Valjean disconcerted him. All the axioms which had served him as points of support all his life long, had crumbled away in the presence of this man. Jean Valjean's generosity towards him, Javert, crushed him. Other facts which he now recalled, and which he had formerly treated as lies and folly, now recurred to him as realities. M. Madeleine re-appeared behind Jean

> Valjean, and the two figures were superposed in such fashion that they now formed but one, which was venerable. Javert felt that something terrible was penetrating his soul — admiration for a convict. Respect for a galley-slave — is that a possible thing? He shuddered at it, yet could not escape from it. In vain did he struggle, he was reduced to confess, in his inmost heart, the sublimity of that wretch. This was odious.
>
> (Victor Hugo[72] p. 214)

While Hugo's[72] novel, and thus the exchange recounted above, depicts a period of French history, it can be argued that this belief that one's past dictates one's future still holds true. For example, current education standards require a criminal record check of individuals wishing to become professionals (nursing, medicine, law, education, etc.), thus reifying the truism, "once a criminal, always a criminal". Such examples exemplify the Deleuzo-Guattarian notion of stratification as immobile.[45,46] Stratification can be a useful means by which objects and subjects are sorted and located; however, locating individuals at predetermined levels within this social stratification restricts lateral, and eliminates, vertical movement – an individual placed within a lower stratum is socially constrained to remain within that stratum.[73]

Microfascism

Organizing bodies spatially is not sufficient for the maintenance of order because keeping people within their respective strata requires governing bodies to continually, diligently, and actively control all of their subjects. According to Foucault,[60] Plato believed that laws are not enough to maintain social ethics, and proposed a method by which the tyranny of stratifying individuals can be made subtle and pervasive, and which will be maintained by the subjects themselves, by placing the onus of self-regulation on the individual, thus eliminating the direct involvement of any authority figure. He suggested four mechanisms for achieving this: The first mechanism is public opinion, wherein culturally accepted beliefs are unanimously accepted and internalized to the point where the prohibited behaviour is voluntarily avoided; the second device is glory – feelings of intense

personal satisfaction, and sometimes, public approbation, occur when an individual chooses the acceptable option – honour can then be invoked to entice individuals to behave civilly (as good citizens); the third instrument is a sense of duty to demonstrate a difference between mankind and the other animals;[60] and the final mechanism is public shame, which prevents the individual from disclosing participation in forbidden activities. Moreover, if an individual does secretly indulge in proscribed activities, this shame is internalized as guilt.

Deleuze and Guattari[45,46] were interested in the process by which individuals are "marked, scarred, transformed, and written upon or constructed by the various regimes of institutional (discursive and non-discursive) power as a particular kind of body"[62] (p. 33). In both *Anti-Oedipus*[45] and *A Thousand Plateaus*,[46] they examine the ways in which individuals (bodies) are encouraged to regulate their own behaviour (i.e., the same process that Plato describes), and posit that inscriptions of docility scar the surface of the body (individual) while achieving in-depth effects that express themselves through the creation of subjectivities. A history of engaging in illicit behaviour may result in the individual being *branded* (previously physically, now electronically) with a criminal record. This not only scars the surface of the individual (social position), but may also cause changes in self-definition wherein the individual begins to self-assess as a "criminal" rather than as someone who has committed an act which is contrary to social standards. Various regimes of power (of which desires are a part) "give rise to a soul, to a subject, because these regimes of power (public health rules, etc.) texture the body, giving it a form, an external appearance that reflects the subject's 'psychic interior'"[62] (p. 35). According to Deleuze & Guattari,[46] the process proposed by Plato[74] is in essence that of *microfascism*: that is, a personal desire to order, rank, control, repress, direct, and impose limits on oneself.

To dissect this word, first, *micro* arises originally from Greek, meaning "small", while *fascism* is one of the more subtle faces of totalitarianism – the complete subjection of humanity to the political imperatives of systems whose concerns are their own productivity.[75]

Totalitarianism forcibly does not allow anything; fascism coerces the allowance of only itself. In light of this argument, *microfascism* is not too strong a phrase to use because the exclusion (or disqualification) of targeted practices relies on a process that is saturated with an intolerance of alternative lifestyles, and operates in conjunction with powerful political structures (public health authorities, for example). This invariably steers and sustains scientific assertions in the direction of the dominant ideology (norms).

Unfortunately the positive face of *microfascism* makes it attractive to us all (the subjected), and requires little more than the promise of success (healthy living, etc.) from following its precepts to get everyone to participate wholeheartedly.[75] In a *microfascist* society, it is the culmination of numerous actions that produces a population which is willingly involved in self-restriction/oppression. There must be many molecular foci of energy before state domination can occur. (However, two clarifications must be made. First, state domination is not used with a Marxist meaning, in that there is an oppressive ruling class. Rather, it I used to indicate a social system wherein all individuals are subservient to, but also enforcers of, socially restrictive regulations. Secondly, in this context, molecular, means the most basic (non-reducible) form, and in a social system, the molecular level is the individual.) Bearing this in mind, Foucault[60] put forth that it was Plato's[74] proposition that societal control should be exercised at this molecular level through the agencies of guilt, shame, glory, and public opinion; he proposed harnessing the power of the masses as the means of governing them by encouraging public opinion (comprising many individual opinions) to develop a distaste for rebels, law-breakers, critics, and other risk takers.

Fascist logic derives its true power from a mass of individuals within the population who espouse the fascist movement; at this point, the impetus for self-oppression has penetrated the most basic units of the system, thus ensuring the continuation of the system. It is these *micro-formations* that shape postures, attitudes, perceptions, expectations, and semiotic systems regarding health. Unfortunately, it is deceptively easy to adopt an anti-

fascist position, and not see the fascist repercussions of one's own behaviour. If one were to propose an ultimate solution to *microfascism*, in which all other options are excluded, the result would be nothing more than the creation of yet another *microfascist* system. Fascism is the self-reproduction of a "truth",[49] which occurs through the mass, by the mass being convinced, convincing itself, and convincing others that a particular answer (a healthy lifestyle) is the only acceptable answer. Thus, this internalization of specific conducts/practices results from the interplay of several *technologies of government* that are charged with the goal of shaping the individual's behaviour in such a way as to produce certain desired effects (including certain types of subjectivities) while simultaneously averting particular undesired events (risk management).[76]

When placed in opposition to free choice, any and all causes can become fascist because only one of the available choices or answers is socially accepted, and thereby permitted; Plato's[74] mechanisms of public opinion, shame, and guilt offer a very effective means for achieving this. Most individuals encounter opportunities for engaging in risky practices where the risk can be identified as a possibility of having to endure specific consequences. Such consequences may not be a direct outcome of the practice, but rather, may derive from the need to undertake the risky action in secret: feelings of guilt may appear coupled with the fear that others will learn of this activity, resulting in public shame (see Holmes & Warner[21]). The individual must then endure the reproach of fellow citizens. Viewed from this perspective, Plato's *microfascist* society provides only a mirage of free choice because individuals are free to choose any behaviour only if they are also willing to risk potential censure and ostracism. The risk of the risk comprises not only its direct outcome, but also its social perception and the potential repercussions. In fact, opposition to *microfascism* is one of its necessary components, with the refusal to accept the hegemonic proposition of existence being part of the fluidity of the power struggle that serves to have forced overt methods of behaviour modification into those of covert *microfascism*.

Becoming

The third idea of importance drawn from Deleuze and Guattari[45,46] is their concept of *becoming*. For these authors, the term *becoming* denotes an action that is forever in flux, unfinished, and infinite. Used in this sense, *becoming* is not the process of movement between two reified points, but rather, it is perpetual action without start or finish. Engaging the individual at the periphery of both corporeal and conceptual logic, *becoming* destabilizes conscious awareness, and thus, forces the release of a genuinely creative response. For Deleuze and Guattari,[45,46] the act of *becoming* initiates an existence in which the individual's subjectivity is propelled into new ways of thinking and being; it is about *becoming* something else, changing in time and space, irrefutably and, most importantly, irrevocably. *Becoming* involves entering into a relation with another entity where the parameters of each become fuzzy and zones of being shift toward non-compliance, (re)creation, and resistance. It is an act of widening the gap between oneself and the majority,[52] the act of being in the margin. Thus, this line *becomes* the individual's identity, and since this line is an ever-occurring process, the notion of a fixed identity is rejected. The selection of one desire through the process of *becoming* is illustrated in figure 2.3.

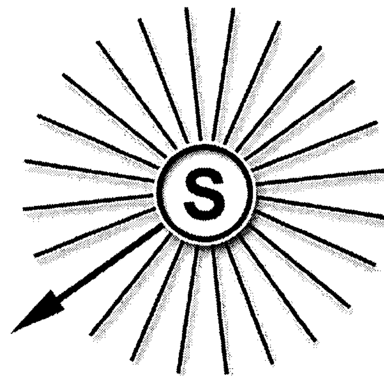


Figure 2.3: *Becoming*

Nevertheless, *becoming* is not about physically metamorphosing into something else by imitation or replication.[45,46] For example, for Deleuze and Guattari, a man may take female

hormones and grow breasts, but he is not *becoming* woman; he is imitating woman. To *become* woman requires the acquisition or production of the fundamental attributes that make woman what she is. Therefore, for a man to *become* woman he must be able to enter a space and produce the effect that a woman would have on the people already in that space – that is, to induce the responses, expectations, and desires that a woman would elicit.[52]

Becoming Minor

As a sub-concept of *becoming*, Deleuze and Guattari[45,46] describe *becoming minor*, a process by which individuals reject the cultural structures of access, power, and value. For these authors,[45,46] the term *minor* is not used in relation to numbers, but rather, in relation to power, and thus encompasses all factions excluded by the hegemonic, power-wielding group. In this regard, these counterparts – minor(ity) and major(ity) – define each other because the *one* and the *other* are always born simultaneously.[77] Within the context of sexual health, public health authorities concomitantly create the definitions of the majority and the minority positions by establishing a standard for safer sex practices. This standard serves as the majority position (the proscription of unprotected sexual contact and drugs use) from which individuals may dissent – an action that is impossible until a common or official (i.e., majority) viewpoint is established.[49] In this respect, *becoming minor* is as much about *becoming* non-dominant as it is about *becoming* something other than the powerful majority. Individuals who reject the safer-sex imperatives of the public health system, and disregard public health interventions aimed at the GCP subculture exemplify this process of *becoming minor*. Thus, *becoming minor* is about breeching the confines of stratification in order to reside in the margins. In figure 2.1 all lines are available, in figures 2.2 and 2.3 the correct line has been demarcated, but in figure 2.4, the boundaries of stratification are rejected.

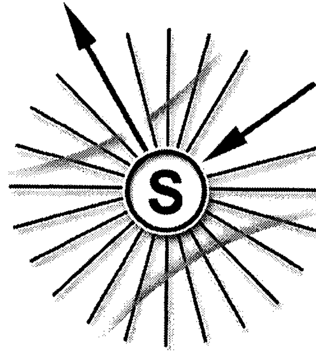


Figure 2.4: *Becoming Minor*

However, the processes of *becoming* are forever *in potentia*, and thus, *becoming minor* and stratification are perpetually changing in relation to one another. For example, to counteract *becoming minor,* stratification adopts terms, such as, deviance or non-compliance, to define the transgressive behaviours. The very action of labelling an unconventional lifestyle, or an individual who chooses it, as deviant, is an attempt to reduce the infiniteness of *becoming minor* by creating a dichotomy. The unconventional path is affixed to the map as one which should not be explored because it is dangerous, thus inhibiting its potential; it then begins to serve as little other than a confirmation of the hegemonic rule. It is simply the *other* that confirms the power of the *one*.

Body without Organs (BwO)

The fourth Deleuzo-Guattarian[45,46] concept of importance within this project is the *Body without Organs* (*BwO*). For these authors, this concept describes a non-physical location where the conflicting forces of the individual's desires and the social stratification system clash. They[45,46] suggest that social norms attempt to mark (map) or territorialize (stratify) and shape the subject (figure 2.5a) and that this non-anatomical body is a surface of inscription, a *BwO*. In contrast to the incarnate body, as represented in health care and psychology, this inscriptive body is a *political surface* on which laws, social values, and moral predicaments are engraved. The *BwO* is not a definite substance, but rather, a

receptive and "giving" surface; its boundaries are realized through the connections that it forms with other *BwOs*.[62] Thus, the *BwO* is not an entity, but a set of practices[45,46] that are always in the process of *becoming minor* – a *deterritorialization,* which is never fully achieved. Fuelled by its desires, the *BwO* is infinitely mutable, and cannot be solidified, even beyond the point of death, because other people's memories of the individual will continue to change over time (figure 2.5b).

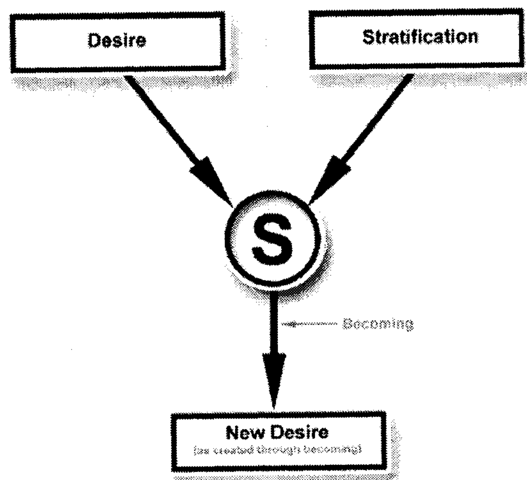


Figure 2.5a: The Subject

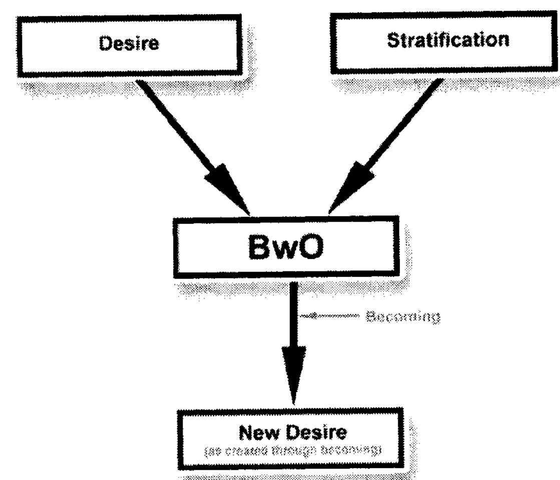


Figure 2.5b: The *BwO*

Elizabeth Grosz

Architecture and Design

The work of Elizabeth Grosz[62,63] can be used to locate the aforementioned Deleuzo-Guattarian[45,46] concepts within the environment of the GCP. She states, "space and building have always been conceived as sexually neutral, indifferent to sexual specificity, directed to human – the collectively and individually human subject – which may have been conceptualized in terms of geographical, racial, or historical specificity but never in terms of sexual specificity"[63] (p. xix). According to Grosz,[63] social constructions conceive of space as inert – as structures that exist, and have no effect on those who inhabit them. She maintains however, that, on the contrary, architecture determines, in part, the functions that occur

within it. Foucault[47] and Rakatansky[78] contend that architecture is not silent, that buildings tell stories and that walls talk. Consequently, empirical processes which examine architecture should address the discourses, not only of design, but also of the practices that occur within such places.[79] A Deleuzo-Guattarian framework posits that buildings are not the result of sedimentation, but are, rather, ways of opening spaces for experimentation.[63] In other words, the physical environment is responsible, in part, for creating subjectivity:

> The subject can take up a position only by being able to situate its body in position in space, a position from which it relates to other objects. This anchoring of subjectivity in its body is the condition of a coherent identity, and, moreover, the condition under which the subject has a perspective on the world, becomes a source of perception, a point from which vision emanates. (Grosz[63] p. 38)

Reality is the perspective of a body as it is located within space; together, they produce that which appears. For Turner,[80] spaces that construct realities constitute *liminal* spaces, involving ambiguity, ambivalence, and pushing the limits, and where the new and the novel can be experimented with and indulged in. Rewritten using Deleuzo-Guattarian terminology, the environment territorializes and deterritorializes the *BwO* as this entity expresses *becomings.* Spaces are as much the products of communities as they are the creation of the architect/designer. The gay community creates GCPs as spaces/locations outside the containment of *heterocentricity*.

Bataille

Eroticisation of the Forbidden

While from a Freudian[64-69] perspective it is assumed that the law precedes desire and for Deleuze and Guattari,[45,46] desire is a positive force, not a reaction to a prohibition, for Bataille[57], forbidding something provides a reason to do it. While this may seem to resemble the psychoanalytic definition of desire as a reaction to a lack, in this case, the individual has a positive desire that drives the body toward something that is specifically

prohibited, not lacking. The individual is not deprived, but rather, seeks a certain experience because it has been labelled unattainable. For some individuals, the prohibition of sexual practices, such as, unprotected anal sex between men, or the use of illicit drugs, makes these practices more seductive. For example, in one way, labelling a practice or set of practices as sinful may exacerbate shame to the point that it/they culminate in a new form of eroticism. Hence, abandoning the limits of social norms constitutes, not only a transgressive act, but also a possible form of resistance, a *becoming minor*. In the realm of sexuality, the range of transgressive sexual acts is infinite because of the narrow parameters (stratification in the Deleuzo-Guattarian[45,46] sense) imposed by mainstream public health discourses (refer to figure 2.2). As Bataille[57] wrote "there is nothing that can set bounds to licentiousness ... [for] the best way of enlarging and multiplying one's desires is to try to limit them" (p. 48). Thus, stratification produces limitless outcomes.

Michel Foucault

Bio-Power

The work of Michel Foucault[58-61] is useful in illustrating the methods by which sexual practice is socially regulated and maintained as a construct. His work can also be used to illuminate the *model of inscription* that comprises the disciplinary technologies deployed to govern the sexual conduct of individuals within society. Disciplinary tactics are central to the regulation and maintenance of sexual social order and, as such, reinforce the reproduction of the norm within society. Individuals are bodies on which the sexual behaviours that are expected from a person are inscribed, and thus, they *become* the model created from a set of standards promoted by society. Foucault's[58] concept of bio-power is theoretically fruitful for exploring the deployment of mechanisms which transmit and secure the image of acceptable sexual practices.

Bio-power, a term coined by Foucault[58] to denote power over all aspects of life, describes a governing instrument which emerged as a response to rapid demographic expansion. In the 18th century, bio-power focused on the body as a machine that can be rendered docile, conformed and useful.[58] It is a productive form of power that is able to "optimize, administer, and multiply life, subjecting it to precise controls and comprehensive regulation"[81] (p. 259). If necessary, bio-power is capable of using violence to achieve its goals; however, "deduction has tended to be no longer the major form of power but merely one element among others, working to incite, reinforce, control, monitor, optimize, and organize the forces under it; a power that is bent on generating forces, making them grow and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them"[81] (p. 259). While it is clear that disciplining the individual has an impact on the population, bio-power should not be seen as a totalitarian or violent means of governing individual and collective conduct. Instead, bio-power is a subtle and organized method of governing by using a variety of power techniques.[58] For example, confession techniques, as well as the therapeutic practices of health care professionals, constitute an efficient method of enhancing the productivity of the body by subtly organizing its forces. By the 19th century, this (bio-)power had evolved into the two separate dimensions of anatomo-politics and bio-politics. Within this dissertation, however, on the basis of relevance and applicability, only the concept of anatomo-politics will be explained.

Anatomo-politics

In his book *Discipline and Punish*,[58] Foucault describes how the technologies of power used in prison settings escaped their initial locus, and permeated society. Foucault refers to these prison-based techniques of disciplining the body as anatomo-politics, which is the "docilization" and domestication of each individual. While such techniques transform each body, one at a time, on a large scale these processes result in the regulation of entire

populations. He illustrates this process of population control by describing the construction of an army as the molding of each single soldier:

> The soldier has become something that can be made, out of a formless clay, an inapt body, the machine required can be constructed; posture is gradually corrected; a calculated constraint runs slowly through each part of the body, mastering it, making it pliable, ready at all times, turning silently into the automatism of habit; in short one has got rid of the peasant and given him the air of a soldier (Foucault[58] p. 135).

One could easily replace the soldier with the sexualized body, transformed by social norms and disciplinary technologies, which are polymorphous when fabricating subjectivities. The anatomo-political dimension of bio-power is aimed at maximizing the body as a machine, thus enabling an increase in social, economic, and ultimately, useful potential. This form of discipline extends beyond prevention and punishment; it targets bodies to train them according to a pre-determined set of standards,[58] and is a type of power that cannot be identified with one institution, one apparatus, or one device. In fact, this form of power relies on the use of many disciplinary techniques, such as hierarchical observation, normalizing judgment, and examination, which culminate in the production a total technology of the body.[58]

Hierarchical observation

The first technique of disciplinary power proposed by Foucault[58] is hierarchical observation, which encompasses all functions related to organizing bodies in order to create each one as a distinct "case" whose performance can be measured against group norms as satisfactory, or in need of improvement. To induce such results, mechanisms that are capable of constant and total observation must exist. Foucault[58] identifies the organization of military camps and prisons as a means of controlling groups of bodies because their structures promote the visibility of the soldiers/inmates. However, in addition to military camps and prisons, architecture and words can also constitute a means of surveillance and, as such, can render people docile and knowable. Currently, to render individuals fully

visible, such observation includes the functions of many social authorities (health care professionals, researchers, educators, and clergy, etc.), and their corresponding sophisticated techniques of observation, such as, audiovisual devices, confession, journaling, et cetera. Thus, hierarchical observation now functions both overtly and covertly in many contemporary institutions that, superficially, are not traditionally thought of as disciplinary in nature, for example, schools, universities, and health care settings.[58] Nevertheless, these organizations are vested with power because their structures promote a hierarchical surveillance of their inhabitants. For example, in schools and universities, students are ranked according to their ability to provide answers that accord with mainstream social ideologies, while within health care settings, patients are physically and psycho-socially observed and ranked according to anatomical and physiological developmental and performance charts.

Normalizing judgement

Foucault[58] identified the second disciplinary technique as normalizing judgement, which describes the procedures involved in ranking and training observed bodies. Of particular importance is the fact that training has replaced discipline – a modification that reformulates the consequences related to hierarchical rankings (i.e., satisfactory or unsatisfactory performances) from being centred on punishment to being concentrated on providing corrective and supportive measures that will help individuals enhance or attain satisfactory performances.[58] The judgement of an expert allows for the identification of a need for, and the development of, corrective strategies and micro-penalties to categorize individuals and their natures, their potentialities, and their level or value, rather than to evaluate their actions.[58] To accomplish this, university and school officials, as well as prison and military authorities, apply an array of techniques concerning time, activity, speech, body, and sexuality.

As one example of this process, the examination methods employed in health care settings force individuals to be evaluated by an "apparently" objective and knowledgeable source. As knowledgeable experts, nurses sort through a myriad of information that arises from a history-taking process, the results of physical examination, and from more in-depth exploratory apparatuses.[82] Once this examination and assessment is completed, nurses construct an overall picture of the patient as "good or bad" according to a pre-determined set of standards. However, examination is not the only role of the nurse. In addition, corrective/ameliorative suggestions must be given based on the findings of the physical examination. To accomplish this, nurses counsel patients, and provide them with individualized courses of action that address the specific methods by which they can improve/enhance their current states of health.[19,82] Taken as a whole, this entire process facilitates the personalization of health information, and ensures that individuals understand the implications of the rank to which they have been assigned.

Examination

As the third disciplinary technique, examination encompasses all of the means used to inspect and scrutinize individuals, whether students in schools or patients in hospitals.[58] Throughout the acts of interviewing or testing, the power of a professional's gaze (i.e., health care provider, teacher, etc.) results in good and bad patients/students and good and bad "future" patients/students.[58] In doing so, the examination is the precise mechanism used to elicit information which makes it possible to rank and observe (hierarchical observation) and correct and reform (normalizing judgement) the subject.[58] Consequently, the examination is a ritualized ceremony through which the subjection of each individual is achieved, and which represents the perfect instrument for linking the formation of knowledge to the exercise of power, thus creating power/knowledge.

According to Foucault,[58] a form of scientific method eventually develops, which can be applied formulaically to induce a confession properly and effectively. The first step in this process is a clinical codification of the inducement to speak;[61] it requires an interview script based on an understanding of the science of relevant signs and symptoms that must be assessed and addressed. Secondly, the postulate of a general and diffuse causality must be included. This means that everything must be described, no matter how insignificant it may seem to the speaker (or the listener) at the time, because it may, in fact, hold the key to unlocking the speaker's sexual truth. The direct link with Freudian[64,65] "free association" is obvious: for a thorough and useful sexual history and examination to be complete all of the speaker's narrative should be included. Furthermore, the confession of everything addresses the principle of latency, which is intrinsic to the Western view of sexuality – the truth of sexuality is hidden and must be extracted.[60] To achieve this, the listener must also be able to search for and recognize that which is, or might be, hidden by developing confessional techniques that enable the speaker to delve further into the unconscious and the unknown. The listener must also be able to interpret the truth within the confession that is being given to the expert because it will be expressed in a diffuse, generalized manner – a chameleon camouflaged against its background.[61] The final requirement of this process is that it should be viewed as a therapeutic exercise rather than as an interrogation. The anxiety, discomfort, and invasion of privacy that may be experienced by the speaker should be worth the end result. The present pain should be seen as an aid to solving greater pains: the lancing of an infection to evacuate puss and relieve the pressure, thus removing the pain. Reframing the confession as a mildly anxiety-producing situation that results in a less stressful state than was experienced before the confession transpired creates the necessary discourse apparatus for disclosing intimate secrets, and promotes a theoretical environment in which the listener is expected to remain absolutely neutral to all that is heard, thus

encouraging speakers to seek out the listener as a means of calming personal anxieties and learning their own sexual veracity.[59-61]

In the health care domain, individuals are encouraged to disclose their health practices to an observer who is deemed objective, unbiased, and capable of assessment in accordance with statistically calculated and measured norms.[19,82] Nurses, for example, are involved in such processes of acquiring in-depth and intimate information through history taking, treatment, education, and counselling.[82,83] The process by which nurses accomplish this task is based on a formal cognizance of health related information combined with their ability to promote a dialogue in which patients willingly disclose personal information.[84] The main purpose of this examination is to facilitate discussions about relevant testing, counselling, and/or treatment. By collecting this personal data, nurses are able to ensure that all health needs will be met, and can then create an individualized assessment for the patient. However, this gathering of information is never an objective process because the speaker cannot divulge information devoid of emotional attachment and the professional cannot listen without incorporating their own personal perspective. Thus, through an intertwining of art and science, the nurse transfers a specific form of knowledge regarding health to the individual – a procedure that could also be interpreted as the method by which nurses modify individuals and encourage the internalization of population standards.[19] Consequently, the work of nurses has a two-fold requirement: first, appropriate care will be provided to patients, and secondly, patients will internalize the provided information and commence performing the appropriate behaviours.[82]

In this regard, to be effective, the examination process should not be unpleasant.[85] Since humiliation has been identified as a primary reason why some individuals avoid health care services,[85,86] perfection of the art of interviewing allows individuals to feel less stigmatized during this process of revealing their inner secrets. The interview serves as the most precise step in this construction of identity because it allows for an interaction between

the patient and the nurse.[87] The art of such an exchange encourages patients to disregard their anxieties, to divulge private information, and to work with the nurse in identifying personal practices, which are transgressive. The power derives from a surrender of autonomy, that is, the individual's willingness to admit discrepancies between personal practices and established norms, and from the fact that information is willingly divulged rather than painfully extracted.

Sexuality

To accomplish the aforementioned disciplinary techniques, individuals have to be evaluated in comparison to a pre-established set of cultural norms.[60] As this relates to sexuality, historically, there have been two general means by which different cultures have constructed the precise information of their sexualities: One that is fluid, learned through experience, and the outcome of pulsations (i.e., *ars erotica*), and the other that is acquired through dedication to learning the rules, the ranking, and the sorting of sexual practices (i.e., *scientia sexualis*).

Ars Erotica

As the first method of developing cultural sexual norms, *ars erotica* is the "art of the erotic" within which sexual pleasure is both its process and its primary goal.[60] The Kama Sutra, an ancient oriental text on sex, stresses the personal practice of sexuality as an art, and within which the purpose and goals of sexual pleasure are intensity, experience, duration, and reverberations within the soul, as a qualitative and personal (or interpersonal) event. In this context, sexuality is a practice that culminates in experience from experience.[60] Within this belief system, pleasure is a subjective expression of art: the body experiences a sensation, and then determines whether it was pleasurable, or not. Thus, the comparison of one individual's sexual practices to an external law is impossible (although, in practice, such judgements have been imposed by public opinion, personal beliefs, religious

doctrines, and so-called scientific evidence). In the absence of an external measure against which one can compare personal sexual practices, personally experiencing different sensations is the essential measure of ecstasy. This is a process of feeling, not thinking, by which the body experiences novel sensations until it reaches an ultimate rapturous state. Each individual in relation to him/herself determines pleasure alone, not on a scientifically pre-determined measure of normal sexuality. This permits the body to explore and discover methods of attaining sexual bliss that would otherwise be unobtainable.

By making *ars erotica* a function of the body – of skin, of sight, of smell, of sound – any attempt to transfer it from the concrete to the abstract, from sensation to thought, severely diminishes its power.[60] Therefore, this knowledge must be kept secret, not surreptitiously, but rather, to protect it from devaluation. *Ars erotica* loses its power when individuals learn about it without experiencing it. Thus, the individual who had experienced the power contained in *ars erotica* held a position of utmost importance.[60] It was through the practice of sexuality that the esoteric knowledge of sexuality was transferred from the teacher to the student; moreover, such a transfer was expected to be an experience of bliss in which time and death ceased to exist, leaving only absolute pleasure. Consequently, this form of sexuality could only be taught through apprenticeship, not through a discussion of the intricate processes that produce it.

Scientia Sexualis

In addition to the above (primarily Eastern) approach to sexuality, Foucault[60] described a second, and more Western, sexual attitude. In contrast to the *ars erotica*, *scientia sexualis* arose in the 19th century due to a widespread fascination with science that resulted in the common perception that all aspects of human existence needed to be scientifically coded, analyzed, and understood.[60] Human sexuality was not exempt from this, and consequently the study of sex was placed under the lens of western scientific

methodology. When this occurred, examination split into two very different fields with two very different sets of rules: the biology of reproduction and the medicine of human sexuality. Those studying the biology of reproduction were primarily interested in anatomy and physiology, and abstained from dealing with the "psychological" aspects of sexuality. The latter was left to medicine, which, by applying all its standard techniques of palpation, examination, observation, interviewing, and interrogation, attempted to enable medical professionals to see, provoke, and solicit the inner truth about sexuality.[60]

With the advent of *scientia sexualis*,[60] sexuality became an item of observation and surveillance, and confession became the main tool for observation, while also being the standard method by which individuals helped to expand the body of knowledge about sexuality and by which they became capable of realigning their sexuality with normality. In addition, the difficulty in this method resides in the belief that secrets of sexuality are hidden not only from the expert, but also from the individual who is confessing. Therefore, the confession became a partnership[61] in which there must always be a listener who has been authorized to silently absorb the confession to effect subsequent judgement, punishment, forgiveness, consolation, or reconciliation. Whether this process was voluntary, or not, is irrelevant to the end product: the production of truth surrounding sexuality.[59-61] However, these confessional techniques are not the mechanisms of truth elicitation, but of truth production.[60] Like the science of reproduction, the psychology of human sexuality encountered determined social resistance, which fundamentally blocked its logical progression. During this time, research results were not progressive; they were based on axioms and a refusal to acknowledge facts that were directly observable. For example, in medical dossiers, information that had been observed by physicians, or directly stated by patients, was edited out during its transfer into publication.[61] Public opinion, including that of medical researchers, seemed to be more involved in promoting self-serving beliefs about

human sexuality than in discovering the truth. "Knowledge" served to hide accurate descriptions of sexuality that would disrupt the status quo.

Limit Experience

The next Foucauldian concept to be drawn on as part of this theoretical framework is the *limit experience*. By *limit experience,* Foucault[88] did not signify the end, the outside, or the furthest extent that one can go. He used the term to describe a process of reaching past the limit, a way of "pushing the limits", which could be defined as the boundary separating life from death, or the line dividing pleasure from pain. During a *limit experience*, the body must push the existing boundaries, and transgress or transfer to a state in which the previous state of existence can no longer continue. According to Lyng,[89] playing with, and transgressing, boundaries may be the sole remaining form of resistance available in contemporary society, one of the few independent human possibilities left in a disciplinary society where regulations and the reification of normative behaviours is pervasive. Deleuze & Guattari[45,46] might recognize this process as a form of *becoming minor*. Thus, *limit experiences* provide a way of putting resistance into concrete practice by allowing individuals to overcome restraint and become something new: that which confined and defined the prior subjectivity has been pushed beyond its former limitations. The *limit experience* is reached when the subject is torn from itself through a real or metaphorical death and becomes something new through the process of de-subjectivication.[90] Once attained, however, the *limit experience* is lost because the line that veers from the original subjectivity and crashes through the walls of appropriate behaviour becomes the new definition (self and social concept) of the subject. This is not a predictable process; it is an art form, not a science, which allows and requires learning to be experiential, thus enabling the creation of alternative or "extreme" practices. For example, activities such as sadomasochism (S&M), become a means of pushing sexuality to the limit. Foucault[88]

asserted that S&M practices embody the *limit experience*, that by employing unconventional methods they attempt to break down the boundaries that contain the body. Thus, the *limit experience* forces a redefinition of the individual without actually creating this new definition.

Consequently, the first step in determining and analyzing a *limit experience* is to address the structures that force the body to conform. For example, according to most religions, the body and soul (mind, spirit, or self awareness) limit one another in a dynamic, interactive process: the soul imprisons the body (through fear of moral repercussions) and the body is the prison of the soul (by placing physical restrictions on desire).[91] Therefore, the essential requirement of the *limit experience* is that one of these two components must be destroyed, either permanently (by death) or temporarily (by pain or injury). However, this destruction need not be physical to achieve the *limit experience*; pushing the body beyond any of its usual limits, and thus creating a sense of immanent danger (for example, sleep deprivation, drug trips, law breaking, sky diving, car theft, bungee jumping, in fact, any extremely risky activity) can produce the same results. The principal focus of *limit experience* is self-creation by playing with the lines that separate the concepts of normality and deviance, that is, the boundaries between licit and illicit practices.

Deborah Lupton

The Imperative of Health

In the mid-nineteenth century, the public health system became increasingly concerned with health issues related to increased urbanization and population density.[18] The main issues of dirt, disease and pollution (contagion) were driven by an illness prevention philosophy that transformed into an imperative of health.[18] Since then, the public health movement has broadened to include two fundamental aspects: health promotion (health status amelioration without pathology as its motive), and illness prevention (behaviour modification as a method of reducing the future risks of particular diseases).[29]

While at first glance, these ideas seem neutral, unbiased, and broad enough to encompass diverse cultural beliefs and values related to health issues,[92] there still remains an uncritical acceptance of an innate imperative of health – that is, that all individuals are ultimately self-motivated toward being healthy, and that if they engage in unhealthy practices, that they must do so out of ignorance or underlying psycho-pathology.[18] Unfortunately, when healthcare professionals rely on this assumed imperative of health they overlook some of the fundamental and socio-politics reasons why individuals engage (intentionally or otherwise) in unhealthy practices, and in doing so, may unintentionally promote/maintain racism, sexism, and class disparities.[93] In effect, policies based on the philosophy that health is an imperative have resulted in victim blaming: at-risk individuals are viewed as intentionally causing their own demise or death.[92]

Lupton[18] argues that the modern public health system has evolved into a population-based mechanism for ensuring that everyone wholeheartedly endorses the imperative of health and modifies their behaviour to lead healthier lives.[18] She maintains that the mainstream health disquisition is nothing more than a control apparatus: the regulation of bodies through a variety of methods to compel them to internalize health-improving activities to the point that self-control enables individuals to have power over their health.[18] This government of bodies through polymorphous techniques serves to engage individuals, groups, or communities in the internalization of health-improving behaviours, thus resulting in a greater capacity for self-control while enabling individuals to take control of their own health and to make healthy choices.[18] This is achieved by employing techniques, such as, empowerment, a concept that in health care describes when health care professionals promote autonomy by encouraging patients to be responsible for actualizing behavioural/ health status changes that have been mandated by the health care professional. Thus, empowerment provides the appearance of willing behaviour modification while preventing

the individual from realizing that someone, or something, external to the self is, in fact, dictating the change.[94]

To accomplish such changes, patients are invited, or coerced, with the help of a health professional, to improve their health through behaviour-modification programs and/or therapies.[48,94,95] They are then expected to reflect on their daily practices and eschew any proscribed behaviour in which they formerly indulged. At this point, the conscious seeking of health transforms from an avoidance of illness into the moral imperative that personal choices should be congruent with current health standards. This discourse requires individuals to master themselves, thus maximizing their health and their quality of life: "The self is to style its life through acts of choice, and when it cannot conduct its life according to this norm of choice; it is to seek expert assistance"[76] (p. 158). However, some individuals reject this tyranny of order and despotic *normativity*, and by doing so locate themselves in the margins of society.

Because the public health system is an apparatus for ensuring the health of individuals and populations, dissociation from the health practices it promotes is often labelled as non-compliant or transgressive behaviour, and this non-compliance is a central theme within the public health nursing domain.[18,95] Public health researchers attempt to address the question of how best to engage such non-compliant communities by identifying and developing new health promotion/prevention techniques and approaches. In the realm of sexual health, the concept of unsafe sex occurs only in contrast to the sexual health imperatives that have been developed to combat the spread of STIs. In fact, without the notion of safer sex (as created by public health disquisitions on sexuality), the idea of unsafe sex does not exist. Sex is labelled as unsafe when individuals engage in any sexual practice which contravenes the recommendations that public health departments promulgate to reduce the chance of acquiring STIs.[19] Thus, both safer and unsafe sex are dichotomized into appropriate and inappropriate practices. If the individual engages in unsafe practices

without prior knowledge of the consequences, this behaviour is regarded as an incorrect practice; however, a blatant disregard for sexual health information is often viewed as constituting deviant behaviour. Individuals who reject the public health ideology of self-control are then relegated to the margins of society's sexual norms. At this point, the issue of unsafe sex becomes more complex because individuals who deliberately disregard the central theme of safer sex may put their own health and that of others at risk, which provokes condemnation. In addressing this problem of sexual deviance, Lupton[18] suggests that, in the case of individuals and subpopulations who define their sexuality or their social status as outside the norm, and who reject middle class heterosexual mores, the mainstream public health discourse regarding safer sex practices is, for the most part, non-applicable. The personal health practices of some members of these groups could be reframed as neither actively resistant, nor ignorant, but as praxes of their own health beliefs, particularly in relation to risk.

Risk

In health care, risk is an important concept that permeates research, education, counselling, clinical work, and policymaking. Since the advent of the Lalonde report,[97] governments and health care professionals have expended increased resources in the area of risk analysis as a means of improving preventative health care. However, although it is regularly addressed and analyzed, risk is viewed as axiomatic and is accepted as a natural/neutral component of human existence. In contrast, Lupton[18] identifies risk as existing along a continuum between objective hazard (realist risk) and social creation (strong constructionist risk), with the midpoint of this spectrum being that risk is a cultural construction (weak constructionist risk).

Realist Risk

At one end of the spectrum, risk is defined as, "the product of the probability and consequences (magnitude and severity) of an adverse event"[19] (p. 18). This definition, espoused by fields including economics, engineering, epidemiology, psychology, statistics, and nursing, reduces risk to a technico-scientific quantity – meaning that risk is a statistically calculable chance of an event occurring. In this regard, risk is seen as an objective hazard, threat, or danger that pre-exists in nature, is independent of the observer, and can be discretely measured to produce a formula to predict the specific likelihood of an event occurring. This means that, within this particular category, risk is considered innate in the physical environment and, therefore, its existence is not debatable. It is the appropriate appraisal of risk and its pertinent management that is of concern, not theoretical discussions surrounding its social implications. Thus, discourse revolves around the accuracy of the specific definition of a particular risk[19] and the effectiveness of an intervention; accuracy and precision within definitions are essential.

Furthermore, within this model of risk, a hierarchy of risk beliefs and risk appraisal can be described. This categorization is a dichotomy of objective and subjective risk appraisal, an appraisal, which has also been labelled as the discrepancy between the lay and the expert opinion. This conception of risk does not deny the subjective experience associated with risk, but it subordinates this experience to the knowledge of the expert. Believers in this classification of risk may argue that although risks exist objectively, individuals respond to them based on their subjective appraisal of each risk. However, the acknowledgement of the subjective appraisal sometimes leads to a poorly hidden contempt for the layperson's proper knowledge about risk by both the expert and the layperson him/herself. Such contempt illustrates the *realist* risk belief held by both groups that the expert evaluation is objective and neutral: experts do not have biases, but laypersons do.

Weak Constructionist

Positioned at the midpoint on the risk spectrum, the *weak constructionist* view of risk posits that risks exist in nature, but that they cannot be known outside their culture of origin, and that they are invariably mediated through social and cultural processes. Thus, for *weak constructionists*, cultural patterns determine what may or may not become a risk. This signifies that the evaluation of a choice as wise or unwise cannot be completed without referring to the cultural context of the action.[19] Yet, despite being accepted as cultural constructions, within this category, risks are considered objective hazards because the cultural inhabitants of each particular culture see that which is deemed as risky from a *realist risk* perspective. Furthermore, this belief system holds that risk is becoming increasingly more pervasive within western culture and that it is a central component in the creation of the western human subject. This indicates that risk is not only a subjective process, but also a process of subjectivity. Based on an individual's level of perception, tolerance, and involvement in risky activities, risks function to define individuals (e.g., he is risky; she should have known better, etc.). Moreover, in the *weak constructionist* view, there is no difference in the accuracy of the layperson's and the expert's appraisal of risk. However, although the appraisal of risk is identical between these two, it is exclusively the expert group who can create/identify new risks.[19]

As part of its cultural construction, this category of risk has a three-step formula that must be followed for the creation of a new risk.[19] The first step is to create the future risk as an object, that is, before a risk can exist, a future risk must be identified and acknowledged. Then, as the second step, the notions of danger and harm must be given meaning: before the object can be appraised as being a risk, the outcome that the individual wishes to avoid must be defined. At this point, the third step can occur: the newly created object can be re-classified as a risk. The concept of unprotected sexual contacts can be used to exemplify this process. Step one is the appearance of the concept of HIV within social and health care

discourses – HIV needs to become an independent and known object. Secondly, the concept of harmful consequences must be defined – western culture has designated infection and disease as threats to optimal health (step two). Then, as the third step, with these two definitions in place, unprotected sexual contacts can be identified as a means of acquiring an HIV infection, and thereby be judged as a risky/unsafe (sexual) practice.

Strong Constructionist

This last conception of risk stands as the polar opposite to *realist risk* because, in this category, risk is believed to be socially and culturally created: nothing in itself is a risk, but simultaneously, everything could be (or could become) a risk.[98] This apparent paradox exists because that which western culture interprets as a risk is seen from this perspective as a product of historically, socially, and politically situated modes of perception.[19] Risk and danger are not innately embedded in an object or an individual, but rather, it is a combination of a number of the aforementioned factors that produce the likelihood of any action being/becoming deemed unacceptable by social norms.[99] The difference between this form of risk and the *weak constructionist* perspective is that for *strong constructivists*, risks do not exist in any reality; they are exclusively situated within the culture that created them.

Furthermore, within this last category, risks are seen as central components in the processes of ensuring social order – every action is political, and no knowledge is neutral (including our own). Yet, the concept of risk, is not only "not neutral", but also serves a specific role in creating subjectivities.[19] Similar to the *weak constructionist* perspective, *strong constructionists* posit that risk functions, in part, to help create the individual's representation of self.[19] In this case, however, the emphasis is on creating appropriate subjectivities, well-behaved subjects, and good citizens. Thus, *strong constructionists* would argue that because of the negative connotation that is attached to the concept of risk – that

which is contrary to the rational survival instinct of an organism and, therefore, contrary to nature[100] – it not only helps to define individuals, but also enables individuals to define themselves in a positive light as responsible and rational individuals who refrain from risk.[99]

In this regard, risk is a construct that has dangerous consequences at both the individual and the population levels,[89] and serves as a technique of *governmentality* where it constitutes itself as a mechanism of surveillance, discipline, and regulation of populations.[99] It is also constructed as a means of encouraging individuals to engage voluntarily in self-regulation in response to social and group norms. Risk, therefore, is created through discourses, with definitions that are continually in flux in order to allow the mechanisms of control to be synchronized with activities that are "risky" to the associated social structure. For this form of risk to function effectively, the constructed concept must be reified and believed in so strongly that individuals accept that what they are told is a risk, in actuality is a risk, regardless of the object's properties. In this case, risk development is a two-step process: first there must be the identification of a socially plausible outcome for an action, and secondly, the individual must decide that such an outcome is undesirable. Such a concept of risk can then be used to identify the mechanisms that western culture employs to maintain its norms.[19]

Integration of the Theoretical Perspectives

Although each of the theoretical perspectives covered in this chapter is important, an essential, central factor of this thesis is the interaction between them within the critical theory paradigm, specifically from the poststructuralist perspective. The work of Deleuze and Guattari[45,46] forms the centre of this theoretical framework; however, due to the complexity and abstraction of these authors, works by Foucault,[58-61] Bataille,[57] Grosz,[62,63] and Lupton[18,19] have been added to provide a means of in-depth exploration and practical application of their concepts. While it is clear that Deleuze and Guattari[45,46] explain their

theories as they relate to the individual, it is the individual within the social system that they address – the individual who was, is, and will be created as a result of his/her interactions with the social system. In consequence, the highly abstract theories of these two authors are completely applicable to broad social phenomena, such as, the GCP. Therefore, it is within concepts of Deleuze & Guattari[45,46] that the theoretical works of Foucault,[58-61] Bataille[57], and Lupton[18,19] will be located and applied. More precisely, as can be seen in the preceding sections, it was the work of the supplemental authors that provided applicability to the substance of Deleuze & Guattari's theories:[45,46] Foucault's[58] concept of bio-power explained and provided examples of stratification; Lupton[18,19] provided further examples of stratification, and both Bataille's[57] work on eroticism as a constituent of desire, and Foucault's[60] ideas of sexuality as an art in his *ars erotica* provide useful examples in this area. Grosz's[62,63] work on the effect of architectural places locates the work within its specific environment. According to Grosz,[63] the "Deleuzian enterprise is so resistant to the notion of application because their "theory is not so much to be applied as to be used" (p.60); therefore, it becomes essential to draw on the works of authors with commensurate ideas to make the works of Deleuze/Guattari[45,46] clinically useful for nurses. The integrated relationships between the works of Deleuze and Guattari,[45,46] Foucault,[58-61] Bataille[57], and Lupton[18,19] are visually displayed in the following figure (2.6).

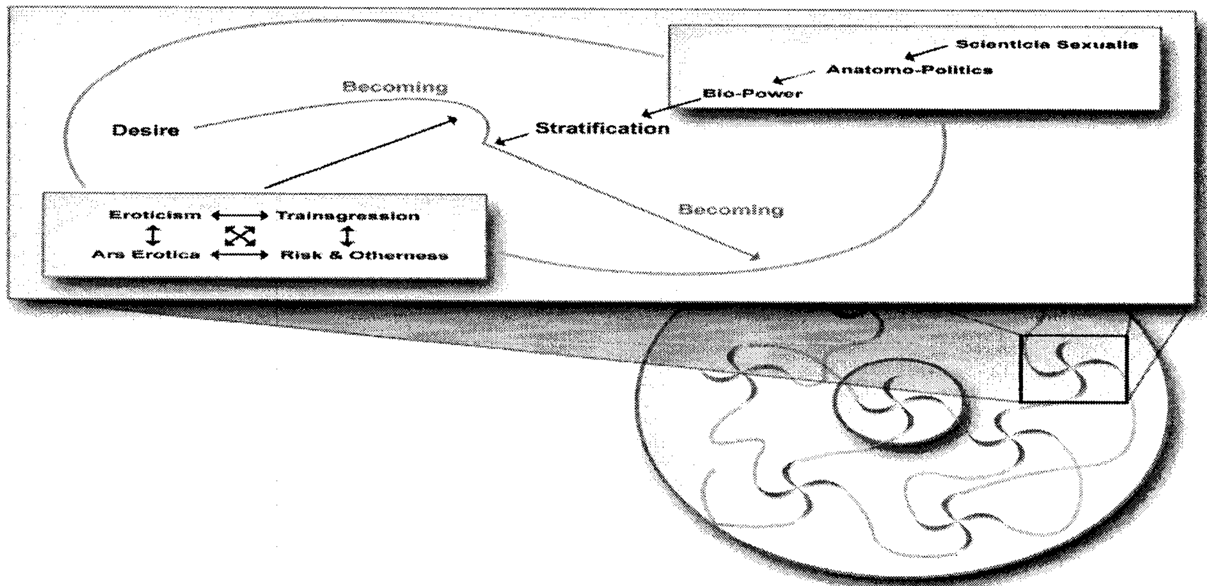


Figure 2.6: Integration of Theoretical Perspectives

Note: Two curved lines from the bottom left to the top right connect the two boxes representing the combined factors of eroticism, transgression, etc., and the combined factors of bio-power. The circular lines connecting the two boxes indicate a dynamic and reciprocal relationship between these two interactive forces. In addition, please note that, within the box at bottom left, all interactions are equal, but within the box at top right, the interactions indicate a hierarchy in which the *scientia sexualis* is the means of regulating the individual body through anatomo-politics, which in conjunction with bio-politics produces bio-power. Ultimately, it is at the point of bio-power that these factors result in stratification. Lastly, the line of *becoming* on the left hand side represents previous impacts and the one on the right represents future ones. This line is not a stagnant process, but illustrates an isolated snapshot of one interaction.

In Figure 2.6, all of the aforementioned concepts have been schematically displayed. Leading in from the left side of the page is desire as a positive force. There is no lack to create this desire. As the desire reaches out, it becomes a line of flight – a *becoming*. At this point, the desire and the subject are in transition. However, this is not a straight line; it is bent in two places. This interaction point of the four converging lines is the *BwO* – that is, the interaction point of desires and social norms. The first influence is a line produced by the interactions of eroticism, transgression, risk, otherness, and *ars erotica*; it enters from the bottom left. The four factors that produce it interact both dynamically and reciprocally and each item alters the other three constructs, producing a resultant line that then collides with the line of *becoming* to modify its trajectory to a slight upward shift. This continues for a very brief period; then, the direction is influenced and re-aligned again by stratification, a

collection of the means by which bio-power operates. Nevertheless, even after the line has been refocused twice, it continues, and will be continuously assaulted by eroticism, desire, and the forces of stratification; through this process, the line is changed. However, this does not result in the line simply taking a different route to its original destination. The goal has changed, and will do so continuously throughout the entire process – a process, which was accomplished by negotiation, combat, resistance, tolerance, and acceptance. Therefore, the goal is, in fact, not a goal at all, but rather, another of the mechanisms of the stratification process and bio-power, which ensures that the line does not fixate on the process through which it continuously passes; such a fixation would prevent the subject from conforming to the norms created to govern populations.

Based on combinations of these concepts from varying authors, the concepts of Foucault,[58-61] Bataille,[57] Grosz,[62,63] and Lupton[18,19] serve to flesh out the concepts of Deleuze and Guattari,[45,46] which provide the guiding theoretical perspective of this research project. This integration allows for a more robust and comprehensive theoretical framework for understanding desire, and permits a greater exploration of many relevant subtopics within the GCP subculture, as they relate to drugs, and unsafe sexual practices.

Chapter Three – Literature Review

Introduction

This chapter addresses the existing literature about GCPs from the perspective of the theoretical frameworks outlined in the previous chapter (Chapter Two – Theoretical Frameworks). First, public health surveillance reports on sexually transmitted infections (STI), with their corresponding incidence and prevalence rates, are reviewed, followed by a presentation of the available literature on gay culture and drugs. Then, literature analyzing raves is addressed. Finally as the culmination of all the aforementioned literature, there is a discussion of the GCP subculture itself.

Sexually Transmitted Infections (STIs) and HIV

According to the Public Health Agency of Canada (PHAC),[20] there are several main STIs of concern in North America: human papillomavirus (HPV), herpes simplex virus (HSV), chlamydia, lymphogranuloma venereum (LGV), gonorrhea, and syphilis; and while not classified as an STI due to its ability to be transmitted through non-sexual means, the human immunodeficiency virus (HIV) is a highly relevant infection within this context, and consequently is included in the literature review. Furthermore, while the goal of this research project is to fill an apparent knowledge gap between the reporting/surveillance guidelines and the effectiveness of sexual health campaigns aimed at MSM who attend GCPs, it should be noted that MSM who attend GCPs self-define themselves as gay, homosexual, queer, bisexual, and heterosexual.[101] Therefore, the analysis of the health sequelae of STIs/HIV in this particular subpopulation must be done in conjunction with, and inclusive of, all other populations to whom individuals can, will, and do transfer these infections. At this point, an overview of these infections will be provided. Please note, because HPV and HSV

are not reportable infections under Canadian laws, specific surveillance data can be provided only for chlamydia, gonorrhea, syphilis, and HIV. (In addition, for a synopsis of transmission of STIs, please refer to Appendix A, Table 1, and please note that within this dissertation, "unsafe" in relation to sexuality refers exclusively to practices which can transmit the aforementioned infections.)

Human Papillomavirus (HPV)

With similar infection rates throughout the western hemisphere, HPV is the most common STI in developed countries.[102,103] According to Holmes et al., nearly 15% of the adult population will have a clinically apparent HPV infection (1% genital warts, 14% HPV related abnormal cytology), and 55-70% of adults will have a sub-clinical HPV infection, leaving only 15-30% uninfected. Thus, regardless of their knowing about it, 70% to 85% of adults have at least one genital HPV infection in their lifetime, with approximately 20-50% of sexually active adults being infected at any one time.[103-105]

Such high rates of HPV infection may be explained by the fact that the acquisition of this virus requires only skin contact (not penetration) because HPV is a localized skin infection with an affinity for the moist mucosal epithelium of the anogenital region.[20] For women, typical infections occur in the cervix, vagina, vulva, or anus, while for men, infections are anal or penile. For both sexes, multiple sites can be involved. HPV is both prevalent and potentially serious, with associated health concerns such as the possibility of cervical/anal cancer in individuals who engage in receptive vaginal/anal sex.[20] Particularly for males who have sex with males (MSM), recent reports have demonstrated a link between HPV infection and anal squamous cell carcinoma.[20] Unfortunately, although condoms have been shown to effectively reduce the spread of the HPV strains that cause genital warts, they have proven unreliable in diminishing the transmission of the high-risk cancerous strains.[106] The recent creation of recombivant HPV vaccines, which target the

aforementioned high-risk HPV strains (6, 11, 16, and 18), should effectively decrease the prevalence of genital warts (~80%) and pre-cancerous cervical cellular changes (~75%).[20] While quadrivalent and bivalent vaccines against HPV infections have been developed, to date, research has only been undertaken on women, thus eliminating the current relevance of these vaccines within the scope of this project.

Herpes Simplex Virus (HSV)

In contrast to the negative health sequelae associated with HPV, the outcomes related to HSV are limited to clusters of, often painful, lesions or blisters, concerns of neonatal transmission, and feelings of decreased self-worth, including depression.[20] However, despite not causing severe health concerns, the presence of HSV lesions increases likelihood of acquiring other STIs, including a twofold increase in the probability of HIV acquisition.[107] Moreover, due to HSV not being a reportable infection in Canada, the annual incidence rates of genital herpes due to both HSV-1 and HSV-2 are not known;[20] nevertheless, in the United States, annual incidence rates for HSV-2 are estimated to be approximately 1,640,000.[108] Additionally, it is estimated that 70% of the new cases of transmission occurred during periods of asymptomatic shedding.[109] Furthermore, vaccines have shown to be ineffective for HSV, thereby restricting treatment to either episodic or long-term suppressive therapy, both of which have been shown to reduce transmission. At present, this leaves prevention as the only intervention available for HSV.

Chlamydia

According to recent Canadian STI reports,[110] from which all of the following STI rates are cited, the incidence of chlamydia, (as calculated on a 100,000 population size), has increased over the last decade. Since 1997, the incidence of chlamydia infections has jumped by 74.2%. Such a jump signifies an average annual rise of 6% in incidence rates across Canada.[110] Specifically, in 2002, the national rate was 178.9 (178.9/100 000), which

increased to 188.2 in 2003, and is projected to be 208.0 for 2004. In a 2003 provincial breakdown, the rate in British Columbia's was 195.2, in Ontario 154.7, and in Quebec 164.3. No age-specific statistics are available as of yet for 2003, but the 2002 figures showed the male rate to be 112.1 and the female rate to be 244.1, with the ages between 15 and 24 having the highest rates for both women and men.[110] Approximately 50% of men and 70% of women are asymptomatic – if symptoms do develop, they usually appear within one to three weeks post infection.[20] Women may experience vaginal discharge, dyspareunia, inter-menstrual or post-coital bleeding, pelvic pain, and/or dysuria. One-third of women with untreated chlamydia will develop pelvic inflammatory disease (PID), and one-fifth of PID infections will result in infertility.[41] Men may experience urethral discharge, dysuria or urethral itching, and/or testicular pain. If left untreated, the chlamydia infection may cause epididymitis. In addition to urethral and vaginal infections, oral, rectal, and ocular infections are possible. Furthermore, chlamydia infections cause trauma to the genital mucosa which can increase the likelihood of HIV acquisition for both men and women.

In addition, lymphogranuloma venereum (LGV), a sub-form of chlamydia that was previously seen only in tropical regions of Africa, has begun to appear in Western and Scandinavian Europe as well as in North America. If left untreated, this infection can cause scarring and internal deformities in the genital/perineal area. Due to its recent appearance (in January 2004), the only current statistical data available for LGV is that thirty-three cases have presented, of which twenty-two were confirmed and eleven remain as suspected.[110] Furthermore, twenty of the reported cases have also been identified as having a concurrent HIV infection, and all cases have been in MSM.[110]

Gonorrhea

Since 1997, gonorrhea incidence rates have increase by 81.5%.[110] Specifically, in 2002, the incidence rate for gonorrhea was 22.9; this climbed to 26.0 in 2003, and is

projected as 27.9 in 2004. Such an increase represents an average national increase of 4.3% between 2003 and 2004. According to the 2003 statistics,[110] the rate for British Columbia was 16.6, Ontario was 31.0 and Quebec was 11.7; however, the most recent statistics by age (from 2000) are misleading because the surge in gonorrhoea in the last two years is not reflected in these rates. Males between the ages of 20 and 29 and females between the ages of 15 and 24 are most likely to contract gonorrhea.[110] The majority of infections for both men and women are asymptomatic, although men are more likely to display signs. The symptoms of gonorrhoea are similar to those of chlamydia, but usually more pronounced and with earlier onset; they typically appear within two to ten days post infection. Female symptoms include vaginal discharge, dyspareunia, inter-menstrual or post-coital bleeding, pelvic pain, and/or dysuria and this STI is the second most common reason for the development of PID.[41] Men may experience urethral discharge, severe dysuria, and/or testicular pain.[20] As with chlamydia, gonorrhea causes trauma to the genital mucosal membranes that can increase their permeability to other infections, such as HIV.

Syphilis

Although syphilis has also shown an increase, the rate is not high compared to the STIs noted above. However, it is more alarming because while between 1996 and 2000 there was a 0.5 new infection rate per 100,000 individuals, this rate increased steadily from 1.5 to 2.7 between 2001 and 2003, and has a projected rate of 3.8 for 2004; and while the increase in incidence for syphilis between 2003 and 2004 was only 34.8%, its increase since 1997 has been a massive 908.6%.[110] For British Columbia, the 2003 rate was 6.3, Ontario was 2.9, and Quebec was 2.1. The age rates for syphilis have been unavailable since 1999, when males aged 20 to 60 and females aged 15 to 39 were most likely to contract syphilis. Again, this age statistic is misleading because there has been a significant resurgence of syphilis since these age specific statistics were produced.[110] Syphilis typically

presents as a painless, indurated lesion (which is highly infectious) anywhere on the body, but usually appears at the site of first infection.[20] During this time, regional lymphodenopathy is typically present as well. The lesion and lymphodenopathy resolve within two to six weeks, and the highly variable secondary syphilitic symptoms of a rash on the trunk, hands, or feet may appear.[41] After these resolve, no further symptoms will present, until the infection begins to attack a major organ, and presents symptoms that range from dementia to cardiac arrest.[41]

HIV

Since HIV testing began in 1985, there have been 55,180 individuals diagnosed with HIV in Canada.[8] In addition, it is estimated that 17,000 HIV sero-positive individuals are unaware of their serostatus. This group represents roughly 30% of the current HIV population. Furthermore, this group presents a public health concern because they could potentially and unintentionally be infecting other individuals. While from the mid-to-late 1990s, MSM HIV rates dropped from 75% to 37% of newly diagnosed HIV infections, over the last four years this proportion has increased to 44.4%.[8] This statistic illustrates that, even though MSM are a relatively small proportion of new HIV infections, they still constitute the largest at-risk group, and that the number of new infections within this population is increasing. Furthermore, current HIV statistics illustrate that MSM have the highest HIV infection incidence rate,[8] and that the GCP subculture could be associated with a significant proportion of these new HIV infections.[4,5] In the case of HIV, prevention is the only current solution because there is no available cure.[111] In relation to HIV symptoms, they are vague, ambiguous, and potentially caused by an array of disparate health problems (e.g., sero-conversion flu, fatigue, and weight loss). Thus, they will not be discussed within this dissertation.

<u>Gay Culture and Drugs</u>

Added to the direct health concerns of STI/HIV transmission, including PID, infertility, chronic pelvic pain, and eventual death, the latest research addressing drug use (crystal meth, Viagra, ecstasy, ketamine, and gammahydroxybutyrate) and risky sexual practices has indicated that drug consumption occurring within the context of GCPs may lead to an increase in risky sexual practices, such as, unprotected anal intercourse.[3-7,9,10,28,34,38,112] Therefore, due to this indicated relationship between drug use and STI rates, at this point, a general overview of crystal meth, Viagra, ecstasy, ketamine, and GHB will be provided. Please note that a more in-depth analysis of crystal meth has been undertaken (than of the other drugs) because media, police, emergency department and research reports implicate this drug as a cause of many new and recent HIV infections in MSM in relation to the GCP subculture. For a synopsis of all below-mentioned club drugs, please refer to Appendix A, Table 2.

Crystal Meth

At the beginning of the 20th century, crystal meth was prescribed as a wonder drug, a fix-it-all medication, which could be used for a long list of unrelated ailments, including allergies, asthma, depression, dysthymia, and anenergy.[113] However, its use was quickly limited to that of a bronchodilator.[114] Then, with the advent of the Second World War, its use returned to the forefront when it was widely given to American, Japanese, and German soldiers to combat fatigue and increase performance.[113] Looked at in the context of its history, it seems logical to presume that such a drug would be end up being used to enhance partying-related practices at sixteen- to eighteen-hour, energy-filled GCPs.[22,115] Unfortunately, this remains a moot point because little research has been directed at this topic.

Pharmacology

Currently, crystal meth, often referred to as speed, meth, Tina, Yaba, Gak, chalk, fire, ice, jib, crystal, crank, crack and glass, is available as a white, odourless, bitter-tasting crystalline powder or rock (i.e., crystal) that dissolves easily in water.[114,116] This drug can be ingested, snorted, dissolved sublingually, inserted rectally or vaginally, smoked, injected, or consumed in a beverage. The different methods of use will result in varied onset times, durations, and levels of psychotropic effect. With methods such as rectal, vaginal, or sublingual insertion, or nasal inhalation (i.e., snorting), the area of contact between the drug and the relevant mucosa becomes instantly anesthetised and the physiological and psychotropic effects begin approximately five minutes later. With ingestion, the onset is delayed about twenty minutes, while for both smoking and injecting result the effects are immediate. Colfax et al.[117] report that typical consumption of crystal meth is approximately 20-40mg every three to four hours, which leads to a dose of anywhere between 0.3-1g during a 24 hour period. The half-life of crystal meth – the time it takes for the body to process half of the ingested substance – is twelve hours.[117] In comparison, the half-life of cocaine is 90 minutes. Therefore, because of a relatively cheap cost and a longer duration of effect, typical crystal meth use is reported as occurring in a "binge-and-crash" pattern,[6,114] thus producing, on average, a 25% decrease in the cost of crystal meth, versus cocaine, use.[113]

Physiology and Psychology

The lipophilic chemical structure of crystal meth allows for easy penetration of the central nervous system and a more potent effect than amphetamines.[118] Physiologically, this drug stimulates the sympathetic nervous system, with the associated symptoms of tachycardia, hypertension, papillary dilation, diaphoresis, tachypnea, peripheral hyperthermia, and hyperpyrexia.[118] In the context of the GCP, prolonged physical movement

and crystal meth use can produce dehydration and hyperthermia becomes a major concern because sympathetic stimulation prevents the natural cooling mechanism of vasodilation from dissipating heat from the body's core.[113] However, counterbalancing the numerous negative sensations produced by these strong sympathetic reactions is a powerful interruption in the normal cycle of the neurotransmitter gamma-aminobutryic acid (GABA), which is mainly responsible for preventing the over-excitation of nerve cells. Crystal meth prevents the release of GABA and the re-uptake of catecholamines,[119] another class of neurotransmitters that include norepinephrine and dopamine.

The popularity of this drug is due primarily to its reported acute physical effects, including altered states of perception, such as, increased sensory acuity combined with decreased pain sensation, decreased appetite, lowered need for sleep, and a marked increase in the sex drive and sexual pleasure. In addition to these physiological changes, this drug also enhances the inter-personal and inter-subjective feelings of sexual appeal, confidence, charm, power, grace, and warmth[6,28] and many crystal meth users report feelings of heightened attentiveness and curiosity, euphoric disinhibition, increased energy, grandiosity, and a decrease in anxiety.[120]

However, crystal meth users also report that this drug produces impairment in judgement, extreme psychomotor agitation, and formication (the belief that insects are crawling under one's skin).[120] Therefore, the reported psychotropic effects of this drug may be either feelings of euphoria, or psychotic symptoms which resemble those experienced in schizophrenia – a hypersensitivity to environmental stimuli, paranoid ideation, auditory and visual disturbances, and persecutory delusions.[11] Research indicates that these symptoms may arise from catecholamine depletion during the acute withdrawal phase.[121] Once the acute withdrawal phase ends, the crystal meth user may enter a withdrawal period with symptoms of depression, such as, severe dysphoria, irritability, melancholy, anxiety, fatigue and hypersomnia, drug craving, and potentially lethal suicidal ideation that can persist for up

to one year.[113] To counteract these symptoms, benzodiazepines may be ingested, a practice that reportedly produces greater harm than crystal meth use alone.[120]

Due primarily to the massive and repeated influxes of dopamine, one of the principle neurotransmitters responsible for pleasure regulation,[114] crystal meth has been shown to produce permanent cortical changes, including reduced cognitive function, poor mental health, and attention deficit disorders.[122] This strong link between pleasure regulation and crystal meth use may lead to the development of a psychological dependence. However, no evidence exists to suggest that one time use will produce such an addiction.[116] While drug associations, such as, the American National Institute on Drug Abuse (NIDA),[114] report that crystal meth quickly produces such psychological dependence, most MSM crystal meth users identify themselves as moderate users, not addicts,[6] and do not see themselves as being at high risk.[12] Nonetheless, other research indicates that the psychological effects of crystal meth use can lead to decreases in the amount of pleasure experienced during activities and practices that had been enjoyed previous to the start of methamphetamine use.[11,123] Furthermore, dopamine deficiency is linked to Parkinson's disease, which has lead researchers to speculate that the irreparable damage caused to cortical structures could create a predisposition for the development of this ailment.[113] In addition to neurological damage, methamphetamine use has been associated with other physiological failures such as strokes, cardiac valve thickening, decreased liver function, and pulmonary hypertension[124] as well as problems with work, family, personal relationships, and the legal system.[125] As a result, in 2005, methamphetamines were reclassified in the Canadian Controlled Drugs and Substances Act from Schedule III narcotics to Schedule I, thus increasing the penalty for the indictable offences related to crystal meth production and possession from three to seven years in prison.[116]

Manufacture

The popularity of crystal meth within the GCP subculture[38] has increased, in part, because it is inexpensive and easy to manufacture. This drug can be produced from easily obtainable, non-prescription elements, and its manufacture requires very little knowledge of chemistry. In fact, a book entitled, *The Secrets of Methamphetamine Manufacture: Including Recipes for MDA, Ecstasy, and Other Psychedelic Amphetamines,*[16] is easily obtainable from amazon.ca with a 30% discounted price (information retrieved Sept 23, 2005), and has had a sales ranking as the website's 545th most popular on-line purchase. This manual for making methamphetamines, lists easily obtainable ingredients, such as: "Hydrochloric acid, lead acetate, drain cleaner (Drano), battery and pool acid, lye, lithium batteries, lantern fuel, liquid fertilizer, iodine, lighter fluid, anhydrous ammonia, ether, sodium cyanide, acetone, red phosphorus, antifreeze, pseudo-ephedrine [Sudafed, Claritin, Tylenol Cold & Sinus], phenyl-propolamine, ephedrine, and ammonia"[11] (p. 1).[16] However, the purchase of this book is unnecessary. By browsing the Internet with text, such as, "how to make crystal meth", directions, complete with lists of ingredients, the exact locations where they can be purchased, and the means by which they can be acquired without suspicion can be found. Furthermore, the latest methods using ephedrine and pseudo-ephedrine reduction are simple, cheap, more efficient, and produce a greater (purer) yield of the desired chemical.[113]

Motivations of Users

According to Semple, Patterson and Grant,[6] MSM principally use crystal meth for the following reasons: 1. to experiment; 2. to party; 3. to get more energy; 4. due to peer pressure; and 5. to cope with their moods. Additionally, methamphetamines are used to heighten self-esteem, while providing cognitive dissociation and withdrawal from emotional and psychological stress. One reason for self-medication is that both HIV sero-positive and HIV sero-negative MSM who have internalized feelings of homophobia identify the drug as a

means of escaping feelings of exclusion induced by sexual orientation. As an extra factor, HIV sero-positive MSM identified that crystal meth allows them to forget the negative associations of their serostatus, including an intentional non-adherence to medication regimes.[115] For HIV sero-positive MSM, non-adherence was a necessary aspect of temporarily escaping their illness because the medications were seen as a burden and a reminder of reality. In addition, crystal meth was also identified as an enabling mechanism for closeness and intimacy in situations where such experiences would otherwise have been impossible; conversely, it was also reported as facilitating non-emotional, strictly sexual relations.

An additional motive was sexual enhancement.[6] One study found that 97% of its consumers used crystal meth either before, or during, sexual contacts and that these individuals were less likely to employ any form of protection while engaging in sexual activities.[126] Sex was identified as being more pleasurable and the "highlight" of the meth trip. Specifically, HIV sero-positive MSM were found to be taking greater risks, and thus were more likely to be meth users.[126] However, there may not be a causal relationship between crystal meth and risky sexual practices – another study by Halkitis, Shrem & Martin[22] found that crystal meth use does not increase the potential for sexual risk within the individual, but rather seems to be an indicator of sexual risk between individuals. In other words, hypersexual risk-takers could be attracted to crystal meth use, rather than the drug being responsible for the risky practices associated with it.

3,4-methylenedioxymethamphetamine (Ecstasy)

Chemically, ecstasy has a structure similar to that of mescaline and methamphetamine;[127] it was originally developed by Merck (currently known as Merck-Frosst) in 1912 as an appetite suppressant medication. However, after a brief period of use, health authorities declared the drug to be unsafe, and restricted its usage until the 1970s

when it was reintroduced as an adjunct to psychotherapy. However, due to its often-irreversible effects on serotonin receptors, and because of the occurrence of a post-high depressive state with side effects of confusion, insomnia, hallucination, severe anxiety, violent and irrational behaviour, hyperthermia, hypertension, and heart/kidney failure, the medication was again declared dangerous. Nevertheless, this drug remains popular at *techno dances* because it enhances physical sensations, particularly those linked with proprioception (that is, ecstasy enhances the pleasure of movement) by flooding the brain with serotonin and dopamine to produce feelings of empathy, emotional warmth, openness, a feeling of genuine communication with others, and a reduction of critical and cynical thoughts.[38]

Ketamine (Special K)

Invented as a veterinary anaesthetic in the 1960s, ketamine produces a loss of attention span, delirium, amnesia, hypertension, and respiratory distress, in addition to its potential to induce vomiting in overdose situations.[11] These effects occur due to this drug's high lipophilic properties, which block the functions of two central nervous system excitatory amino acids, glutamate and aspartate,[127] for an average duration of two to four hours.[128] However, when the dosage is calculated precisely, ketamine also produces states of euphoria, a fact which may be linked with its increased use at GCPs.[128]

Gamma-hydroxybutyrate (GHB)

Another popular GCP drug is GHB, which was invented in the 1960s as an anaesthetic, then trialed as an attempted treatment for narcolepsy; however, it was quickly declared as too toxic for medical use. Its chemical structure matches that of the major central nervous system depressant neurotransmitter, GABA.[127] This drug, which is available as a bitter tasting powder or clear liquid, is used at GCPs as a sedative hypnotic with disinhibiting effects that foster euphoria, heightened sensuality, and dramatic enhancement

of sexual pleasure. When ingested, the effects of GHB are typically felt within a few minutes, and may last from one to four hours.[127] The danger of this drug arises from its narrow therapeutic range and its steep dose response curve in conjunction with a delayed rate of response. This means that the margin between euphoria and overdose is narrow – a small quantity of the drug produces exponential effects, and can take up to two hours to start showing any effect.[11] Loss of consciousness when using this drug is also a common occurrence.

Phosphodiesterase (PD-5) Inhibitors

The aforementioned party drugs (crystal meth, ecstasy, ketamine, and GHB) have been shown to cause impotence. To offset this effect, users have indicated that they engage more readily in receptive anal intercourse.[22] To facilitate this, crystal meth, especially when inserted rectally, enhances the sensitivity of the highly innervated perianal region, and reduces the pain associated with anal penetration.[6] On the other hand, as an alternative to engaging in receptive anal penetration, PD-5 inhibitors (sildenafil, vardenafil, tadalafil, but known better as Viagra® or Cialis®) can be used to counterbalance impotence. Physiologically, PD-5 inhibitors increase the duration of an erection, increase blood flow, and increase mucosal susceptibility.[14] However, in addition to drug-induced impotence, recent studies of the general population have shown an average impotency rate of 9% in 30 to 39 year old males and 11% for 40 to 49 year old males, while 53% of HIV sero-positive MSM suffer from erectile dysfunction, which may explain the 312% increase in the prescription of PD-5 inhibitors to young males.[14]

Moreover, PD-5 inhibitors can be intentionally combined with other club drugs, such as crystal meth (due to its effect of increasing the sex drive and decreasing pain sensations), to provide the necessary physical and psychological requirements for counteracting impotence and refractory periods, thus enabling an erection to last for

extended durations, and thereby facilitating "sexual marathons". These lengthy sexual escapades occur when individuals engage in sexual activities with one or possibly multiple partners for longer periods of time than are possible without these drugs. Unfortunately, the practice of combining club drugs and PD-5 inhibitors can result in a decreased awareness of skin deterioration and abrasions caused by sexual activity, thus increasing the possibility of acquiring STIs.[15] According to Swearinger & Klaussner,[14] sildenafil (i.e., Viagra®) users are more likely to acquire an STI, and twice as likely to be diagnosed as having HIV, but Wong, Chaw, Kent, & Klaussner[126] found that both the use of crystal meth alone and the use of crystal meth in conjunction with sildenafil were associated with an increased number of partners, unprotected anal intercourse, and STI acquisition, while the use of sildenafil alone was not.

Additional Health Concerns of Drug Use

Research indicates that the use of all of the abovementioned party drugs puts individuals at risk for acquiring STIs due to decreased condom use, an increased incidence of receptive anal sex, and an increased number of partners.[6,7] In fact, according to a San Francisco Health report, crystal meth users are twice as likely to be infected with HIV, 4.9 times as likely to receive a diagnosis of syphilis, and 1.7 times as likely to test positive for gonorrhea.[129] Recreational drugs are also associated with hyperthermia and dehydration,[34] which have resulted in young adults requiring lifesaving measures in emergency departments worldwide.[32,35-37,155] They are also implicated in other health sequelae such as cardiac, hepatic, and renal failure.[31-33] Furthermore, the use of these drugs has been linked to problems, such as, depression, anxiety, paranoia, irritation, and unsociable behaviour, that persist well past the withdrawal phase.[7,36,38-40]

Raves

As the next step in the literature review, an overview of previous research about raves will be presented. The rationale for this presentation is that raves manifest some similar properties to GCPs. For example, both parties often take place in large party venues in which repetitive, loud, and heavy "drum 'n bass" music is played at a fast tempo in conjunction with intricate and elaborate light and laser shows while huge crowds of individuals dance, and often consume drugs. In addition to these similarities, another benefit of understanding raves is that, on average, the general public may be better aware of raves than of GCPs. As a consequence of this, a much larger quantity of research conducted by different disciplines and applying diverse research methods to gather and analyze data about various phenomena of interest at these parties has been undertaken, as compared to that related to the relatively unknown (and thus less politicized) GCPs. Thus, because raves can provide additional information and a broader perspective for understanding certain aspects of GCPs, it is beneficial to acquire greater knowledge of them. In addition, for the aforementioned reasons, an analysis of raves is thus an excellent transition concept between "gay culture and drugs" and "GCP subculture".

History

In comparison to many social histories, the short history of raves began approximately three decades ago in Chicago,[130] with the advent of what came to be known as acid house parties, named for the type of music that was played at them;[131] acid house is a type of music that somewhat resembles the aforementioned "drum 'n bass" music that is currently played at raves and GCPs. At the most basic level, the ultimate defining nature of acid house parties was the specific form of dance music which was played at them – music that quickly spread from the United States to Europe (mainly the United Kingdom, France,

Belgium, and Holland) and Australia where it had a profound effect including the instigation of significant societal movements and reactionary political impositions.[131-134]

However, the emergence of raves from acid house parties was not solely due to the development of this new subtype of music; an additional factor – the widespread recreational use of the drug 3,4-methylenedioxymethampethamine, more commonly known as MDMA, or ecstasy – was needed before the nature of acid house parties transformed into the type of gatherings now commonly known as a raves.[132,135] Thus, it was not exclusively a change in the music that produced raves; it was the combination of the music and the non-therapeutic use of a discontinued pharmaceutical agent. This simple change to an already popular party-scene distinguished the new form of partying from other concurrent, or previously held, types of parties to the point that extreme political pressure was exerted to prevent them. Reiterated succinctly: at some undetermined point in the mid-to-late 1980s, acid house parties where ecstasy was being consumed mutated into raves, which exist today as relatively underground dance parties where house music and ecstasy are commingled by numerous individuals to produce pleasure.[131-133,136,137] In other words, raves became the popular culture descriptor for a subculture of partygoers who wish to enjoy a certain type of music while consuming ecstasy.[138] (Note: In scientific literature, "nocturnal dance parties" is the technical term used to describe raves. See van Sassenbroeck et al.,[137] for example.)

After their inception, for a brief period during the late 1980s, raves increased drastically in popularity.[132] For example, in London (UK), a particular set of parties began to attract crowds of approximately 25,000 individuals, a drastic contrast to the average attendance numbers of 4000 that had been common only a few years earlier.[131] This increase in attendance is partially ascribed to the social and cultural changes that were concomitantly occurring in England at that time – a dramatic decrease in the rivalry, popularity, and adrenaline-pumping nature of soccer culture, and a general loss of political

momentum by organized social movements and unions.[139] This diminished social cohesion is often proposed as a primary reason why acid house parties, and their subsequent sub-cultural derivatives, raves, increased so suddenly in popularity. In fact, the popularity of raves in England is often described as being an outward manifestation of an underground societal rejection of Thatcherism.[140] Raves provided an outlet against the prevalent sense of social isolation, and provided large groups of individuals with a non-aggressive platform for congregation and social interaction.[132] Some authors[141] have argued that the only aggressive aspect of the rave culture is its transition to include alcohol within the last decade. However, in sensationalist and hysterical news stories, early media coverage depicted these parties as hedonistic and dangerous.[139,140]

Due primarily to this scare mongering (and prior to becoming the more commonly accepted, legal parties that they are now), raves in the experienced a transition period throughout the early 1990s when these parties came to be regarded as illegal congregations, and were consequently forced to take place in clandestine locations;[133,139,140] in fact, the location of a proposed party was not disclosed, even to "insiders" until mere hours before the party was to begin.[133] During this time, an increasing number of politicians began speaking out against raves, and, in conjunction with the police, initiated a concerted effort to eliminate/eradicate them. Furthermore, many heath care professionals also publicly supported banning raves because of the negative health outcomes that were occurring due to ecstasy use during them.[132] As a result, the general public did not oppose the outright suppression of a non-violent and non-threatening recreational practice to the point that acid house music (in this case, used in reference to the music, and not the type of party) was banned from public play on radio, television, and at retail outlets.[141] However, despite this focused proscription, raves continued until, after a period of unsuccessful attempts to eradicate them, much of the same legislation that made raves illegal was amended to permit a legal congregation of ravers at licensed venues.[133,139,140]

The Philosophy of Raves

Within the context of this literature review, the "philosophy of raves" does not refer to the theoretical analysis, ordering, and discussion of partying as a concept, but rather, it describes the underlying reasons that have been proffered to explain why ravers attend these parties, and why they party in the manner in which they do. Put in another way, this section presents the findings of previously undertaken research which has addressed the basic motivations and expectations of individuals who purposely, and often routinely, attend raves to the point that they self-identify as "ravers".

To begin, the majority of the research that has been undertaken to date has found that raves are parties which arose in a climate of socio-political ennui where trade unions had limited power (described above), and which, to this day continue to function as a rejection of the "me" mentality of Western society.[131,139,140] Ravers report that their partying practices are an outward manifestation of their worldview that rejects the individualistic culture of Western society in which, it could be argued, "individuality has become the new conformity".[142] In contrast to this self-centred and egotistical social structure, ravers insist that their underlying reasons for attending raves are to engage in a celebration of peace, love, unity, and respect (known as the PLUR principle of raves).[132] In fact, the main reason that ravers give for attending the parties is to engage in an experience with other individuals who fundamentally desire and support an unbiased and non-judgemental party atmosphere.[132] However, it is important to remain critical of this seemingly utopian party milieu, particularly because it is the ravers themselves who are being interviewed and who are providing this information. In other words, the research studies that reported these findings based them on interviews with individuals who routinely attend raves (i.e., ravers), and thus, it is unsurprising that these findings are positive and reveal that these parties are sites of nearly total acceptance of other like-minded individuals.

Consequently, on one hand, it could be suggested that these findings that raves are locations of peace, love, unity, and respect (i.e., PLUR) could possibly be nothing more than wishful thinking by willing research participants who are well aware of the controversial reputation of raves (due to their associated drug use) within current society. From this perspective, the findings of research on raves can be understood as politically motivated; they are social justifications of a particular partying practice that is pleasurable to the research participants. On the other hand, the PLUR principle may, in fact, be more than wishful thinking – research about raves conflicts directly with research about heterosexual clubs and bars. In the bars and clubs, the goal of those who attend them is to consume large quantities of alcohol to "get wasted" and "get out of control", a practice that is often associated with the high levels of violence seen in these environments.[141,143-4] In contrast, observational evidence gathered at raves has shown them to be party locations in which individuals prefer to use drugs to enable them to "get in touch" and feel the atmosphere and environment, and to enhance the sensations of their physical movements.[146] The evidence indicates that at raves, violence and other forms of overt intolerance of others are virtually non-existent – a fact that could be interpreted as support for the claims that the PLUR principle exists not only in speech, but also in action. Thus, raves could, in fact, be sites where individuals actively seek out the opportunities to indulge in community, acceptance, and enjoyment with fellow human beings.

Drug Use at Raves

Because the original definition of raves arose, in part, from the usage of drugs while listening to a certain type of music (i.e., acid house), it is not too surprising that, to date, nearly all research has indicated that drug use continues to constitute an important aspect of these parties.[131,133,135,138,146-148] In fact, most research indicates that not only is drug use pertinent and pervasive, but also that ecstasy (i.e., the first drug associated with raves)

continues to be the principle drug consumed.[131,133,135,138,146-9] This has lead several authors to posit that this particular drug may, in fact, be a highly important, or even required, ingredient in the rave experience and that the specific psychotropic effects attributed to ecstasy are specifically desired by ravers because they are capable of producing a desired state when consumed in conjunction with rave music and party attendance. [131,133,135,138,146-8]

However, other trends in rave drug use have changed, and amphetamines, ketamine, gamma-hydroyxbutyrate (GHB),[138,150] but not methamphetamines for the most part,[135] are now also associated with these parties. Of these, amphetamines are the second most commonly used substance, which may not be surprising because of the high-energy, multi-hour, nocturnal nature of raves (like GCPs).[133] At this point, it is important to note that, while some researchers have identified raves as the reason why some individuals use any of these drugs (in particular amphetamines in order to stay awake and continue to party), no definite evidence has ever indicated this to be the case.

Furthermore, and as an adjunct to drug use, other researchers have indicated that due to an increased popularity of dance and techno music, (which corresponds with the legalization of raves nearly a decade ago), an associated increase in ecstasy use has occurred across the general population.[130,131,136,148] Again, this finding seems to support the claim made 15 years ago in England that rave music (previously called acid house music) was directly linked to, and possibly the cause of ecstasy use.[151] However, when contrasted with other research that has attempted to study ecstasy use, this claim seems to be nothing more than sensationalist conjecture; the majority of rigorous research studies that have been undertaken to examine changes in ecstasy use have found that its usage has reached a plateau over the last decade.[135] Thus, in stark contrast to the causal relationship proposed by some researchers, rave music (when its use by both rave and non-rave groups is compared) does not seem to be inherently or intrinsically related to ecstasy use.[135]

Raves, Drug Use, and Risk

The concept of risk, as it relates to the use of drugs at raves is the next topic of importance, especially its relevance to GCPs and this dissertation, because, as presented above, the majority of the physiological outcomes of harm (i.e., hyperthermia, respiratory depression, unconsciousness, death, etc. – but not the psycho-social and behavioural changes) that are associated with club-drug use were studied in relation to rave subpopulations, not GCP groups. (For more information about these outcomes, please refer to pages 55 through 64.) However, other research examining the relationships between raves and drug use, which was specifically aimed at investigating the attitudes, beliefs, and cognitive evaluations of ravers about the outcomes that are associated with their partying practices has also been undertaken. The results of these studies follow the general trends presented in the majority of medico-scientific literature, perhaps because nearly all research that has been undertaken addressing the nature of risk, the appraisal or risk, and the ravers' understanding of risk was underpinned by the pre-established, mainstream assumptions about what these risks are, what they signify, and how they should be approached (see Rome[150]; Laidler[131]; Maxwell[147]; Lin[152]). Consequently, most of these studies have indicated a high level of ignorance among ravers in relation to their drug use practices and the associated outcomes of their partying practices as they relate to what the researchers have deemed to be negative health sequelae.

However, such findings are subject to both methodological and philosophical limitations. The major methodological limitation is that these findings have, for the most part, been discovered using traditional epidemiological methods (such as, surveys), which have been restricted by the assumption that ravers understand and respond to the terminology used within these surveys in the exact way that the researchers intend them to. This assumption, however, has been criticised by many other researchers, who have demonstrated the absolute necessity for a mutual understanding of the language used by

both groups.[55] That is, there must be a common understanding of both the "slang" terminology used by the non-mainstream population and the "professional" language (jargon) of the researcher by all parties involved in the conversation. Therefore, the findings of these surveys should be approached with extreme caution because no verification can be made to ensure that the sampled ravers even understood exactly what they were being asked. Other research (most done using in-depth qualitative analyses) has illustrated that interactive data collection methods reveal, first, that to avoid misunderstanding, many terms must be defined during conversation, and secondly, that when a common understanding of vocabulary is achieved, many ravers are, in fact, highly educated about their practices and the associated risks.[133,135,148,149] Specifically, in relation to the use of vocabulary, it has been revealed that ravers are often using terms, such as, danger and harm with broader meanings than those assigned by the researchers when interpreting them, and that harm and danger are being subjected by the ravers to a behavioural calculus in which potential risks can be neutralized or negated quite rationally by the possibility of desired benefits.[135]

In addition to these methodological concerns, from a philosophical perspective, a problem, which recurred in the medico-scientific assessments of risk, was the designation of risk as an inherent, objective property of life. That is, the majority of the research studies that were found in this literature review on raves relied on a commonly held understanding of what constitutes risk, and then proceeded to assume that this understanding was identical for all other individuals. However, many other authors have argued that risk is created though, and by, each individual's interaction with their specific context, and, consequently, that nothing is inherently risky or dangerous. In the same breath, however, this also means that simultaneously, everything could be a risk because it is the perception, not the essence, of an object that determines its level of danger.[98] This seeming contradiction exists because the outcomes, which we, as Westerners, regard as unwanted or undesirable are understood as such as a direct result of historical, social, and political

processes (For more information, see Lupton[18,19], or the discussion of risk in the previous chapter; pages 42 to 46). Therefore, risk can be seen as the synergistic culmination of a variety of factors, which result in a particular object, action, or individual being declared as risky.[99] What this signifies in the context of this literature review is that, in addition to possible terminological misunderstandings having occurring between the researchers and the research participants, there may also have been a more fundamental misalignment of the basic understanding of key concepts (in this case, risk, but possibly others) underpinning the research that has been undertaken to-date.

Drug Use and the Sexual Practices of Ravers

While the harmful physiological outcomes of drug overdose have been studied extensively, research into the socio-behavioural effects of club-drugs on the sexual practices of ravers has been limited. In fact, in the majority of literature reviewed, most (but not all) discussions of sexual relations (e.g., number, type, frequency, etc) were made in reference to other literature that had been directed at GCP attendees – rather than toward ravers (see Weir[132], for example). This causes a few problems because all research that discusses the sexual practices of individuals who attend GCPs has thus far been focused exclusively on the MSM population, with the almost exclusive intention of understanding the relationships between GCPs, drug use, and unprotected anal intercourse. Therefore, the extent to which this latter research is applicable to rave populations is undeterminable, and may, in fact, be absolutely inapplicable. This also means that the literature on raves as it relates to sexual practices does not contribute anything significant, whether through comparison or contrast, to the understanding of drug use and the sexual practices of GCP attendees.

Moreover, in the limited number of studies, which did focus on the relationship between drug use and sexual activity in raves (and not GCPs), the results were often highly

conflicting. Some of the literature indicated that drug use at raves produced a heightened probability for sexual contact,[133,152] while other research showed no such relationship.[146] For example, further examination of the literature revealed one study,[146] which found that an increase, a decrease, or no effect on the number of different sexual partners were all attributed to drug use, depending on the individual reporting the information. In each of these cases, it was the specific reaction of particular individuals to drug use that caused a change in sexual practices; it is also important to note that the aforementioned reactions remained consistent for the individuals who did experience changes in their sexual practices. This indicates that the psychotropic effects of club-drugs are highly situational and subjective, and that any attempts to extrapolate objective or generalizable behaviours that are associated with drug use within raves are highly questionable. It is also worth noting that, while the above information may be pertinent from an STI/HIV perspective, the relationship between drug use and the ensuing likelihood of sexual contact was the only aspect of drug use and sexual practices that was studied in the rave population; all other aspects were markedly absent. This reveals a bias within this research literature: a focus on what some authors have considered a "promiscuity paradigm".[153]

A possible outcome of the above findings is the conclusion that sexuality may not be a significant component of raves – a fact that would conflict directly with the majority of the research presented about the effects that many club-drugs (in particular crystal meth) have on MSM. Equally likely, though, are the possibilities that, either the sexual component of raves is much less overt than that of GCPs, or that researchers have, thus far, simply refrained from investigating this aspect of the rave experience.

Ravers

The next area of importance in this literature review – one that is often discussed extensively within socio-behavioural scientific literature – is a description of the nature,

characteristics, or profile of the individuals or group of individuals who engage in designated risk behaviours (which in this case is the aforementioned indulgence in club, or designer drugs and rave attendance). However, in the research literature reviewed, no detailed description of ravers was available. In fact, the majority of the research provided no socio-demographic or descriptive information whatsoever. At best, one qualitative study provided a vague portrait with limited data on the characteristics of individuals who attend raves in an effort to give a thick description of the participants.[154] In other words, generalizable profiles, which describe individuals who attend raves, were unavailable, and only one transferable profile was found. Within the latter, ravers were described as the "geeks" or the "nerds" (*sic.*) who chose to gather in inclusive events that celebrate difference, accept individuals, and allow for expressive dancing and short periods of unusual or atypical behaviour (p 1844).[132] Subsequently, this description of ravers has been drawn on to explain the androgynous dress habits that are commonly seen at raves, and how this culminates ravers' actions and attitudes toward difference and uniqueness.[132] However, such extrapolation is potentially little more than a *cum hoc, ergo propter hoc* assumption, and should not be accepted at face value without further studies that either reinforce or refute it.

A further item of interest concerning the research about ravers is that sexual orientation is never mentioned. In fact, in the studies that were analyzed as part of this literature review, the ones that did discuss sexual contacts (frequency, type, and whether or not protection was used) never mentioned if these contacts involved males, females, both, or a mixture in dyads, triads, or groups (see for example, Lin[152]; McElrath[146]; Riley et al.,[133]). This leads to the speculation that either this information was not regarded as significant or useful by the researchers, or that these researchers were assuming that, unless otherwise specified, the ravers should be considered heterosexual. However, these possibilities were never confirmed. Thus, this major oversight (major when evaluated from the perspective of

using the research that was done on raves to inform research to be done on GCPs) further decreases the applicability of this research to this project.

Limitations of Using Rave Research for GCP Research

At this point, it is appropriate to address the limitations of using the research findings concerning raves to inform the study which is being presented in this dissertation. First, while studies on rave culture, its associated drug use practices and trends, and its sexual practices that occur in relation to party attendance and substance use, may provide some guidance for research on GCPs, the overall benefit may be limited because the research concerned with raves is not directly related to sexual orientation. Consequently, although this difference may seem slight, the fact that GCPs were created and defined in relation to the celebration of, and by, a particular sexual orientation makes this difference significant in limiting the applicability of the former studies on the latter. In practical terms, this means that, while raves and GCPs are both parties that have been created by non-mainstream populations, and that both of these parties involve a similar type of music and drug use, these two non-mainstream populations are markedly dissimilar. GCPs were designed by and for a subset of men who have sex with other men; raves seem to attract a more undifferentiated, non-mainstream grouping. Accordingly, a review of available literature on GCPs will now be presented.

Gay Circuit Party (GCP) Subculture

Moving beyond raves and specifically into a review of the research on GCP subculture, one can start with the formula that is proposed by Ghaziani & Cook[156] for describing the impact of the GCP subculture on STI/HIV diffusion. While this formula has no practical or mathematical application, it serves as an excellent summary of the previously identified areas of concern within the GCP. The theoretical formula states that one must

multiply the prevalence of risky sexual practices by the median number of parties per year, while considering the growing popularity of these parties and the number of attendees to estimate the likelihood of STI/HIV transmission. Visually, this formula could be represented as follows:

((Prevalence of risky sexual practice) x (Median # of parties))

This impact formula will be applied here as a means of structuring the literature review of this section. Each component of the formula will be addressed in turn: an overview (to situate the discussion), the history (to illustrate the growing popularity of these parties), a description of the participants, their drug use and the STI concerns (as the prevalence of risky sexual practices), the environment (as a compounding factor for the parties' growing popularity), and, finally, an analysis of a previously proposed framework for understanding the GCP phenomenon.

Overview

As was stated in Chapter One, GCPs can be defined by their physical characteristics as multi-day gatherings of tens of thousands of gay and bisexual men in diverse venues that incorporate intricate light shows, unique dress codes, live disc jockeys, and various other live performances.[3,156] However, the GCP is a difficult phenomenon to define precisely because the absence of a rigid definition is part of its attraction. It is forever changing, and continually providing new forms of excitement. The only characteristics that remain constant are: it is a gathering of predominately gay men at a thematic disco-type party, in the same city, each year. While these parties strongly resemble raves, the main difference arises from the fact that GCP are legally sanctioned, typically occur in larger venues, and can attract upwards of 25,000 self-identified MSM. One particular party in Montreal, the Black and Blue Festival,[157] has an average attendance of 80,000 individuals over the course of seven days;[156] in fact, this GCP festival has been identified as the city of Montreal's second largest

source of tourism income.[156] A second difference between raves and GCP is that the average age and socio-economic status of attendees at the latter are significantly higher.[101] Raves are more often attended by youth, while young to middle aged adults more often attend GCPs. Additionally, differences in drug use have been observed between the two types of party: drugs such as ecstasy are used extensively at raves, while within the GCP, a broader scope of party drugs (crystal meth, ecstasy, ketamine, and GHB) are more popular.[1]

History

In addition to GCPs being defined by their physical attributes, there is an even broader psychological and socio-cultural definition that helps to explain why the GCP culture has grown in popularity over recent years.[3,4] Despite the fact that it was still illegal in the United States for gay men to congregate,[158] in 1977, Corbett Reynolds, the man attributed as the founder of the GCP movement, created what he called a one-night party to end all parties in Columbus Ohio. From this, the idea of creating a gay space where men could celebrate being gay came into existence. This first party, which became known as the Red Party, continued annually for 25 years, until the death of its creator.

In the 1980s, as anti-gay discriminatory laws were being abolished and gay men were provided with areas in which to congregate and express a gay lifestyle, GCPs began to emerge worldwide, but especially in North America.[158] Since this time, the cities in which these parties are now held have become popular gay travel destinations. However, the popularity of the GCP did not increase continuously over the past thirty years. In fact, after steadily gaining in popularity in the late 1970s and early 1980s, the advent of HIV/AIDS caused a dramatic decrease in attendance, which was followed by a resurgence in the mid-1990s.[1] Shortly after the death of Corbett Reynolds, many GCPs began to function as a

means of raising money and awareness for HIV/AIDS; a cause that many continue to support to this day.

Over time, these parties have become more than just social gatherings; they have expanded into a symbol of freedom for the gay community[156] and a GCP may very well be the largest aggregation of gay men that an attendee will ever see.[159] The GCP attracts gay men as a safe place for cultural identity within mainstream society's heterosexual hegemony.[159] It is a carnivalesque reversal:[160] a celebration of the stigmatized.[100] Many attendees report feelings of friendship, family, community, and bonding, and because this is an escape from the classification of abnormality, attendees report feelings of disinhibition because they are allowed to be themselves.[100] Therefore, while being a celebration of gay men, the GCP might be more precisely designated as a celebration of a particular type of gay man.

Participants

For a variety of reasons, attending a GCP is expensive. First, many participants must travel great distances to reach the specific destinations, and then must stay in hotels.[101] Secondly, GCP ticket prices are not cheap. For example, tickets for the Black and Blue Festival range between $80 CAD and $600 CAD.[157] Therefore, it is not surprising that recent studies have found that the education and socio-economic levels of many GCP attendees are above the North American average.[161] Participants are typically twenty to thirty years old, Caucasian, university educated, and have mid to upper-class backgrounds.[156] Additionally, a disproportionately large number of attendees (approximately 25%) are HIV sero-positive,[156] and a further disproportionate number of the latter reported using drugs during their GCP experience: 21% of HIV sero-positive men reported using drugs in contrast to only 9% of HIV sero-negative men.[27]

Apart from being costly and disproportionately attended by HIV sero-positive MSM, GCPs have become places where "rules don't apply, boundaries are non-existent, and physical perfection is demanded" (with this quotation being the "tag line" for the movie *When Boys Fly*[162]). These parties have become places that attract individuals who have become labelled "A-gays"[163] and their admirers, those who aspire to be part of their group; as such, GCPs have evolved into a social phenomenon within the gay subculture of the A-gays: a place of socialization, making friends, and being in a gay friendly environment. A-gays, also known as circuit boys or circuit queens, are relatively young, have youthful appearances, good looks, hard muscles, and the trappings of prosperity, which include expensive cars, clothes and drugs. They dress in athletic pants and tennis shoes, are tattooed with tribal insignia, hold onto a glow stick, and are often surrounded by a clique of other gay men; they also dance for hours or days, under the influence of recreational drugs.[100,156]

The GCP dance floor is filled with stereotypically hyper-masculine-looking men who intermingle and intertwine in a vast network of non-stereotypical masculine gestures and embraces.[164] In addition, scantly clad *go-go* performers, some of whom are gay porn stars, dance on risers and pedestals.[165] According to Westhaver,[100] although it is done independently and at separate locations from the GCP, pornography is filmed during the course of these events because these parties bring together a large collection of attractive men.

Drug Use and STI Concerns

Although they are now generally held with the purpose of HIV/AIDS education and prevention, GCPs have become known as nexuses of drug use and sex, and ironically, these parties have become a site for HIV transmission.[1,3,4,5,156,161] Findings have repeatedly indicated that, within the GCP milieu, drugs (especially party drugs, such as crystal meth) are taken extensively by well-educated and highly functioning individuals,[120] and

furthermore, that the use of crystal meth has been implicated in an increase in risky sexual practices. According to Tong & Boyer,[101] 80% of those surveyed used drugs during GCPs, and 25% reported an overdose during the previous twelve months (not specifically within the context of a GCP, however). The drug taking patterns of these users have been identified as primarily episodic, rather than continuous and such practices seem to be more prevalent during GCPs. [4,5] Mattison et al.,[4,5] speculated further that drugs might provide a "scripted" release from internal, social, and peer group norms, resulting in more autonomic practices because an awareness of consequences is diminished.

Gay men who are not as physically attractive as the A-gays at the GCPs report feelings of inadequacy caused by the latter's presence at these events.[166] As a result, some non-A-gay men have begun engaging in activities such as drug use, and bug-chasing, (an intentional search to become HIV seropositive) that will enable them to join the culture.[166] Such activities, while apparently extreme, offer not only the possibility of joining the desired group, but also of enjoying the benefits of prescription medications such as human growth hormones, which can accompany HIV antiretroviral treatments. Thus, these parties trigger feelings of inadequacy among the less attractive participants who may then engage in risky practices such as drug use and sexual escapades (in which they might not otherwise indulge) in order to keep up and "party with the big boys"[100] (p. 362). However, while sexuality is blatantly promoted as part of the GCP, unsafe sexual practices are not.[161] As a consequence, there has been speculation that problems may arise when feelings of community and trust conflict with the perception, common among gay men, that condoms signify distrust.[100]

The GCP provides a means for participants to avoid loneliness, deal with aging and illness, and allow for sexual variety and freedom.[1] However, in addition to the men who report attending GCPs for social reasons, there exists a subgroup whose attendance is motivated by sensation seeking; it is this group that is most likely to use drugs and engage

in sexual practices while high.[167] While one eighth is a relatively small fraction of the participants, when this percentage is applied to an average attendance of 25,000, it results in a population of roughly 3,000 who attend GCPs with the conscious intention of combining drug use and unsafe sexual practices.

Environment

Music has a strong physiological and psychological effect on listeners. It has been employed to reduce stress and anxiety in surgical patients,[168] and has also been shown to increase satisfaction during exercise.[169] In addition, there is a growing body of research on the effects of the recent increase in the popularity of repetitive beat (i.e., dance or trance) music. According to Gerra et al.,[170] dance music causes marked physiological and neuroendocrine changes in healthy individuals: regardless of a pre-existing music preference, fast, repetitive music incites a noradrenergic response, often called the stress response.[170] Gerra et al.[170] also reported that fast music induced an increase in norepinephrine levels in listeners. There were marked changes in heart rate, respiratory amplitude and skin temperature, pain threshold, and anxiety levels. Furthermore, Stepcoe & Cox[171] found that during physical exercise, music increases endurance, and ameliorates performance perception.

The effects of this physiological "high" from dance and trance music have also been reported in Dublin and New York City where there has been a recent trend in its use in dance clubs in which drugs are strictly prohibited. Such venues have been reported/promoted as "a more healthful way [than drugs] to open up into the altered states of awareness which dance and music can bring you to"[172] (p. 52). For some individuals, beat-driven music combined with dancing has become a new form of meditation, in which the repetitive movements of the fast paced music are capable of inducing physiological highs.[172]

The loud volume of the music at GCPs has been identified as a factor contributing to the sexuality/physicality of the environment. Drug use, in conjunction with loud music decreases the effectiveness of verbal communication, not only in transmission, but also in thought formulation and structure.[100] When the ability to hear vocabulary and tone of voice is severely diminished, body language becomes dominant. Consequently, when non-verbal communication and the physique are the easiest forms of communication, physical attractiveness becomes of the utmost importance and beauty becomes power.

Furthermore, Westhaver[100] proposes that emphasis on the physicality and sexuality of the body leads to a loss of self-awareness. Sexual pleasure induces a loss of subjectivity – a state in which the subject seemingly dissociates from the body. This loss of the self has also been associated with large crowds. As has been observed in mobs, a large group can reduce an individual's sense of self, resulting in a decrease in the normative behaviour of psychological and moral constraints. This also leads to an increase in the likelihood of physiological arousal and impulsive, atypical, and non-normative actions. As the individual is absorbed into the larger organism that the group represents, and becomes only one small part of it, a sense of both reduced accountability and reduced self-awareness occurs.[156] Therefore, the combined attributes of loud Table 3.1 illustrates the relationship proposed by these authors.[156]

Main Agents	**Mechanisms**	**Mediating Factors**	**Outcome**
Behavioural Expectations	Pharmacology	Cognitive Distortion	UAI
Cultural Meanings of Drugs	De-Individuation	Libido	
Dance Floor	Social Connectedness		
Sexual Expression			

Table 3.1 Ghaziani & Cook's[156] Outline of GCP Framework

According to Ghaziani & Cook[156] many men attend GCPs with the intention of having sex, but not with the direct intention of engaging in unsafe sexual practices. The combination of the molar agents (which are present both prior to, and during the dance party) produces a stage for the GCP. It is the dynamics of the dance floor, the expectations with which participants arrive, and the models of sexual activity that are present within the erotically charged crowd that promote the creation of social connectedness and its associated loss of self. Further increases in libido and cognitive distortions occur with the addition of drugs. According to these two authors,[156] unprotected anal intercourse results as the end point of this.

However, the sequence proposed by these authors results[156] in a Markov chain explanation for sexual practices, and relies on the assumption that individuals unintentionally engage in unprotected sexual practices. Such an explanation, while useful for presenting the interactions of relevant factors, may over-simplify an intricate process, and overlook the underlying nature of eroticism within these contexts. As can be seen in this literature review, the GCP is a complex, and often conflicted phenomenon, which requires further in depth study of its multiple factors to arrive at a useful, practical, and practicable understandings both of its associated population and of the associated sexual health problems at an individual level.

Chapter Four – Methodological Considerations

Introduction

An outline of the ethnographic process that structured the description and analysis of the environment of the GCP as a collision and intertwining of sex, space, music, movement, and bodies is contained in this chapter. Building on the general overview of the GCP provided in Chapter Three, this section describes the actual research methods utilized in this project. First, the research setting is described. Then, the data collection methods of direct observation, mute evidence collection, self-administered questionnaires, and interviews are delineated, followed by a detailed account of the criteria of rigour and the process of analysis.

Ethnography

In its broadest sense, ethnography is a form of social research[173] with sociological and anthropological roots.[174] Its objective is to describe and interpret a specific culture or social group. For a study to be called ethnographic, a large proportion of the following four characteristics must be present: (a) the study is undertaken to explore social phenomena; (b) the collected data is coded before collection is complete; (c) the number of cases studied is small, with the potential for studying only one case; and (d) qualitative analysis is used to interpret the meaning and functions of human practices.[173] Regardless of the subtype or school of ethnography that is being applied (e.g., functionalism, symbolic interactionism, cultural and cognitive anthropology, critical theory, or poststructuralist),[175] the basic elements of ethnography as the study of people's lives over a prolonged period of time through direct observation, interview, and mute evidence collection remain approximately the same.[55] The variance of these approaches can occur within the rationale for undertaking

the study, the exact methods of application of these data collection methods, the analysis of the collected data, and the emphasis placed on the truth-value of the findings. Nevertheless, all forms of ethnography serve to produce a cultural portrait: an overview of the entire culture that is obtained by pulling all of its parts together while respecting the nuances and complexity of its systems.[175] For this project, ethnography appears to be the appropriate methodology because, on the one hand, the GCP subculture constitutes a community in itself, and on the other, the proposed research questions require an exploratory, qualitative design. Moreover, an ethnographic perspective will allow the gathering of crucial information regarding the architectural and design features of the GCP while promoting an investigative sensitivity to how these features influence behaviour.[174]

According to Grbich[173] ethnographic studies can be divided into three categories: classical, critical, and poststructural; this project employed the last of these. At the outset, it is important to note that the form of ethnography developed by Leininger[176] was rejected precisely because her approach is classical/critical in form. Instead, the poststructuralist approach, with its associated decentred position and greater emphasis on language and the discourse of power relations as they apply to the researcher, the researched subject, and the construction of each of these two concepts was used for this study. By applying poststructuralist conceptual methods, the notion of power changes from a belief that is stable, and is imposed by A onto B, into a function that arises from the social interaction between A and B.[58] This notion of power *between* rather than *over* is an outright challenge to the contemporary definition, which is understood as a relatively stable attribute with which certain individuals have been vested (whether inherently, deservingly, or improperly) and thus hold over others.

Furthermore, poststructuralist researchers believe that those who subscribe to the other two schools of ethnography overlook the importance of the investigators' subjective influences on any results, and assume that these individuals possess omnipotent and

objective viewpoints.[173] Classical and critical ethnographies view a community under analysis through the cultural lens of the dominant social group, and in doing so, may further marginalize a particular group and its practices by measuring differences as defined by the mainstream cultural *norm,* instead of describing the significance ascribed to observed practices by the collectivity being studied,[177] as exemplified by the different values allotted to silences and avoidances in different cultures. In classical and critical ethnographies, these omissions may be deemed insignificant; however, for poststructuralist ethnographers, such gaps illustrate an important aspect of the culture: silences speak as loudly as voices, and avoidances are as important as practices.[173] The poststructuralist ethnographic approach challenges many traditional methods of knowledge development, and rejects the findings of researchers who claim the high level of objectivity purported by classical and critical ethnography.[173]

Another assumption of mainstream science that is challenged by poststructuralist perspectives is the quasi-religious notion of enlightenment. Under this belief system, each time a problem is solved, there will be one fewer, until none remain. In contrast, the poststructuralist approach is based on the idea that the solution of one problem will generate others.[45,46] By rejecting the notion of finding the true answer, it is the poststructuralist ethnographers' intention to allow the voice(s) of marginalized populations to be heard (rather than to speak their words for them), while at the same time recognizing that this is not entirely possible because the act of asking a question always affects its answer.[178] How the question is asked, why the question is asked, and where the question is asked all influence the response to it. By focusing on a phenomenon, the researcher invariably changes it, even when doing nothing more than watching an object and making it aware of this observation. As Foucault[58] illustrated, this is a means of behaviour modification. Poststructuralist ethnographers believe that cultural analysis must also include an unravelling of texts and competing power discourses.[179] There is also the assumption

within the poststructuralist paradigm that patterns do not exist outside the research setting; that which may appear to be a pattern to the researcher is only a pattern within the context of the research, and lasts no longer than the research process.[44] This means that if a researcher finds a pattern, he or she must be disregarding the subtle differences that make the pattern aperiodic. This politics of difference posits that every difference is unique, that is, each difference is different from every other difference. Therefore, the only possible similarity is that each difference varies.[180]

Foreshadowing

The first step of the ethnographic process was to foreshadow problems through a comprehensive review of the literature (undertaken in Chapter Three). While some qualitative researchers argue that a literature review should not be done until after data collection is complete,[181] from a poststructuralist perspective, the researcher's personal knowledge affects the data regardless of foreshadowing. Therefore, foreshadowing no more constricts research than does a researcher's pre-existing personal beliefs. As an already socialized adult, the researcher cannot be a *tabula rasa* who allows the research results to be attained in an unbiased fashion. Consequently, both academic and non-academic sources were reviewed whenever possible.[48]

Furthermore, to impose the notion that academic learning is the pinnacle of knowledge and to exclude the common knowledge that exists in newspapers, public health department reports, and Internet postings would be to de-legitimatize the realities of those individuals who were interviewed, and to impose the belief that only academia is capable of accurately interpreting reality. This would have applied a paternalistic approach to the process, and have been a contradiction to the poststructuralist principles of pluralism and multivocality that guided this research. Viewed from this perspective, scientific literature is not the highest-ranking form of understanding, but rather, is as much a part of the social,

political, and public health constructions of GCPs as are all others forms of knowledge. By including a variety of sources that are both academic and non-academic, and from various disciplines, this research strives to become a voice for, rather than a description of, a marginalized population.

The next step in this ethnographic research was a meticulous collection of data regarding context, group beliefs/attitudes, social organization, language, rituals, social control, events, behaviours, actions, and practices.[173] Since the major critical theory construct of subjectivity stresses the importance of primary data sources, both direct observation and participant interviews (formal and informal) were used to gather first-hand data. Various unidirectional and interactive sources, such as, quotes, stories, legends, artistic and visual representations, ideally gathered from primary sources, were also employed.[182] Secondary sources consisted of anything that forms part of the GCP; pamphlets, newspaper articles, posters, policies, and laws were all analysed.

Research Setting

As a culmination of the underlying factors affecting human responses and their resultant observable practices, GCPs constitute a privileged setting for educational programs and STI/HIV prevention strategies, that is, the ideal location in which, and from which, to develop nursing knowledge as it relates to GCPs. Therefore, this research project was conducted within the contexts of two GCPs held on New Year's Eve and New Year's Day, 2006/2007. Studying two parties, rather than one, made it possible to observe a broader range of physiological states, depending on how long each individual had been participating – partying for one, or two nights, consuming varying quantities of drugs, and awake for any number of hours. Additionally, the two parties afforded a greater opportunity for the recruitment of individuals for the various methods of data collection.

Entering the Field

Since GCP organizers invest both time and money in drug and sexual health education (both at their events and through charitable donations to HIV/AIDS organizations), it is important to emphasize that the intention of this research was not to gather data that could eventually be used to close these parties. Rather, the goal was (and continues to be) to provide a voice for a specific population in the face of current public health initiatives and to provide GCP organizers (of both this target GCP and others, as well) with new information that they can use to address issues connected with unsafe practices. This, however, proved to be more of a challenge than had been anticipated due to a previous encounter that the specific GCP organizers who were being targeted for this research had had with researchers approximately twelve years ago.

This difficulty manifested itself in the following way: Initially, requests to meet were not declined, but ignored, a fact that made entering the field for this project quite difficult. However, to ultimately gain access and undertake this project, a fellow classmate informed me that he knew one of the *go-go* dancers at the targeted GCP, and he referred the researcher to this dancer. After a few months of discussions with this dancer, he contacted the physician who is responsible for health promotion and medical care at a certain subset of GCPs. After repeated meetings with this physician, he put forth the researchers name with recommendation to the GCP organizers, who, for the first time in twelve years, granted a second researcher permission to undertaken research at their parties.

Data Collection

Because this project was undertaken as ethnographic research, it gathered information about the environmental aspects of history, culture, gender, and sexuality. Much attention was given to the environment, social interactions, and the culmination of all the physical/non-physical and vertical/horizontal connections that produced the overall

ambience of the GCP. Directionality (horizontal and vertical) is specific to descriptions of equality and inequality; time (vertical), history (vertical), competing histories (horizontal within a vertical layout), and sexuality (specific sexual practices are both horizontal and vertical depending upon the varied organs involved and the relative dominance of the sexual position) are all examples of this concept.[62] Therefore, based on these principles, data collection occurred through direct observation, through auto-administered surveys, and through formal interviews.

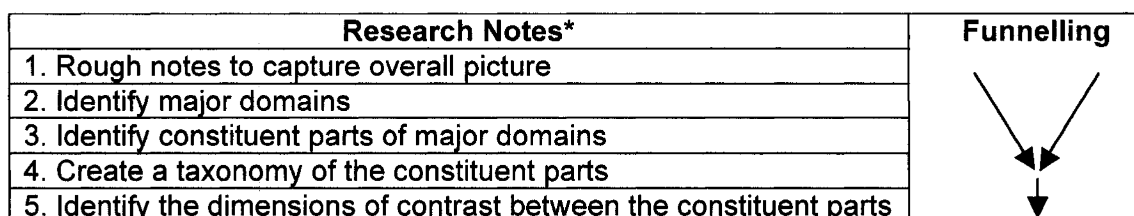
Direct Observation

Direct observation to capture natural interactions within the context of the GCP was the first method of data collection.[55] However, during this process of direct observation, there was a probability that the attendees would modify their behaviours depending on whether they immediately identified the researcher as an outsider, or not. This possibility undoubtedly influenced the outcome of the research results.

Following the directions of Fontana & Frey,[183] the researcher, regularly and promptly, but inconspicuously, recorded these observations as field notes. This ensured the contemporaneity of the notes, while potentially reducing the behaviour modifications that may arise when an individual or group is alerted to overt observation. Consequently, to ensure that the interactivity between the research and the researched was addressed throughout all phases of the project, data collection was undertaken with the assumption that the data were created through both the researcher's paradigmatic lens of critical theory and his beliefs as they interact with the GCP. Therefore, field notes were not documented separately from the data being collected, but were written in conjunction with them to illustrate that research findings and personal feelings interconnect inseparably to produce research results. Furthermore, because field notes should record everything that occurs (no matter how unimportant it may seem at the time) to provide the researcher with a larger

base for analysis, explicit notes were written immediately after an interaction had finished because note taking during the communication process would have been too conspicuous. Please refer to Appendix A to see the ethnographic data collection chart. Each hour, the researcher left the research booth to commingle with the GCP-attendees, and then returned to the booth to inconspicuously record what had been observed. This chart was filled out each hour at the GCP to capture chronological changes, such as, the effects of drug and alcohol over time.

In addition to Appendix A, unstructured research notes were taken. This process started with broad observations, and became more specific with time – that is, after the global picture had been noted, more observations were made to further particularize the preceding observations.[173] This funnelling process is illustrated in table 4.1.



Research Notes*	Funnelling
1. Rough notes to capture overall picture	
2. Identify major domains	
3. Identify constituent parts of major domains	
4. Create a taxonomy of the constituent parts	
5. Identify the dimensions of contrast between the constituent parts	

Table 4.1: Data Collection and Analysis Methods

*It is important to note that the linearity of Table 4.1 illustrates the observational methods as being consecutive. While this may be the case in print, during the actual research process, as the major domains (step 2) were established, identification of the constituent parts (step 3) was already underway. Thus, all five steps were undertaken somewhat simultaneously, and provided feedback in both an upward and downward direction.

As indicated by Table 4.1, the initial observations of the GCP were made with the *large picture* as the goal. While such an exercise is usually associated with visual data, all senses were employed – especially auditory, since music is an integral aspect of GCPs. The research notes comprised two parts: 1. a rough sketch of the interaction between individuals, and 2. an identification of the *major domains* of the data. The next item consisted of parsing the large picture into its constituent elements in a process called *focused observation*,[173] including roles, interactions, and clothing. This process identified

items of significance to the researcher, which provided reference points (qualitative probes) for the semi-structured interviews. After this, the data were further differentiated (funnelled) into a *taxonomy*, called the *selective dimensions of contrast*: items that seemed identical were compared based on a changing variable that was present in both – for example, GCP attendees who took drugs, and the locations where these drugs were either obtained, or consumed. The constant factor in this example is drug use; the variable elements are the location of drug acquisition as one example, and the location of drug use as the other.

Mute Evidence

Because of its importance, complexity, and potential for being ignored or overlooked, mute evidence has been addressed specifically. By definition, mute evidence is anything that is unable to speak, but which combines with other objects, both animate and inanimate, to produce an identifiable culture.[184] Historically, ethnography has used cultural artefacts to gather data.[184] Since cultural artefacts pre-date the event and persist beyond it in time, their effect on the event was addressed as both essential to, and inseparable from, the creation and definition of the GCP.[184] In this study, handouts provided at the GCPs, websites dedicated to the event, main-event programs, posters that adorned the walls at the GCP, and documents such as those found in public health departments, as well as articles in local newspapers (for both the gay and heterosexual communities) were collected.

Self-Administered Questionnaire

Non-probability sampling created a convenience sample, and thus, may not be representative of the entire population. It cannot be over-stressed that the purpose of the questionnaire within this research project was not to create inferences, but rather, to facilitate recruitment of interview participants, therefore, making representative sampling unimportant within this context. The sample was created from individuals who self-selected to complete a questionnaire. Nevertheless, these surveys were self-administered and

anonymous to decrease the likelihood of the Hawthorne effect – the effect of desired answers being given when an individual suspects that he or she is being observed. As part of the questionnaire, the participants were asked to report their socio-demographic data, such as, age, gender, self-defined sexual preference, income, education level, occupation, employment status, ethnic origin, language preference (Francophone/Anglophone), partner status, preferred sexual practices, frequency of visits to GCP, number of anonymous partners, preferred locations for sexual activity, the reasons for this preference, drug use, and drug preference. Please see Appendix D to review this survey.

Interviews

The fourth and final method of data collection was interviewing. However, because this project is situated within a poststructural ethnographic perspective, these interviews were not a formulaic means of acquiring information in an "ask-and-know" format, but rather, they were constructed interactions.[183] The interview process is not an unbiased one, and cannot be equated to an objective measurement tool because it is an interaction between at least two parties.[183] Moreover, the interviewer creates the situation by designing the project, initiating the interview, and addressing the topic. This constitutes one of the aspects of the power differential that exists between the role of the researcher (active, seeker) and the role of the participants (passive, sought after). It also illustrates that the area under study has been subordinated to the researcher's perspective. Poststructuralist researchers argue that to claim that a researcher's feelings do not interfere with the research process is to view research as a theoretical rather than practical process; they believe that as soon as interviews take place, the feelings, beliefs, and subjectivities of both the researcher and the participant combine to construct the data.

Furthermore, the socio-economic status and language of both the interviewer and the interviewee, and their separate (and combined) reactions to these factors, all affect the

results of any interview. Within the poststructuralist framework, language is seen as constructing reality, and is, regardless of intention, always open to ambiguity and interpretation.[50] Consequently, a difference in cultural background between the researcher and the research participant can present a major problem in any study involving interviews. Within this theoretical framework, language is not an objective descriptor of reality. Created by the specific background of the individual, it is one of the many means by which personal reality is sculpted, and also one of the means by which hegemonic power structures are maintained. In this project, the problem of language was compounded by the fact that much of the vocabulary described the sexual practices of the subjects. It has been well-documented that the choice and use of words connected with sexual practices goes beyond a mere recounting of these practices to include not only a more global description of the individual's sexual identity, but also an expression of this identity within society.[58] Therefore, all terminology was clearly defined during each interview. Moreover, because this project was explorative, open-ended questions facilitated a discussion about desire, drugs and unsafe sexual practices.

Informal Interviews

Informal exchanges, which occurred within the context of the GCP, expanded the quantity of data collected by direct observation. These spontaneous interviews arose when individuals approached the researcher; they were then recorded in the field notes immediately after the fact. Refer to Appendix A for the field note guide. In contrast to the formal interviews which were semi-structured in style, but unavoidably framed by the formal academic settings within which they took place, the informal interviews were extemporary, *in situ* exchanges between GCP attendees and the researcher. However, while the informal interviews were recorded, Hammersely & Atkinson[55] warn that unsolicited information is of no greater validity than any other type of information.

Formal Interviews

Formal interviews were also a part of the research process; they were conducted at a later date, at other sites. During these interviews, participants completed a self-directed questionnaire, and took part in a taped, in-depth, semi-structured interview, which lasted approximately one hour. The goal was to continue interviewing until the interview material being presented no longer provided new information (data saturation) – the method for measuring this is addressed in the following section on data analysis. Participants were selected according to the degree of information they were willing to share, their socioeconomic status, and educational background, etc; in addition to this, an attempt was made to include ethnic diversity in the sample.

To accomplish these interviews, open-ended questions were used. This method has been accused of having two major shortcomings: 1. that the researcher answers questions asked by the interviewees and 2. that the personal opinions of the researcher interfere with the research process. However, it has also been argued that these two pitfalls are, in fact, major benefits of this method because answering interviewee questions, instead of stealthily attempting to evade them, augments the rapport and trust between the interviewer and interviewee.[183] Since an interview is an interaction between two individuals, and the purpose of the semi-structured interview is to gain a better understanding of the subject, the interviewer and the interviewee must communicate openly.

Furthermore, the feminist approach to interviewing, which requires greater openness to the interviewee, the engagement of emotional issues, and the development of trust was employed. This personalization of the interview process has the potential to redefine the interview context, and equalize the power differential between the interviewer and the one being interviewed[183] because this closer relationship reduces the power disparity and the unidirectional structure present in the standard interview.[183] In this case, it allowed the interview to wander into areas that the interviewees chose.

Recruitment for the Formal Interviews

Formal interviews were conducted with individuals who attend GCPs, use drugs, and engage in risky sex. Since MSM who frequent GCPs also frequent other sexually charged areas designed to facilitate sexual relations between men,[21] recruitment for this study was not restricted to the target GCPs; it also occurred in other types of communal settings, using direct recruitment, poster distribution, and snowball sampling methods. Posters were placed in bathhouses, gay bars, clubs, and gyms, and sexual health clinics in Ottawa, Montreal, and Toronto, three of Canada's biggest cities, which have the largest urban Anglophone and Francophone populations. These cities allowed for greater cultural diversity within the interview and ethnographic sample. Furthermore, two of these cities host the largest GCPs in Canada.

To accomplish the snowball sampling, interviewees were given the researcher's contact information, and asked to pass it on to other individuals whom they believed would be interested in participating. This recruitment method has been shown to be effective for *infiltrating* a group that engages in marginal practices.[185] A phone number and an email address were printed on all posters and the researcher's University of Ottawa business cards were distributed at the GCP. By making contact information readily available, it became the individual's prerogative to initiate the semi-structured interview process. Because researchers have an unwritten socio-economic power over research participants, the time interval between the individual's first contact with the researcher and their second allowed any possible feelings of obligation to participate in the study to dissipate. That is, the time lapse allowed individuals who are less likely to actively resist the invitation of a researcher to decline the project passively without any negative consequences (e.g., the anxiety caused by saying no to someone who is in a socially constructed position of superiority or power). There was also the possibility that during the GCP attendees were under the influence of alcohol or drugs;[10] therefore, no formal interviews took place at that

time. The self-administered questionnaires that were completed at the GCPs were also used as an additional means of recruiting individuals to participate in the formal interviews.

Data Analysis

According to Hammersley & Atkinson,[55] ethnographic data analysis is not a linear operation; it is a circular process that starts informally during the pre-fieldwork phase, and from this ambiguous beginning, starts to take form with the advent of field notes. In its characteristic funnel form, the data analysis and the research design fed into one another to produce the final results of the research. However, ensuring that this process is interactive and not linear demands diligence,[55] and requires the researcher to be forthcoming about his/her theoretical perspective at the outset of the project and to accommodate potential changes that may arise from the focusing of the research project through data collection. In this project, four methods of data collection were used: direct observation, mute evidence collection, self-administered questionnaires, and interviews. As has been noted in Table 4.1 (page 92), data collection and analysis were simultaneous procedures: as new information surfaced, it was analyzed and then used as a lead to collect further information. In this manner, data collection and analysis were not two independent phases, but rather, two interrelated steps that helped to focus and funnel the entire process toward the final results.

Direct Observation Field Notes and Mute Evidence

Direct observation field notes and mute evidence were analyzed continuously throughout the research process. In addition, the same methods were used; therefore, an overview of the analysis techniques for both of these data collection is presented together here. To begin, as a first step, mute evidence collection was initiated prior to entering the field. This helped provide an understanding of how posters, Internet postings, and media descriptions and comments viewed and presented the GCP sub-culture. As part of the

analysis of the mute evidence, it was important to determine the target audience, the time at which the artefact was created, the anticipated outcomes of the item, and the relationship between the created artefact and its recipient. Furthermore, while also used to foreshadow this research project, scientific literature constituted a form of mute evidence. Thus, the scientific portrayal of individuals who engage in practices that increase their likelihood of acquiring STI/HIV was used as both a privileged form of knowledge and as a cultural artefact that facilitated the comprehension and construction of the overall understanding of this culture.

Furthermore, the field notes were analysed at regular intervals because, while having a large quantity of data may be beneficial during the analysis phase, undifferentiated data needs to be analysed frequently to enable the researcher to notice trends that had been previously overlooked during the initial recording stage. This allowed for the gathering of more specific data on a topic during the initial research phase rather than returning to it after data collection had finished.[55] While it could be argued that the funnelling process unavoidably skewed the results of the research – due to observational biases – the poststructuralist approach to data collection holds that since all data are interactively created (thereby biased by the researcher) the concept of objectivity is unrealistic, and thus, unimportant. Consequently, researchers should be forthcoming about their theoretical beliefs and the frameworks within which they work and to which they subscribe to counteract this inherent fallacy. Therefore, the theoretical basis of this dissertation has been explicitly and thoroughly explained in Chapter Two.

Self-Administered Questionnaire

The collected survey data were subjected to univariate analysis using SPSS; indices of central tendency (means, medians, and modes) were applied to continuous ratio-level variables, such as, age and number of sexual partners, and then frequency distributions

were then established for the nominal and ordinal level variables of education, sexual orientation, gender, occupation, employment status, and language. Such information was useful in describing the socio-demographic background of GCP attendees, but beyond that was not applicable within an exploratory, qualitatively based, ethnographic study. Therefore, the interpretations of this data did not include interferential statistics, but remained as descriptive calculations of the sample. To review this information, please see Appendix G.

Interviews

Guided by the research questions and theoretical framework, consecutive, or constant comparative, analysis structured the analytical process, and was employed after every interview to guide the questions for each subsequent interview. To accomplish this task, each interview was transcribed and coded based on an analysis of the interview content; that is, codes were assigned based on the content of the statements, the overall meaning of the interview, the language and sentence structures employed by the interviewee, and the general positioning of these within the larger political structure. This analysis included a line-by-line reading of the text, and a second reading to identify metaphors and content.[186] The metaphorical reading included a language and content analysis, which was performed within the aforementioned theoretical frameworks (Chapter Two), and focused on the themes of desire, drug use, and sexual practices. Once this was completed, the metaphors were linked together using the same theoretical framework. Because the research data were organized according to the perceptible characteristics of each participant as well the context of the interaction, the interview transcripts were first scrutinized separately, and then in combination.[187] The theoretical lens was applied to identify areas which were anomalous. These areas were not identified as more important than others, but were used to help focus areas of further exploration in subsequent interviews.

After the first interview, the codes were sorted and those that were similar were grouped into themes, and entered into a codebook – all subsequent interviews were coded based on this. (Please see Appendix F for a review of the outcomes of this coding process.) The goal of this coding was to reach a stable set of categories that were mutually exhaustive and inclusive.[55] All codes that were identified remained as part of the analysis, regardless of the number of times that the code(s) was/were presented by an interviewee. Themes that were expressed by a greater number of interviewees were assessed as being more central/common to the MSM group under study. To ensure the integrity of these themes, texts from various interviews were compared to ensure that the codes remained the same throughout the coding process. At this point, there was a search for cases that did not fit the model. These negative cases "either disconfirm[ed] parts of the model or suggest[ed] new connections that need[ed] to be made";[187] (p 165) these negative cases were recognized, and either accommodated or assimilated within the categories and themes.

As themes arose, they were added to the codebook and previous interviews were re-examined to see if the new theme had, in fact, been present, but overlooked. Such information was then placed on a grid (again, please refer to Appendix F), where the themes were listed along the vertical axis, and the interview numbers were listed along the horizontal. As the interviews progressed and more themes were introduced, they were added to the bottom of the vertical axis. Funnelling classified this data into the following categories: 1. Themes – global descriptions that encompass the entire situation at a highly abstract level; 2. Sub-themes – middle level classifications which describe a subsection, or a sub-population trend, at a partially concrete level, and 3. Categories – empirical indicators or tangible phenomena that are not predetermined by the research subjects' culture. Data saturation occurred at the point when the interviewees no longer introduced new concepts, themes, and categories.

According to the poststructuralist perspective within which this project is located, the influence of researcher biases as well as that of the emic position at the GCP was addressed at the outset of the analysis. Furthermore, at this point, the impact of the social authority of researchers and academics was also addressed. By analyzing these roles, it is important to acknowledge and reconcile that researchers are integral parts of their research processes and that their paradigmatic lenses unavoidably alter, not only the research data and results, but also the experience (in this case, the GCP) for everyone with whom the researcher interacted. During the analysis process, the researcher assumed the privilege of a distanced stance, which allowed for the identification of phenomena that might be overlooked by the GCP participants due to their proximity to them or because of their potential lack of interest in exploring, rather than experiencing them. However, at the same time, the researcher had to guard against the ethnocentrically biased stance of evaluating the GCP subculture against the white, heterosexual, middle class population. Two methods used to achieve this process were: to identify the researcher as belonging to this hegemonic majority, and to remain aware that all subsequent analyses were undertaken with this factor irrevocably incorporated into them.

Order of Analysis

The analysis began with the description of the theoretical perspective (Chapter Two) and a foreshadowing of the literature (Chapter Three). Once this initial description of the phenomena was completed, the researcher directly observed the GCP, reviewed the mute evidence, distributed self-administered questionnaires, and interviewed participants. The data collection and analysis of these four items, however, was not linear, but rather, was done concurrently. As the researcher identified novel themes, further foreshadowing occurred to ground the understanding of these topics. Based on this gathered and analyzed information, the initial explanations were modified as needed.

1. An initial description of the phenomenon was provided.
2. Aspects of the phenomena were investigated through foreshadowing, field notes, mute evidence review, self-administered questionnaires and interviews, documenting explanatory features.
3. An explanation was framed on the basis of analysis of the data, designed to identify common factors affecting the cases.
4. Further cases were investigated to validate and determine the exhaustiveness of the description.
5. The initial explanation was modified to accommodate and assimilate new findings.
6. This process was repeated until new cases continually confirmed the validity of the description (data saturation). [55]

Please note that while these steps occur in a linear fashion, all steps are circular and repetitive.

Criteria of Validity (Rigour)

An evaluation of research rigour helps to determine the reliability and validity of a study by evaluating its worthiness, strengths, and limitations. Traditionally, the four criteria of credibility, transferability, dependability, and confirmability are used to evaluate the rigour of qualitative research projects. For this project, credibility and transferability were applied, but dependability and confirmability were not considered. The first criterion, credibility (as the assessment of the truth-value of findings), was applicable to this project provided that this truth-value was not evaluated based on the type of data, or the methods by which they were collected.[55] In fact, credibility was used as a measure of the data analysis. It ensured that this analysis was undertaken in a manner that addressed the interaction between the data collection methods, the assumptions of the paradigm, the theoretical framework, and the consistency of the findings. Secondly, the criterion of transferability mandated a detailed

description of the research population and setting. This was done to allow for the possibility that these findings could be applied to similar groups who match the description of the research sample. In this specific case, transferability is not generalizability (inferring general principles from specific cases); rather, it is the criterion that stipulates that the sample be well enough described that the results can be transferred to another, similar group. The two remaining criteria, dependability and confirmability, were not applied because they do not support credibility within a poststructuralist perspective. Since poststructuralist ethnography is based on the assumptions of critical theory (i.e., reality is a subjective experience that creates, rather than discovers, research results as a process between researchers and research participants), applying these final two aspects of rigour would have violated the commensurability between the rigour criteria and the paradigmatic assumptions of this project. In other words, to say that these findings could be reproduced in a second study would be a direct contradiction to the interactive research paradigm within which this project was undertaken.

In addition, to maintain rigour within this dissertation, the concept of reflexivity, as defined by Bourdieu[188] was substituted for dependability and confirmability. According to Bourdieu,[188] reflexivity requires researchers to apply the analytical and critical principles of research data analysis to their own behaviours, beliefs, and reactions. This principle validated the research process by removing the myth that researchers are objective viewers and introduced an inclusion of *self* into the research process; the researcher was required to accept that the results were affected by his presence and that *merely* observing a phenomenon altered its existence and structure forever.[60] Therefore, to address this requirement of rigour adequately, field notes included a critique of the researcher's behaviour and feelings before the research began, within the research setting, during the analysis, and, finally, during the post-analysis phase. Furthermore, these critiques were analyzed in conjunction with the direct observations and interviews. Such reflexivity, through

the use of field notes, complimented the criterion of credibility, and allowed for a contemporaneous appraisal of a situation. An acknowledgement of feelings at the time that they appeared facilitated a more appropriate analysis of the factors that might have, in part, combined to produce the findings. Therefore, the use of field notes greatly enhanced the rigour of this research.

Ethical Principles

Ethical concerns with ethnography arise because it is a methodology involving humans and because of the unequal power distribution between that which sees and that which is seen – the observer and the observed.[55] Moreover, the associated potential negative outcomes are increased in marginal research because of the political nature of the subject matter and because the group under study may be vulnerable.[189] Therefore, the following sections address the ethical issues of researchers entering a GCP and the potential social repercussions of studying a subculture, which engages in practices that may be deemed immoral, risky, or dangerous. In the case of marginalized MSM populations, it is essential to be aware of these power inequalities. This final section is dedicated to addressing the ethical issues that arose within the context of an ethnographic study of GCPs. These issues are addressed as ethical concerns related to the presence of a researcher as an altering aspect of the GCP subculture.

Confidentiality

The first ethical concern is confidentiality, which applies to GCP organizers, attendees, and sponsors. First, confidentiality was assured by removing all identifiers that could link this dissertation with specific locations. Secondly, on-site confidentiality concerns (which may have arisen if GCP attendees were identified/targeted as individuals who engage in marginal and/or illicit activities because of their interaction with a researcher who

is studying drug use and risky sexual practices) required that data collection was inconspicuous and anonymous – on-site data collection was undertaken using codes to ensure that police and other authorities cannot/could not obtain any incriminating information from it.[190,191]

Confidentiality is also a concern for all individuals who participated in the in-depth interviews. This issue began in the recruitment phase: posters were located in discrete areas where individuals could feel free from observation. These precautions were taken to allow individuals to be interviewed without others knowing. The next concern addressed contact procedures for the in-depth interviews: participants were given the choice of a research cell phone number, or a university email address. Correspondence through both phone and email was not linked to names and all emails were deleted immediately after an interview was complete. However, since this was always a traceable path for email and Internet interactions, the inclusion of a research phone number allowed participants to circumvent this possibility.

Furthermore, confidentiality also was addressed during the interview process. First, interviews took place within closed/locked rooms at a predetermined location. Secondly, all interviews were coded alpha-numerically to identify city, date, and interview number. Thirdly, interviewees read and signed an informed consent regarding the nature of the interview – that is, as sexually explicit, and involving in-depth sexual inquiry.[189] Fourthly, participants were informed that they were not required to answer all the questions and that the interviews at any time. In addition, the researcher acknowledged that power relations may have prohibited an admission of reluctance regarding the interview questions, and was therefore alert, not only to verbal, but also to non-verbal cues of uneasiness, and then voluntarily revoked questions as needed. The retraction of questions was also included as a part of data analysis.[192] It is impossible to provide a clear quantifiable measure that was

used to judge relative participant ease, other than to say that it was a combination of research judgement and clinical nursing judgement in sexual health.

Invasion of Privacy

Another ethical aspect of this project that had to be addressed was invasion of privacy. While GCPs are organized with the purpose of fundraising for HIV/AIDS awareness, this should not be interpreted as an open invitation for researchers to freely enter the milieu. First, since GCP organizers are primarily concerned with participant enjoyment, allowing researchers to interfere in the festivities by observing, questioning, or directly interacting with individuals, allows a potential dampener into the party. For on-site issues, the most basic invasion of privacy could have occurred if the researcher had recognized a GCP attendee.[193] Such an individual might have been a work, personal, or social acquaintance who has not disclosed his sexual/leisure practices. However, no such situations occurred.

Political Concerns

In addition to the researcher's direct effect on the ambience of the GCP, there are also potential political concerns that could develop after the results are disseminated. If individuals interpret these findings to conclude that GCPs are locations of debauchery, drugs, unsafe sexual practices, and disease transmission, it could have significant social and political implications. Therefore, researchers must be careful in their portrayal of GCPs because findings that produce negative social reactions could elicit feelings of betrayal from the GCP organizers and attendees who cooperated with them.[182] Furthermore, unfavourable research results could also cause additional problems within other, non-MSM populations – for example, reinforcing the current level of complacency within a heterosexual population that sees itself as not-at-risk for STIs/HIV because such infections are "gay diseases".[194] Another political concern is that ethnographic methods have the potential for taking non-

vulnerable populations and marginalizing them, thereby making vulnerable those who had not previously been so.[195] For example, the study of a particular subculture and its risky practices could lead to political reprisal against this group, such as occurred with the advent of AIDS in the early 1980s, when public political discussion of quarantining gay men and immigrant Haitian populations occurred across North America and Europe.[196] In Canada, self-identifying as gay still results in prohibits an individual from donating blood.[197]

To address these political concerns, the principle of non-maleficence (any intervention, including research, must result in more good than harm) was applied.[189] This principle justifies the imposition of a researcher into a GCP for the purposes of health promotion and the provision of a voice for a marginalized population because "unless someone will walk the ethical tightrope, the only source of information will be the police department, and that's dangerous for society"[198] (p. 101). While risky, walking this ethical tightrope must be attempted to enable a more thorough understanding of the health beliefs and practices of GCP attendees and, hopefully, as a result of this research, GCP participants will be able to engage in activities that they enjoy while benefiting from the services that public health departments are able to provide.

Chapter Five – Results

Scientific sexuality [can] be publicized, but erotic sexuality [can] hardly be mentioned. Putting a percentage in front of the topic ma[kes] it speakable.
John H. Gagnon

Introduction

In this chapter, the observational, mute evidence, self-directed questionnaire, and interview results are presented. To facilitate this process, each data collection method is divided into subsections that provide a more detailed account. First, the observational data section describes the physical GCP location and the participants (data collection method one); then the mute evidence component comprises the popular literature, posters, and handouts that were presented at, during, or about the GCPs, which were attended for this research (data collection method two); the final portion encompasses the qualitative themes that arose from the interview data (data collection method three). Following this, a synthesis of research results is presented.

Data Collection Method One – Observational Data

A data collection tool, which regulated the time, place, focus, and attributes of measure for the observations, was used to maintain the rigour of the observational data. For a review of this tool, please see pages 91-93 (observational data collection overview), Appendix B (the specific data collection graph), and/or Table 5.1 (the completed data collection grid). In total, two consecutive (night-after-night) GCPs, both of which opened at 22h00 and closed at 12h00 (noon) the following day, were attended. Each party totalled 14 hours with a 10-hour break between them. In combination, these two parties were open for 28 hours of a 48-hour period. Within this time frame, there were 18 hours of direct

observation: ten hours the first night (22h00 – 08h00), and eight hours the second night (22h00 – 06h00).

Hours of Operation

Although these parties lasted for many hours, in-and-out privileges were not allowed; therefore, if an individual wished to stay for the full duration of a party, he could not leave at any time. Informal discussions with individuals at the GCP indicated that such restrictions on leaving resulted in: 1. decreased energy (due to hunger) because no food is available within the party, other than peanuts and chips; 2. an inability to leave the party to use or acquire more drugs; and 3. the creation of concealed means for passing illicit substances through the security check points in order to eliminate the need to leave.

In addition, it is of interest to note that in all of the interviews (both formal and informal), no one indicated that they shortened their partying time due to hunger, fatigue, or running out of drugs. In fact, some participants stated that their time spent partying was established based on drug use and that in accordance with this prerequisite a specific quantity of drugs were brought into the parties for consumption. The following two participants highlight the importance that drug use has for them:

> No, I go to the parties, I have drugs on me. If I meet somebody and they're like, you know, let's go party, can you get your hands on this? Then yeah, I always have it with me. (TO-1)

> I've had friends who went without [drugs], and at two o'clock in the morning they had enough; compared to us who are on drugs, at three o'clock; you're tired, pop another one. (Ott-5)

The above two participants highlight that they are not only capable of passing drugs through the security and pharmacist check-points, but also that they use them within the GCP. As was mentioned before, this behaviour was described during both the formal and informal interviews, but was never directly observed.

In addition, other informal interviews revealed that the participants calculated the required quantity of drugs based on the knowledge of how quickly they would consume them. In this manner, the use of drugs functioned as an alarm clock, which signalled when to leave the party. For example, in the above quotation the participant (Ott-5) explains that, without drugs, "at two o'clock in the morning they had [had] enough". However, due to the possibility of acquiring more drugs within the GCP, this signal to leave was context dependent; parties with a *good feel* would result in additional drugs being borrowed from friends, or purchased from a dealer at the party. While these practices were not directly observed, they were reported during the informal and formal interviews.

Physical Location

While GCPs may take place in locations varying from outdoor parks to arenas, because the studied GCPs occurred between December 31st and January 2nd, the cold weather mandated that they be held indoors. The selected milieu was a popular mixed gay/straight club situated on the edge of a gay village in a large Canadian urban centre. (This information was obtained from the club's website, but to maintain confidentiality, will not be reproduced in text, or cited.) Tickets for the first night cost $75 in advance and $100 at the door, and the second night cost $40 in advance and $50 at the door. This price difference was due to the fact that the first night was New Year's Eve.

Upon arriving at this location, the researcher noted that the club was identified by a sign displaying its name and insignia. Below this, two stainless steel doors opened onto a busy downtown street; a posted fire safety sign on these doors indicated that the club had a maximum capacity of 1200 individuals. Within, the club was painted a deep, flat, blood red throughout its entirety. A ticket booth was located directly in front of the entrance, with a ticket-identification and security stand to its left. Behind the security stand was a staircase leading to a landing where an optional coat check was located. A second flight of stairs from

this landing took attendees to the second security checkpoint. While the security guard on the first floor had verified tickets and age of majority, at this second security stand, individuals were systematically searched in an effort to ensure that no banned items entered the premises. Banned items included weapons, alcohol, illicit drugs, water, and food, to name a few. Also at this second stand, there were two police officers and a pharmacist, who, when drugs were found, would identify if the drug was a prescription medication, and if so, would further identify if it was one that should be allowed into the party. In addition, a sign that read, "If you have HIV medication on you, please inform in advance the security agent doing the search", was posted beside this second security checkpoint. This sign was intended to ensure that these medications could be given to the pharmacist before the search in an effort to prevent individuals from stating after the fact that undeclared drugs that were found during the search were for medicinal purposes. The presence of this sign indicates the organizers were aware that a proportion of the partygoers might be HIV positive. It also highlights that many individuals would remain at the party for a length of time that would interfere with HIV medication schedules, and that the ban on leaving the GCP and then returning requires that HIV positive participants bring their medications with them. The pharmacist left at 03h00, leaving the assessment of discovered drugs during the subsequent nine hours in the hands of the two police officers who were present at the security check. In addition, there was a staff complement of thirteen security officers during both observed parties. This was in contrast to the six security agents who routinely work when the club is open. Moreover, two circulating paramedics were on-site to address any emerging health related concerns.

Once past the security/pharmacist/police check, individuals entered the party. On this second floor, were a bar, two bathrooms, and a third staircase leading to the dance floor above. At the bar, one could purchase alcohol (beer, gin, vodka, whiskey, and rum), energy drinks (Redbull, Rev), bottled water or Perrier, Gatorade, Orangina, cranberry juice, and pop

(Coke, Pepsi, Ginger Ale, 7UP); the cost for a drink was $6.00 regardless of the beverage chosen. On one side of this bar was a nook in the wall that provided privacy from the passing crowd. A table was put in this space so that participants could complete the research surveys unobserved (Please see Appendix G for the results of this survey data). On the other side of the bar, was a vending machine that sold chips and lifesavers for $2.00 a packet. Beyond the vending machine were the two separate bathrooms that were used indiscriminately by males and females, despite the fact that one bathroom was equipped with urinals and stalls, while the other contained only stalls. Between the entrances to the bathrooms was a large spiral shaped container (approximately $50cm^3$) filled with safer-sex packages. These packages contained one condom, a package of lubricant, and a direction sheet with pictures and French text explaining how to use condoms. In addition, posters that warned against the combined consumption of GHB and alcohol were posted on many of the walls. As the last item on this second floor, directly across from the bar on the second floor was a staircase leading to the third floor.

On this third floor, the lights were dimmed, partially concealing an unpainted cement floor; here, the volume of the dance music was very loud. At the top of the stairs, a 100cm x 300cm x 100cm box forced individuals to move either to the right, or to the left of it. This obstacle served both as a marker for the outer region of the dance floor, and as a riser – an object upon which individuals could climb and *go-go* dance above the crowd). On the other side of this riser, the dance area was demarcated by plywood on the floor. In this area, there was also a lighting apparatus, composed of metal piping to which lights could be attached, detached, and easily moved to allow for the creation of new light shows, hanging from the ceiling. However, for the duration of any given evening, the lights were fastened in fixed locations. During both GCPs, there were approximately 25-30 lights on this structure, a centrally positioned disco-ball, and a display of multi-coloured tinsel, ribbons, and balloons. In addition, suspended above the disco ball was a tightly knit mesh net that contained white

balloons and confetti. At midnight, this netting was withdrawn and the balloons/confetti fell onto the crowd. At the far end of the dance floor, there was a raised stage (50cm high x 400cm x 600cm). Surrounding this dance platform were four separate sets of speakers, two of which stood 250cm tall while the other two, which were closest to the stage, were suspended from the ceiling. These speakers bordered the perimeter of the plywood-covered dance floor. In addition to all this, there was a partitioned area behind the speakers that contained two massage tables, which were in continuous use throughout the night. The cost of a ten-minute massage was $5.

Moreover, at a height equal to that of the light structure there was a DJ booth elevated 300cm above the dance floor; this structure was constructed mainly of glass, thus allowing the crowd to see the DJ and his or her electronic equipment. In addition to the flashing lights from the dance floor, the DJ's equipment emitted flashing and pulsing lights that reflected the continuous modifications to the volume, music, and lighting effects. Flanking the DJ booth was a staircase: on one side, this led to an area that had been furnished with couches, chairs, and benches to provide a *chill-out* zone where individuals could relax; on the other side, the staircase led to an area where all of the furniture had been removed to create additional dancing space. As part of both of these regions, and immediately adjacent to the DJ booth, an area allowed individuals to lean against a safety railing, and watch those on the dance floor below. Please refer to figures 5.1-5.4 for a visual representation of the GCP premises.

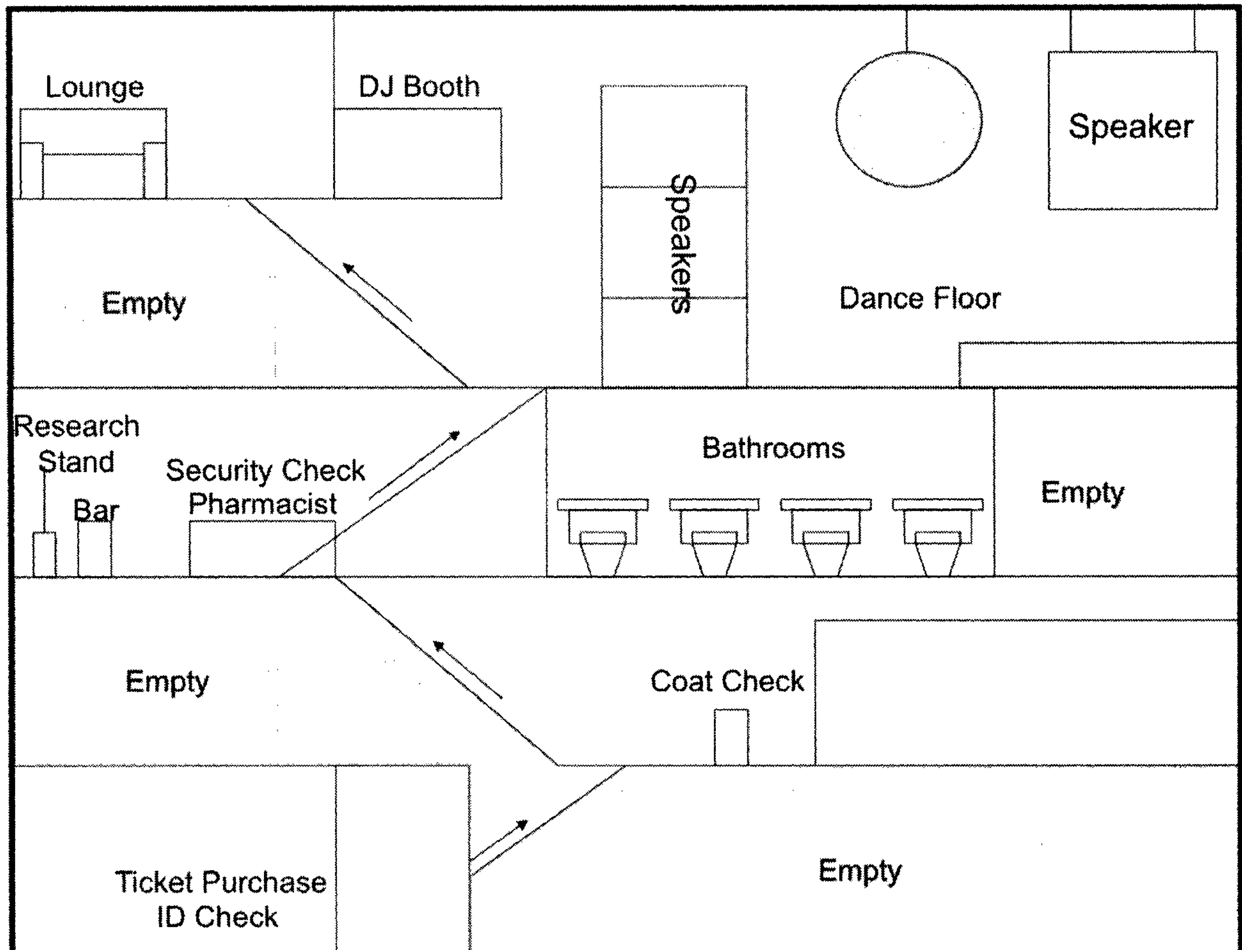


Figure 5.1: GCP Location – Profile View

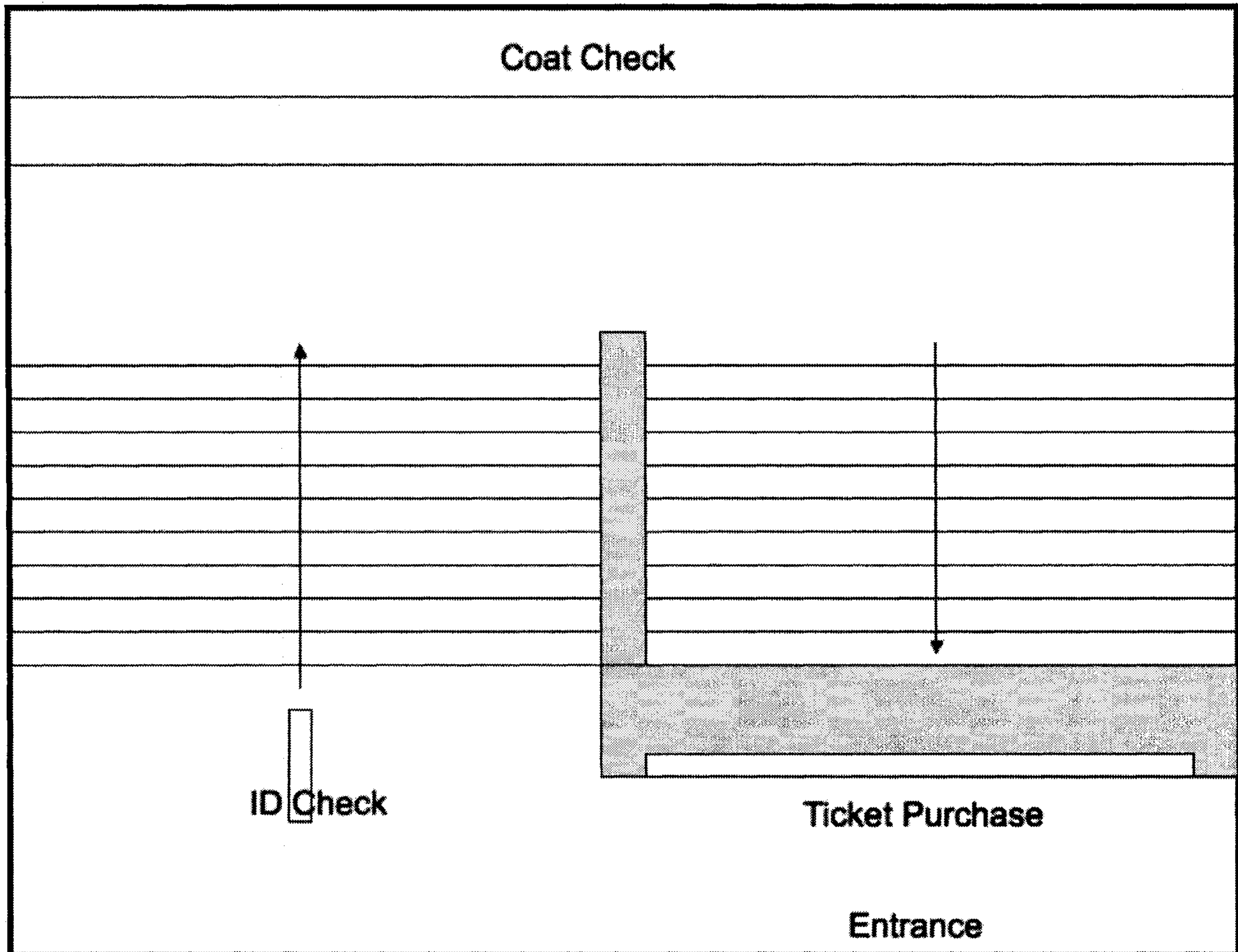


Figure 5.2: GCP Location – Entrance, Coat Check, Staircase

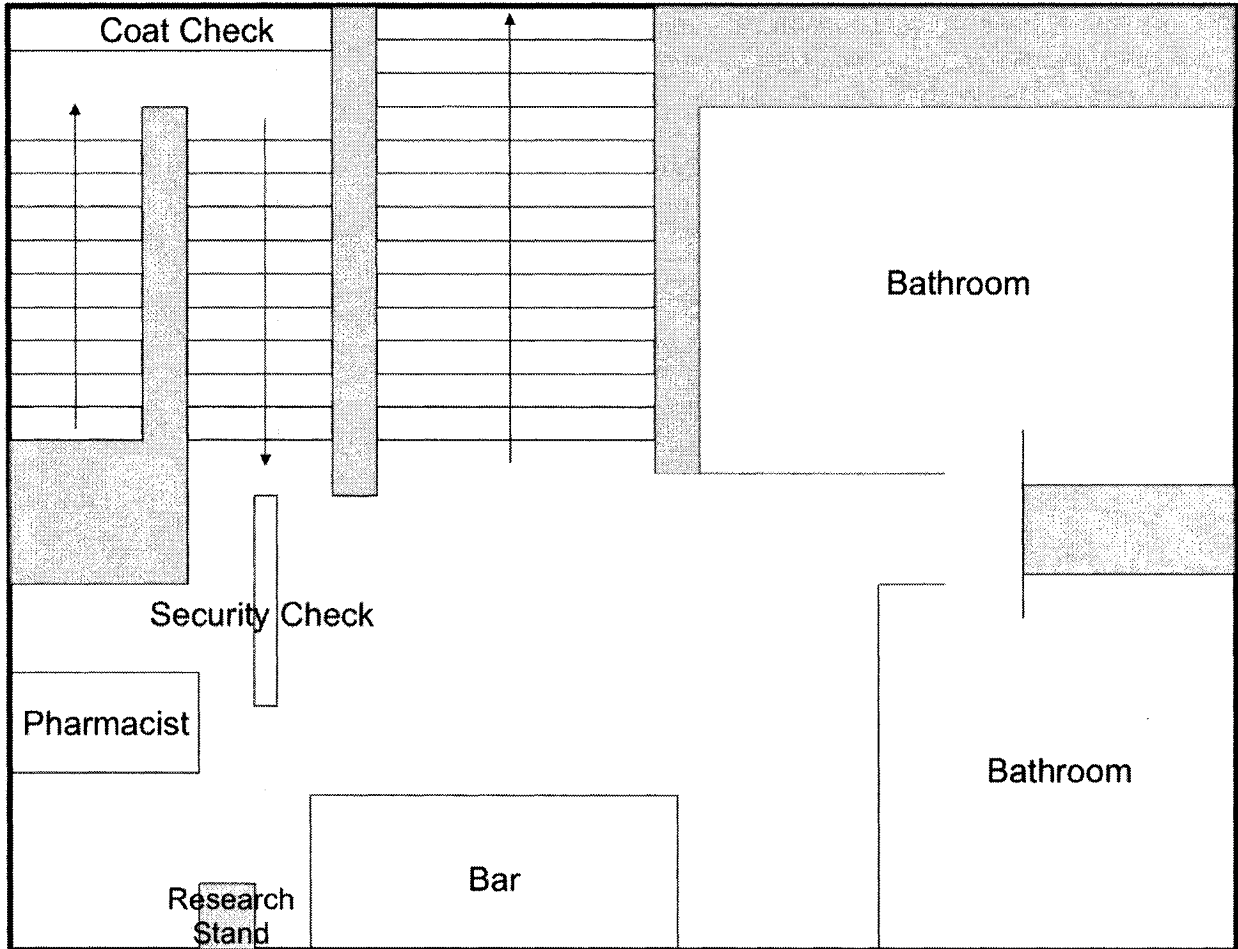


Figure 5.3: GCP Location – Security, Pharmacist Station, Bar, Bathrooms

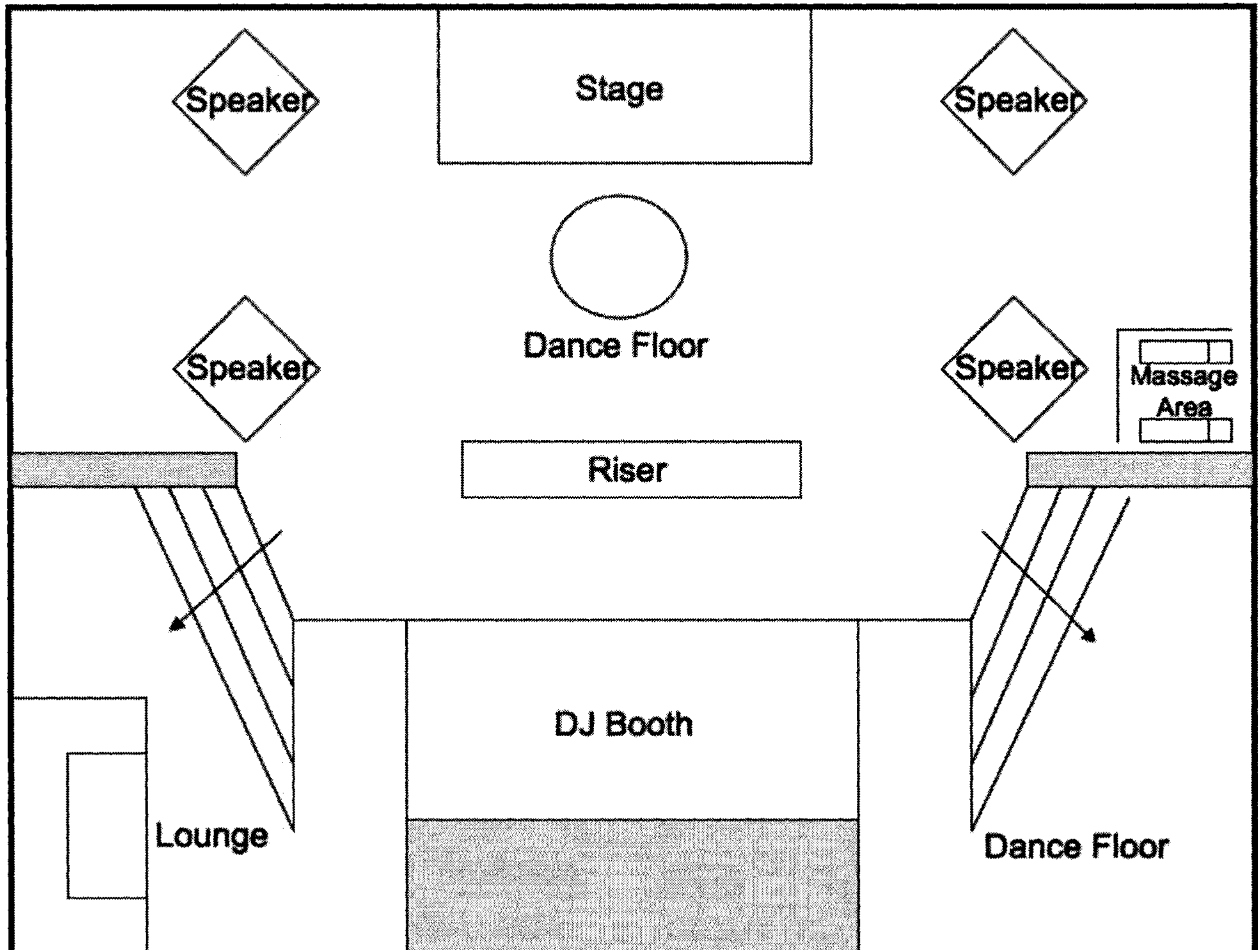


Figure 5.4: GCP Location – Dance Floor, DJ Booth, Lounges

Participant Description

During the GCP, information was recorded at hourly intervals regarding: the music, the participants, and the interactions between individuals. This was completed 11 times over 10 hours of observation, and is summarized in Table 5.1.

Time/ Vol.	# of people	Dress	Activity level	Physical appearance	Interaction
1000 68db 126bpm	No GCP-goers present	N/A	N/A	N/A	N/A
1100 75db 126bpm	1-3	Fully clothed Loose pants Tight shirts	Low activity Mostly standing	Normal gait	Solo dancing
1200 75db 126bpm	3-4 few couples	~1/3 of dancers topless	Energetic dancing New Year's countdown	Normal gait Increased excitement Searching for friends	Hugging Kissing, excited yelling Dancing groups
0100 75db 126bpm	3-5 dancing chains	95% of dancers topless	Energetic dancing Temperature increasing	Normal gait	More contact between people Hugging, leaning, petting
0200 75db 126bpm	Dance floor has become one group	All topless on dance floor Individuals have visible perspiration	Dancers have engulfed surrounding structures Energy is high	Visible perspiration Red faces Blood-shot eyes Normal gait mostly, with occasional staggering	Increased physical touching and proprioceptive movements
0300 75db 126bpm	1 group	All topless ~1/4 are pantless (underwear & shoes only)	High energy Continuous movement Rhythmic movements No elaborate dancing	Red faces/eyes Visible perspiration Many individuals are taking "time-outs" and resemble athletes taking a break (in hunched over tripod positions)	Increased physical touching Discussion remains high Last call for bar Male/female couples enter and rush to bar Male/male groups do not approach bar
0400 75db 126bpm	1 group	Topless ~1/4 pantless Occasional individual in leather chaps	High energy Continuous movement Very rhythmic movements	Red faces/eyes Visible perspiration "Time-outs" continue	Increased physical touching Discussion remains high Hypermasculine men touch each other's muscles (arms, chest, back)
0500 75db 126bpm	1 group	Topless ~1/4 pantless	High energy Continuous & Very rhythmic movements	Red faces/eyes Visible perspiration "Time-outs" continue	Increased physical touching, but discussion remains high No faltering in communication Medics assist 1-2 individuals
0600 75db 126bpm	1 group	Topless ~1/4 Pantless	High energy Continuous & Very rhythmic movements	Red faces/eyes Visible perspiration "Time-outs" continue Exhaustion apparent	Increased physical touching Discussion reduced
0700 75db 126bpm	1 group	Topless ~1/4 Pantless	High energy Continuous & Very rhythmic movements	Red faces/eyes becoming greyish for those leaving Visible perspiration "Time-outs" continue Exhaustion apparent	Increased physical touching Discussion reduced
0800 75db 126bpm	1 group	Topless ~1/4 Pantless	High energy Continuous & Very rhythmic movements	Red faces/eyes becoming greyish for those leaving Visible perspiration "Time-outs" continue	Increased physical touching Discussion reduced

Table 5.1: Observational Data

As can be seen in table 5.1, the music started at 68dB, and within the first hour increased to, and remained at, 75dB for the duration of the party. Throughout the evening, a constant flow of individuals entered the GCP, with the majority walking immediately past the survey table to look for, or ask about, the presence of friends. Others headed directly to the dance floor. No one immediately went to the bar to purchase drinks after entering the club. The majority of the individuals who entered the GCP were lean, muscular men, with no hair on the exposed areas of their bodies (later, it was noted that this included chest, back, abdomen, and sometimes, legs).

On the dance floor, as the night progressed, the solo-dancers began to accumulate dance partners, and the groups increased from small clusters of two to three individuals into a large mass of people who could not be identified as belonging to one particular group. In addition, as time passed, the individuals who were dancing began to shed their clothing; approximately one-quarter of the crowd ended up wearing nothing other than undergarments. Furthermore, by 02h00, the GCP participants had become visibly sweaty with reddened eyes and faces; their previously erect postures had become less rigid, and their movements more rhythmic and slower in speed. During this time, the temperature in the entire building had begun to rise, especially on the dance floor; by this point, the effects of fatigue and increasing heat were visible, and there was a continuous occupation of the second and third floor lounges. Meanwhile, although tactile and verbal interactions were still taking place in the area near the bar, in the lounges adjacent to the dance floor, individuals were neither speaking, nor were they receptive to being spoken to. In addition, all individuals within both these areas were conscious, and aside from two individuals who were assisted by the paramedics, no one exhibited any signs of distress, other than exhaustion. Brief interactions with individuals indicated that they were experiencing the effects of substance use, and were *chilling out* before returning to dance; they quickly

dismissed all verbal initiations from the researcher (particularly in the lounges attached to the dance floor).

With each passing hour, the dancing incorporated more contact – particularly involving muscles of the arms, back, chest, and buttocks – and became more proprioceptive, that is, the dancers moved their limbs specifically to experience the physical sensations produced by such actions. As the style of dancing became more physical (touching and proprioception), the physical interactions within the lounge areas also increased, with more petting, leaning, and hugging occurring. However, by the end of the night, this physicality had dissipated, and the reddened eyes and faces of the GCP attendees had taken on a greyish pallor; the movements of both those who were still dancing, and those who were leaving the party, showed signs of exhaustion.

Data Collection Method Two – Mute Evidence

The most powerful form of mute evidence that was connected to GCPs was media reports about substance use, specifically, crystal meth. The media described GCPs as extensive and uncontrolled gay nexuses for drug use. Even quick Internet searches with the terms "gay circuit party" and "substance" yielded multiple websites that positioned GCPs as loci of excessive drug use – one such site was called "LifeOrMeth.com". In fact, many related websites cited scientific research as proof of the dangers of GCPs. However, a critical review of the cited research showed that statistical data has correlated only substance use and sexual practices, which signifies that the causal relationships between these two practices described on these websites is conjecture (see references Kurtz[1],Mansergh et al.,[3],Mattison et al.,[4],Mattison et al.,[5],Tong & Boyer[101],Ghaziani & Cook[156],Taylor et al.,[161]). This is not to say that such reports exclusively misuse (un)biased scientific literature. Conversely, this critical review also revealed that the results of scientific research do seem to be swayed by mainstream beliefs that substance use is negative and

that GCPs constitute specific locations wherein such behaviour occurs without reservation (see Chapter Three – Literature Review). Therefore, a dearth of analysis of the motivations for GCP attendance and substance use has limited most of the existing research to little more than scientific constructions that fuel an already heated debate about substance use within western, and more specifically, gay culture.

Furthermore, the results of the mute evidence data collection yielded a few books of fiction in which crystal meth was classified as the most powerful and seductive drug known to man; they purported that one single use would invariably produce an irreversible spiral toward addiction and destruction. In addition to literature, websites which propagated this belief, were also found; for example, the "Just Once" campaign, which stated that using crystal meth just once results in addiction (see http://notevenonce.com). This finding may be due to the fact that most of these writings and Internet sources were produced in the Southern USA, which is known for its "war on drugs", and abstinence-based approach to substance use.

Finally, within the GCP itself, posters, pamphlets, and "safer sex" packages, which provided information regarding these topics, were also collected as mute evidence. The most readily available pamphlet about safer substance use contained an overview of each substance listed in Appendix A, Table 2. This pamphlet provided information on the expected effects of each substance, signs of overdose, and warnings regarding the combination of certain substances, such as, GHB and alcohol. It also included strategies for addressing potential outcomes related to substance impurity and personal reactions to specific substances. These pocket sized, full colour pamphlets, were offered to each participant at the entrance to the GCP, and were also available on the Internet.

Data Collection Method Three – Semi-Structured Interview Data

In total, 17 semi-structured interviews were carried out, each lasting approximately one hour. These research participants were recruited from the above-studied GCP, and from recruitment signs posted in Ottawa, Toronto, and Montreal. Of these interviews, 15 occurred in Ottawa, and two in Toronto. However, three of the individuals who were interviewed in Ottawa, reported living in Montreal. In total, only one of the interviewees had attended the particular GCP where the direct observation took place. Through analysis of these 17 interviews, three main themes, and a multiplicity of sub-themes and categories, emerged. These are outlined in figure 5.5. (Please note, referring to this figure as a "roadmap" while reviewing the results is recommended.)

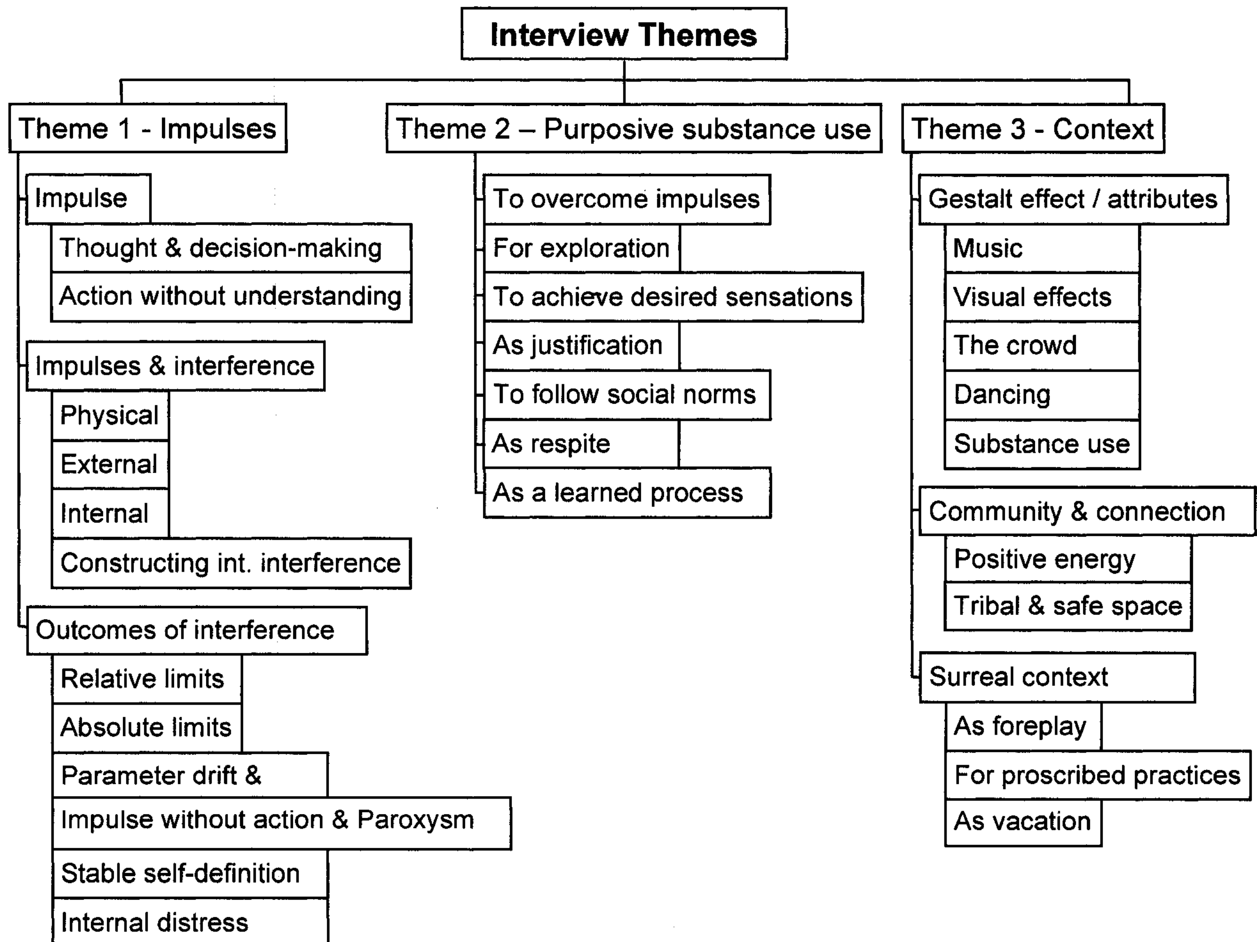


Figure 5.5: Interview Themes

Theme One – Impulses

The first theme, impulses, emerged during analysis of the research participants' interview text which discussed the positive forces that produced their thoughts, emotions, and actions. While such descriptions were pervasive during the interviews, one problem, which delayed the creation of a single, comprehensive understanding of these forces was that the participants used a variety of terms to express the same idea. To address this problem during the analysis phase, the term, impulse, proved highly, and, in fact, the most, applicable for representing the common meaning of these multiple descriptors – e.g., "desire", "mood", "feeling", "intention", "goal", "preference", and/or "drive" – because it captures the common theme that is embedded in each of these terms. In other words, the term impulse was never explicitly stated by any of the research participants; rather, this term came to be used in this context because data analysis revealed that many of the processes that the research participants described, such as, mood, feeling, and/or drive, all had similar underlying properties that could be captured by the term impulse. Thus, impulse came to be the umbrella term used to denote all of the forces (i.e., impulses) that were described by the participants. (For an overview of the analysis process by which this occurred, please see Appendix F.) Therefore, with this understanding, and as indicated by the research results (shown below), impulses are the main impetus behind GCPs. However, most often, these impulses are not reactionary coping mechanisms to deal with an unsatisfied existence, unfulfilled wishes, or insatiable drives, but rather, they are impulses for *limit experiences*, for particular sensations, for safety, for vacation, for foreplay, and for sex, to name a few.

Furthermore, please note that within the context of this research, the term impulse is not used to denote "a strong and unreflective urge or desire to act",[199] but rather, this is a modification of its meaning as used in the science of physics to denote "a force acting briefly on a body and producing a finite change".[199] In this sense, impulses (that is, moods, desires, goals, etc.) may occur with or without reflection, and are thus, not necessarily a conscious

"drive". For example, the two participants quoted below use the terms "feeling" and "mood", respectively, to describe the motivation for their actions, but do not seem to have a full understanding of the rationale behind these impulses; that is, when these two participants were asked specifically about their sexual practices, they provided an unreflective overview. They state:

> It's not like I have those expectations – whatever I'm feeling that day or that evening. (Ott-3)

> A lot of stuff, sucking, fucking, and it depends on the mood; I can't really tell you step by step. (TO-2)

The use of the terms "feeling" and "mood" in the two passages above illustrates that the scope of this force extends beyond the colloquial or formal definitions for either of these terms, again illustrating why "impulse" was selected as a more global term to denote any urge to act, regardless of whether or not the participant was aware of its impetus.

Adding complexity to this concept of impulse as the underlying driving force behind all emotions, thoughts, and actions, participants also noted that any given action is often the culmination or outcome of multiple impulses interacting with one another – for example, this could have been two desires, two goals or feelings, or a mixture thereof. In this way, some impulses interfere with other impulses to result in a particular outcome. Please note that within this dissertation, interference is defined as it is used in physics, that is, as the combination of two or more waves (i.e., impulses) to produce a resultant wave (new impulse).[199] This definition was chosen because it encompasses the non-negative tone that the participants used to discuss these transformations better than any other word, while still describing the modifying effects. For example, when participants reported impulses that result in a self-imposed reluctance to fulfill another impulse, they were often unable to explain the rationale behind their hesitation. The following participant exemplifies this when he states that he thinks about going home with a sexual partner (impulse one: his thought and inclination to "go home with a sexual partner"), but for some reason (impulse two: that

unnamed internal drive, or reason, that stops him from doing so), he does not: "Yeah. I'd think about it, but I really don't think I'd bring them home" (Ott-8). For this participant, his impulses occur ("I'd think about it"), but never materialize ("but I really don't think I'd bring them home"). At this point, additional, unacknowledged/ unknown impulses interfere with his first impulse. In this way, impulses interact and interfere with other impulses. The following sections will outline this process, and then delineate the interferences that arise as multiple impulses interact using the following major sub-themes: impulses; types of impulse and interference; and the outcomes of interference.

Sub-Theme One – Impulses

As revealed by the data analysis, the research participants have a variety of impulses, such as, sexual fantasies, interest in particular people, partying practices, and substance use, among others. In addition, these impulses are also the forces, which impel the enactment of social duties and responsibilities. In fact, broadly speaking, impulses are any thought, emotion, or action that an individual experiences. However, analysis of the research participant's discourses revealed that this overarching theme (i.e., impulses) was broader in meaning than that which is encompassed by the terms thought, emotion, or action – again, a point that necessitated the usage of a term that was outside the language typically used to describe the forces that drive people. For example, note how the following participant vocalizes this point by describing his impulses not as "positive or even negative desire", but instead, as "bursts of energy". As can be seen explicitly in this case, the participant struggles to define that which impels him, and in doing so rejects commonly used terms. He states:

> And then, just totally irrational behaviour, total satisfaction. It seems totally disconnected. So it's not like almost a positive desire or even a negative desire; it's a burst of something that then disappears. It's this element that takes us over and makes us do something that could hurt us, or it could lead us in ways that are not healthy for us, and yet if we don't go that route we're also unhealthy. (Ott-13)

This participant clearly articulates a sentiment that was described by many other participants: they experience, what could be called, impulses, which are neither "positive", nor "negative", but rather, are strictly "bursts of energy" that appear and disappear ("it's a burst of something that then disappears"). Consequently, these impulses may be disconnected from one another, or seem irrational when juxtaposed. For example, for the previous participant (Ott-13 above), "total satisfaction" is a "totally irrational behaviour" that "seems totally disconnected", in part, because it does not coincide with mainstream ideas of being "healthy". Inherent within these seemingly "unhealthy" and "disconnected" "bursts of energy" is a release of desire; it is an expression of who the individual is, and who he wants to be. In this regard, impulses are expressions, rather than undertakings, and may manifest as thought, emotion, action, or all three. The following participant further illustrates this point:

> Well, sometimes, I will fantasize about my sexual desire and, according to how horny I am, I will fantasize on what I would end up wanting to do. I will fantasize on the type of person I would like to meet. I think I'm one of the lucky ones. I think I have a broad spectrum of people I meet. So, I will think of these things. You know the level of intensity that drives you in terms of sexual desire, and that also impacts the way you're going to dress, and in my case, it impacts my attitude. I can be a little bit more passively aggressive in terms of trying to meet someone than some other evening. (Ott-6)

For this participant, impulses shape his thoughts, feelings, and actions, while simultaneously allowing him to form connections at the moment of incipient impulse as sexual fantasy. These impulses culminate in multiple actions that affect the above participant's thoughts ("I will fantasize on what I would end up wanting to do. I will fantasize on the type of person I would like to meet"), his feelings ("the level of intensity that drives you"), and his actions ("that also impacts the way you're going to dress"). As this participant reports, such connections, while routinely intangible, and often imperceptible to others, impact on his thoughts and affect his expectations. Nevertheless, in addition to sexual activities, participants also repeatedly noted impulses to dance, that is, to engage in rhythmic

movements that are synchronized with the music, the environment, and other bodies, as illustrated by the following quotation:

> I love dancing. I just like to get into my own space and dance. Even if I go with friends, I don't see them; I just dance. For me, it's a big stress reliever. (Ott-6)

For this participant, (Ott-6), his impulses are not exclusively sexual in nature; in fact, he states that he does not "see" his friends and that he dances by himself. Thus, dancing is an action that arises from his impulses. Yet, in addition to being an expression of impulses, dancing also constitutes an expression of other impulses, such as, an impulse for stress relief ("for me, it's a big stress reliever"). In this case, dancing becomes an impulse (because it has transformed into being the means) to achieve other impulses (stress relief), rather than being the goal of the primary impulse itself. It is a collection of movements, which acts as an outward expression of that which cannot be communicated or experienced through language, but is nevertheless perceptible. The following participant confirms this by stating that the expressive nature of his dancing contrasts with his otherwise structured life. From his perspective, his impulses, which culminate in dancing, are an "expression" that is not a direct opposite to structure, but rather, are distinct enough so as to result in his contrasting "expression" and "structure". He states:

> Maybe I just NEED that expression in my life because my life is generally so structured and so planned and so determined that I DO need these moments of expression to live. (Ott-8)

For this participant, dancing, as an impulse, constitutes "moments of expression to live" that, by being acted upon, create visible representations and temporary connections with other bodies. However, as noted, these connections need not be sexual. In fact, within this context, impulses comprise all the driving forces that impel an individual. For example, another participant explains that his impulse to dance at GCPs is more powerful than his desire (impulse) for sexual contact:

> I think I go to [GCP] like thirty percent for sex, and then maybe seventy percent dancing/ entertaining myself. (Ott-6)

For the above participant, as illustrated by his 70% emphasis on dancing, it is more important than sexual contact. This re-enforces the idea that the participants have and engage in impulses, which form connections with a variety of objectives (whether conscious or not). Moreover, other participants also reported that their impulses (thoughts or emotions) often culminate in action. For example, for the following participant, the impulse was a desire to dance, and the action was "go[ing] out and danc[ing]": "Sometimes I'm just in the mood to go out and dance" (Ott-10). According to this participant, occasionally, he develops an impulse (described here as being "in the mood") to engage in physical movements ("to go out and dance"). For him, impulses dictate and produce his actions in and connections with the external world.

In the same way, for the participant quoted below (Ott-11), dancing and enjoying himself is also a method of forming connections (that is, of indulging in his impulses), but in this latter case, these connections are formed as he loses himself in the moment. It is a potential means by which this participant can overcome the perceptual limitations of his physical body being firmly located on the ground:

> It's almost like being on stage because there are so many people around you. It's almost like you're flying in the sense that it's just people forgetting all their worries. The only thing they care about is the music and they're dancing to it. So, it's a pretty good feeling. (Ott-11)

For the participant above, his impulses result in a "pretty good feeling", during which he seems to be engaged in the moment to the point that he recalls feeling "like you're flying in the sense that it's just people forgetting all their worries". It is a period of stress relief that is created by physical movement and through his experience of being surrounded by, and forming connections with, individuals who are similarly enjoying themselves. Thus, he forms attachments through his perceptions of the crowd and his subjective appraisal of their shared experiences. In this case, his connections are not physical contacts between

dancing bodies, but are intangible emotional and cognitive links that occur due to proximity and shared experience. Other participants also reported having impulses that drive them to be surrounded by a crowd of people who are similarly enjoying themselves, as is the case for the following participant:

> **Anything about the environments that you liked?**
> People having fun. Dancing people all look so happy; I know they have their own worries, but for the moment they look very fun. (TO-2)

As with previous statements, it is possible to identify the above-cited participant's desire to be with a particular crowd (i.e., with "people having fun"), and the act of going to a party and dancing, as yet other impulses that constitute the aim and execution of his impulses. Furthermore, it is important to note this participant's lack of precise description identifies that impulses may not be readily identifiable. In addition, the above quotation also serves to emphasize that impulses can assume a variety of forms: thoughts ("worries"), emotions ("worries" and/or "fun"), and actions ("dancing"). Therefore, the term, impulse, denotes the energy that drives an individual (e.g., their mood, desire, goal, intention, etc.), as well as the energy of the outcome of the drive (e.g., the ensuing thought, emotion, or action). Moreover, from the participants quoted above, it is possible to state that all three forms of impulse have influential and interactive effects on one another.

Thought and Decision-Making as Impulse

While impulses have thus far been presented as the underlying force that drives action, further analysis of the interview data revealed that impulses are sometimes linked with thought. In these cases, the participants identified that a perception of their impulses had to occur (step one: impulse), followed by a cognitive interpretation of this impulse (step two: cognitive awareness), both of which culminate in tangible results (step three: verbal or physical expression of impulse, or not). Thus, GCP attendance involves more than a strictly unconscious impulse; it is the result of an assessment of consonance between the

participants' moods (step one: the impulse) and their beliefs and cognitive assessments regarding the ability for one venue type versus another to be able to provide the sought-after stimulation (step two: the thought), whether that be through dancing, socializing, or sexual activities. Thus, conscious thought becomes the vehicle by which the actions that impulse dictates can be achieved. The following participant provides an example of this process by his assessment of a specific venue size in relation to his mood:

> Depends on the mood. Depending if I'm going to socialize with my friends or to dance, then you want to be in a bigger place or something where there's more people. (Ott-10)

The language of this foregoing participant ("depending if I'm going to") illustrates the interactive processes that transpire between thought (his intentional selection of party environments) and impulse ("socialize with my friends or to dance"), ultimately, resulting in action (attending one specific party environment). Thus, while impulses need not be cognitive, the process of indulging in such impulses, such as the decision to attend a GCP, is a mixture of varying types of impulses: specifically, mood ("depending on my mood"), and thought ("depending if [he's] going to socialize ... with friends [Option A] or to dance [Option B]"). Thus, the first impulse (the mood/desire) is disconnected from thought – it surfaces without cognitive request, while the second impulse (the choice to attend a larger or smaller venue is a cognitive process) is an evaluation of the specific aforementioned differences between parties based on their perceived alignment with the particular impulse. Another example of a specific sub-element that involves both cognition and impulse, and which may be involved in this assessment of party attendance, is substance use. As with the previous participants, the following participants' inclinations about substance use arise from impulses, rather than being cognitive decisions, but the method of using the substance, how to acquire it, and where to use it are all thought processes. These participants state:

> Sometimes, it's not always the case; it just depends on how I'm feeling that day. Or, I'll go and won't do any drugs. (Ott-11)

Do you find any differences between the [GCP] and the other parties?
Age, that's about it. The [GCP-1] is more preppy, bouncy kids. As I call them, Twinkies. Where the [GCP-2] is more reserved for older guys. Not like 80 years old but guys 30 +; where the preppy [GCP-1], there are 18-19 years old.
Do you find that makes any difference?
Sometimes none, but most of the time, the energy. The older crowd. The music is loud, and high pitched or low pitched, and it's at a medium pace, and you're not bouncing all over the place. It's more slower songs, a lot of older songs.
Do your drug use patterns change between the [GCPs]?
Yes. [GCP-2], I'm usually baked out of my tree when I get there and I'm still baked when I leave. Where the other ones, I'll go to the party totally sober, and if I get high when I'm there then that's fine. (TO-1)

According to these participants, substance use is not always desired, and its usage depends entirely on their impulses toward the processes and effects of its consumption. Thus, impulses may direct substance use ("[drug use] depends on how I'm feeling that day", or "if I get high when I'm there then that's fine"), or equally, they may result in non-consumption ("Or, I'll go and won't do any drugs"). In this regard, the participants point out that their impulses transform into actions through cognitive involvement and appraisal of whether or not they will use drugs in order to follow through on their ascendant impulses. However, in these cases, such cognitive involvement does not entail a rational evaluation of the outcomes/consequences of their actions ("if I get high ... that's fine"); conversely, such thought processes are involved strictly to determine the plan of action that is most likely to satisfy the demands of their impulses, that is, choosing to get high or not. The following participant illustrates this differentiation between cognitive involvement regarding consequences ("you don't care about diseases") and those required to undertake action (i.e., feeling sexual gratification requires some form of sexual activity). He states:

It's about how you feel. You feel closer. At times you don't care about it [skin contact], about diseases, you feel this kind of sexual gratification. (TO-2)

For this participant, the involvement of cognition is limited to allowing him to achieve the feelings of closeness and sexual gratification that his impulses dictate. However, not all

participants were consciously aware of their reasons for undertaking particular actions. This second phenomenon will now be examined.

Impulse and Thought: Action without Understanding

The previous section identified that thought was sometimes involved in transforming impulses into action; however, it is essential to note that such transformations may occur without the participants having a full appreciation of their underlying impulses. In other words, impulses surfaced as unreflective actions (verbal or physical). For example, many of the research participants were completely unaware of (or unwilling to acknowledge/vocalize) the impulses that impel their actions. Discussions with the participants revealed the importance of action without thought (actions undertaken without conscious recognition of the impulse) as a central sub-element of this process. In this case, participants would describe actions that they had undertaken without understanding their reasons for doing so. The following participant illustrates this process of engaging in actions that he does not fully understand by describing a sexual experience as a "total disconnect[ion]", and as "a burst of something". To revisit a previous excerpt:

> And then just totally irrational behaviour, total satisfaction, and he's gone. It seems totally disconnected. So it's not like almost a positive desire or even a negative desire; it's a burst of something that then disappears. (Ott-13)

The above-quoted participant illustrates that he engaged in actions without cognitive awareness of why they happened, or even what happened. Witness his description of "irrational behaviour", "total satisfaction", and the use of the word "something" as the outcome of his "burst of" "desire". Even after the fact, he remained unable to describe the impulses that motivated his actions. Through analysis, these actions were identified as the outcomes of impulses that often increased the likelihood of desired activities occurring without any conscious acknowledgement or awareness of the underlying impulses – that is, the participant was unaware of the influence of these impulses on his actions. Thus, these

impulses affected his actions regardless of whether or not he was aware of them. Similarly, for the following two participants, this same phenomenon arose in situations where opportunities were capitalized on, rather than created, such as, being open to meeting someone, but not actively looking – that is, seemingly accidentally (i.e., "end[ing] up") "hav[ing] sex":

> I go out for music/fun, but if at one point I meet somebody, I'm open to it. (Ott-5)

> It has happened that I've gone out and didn't plan anything and ended up somewhere but not to purposely have sex with someone. (Ott-10)

For these participants, the impulse to engage in sexual activities is not explicitly stated, but rather, is described as their being open to such actions. However, further analysis of the excerpts illustrates that these individuals were placing themselves in situations where such opportunities could arise. Notice the statements, "it has happened" (passive voice – no acknowledged intention), and the lack of plan for sexual contact, ("didn't plan anything" / "I go out for the music/fun"); however, if opportunities arise ("if ... I meet somebody"), then these individuals would be "open to it", even though all the actions that result in these sexual activities were not undertaken "purposely [to] have sex with someone". Another research participant (quoted below) confirmed that he also experiences unreflective impulses for sex, but he ventures that his openness to sex is "probably" the expression of an impulse to prolong the feeling of elation that occurred during the party. He states:

> The sex that happens during or afterwards is probably because you want to continue that feeling, you feel so good, about yourself with other people that to go home alone is quite the let down. (Ott-15)

For the above participant, the impulse for sex is not completely acknowledged as such, but as a "probable" continuation of the party experience. Other participants affirm this belief that the search for sex is not overt, but occurs because the whole GCP experience is constructed as one that promotes the possibility of sexual connections. The following

participant indicates that he does not intentionally attend GCPs in order to have sex. Instead, he describes his repetitive sexual contacts as accidental occurrences:

> I don't GO to have sex. I really go NOW to enjoy. If it does happen, I'm not looking for it. I NEVER go out and say, okay I'm going get somebody tonight. It's always, somebody talks to me and things happen and I didn't expect to meet you. But I never go out thinking I'm going to have sex. (Ott-5)

Analysis of the above participant's stated lack of expectations and intent ("I don't GO to have sex", "I NEVER go out and say, okay I'm going to get somebody tonight") in conjunction with his repetition of an openness to sex ("if it does happen", "somebody talks to me and things happen", and "I didn't expect to meet you") reveals the presence of underlying impulses for seemingly random, or unexpected, sexual contacts. By recurrently putting himself in situations where sexual contact may arise, and undertaking many purposeful actions that will promote the likelihood of impulse-driven activities, this participant engages in activities that augment his possibility for sexual contact. Thus, actions are undertaken without a conscious, or at least verbal, acknowledgement of the underlying impulse to engage in sexual activities – which should not be limited to acts exclusively involving the genital organs, but rather, should be expanded to include all forms of eroticism – for example, the following participant provided an example of a sexual contact in a bathhouse where he engaged in activities based on unacknowledged impulses to achieve pleasure through pain:

> Recently I heard some slap slap slap slap very hard there so I went to one of the rooms and there was someone using a piece of leather and not really hitting someone, just tapping on the person and I just went for it. I left it. It was a bit like those Chinese massage they use that technique and it was extremely erotic, I mean it was orgasmic, very quickly, and it was a profound relief, a sense of extreme pleasure, I was so happy, I mean the guy couldn't believe how I was taking off on this. (Ott-13)

The participant above experienced "extreme pleasure" from a previously unknown sensation: one, however, toward which he was driven by his impulses. This individual reported that during the experience he was pre-occupied with the pleasure, and thoroughly

enjoyed himself, but afterward, because of its novelty and its unique social status as a "negative form of sexuality" (quoted below), he reflected on the process. He also reported that his indulgence in an activity to which he was drawn without conscious awareness "freed some obsessions" that he had:

> Then when I came back home and I thought about this and it could turn almost into a fetish. And that's not the way I want to go, and it's not what it meant to me. It also freed some obsession that I've had over the years with bondage, S&M, submission, that type of stuff, being hit, it's gone. In one way it was only seen as a very abusive or maybe negative form of sexuality from my terms and that I would not agree to. And yet it was simply having wonderful fun, it connected with forms of massages that I do when my back is in a light pain. (Ott-13)

This participant also stated that his experience, although not engaged in with conscious intent, was able to satisfy a latent desire that he already had. Consequently, the desire ("obsessions") he had for this form of sexuality was satisfied. Nevertheless, it was by indulging in an unpremeditated action that he experienced and understood his underlying impulses for this form of eroticism. For this participant, the experience made him aware that he enjoyed this practice:

> It relieved all of those obsessions that I've had; then it was over and left me with the question, ok now, this is a sexual practice and let's say I have a love relationship on the other hand, how would the two mix? In a way that is not going into what you can do in simply having casual sex or into fetishistic behaviour, but then it built into a relationship and not going into the kinky stuff, it was not kinky, it freed me of all these concepts, they were erased completely. And it freed me from trying, in a way to go and avoid be dominant in a relationship. It was unbelievable, that freedom that happened, luckily I was in the right context in the right time with the right person with the right attitude, but I kind of avoided anything that would be associated with that, you know, the Leather Parties and all of that stuff. But it was only perceived by me as that. (Ott-13)

Based on this participant's prejudices toward sadomasochism and bondage, he was only able to satisfy that obsession by following an unreflective impulse toward a chance opportunity. Thus, "in the right context in the right time with the right person with the right attitude", this participant followed his "obsession", and in doing so, satiated an impulse that he was previously unaware that he had. The experience, while challenging his beliefs ("I

[previously] avoided anything that would be associated with ... Leather Parties and all that stuff"), provided him with an extremely pleasurable situation and, temporarily at least, extinguished this particular impulse ("it freed me of all these concepts, they were erased completely").

However, other individuals more openly acknowledged their desires for engaging in sexual activities, and are aware that many of their actions arise from such impulses. According to the participant quoted below, his nature as a self-aware "sexual being" ensures that even without intent ("subconscious"), his impulses are toward sexual contact, even if he is not aware of this:

> I think everybody, subconsciously, every time you walk out the door, you want to have sex. We're sexual beings, that's all it is. (Ott-11)

This participant explicitly states that his impulse for sexual activity is pervasive, but not necessarily conscious in his life, and acknowledges that even in situations when he is unaware of these impulses, they continue to surface as actions without thought. At this point, the interaction (i.e., interference) that occurs between competing impulses will be examined.

Sub-Theme Two – Impulses and Interferences

In addition to the participants describing impulses that drive their actions (whether overtly or otherwise), analysis also revealed that there were specific types of impulses; the outcome of multiple impulses, as they interact with one another to produce the final outcomes, was revealed to be an important finding. As a direct effect of many impulses arising from multiple sources, these impulses interact with one another to ultimately produce modifications. In the data analysis, these modifications often take the form of limitations and restrictions, but they are not better or worse, positive or negative, simply different and transformative. Within this context, these interactions have been defined as interference (see page 126). This definition emphasizes the non-negative nature of these interferences

as they occur between impulses. It is important to note here that these interferences are not impositions that inhibit or prevent an initial impulse, but rather, that interference represents the interaction point(s) of multiple impulses; in other words, it is the modifying effect that impulses have on one another. The participants identified three main forms of impulses and the interference that they produce: physical, external, and internal. Physical impulses and interference encompass the impulse interactions produced by time, space, and the human body; external impulses and interference occur due to the impulses of social norms, customs, laws, religious and moral values, and rules of propriety; and internal impulses and interference are the amalgamation of physical and external limitations, known in colloquial language as personal limits, wherein, two or more impulses within one individual produced impulse modification.

Physical Impulses and Interference

The first form of impulse and interference that the participants identified occurred in relation to the impulses of physical objects, time and space, and human anatomy and physiology. In the first case, space and time produce physical interferences, such as, the distance between two sought-after objects, or the presence of physical obstructions that interfere with achieving specific outcomes. As the second source of physical interference, anatomy and physiology produce physical interference related to corporeal existence, such as, when the research participants reported that they had consumed more drugs than their bodies could effectively process or, such as, from dehydration, fatigue, substance use, infectious disease acquisition, or anatomical endowment. In this second type, physical interference arises from the interactions between physiological impulses and other personal impulses. In either case, physical impulses and the resultant interferences occur as a result of the interactions between the impulses of an individual and the impulses of both animate and inanimate objects as well as from the physiological impulses of each individual's body

interacting with his other impulses. However, regardless of the source, analysis of the research results revealed that these limitations occur as a direct result of impulses arising from the physical world, and transpire regardless of belief or perspective.

For example, the following participant indicates that physical interference occurs when he attends a GCP that is far from his home (that is, his impulse to attend a GCP interferes with his impulse to arrive home safely). The distance constitutes a physical barrier to his going to the GCP, and returning home quickly/safely, thus situating his impulses to attend a GCP and to engage in prolonged substance use and sexual activity in direct conflict with his impulses to return home after the party is finished. As noted below, for this participant, "a two-hour drive" produces physical interference between varying impulses because of time and space constraints:

> Now, living in Ottawa, I've got a two-hour drive. So that kills the buzz. So, when I go to Montreal and a guy's attracted to me, if he dances with me, fine; if he kisses me, fine, but if I see he's interested in longer, or more, I will tell him flat out, listen, go find yourself somebody else because I have to drive. So, no, I don't go there anymore for sex.
> **Is that just due to having to drive home?**
> Yeah. If it wasn't, it would be a different story. The answer wouldn't be the same [for sex]. (Ott-5)

According to this participant, he is forced to choose one impulse, and notes that his impulse to drive home modifies his impulses to engage in sexual activities. Witness his statement that, "I don't go there anymore for sex", because "now, living in Ottawa, I've got a two-hour drive", but "if [he didn't], it would be a different story." He acknowledges that if interference (the need to drive home) were non-existent, he would remain at the GCP, and engage in sexual activities. Thus, the physical requirements of one impulse eliminate the potential for another to be acted on. While not within the GCP context, the following participant (Ott-10 below) provides an additional, and concise, example of physical impulses producing interference. In this case, however, it is context, not distance, which acts as physical

interference; he is in a straight bar where he is restricted from being able to meet other gay men. The participant describes this in terms of being subjected to boredom:

> A while ago, I did leave the straight party to go to a gay bar in the middle of the night and I left without telling them [my straight friends] because I thought it was getting boring. (Ott-10)

For the above participant, the physical limitations of location produce conflicting impulses related to friendship and desired sexual activity. In this case, he chose to follow his impulse to escape from boredom by leaving the straight party to go to a gay bar.

However, surmounting the interference caused by physical impulses is not always possible. Sometimes, it is the cellular and molecular impulses of the human body that modify the outcome of physical interference. For example, some participants reported that nearly fatal substance use produced physical impulses that interfered with other impulses. For these participants, it was not the location that produced physical interference, but rather, the physiological limitations of their bodies to process consumed substances (that is, physiological impulses of detoxification). The following participant illustrates that the outcome of this physical interference (the impulses for drug use, the impulses of the consumed drugs, and the physiological impulses of his body to process these drugs) resulted in multiple drug overdoses on a few occasions:

> I am an artist so I think I'm really intense. So I work hard and play hard and I do everything intense. So, when I discovered different drugs, I would, I'm a very addictive person, power-user. And each time I came across drugs, I lost control. When I was twenty-nine, I went to rehab for a month for cocaine. I had a drug overdose in South Beach and that's why I went. I almost died four or five times in my life. And all of them because of drugs. (Ott-7)

The above participant described his impulses to engage in substance use as "intense", and stated that they drove him to excessive indulgence to the point of overdose and physical harm ("I lost control"). However, physiological limitations (his body's ability to process ingested drugs) continued to produce impulses that interfered with his impulses for drug consumption (resulting in overdose).

Notwithstanding, for most participants, this form of physical interference was uncommon; the effects of physical interference did not regularly threaten their physical integrity. Furthermore, while many of the aforementioned examples of physical interference have been restrictive, some participants also identified beneficial or positive forms of physical interference. More frequently, however, they reported that substance use caused impulses and resultant physical interference relating to sexual difficulties, such as, erectile dysfunction or orgasmic delay/inability. Therefore, a participant's impulses to engage in substance use may physically interfere with his concurrent or subsequent impulses for sexual activities. According to the following participant, substance use impedes his sexual performance. For him, the fact that everyone at the GCP is high creates sexual tension, in part, because they are unable to get erections:

> So it's just everybody's high, but there's TENSION because you WANT sex, but like I said, you can't get HARD, so you're not having any; so there's also a tension in your BODY. (Ott-5)

For this participant, substance use causes physiological impulses that produce the physical interference of an internal and external sexual tension that limits his ability to engage in sexual activities. In this case, the physiologically induced effects of substance use interfere with the participant's bodily processes ("you can't get HARD"), and this interference allows his underlying impulse for sexual tension to materialize ("a tension in your BODY") based on the physical limitation imposed by this substance use (erectile dysfunction). In effect, these impulses interfere with one another – neither producing an additional impulse, nor restricting the continuation of the initial impulse. The same participant further explains how ecstasy (referred to as "E"), allows him to achieve a desired state of sexual tension:

> So that's what attracts ME to those parties. Of course there's the drugs and there's the sex aspect, and there's a sexual tension. I call it sexual tension because most men can't get hard, and I'm one of those on E. So, I'm not going to the circuits to get laid. It's that the PARTY and the E [ecstasy] put you in that sexual tension mood. (Ott-5)

Ultimately, the physical interference produced by this participant's impulse for substance use causes one of his impulses to induce a physical reaction that he desires ("So that's [the E induced sexual tension] what attracts ME to those parties"). This resulted in this participant actively seeking specific outcomes of physical interferences (erectile dysfunction and sexual tension). Unlike the previous participants who reported that physical interference required them to select one impulse over another (e.g., sexual activity versus driving home), in this case, the interference does not create an "either or" situation, but rather, it results in a transformative process whereby initial impulses are achieved through the conscious selection of physical impulses that will produce desired physical interferences, and thereby, desired outcomes. Another participant supports this finding by identifying that the physical milieu of the GCP produces positive interference because multiple individuals congregate to dance and have fun, which contributes to his sensations of pleasure. He states:

> It's almost like being on stage because there's so many people around you. It's almost like you're flying in the sense that it's just people forgetting all their worries, the only thing they care about is the music and they're dancing to it. So, it's a pretty good feeling. (Ott-11)

For this participant, the effects of a large crowd of individuals who are "forgetting all their worries" produce physical feelings of euphoria and "flying". Thus, the physical environment and the physicality (contact of naked skin while dancing) of GCPs induce physical interferences and positive outcomes for this participant.

However, it is important to acknowledge the subjective effects of perception and interpretation in relation to physical interference. While physical impulses may occur regardless of perspective, the interpretation of such impulses uniquely transforms their effect on each individual. For example, while for the above participant, large crowds are a positive experience ("It's almost like being on stage because there's so many people around you"), for the following participant this is not the case. He states: "It was just too many

people. I feel overwhelmed with a lot of people" (Ott-8). For this participant (Ott-8), large crowds produce negative feelings. Thus, the physiological outcomes that result from a particular physical interference (in this case, a crowd) produce different experiences for each individual because the individual must perceive and then interpret the physical impulses (large crowd) according to their own subjectivity, and then react to it in their own way.

Furthermore, participants frequently identified the effects that substance use has on perception as another form of physical interference. The following participant illustrates how substance use distorts his visual perception to the point that he (or another individual) might begin to evaluate an "unattractive" person as a potential sexual partner:

> It's not usually what you did, it's usually who you did it with; it's that's what they're referring to. It's like, 'oh I can't believe I took that monster home'. (Ott-11)

This participant reports that perceptual disturbances caused by substance use (physical interference) permit sexual activities to ensue with otherwise unattractive partners.

In addition, the associated physical interference that occurs due to substance use may change over the course of its usage. In other words, the initial "high" effect of an ingested substance (the results of impulse interference) eventually transforms into different sensations such as withdrawal symptoms. For example, according to the participant cited below, his drug consumption first results in direct modifications to his perception of fatigue and to his energy levels, but later, results in a secondary physical interference (rebound effect or withdrawal period) during which he experiences extreme fatigue:

> I'd be there for days. It wasn't even that I wanted sex anymore because it would make you so wound up, you'd still be looking for sex, 24-36 hours later. The longest I was away for was five days. It's really out of control. You're talking about five days without taking care of yourself. And then you have to crash and sleep for five days because you have to repair yourself. And then you just wake up, and go all over again. (Ott-7)

This participant's impulses for heightened physical pleasure and prolonged energy require that he engage in substance use to produce direct physical interference. However, physical interference to such a degree often results in reactionary physical impulses (and resultant physical interference) where the physical limitations of the body necessitate a recovery period. Typically, this recovery period is not as prolonged as five days. In fact, the following participant illustrates that the recovery period is usually relatively brief: "Usually the comedown is just the next day" (Ott-2). According to this participant, the rebound/recovery period reflects the magnitude of the physical impulses of the ingested substance. In other words, participants highlighted that the more profound/excessive the substance use, the longer/more severe the recovery period. In addition, another participant's statement reveals that physical interference also includes the unintended side effects of substance use. For example, the consumption of ecstasy often diminishes the body's ability to cool itself, as is the case for the following participant:

> Well, you don't bring yourself completely right down to the exact last stage, you know your body and once you start partying, you realize your body. Like, I'm getting too hot, like I'm really sweating, not having fun anymore, then I'll bring myself down. (Ott-11)

For the above participant, the physical effects of substance use sometimes interfere with his simultaneous impulses to dance and engage in continued substance use by causing his body to overheat and by requiring him to make deliberate efforts to cool himself. In this way, self-regulation to prevent hyperthermia arises from externally acquired knowledge about substance use, the human body, and appropriate care in cases of substance overdose.

External Impulses and Interference

The second form of impulses and interference that was identified during analysis of the participants' interview data was external impulses and interference, which encompass the impulses of cultural regulations including all interactions that occur when the impulses of one individual mesh with the non-physical impulses of other individuals. In this regard,

external interference encompasses the intangible societal constructs surrounding the social interpretations of ontology, epistemology, history, politics, etc., that are generated by other individuals. In other words, external interference is knowledge – that is, a collection of individuals' competing impulses, which ultimately end up producing somewhat agreed upon social perceptions and interpretations of the world – that is, consensus.

According to the participants, such regulations and knowledge take the form of social norms, laws, customs, peer pressure, and religious and moral values, in addition to scientific, cultural, and religious ideas about the human body. Furthermore, participants also included perceptions of beauty and physical attractiveness as forms of external interference because they encompass societal interpretations of the body. While superficially similar to physical interference, it is important to emphasize the differences that were made by the research participants between physical interference and external interference. The participants identified the former as arising as a direct result of impositions that occur regardless of perception and belief (such as, drug overdoses), while the latter depends on strictly cognitive limitations, such as, the legal restrictions on recreational drugs. However, while such legal restrictions are nothing other than external impositions, which may prevent (i.e., as a form of interference) an individual from engaging in drug use, participants reported that these external forces are usually manifestations of internal impulses:

> I think the police is the external force or the external manifestation of the force that we have in ourselves, I think as human being we do have that part of us that needs policing. (Ott-13)

This participant states that although the "police" function as an external control mechanism (impulse), they are, in fact, an external "manifestation" of an internal impulse that he recognizes within himself. This is particularly relevant because, within the context of this quotation, this research participant is not referring to the legal role performed by the police, but rather, is metaphorically referring to the police as a representation of (self) control. This, in effect, positions "the police" as any and all forms of restriction (over that "part of us that

needs policing", or controlling), not as a governmental agency. Thus, this transforms societal restrictions (embodied in this case by the police) from being an external source of proscription into a visible display of internal impulses. This means that, ultimately, external impulses provide cultural frameworks for facilitating group cohesion. In this way, the research results identify that external interference is neither positive, nor negative and that it constitutes a mechanism by which desire is structured (but not created). This interference is an outcome of the expression of multiple impulses, and while it can be restrictive, it also functions to provide an outline of provisional rules for human interaction.

However, analysis of the below-cited participant's excerpt challenges the above participant's statement that external impulses (i.e., the restrictive force which Ott-13 describes as a police-like force) are secondary results of original internal impulses. For the following participant, his upbringing is an impulse that produces such a powerful external interference that it has resulted in his identification with one culture rather than another, even when this second culture (i.e., the gay community) is of central importance to his self-definition. He states:

> I STRONGLY believe that the fact that I'm not in the typical [Gay] scene has something to do with my upbringing. I STRONGLY believe that the fact that I was brought up a certain way, even before I REALIZED that I was gay. I really think that the way I was brought up, the values I have, the things that my parents gave to me, not monetary, but the things that they gave me as in values and morals, culture, religion, and things like that. I really do think that that dictates what I've become. (Ott-8)

This participant states that external influences such as his parents and the values and morals that they taught him, have shaped his sexual behaviour because these impulses exerted their influence (produced interference) prior to his development as a sexual being. By juxtaposing the first participant's statement that society is what we make it to be (police as an external manifestation of internal impulses) with the second participant's statement that he is what his early environment (society) made him, it becomes obvious that cause and effect cannot accurately be determined, possibly because these relationships are not

simple or linear. Furthermore it highlights that the individual and society dynamically interact, and thus interfere with one another. This is echoed by yet another participant, who suggests that even the impulses of scientific knowledge produce external interference through its methods of acquiring information about human behaviour:

> In a way, understanding human behaviour is a form of policing. It is not repressive, but it could be guiding in the opening you refer them to when they need help, because it's so powerful. (Ott-13)

For this participant, knowledge represents an externally imposed form of regulation ("a form of policing"), that is, it is an impulse capable of producing external interference. In fact, the above participant is quite explicit in saying that "understanding human behaviour is a form of policing" because the knowledge that is developed serves to guide the individual's behaviour. In consequence, these external impulses, at times, conflict with personal impulses that arise when an individual's sexuality begins to surface, thus producing interference. Another participant continues that his impulses to follow external norms and regulations occasionally conflict with his desires as a gay man:

> I'm focused; I've found good friends who are FAIRLY conservative, fairly religious. It's a lifestyle. I just hate the lifestyle choice. (Ott-8)

According to the participant quoted above, a "religious" and "conservative" upbringing helped him to acquire the necessary knowledge and skills for guiding his life in the direction he feels it should take (see next quotation from same participant). However, when he states that he "hate[s] the lifestyle choice", he is not referring exclusively to the "gay lifestyle", but to the need to be congruent in behaviour. Consequently, he experiences an internal conflict due to his perception of the incompatibility between his lifestyle choices. This participant's conflict arises from his impulses for two simultaneous lifestyles that he sees as being incompatible: his impulses as a gay man, and his impulses to be a physician (quoted below). For this participant, his career/school choices constitute one impulse, and the social requirements that dictate that, as a future physician, he must restrict his actions constitute

an opposing impulse, and thus a form of external interference. Further exploration with this participant clearly illustrates the effects of external impulses and the resulting interference when he ascribes the social characteristics of maturity and responsibility to an academic pursuit. In response to the question, "Have you ever gone to GCPs and gone home with somebody?", he states:

> That weren't my friends? No. It's more people I already know. I'm going to med school; I am responsible, you know. Not to say that other people are irresponsible, that could go to med school, but, sure, it HAPPENS, fine, but I don't go there looking. (Ott-8)

In the excerpt above, the participant responds to the question about meeting sexual partners at a GCP by stating, "I'm going to med school", then validates this statement by indicating that this signifies that he is responsible ("I am responsible, you know"), and then admits without prompting, but with reluctance (note the "fine" within his comment), that on occasion he has met people, but stresses that he has never done so intentionally ("it HAPPENS, fine, but I don't go there looking"). For this participant, having anonymous sex (i.e., indulging in such impulses) is incompatible with the regulations that are imposed by his primary community, that is, "med school" (external impulses). Within this excerpt, the external nature of the impulses that are producing interference is best articulated through his assumption that the researcher would naturally be aware that attendance at medical school is a sign of his responsibility ("I'm going to med school; I'm responsible, you know"). In this way, this participant clearly illustrates how social hierarchies of profession constitute a form of external impulse that results in interference. Nevertheless, despite such external interference, this participant does engage in such activities occasionally, and only by chance, because they are not something that he intentionally seeks out (despite the fact that he regularly attends GCPs). For him, a career in medicine and his family values/morals are all forms of external impulses, which, in consequence, interfere with his impulses for sexual contact. This participant continues:

> Yeah, the INTENTION is there, but then I wouldn't act on it. Like, I have a friend; we went out a couple of weeks back and he was like, 'I am going to pick up a guy tonight'. And sure enough, he picked up a guy, and now, they're going out. He and I talked about it, and I just don't know HOW. I would never be able to do that. And they're still going OUT, so I ADMIRE him for being able to do that. (Ott-8)

For this participant, external impulses surface as his determination to remain faithful to his perceived social obligations of ensuring that his impulses to fulfil his role as a medical student negate his impulses to "to pick [someone] up" (i.e., meet a sexual partner). However, regardless of his behaviour, his impulses to meet a potential partner continue to exist, as is evidenced by the statement, "I admire him for being able to do that".

Another participant illustrates that, in addition to the social demands of career, socially imposed responsibilities to one's family also produce external impulses and interference. In the quotation below, this participant illustrates how obligations to his dog, mother, friends, and family produce impulses that interfere with his impulses for sexual activity:

> Even if I'm with a guy, it won't happen. You're thinking about your dog, your Mom, and everybody that's waiting for you at home, and this guy that's hard and wants to have sex, and you can't. So you're, so you just said no. (Ott-5)

This participant limits his impulses for sexual activity because he has a dog, a mother, and others waiting for him to return home ("you're thinking about your dog ..."). However, it is important to note that because his mother and dog are in Ottawa; while he is partying in Montreal, neither of them is capable of physically forcing him to return home. It is his sense of social obligation and responsibility (external impulses) that force him to do so. In addition, at no point does this participant state that he does not wish to engage in sexual activities, but rather, he says that he "can't". Therefore, family obligations are one form of external interference that requires this participant to restrict certain impulses.

Thus far, external impulse and interference have been limited to restrictive impositions. However, some participants also noted that, at times, external interferences

served to promote proscribed activities. The following participant states that Montreal provided one such external interference:

> I've done something extremely worse than what I've ever thought I'd do in my life in Montreal. I don't think it would have happened in Ottawa. Just because of the attitude with people, there just seems to be no judgment. Complete freedom I guess. (Ott-10)

For this participant, the ambience of Montreal (an impulse) produced sufficient external interference to persuade him to indulge impulses that he would not have done in another context (Ottawa). Moreover, other external impulses that produce interference arise from social perceptions of the body, and not from the actual physical limitations of the body itself. That is, cultural perceptions of beauty and physical attractiveness are external impulses that can interfere with other impulses to ultimately change the outcomes of the original impulses. For example, the following participant reports how feelings of popularity and acceptance at GCPs helped him overcome his childhood memories of physical disfigurement:

> I liked the popularity [at the GCP]. It was a real acceptance thing because as a kid I came from an alcoholic home. I was also plagued with a bad skin problem at a really young age, so that never made me feel sexy. And it was really strange, it turned out later in my twenties and thirties, I discovered that it was almost like a true peel. So for me, it was a really strange way of being accepted. (Ott-7)

According to this participant, a negative self-image resulting from a childhood skin disease impeded his ability to feel sexually attractive. While his self-perceptions constitute internal interference (discussed below), the relevance of his statement here is that he ascribes a significant role to other individuals in the creation/modification of this internal perception. Witness how he contrasts the "popularity" and "real acceptance" of the GCP with "com[ing] from an alcoholic home" and being "plagued with a bad skin problem", and then describes the effect of this contrast (that is, finally "being accepted" in his "twenties and thirties"). In this case, the participant provides an example of external impulses interfering with his impulses of self-image when he states that GCPs constitute locations where his previous social rejection is revised by perceptions of "popularity" and "real acceptance". For this

participant, two different outcomes have resulted over time from the same physical condition: he perceives that the markings of his skin condition interfered negatively during his youth, but with age, these same markings transformed into a beneficial attribute. Furthermore, other participants echoed these beliefs about physical appearance, and reported that their sexual practices change based on the physical attractiveness of their sexual partners. This supports the finding that perceptions of beauty can result in external interference. However, in these latter cases, by changing their sexual practices based on physical appearance, these participants also serve as sources of external impulses for their sexual partners. In this way, each individual acts as a source of external impulses and interferences for other individuals. The following participant illustrates this point:

> If I'm just with the person to get off, then it doesn't matter to me. I've already fulfilled my needs to get out. But if it's someone who I'm really attracted to, or I'm sort of into physically, or we had a good connection, then I definitely want to get them off as well, so I'm sort of more into it. (Ott-2)

For this participant, his impulses to satisfy his partner's sexual impulses depend on whether or not he finds this partner physically attractive. Such changes in sexual practices act as external impulses for his partners by reinforcing (interfering with) their personal perceptions of their own physical attractiveness. For many participants, the types of sexual activities that they will engage in depend on the physical attractiveness of their partners. In fact, for one participant who reported being reluctant to engage in receptive anal intercourse, the physical attractiveness of his partner would be sufficient to persuade him, without verbal coercion, to engage in this sexual practice:

> I prefer sucking, being sucked, or fucking, but I will get fucked by someone if I want. Basically as a favour to them because they're hot, or they have a nice cock that I want to suck off. And, if the only way to get that is to get fucked, then, I'll do that. (Ott-1)

This participant illustrates that those whom he finds attractive act as external impulses that dictate how he will behave. In this regard, the participants reported that perceptions of physical appearance represent two forms of external interference. First, social norms of

beauty dictate what they find attractive, and, secondly, the actions (impulses) of other individuals identify how closely they align with these societal definitions of beauty. In this second case, the perceptions of other individuals interfere with each participant's criteria of personal attractiveness.

Moreover, while external interference is distinct from physical objects, it still is capable of exerting control over those objects, and vesting them with power, as was evidenced by the need for a ticket to enter a GCP, and the prevention of re-entrance into a GCP. Included within this context is the capacity of consensual knowledge (in the form of accepted rules and attitudes) – that is, the consensus of cognitive impulses – to redefine, or redirect the impulses of physical objects by investing them with agreed upon power, and thus making them purposive agents of external interference. For example, as evident in the observational data, the uniforms and paraphernalia of the security guards visually transform them from being ordinary folk attending a GCP (with whom the participants could party, or have sex) into restrictive physical forces that prevent drugs, or unauthorized individuals (no ticket) from entering the GCP premises. Although it is true that the security guards are capable of producing physical interference because of their body structures, this physical exertion is not required because each GCP attendee understands (is part of the consensus of cognitive impulses known as knowledge) and accepts the guards' potential for physical interference, and chooses not test it. Furthermore, it is also generally acknowledged that, while security guards restrict access, they also promote order – the power that prohibits, also helps. In this way, the external impulses connected with their job interact with the physical impulse of their uniformed presence. Similarly, the paramedics present at the GCPs also constitute examples of physical impulses (their uniforms and equipment etc.) that have been vested with the power of the external impulses associated with their profession – in this case, to promote health in emergency situations, such as when the

impulses of consumed drugs produce physical interference that an individual's body is incapable of accommodating.

Internal Impulses and Interference

The last sub-category of impulses that was identified was internal impulses and interference, which emerge from an individualized assimilation of the combined effects of physical and external forces. That is, this last form of interference arises from the interactions between multiple impulses within one individual. Internal interference was most readily described by the participants as self-control or self-discipline. It is the ability to overcome an impulse that has become perceptible, is deemed unacceptable to the self, and therefore, requires mastery. As such, internal interference is the interaction between an impulse to engage in an activity and a competing impulse not to do so for other reasons. In this way, it could be suggested that some internal impulses are the products of external impulses, and that through learning and mastery, that which is external becomes internalized. Thus, impulses of morality, or fear, et cetera interacted with the impulses for drug use to ultimately prohibit the action. In this regard, internal interference is a highly effective method of group control because it is the internal regulation of behaviour through social constructs (i.e., external interference), as opposed to the use of overt violence to dissuade such actions. In this way, personal beliefs about morality and fear of reprisal, and ideations of social function, all combine within the individual to often prevent him from breaching societal rules without any overt form of external interference occurring.

In fact, data analysis revealed that the participants described this form of impulse and interference as their personal interpretations of both physical and external interference. Consequently, each participant's interpretations of these interferences varied significantly. For example, the aforementioned perception of physical attractiveness was one such internalization of external constructions of beauty that varied greatly, as was each

participant's comfort with, and preference for, specific drugs. The following five participants provide examples of varying levels of comfort with different sexual and substance use practices:

> If you're going to have sex with somebody and not use a condom that is your problem, your prerogative, but if you put yourself into the position of being drugged, on Viagra, with a hard-on, not everybody has a condom in their back pockets and lube, so I think that's foolishness; I think that's really putting yourself into that position. (Ott-5)

> You look forward to going to Club on a Saturday, and picking up whatever beforehand, and planning your whole night out, and if it escalated beyond that, so be that too. (Ott-7)

> And, you know, except once with my partner of a long time, I never had anal sex without condoms. But blowjobs – never used a condom. (Ott-6)

> I can be fairly open and forward so I don't mind meeting someone on the street and necking with them and stopping traffic or stuff like that. You know, going off somewhere and sucking them. (Ott-1)

> I won't approach anyone usually, even if I drink or not. (Ott-3)

These participants illustrate the individualized nature of the internal interference that arises from intrapersonal impulses by describing personal differences in similar practices. Nevertheless, these excerpts only identify that personal variation exists; they do not identify the personal elements such as, conceptualizations of right and wrong, personal definitions of acceptable behaviour, self-esteem, and self-confidence, which are involved in the creation of these differences. The following participant exemplifies the effects of self-esteem as an impulse that produces internal interference when he states:

> I think it's easier on me self-esteem-wise. Let's just not have a plan and let's just see what's going to happen. And if something DOES happen, sure, it'll be cool. Then, I think it'll be more of a let down, if I establish a plan, go to the bar, and the plan fails. Maybe that's how I'm trying to get out of it. (Ott-8)

As indicated, for this participant, self-esteem is an impulse that produces his internal interference. Other participants reported that internal interference could arise from any number of competing personal impulses that would limit behaviour, and ensure that actions coincided with the mandates of external impulses. In this way, internal interference can be

concisely described as an individual's ability to exert self-control, and to regulate personal actions regarding specific sought-after sensations. Thus, an internal interference, which functions to ensure that behaviour remains within social boundaries, is a conscious decision, although one that, according to the participants, forms based on an internalization of social requirements. The following participant highlights the most commonly cited form of internal interference – self-control: "I like to have control, so, I don't get completely smashed" (Ott-3). For this participant, his internal interference originates from a conscious decision (impulse) to maintain personal control, an impulse that prevents his excessive alcohol consumption.

Nevertheless, internal interference did not always occur as a conscious process. Analysis of the interviews with other participants identified that participants were often unaware of the internal impulses that produced internal interference to ensure that their actions reflect group norms. In these situations, the participants revealed that they undertake a form of self-policing when they unknowingly allow one impulse to modify another impulse, and thus, internal interference produces unintentional personal regulation of their actions to ensure that they conform to the social group. The following participant describes his personal interference regarding alcohol consumption:

> Maybe under some sort of gauge, to kind of check myself, 'have you had enough to drink?', or 'are you doing anything beyond what the rest of the people are doing?' (Ott-12)

For this participant, the outcome of internal interference ensures that he drinks what he deems to be acceptable amounts of alcohol (not too little and not too much). This participant exemplifies that internal interference may require that he consume more alcohol to maintain group norms ("have you had enough to drink?"). Thus, for him, internal interference prevents him from pushing his limits too far. In this regard, the participants reported that internal interference is not a restrictive force, but one that ensures that their actions conform to contextual norms.

The data analysis also revealed that some participants rely on substance use to produce physical alterations (physical interferences) that modify their internal interferences. Such modifications allowed the participants to match situational social norms. For example, the following two participants illustrate how alcohol consumption allows them to make decisions and engage in actions that otherwise they would not:

> You're intimidated, you're shy, and you want to have a drink. (Ott-6)
>
> You make decisions that you wouldn't normally if you were not drunk. (Ott-10)

For the above two participants, substance use produces physical impulses, that is, the associated physiological and psychotropic effects, which interfere with other internal impulses and ultimately result in interference and actions that in other situations would not occur. The impulses that would normally be restrained are unleashed. At times, however, such over-indulgence may be counter-productive to the social body; another participant highlights that while internal interference is seemingly restrictive, it also provides the positive outcomes of self-restraint and group order. This participant posits that self-policing is an internal force of necessity:

> I think the police is the external force or the external manifestation of the force that we have in ourselves, I think as human being we do have that part of us that needs policing. (Ott-13)

As is indicated by the above quotation, not all forms of interference are negative. In fact, the participant quoted above emphasizes that the internal regulatory force ensures that he refrain from certain actions in order to ensure group cohesion, while it also prevents him from being excluded from the group because of excessive behaviour. The power of impulses is one that may, at times, need containment, thus allowing its power to be harnessed. However, the influence of internal interference is often overlooked because the

participants are often unaware that such self-regulation is occurring. For example, the following participant comments on the controlled nature of his own responses:

> I would have listened to this conversation I would sound like a control freak slash martyr. (Ott-12)

This participant's self-reflection on his own answers highlights his acknowledgement of personal self-regulation and how his actions are the results of internal interference.

Constructing Internal Interference: Learning Social Norms

The transformation of contextually appropriate external impulses into the internal impulses of each individual constitutes a method by which social norms are learned. In this case, the transfer process encompasses the methods by which each individual acquires, not only appropriate understandings and demonstrations, but also, the correct beliefs and value system of social rules. Ultimately, the construction of internal interference (that is, the acquisition of personal impulses that interfere with other personal impulses) is the method by which individuals begin to desire group-mandated impulses, a process that is accomplished through both overt and covert forms of violence. The overt forms of violence are often readily apparent, with most individuals being cognizant of their existence. These include not only the vigilante actions of hate crimes (e.g., gay bashing), but also legally sanctioned actions, such as, physical arrest, imprisonment, and reprimand from social authorities (nurses, physicians, lawyers, police, etc.), which dissuade individuals from undertaking socially marginalized (but not always illegal), practices. The following participant explains how being "fagged out" resulted in physical violence:

> I was at an after-hours party, and it was a guy who had seen me once before, and he basically came up, to me and was like 'you're a fag', and I'm like 'yeah so! Whatever.' And he just started hitting me, started punching me, in the face mostly. The story I got later was that he was from a small town and homophobic and not used to encountering gays, and I was pretty 'fagged out'. (Ott-2)

The above quotation provides a clear example of overt violence being used to punish the participant for being "fagged out," that is, not conforming to conventional codes of conduct. However, such obvious examples of social norm enforcement are less common than examples of the subtle coercion, which is applied to ensure that individuals behave appropriately. For example, below, a participant reports that in one city, without being directly told, he notices contextual differences:

> In Montreal, there's passion. The way people dress; I dress differently if I go to Montreal dancing because there seems to be a more acceptance, more sexual appeal within the community. It's fashion; it's touching. And also the language. There's a certain kind of language within these environments. You'll make all kinds of joke pertaining to the behaviours of gay people that you wouldn't make somewhere else (Ott-6)

The above participant highlights the "unwritten" rules of conduct that exist within specific cultures. In fact, in contrast to the more easily recognizable methods of authorized rule enforcement, covert violence involves peer acculturation, stigmatization of the abnormal, ostracism, fear mongering, and the "caring" advice of social authorities. The same participant continues to explain the "caring", but moralizing, reaction that he received at a hospital:

> **What was the reaction after you went to the hospital?**
> I think that they were more concerned with the fact that I was using drugs at the time than they were with the actual injuries that had occurred because I needed stitching to my face, and like painkillers. But they were definitely more concerned with the fact that I had taken ecstasy than I had any injuries. And I found it particularly awkward. I knew what was going on, and I was very coherent, and I was sort of taken aback that they sort of treated me that way. (Ott-2)

As is evident in the excerpt above, the methods of covert behaviour modification are intangible forms of power (rejection, humiliation, abandonment, shame, disgrace, etc.) that do not leave the traditional marks of physical harm, and therefore, are often unrecognized as forms of violence. Instead, they are seen as examples of normal group interaction. Consequently, these methods of social regulation are invisible or unacknowledged as such, while still functioning as techniques by which individuals are trained or moulded as good

citizens. Often, covert violence is used to enforce the observance/continuation of traditions, conventions, and rituals that are considered as unassailable commandments, although not written formally in law or scripture.

Sub-Theme Three – Outcomes of Interference

So far, only the types of impulse and interference have been examined. At this point, the outcomes of the aforementioned interferences will be provided. An important revelation of the analysis was that sometimes the interference between varying impulses produces results that seem incongruent with one another. The following participant exemplifies this phenomenon as a distinction between the rational mind and the subconscious:

> I think desire could be out of control, or it could be expressed in terms that to the rational mind would seem crazy, but that the subconscious mind would understand. (Ott-13)

The above participant describes a process that many others alluded to; that is, from the perspective of "the rational mind", certain impulses "seem crazy". Examples mentioned by other research participants included the inclination toward objects that are not beneficial – the impulse toward sexual partners who could result in social difficulties (e.g., infidelity and divorce), or the drive to undertake actions that may compromise the integrity of the body (e.g., STIs or HIV). According to the above participant, such impulses ("desires") "could be out of control," and would thus be incomprehensible to the intellect, wherein all actions must benefit the individual, or they "would seem crazy". However, the same participant warns that while seemingly different, these impulses are actually an interactive and mutually necessary interplay between rationality and irrationality. He states:

> It could be that there's interplay between this irrational part and the rational part. And one fits into the other in a way that, if one takes over too much, the other one will come in. It's a bit like the judge sentencing the prostitute for what they've done together, and it could be that the rational mind cannot accept how the irrational part of us would express itself. And they don't speak the same language, and they don't seem to have a translator to kind of agree with one another. (Ott-13)

The participant above questions the validity of using rationality as the determinant for irrationality, thus illustrating that for him, rationality and irrationality are equivalent and dynamically interrelated. It is not that one is superior to the other, but rather, that neither can be judged by applying the requirements of the other because "they don't speak the same language, and they don't seem to have a translator to ... agree with one another". For this participant, the irrational part of his existence is expressed through impulses that may be contrary to his perceptions of rationality. In this regard, his impulses do not seem to incorporate consequence, but with further analysis, there is an in-depth, penetrative interaction between them. Furthermore, the previous participant, (Ott-13), also suggests that rationality and irrationality are inseparably interrelated. This participant compares the relationship between them to that of a judge who condemns a prostitute for having intercourse with him; that is, although the rational mind might censure dialogue with the irrational, in actual fact, their relationship is intertwined, with the processes of one penetrating the other, and vice versa. He further states that the distinctions made between these two (judge and prostitute) are superficial ones arising from observers being unaware of the more intimate interactions that occur. In this manner, cognition (representing impulses that follow the dictates of logic and rationality) and impulse seem distinct, but actually intertwine where they cannot be observed doing so. The following participant also exemplifies this lack of absolute distinction between cognition and impulse. He wants to fulfill his impulses for sex, but heeds the possibility of infection. He then reports that the interplay between these two forces does not always produce a cognitively correct result; nor is it an exclusively impulse driven action. In contrast, he practices sex in as safe a manner as possible, and thus, these two forces interact to create a new impulse. He states:

> I haven't been in a relationship for more than two years, but I do have a desire to fulfill my sexual needs with other men, and I do this regularly with either regular friends or new friends that I meet. But I am aware that there is, even though I do practice sex in as much as I can in a safe way, there's always a possibility of infections, and so on. (Ott-6)

For this participant, impulses result in physical connections with other men that are affected by personal beliefs about risk. Thus, analysis of the interview data reveals that interferences ultimately produce two main limits – the first was identified as the relative limit, and the second as the absolute limit. (Please note that while this terminology of relative and absolute limit have been borrowed from Deleuze and Guattari,[45] the concepts are not the same.) It is important to note that the research participants identified these two levels as limits, not limitations (please see the next section for quotations). This means that these levels constitute benchmarks, or distance measures, rather than impositions or restrictions. Often, however, participants revealed that these limits function as a limitation that they would not transgress. Furthermore, for any given individual, these limits are not fixed, innate, natural, or identically situated, but rather, are subjective, and subject to change, across time and between contexts.

Relative Limits

The first limit that the participants described was labelled the relative limit, indicating that its position is always in relation to other objects, thus making it continually susceptible to modification. Data analysis revealed that relative limits must be understood as the outcomes of interferences that produce a somewhat consistent expression of action, thought, and emotion. In addition, some of the participants recounted examples of relative limitations experienced during day-to-day mainstream social interactions when they follow prescribed social regulations, and behave according to rigid heterosexual rules of engagement, regardless of their personal beliefs. In this regard, relative limits are established both when rules are followed strictly due to acquiescence to the prevailing code of conduct and when rules are followed due to beliefs in contextual propriety. The following participant identifies such contextual beliefs in propriety regulating acceptable contact between men in various cities:

> I would never walk on a busy street in Ottawa holding hands with a guy. But in Montreal I've done it without even being concerned. (Ott-10)

For this participant, such contextual beliefs signify that different environments allow different behaviour. In addition, relative limits may also be produced by physical limitations, but being relative, are easily surmounted. The following participant illustrates how his relative physical limitation of fatigue can easily be defeated through substance use:

> At around four o'clock in the morning it will probably be ecstasy and usually when you come down from ecstasy you use marijuana so you don't come down harder. (Ott-11)

For this participant, ecstasy is used to overcome fatigue. He then continues that subsequent to ingesting ecstasy, he uses a second drug to counterbalance its withdrawal effects. The combination of these two substances results in prolonged energy and then a reduction in the rebound effects of lengthened arousal (witness: to "come down" you use "marijuana so you don't come down harder"). Such a combination of substances allows this participant to shift his (relative) physical limits at will. However, not only physical attributes constitute relative limits. For example, an individual's self-permitted sexual practices are relative limits that alcohol consumption can modify. The following participant states:

> I'm STILL able, when I'm drunk, to recognize my limits – what I'd do and what I wouldn't do. All the times that I went out and got smashed, I never brought a random home. So, I think that kind of says that I still DO have limits when I'm smashed. I just know what they are. (Ott-8)

According to the above participant, despite intoxication, he is still able to "recognize [his] limits". Embedded within this quotation, however, is the revelation that alcohol functions to change his limits. As evidence of this, notice his comment, "all the times I went out and got smashed, I never ...", and consider that his reflex is to reflect on times when he was intoxicated. This response reveals that he views "those times" when he "got smashed" as the times when he was more likely to exceed his limits. Therefore, for this participant, alcohol intoxication might permit him to indulge in activities that he would not engage in when sober, but, to date, this has happened only to a point. In this way, it is possible to

recognize the existence of a secondary limit: a limit beyond the relative limit that, regardless of intoxication, will not be overstepped. For this participant, this secondary point is represented as the limit that he "just know[s]" and that he "still DO[es] have ... [even] when ... smashed".

Absolute Limit

The secondary boundary that the research participants identified was the absolute limit, a point that they were neither ready, nor willing, to go beyond due to their perceptions of the resulting consequences of doing so (whether those were physical harm, psychological distress, or threats to their personal self-definitions). However, there are two important points regarding the absolute limit. First, the absolute limit is not the point past which individuals cannot return; instead, it is the point past which they do not wish to venture because they believe that they cannot return from beyond it without incurring irreparable physical, emotional, cognitive, or psycho-social change/damage. For example, an individual can surpass his absolute limit by becoming more intoxicated than usual and then (to use the above quotation from Ott-8) go home "with a random". In this case, the effect of surpassing this limit (i.e., surpassing what he describes as that which he "wouldn't do") would be a forced re-definition of the self. In this example, the participant would need to reconcile his self-definition with a new behaviour because the act of random sex would no longer be something that he "wouldn't do", although it could be something that he "wouldn't do" again. Secondly, absolute limits are not universal because each participant identified his absolute limit differently. For example, engaging in anonymous sex was one action that was an absolute limit for some participants, a relative limit for others, and no limit at all for still others. Thus, the interviews revealed that, although absolute limits are unique to each individual, they consistently function as the point beyond which they will not go – for some these limits represent a distant line that will not be overstepped; for others, it is about

approaching this line, without exceeding it. Thus, the absolute limit can be goal, a limit, or both – the objective and/or the terminus. It is the cliff edge wherefrom the best view can be captured, but not without the ever increasing likelihood of falling. Consequently, this limit constitutes a point that, if reached, produces maximal results, but if exceeded, produces unacceptable results, such as, the loss of something valuable, or physical harm. The following participant exemplifies this by stating that his alcohol and drug consumption went beyond his absolute limit, and made him feel like an addict:

> You basically feel that you're an alcoholic and you're a drug addict. And you need your cocaine to finish your day, you need your alcohol because you're thirsty, and you need your sex because you feel that's what's keeping you alive. (Ott-14)

For the participant above, the process of pushing his relative limits relating to substance use eventually culminated in him exceeding his absolute limits, resulting in addiction. Fortunately, he was able to address his substance addiction without any reported irreversible harm. Thus, while exceeding the absolute limit often results in outcomes, which are deemed negative (i.e., intolerable risks), surpassing this limit does not necessarily result in negative outcomes that are completely irreversible. Another participant demonstrates this reversibility of unfavourable outcomes when he surpassed his absolute limit, and experienced the effects of multiple drug overdoses. He states: "I died maybe four-five times in my life, and all of them because of drugs" (Ott-7). For this participant, the result of exceeding his absolute limit was not self-reported as addiction, but rather, as near-death experiences. As with the previous participant, (Ott-14), the consequences of going beyond the absolute limit were, for the most part, reversible in the present time; that is, he was revived. However, while at this moment in time the outcomes of this participant's excessive drug overdoses seem reversible, it must be cautioned that some irreversible results (such as neural, hepatic, or renal damage) might not manifest until later. Furthermore, other participants identified that the outcomes of surpassing their absolute limit were not

completely reversible, and emphasized that sometimes life does not forgive. The following participant identifies how by exceeding his absolute limits he ended up with multiple reversible outcomes, and one that was not. He fought addiction, had his teeth repaired, regained his health, but nevertheless, at the end, acquired an incurable infectious disease:

> This is one thing people don't know when they touch a drug like that [crystal meth]. It's like destroying yourself. The path to recuperating is really hard. Broke all my teeth; that was a real mess. Health's back; there's nothing wrong with me now except for my HIV, and that's under control. (Ott-7)

The above participant explains how exceeding his absolute limits produced many reversible outcomes (that, however, required varying degrees of work to repair the damage), but also one outcome that was irreversible. In fact, this participant illustrates that as his experiences surpassed his relative limit, and then his absolute limit, a marked decrease in reversibility occurred, with one consequence being absolutely final – the acquisition of HIV.

Parameter Drift and Parameter Shift

According to the participants, they employed both unintentional and intentional methods – henceforth referred to as parameter drift and parameter shift – to navigate their relative and absolute limits. The main difference between these two forms of parameter change is intent. The first method, parameter drift, encompassed all the ways in which the participants enabled desired activities by changing the context or circumstances. To repeat a previous excerpt, the following participant exemplifies how a change in context allows him to engage in different actions. He states:

> I would never walk on a busy street in Ottawa holding hands with a guy. But in Montreal I've done it without even being concerned. (Ott-10)

For this participant, changing cities permitted him to be more comfortable engaging in public displays of affection with another man. Throughout the interviews, many participants revealed that they often achieved such modifications without consciously intending to do so. While the previous quote (Ott-10) reveals a conscious awareness of how context can

change practice, other examples included the effects produced by changing peer groups and physical locations. The parameter drift is directly related to the modes of conduct deemed acceptable within varying environments. In these cases, the participants engaged in contextual changes without conscious awareness of how this would satisfy their impulses. The following participant illustrates a parameter drift in which he allows the group to select the party setting:

> If the group wants to just go out dancing then we go to a more club place, or if they just want to go out and sit down on a patio, and stuff like that. (Ott-12)

For this participant, the absence of decision-making regarding location selection partially absolves him from the outcomes of his actions within that location. Thus, the parameter drift occurs in this case as part of a group process; that is, parameter drift occurs according to what "the group wants", rather than as a result of the independent decisions of the participant. In fact, the only decision that the participant makes is to relinquish his autonomy to the group. (Witness his usage of "if the groups wants ... then we", and note how he has managed to subordinate his desires to the point where he is no longer the individual speaker within his own sentence: i.e., he does not use the first person pronoun.) Therefore, as indicated by the previous participant (Ott-10) who explicitly articulates that location, in part, helps to define acceptable behaviour, it is possible to state that in this case, by agreeing to (rather than making) decisions, this second participant (Ott-12) is strictly conforming to group norms of behaviour, not intentionally fulfilling his impulses. Ultimately, this provides an example of parameter drift because, without forming the intent for a specific milieu, he allows what, "the group wants" to dictate location. In the same way, attending a GCP is also a form of parameter drift of relative limits, which occurs because GCPs constitute areas where individuals can consume legally controlled substances, such as, alcohol, while allowing for different types of interactions, such as, dancing or erotic contact.

However, location selection can also be intentional, at which point, the method of navigating limits becomes parameter shifting, that is, the act of intentionally engaging in practices that will directly result in the modification (whether actual or potential) of a specific limit. The following participant acknowledges personal intent when he consumes alcohol in bars:

> You go to a bar to drink and dance. Now, I'm not saying get drunk, but have a drink. (Ott-7)

For this participant, attending a bar is not due to a group decision, but rather, is part of a conscious intent to consume alcohol: ("you go to a bar to drink"). Analysis of the text provided by some of the participants revealed that this form of conscious intent is also a factor that motivates GCP attendance for many of them. That is, GCP attendance can be a form of parameter shift because it allows the participants to act on impulses in ways that that they might not in other environments; thus they act on purposive decisions that will likely result in the fulfillment of their desires. For example, participants often related that their reasons for attending GCPs were that they are gay-friendly environments within which the consumption of drugs and the seeking of sexual contacts are socially (but not legally) condoned. The following participant states:

> So that's what attracts me to it, being surrounded by 15,000 people is nothing that can be compared to a nightclub that holds two, three, four, or five hundred. So that attracts ME to those parties. Of course there's also the drugs and there's the sex aspect and a sexual tension. (Ott-5)

While this participant acknowledges that he likes large crowds, he also states that he is attracted to the sexual and drug use aspects of GCPs, thus identifying his attendance at GCPs as parameter shifts. In a similar vein, another participant illustrates that drug use can also be used to achieve a parameter shift. This is exemplified in the following excerpt in which the participant reveals that he does not "do things because of drugs", but rather, that he uses them "to stimulate" the experiences that he already desires:

> I don't do things because of drugs. But the drugs are there to stimulate it, to arouse your desire, and to I guess to add to the whole sexual experience. You hear the music differently. (Ott-15)

For this participant, drug use constitutes a parameter shift (notice when he says, "I don't do things because of drugs", that he has a pre-existing intention of using them to "arouse [his] desire"). This allows for the substance use to produce its effects of parameter drift and shift ("the drugs are there to stimulate"). The drift results in "hear[ing] the music differently"; while the parameter shift is the intentional drug usage to achieve sought-after stimulation and arousal (to "add to the whole sexual experience"). Thus, even through parameter drift and parameter shift are different methods for negotiating limits, they are often irrevocably intertwined.

Impulse without Action and Paroxysm

Analysis of the interview data revealed that the two main outcomes of navigating personal relative and absolute limits were impulse without action, and paroxysm. Impulse without action occurred when one impulse (often, a desire) was overridden by another impulse (usually, common sense, logic, rationality, or knowledge), thus resulting in the first impulse being ignored. In these cases, despite the participants being aware of their impulses and clearly articulating them, they consciously refrained from fulfilling them; that is, the resultant interference of multiple impulses was to refrain from satisfying their desires. In the following case, the participant is aware of his impulses, but reports that he will never satisfy them because of other impulses he has regarding sexual health risks:

> Sometimes you wish you would be able to do it, but there's so many risks out there that you just don't do it because of moral values or whatever. (Ott-10)

In the above quotation, impulse without action is exemplified when the participant describes his desire to act out sexual fantasies, but restricts such actions due to what he terms "risks [and] ... moral values or whatever". For him the impulse is recognized and he is matter-of-fact as he relates that he has these impulses, but will not indulge in them ("you just don't do

it"). Further exploration with other participants revealed that interference that results in the restriction of a desire (i.e., an impulse for sex) may produce a reactionary emotional/psychological response. In the above quotation (Ott-10), the tone of the participant and his reasons for making this statement reveal a sense of pride in his ability to be self-disciplined ("you wish you would ... but ... you just don't"). To him this internal conflict, where one impulse overrides another, seems to correspond to the triumph of good (rationality) over bad (hedonistic sexual indulgence). At first glance, the same process seems to be described in the following quotation: one impulse negates another. However, the resultant emotional experience in this latter case is negative. In fact, in the following case (Ott-3), a contextual reading of this participant's statement reveals that he has the desire to meet new partners (the initial impulse), but that he fails to act on it for unspecified reasons (secondary impulses), and as a result, he "do[es not] feel good about [him]self" (the outcome impulse) when his impulses to meet potential partners are not acted on:

> Yeah, my friends and I have talked a lot about how we go out to the clubs and we might see guys that we're interested in, but we may not approach them, and then after we leave the club, we get down or we get a downer at the club and we still go. Like we don't feel good about ourselves. (Ott-3)

For the above participant, an impulse to meet partners exists, but failure to seek out such partners produces negative feelings, described as a "downer". In this regard, the lack of materialized impulses produces disappointment. In addition to these internally imposed restrictions on behaviour, whether out of self-discipline (Ott-10), or for unspecified reasons that prevent action (Ott-3), further exploration of this topic with Ott-3 confirmed that such restriction can also arise due to external interference. He reports that in addition to not "mak[ing] the effort to pursue", someone "not [being] interested" also results in a "downer". He continues:

> **Are there other things that may cause the downer?**
> I guess just when you see someone that you're interested in, and they're not interested in you, or you don't make the effort to pursue. (Ott-3)

For this participant, the thwarting of his desire to act on his impulses may result from either external interference – the other person is not interested, or from internal interference – his own insufficient effort to achieve his goals. In either case, while fantasies are present, the impulses occur without a follow-through action, and result in unhappiness. Such a reaction to unfulfilled impulses was common during the interviews. However, the intensity of the reaction varied greatly. For this participant, his response to unfulfilled impulses is repetition (notice the use of the present continuous tense of the verb "are...going" in the following quote, indicating a continual process). He states that despite negative feelings at GCP/ clubs, he continues to go: "We don't feel good about ourselves. Why are we going there anyways?" (Ott-3).

On the other hand, some participants reported experiencing more profound reactions when impulse without action occurred. One possible result of unfulfilled impulses that the participants identified could be summarized as a paroxysm, or "a sudden or violent expression of a particular emotion or activity".[199] According to some research participants, when their impulses are restricted, they do not disappear; but rather, they increase in intensity due to this restriction. For some individuals, an increase in intensity may produce explosive indulgence during subsequent gratification of these impulses. For the following participant, regular satiation of his impulse for sexual contact results in its abatement, while restriction of sexual contact results in multiple (concurrent or consecutive) sexual contacts:

> Sometimes when I go to bathhouse I can't get sexual. But sometimes, if I didn't go to bathhouse for like a week or something, you feel like you're going to fuck five to six guys. (TO-2)

For the above participant, abstinence produces a more powerful sexual charge, with a direct increase in his sexual appetite as well. The restricted impulse for sexual activities increases the intensity of his impulse, which causes a parallel increase in the minimum amount of activity required to sate his impulse. In the following excerpt, the participant describes this release from the built-up intensity as the removal of a physical pressure from his chest:

"Sometimes you just go there to release the pressure off your chest" (TO-2). While for this participant sporadic indulgence in impulse is described as an act of releasing pressure, continual indulgence in an impulse through the sheer availability of sexual activities lessens its intensity and regular sexual contact means that his impulse for such contact does not become a preoccupation. The following participant validates this finding when he states that regular sexual contacts reduced his preoccupation with attaining sexual contact:

> I probably had sex every day. Sex just happened all the time. It was just around at the time. It was at the gym; it was at the dances; it was at the parties. It was just available. So, I didn't have to fixate on it because it was going to be there anyways. (Ott-7)

According to this participant, he was not preoccupied with the impulse for sex because sexual contact was always readily available, thus confirming this finding.

Stable Self-Definition

Data analysis revealed that, as an effect of impulses, their interferences, relative and absolute limits, and parameter drifts and shifts, the majority of the research participants exhibited stable self-definitions. These definitions comprised their thoughts, emotions, and actions, and, in turn, served to monitor their behaviour by generating interference for any new impulse that might threaten the boundaries of these pre-existing self-definitions. The following participant highlights how this perceived stability helps him to define himself in contrast to other people. He states:

> I'm definitely not one of those people. I'm pretty forward when I'm sober, so I tend to be pretty much open. I'm not a shy person at all. I'm pretty bold. So, that's not a reason for me to use drugs. (Ott-2)

According to the above participant, he does not simply describe himself as not needing drugs to overcome shyness, but instead, self-defines as "not one of those people" who need drugs to act in a particular way. This statement illustrates a belief, which was commonly held by many of the participants – that specific types of individuals engage in specific types of activities. While for the participant quoted above, his statement was in relation to drug

use, the following participant highlights that for him, self-definition involves the locations where he meets potential sexual partners: "I've never gone to a bathhouse. I don't do that kind of partying" (Ott-8). For this latter participant, not going to a bathhouse is more than simply an action, it is a definition of the "kind of partying" that he engages in and of the kind of person that he believes himself to be. These statements illustrate the assumptions that the participants make about the stability of their personas and subjectivities. The following participant also illustrates this credo of stability regarding his sexual practices. He states:

> Except once with my partner of a long time, I never had anal sex without condoms. Blow jobs: never used a condom. And most of my friends, it's the same thing. (Ott-6)

For this participant, in addition to location, perceptions of acceptability regarding sexual practices also remain constant for him. He not only emphasizes that specific forms of sexual contact are always undertaken in a similar fashion ("anal sex," "never ... without condoms [but] blowjobs: never used a condom", but also that members of his social cohort follow the same precepts, ("And most of my friends, it's the same thing"). In this case, the self-definition is also being applied to his chosen social group based on the assumption that his friends always behave the same way that he does.

However, many of the participants also emphasized that, at times, particularly in relation to drug use, this stability could be shaken. The following participant states:

> It was getting to the point you could take your personality into darkness, into doing more risky. It [crystal meth] would just push you to the dark side, to push you to limits that you'd never do in a million years on your own. (Ott-7)

For this participant, crystal meth is a drug that is capable of pushing his personality into areas that would breach its natural stability. While his self-definition is relatively stable, drug use made him engage in activities that he wished to, but would not have done otherwise ("on his own").

Internal Distress

While participants reported that a restriction of their impulses (relative limit) results in paroxysm, they also reported that whenever an action was undertaken that pushed their relative limits to the absolute limit, a state of internal dissonance occurred. That is, indulgence in activities that the participants had situated beyond their relative limits, and/or which violated their stable self-definitions, often produced (reported) feelings of anxiety, guilt, or remorse after the fact. Even in cases where the research participants reported that their relative limits are self-imposed for exclusively external reasons (e.g., to demonstrate socially mandated behaviour) they disclosed experiencing internal distress when they exceeded these limitations, regardless of internal impulses that supported surpassing these limits. Any reduction in the gap between these two limits resulted in such distress – a state of conflict between two internal impulses. According to one participant, engaging in anonymous sexual relations results in religious guilt:

> A lot of people I know, they're ok with just picking up a complete stranger and going home. I have done it, but it wasn't for me; I feel a Catholic guilt. (Ott-12)

The above participant admits that he has engaged in anonymous sexual encounters and one-night stands, but that this behaviour produced internal distress that he labels as religious guilt ("Catholic guilt"). To avoid this inner conflict, he now refrains from engaging in actions, which may precipitate this; that is, the effects of ensuing guilt (e.g., feelings of anxiety, shame, etc.) deter him from repeating particular actions. However, this is not always the case. In fact, in the following case, while similar feelings of anxiety and internal discomfort are reported (as evidenced by the personally chastising statement, "I am not safe for myself"), it seems that knowledge alone (regarding "safe[ty]" and "risks") is not enough to prevent dissonance- producing actions. In other words, secular knowledge of health risks is not as powerful for the participant below as religious-based guilt is for the one quoted above. This contrast is evident in the following quotation:

> Chastity is not much of an option, but is healthy. It is to some people, but not for me. So I've begun having sex and I realized that I'm not safe for myself. What I feel in me, in the having sex theme, is something that goes way beyond my conscious control. That seems to overtake me, and what I notice of other people's behaviour, I feel the same. Sex is way more than so called conscious awareness that we may have, whether it's casual sex, or sex in an ongoing intimate loving relationship. It is something way beyond that, that seems to go into a crazy part of us and that takes over and, so if one is into a fairly regular, stable relationship, the risks are not too big. (Ott-13)

Despite saying that "the risks" are overwhelming, this participant continues his anxiety-producing sexual practices. In this case, the participant chooses to continue engaging in the activities that produce anxiety, not because the benefits gained by engaging in these activities outweigh the potential harm of engaging in these practices, but rather, because he is driven to do so by his impulses ("what I feel in me ... seems to over take me" and "a crazy part of us ... takes over"). Thus, his impulses for sexual contact exceed his conscious control, and constitute a practice that is defined as crazy by the cognitive mind, but is still wished for by the individual. This same participant continues to explain that he engages in activities, which he believes could result in physical harm:

> But there's an element that seems to be stronger and that's what I mean by crazy. It's not the type of craziness you would expect of a cruel murderer or sadist. It's just something and it's this element that takes over us and makes us do something, but it could hurt us in quite a bad way, or it could lead us in ways that are not healthy for us and yet if we don't go that route we're also unhealthy. It's a very bizarre thing and that is unexplained. Maybe it's the rational mind that would like to get our satisfaction. And the rest of the body doesn't really care much about that. (Ott-13)

The above participant's impulses often override the rational arguments of his mind, and disregard public health directives to refrain from actions that may result in injury or damage. However, this participant is in a quandary because, while engaging in a desired activity may result in anxiety about unhealthy outcomes, not engaging in this activity also results in internal distress because the unfulfilled impulse produces paroxysm. Nevertheless, this ambivalence was often overcome through the intentional and purposive usage of drugs and alcohol.

Theme Two – Purposive Substance Use

The second theme that surfaced during the interview analysis was *purposive substance use*. According to the participants who took part in this research, they use substances (drugs and alcohol) within the context of GCPs in an effort to achieve particular sensations, which include, but are not limited to, intentional unsafe sexual practices. Thus, the participants reported that substance use does not cause them to engage in unsafe sexual practices, but rather, that they intentionally use substances to engage in those sought-after (i.e., desired) risky sexual activities. However, as was identified in the previous section (theme one – impulses), the participants were not always fully aware of their intentions. The following participant exemplifies a lack of awareness about his underlying intentions regarding GCP attendance in the following quotation where he questions his motivation for attending GCPs:

> I don't understand it sometimes. Why are we going there anyways? It's kind of like the feeling, 'oh we're single, and we're not meeting anybody, and why are we going out to these clubs', but when we go, we're not looking for someone, at least, not consciously. (Ott-3)

The above participant illustrates that he is unaware of his intention ("I don't understand it sometimes. Why are we going there anyways?"), but during the interview process (and in this quote specifically), he begins to wrestle with the idea that he may not be consciously aware of his motivation for doing so ("but when we go we're not looking for someone, at least, *not consciously*" – emphasis added). In such cases when the participants were not aware of their underlying desire(s), it was through the research dialogue process (e.g., questions about the rationale for certain actions, and/or dialogue about repetitive *accidental* occurrences) that purposive substance use as a mechanism to engage in activities that would satisfy impulses was identified. At this point, the sub-elements of purposive substance use will be examined. In total, there are seven sub-themes which are as follows: purposive substance use: 1. to overcome impulses; 2. for limit experience; 3. to achieve

desired sensations; 4. as a justification for behaviour *ex post facto*; 5. to follow social norms; 6. as respite; and 7. as a learned process.

Sub-Theme One: Purposive Substance Use to Overcome Impulses

First, participants identified their purposive substance use to overcome physical, internal, and external impulses, which prevent them from achieving specific desires. Rather than substance use causing the participants to engage in activities that otherwise they would not, the participants reported that drugs and alcohol are tools that they use at will to achieve desired actions. This involved drugs/alcohol use to overcome physical interferences (i.e., fatigue, muscle relaxation, hunger, erectile dysfunction, the use of condoms), and internal and external interferences (such as, guilt and/or knowledge of epidemiological risks), all of which culminate in the prevention and restriction of indulgence in otherwise sought-after activities. For example, according to the following participant, alcohol diminishes the effects of his internal interferences (internal policing) to the point that impulse-driven activities can be sought out and acted on:

> Sometimes you wish you would be able to do it [engage in sexual activities], but there's so many risks out there that you just don't do it because of moral values or whatever. But then, once the alcohol sets in, it allows things to be more easily done. (Ott-10)

The above participant highlights that, regardless of "moral values", his impulse to have sex exists prior to his consumption of alcohol (witness how prior to the "alcohol set[ting] in" he "wish[es that he] would be able to" have risky sexual contacts). While seemingly inconsequential, this sequence alteration from drug use causing risky behaviour to drug use being used to engage in risky behaviour signifies that substance use is a method by which this participant can achieve his desired sexual practices, rather than substance use causing his risky sexual practices. In addition, another participant supports this finding by stating that while substance use affects his inhibitions, it does not eliminate them, or produce drastic changes in his values:

> I think it MIGHT kind of get rid of SOME inhibitions, but I don't think that it actually changes your values. (Ott-4)

In the quotation above, the participant does not indicate that substances are used with the intention of overcoming inhibitions to allow him to push his limits; however, there is an acknowledgement that "disinhibition" occurs when he consumes alcohol, but not to the point of changing his values.

For another participant, (quotation below), substances act as agents that allow him to consciously engage in impulses that he has "been repressing a lot", such as, the impulse to breach the social standard of monogamy ("you're supposed to be monogamous"). In addition, the following quote indicates that his drug use does not cause or change his behaviour accidentally, but rather, that substance use makes him "more open and acceptable" to following his impulses to "have sex with other guys":

> I think it will disinhibit feelings that you've been repressing a lot. So as a couple, you're supposed to be monogamous; you're supposed to be in love with each other; you're supposed to only have sex with each other, but the desire to have sex with other guys is there. So, drugs both enhance your sexuality and your sensuality; you're more open to have other people join. (Ott-15)

According to the above participant, due to external impulses (witness the moral judgement in the phrase, "you're supposed to ...") and "repressed" impulses ("but the desire to have sex with other guys is there"), his feelings are inhibited. Because the above participant states that he is not "supposed to" have sex with people outside his "monogamous" relationship, this does not mean that he does not wish to do so. He states that substance use serves as a mechanism for overcoming his personal inhibitions. This participant sheds light on the fact that substance use is undertaken purposively to overcome limiting internal impulses, and thus allows for restricted impulses, not only to be acknowledged, but also to be permitted and accepted. The quotation above clearly illustrates that although the sexual practices of this participant are interrelated with substance use, the desire for promiscuous sex preceded his use of alcohol and or other drugs. In other words, substance use does not

create impulses, it allows for them to be realized, and indulged in. Moreover, the following two participants both illustrate this point by identifying a cognitive awareness of their personal reactions to alcohol and drug consumption prior to their use of these substances:

> With some drugs, or especially alcohol, I become very sexual. And even though I don't go with the intent, as soon as I'm a bit drunk, then the intent becomes a true reality. (Ott-5)

> **But you're more likely to go home if you're on something than if sober?** Yeah, just because, more likely, I would be horny if I was on something. (Ott-11)

For these two participants, substance use allows their sexual impulses to override their monitoring impulses. The first participant (Ott-5), notes that "with some drugs or especially alcohol, [he] become[s] very sexual". Looking at this sentence alone, it could be argued that substance use does cause him to change – in that he "become[s] very sexual", and this seems to be supported by his subsequent sentence, in which he states that he "do[esn't] go with the intent", but that "as soon as [he's] a bit drunk, then the intent becomes a true reality". At first glance, it seems that substance use causes, or creates sexual urges. However, it is important to unpack the latter statement because there is an almost imperceptible contradiction in his words: "I don't go with the intent" and "as soon as I'm a bit drunk, then the intent becomes a true reality". At first, this participant denies that he has pre-existing intentions to attend GCPs for the purpose of sex, but then subsequently states that this "intent becomes a true reality". The second participant quoted above (Ott-11) helps to shed light on the fact that it is not the "intent" that is affected by being "on something", but rather, that by using alcohol he allows his impulses to be "horny" to transform into actions. In summary, these participants illustrate that substance use does not create impulses for (risky) sex. In fact, it allows the participants to proceed to a previously desired (whether acknowledged or not) state of being that they describe as one of being "very sexual" (Ott-5) or "horny" (Ott-11). Stated in another way, the above participants do not purposefully use

drugs and alcohol to modify their intent for sexual practices; instead, they consume substances to allow their intent for sex to surface.

In contrast to the above participants, who did not explicitly acknowledge that substance use functioned in a purposive manner for them, the participants quoted below clearly state that their substance use is absolutely intentional – they consume drugs to permit them to be more sexually explorative:

> You do the drugs to lower your inhibitions so that you will try things that you normally wouldn't do on a regular basis. But if you don't do the drugs, you're not going to go there. (TO-1)

> I can recall once when I was sober and if I had been drunk, probably something would have happened differently. But when you're drunk, everything happens so much more easily. Not that it's a good thing, but you forget about the risk, or don't care momentarily. It's like an instant reward thing and you forget about the long term. (Ott-10)

These two participants emphasize the fact that substance use does not produce their impulses for sex, but that it can modify the actions that arise from these impulses (e.g., "when you're drunk, everything happens much more easily"). In addition, the second participant quoted above (Ott-10), says that substance use allows him to "forget about the risk[s]", thus illustrating that substance use allows him to overcome regulating internal impulses (e.g., "don't care momentarily" and "forget about the long term") so that he can indulge in the moment, in the "instant reward thing". For both the above participants, substance use facilitates engaging in socially proscribed activities by eliminating their regard/respect for social rules and their methods of enforcement (i.e., self-discipline and self-governing through shame, guilt, pride, etc). However, this does not mean that terminating substance use would prevent these practices from occurring because the participants' impulses to party and have sex pre-exist the substance use. To re-emphasize this point, the following participant confirms that he intentionally consumes substance so that he can pursue certain impulses:

> **Ok, was it something you wanted to do and the drugs were allowing you to do it, or was it something that the drugs were making you do?**
> No, I wanted to do it. It's [drug use] to get into the moment. It was facilitating. (Ott-14)

As explicitly stated by the participant above, drug use did not motivate his practices, but rather, it allowed him to subdue (ignore, disregard) other internal impulses that were preventing him from partaking in these practices. The above quotation reveals that "facilitating" does not equate to creating or producing impulses; instead, it allows for pre-existent options to be achieved with less effort. This is further supported by the fact that, for the following participant, even while under the influence of alcohol/drugs, he continues to cognitively evaluate the outcomes and risks of actions before he does them. He states that regardless of substance use, he engages in some impulse-driven activities, while refraining from others that he does not wish to undertake:

> It [drugs] wouldn't allow me to do something that I didn't want to do. So as long as you have those set rules in your mind before, because before I even did anything, I would second question myself. (Ott-4)

This above participant validates that, for him, substance use is not a causative agent for proscribed actions; it is an intentionally selected tool for accomplishing a particular, sought-out, and desired action. A second reading of this above quotation also reveals that this participant specifies that his actions are determined by a predetermined "set of rules", and that before engaging in any activity, he "second questions [him]self". Consequently, this participant cannot be seen as *impulsively* engaging in impulses. Quite the opposite, this participant emphasizes that forethought accompanies his actions and that his pushing of limits occurs in a regulated and controlled fashion. The following excerpt illustrates that the goal of the participant below is to be aware of his limits, to reach these limits, but not to surpass them. He states that he knows when to take, and not take, drugs in order to respect his personal limits:

> I know what my limits are. I know when enough's enough. I know what time to take them. Like, I never take them past a certain time; do not take too much; I'm never up for days on end. I'm very wary of that. (Ott-2)

This participant (Ott-2) also emphasizes the importance of being aware of his personal limits in order to prevent his withdrawal period (the "hangover" or "burn out" period) from affecting too many subsequent days ("I'm never up for days on end. I'm very wary of that"). Thus, this above participant, and many subsequent participants, highlight that even while substance use is strongly linked with impulse-driven sensations, for most participants, substance use occurred as a result of impulses (not vice versa) and that these impulses were undertaken within limitations. Stated simply, the participants consumed drugs to enable them to engage in specific wished for practices, but within a limited scope. Substance use allows the research participants to disregard certain social regulations in favour of pushing their practices to each participant's respective limits. The integrity of this limit is so powerful for some that when the potential of overcoming it becomes too likely, they will eschew whatever substance they feel is facilitating this. For example, for the following participant, this was done by restricting alcohol intake to bars and drug use to GCPs in a conscious effort to ensure that sexual practices only occur during pre-selected times:

> **Okay, so greater risk when you're on drugs?**
> Exactly.
> **So, when you're drunk or sober you'll make the same judgments?**
> Yeah, exactly.
> **But, if you're on drugs, or stoned, you'll have differences in choices?**
> Exactly.
> **And when you go out to bars, is there any difference from GCPs?**
> No. I would say that I am doing drugs a lot less. Um, at those kinds of bars I would be definitely drinking more. But I mean I have on occasion when you go out to regular dance bars I have on occasion used cocaine but the effects are very short. You don't stay high for very long, so it doesn't really affect you that much. And I only use small amounts. (Ott-2)

The above participant makes a firm distinction between alcohol and drug use. Under the influence of drugs he knows that he is more likely to engage in "riskier" sexual practices

than he would during alcohol use. Consequently, the above participant restricts meeting sexual partners and his drug use to different locations in an effort to control his behaviour. This illustrates that he is fully aware of the differing effects of these substances, and knows in advance when to use a specific substance in a purposive manner: to meet partners at bars while consuming alcohol, and to consume drugs while at a GCP where he will be with friends, and thus less likely to seek potential sexual partners. This same participant (Ott-2) continues to explain this process:

> If I'm going out like for an evening to a regular dance bar, then it's definitely more of an occasion to pick up because we leave at 2am, and it's an early night. But I find that if I'm going all night, or if I'm on drugs, it's usually more of an involved weekend big party and it's usually with friends. So I don't usually do it. But like I said, it has on occasion happened. (Ott-2)

For this participant, the distinction that limits alcohol and sex to bars and drugs to GCPs (which he describes as "an involved weekend big party") is not rigid, because he states that, at times, he has had sexual contacts at GCPs, while under the influence of drugs.

Other participants also noted that they engage in substance use, not only to remove their inhibitions, but also to intentionally overcome physical interferences. For example, substance use allows the following participant to exceed his limits of physical fatigue. For him, alcohol and drugs permit him to extend his GCP experience beyond "three o'clock" in the morning:

> I wouldn't go with just booze, or I wouldn't go. Because at one point you need the drugs to dance and to be awake. I've had friends who went without, and at two o'clock in the morning they had enough; compared to us who are on drugs, at three o'clock; you're tired, pop another one. (Ott-5)

The above participant's impulse to continue dancing, and to stay awake not only positions his drug use as an additional method by which desired experiences can be achieved, but also as a personal requirement to ensure that his experiences at the GCP are maximized. He states that to remain awake and dance, he needs drugs. In fact, his substance use becomes a regulated and purposive procedure that occurs at specific times, such as at

"three o'clock" when he begins to feel tired. Furthermore, beyond fatigue and tiredness, other participants report that substance use serves as a means of overcoming disabling physical sensations. For example, the following participant highlights that tired legs can be a problem, but that this can be overcome through substance use. He says:

> If I go out and friends want to go dancing, and you feel if you're legs are sore, when you do have the alcohol you don't feel that. (Ott-3)

For the above participant, alcohol diminishes the pain of his sore legs, and allows him to dance when he wants to. In interpreting this quotation, alcohol can be seen as a substance that permits him to overcome physical discomfort and engage in desired actions. However, temporarily overcoming bodily discomfort, or, as mentioned before, overcoming fatigue, are not the only forms of physical interference that can be negated. In fact, due to heightened sensations in some cases and the relaxation effects of muscle groups in others, substance use was also reported as being used to enable participants to engage in sexual practices, which they refrained from during periods of sobriety. For example, substance use allows for the physical discomfort of certain sexual practices to be overcome, or negated. For the following participant, the pain of receptive anal penetration prevents him from engaging in it without substance use:

> I don't bottom unless I'm high. That's just a relax thing. It hurts if I don't, and if I'm high then it doesn't. If, for instance, I want to try something new, then yes, your inhibitions are gone, you just put down your walls and you go when you're under the influence, but there's stuff that I still don't usually do with a stranger, that I've done in the past, so I'll do them with drugs. (Ott-11)

For the above participant, substance use can surmount the discomfort of penetrative anal sex, while also decreasing his inhibitions. Put in another way, the necessary psychological and physical relaxation ("that's just a relax thing") that results from such consumption ("I don't bottom unless I'm high") allows for desired activities and the exploration of new physical sensations ("if I want to try something new"). For this participant, there is a co-existent purpose of drug use to overcome an array of interferences (arising from physical,

external, and internal impulses), which in this case, is engaging in potentially painful sexual practices with strangers.

Similarly, the following participant uses alcohol to overcome physical interferences during sex. For him, however, the difference is that substance use is not to overcome pain; it is to maximize performance. While seemingly an inconsequential differentiation, this participant reframes substance use as being part of intentional performance enhancement. He states:

> **Now is there any difference between when you have sex if you're drunk and if you're not?**
> Yes. It helps you with what you are doing, if it's for a long period of time. (TO-2)

The above participant consumes alcohol with the specific knowledge that he will be able to have sex for longer periods of time. Further discussions with this participant revealed that the increases in sexual endurance that substance use (not just alcohol, but also poppers – which is the slang term for the vasodilator amyl nitrite) produces is not just in length of time, but also in the number of sexual encounters he can have with different men:

> **So when you're on poppers, you can have sex more?**
> Yeah, multiple guys.
> **When you're not on poppers you can't do that?**
> No. Maximum 2
> **Two, and then on poppers how many?**
> 4-5 times. Yeah, 4. (TO-2)

In the above quotation, the participant reveals that substance use allows him to enhance his sexual performance in multiple ways. First, intentional and purposive use of alcohol allows him to engage in sexual practices for a longer period of time than would be physically possible for him when sober. Secondly, poppers allow him to engage in multiple sexual partnerships (witness, "yeah, multiple guys" and "4-5 times").

In addition to the duration and number of sexual contacts, substance use also allows for other barriers to be removed during sexual contact. For the following participant, condoms are the physical interferences that he uses substances to overcome:

> I've had unprotected sex when I've been on drugs, but I tend not to do that when I'm sober. I'll be, hesitant about it, but easily convinced to have sex without protection when I'm on drugs. (Ott-2)

For this participant, drugs are associated with an increased likelihood of engaging in unprotected sexual contacts. Drug use allows him to be easily convinced, or susceptible to the suggestion of having unprotected sex. Again, however, it is not the substance use that produces this sexual practice, but rather, he uses drugs intentionally to decrease his inhibitions, and allow him to engage in a sexual practice (unprotected penetration) that he desires, but does not frequently undertake while sober. In other words, substance use allows him to engage freely in unprotected sex, and his knowledge of this effect of substance use transforms it from accidental to purposive. Thus, in this case, one of the physical barriers that substance use overcomes is condoms. By decreasing personal anxieties regarding unprotected sexual contacts, he reports that he is more likely to be "convinced to have sex without protection when on drugs". However, further questioning with different participants revealed that, yet again, this impulse for unprotected sexual contacts pre-exists substance use, and that despite knowledge about HIV/STI transmission and safer sex practices, unprotected sexual contacts do occur. The following participant illustrates his preference for unprotected sexual contact:

> **And what constitutes safer sex for you?**
> There's a lot of things; condoms for anal sex. Well, I don't use them. I mean most of the time I don't use them.
> **Ok, you don't like them?**
> Sometime the other person doesn't like it, sometimes I don't like it.
> **You prefer having sex without condoms?**
> Yeah. Feeling like more close. (TO-2)

In the above quotation, the participant highlights that substance use does not create sexual impulses; instead, it allows him to engage in his sexual impulses as he wishes. Further exploration with this same individual identified that the sensations of unprotected sexual contact are desired despite the potential for potential negative health sequelae:

> You feel closer. At times you don't care about consequences, and about diseases. You feel this kind of sexual gratification. (TO-2)

This participant clearly articulates his conscious preference for unprotected sexual contact, regardless of substance use.

Ultimately, according to all the participants quoted so far, substance use does not accidentally result in sexual practices that are more likely to transmit STIs/HIV, but rather, permits them to purposively disregard, surmount, and/or remove both the physical and psychological barriers (including condoms, social proscriptions, personal inhibitions, and physical pain) that prevent these desired sexual activities.

Sub-Theme Two: Purposive Substance Use for Exploration

In addition to the impulse to overcome limitations, the research participants also identified impulses to push their limits. For these participants, the difference between overcoming boundaries and exploration is that the former is the process of fighting against a restriction to produce a specific result, while the later is an open-ended, and experimental process without specific goals. The participants highlighted that such exploration occurred through, and as a result of, substance use, partying, and sexual conduct. The following participants illustrate this:

> I guess in my twenties I was exploring, being young, and youthful, and partying, and sex, and all that. (Ott-7)

> I tend to explore. (Ott-4)

While the above two participants discuss exploration, data analysis identified the following nuance: the practices of substance use, partying, and sexual conduct ("being young, and youthful, and partying, and sex") not only represent the limits to be pushed, but are also the mechanisms by which the participants could push their own personal limits. In other words, each of these actions was first, a limit, and secondly, a means of overcoming this limit. For example, participants reported that substance use is a limit, in that there is a maximum

quantity of drugs that they can consume without consequence of overdose, but simultaneously, these participants used substances as a means of pushing the limits of other personal practices. The following excerpt illustrates this:

> I need to know. I mean, people say, 'oh have you tried this?' 'No, but I'll try once', and then I'll know if I like it or not. (Ott-4)

This above quotation illustrates two main points: that exploration is a primary goal ("I'll try once"), and also that this exploration is one that nevertheless remains under scrutiny ("then I'll know if I like it or not"). Thus, for the above participant the goal of pushing limits is to explore them. It is the process of indulging in the sensations of stepping toward a cliff and standing as close as possible without falling off. It is thus a highly regulated and controlled process that involves reaching the limits of self-control, without exceeding them. The following participant clearly articulates how pushing limitations "too far" gives him "everything", but only up to a certain (what could be surmised as safe) level, at which point he realizes that he has gone too far, and will stop pushing:

> What I was saying is that you're pushing; you have everything when you're pushing too far, but there's time when I'll say I'm not playing anymore. (Ott-14)

According to this participant, his goal is to "push too far" because when he "push[es] too far" he "[has] everything". As can be seen, this participant wishes to exceed the limits ("too far") in order to explore that which is beyond them; however, at the point where his exploration leads to something that he does not like, he states that it is the "time when [he'll] say [he's] not playing anymore". It is important to notice in this quotation that that which stops him from "playing" is not reported – perhaps he is unable to describe it – because it is only *post hoc*, after the exploration, that he can explain what caused him to stop "playing". Further investigation with this same participant confirms the underlying exploration when he states that his ultimate goal is "the limit of exhaustion", but at the same time fails to give an absolute example of what would exhaust him. In doing this, he reveals the situational aim of

his impulses (desires) and that it is through exploration that he discovers this contextually dependent goal, which he can only describe concretely in relation to previous explorations. He states:

> I'd push myself to the limit of exhaustion.
> **But not destruction?**
> No. For example, three months ago, I was ready to die and I decided let's go in detox and just give yourself another chance, but I was ready to commit suicide, so I had at least that survival that keeps me. (Ott-14)

In this second statement, the participant provides an example of his exploration to the "limit of exhaustion", which included suicidal ideation. However, at this point, where he has gone too far, a withdrawal occurs ("detox" and "that survival [instinct] that keeps me [alive]") because the goal is to flirt with danger, not to be destroyed. Achieving the results of pushing too far represented a "risk" that this participant did not want to assume. Some participants identified that beyond a certain point, the outcomes were too severe. The following participant illustrates how he would push until he was about to "lose everything", but then draw back:

> To the limit of losing everything, yeah, I would do it completely. And that's what I'm thinking these days is the excess. Now I have to rehabilitate myself in finding pleasure without excess, but I still need my highs. (Ott-14)

For the above participant, excess is linked with the pleasures that he is currently attempting to achieve without substance use.

However, no other participants reported such severe outcomes (such as, detoxification or suicidal ideation) related to their substance use. In contrast, most participants reported that GCPs and substance use both served as the means by which desired experiences of exploration and excess could be realized. For the following participant, his goal was not to exceed the absolute limit and lose control; it was to maximize his experience by touching or reaching this limit. He states:

> So we're going out to a [GCP], we have a good time, and the energy levels rise and we just become more motivated, more willing to consume, and consume, and push our limits (Ott-8)

For this participant, GCPs are locations where excess is permitted, and sexual practices represent a limit that can be pushed by lengthening the duration of contact, by trying new experiences, by modifying a particular practice, or by increasing the number of partners. Prolonged sexual escapades become a challenge, in part, to see if they are physically possible and to push the limits of pleasure to a new frontier. For the following participant, the performance of oral sex for prolonged periods is one method by which he pushes his limits and achieves pleasure:

> I can go to extremes ... I like to do things to extreme. So, for a lot of guys, sucking for hours non-stop is not always the most comfortable thing, but I like to please someone, so having someone pleased, and enjoying what you're doing and enjoying what you're doing, is a turn on. (Ott-1)

The above participant engages in a sexual practice (extended oral sex experience) that is "not always the most comfortable thing", but which transforms through its excess into "a turn on". This practice is an intentional exploration of limits through drug use that allows for sexual practices and new pleasures. The following participant reports that he prefers engaging in sex while under the influence of drugs because it allows him to intentionally push his limits:

> **You would rather have sex with drugs?**
> Yeah I prefer it with. It changes my limitations. I find I can get more into it with drugs than without. I'm more susceptible to suggestion. I will try new things, but things that I would normally not try. I want to experience everything that you can experience. I think it's the whole purpose. Try everything once; if you don't like it, don't go back. (TO-1)

For this participant, drug use becomes important as a means by which the physical limitations of his body (i.e., fatigue, etc) can be surmounted. This is echoed by the following participant who reported that ecstasy ("E") consumption is one method of increasing the limit of partying to "four days". He states:

> After four days of partying most people, unless they were popping E or something crazy like that, their energy lowers, their mood and the atmosphere starts to die down. (TO-1)

In the same vein, another participant relates that he uses ecstasy to offset fatigue:

> That's [fatigue] usually at around four o'clock in the morning it will probably be ecstasy and usually when you come down from ecstasy you use marijuana so you don't come down harder. (Ott-11)

In the previous two quotations, the participants push their limits so that the "mood and the atmosphere [does not] start to die down". This demonstrates the use of drugs to achieve a specific form of exploration – not too much to overdose, but not too little so that they feel fatigued. In the second quotation, specifically (Ott-11), the participant reports using additional substances to dynamically counteract the effects of the previously consumed substances – the " use [of] marijuana so you don't come down harder". In effect, these above two participants illustrate that, overall, their limits, while pursued and played with, must not be exceeded. In fact, sexual and drug use practices are undertaken with extreme calculation. For example, the following participant remains aware of his limits to ensure that the withdrawal period does not last for days:

> I know what my limits are. I know when enough's enough. I know what time to take them. I never take them past a certain time, not take too much. I'm never up for like days on end doing that sort of thing. I'm very wary of that. (Ott-8)

This participant consumes drugs, but not to a point that he feels is excessive. His description of exploring his limit indicates an absolute measure that should not be exceeded. As previously noted, analysis of the interviews identified that each individual possessed different limits, but to each participant, personal limits were reported as objective ("THE limit"): "But know what you're doing and know your limits, or know THE limits" (Ott-4). This quote demonstrates that this participant considers his personal limits to be universal limits. Witness his replacement of "your" for "the" in "know your limits" and "know THE limits".

However, despite the participants describing these limits as objective endpoints, further data analysis revealed that these limits were actually subjective and contextual. For

example, the following participant states that drug use varies based on geographical location and party size:

> When I go to a party I'll bring K [ketamine]; I'll bring two vials of K with me and that's all I'll bring. Where if I go to Montreal, or Toronto for the big parties, I'll go with usually a half ounce. It all depends on the size of the venue and what kind of party it is. (TO-1)

This participant precisely measures the quantity of ketamine that he uses to ensure that he pushes himself toward a specific sensation. In this situation, the participant illustrates that his drug use limit is variable based on the specific GCP and its location. Yet, as before, it is still not necessarily the goal of exceeding limits, but rather of being able to achieve and explore one's personal limits consistently and with precision. According to the following participant, the goal of such exploration is to push his experience by lowering his personal "limitations":

> Yeah there's much more drug use and it lowers your limitations, your expectations, your strengths and weaknesses, depending on how you look at it – your inhibitions. (TO-1)

This participant makes the interesting point that by attempting to achieve an experience that deals with his limits, he reduces his personal limitations, which include not only "weaknesses", but also "strengths". This further illustrates the subjective nature of such experiences.

Moreover, the data analysis revealed another point of importance when many of the participants reported situations where their attainment of desired experiences resulted in their re-evaluation of the partying techniques they used. Most often, this occurred after situations that were labelled as negative, or, in the words of the following participant, when "it was close". This phrase designates a close call, a narrow escape from danger or disaster. In the following case, the participant aimed to push his activities to the limit, but after nearly exceeding these limits (that is, when "it was close"), he reassessed his behaviour in order to decrease the likelihood of such negative consequences in the future.

The following participant reports that such near-misfortunes indicate to him that he must be more cautious:

> To the limit of loosing everything, I would do it completely. And that's what I'm thinking these days is the excess. Now I have to rehabilitate myself in finding pleasure without excess. But I still need my highs, so I just need to find different things. So, like a few times, it was close so then I sort of I need to party but to manage better the risk. (Ott-14)

As can be seen in the above quotation, this participant's goal is to experience "risks", but to remain capable of adequately addressing them. However, other participants reported that one attraction of pushing limits is the inherent potential for destruction. In the case below, the participant relates that "destroying ourselves" is the aim of risky behaviour. He explains that in situations where the stressor, the anxiety-producing agent is un-locatable, pushing limits to extremes becomes a method of fighting back. In situations where the traditional fight/flight conceptual understanding of reactions to external stressors fails, such explorations may provide the necessary release mechanisms. The following participant highlights how his risky and explorative experiences are a method by which he fights against something that he cannot identify:

> A new aspect would be a force of defence that would be going in all kinds of directions. Getting wild and loose, I'm wondering if in order to ensure survival, to protect ourselves, we would do something that will destroy ourselves. Simply because we cannot stay put; we can flee; we can fight. (Ott-13)

This participant raises the interesting point that self-destruction is actually survival in the form of resistance ("getting wild and loose") against unknown stressors, and that these experiences are a method by which he rebels against perceptible, but unidentifiable, forces. For him, impulses and their associated dangerous and irrational practices may be a method of surviving unrecognized stressors.

Sub-Theme Three: Purposive Substance Use to Achieve Desired Sensations

In addition to substances being used to overcome interference, and as a form of exploration, the participants also reported that they purposively consume alcohol and drugs to attain particular pleasurable sensations. First, this sub-theme differs from substance use to overcome interference because it deals with how participants use substances to achieve specific sensations, which may be sexual or otherwise. This form of purposive substance use is about attempting to maximize the pleasure of an experience. In this regard, it is about intentionally achieving desired sensations. For the following participant, this feeling is the measure used to determine sufficient alcohol consumption: "Sometimes I won't notice the amount I've drunk. It's mostly the feeling" (Ott-3). For this participant, his impulses for a specific sensation are precisely located, but depending on a variety of co-factors, he must adjust his substance use to ensure that he achieves the desired sensation. The goal of substance use in these cases is to attain a particular pleasurable physical state, and is accomplished by consuming more or less alcohol or drugs as the situation warrants. The following participant exemplifies this:

> **You just use drugs to have fun?**
> Just for fun, for pleasure, like for the physical sensation of it. (Ott-2)

The above quotation states that it is the resulting pleasurable physical sensation that is the principle driving force behind substance use. In this way, the varying goals of substance use are not exclusive, but rather, are interconnected and interrelated. First, substance use produces particular physiological sensations in and of itself. Secondly substance use can produce a synergistic effect, that is, the resulting high, when combined with sexual arousal and activities culminate in a previously unattainable physical, emotional, and psychological ecstasy which was previously unknown. The following participant states this synergy unambiguously: "We don't have sex because of the drugs; drugs enhance our sexual experience" (Ott-15). This excerpt validates the finding that substance use does not

instigate sexual contacts; participants consume substances with the intention of enhancing their sexual experiences. Intentional drug use is to create gratifying sensations (that is, the physical sensation associated with the consumption of psychotropic agents), as well as to enhance already pleasurable experiences (that is, physical contact, dancing, and sexual contact).

Such enhancements relate not only to the physical sensations of sexual practices, but also to other psychological and physical processes. For many participants, sexual contact and climax involve more than, in the manner of rubbing two sticks together to create fire, simply the process of rubbing skin to achieve orgasm. Some participants report that substance use can be used to delay the orgasm, while ensuring that each and every moment of the sexual contact is experienced maximally. As the following participant describes, substance use results in his climax being stronger and more pleasurable, and in his arousal being more intense:

> The drugs allow you to last longer, so arousal is a lot stronger and the climax is a lot stronger and it's very enjoyable (Ott-15)

This participant (Ott-15) reports that drug use delays orgasm. However, in this case, his goal of delaying orgasm is not to delay his gratification, but rather, to prolong his sexual contacts in order to increase and maximize his arousal. According to this participant, a prolonged sexual experience and its associated requirement for more stimulation allowed him to achieve a stronger orgasm, which resulted in a "very enjoyable" experience for him.

Furthermore, substance use is not exclusively for sexual purposes. For other participants, purposive substance use enhances other attributes of the GCP. For example, it maximizes their perceptions of the music and the energy within the GCP, thereby allowing them to experience a greater a sense of connectedness. The following participant describes this:

> Basically the whole out-of-body feeling about it, and being able to truly feel, well truly feel is a bit of a word, but feel the music and feel the energy. (Ott-4)

According to this participant, substance use produces an out-of-body experience, which enhances his connection with the music and the crowd. Thus, this participant's intention to engage in substance use to achieve specific pleasurable sensations is formed before the party itself. In another example, the following participant relates how he intentionally attends GCPs to meet sexual partners:

> You sense there's more energy, even by the eye contacts because I would say generally that most people are there for a purpose of trying to meet other people and cruising. I know there's people that go there as couples and they may not be open as couples, but my sense is that most of the people in these environments are people that are hoping to be able to meet someone, and engage in sexual activities. I know that's my case; when I go there, I'm hoping to meet a man, and be able to spend the evening with him, and when that happens the whole process from the beginning when you get dressed to go there and consume alcohol, dance, meet, talk, everything to the end, when you have your sexual experience, it's very gratifying. (Ott-6)

For this participant, substance use gives him an overall experience that he describes as "very gratifying". Thus, such substance use becomes part of his experience from beginning to end, and facilitates "eye contact", "meeting people", "cruising", and "having sex". Nevertheless, at no point does the participant indicate that substance use creates the impulses to engage in any of these activities.

Sub-Theme Four: Purposive Substance use as Justification Ex Post Facto

In addition to purposively consuming substances for the effects that they produce, some of the participants identified that this practice also serves a role *ex post facto*. While some participants reported that the GCP is a location where otherwise socially proscribed activities (whether by law or social convention) are allowed, and others reported that substance use permits them to push their limits to the extreme, analysis of the interviews revealed that substance use may also provide an excuse or defence for actions taken while under its influence. Thus, the participants employed substance use to diminish their perceived level of responsibility, and to allow them to breach societal rules of conduct

because it provides them with social justification for this behaviour when they seek to re-enter mainstream society. For example, according to the following participant, excessive alcohol consumption provides him with an excuse for behaving in ways that he would not when sober. Based on the way in which he frames these experiences, alcohol becomes the cause of this behaviour, rather than a way of lowering his inhibitions. He states:

> Sometimes you just don't have the strongest hold on yourself.
> **What do you mean by the strongest hold on yourself?**
> You make decisions that you wouldn't normally make if you were not drunk.
> **So when you're drinking, you do things that you wouldn't when sober?**
> Yeah. (Ott-10)

This participant notes that being drunk results in making decisions that he "wouldn't normally make", and propagates the social idea of "being under the influence" – that is, that substances exert control over his behaviour. However, when another participant (Ott-11) was questioned regarding how alcohol affects his behaviour, he acknowledged that his impulses for these practices existed prior to his alcohol intake. In the quotation below, this latter participant nuances the role of substance use as justification for actions that are judged as socially or personally unacceptable. This participant relates that he uses alcohol to justify sexual contacts with unattractive partners:

> It's not usually what you did, it's usually who you did it with. That's what they're referring to. It's like, 'oh, I can't believe I took that monster home'. That's probably what it is, their vision was really impaired. I think that's what they mean by it. My mother can tell me that she doesn't like getting fucked and I call her a liar, because it's a human bodily function that we enjoy. So, for getting fucked, it's referenced to whom you've been doing it with. (Ott-11)

According to this participant, his statement that a specific sexual contact would not have occurred without intoxication, and that the intoxication drove his action, is only required when he perceives that his actions are not acceptable (e.g., sexual contact with an unattractive partner). Thereby, the interview data illustrate that substance use serves as an excuse for behaviour *ex post facto*.

Sub-Theme Five: Purposive Substance Use to Follow Social Norms

The fifth sub-theme of purposive substance use arose when the participants identified that their alcohol and drug use is a social practice – that is, an action of conforming to group norms and standards. In this regard, the participants reported that the utilization of controlled substances was less about overcoming or pushing limits, and more about reducing individual differences between partying practices. For some participants, substance use was not always about its effects. In fact, sometimes, substance use occurred strictly because it was expected. According to the following participant, he consumes alcohol, in part, to keep his hands busy, and to help him overcome his shyness. He states:

> Keeping your hands preoccupied, and you're intimidated, you're shy and you want to have a drink. I do drink at home once in a while, a glass of wine or a beer, but it's not my biggest kick. (Ott-6)

In this case, the above participant consumes alcohol to match the behaviour of the company, and thus allow for entrance to the group ("you're intimidated, you're shy, and you want to have a drink"). For him, the act of substance use is, at times, a result of peer pressure in which the activity is either explicitly or implicitly expected. Witness how this participant drinks only in specific contexts ("you're shy and you want to have a drink"); in contrast, he only "drink[s] at home once in a while" because "it's not [his] biggest kick". However, other participants reveal that such substance use is not motivated by conformity to peer pressure in a given context; the two individuals below intentionally select a party location that will allow them to engage in substance use with their peers (that is, to follow pre-selected social norms):

> It's like going to a bar, if you sit there sober at a bar and watch everyone else that kind of sucks. Sometimes it's giving into peer pressure, but like I've gotten in and I can party all night long and people are just like 'what are you on?' Nothing! They don't even believe it. It's almost like fitting in, but it's just, the sense is just like you came into this party, you spent like a hundred and something [dollars] on the ticket, you want to enjoy the party. (Ott-11)

> I think the drive, the motivating force, it's coming back to that tribal thing, where we're all drinking, let's have a good time. It's PRE-ESTABLISHED before we go that we're NOT going to have one or two drinks because, well fuck, we're going to have five, six, seven, eight, and so on. As we all do it together, it becomes the bandwagon effect. We're ALL drinking together, or we're all doing drugs together. (Ott-8)

For both of the above participants, the purpose of substance use is to intentionally join a particular social group and to follow specific and desired social norms. Nevertheless, the first participant notes that his substance use is not always consistent ("I've gotten in and I can party all night long and people are just like 'what are you on?' 'Nothing!'") and the second participant relates that group consensus for substance use will often dictate the time and quantity of his consumption.

Sub-Theme Six: Purposive Substance Use as a Respite

While all of the aforementioned purposes of substance use have been to achieve particular positive experiences and sensations, that is, pleasure, at times, the participants noted that substance use also occurs as a means by which they can temporarily elude unpleasant feelings. In other words, for some participants, substance use functions as a mechanism by which to obtain a hiatus from difficult tasks or burdens. Some participants in particular, reported that, at times, their impulses were to temporarily assuage feelings of sadness, and that partying and substance use allowed them to accomplish this. For example, according to the following participant, partying and substance use provided a positive and pleasurable end to his week, and kept him "from thinking the bad stuff". In fact, for him, the respite-giving role of substance use became so important that it prevented him from committing suicide:

> So it's a big difference in why I'm using the drugs right now. But, thank God for the drugs though. Because I was suicidal, and the drugs helped me. I was looking forward to going out Saturday. So, that was my end-of-the-week treat – to go to Montreal; so, it kept me alive, or it kept me from thinking the bad stuff. But, and I'm a strong person, to start thinking about killing yourself is really bad. So, I needed something and I used it and, and you know what, to this day it's still one of the most wonderful years of my life. (Ott-5)

For the above participant, "the drugs helped him", and provided an "end-of-the-week treat" when he was suicidal. During an interval when many aspects of his life had become unravelled, partying and drug use gave him a weekly break from these unpleasant realities, and became a source of satisfaction and pleasure. In this context, substance use could be seen as escaping problems and evading responsibilities; however, this participant clearly articulates that substance use gave him a necessary period of rest and relief that allowed him to deal effectively with his problems during other periods of time.

Furthermore, substance use also serves as an intentional method by which respite from the duties of everyday life can be acquired. The following participant identifies that, for him, substance use is not a mal-adaptive coping mechanism, but a source of respite that creates a positive experience to counterbalance the negative aspects of his life:

> I don't use it [alcohol] for the wrong reasons because I know what the wrong reasons are, and if I catch myself, then it's time to stop – like if you're running away from something, if you're hiding from something, or you want to forget things. A couple of times, I got dumped and went out to a party, but your shit's still there the next day, and you can run for a couple hours, but you have to deal with it sooner or later. (Ott-12)

According to this participant, substance use did not occur for the "wrong reasons". In fact, he states that despite drugs being able to provide him with a break from an upsetting event ("being dumped"), his reasons for being upset remained; however, he admits that he used a particular substance to give him time to adjust to a distressing situation before he had to deal with his problems. In this regard, this participant describes substance use as a form of buffer between the onset of an upsetting event and the point when he is ready to address it. For the following participant, substance use provided him with temporary relief from unpleasantness during which time he could make decisions about his life and dream (decide) what to do next:

> Yeah I was escaping from not being happy. So basically what I would do is drink. For me the drug was important because basically the feeling was to be alone in this crowd and to be able to decide what I want to do and at the same time to be in my own bubble and dream about what I want to do the next day. (Ott-14)

For the above participant, substance use supplied a period of escape from unhappiness, and allowed him to identify and pursue his dreams. He was able "to be alone" and "decide what [he] want[ed] to do"). For him, substance use created a safety "bubble" within which he could purse his dreams. Now that he is happier, he is learning to continue dreaming without resorting to substance use ("It was fun, but now I have to learn all of that without drugs, which is good"). Ultimately, substance use provided him with the needed respite to allow him to recover from the pain and shock of his negative experience before he returned to his problems, and ultimately solved them. The following participant also confirms this finding when he states that substance use was a relief from the pain of abandonment by friends, family, and his lover:

> Because I was abandoned from everything, abandoned from my family, abandoned from my lover, lost my house in the Beaches, lost my business. So it was like, 'Ohh! What a relief' because I was carrying so much pain because of all that. The crystal was an escape when you feel a need for it on every possible level. (Ott-7)

This participant echoes that, for him, substance use served as a form of respite from the anguish in his life. Because he "was carrying so much pain", crystal meth provided a needed temporary "escape" and "relief".

As can be seen, all the examples quoted in the preceding subsection illustrate that although substance use can serve as a reaction to underlying negative emotional feelings, even in these cases such behaviour is purposive.

Sub-Theme Seven: Purposive Substance Use as Learned Behaviour

Data analysis identified the final sub-theme of purposive substance use as a combination of two simultaneous practices. First, it involved learning how to use drugs, and

secondly, it incorporated understanding how to interpret the induced sensations of the consumed substance. The first method that the participants described for acquiring knowledge about these processes was trial and error. Personal exploration to extremes with a substance, revealed both its good points and its shortcomings, and helped them find the optimal route, dose, frequency, and drug to achieve desired pleasurable sensations. The following two excerpts reveal that particularly the *error* led to a better understanding of drugs. They state:

> Trial and error. Like I mean when I first started people would offer you drugs, or you'd be doing drugs and 6am would roll in. Oh, let's take another one. And I remember the next day, I remember that it lasted like 5-6 hours and then you know, you're sort of sketched or cracked out the whole next day. (Ott-2)
>
> Yeah, I think I know my body so well that I just know more what I want. Sometimes it doesn't work; sometimes I brought myself down way too much, I just want to go to a car and sleep and I've done that.
> **And how did you figure this out ...?**
> Just with experience. Trial and error. (Ott-11)

According to these participants, an important aspect of substance use that they needed to learn was the duration of a substance's effect, because using drugs too late at night, for example, resulted in them being "sketched or cracked out the whole next day". However, because GCPs are social events with massive crowds, more experienced individuals were able to provide neophytes with insight into substance use. That is, in addition to personal experience, the participants reported that substance use is also learned through interactions with veteran users. These insights constitute cultural knowledge that is transmitted from senior members to junior members of the group. Furthermore, the following two participants illustrate that, not only does explicit transfer of information occur, but that there is also an observational acquisition of drug knowledge:

> **How did you learn your limits?**
> By talking to people, through other people's experiences.
> **And what did you find helpful?**
> Just knowing what they've been through, and things like that. (Ott-4)

> Maybe after the first time it was a little bit less because the first time I was like 'what's going to happen?, What's happening to me right now?, Am I stoned?' All those questions, but after I knew what it did I just always knew, 'just watch yourself, have fun'. (Ott-12)

For the above participants, learning particular methods of drug use is a skill acquired both through observation – "I saw how other people acted" (Ott-12 quoted below); discussion – "By talking to people" (Ott-4), and personal experience – "What's happening to me right now?" (Ott-12 above). It was observed that it is the combination of these two sources of information that allows individuals to learn personal limitations with substance use. More importantly, however, analysis of the interview data revealed that these activities also allowed the research participants to acquire a culturally appropriate understanding of the effects of specific drugs. For example, the following participant illustrates that his first experience with drugs was an exploratory process in which he compared his experience to that of his peers:

> I saw how other people acted and actually sometimes I would wake up in the morning and be like 'I wonder why I wasn't like that', which is not that I wanted to be like the touchy-feely people, and stuff like that, but that didn't happen to me, I just, it was just something I'm trying kind of think about (Ott-12)

According to this participant, it took multiple times using substances to be able to understand his behaviour when "high", and what effects he was experiencing. This participant clearly illustrates that it takes multiple experiences to gain an understanding of a sensation in order to appraise it as "being high". The following two participants also support this latter point by describing their personal reactions to drug use that did not conform to mainstream ideas of the effects of drugs. The first participant describes that crystal meth left him feeling confused and emotionless (rather than as a crystal meth sex maniac), while the second participant highlights that his experience was different to what he expected:

> When I dabbled in crystal, I didn't understand the feeling. It kind of left me emotionless. I couldn't talk. It was really weird. It was like I couldn't figure out the drug. Then, after more and more times of using it, I found that I had to start to understand the drug because I was going through a lot of sadness. It, it certainly made me forget all that. (Ott-7)

> I don't know, you just see how people react and they're like 'I'm so baked' and they always want to get all touchy and take their shirts off and stuff like that. I didn't have that, but that's not something that I wanted to do. (Ott-12)

According to the above two participants, they observed that substance use caused other GCP attendees to be "touchy", but for them, it produced unexpected effects, such as, being emotionless. These two participants also reported that they could not understand their first reactions to drugs. For each of them, substance use produced a physical reaction, but they could not interpret it in a meaningful way; they did not know exactly how they felt. Other research participants confirmed that this reaction to the effects of a substance is common during initial use, because, at this point, the user has not yet learned to understand a drug's culturally associated psychotropic effects. In addition, first time users had had only limited exposure to the insight and knowledge of their peers to help them frame their perceptions. The following participant highlights this:

> **How did you start figuring out how you were feeling it?**
> Spending more time using it and eventually you just do a better quality crystal and just BOOM, it hits you and you go out of it.
> **Did you have that same experience with E when you started using it?**
> No, E was a pop and off you went. Coke, first of all, was great and off you went. One thing about E was, you can only do so many of them because you get tired. It's an up and a down. Coke was scary because it was ongoing. It was a maintenance drug, which everybody knows about it. The come-down in coke was not the greatest. The come-down on crystal is like DEATH.
> **Now before you met that dealer, what did you know about Tina?**
> Never tried it. I knew people that took it. Crystal was this little taboo drug. Crystal to me was like a real foreign thing that I didn't know. I maybe knew a couple people that did a little bit of it before it became popular.
> **Besides it being taboo, what did you know about the high?**
> I knew nothing about it.
> **Did you know about the high of the other drugs before you tried them?**
> For sure. I guess you just kind of go with the flow, and the norm, and everybody's doing it. I guess because they were just more popular, like you go to a club and everybody's on E. (Ott-7)

The above quotation from Ott-7, when considered in conjunction with his previous statement that when he "dabbled in crystal, [he] didn't understand the feeling. It kind of left [him] emotionless", reveals that previously acquired social knowledge about drugs is associated with their experience. However, further questioning of this same participant disclosed that after more group usage, his reported experiences with crystal meth began to reflect the sensationalized depictions of this drug; he would search for multiple and prolonged sexual escapades:

> On crystal, you're on a hunt. I could be on a hunt for sex; the bathhouse would be a place to go because you're high, so you have to be somewhere. (Ott-7)

According to this participant, the drive for sex was so powerful that he would go to bathhouses because he "had to be somewhere". He reports that his powerful association between crystal meth and sex drove him to "hunt for sex", and that he was completely unresponsive to his surroundings as he searched without regard for safety to sate his impulses for sex. However, although the participant quoted above did exhibit behaviour similar to that portrayed in the popular media, this does not mean that all individuals will react this way. For example, the popular media understanding of crystal meth as a drug, which transforms individuals into sex maniacs, is wholly discounted by the participants below:

> Tina I reserve for the bedroom. I don't find it an energy boost; I find it more of a relaxation. Usually by the time you end up in a bedroom or your private party somewhere, you have it and I find that doing Tina, doing crystal brings me down. If I do Tina by itself, then I'm high, but if I'm already high on one drug and you do Tina I find it brings down, kind levels you out. (TO-1)

> No. I'm deathly afraid of it [crystal meth]. I did it once way back, and I didn't like the feeling that I had on it. It was like I was in a bubble and I didn't want to be around anybody. Almost aggressive-like. (Ott-4)

While crystal meth is associated with sexuality by these two participants, it does not transform them into the popular media depiction of crystal meth users as "sex-crazed animals" (please see Chapter Three). In fact, conversely, the first participant (TO-1) uses

crystal meth as a relaxing drug to level himself out for sex. For him, the effects of crystal meth heighten the sensations of a sexual experience, but do not force him to search uncontrollably for sex.

In summary, it can be seen that the effects of substance use varied for each research participant, and that two important sources of information that provide the foundation for comprehension of these reactions are personal experience (trial and error) and discussions with veteran substance users who are able to promulgate a cultural understanding of the expected reactions to a variety of substances.

Theme Three – Context

Context was the third theme that was discovered through analysis of the interview data. For the research participants, the GCP was identified as a location, which serves multiple purposes, and produces changes in behaviour. Furthermore, the participants reported that this context is created by an array of independent elements that combine to produce connection and fantasy. Contrasts and comparison of the interview data regarding different contexts (i.e., either between different GCPs, and/or GCP versus bar or club) revealed that, the participants consistently identified the same elements as influential and important to their experience(s) no matter what the location.

Sub-Theme One: Gestalt Effect of Party Attributes

As part of the context, the first item that was revealed from data analysis was the notion of gestalt that occurs within the GCP. Stated simply, gestalt means, "an organized whole that is perceived as more than the sum of its parts".[199] In other words, the participants reported that it is not one element of the GCP that, by itself, creates the overall positive and pleasurable effect of the party, nor is it the combination of any particular elements; rather, it is the synergy that occurs when factors such as lights, dancing, music, substance use, and

a crowd of naked men, etc., occur at the same time in the same place. Participants reported that the elements of the GCP build on one another to construct the entire experience. The following participant compares the makeup of a GCP to the composition of house:

> It [the GCP] is like a house, you have all these little parts to make an entire house but without all these little parts the house is incomplete. (Ott-11)

The description above of the GCP reveals it as a combination of many items – the rooms, spaces, and walls that combine to create the total structure of a house. While certain components of a house may seem more important than others, in actual fact, they are all required to create the whole; if one item is missing, the house is incomplete. For example, it is the combination of the walls and the space within them that constitutes a room, and even though the space may seem inconsequential, it is this space as defined by the configuration of the walls that actually is the room. As this idea relates to the GCP, the participants report that while the music may provide the foundation of the party, other attributes, such as, the lighting, the substance use, the other men, the naked bodies, and the potential to meet sexual partners, provide the substance, give it meaning, and make it good. The following participant illustrates this:

> **What makes a party good?**
> The music, the lights, the techno effects, sometimes the crowd. (TO-1)

According to the above participant, good parties are created through a combination of "music, light, techno effects", and the massing of individuals into a single entity – "the crowd" that moves, sways, and dances with the music. In discussing the effects of the GCP, many participants found it difficult to identify specific or separate attributes without including others that were equally important, thus illustrating the gestalt effect of the GCP. The following participants (particularly Ott-10's description of "lighting effects going on with the music") vividly illustrate this finding:

> Yeah, I guess the light. Just because they're down, and it's easier to dance and easier to just let loose and if there's like some light, lighting effects going on with the music. (Ott-10)

> The whole atmosphere, yeah, the lights play a trick on you; the music is glaring your senses. (Ott-15)

These quotes above describe the milieu in terms that are inextricably combined (notice Ott-15's use of a visual term to describe the effects of music: "the music is *glaring* your sense"). This may result from an inability to distinguish one attribute from another; that is, the onslaught of high-energy stimuli (auditory, visual, tactile) results in their senses being maximally stimulated to the point where they can no longer distinguish these stimuli. According to Ott-15, the lights result in visual trickery, and the music in auditory over-stimulation, which is described by the visual term "glaring". This extreme excitation of the senses produces an overall gestalt experience, wherein each element extends from one sense and spills over onto others. Further supporting this is the fact that when specifically questioned if one particular element of the GCP could be more influential than others, the research participants reported that while the music is powerful, and helps to control dancing and sexual practices, part of its power arises from the equal over-stimulation of their other senses. The following participant illustrates the importance of this gestalt effect:

> The music in combination with the trance or the techno effects, the lighting effects, and stuff like that. (TO-1)

For the above participant, the effects of the music are maximized only when experienced in combination with other characteristic features of the GCP, such as, "the lighting effects" and the crowd. This inter-relationship between the party elements is of the utmost importance, as is demonstrated below when TO-1 states that even an overabundance of one element at the party (i.e., substance use) would not be able to compensate for a lack in any of the other elements. He states:

> I've gone to parties where I was there for three hours and turned around and walked out the door because I could do a pound of drugs and it wouldn't help. Everybody would still be standing looking stupid and stoned. (TO-1)

The participant quoted directly above describes a party at which the crowd was not ideal, and states that, regardless of the option of additional drug use, he chose to leave. This indicates that the "good" GCP cannot be reproduced formulaically (in that a certain percentage must come from one attribute, and so forth), but rather, that all elements must operate synergistically.

Furthermore, many other research participants identified that the material elements of the party, which constitute the pleasurable experience extend beyond the aspects that are provided by the party organizers. In fact, the quotation below describes the environment as a combination of not only music and substance use (alcohol in this case), but also, of other men with muscular and fit bodies (described as "testosterone"), which conjoins with the previously mentioned elements to provide the desired GCP experience. He states:

> You know men, and nice bodies, and all with their shirts off, that kind of thing. Of course, the music and the alcohol, and the testosterone. (Ott-1)

For this participant, being surrounded by physically fit, attractive men is another item of importance. For him, the nakedness, the muscular bodies, and the sexuality, produce the cumulative effects that constitute the GCP. The importance of masculine physicality within the GCP signifies that the crowd is more than simply a group of individuals dancing. They are a sexualized body of individuals, with whom one can interact and potentially engage in sexual contacts. In addition, questioning of the participant quoted below about drug use (Ott-5) revealed the importance of an inter-relatedness, which affects the overall impact of the GCP experience. Specifically, the following participant described drugs as being able to produce an internal state of bliss within him (witness his perception of "suddenly everybody's peace and love"). He states:

> I think when you take it [drugs], suddenly everybody's peace and love. I think it's the combination of the music, of the atmosphere, and again, being surrounded with drugs. I wouldn't go straight. (Ott-5)

As described by this participant, drug use is an integral aspect of his GCP experience to the point that partying without drugs is not an option for him because the effects of drug use and how this alters and affects his perception make his experience more pleasurable. In fact, this participant emphasizes that it is not personal drug use alone, but also "being surrounded with drugs" that satisfies his desires. This participant highlighted the need not only for a specific internal sensation produced by drugs, but also a feeling of belonging that is created when everyone is using drugs. This need to be surrounded by individuals engaged in substance use signifies that the crowd must be under a similar state of influence for this individual's personal experience to be satisfactory.

Moreover, the research participants consistently mentioned that five elements combined to produce the gestalt effect of the GCP: music, visual effects, dancing, the crowd, and substance use. While the research participants reported that it is the synergism of these attributes that produces the total experience of the GCP, an in-depth analysis of each separate component will occur at this point.

Music

While the research participants described the GCP as having a multi-sense over-stimulation effect, which produces a gestalt from its many components, they always identified that the role of music was paramount among these various elements. In fact, all of the participants noted that the music was a driving force, and that changes in it (such as, tempo, style, or quality) affected both their physical sensations and psychological enjoyment. Thus, music, with its associated effects that alter mood, dancing, and energy levels, became one of the substances being consumed at the party. The following participant relates how changes in the music diminish his energy for dancing and his adrenaline level:

> Usually toward the end of the night, depending on when the party's going to end, they'll slow the music down, and they'll have beats that don't have as

> many build ups, or things like that. And that definitely affects your mood. It just gets you into this lull where you're not dancing as hard, and you're not as hyper and your adrenaline isn't rushing as much. So it definitely can change your mood. And I think that's probably the reason that that [DJs] do that. The purpose is to sort of slow everybody down; get them out of the club at the end of the night, or the next morning. (Ott-3)

For this participant, one role of the music is to soften the mood at the end of the party and to enable him to leave feeling gratified. This participant reports that when the DJ "bring[s] the music down", his energy level returns to a state that will allow him to negotiate in the outside world ("the purpose is to sort of slow everybody down; get them out of the club at the end of the night, or the next morning"). In this way, music functions as a drug to create the experience, and afterward must be withdrawn gradually to re-integrate individuals into everyday life. In addition, other participants noted that a DJ who is unable to provide affecting music will ruin the GCP experience for those in attendance. Put in another way, the quality of the music can be related to drug quality, that is, bad music equates to a bad drug experience (notice below when Ott-5 describes the potentially fatal outcome of poor music: "it can kill" when "the music suck[s]"). Therefore, it is the DJs responsibility to ensure that the music he produces stimulates the crowd. The following participant describes how one DJ ruined part of a GCP for him:

> **What effect does the music have for you?**
> Lots. It can kill. I've been to a [GCP] where the music sucked; they changed DJ's and for a couple of hours I didn't know why I was down, until they changed DJ's and I went, 'Oh my God, the music was driving me crazy'. So, of course, it's a big factor. (Ott-5)

According to this participant, the effect of the music is so profound for him that it affects his actions. When the DJ plays music that does not reflect this participant's impulses ("I didn't know why I was down, until they changed DJ's and I went, 'Oh my God, the music was driving me crazy'"), he describes it as being able to "kill" his experience ("for a couple of hours I ... was down"). While "downer" music is necessary to bring parties to an end (see Ott-3 above), when introduced at an inappropriate time, the effects on the crowd's

perception of the party can be disastrous. Much like a skilled author who is able to develop a story and build it to a climax, followed by a denouement that releases the reader, and provides a sense of completion, the DJ (or group of DJs), must be able to lead the crowd through the build up, climax, release, and resolution to ensure proper satisfaction. In this way, music facilitates the attainment of desires (impulses).

Furthermore, the participants report that in addition to the potential for music to cause ups and downs, it also has the ability to determine the location and proximity of the dancing; for example, certain music will promote a more exhibitionist style of dancing, while other music will result in more intimate dancing, and still other in more energetic, individual dancing styles. The following participant reports that certain music makes him dance more closely with others:

> It DOES help if the music's really good. If it's a song you like you're going to get up and dance. You're going to get closer with people. (Ott-8)

According to this participant, in addition to determining the style of dancing, good music can cause him to "get up and dance". It is interesting to note that this participant reports that enjoyable music will definitely impel him to dance. Other participants validate this finding, and report that music influences them, or acts as a direct stimulant. For example:

> **What effect do you feel the music has on your body?**
> It controls it. (Ott-5)
>
> **Is there anything different in your mood between when you want to be up on the speaker or down on the floor?**
> Usually it's just the music. If it's just really the right kind and it hits me [here, the sound of the participant smacking his fist into his other hand to emphasize his words], then that's a direct stimulation to jump up somewhere. (Ott-1)

As can be seen, the effect of the music for the above participants is very powerful. For Ott-5, "it controls" him, while Ott-1 emphasized his words by slamming his fist into his other hand to visibly demonstrate the physical power that the music has over him. The action of this latter participant illustrates that for him the main effect of the music cannot be properly

described in words; its effects on the body have to be communicated by body language. Only after this action does he describe that the music is "a direct stimulation to jump somewhere". Thus, at the GCP, music is a powerful facilitator that is able to "control" (Ott-5) and "stimulate" (Ott-1). Yet another participant supports this finding by stating that the crowd is at the mercy of the DJ – he says: "The DJ has the crowd in the palm of his hand" (Ott-15). According to this participant, he becomes a puppet of the DJ. Therefore, it can be said that within the context of the GCP, a good DJ is, not only an entertainer and a performer, but also an auditory substance dealer and a powerful agent of control who must ensure that his product/substance is a commodity that is in demand, and that it is of pure enough quality to produce the trip that is sought-after by its consumers. Ultimately, for the research participants, the DJ deals in the most readily apparent substance used at the GCP – the music.

Visual Effects

In addition to music that overwhelms the senses, data analysis also revealed that for many participants the visual effects at a GCP also heighten the level of stimulation that they experience during the party. These visual effects comprise multiple and varying mechanisms which add to the synergy of the whole. While the research participants often identified lighting techniques as the principle visual effect of the GCP, they also identified others, such as, pyrotechnics, professional dancers, elaborate structural layouts, and audiovisual presentations, as also overwhelming their senses. The following participant highlights the importance of the visual effects: "It's the whole visual thing, too" (Ott-4). According to this participant, the lighting is an important component of his total visual experience. Notice the usage of "whole" in the excerpt, "it's the *whole* visual thing". However, not all the participants identified strongly with the visual effects. In fact, some participants downplayed these effects, and described them as industry-standard flashing

lights. For the following participant, the effect of the lighting is fairly stable regardless of the party, and has no quality that stands out particularly:

> Typically, it's the same wherever you go. I mean some places will have like extraordinary light shows, but it's usually just some flashing lights no matter where you go. It's pretty stable right across the board. (Ott-3)

Even though the participant above dismisses the effects of the lighting, for others, the contrast of the bright lights as they intermittently pierce darkness, generally do cause an effect. In fact, one of the most striking visual effects employed at a GCP is not the lights themselves, but rather, their absence – that is, darkness. For example, the following participants report that darkness provides "mystery" and "privacy" by creating improved physical appearances ("dark[ness] ... make[s] a difference for the cruising potential") and giving them protection against reprisal. They state:

> If it's darker you know there's more kind of the mystery, the privacy.
> **Does it make a difference to you if it's light or dark?**
> Well, obviously if it's a bright lighting, there's not going to be as much of the cruising atmosphere. When's its dark, and how the set up is, can make a difference for the cruising potential, and at a lot of these parties, a lot of couples aren't always monogamous, or they like to play a little bit. So, actually when they're dancing with their partner they, because everyone's tight together, could be playing with you while dancing with their partner, without them knowing. (Ott-1)

> Just because they're drunk, and it's easier to dance and easier to just let loose, and if there's like some lighting effects going on with the music. (Ott-10)

According to the two participants quoted above, the visual effects allow for concealed behaviours to occur in the middle of a crowd; even those who are closest are unaware of these activities. In fact, according to the first participant, he could be dancing with one individual while covertly "playing" (a term used to describe varying levels of sexual activity) with someone else. Thus, active visual effects – those which are created – are combined with passive effects, such as, darkness, to produce an overall visual experience that maximizes the fulfillment of desires.

The Crowd

Another attribute of the GCP that many of the participants frequently discussed was the crowd itself. While the GCP crowd is, in fact, a conglomeration of individuals, the participants reported that once it formed, it became an entity in itself, and that its effects are more powerful than might be expected from bringing a random number of individuals together. One participant describes that while dancing, he "loses" himself in the crowd and in its "energy". Most commonly described as "trancing out", this effect of the entire GCP gestalt causes the participants to undergo an experience in which they become less an individual, and more a component of the crowd – their sense of individuality melts away. The following participant provides an example of this when he describes his dancing at GCPs: "It's basically just connections within this one mob" (Ott-4). This participant also mentions that the crowd exudes energy ("the energy from the crowd around you"). It is interesting to note that he describes the energy as arising "from the crowd", rather than from specific individuals. This provides further support that the crowd functions as an identifiable component of the GCP that is capable of producing effects, which the constituent individuals cannot create alone. The following participant echoes this idea that the crowd's energy is very important:

> The energy in the crowd; lots of people dancing, If it's a standing crowd I call them the model crowd, the stand and model crowd, and they just stand there with drinks in their hands, or water, chit chatting with each other. Well if I want that, I can go to the coffee shop. (TO-1)

The above participant highlights the importance of the energy of the crowd for him ("if I want ["a standing crowd"], I can go to the coffee shop"), and relates it specifically to the actions that are taking place ("lots of people dancing" versus "the stand and model crowd"). For him, an immobile, "stand and model crowd" does not engage in the actions necessary for his energy level to rise. Furthermore, this participant states that he chooses locations for association based on the type of interaction in which he wishes to engage ("dancing" or "chit

chatting"). When attending GCPs, his desires are for energy and dancing; he finishes by saying that if he wanted to stand around, he would have gone to a "coffee shop". This statement illustrates that for him GCP attendance is purposively driven based on pre-existent desires for specific experiences. Other participants noted that in addition to energy, sexuality is also an important attribute of the crowd. The following quotation illustrates that a large number of physically attractive men, who are under the influence of alcohol/drugs, contribute to the appeal of the crowd:

> That's what I mean, the sexual tension meaning that you're surrounded by hot guys; they're buffed up; you're on drugs; you look around; everybody looks good; the sex is there; it's reachable; you could have it if you want to. (Ott-5)

This participant emphasizes that an important aspect of the crowd is the "hot guys" surrounding him. This feeling of possibility and connectivity constitutes an important aspect of his experience (notice the use of the words, "surrounded", "reachable", "you could have it if you want it" that indicate proximity and attainability). This participant describes the physicality of the experience, accompanied by the eroticism of the naked, physically toned men, with his own body being one component of the whole crowd. Note that both the preceding and the following participant emphasize the importance of the naked contact between men. The following participant states:

> Because it's the perfect environment if you're going to take it, especially some of these ones where there's a lot of men, and you're there for long hours and everyone's half naked and so the whole touchy feely thing and the whole loving and just enjoying the atmosphere, it's perfect for that. (Ott-1)

The above participant relates that, for him, an important element of the crowd is the direct physical contact that occurs between individuals, which blurs the boundaries between his body and those surrounding him. As time progresses and sweating ensues, the natural friction between bodies diminishes, and fluid movements become more perceptible within the group "atmosphere". For the above participant, the crowd offers the simultaneous contact of many bodies, and a formation of connections that some participants described as

being a demonstration of love and enjoyment ("the whole loving ... atmosphere") For others, however, the crowd offers simply the physical contact of male bodies against one another – that is, the touching of muscle, and thus, a sexual outlet. The following participant stresses the importance of touching muscle:

> **What do you like about the touching?**
> Just touching men – Muscle. (TO-1)

For this participant, physical contact constitutes a main source of stimulation from the crowd. In fact, many participants reported that the crowd allows for close proximity and with diminished lighting, substance use, and dancing, it becomes a single organism with multiple connections between the bodies that created it.

As can be seen, the gestalt effect of the party comprises several mutually inter-dependent elements, which complement and enhance each other, in order to allow for the maximal effect experienced through and by the crowd. For example, although for the following participant large crowds are intimidating and "overwhelm[ing]", when experienced while under the influence of alcohol, the crowd transforms into something else and, because this participant's comfort level is heightened, he is able to indulge in its pleasures. He states:

> I feel overwhelmed with a lot of people, but then again when I start drinking and get a little hammered and smashed, I'm more okay. Maybe I'm not even paying attention to that. So I guess my priorities or my comfort levels CHANGE as I drink. (Ott-8)

For the above participant, the effect of alcohol alters his perception of the crowd and, allows him to enjoy the sensations it produces. Thus, for him, these two aspects of the GCP (alcohol and the crowd) are inextricably combined.

Dancing

GCPs are sometimes defined as dance parties. When asked, all participants reported deriving pleasure and enjoyment from dancing, and identified it as a central aspect

of their GCP partying experience. For some participants, the pleasure of dancing was so intense that they would dance for prolonged periods of time. The following participant illustrates this:

> I basically dance all night. I've been known to dance for 6-7-8 hours with little breaks in between. (Ott-4)

For the above participant, dancing is a completely gratifying, all-night activity (notice the gratification that is implicitly understood as the impetus for the six to eight hour duration "with little breaks in between"). For other participants, however, it represents a ritualized mating behaviour, in which physical beauty and the ability to demonstrate physical prowess and coordination through dancing combine to attract or repel potential sexual partners. In fact, the relative ability to dance can be either a benefit, or a detriment to a person's overall attractiveness, regardless of their physique. The following participant describes how he dances with an otherwise unattractive partner because this individual dances well:

> I've danced with some people that I don't find very attractive but they're good dancers, and they seem to be enjoying themselves on the dance floor so I'll dance with them a little bit. So there's a connection in that sense like we're both there to have fun and enjoy the music and meet people. (Ott-15)

For this participant, the effect of dancing forms connections. Other participants also noted that dancing constitutes a prelude, or foreplay, to sexual relations. However, the role of dancing is not limited to sexual connections; some participants report that the act of dancing with someone may form a sufficient relationship between bodies. Furthermore, it is important to note that the term, dancing, should not be limited to groups of two, but may also involve chains, circles, and groups consisting of many individuals. The following participant highlights this form of group dancing:

> I think the dancing part is kind of the physical attraction. I'm just having fun; like most of the time, I like dancing. I dance with my friends. (Ott-12)

For this participant, dancing is more than a form of physical attraction; it is a group activity enjoyed by friends. For him, it is a physical performance and a pastime – similar to a

sporting activity. Thus, although it represents different things to different participants, dancing constitutes an integral and irreplaceable component of the GCP.

Substance Use

Lastly, the research participants also identified that substance use forms part of the GCP gestalt by functioning in a complex role. At this point, it is important to note that substance use is being mentioned here as a component of the gestalt, but its analysis will not be repeated. To review the effects, purposes, and motivations of the participants in relation to substance use, please refer to pages 175-205.

Sub-Theme Two: Community & Connection

Another sub-theme that many research participants described was the feeling of community and connection that they experience when at GCPs. Whether these connections were due to music, substance use, sexual contacts, or "safety in numbers", the participants reported that GCPs represent a social location where they can express themselves, and feel a connection with other men that is impossible in everyday life. In part, the participants identified that this process occurs because GCPs comprise a large group of men with similar sexual orientations. Furthermore, they also reported that the positive energy and the tribal atmosphere of a large group of men engaging in dancing and sexualized movements contribute to these feelings.

Positive Energy at the GCP

For many participants, GCPs are loci of positive energy, in which they can pick up the happiness and excitement of the entire crowd. For the following participant, the positive energy of the crowd is something that can be absorbed through osmosis (notice the passivity of this individual regarding the general atmosphere in a group: "if you surround yourself with negativity, you're going to be negative; so if you surround yourself with

positive-ness, you're going to be positive"). He states that being surrounded by positive people results in feeling good:

> Everyone has energy in their body they release; there's energy when people come together like that and some of them are on drugs, some of them are drinking, some of them are just having a great time, and they're dancing, so they're letting off endorphins which go in the air, plus all the sweat and all the other things that get released from your body. If you surround yourself with negativity, you're going to be negative; so if you surround yourself with "positive-ness" you're going to be positive. So you're in a room, basically most of the people are positive, you're going to feel positive. (Ott-11)

For this participant, the act of surrounding himself with individuals who are in a good mood ("positive") will ensure that he, too, will be in a good mood. According to his perception, everyone has a good time at GCPs, and gets along with one another. In this way, the energy emanating from the crowd has the power to ensure that tens of thousands of people can interact happily for many hours without conflict. The participant quoted below also stresses the importance of social gatherings that can cause "twelve thousand" people to smile and coexist without aggression:

> Circuit Parties, I think they're there for a good reason. I went to my first one – the faces of twelve thousand people – it brings twelve thousand people together. Everybody has smiles. What's so wrong about that? There are no fights. Okay, we're not going to go on the physical and what it does to your body; let's not go there. That's not what we're talking about. I'm just saying that twelve thousand people are smiling and having fun. (Ott-5)

This participant emphasizes the importance of social gatherings consisting of large numbers of people who are able to avoid physical conflict, and enjoy themselves. Substance use is present, but serves to decrease the potential for violence within the crowd, and helps them "smile and have fun".

Tribal / Safe Gay Space

The research participants also described the GCP as a tribal space – a location where they can engage in rhythmic and primitive movements and actions and become more in touch with their physical natures. In fact, it is this tribal component of the GCP, which

provides the distinct set of rules, taste, and argot that allows for interactions to occur with only "some talking", but mostly "eye contact and body movement". Note the following participant's comment regarding "everybody going for the same reason" and the similarities in "music", "vibe", and "primal beat" at the GCP. He states:

> Society has progressed to such a point where everybody's alienated, so now everybody's trying to get back to that kind of tribal feel: that little village, or that more togetherness. Everybody's going for the same reason. They offer a good time, just letting go, the same music, the same vibe, a very primal beat. There's always some talking going on, but I find that it's all eye contact and body movement. (Ott-4)

The above participant highlights the similarities (tribal identities) of the GCP attendees ("going for the same reason", that is, "to get back to that ... tribal feel, that little village, or that ... togetherness"). Other participants support this finding, but, rather than explicitly using the term tribe, they describe the GCP as a safe gay space where they, as gay men, feel comfortable and accepted in an otherwise heterosexist mainstream culture. The following two excerpts illustrate this:

> I was just not really in the gay social community at all, and not that I'm really happy to be in it now, but seeing people and being surrounded with people that are more like you, it's like a comfort zone. Some people use it for different things, for me, it's to go out somewhere where no one is going to look at me and judge or think something. (Ott-10)

> The fact that the majority of other men there are gay – that's about it. Like if I'm going to a place where there's less gay men, I feel like I can't be myself. (Ott-3)

For these participants, GCPs are locations free of judgment and the debasement of their non-hegemonic sexuality. In other words, they are places where a non-mainstream sexual tribe can gather in safety. The following participant echoes this:

> So I find that it's really different from going out in the regular straight club and I'm not sure if I like it or not, but it's a sense of a comfort zone. It's just really different, and you don't have to be scared of people seeing you doing whatever, like dancing like crazy, which can be seen a little bit different in a straight bar as opposed to a gay bar. I guess it's a sense of freedom. Freedom from being judged, from stereotypes, from all that. (Ott-10)

This participant states that GCPs provide escape from negative judgments of homosexuality. They constitute a location where it is safe to be gay ("it's a sense of…comfort"), where it is acceptable to behave as one wishes as a gay man ("you don't have to be scared of people seeing you"), and not be looked down on for doing thus ("freedom from being judged, from stereotypes").

In addition, the participants identified that the GCP is a location for "hunting," where everyone knows and accepts that those who are there will not be adverse to the advances of other men, and will accept some of these advances. For some participants, dancing comprises the pre-hunt tribal activity in which the hunters engage in rhythmic movements to prepare themselves for the hunt itself (that is, for locating, securing, and engaging with a sexual partner). The following participant vividly describes this:

> We DO become TRIBAL because we're hunting. So of course that analogy is great because we do become animals. And it's the rarest of forms of bestiality to a certain point because we do dance and at one point at the end of the [GCP Name] I've heard stories, never saw it, of guys having anal sex; so it's like, it's at the end of the day; you've got your kill, and you go for the kill. So it's all part of the dancing, part of the music. That's exactly it. They dance because they come back from the hunt, or THEY'RE going to the hunt, or they celebrate that, the hunted. They celebrate the meal, so it's kind of the same thing. (Ott-5)

According to the above participant, the GCP provides an environment that is conducive to sexual "hunting" (i.e., dancing, having sex, or going back to find a new sexual partner) and his understanding of dancing transforms it into a preparation, into a hunt, and into a celebration of his prize.

Sub-Theme Three: The GCP as a Surreal Environment

In their descriptions of the GCP, many participants used words that depict it as surreal – a mixture of fact and fantasy, a space for the release of creativity, and "a place to play". The participant quoted below states:

> It's unbelievable. It's not really there. It's Barbie dolls, and it's just a place to play. It's an adult playground. And there are all kinds of people having fun. (Ott-7)

For this participant, the environment contains elements of the hyperreal – "It's Barbie dolls" – plastic representations of exaggerated, glamourized Western adult bodies. He compares the GCP to an idealized polymer representation of a desired of reality, and describes it as "unbelievable" and "not really there"..."it's just a place to play. It's an adult playground. And there are all kinds of people having fun" (Ott-7 above). In a similar vein, the following participant states:

> ... you ARE in a different world, but I think it's the same thing if you go to Disney World. The drugs, the smell, and everything I'm describing now can be related to Disney World – the smell, the hot dogs, the Mickey Mouse, the costumes, music, entertainment. (Ott-5)

This second quotation compares the GCP experience to a visit to Disney World, a famous theme park based on fantasy, a place to holiday and to have fun. For both Ott-7 and Ott-5, the GCP is not a place to live, to take seriously, it is a fantastical, surreal milieu in which to have fun and satisfy their desires (impulses).

GCPs as Foreplay / Sexualized Environments

For other research participants, one of the main functions of the surreal nature of GCPs constitutes them as sexualized environments that were described as foreplay to sex. In this regard, the participants identified their goal when attending GCPs, not as an outright bid for sex, but rather, as an activity (foreplay) to determine if further sexual activities will ensue. Thus, the GCP is not an intended location for sex; instead, it is a venue where sexual initiations are readily available. Comparable to grocery stores, GCPs offer a display of the potential wares to be consumed, but as with the grocery store, this "food" requires selection, and often, preparation. The following participant illustrates this process as it progresses from prelude to payoff:

> Now there's the rave, there's the clubbing, there's the prelude, the foreplay for the sex that happens after, so people actually go there and to dance and to have fun. (Ott-15)

Thus, for this participant, GCPs do not provide locations for sex ("the sex...happens after"), nor do they promote sexual behaviours, but rather, they provide an acceptable social environment for a group of like-minded individuals who have gathered for a similar purpose (that is, to "rave", to "club"). However, as the components of the GCP collide, one participant emphasizes that the boundaries between that which defines a party and that which constitutes a bathhouse begin to blur. He states:

> So, a lot of it could be the heat build up, the sweat. Because they can be just dripping because it's hot. So it's a combination of the heat, the drugs, the alcohol, the loosening up, the sexual environment, and then, the transition between a party and a bathhouse becomes a bit muddled. (Ott-1)

According to this participant, the heat, the sweat, the substance use, and their combined effects begin to distort his ability to distinguish GCPs from bathhouses. His perceptions become "muddled", and the public GCP locations transform into the private (and sexualized) environments of a bathhouse. In this way, this participant's attendance at GCPs, and his engagement in GCP activities (i.e., dancing, substance use, etc.) serve to create sexual tension (described by the two participants quoted below). However, for Ott-5, this tension is not to be discharged immediately; instead, it should be delayed – to be wallowed in as the beneficial and satisfying sensation that he desires. Consequently, this participant engages in a form of foreplay at the GCP that continues to increase his excitement:

> That's what I mean, the sexual tension that you're surrounded by hot guys; they're buffed up; you're on drugs; you look around; everybody looks good; the sex is there; it's reachable; you could have it, if you want to, but that's what I mean by sexual tension. It's all around you. It's part of the excitement. (Ott-5)

> I feel excited because there's beautiful men and I get aroused, and for me getting aroused that way is good. (Ott-6)

For the above participants, sexual tension is of the utmost importance (the tension "is part of the excitement", and that "getting aroused that way is good"). These quotes illustrate the centrality of such tension to their partying experiences.

However, other participants reported that this tension eventually begins to boil over, and the impulses for sex surmount all inhibitions (often with the help of substance use). At this climactic moment, sex ensues, and the GCP transforms into an environment where sex occurs. The following participant describes this process:

> **And the sex component to the parties, how do you feel that fits in?**
> It fits in a big way because I think that basically being all GUYS, everything's fairly physical. So at one point, you just quit and you just get on the rollercoaster. Oh it's very sexual. (Ott-4)

According to this participant, the sexualized nature of the GCP is best described as a rollercoaster – that is, an up and down thrill ride. GCPs are "basically... all guys", and "everything's fairly physical". For this participant, this experience is "very sexual", and, "at one point", he indulges. As with the previous participant, the following participant identifies how prolonged exposure ("like four or whatever hours") to sexual tension eventually culminates in his impulses for sexual contact:

> It's only after seeing hot bodies for like four or whatever hours, and you're drinking and doing drugs, that yes it does turn into sex. (Ott-11)

According to this participant, his impulses for sex eventually materialize. Nevertheless, it still requires multiple hours of foreplay ("seeing hot bodies for like four or whatever hours") and the use of alcohol and drugs before "it does turn into sex".

GCPs as Sanctioned Environments for Proscribed Practices

In addition, many of the research participants described the GCP as a location where they engage in socially proscribed practices without fear of immediate social reprisal. For them, GCPs constitute milieus where the normative range of practices and behaviour

differs from mainstream social environments. The following participant describes this as a zone within a zone:

> For me, anyways, from what I've seen and what I've experienced, it's a little zone amongst a big zone that allows us to behave a certain way for a certain amount of time, in that ZONE. (Ott-8)

According to this participant, while GCPs provide protection against reprisal for socially proscribed activities, this period is only "for a certain amount of time". Once the party is over, the safety provided by the GCP disappears. For example, nurses at a Canadian hospital chastised the following participant for his substance use, despite his obvious need for nursing care after he had been assaulted for being gay. He states:

> **What was the reaction after you went to the hospital?**
> I think that they were more concerned with the fact that I was using drugs at the time than they were with the actual injuries that had occurred because I needed stitching to my face, and like painkillers. But they were definitely more concerned with the fact that I had taken ecstasy than I had any injuries. (Ott-2)

For the above participant, the GCP environment had allowed him to engage in substance use that would be not be tolerated elsewhere, but once he left the party, he became vulnerable, not only to assault, but also to condemnation of his activities.

Moreover, the two participants quoted below illustrate how even a legalized drug such as alcohol, becomes a "novelty" because of the "ambience" that it helps to create. For the following participant, this substance is part of the entertainment process, and a main reason for attending GCPs:

> Well, I think it's just because of the environment. I think I purposely go there for cruising and part of the entertainment, but I think part of the entertainment is the novelty of having a drink. (Ott-6)

For the above participant, the "novelty of having a drink" (the ability to engage in substance use) is part of the appeal of GCPs. For this participant, substance use is a purposive action that functions as part of the pleasure and enjoyment of the party. The GCP provides a location to indulge in otherwise proscribed practices because they are locations where the

total experience is to be captured through substance use, dancing, and sexual contact. The following participant illustrates this by contrasting restaurants and movie theatres and their respective required behaviours to GCPs, where substance use is socially permissible:

> So to me, drinking is part of it. I've been a bartender; I've been a bar manager, so drinking in bars is for me important. It's like for those who are very healthy and go to a restaurant and eat like a salad like with no dressing. I'd stay home. It's the same thing. If I go out even though I watch my weight, I'll eat a steak with probably mashed potatoes and lots of butter because I'm in a restaurant; so, if you don't want to drink, don't go to a bar. It's like going to a movie and not watching the movie, or not eating popcorn. Come on; it's, it's the whole experience. Or go to casino, but I don't want to gamble. (Ott-5)

Analysis of this participant's statement reveals that GCPs are not devoid of rules, but rather, that they are regulated environments with their own conventions and set of rules of propriety that are different to those assumed by conventional society. Ott-5 acknowledges this particularity of function when he says, "if you don't want to drink, don't go to a bar". In a similar vein, the research participant quoted below (Ott-12) identifies that substance use, expressive movements, conversations, and physical contact become practices that are, not only permissible, but are expected of those who attend GCPs. In conjunction with the previous quotation (Ott-5 above), this indicates that the mindset when attending GCPs is one that allows for an alteration of the conventional rules of propriety, and functions to allow, promote, and require behaviour that is deemed as non-traditional by mainstream society. The following participant illustrates that even activities, such as, talking with strangers, is more permissible within GCPs:

> I think [GCPs] set up an environment where you already know people are out there for a reason. It's a public area where it's contained and social, whereas on the street nobody signs on to be like, 'oh, yeah, come and approach me'. And especially in gay bars, it's easier too because you can go up and know that this person is gay. And in the street and in the mall, you can't just do that. It's more a mess out there. Like nobody is going to look at you oddly if you walk up to them and start a conversation. (Ott-12)

For this participant, GCPs are locations of indulgence that he visits with specific intentions ("people are there for a reason"). Thus, it is not that GCPs require that he behave in a

manner that he does not wish to, but rather, that he attends GCPs with the prior knowledge that he will be able to follow a set of social rules that are different to those he encounters in the other facets of his life. In fact, this knowledge serves as a primary motivation for him to attend GCPs because they allow him to express himself through actions and impulses that otherwise must remain restricted. In this regard, for the research participants, GCPs are locations of alternative expression from that of mainstream heterosexist culture.

GCPs as Vacation

The research participants also identified that GCPs provide a vacation from monotonous routine life and from harsh realities. In this way, the GCP milieu provided a location where respite from everyday cares can be found because they are locations in which the participants allow themselves to enjoy the positive energy of the environment. For some participants, this experience occurred at times when such positive outlets may not have been present otherwise in life. The following participant illustrates how GCPs have served as a vacation from a bad mood:

> I find myself sometimes where I was just having a bad day or unhappy in certain situations. So I HAVE used partying as kind of way out of this bad mood. You have a good time. You kind of GOT out of that. You kind of exit the bad mood, but I've done other things: I've gone to the gym, or I've gone to sing, or I've gone to play violin, you know, to get out of a bad mood. (Ott-8)

According to this participant, partying serves to provide an outlet to overcome a "bad mood" or "unhappy ... situation" because if the partying is of sufficient duration and intensity, the following day the upset mood has passed. In addition, other participants also support this finding by reporting that GCPs are locations of excess and indulgence where, temporarily, escapes (or escapades) can be carried out. However, according to the following participant, applying the term "escape" to his description is invalid in relation to his intentions (that is, before he leaves to attend the GCP) because he does not feel that he is escaping from

something; nevertheless, he describes a situation in which, after his return, he is faced with the reality from which he had needed a break. He states:

> **Do you find it an escape from routine?**
> Not an escape, not an escape. When you GO, you don't think of it as an escape. When you do come BACK though you face reality because for twelve hours, you ARE in a different world, but I think it's the same thing if you go to Disney World. The drugs, the smell, and everything I'm describing now can be related to Disney World – the smell, the hot dogs, the Mickey Mouse, the costumes, music, entertainment. Look at circuit parties; now you have the drug factor that is a plus for the circuit, but otherwise, out of Disney World, driving back home, you're going, 'Okay go back to Monday morning'. (Ott-5)

This participant emphasizes that his goal, prior to attending a GCP is not to "escape"; in fact, he seems unaware of this impulse until he is returning to his usual life after the GCP is over. Nevertheless, he compares his entrance into the different world of the GCP to a visit to Disney World, a well-known fantasy vacation destination. Similar to a pre-planned annual vacation from work, the GCP constitutes a predetermined, temporary leave from regular life – an accepted absence that is based on pre-existing conditions of return. Therefore, the term vacation has been adopted because unlike the term escape it denotes a positive action, which is not necessarily motivated by negative circumstances. The following participant highlights how GCPs allow him to escape from his isolated existence:

> There's a closeness that goes on that you don't see in everyday life. You're just walking down the street; everybody's into their own little cocoon.
> **And so would you find that the parties are kind of an escape from this?**
> I think so. Escape from just everyday life. It's basically just all connected to this one mob (Ott-4)

According to this participant, GCPs provide a means by which the detachment and solitude of everyday life can be overcome. He states, "in everyday life ... everybody's in their own little cocoon", and by being "connected to this one mob" within the GCP, it allows him to escape or take a vacation from this. This statement further supports the finding that the GCP context is separate world with its own cultural attitudes and rules, and is highly important and relevant in any analysis involving them.

Résumé

The objectives of the study upon which this dissertation is based were 1. To understand the motivations of MSM who use drugs and engage in risky sexual practices within the GCP subculture, and 2. To understand how the circuit party environment affects drug usage and sexual practices. The first finding of significance as it relates to these objectives is that the research participants' desires to engage in unsafe sex and to use drugs were not motivated by underlying psychological deficits (e.g., poor coping skills, dependency, etc.), or emotional disorders (e.g., depression, dysthymia, or schizophrenia); in addition, these practices did not occur as a result of peer pressure, nor was the undertaking and outcome of these practices usually accidental. Instead, the research data revealed that participants' desires, and their indulgence in them, represent, or express, how the participants see themselves and how they want to be seen by others, and thus reflect the tribal solidarity of the GCP subculture.

As a result of the above finding, participants' desires were labelled as *impulse* because they were the bursts of energy that connect bodies to one another, and which often became known to the individual, and to others, only through their expression as thought, emotion, and/or action. As such, desires (as impulses) constitute and create meaning for any given individual during a particular and specific time. Stated simply, the perception of an individual is based on what they do and what they want to do. For example, acting on the desire to attend a GCP constitutes an individual as someone who attends GCPs, thus changing the definition of this individual. In this way, desires define the individual who expresses them – even if this change in definition is only minor or fleeting. The research results also revealed that it is possible to understand each individual as a composite of his desires (impulses) because the research participants revealed that their desires (impulses) would often interact and interfere with each other and that, as a consequence of this, the participants would often control their impulses (desires) to enforce pre-established personal

limits. In addition, although each individual's limits were both unique and context dependent, the outcome of preserving them through interference consistently contributed to the formation and maintenance of stable definitions of the self, and of other individuals, to the point that these definitions allow (to a limited degree) for the prediction of future behaviour.

In short, the research participants experienced desires for unsafe practices (sex or drug use) were not motivated by underlying psychological distress, and these desires became part of the definition of the participant who expressed them. Furthermore, the participants strictly regulated their desires so that, most of the time, their actions remained within the parameters of their personal limits and within designated locations – for example at GCPs.

As informed by the research data, the second finding of significance in this dissertation is that the participants reported that drug use did not cause them to engage in so-called unsafe practices (such as, unprotected sex, or further/experimental drug use), but rather, that drug use allowed them to indulge pre-established impulses (desires) for these very activities. In other words, drug use was a pre-meditated means by which particular experiences were sought out and achieved, not an impelling force that produced unplanned or accidental unsafe behaviour, which could result in unintended or unexpected drug interactions/reactions, such as, overdose, respiratory depression (caused by the mixture of GHB and alcohol), or STI/HIV acquisition (due to a drug-induced disregard for habitual safer sex practices). Thus, for the participants in this research, drug use occurred because they desired a particular activity, such as, engaging in unprotected, anonymous sex, exceeding the limits of their bodies' normal capabilities by staying awake for prolonged periods, or having multiple simultaneous/consecutive sexual partners, et cetera. The goals of such purposive substance use also included drug use for the associated pleasurable or psychotropic effects, drug use to overcome physical or psychological barriers that were preventing participants from engaging in their desires, and drug use to provide them with an

excuse *ex post facto* when they had undertaken an action that did not fit with their desired self-definition. In all of the situations above, the participants were often fully aware of the precise effects of the drug(s) that they were consuming, or that they desired to consume, either because they had taken them previously, or because they were consuming these drugs purposively to achieve these particular (and desired) effects. In any case, this second finding revealed that while a correlation between drug use and unsafe sex does exist, this relationship is not causal – the participants reported engaging in drug use with the premeditated intention of employing these chemicals to allow or enable them to indulge in their pre-existing desires for unsafe sex and the psychotropic effects of these substances.

Furthermore, similar to the second major finding, the third major finding of this research is that GCPs do not cause the behaviours that are associated with them (drug use, unprotected sex, and erotic close physical contact between men). Rather, the participants described GCPs as safe locations where they could fulfil their pre-existing desires for these activities. While at first this finding may seem to be a contradiction in terms, this is not the case because, although many of the research participants only engage in these unsafe practices when at GCPs, it was not the GCP *per se* that created these impulses, even though the participants often articulated these desires as wanting to attend GCPs because the cumulative effects (attributes) and stimulation that are possible at GCPs are significantly more profound than is possible if any of the them is experienced in isolation. In other words, the GCP is a nexus of desired attributes (i.e., music, visual effects, the crowd, dancing, and substance use), which combine synergistically to provide a locus for individuals with pre-existing desires to engage in particular activities. In this way, GCPs offer positive energy, as well as sexualized environments that satisfy the desires of the individuals who attend them. That is, the pre-existing desires of a particular group of individuals create the GCP, not vice versa.

In summary, data analysis revealed that the research participants' desires for drug use, close physical contact with other men, and unsafe sex preceded their actions of GCP attendance and drug use, thus suggesting that an elimination of such party venues would not result in the eradication of the impulses for such parties. In fact, analysis of the above results reveals that closing GCPs would function only to drive the indulgence in these desires further underground.

Chapter Six – Discussion

"Desire is man's very essence."
Spinoza

Introduction

This sixth chapter presents a discussion of the major findings that were revealed in Chapter Five – findings, which will be considered in light of the theoretical approaches introduced in Chapter Two, and contrasted with the current knowledge in the field that is highlighted in Chapter Three (the literature review). Following this examination, the last section of this chapter offers some potentially profitable future directions for nursing research, education, and clinical practice in public health that became evident as a result of this research.

As summarized in the résumé at the end of the previous chapter, the results can be stated as follows: desires for socially or scientifically proscribed practices, such as, partying, drug use, non-monogamous, or homosexual sexual contacts, et cetera, do not result exclusively from psychological dysfunction, or a lack of judgement; drug use does not necessarily cause individuals to engage in proscribed behaviours, such as unsafe sex; and finally, GCPs do not routinely induce individuals to undertake these prohibited practices. To structure the discussion of these three points, they will be addressed sequentially; however, due to the similarities between the second and third findings – they both reveal that external agents, whether in the form of drug use or GCP attendance, do not cause individuals to engage in illicit activities – these latter two points will be discussed together.

Major Finding One: Desire Revisited

The first major finding of the research supporting this dissertation is that the research participants experienced and expressed many desires that did not occur as a result of

restriction: for example, the majority of the participants did not desire to have unsafe sex exclusively because it is prohibited by mainstream public health suggestions of safer sex. Consequently, the findings of this research project are incongruent with mainstream Western beliefs regarding partying, drug use, and sex, which are often based on pervasive psychoanalytic perspectives[64-69] that position desire, urges, and psychological forces as arising either directly from innate biological drives, or indirectly from the restriction of these instincts. In fact, Western thought has been extensively permeated by this psychoanalytic perspective to the point that individuals, such as, nurses, researchers, the general public, and policy makers alike, do not consider these explanations to be particular theories of psychoanalysis, but rather, they believe that these statements are irrefutable truths about how all human actions are motivated either by basic human instincts, or by the resultant psychological backlash, which occurs when these drives are restricted. In effect, this mindset in Western society has resulted in a division between what is seen as natural desire, and what is judged as constituting an unnatural or deviant desire.[64,66] As a secondary effect, and as proof of the uncritical acceptance of such psychoanalytically-based theories within Western nursing knowledge, to date, these assumptions have been used as the nearly-exclusive guiding principle for the majority of public health nursing interventions related to sexual health.[201] For example, public health campaigns which are designed to dissuade individuals from engaging in drug use or unsafe sex reveal the underlying assumptions of the nurses who design them: that individuals who have desires for such activities need to be corrected/disciplined.

However, as previously mentioned, the findings of this research do not support the traditional psychoanalytic perspective. Instead, the understanding of desire uncovered during this project more closely aligns with the definition of impulse as it is used within the discipline of physics: an impulse is "a force acting briefly on a body to produce a finite change".[199] As such, the term, "impulse", was used throughout Chapter Five to represent

any, and all, qualifying aspects of each participant's desires in relation to their GCP experiences – for example, the duration, quantity, and intensity of the experience – in contrast to the psychoanalytic meaning of this term, wherein impulses are considered to be direct manifestations of instincts that occur (in thought and emotion, but not necessarily in action) regardless of societal impositions.[65,66] (Please note the distinction between the psychoanalytic definitions of desire and impulse: impulses are naturally occurring, while desires are not because they are the outcome of restricted impulses.[65]) Ultimately, the definition of impulse from the field of physics was adopted because it became evident during the research that each and every action, thought, emotion, belief, perception, et cetera, which the research participants described was actually a component of their desire – an impulse, or set of interrelated impulses – a force, which produces change, and in doing so, creates connections between the object that is desiring, and the object that is being desired. In fact, the results revealed that the effect of desire is so profound that the objects that it connects transform into what Deleuze and Guattari[45,46] call assemblages or machines – a desirer-desired apparatus.[202] In this way, each object ceases to be what it was before, and is transformed through such connections into something new: a new entity, a new assemblage, a new structure that is no longer the simple combination of the desirer and the desired, but rather, a synergistic device/machine that arises from the interaction of the two.[203] Furthermore, this means that the original two objects cannot be recovered in their initial forms after such combination, because the connection has entirely changed each, and melded both into a new object.[204]

While this connective and productive potential of desire has thus far been explained by means of the physics-generated definition of impulse, data analysis revealed that the underlying conceptual meaning of desire actually best aligns with the theory of Deleuze and Guattari.[45,46] In fact, the notion of desire presented by these two authors coincides precisely with the concept of impulse that was described in Chapter Five in all ways, but one. At this

point, this single difference will be discussed, followed by a thorough analysis of the similarities.

The one difference is that, while Deleuze and Guattari[45,46] restrict their concept of desire to human activities (although they never state explicitly that they are doing so), based on the research data provided, this theory has been expanded to include the effects, connections, and impulses that are produced by all objects, whether animate or not. While this alteration may seem to be a rather important distinction, in actual fact, it is only a slight difference because the meaning of the theoretical concept remains the same; it has simply been extended to encompass all objects. For example, based on this expanded application of desire as impulse, even the walls that often surround GCPs produce desires. However, according to Standard English usage, saying that walls desire makes no apparent sense; consequently, the term, "impulse", was adopted as the generic term, and "desire" was used as a more specific term that denotes these impulses when they are expressed by people. Therefore, put concisely, desire is the pulse and flow of non-physical human impulses.[200,202] However, it *is* possible to conceive of walls as doing things (impulse), as opposed to just existing, because they function as both barriers and protection to keep some individuals out (one set of impulses), while providing safety, security, and boundaries for the actual party environment (another set of impulses).[205] Similarly, the effect of any given drug could be understood as the outcome of its exerted impulses (desires) as they interact with the desires (the physical and cognitive impulses) of its user. Therefore, beyond this single, minor difference in application between impulse, as used in this context, and desire, as understood by Deleuze and Guattari,[45,46] these two concepts are functionally identical: they both describe positive forces that form connections, create reality, and define objects and individuals.

Consequently, Deleuze and Guattari's[45,46] conceptualization of desire will be used to situate the meaning of desire as it was described by the research participants: that is, as an

underlying force that impels, and is, action, thought, and emotion.[200,202] To begin, the first way in which Deleuze and Guattari's[45,46] theory is useful in explaining the research results is that it describes that which is acted on (e.g., drug use or unsafe sex), thought about (e.g., considering drug use or unsafe sex), or felt (e.g., longing for drug use or unsafe sex) as the outcome of expressed (by words, gestures, or conduct) desires. This statement, however, requires unpacking because it actually reveals two concurrent phenomena: to say that actions, thoughts, and emotions are the outcome of expressed desires means that desires produce these actions, thoughts, and emotions, but it also means that these actions, thoughts and emotions are simultaneously desires themselves.[77] In other words, desire (or impulse) is both the impetus and the outcome.

In this regard, it becomes possible to understand impulses and desires as positive forces because they produce connections between individuals:[49] for example, the impulse/desire to engage a potential sexual partner's attention creates a connection between the body of the desirer and that of the desired, regardless of whether or not physical (and in this case, specifically sexual) contact actually takes place; this is because the impulse/desire to engage a particular individual changes how that other person is perceived by the desiring person – that is, as a desired object, rather than simply as another body at the same party. The research data also revealed that impulses/desires produce connections between individuals and desired objects: for example, the research participants' impulses/desires for specific drugs identified a definitive set of societally associated effects that they wished to experience. This again illustrates the interactive (assemblage-like) nature of desire and impulse; that is, connections made due to desire change the objects that are involved in the desiring apparatus through the processes of re-definition.[202]

In addition, this also illustrates that impulses are not necessarily deficit-driven; they are essentially outputs of energy, which can neither exist as "nothing", nor arise from nothing.[49] A deficit, or lack (nothing), cannot create or interfere with something because

"nothing" is a term used to describe a state of non-existence and, in order to exist, nothing would have to be something. In other words, something must interfere with something else to produce yet another something, regardless of what any of these "somethings" happen to be. For example, even when the research participants described restrictive forces, such as, the police (external control) or self-control (internal control), they were nonetheless describing perceptible forces, rather than voids or deficits. Therefore, one must conclude that, although desires and impulses may sometimes be described as unpleasant (having negative outcomes) they are, in and of themselves, positive forces because they create, and interact, with one another. Consequently, desire cannot arise from a lack (zero), as is proposed by psychoanalysis.[69] (Please note that within this context, the terms, "lack" and "zero" are used to designate an absolute nothingness.) However, it is important to nuance the above by stating that, while desire is a positive force, it may still occur as a response to unpleasant feelings, such as, sadness or loneliness, or due to a paroxysmal response to restriction. A few participants did, in fact, report using drugs, or attending GCPs, due to such feelings, although even they reported that these motivations were infrequent when compared to overall reasons for attendance.

The above, however, is in direct contrast to research previously undertaken by Semple, Patterson, and Grant[6], Reback, Larkins, and Shoptaw,[115] and Wong, Chaw, Kent, and Klaussner,[126] which found that drug use occurred almost exclusively as a direct result of desires to overcome negative feelings – for example, drugs were used to cope with feelings of isolation. In contrast to the above, this present study found that even in the small number of cases when negativity was reported as being the impetus for unsafe sex, drug use, or GCP attendance, these desires were still *positive* (i.e., productive, connective, and assemblage-forming) impulses.

Moreover, the data analysis also revealed that, regardless of whether desires (impulses) occurred due to pleasant or unpleasant feelings, they do not occur in isolation. In

fact, a multiplicity of impulses occur simultaneously, and interact (i.e., interfere) with one another, not just to modify previous impulses, but also to produce new impulses.[206] Consequently, this heterogeneity of impulse interactions renders unidirectional, cause and effect explanations, such as, the statement that a particular emotion (e.g., dysthymia) exclusively and directly produced a particular socially or scientifically forbidden desire (drug use), as oversimplifications of why any specific desire arises. This rejection of "simplistic" explanations is a result of the analysis of the research data, which revealed that the number of impulses that interfere with one another prior to the expression of any specific desire is immeasurable, especially as observed in the interactive effects produced by physical, external, and internal impulses.

Furthermore, augmenting the complexity that arises from these three forms of impulse is the fact that the genesis of one desire could be nearly instantaneous, while another may have required years of specific impulse interactions to materialize. Again, this is in direct contrast to the majority of research presented in the literature review (Chapter Three). For example, Guss[28] and Semple et al.,[6] reported linear findings: they state that the individual's desire for drug use arises from a desire to experience heightened attentiveness, euphoric disinhibition, or decreased anxiety. Based on this present research, it becomes evident that statements such as those disregard the socio-political, psycho-sexual, and erotic components that are interrelated with drug use and, while the results of the research underpinning this dissertation do not support such simplified explanations, the latter can be used in combination with Deleuze and Guattari's[45,46] concept of stratification to explain how vast numbers of impulses and interferences can be effectively restricted and sorted into seemingly stable and recognizable patterns to such a degree that researchers are confident in making statements, such as, in the cases of the above examples. (This, however, will be further discussed shortly in relation to Deleuze and Guattari′s[46] concept of *microfascism*.)

Therefore, at this point, it is essential to explain how the phenomenon of impulses interacting with each other to produce interference directly coincides with Deleuze and Guattari's[46] concept of stratification. The most important point of similarity between these two concepts is that neither process can be considered negative, positive, or neutral; that is no value judgement need be assigned to either of them. This means that the outcomes of both interference and stratification are neither better, nor worse than what came before and that objects have no values other than the ones which are assigned to them based on sets of pre-existing societal rules (impulses). Stratification is the process whereby impulses are assigned, and then restricted to, a unique spatiotemporal location[207] – for example, when the research participants described a hierarchy of drugs. In effect, this allocation process (stratification) illustrates how the perception of objects tends to remain stable over time because they are assigned a stable location within the prevailing hierarchy; objects do not possess intrinsic attributes or inherent characteristics that produce this stability as a logical outcome.[208]

However, in relation to desire, the interference-effects of spatiotemporal assignment within a hierarchy were quite variable; according to the findings, they ranged from a complete termination of the desire to an enhanced intensity (as in the case of paroxysm). At this point, it must be stated that, although the phenomenon of paroxysm may, at first glance, seem to support the psychoanalytic view that restriction creates desire, this is not the case because, while the restriction of impulses intensified desire for some research participants, it never created the original desire, thus refuting Freud's main supposition regarding desire (see Freud[66]). In fact, the research results seem to be better explained by Bataille's[57] concept of the eroticization of the forbidden because, for some research participants, the interaction of desires produced outcomes that were more intense than the preceding impulses. As a response to this commonly occurring phenomenon, Bataille[57] further

suggested that removing or eliminating the societal restrictions which are placed on desire would result in a reduction of eroticism: if nothing is forbidden, then nothing can be erotic.

However, Bataille's[57] perception of the effects of restriction proved insufficient during the data analysis phase because he argues that the forbidden exclusively intensifies eroticism. In contrast to this, the findings of this research suggest that any form of interference, whether restrictive *or not*, can change, but not necessarily increase, the intensity of a desire. For example, some participants reported that their desire for a particular drug, or person, was intensified because other individuals also desired it (competition), and in other cases, indulgence (as opposed to restriction) resulted in stronger desire (e.g., drug use or sexual contact intensifying the desire for more drug use or sexual contact). Stated in the terminology used in this dissertation, this latter process is the outcome of one impulse (the desire for drugs and/or sex) as it interacts (interferes) with other impulses (consuming drugs or having sex) to produce changes in the initial impulse (an intensification of the desire for these activities). Similarly, the finding that restriction did not always make the restricted object more desirable also highlights the limitations of Bataille's[57] theory for adequately capturing the full scope of these results; for example, restriction sometimes resulted in an absolute and uneventful dissipation of the original desire for some of the research participants.

Nevertheless, returning to the point at hand, impulses and desires interfere with one another to create social hierarchies (or stratifications). While such stratifications are often seen to be repressive,[46] they can also promote social organization and order.[209] According to Rousseau,[209] the stratification of impulses and their resultant interferences creates the rules and regulations which constitute the social contract whereby individuals are obliged to follow group rules in order to receive the benefits that such group efforts produce. This means that by submitting to the forces of external impulses, individuals are restricted from expressing some impulses, but they are simultaneously enabled to express other impulses

that would be impossible to achieve if they were required to engage in all processes necessary to fulfill their personal physiological needs.[209] In relation to this present research, the participants who dedicate themselves to a strict work ethic, experience the associated benefits of a high salary and flexible job (please see Appendix G for a summary of the socio-economic status of the group under study) and this acceptance to the prevailing social rules allows them to enjoy the benefits of being able to travel to, attend, and partake in the luxuries associated with the GCP subculture (please review Chapter Three to see the high cost associated with attending these parties). Thus, the social body allows individuals to achieve that which would otherwise be impossible if they were to follow the required set of social rules.[209] In the language of this dissertation, this would read as follows: the organization of impulses into a stratified system allows for a predictable and functional social body, which functions synergistically to provide opportunities to its members who obey these stratified regulations of external impulses in order to engage in impulses that would otherwise be unattainable.

This illustrates that stratification structures desire. In addition, from the research results, it was revealed that context (and architecture specifically) also structures (i.e., stratifies) desire. To address this, Grosz's[62,63] work is pertinent because it illustrates how architecture also functions as a component of this stratification process: the structuring nature of architecture produces its own set of impulses (desires) that interfere with the desires of the bodies that inhabit it. In this way, architecture acts, not only as the setting (stage) for a particular group of individuals in a specific set of circumstances, but also influences the significance of their interactions (the script) within its designated place, so that the meaning changes based on the actual composition of this stage (setting).[210,211] That is, the meaning of one set of impulses changes based on the meaning of another set of impulses as they interfere with one another to the point where, at times, the impulses of the architecture (the stage) serve to entirely re-frame the script for the initial set of

impulses/desires.[62,63,210,212] For example, without a framing context, the brushing of bodies against each other, as was described by the research participants, is ambiguous; it is merely a set of impulses that interact to produce a variety of tactile responses, which would depend on the setting. However, when additional, disparate impulses were added, in the form of different locations – a busy public transit corridor, a crowded coffee shop, a GCP, or a bathhouse – the interference associated with the original set of impulses (the touching of bodies) conveyed different messages, and formed different connections, with varying corresponding levels of intensity. In other words, a change in the stage results in a change in meaning of the script that is acted on it: touching may produce sexual stimulation, annoyance, fear, or indifference depending on the context within which it occurs.[212] Thus, Grosz's[62,63] work on architecture helps to frame an understanding of the research results which indicated that objects are not absolute or fixed entities, but rather, that particular perceptions of impulses (note that the perceptions of these impulses are also impulses) constitute the essence of any given object, at any given time, thus making all objects mutable, context-dependent, and subject to interpretation.[213] In fact, within social contexts, the interactions of collections of impulses (that is, individuals and objects) produce entire social constructs and environments.[62,63]

To further explore this, Deleuze and Guattari's[45,46] concept of the *Body without Organs* (*BwO*) has proven useful in expanding and explaining the idea presented above – that objects, as well as social situations, can be viewed as collections of impulses and interferences, which occur on, around, and within them – because this concept provides a theoretical grounding for understanding bodies as they were described by the research participants: as non-stable entities, as processes, and as sets of practices.[45,46] Thus, as a dynamic collection of actions, each individual continuously creates and re-creates (through the interaction of physical, external, and internal impulses) their personal *BwO* throughout the lifespan, regardless of intention.[214] This helps to explain how, and why, the participants

defined themselves as they did: as an accumulation of actions, thoughts, and feelings that they had undertaken and experienced. In effect, while not necessarily being aware of doing so, the research participants described the fluctuations of their own personal *BwO*s that had occurred throughout their life spans. This latter finding thus signifies how important it is for nurses to understand their patients, not as this or that *type* of person, but as a collection of interacting, competing, interfering and continually changing impulses: a set of impulses, which, when combined, give the impression that *BwO* is a fixed, historically located entity.

In fact, however, the *BwO* is the outcome of perceptions by the self and by others (one impulse) of particular actions (groups of impulses) that create and recreate the *BwO* (a collection of various groups of impulses) as it is continuously fuelled by desires (yet other impulses).[49,77] When this sequence is related to substance use, an object (the chemical substance) acts as a focal point, and exerts its effect. However, this object exists only as a focal point for perception because its definition and constitution are created by the perception and interpretation (which produce an understanding) of the impulses that move away and toward it.[202] Thus, the concept of the *BwO* helps to elucidate the unstable nature of all objects because it describes a *body* (the focal point) without any solid internal essence (it is *without organs*), and interprets the bodies of the research participants and the physical/chemical properties of the drugs that they reported using as vessels of potentiality that are given substance (the organs of the body) through the perception of the impulses (desires) that connect with them. In this way, the substance (the *organs*) of the body and any associated objects actually consist of reified social constructs, which bring them into existence; that is, this substance does not comprise innate essences of the body. In other words, the desiring-machine or the assemblage (i.e., *BwO*) is but fleeting in its existence.

To further explain this, Judith Butler's[50] work on *performativity* can be added because it is theoretically fruitful in helping toward an understanding of how *BwO*'s are actually sets of impulses that, when combined together (regardless of whether or not these

impulses should be combined) in the minds of individuals, constitute a recognizable individual – this is how performance creates the substance (or the perception of *organs*) within the *BwO*. Thus, despite not being originally described in the theoretical framework prior to undertaking the research, this concept needs to be drawn on to help explain the data provided by the research participants in relation to their stable self-definitions because, according to Butler,[50] *performativity* comprises the sum total of all the actions (which within the context of this dissertation would be labelled as impulses) that have been learned, both consciously and unconsciously, by an individual about how he or she must act, based on anatomical structure. However, while Butler[50] uses the term, *performativity,* exclusively in relation to gender expression, in this dissertation, the definition has been expanded to include the perceptions of and actions by all objects. Thus, there are two important distinctions that must be highlighted here. First, the term "expanded", denotes that Butler's[50] original conceptualization of *performativity* has been changed from strictly relating to gender into a concept that encompasses all the impulses that constitute the performance of being an individual. In other words, *performativity* is used here to describe the creation of the self. Secondly, in this thesis, *performativity* represents the perception of an object rather than its perceptible behaviour. Thus, it does not describe a specific action (i.e., impulse), but rather, the perception of that impulse. Therefore, within this context, *performativity* has been sufficiently broadened to include even the immobility of an inanimate object because its appearance (that is, the perception of it) as being motionlessness fulfils its required role, or performance as a stationary and invariable thing within its environment – a stable object rather than an assemblage that acquires its meaning through the connections (i.e., desires, impulses, or performances) that it makes. In this way, *performativity* is no longer necessarily a set of behaviours learned by a body, but instead, it is the perception of these impulses that is based on culturally mediated learning. At this point, *performativity* becomes useful for theoretically explaining the research results, which became evident when different

participants described identical drugs as being agents of relaxation, stimulation, experimentation, and/or innate danger for them, thus exemplifying how perception actually creates and defines the performance of each specific drug for each particular individual – a finding that contrasts sharply with the majority of the literature presented in Chapter Three, which was based on the bio-medical premise that all drugs produce absolute and identical reactions every time, and for every individual, despite the fact that the bio-medical research model often relies on mathematically calculated average effects, which represents only a certain portion of the entire sample.

In contrast to the results from the literature review noted above, the results of this research project revealed that the effects of recreational drug use, when understood as the outcome of impulses and their interaction, is a display of the specific performance (or script) that is associated with the particular psychotropic agent by a particular individual or group, and is, therefore, incommensurable with the bio-medical perspective. Consequently, the interpretation of substance use within the context of this dissertation is based on the beliefs, motivations, expectations, and connotations particular to the individuals or groups who use them, rather than on the notion of the unvarying properties of any particular drug. Thus, even the perceptions (rendered as findings) of researchers who have undertaken rigorously designed and executed studies on recreational drugs and drug use, ultimately end up reflecting the researchers' own underlying assumptions and judgements about drugs and drug use. In this way, a report of exclusively negative outcomes and hazardous effects associated with drug use within the GCP context reveals the underlying assumptions of the researchers who undertook the research, the journal editors who accepted these studies for publication, and the scientific peers who reviewed these studies (for examples, see references Husbands et al.,[2] Mansergh et al.,[3] Mattison et al.,[4] Mattison et al.,[5] Purcell et al.[10]). In all of these cases, the published results indicate, not only the findings that drug use produces many negative side-effects, but also that the researchers, editors, and peer

reviewers involved with these publications uncritically accepted the supposition that drugs and drug use are inherently bad without even investigating the possibility that this might not always be the case. This becomes particularly evident when the literature review results are compared with the results of this present research, because the latter uncovered evidence that that drugs and drug use are capable of producing an array of associated outcomes ranging from physical harm to absolute physical pleasure, and furthermore, that these outcomes have no inherent value outside their respective systems of stratification (i.e., social systems/machines). Therefore, this research emphasizes the importance of critically reviewing many underlying health-care practices and research assumptions about drugs because the results of the this study indicate that drugs are, in fact, *BwO*, performances, or assemblages, and, therefore, are not necessarily intrinsically good or bad, but acquire their meaning and relative value from their position within their culturally-created socio-temporal location.

To further clarify the difference between these research results and the results of the majority of the previous research, Deleuze and Guattari's[46] concept of *becoming* will now be included in this discussion because this concept enhances the understanding of the *BwO* (and thus the understanding of the research results) by allowing the *BwO* to be recognized as a set of impulses that are always in the process of *becoming* without ever being fully realized. This means that every manifested impulse for drugs, for sex, and for partying that the research participants described is actually a process, rather than a complete and ultimate self-definition, or the means to arrive at such a destination. This signifies that even the research participants who used drugs the most were not "drug users", but rather, that drug use is/was a process through which they transition(ed); that is, drug use is an activity rather than a definition. In the language of this dissertation, drugs and drug use are one type of impulse/desire that can form a connection between two or more objects, and thereby dynamically re-define these objects into mutually-interactive *BwO* or assemblages. This

approach helps to frame the fluid nature of impulses/desires as the participants described them, and when combined with the concepts of the *BwO*, *becoming*, *performativity*, and desire, provides a deeper understanding of the research results: in fact, it illustrates how viewing drugs and drug use as processes (i.e., performative *becomings*), rather than as stable entities, produces the significant differences between the results of this research and those reported in the research presented in the literature review. (Within this research, all objects seen to be forever *in potentia*, whereas the research reported in the literature review presented findings that were based on the premise that objects are stable and context-independent.) Furthermore, the combination of the theories presented here sheds light on how individuals who use drugs *become* (defined as) drug users: when an individual's impulses/desires for drug use are inevitably subjected to external impulses (stratification) in the form of concern, judgements, epidemiological surveillance, and the attitudes of others, this, consequently, transforms both the self-image and the persona of this individual into something different and seemingly concrete – "the user". Thus, the original impulse for an activity (substance use) forces the individual to *become* something new – a drug user – as opposed to being perceived as the original individual who now uses drugs. In this way, desires actually define, create, and construct individuals.

Moreover, the assumption that objects are fixed and stable entities rather than always engaged in the process of *becoming* also helps to explain some of the drastic differences between the results reported in the literature review and those of this research in relation to sexuality. Specifically, this was particularly evident when the research participants described how forming a particular physical connection with another body was interpreted by researchers, nurses, and the social body in general as an irrefutable sign of their quintessence. That is, as males, the research participants' sexual contact with other men transformed them from bodies engaged in sexual contact with other bodies, into homosexual, gay, or bisexual individuals and furthermore, based on the precise connections

that their desires dictated (i.e., the type of sexual contact), it might also transform them into risky homosexual, gay, or bisexual individuals. In this way, the research participants' desires for a particular type of sexual practice transformed them into a particular type of person, regardless of whether or not the expression of these desires actually produced changes in the body that engaged in them. Therefore, in the social and intrapersonal realm, desire creates and enforces definitions of the research participants, as is directly evidenced by the research produced by the Public Health Agency of Canada (presented in Chapter Three), in which the goal is to achieve generalizable results about MSM. In fact, these assumptions about the generalizability of results concerning MSM are based on a further assumption about the perceived stability and inherent nature of these individuals – that all MSM must inherently be similar, stable, and identifiable. When examined closely, this attitude reveals itself as identical to an assumption, such as, "all gay men have a good sense of fashion", for example, and immediately becomes recognizable as stereotyping.

As a response to the above, the concept of the *BwO*, when understood as a performance that is forever in the process of *becoming* helps to shed light on the ways in which the idea of the stable, constant, and unchanging individual is actually created by nothing other than the perception of a series of impulses/desires.[214] In fact, when individuals are understood as the social and personal perceptions (i.e., stratifications) of their *BwO*s; when these *BwO*s are understood to be sets of impulses; when these sets of impulses in combination are understood to be a performance; and when these performances are understood to constitute *becoming*, this frames the understanding of individuals, their experiences, their actions, and all perceptions about them as forever being *in potentia*.[45,46] Thus, in contrast to the conceptualizations of an incarnate body presented in the literature review (such as, when researchers, such as, Colfax et al.[27], and Ostrow[26] state that the past actions of GCP-attendees are absolutely indicative of their future actions), Deleuze and Guattari's[45,46] concepts of desire, the *BwO*, and *becoming*, and Butler's[50] concept of

performativity provide a different interpretation of the present research results: the research participants described themselves as perpetually recreated political surfaces upon which and through which laws, social rules, and moral codes (i.e., external impulses or stratifications) are transformed into internal impulses, and that, as such, the boundaries of their bodies are produced and reproduced through the interactions of impulses.[62] As seen from this perspective, the past actions of the research participants do not necessarily predict their future actions, or even have any bearing on the future whatsoever. For public health nurses who work in sexual health, such a finding is highly important because it focuses attention on the idea that nurses must understand how their own actions (whether in front-line clinical work, or in population-based intervention work) constitute impulses that interfere with the impulses of their clients and, by extension, interfere (through interaction with social, cultural, religious, scientific, epidemiologic, and personal impulses) to define each patient or community group according to the nurses' own particular perspectives.

Beyond this, Deleuze and Guattari's[45,46] investigation into the process by which the individual comes to be reified as a stable and identifiable object through interactions with various social bodies, researchers, etc, and not just nurses reveals that the effects of these interactions (inscriptions), especially those related to research, which transform *BwO*s into seemingly stable individuals are not strictly superficial. In fact, these inscriptions that mark (or possibly scar) the surface of the *BwO* also achieve in-depth effects that express themselves through the creation of a seemingly stable subjectivity (or as labelled within this dissertation – as a stable self-definition). The research participants revealed that various regimes of power (of which desires are a part) create the individual by mapping its body, mind, and soul. In this way, the perceptions of specific impulses/desires combine (in the minds of others, as well as of the self) to produce identifiable groups and particular kinds of bodies through this process of inscription; for example, the processes that Foucault[60] described as being involved in ascribing a list of associated behaviours and characteristics

to individuals who form particular sexual connections, that is, in relation to the creation, rather than discovery, of the homosexual in psychiatry. Based on this research, however, such stable definitions of objects and individuals came to be seen as equivalent to the act of defining a mobile object based on one still photograph of it; a process that would readily criticized for reducing a fluid and moving object into an immobile and frozen item.

However, the fact that the surface of the body is mapped, marked, inscribed, and fixed in location by various (public) health discourses and societal constructions of eroticism does not imply that it is actively disciplined through force;[58,60] in fact, the internalization process of social norms, such as, the convention to refrain from recreational drug use, is not necessarily one of overt violence. For example, readily identifiable oppression such as that undertaken by "Big Brother" in George Orwell's[215] *Nineteen Eighty-Four* was not uncovered during data analysis. In fact, none of the research participants described experiencing overt, forceful, or violent punitive restrictions as a result of using drugs. However, they did report more subtle forms of power, such as, judgemental comments by nurses, family members, and friends (that is, being subjected to social imperatives and rules) that served to deter their drug use. This form of pressure allows, but also forces, individuals to engage in covert and often-unacknowledged forms of resistance – a fact that was supported by the research findings. For example, many research participants spoke repeatedly of their desires for, and indulgence in, drug use and public sex (that is, practices that are illegal in many jurisdictions), and extreme partying juxtaposed with the ensuing internal conflict that was generated by these desires. This process can be further understood as the interactions of various (physical, external, and internal) impulses that continually shape the ever-changing object (i.e., the *BwO*, assemblage, or machine). In saying this, however, it is important to nuance that while social imperatives may be initially externally imposed, they usually eventually transform into a source of internal impulses. That is, restrictive external impulses are imposed by another individual or group, which desires either personal self-restraint or

self-restraint by others. These impulses are then inculcated into each individual to the point where they become accepted, self-acknowledged personal attributes (complete internalization). At this point, the social restriction becomes an individual restriction, that is, a form of internal interference.

For Deleuze and Guattari,[46] this internalization of external impulses would constitute *microfascism* – that is, desire desiring its own repression, or, the individual's self-oppression. Described in another way, *microfascism* is the collective processes involved in inducing individuals to develop a desire to repress their own desires.[216] It is a method by which individuals learn to restrain and control themselves because of the conviction that such restraint and self-control are for their own welfare. Thus, individuals are encouraged to be fearful of external objects, as well as of personal capabilities. For example, fear of the potential negative outcomes of drug use was described as a principle reason why many research participants adamantly refused to experiment with crystal meth despite the fact that the majority of them had never experienced or directly witnessed any of the negative outcomes attributed to this drug. A similar process was also discovered during analysis of the data related to self-imposed restrictions of desired sexual practices, which resulted from the fear of STI/HIV acquisition induced by public health messages and society at large. This, then, begs the question: what is the real purpose of this fear?

Again, Deleuze and Guattari's[46] concept of *microfascism* helps to explain the meaning of the research results: a specific social understanding is created in reference to the effects of a drug (or the outcome of a behaviour) so that the individual himself, rather than an external policing group, becomes the agent that extinguishes, or at least overcomes, any impulses for such illicit activities. From the research results, the societal proscription of drug use most often occurred as a direct result of this internal interference (*microfascism*). In fact, the participants reported that their restriction of drug use did not usually require external impulses, but rather, that they restrained themselves for reasons of

morality, social order, law, and most often, due to fears of the associated repercussions, including physical harm, such as, addiction or overdose. In this way, impulses of external origin interfere with an individual's impulses for drug use to the extent that, ultimately, this individual prohibits the very action he desired, without any overt form of external interference occurring. Thus, *microfascism* accurately describes the processes by which external impulses are internalized to produce a highly effective method of population control and self-government.[217]

However, one must be careful not to polarize or demonize *microfascism*, because, as Deleuze and Guattari[46] describe it, the notion of *microfascism* does not make value judgements concerning what constitutes control, or whether or not this control is seen as negative or restrictive. For example, ensuring that individuals willingly engage in alcohol or drug use at a club is also a form of *microfascism*, which is more commonly referred to as peer pressure. Nevertheless, this peer pressure serves to maintain an internally regulated expression of socially prescribed behaviours, actions, and practices, (in this case, substance use) in order to maintain group cohesion. Furthermore, *microfascism* could also be employed to describe how this pressure to conform to the attitudes and behaviours of one's chosen group could also include the internalization and resultant replication of findings, which reinforce those of previous research that assert that the participants in this study are reckless or dangerous. In fact, data analysis revealed that such research findings were incorporated by some of the research participants into their self-definitions to the point where a few of them subsequently began to produce the expected behaviours that were previously chronicled by population-level epidemiological research studies.

In the same vein, Freud[68] posited that societal restrictions, which he identified as "the law of the father", interact with the innate drives of the individual to produce what he called the superego, that is, an internalized set of social rules that require individuals to regulate their own behaviour. However, according to the research results, the effects of

external interference are often the result of many internal impulses being manifested as self-imposed interference, not the imposition of an all-knowing and all-powerful regime (the father figure). Therefore, the research results cannot be explained using this psychoanalytic notion of a single entity (the father) whose omnipotence controls the social realm. Instead, the research data revealed that desire desires its own repression because repression is, in fact, an important type of desire. Stated baldly, social oppression cannot appear out of nowhere (refer to page 237-238 for the discussion of nothing being unable to produce something); both self and social oppressions are the impulses (desires) of certain individuals that have been transformed into a polymorphous technique of population control that does not require an individual in a position of absolute authority to dictate and enforce how individuals should behave. Instead, this method of population control is dictated by the masses to the masses.[216] This was, in fact, explicitly stated by a few of the research participants, who revealed that they derive great satisfaction from being able to control themselves. This last finding is somewhat at variance with Deleuze and Guattari's[46] theory of *microfascism* because the research results suggest that individuals are not necessarily trained to be oppressed, but rather, that people's desires to oppress (dominate) and to be oppressed (be dominated) have culminated in a social system, which fosters such global and institutionalized expressions of self-oppression.

Nevertheless, a major challenge still exists for a system that feeds on individuals' desires for (self-)oppression: that is, how to make the entire social system work synergistically to ensure that collectively sanctioned external impulses are universally accepted and obeyed by all individuals, rather than allowing diverse individuals to desire different forms of oppression. Again, the concept of *microfascism* can be used to explain the process of internalizing contextually appropriate external impulses that was revealed during the analysis of the research participants' interviews. Deleuze and Guattari[46] delineate the methods by which the smallest (indivisible) unit of the social system – the individual –

acquires an unquestionable and axiomatic belief in the rightness and righteousness of the prevailing social rules upon which the existing value system is based.

Ultimately, the construction of internal interference (used within this dissertation to mean the restriction of one desire/impulse by another desire/impulse) is the method by which individuals begin to adopt and express group mandated desires and exclude all other thought/belief systems: a process that is accomplished through both overt and covert forms of repression. The overt forms of repression are often readily apparent; these include legally sanctioned actions, such as, physical arrest, imprisonment, and reprimands from social authorities, such as, nurses, physicians, pharmacists, lawyers, police, security agents, et cetera, which are intended to dissuade individuals from engaging in proscribed behaviour. However, more specifically, within the context of this dissertation, this repression may also encompass unsanctioned, overt violence, such as, hate crimes (e.g., "gay bashing") that are intended to punish individuals who participate in socially marginalized, but not always illegal, practices. Moreover, in addition to these evident forms of rule enforcement, more subtle forms of power, such as, peer acculturation, stigmatization of the abnormal, ostracism, fear mongering, and the "caring" advice of social authorities also serve to enforce adherence to the mainstream belief system. These covert methods often employ intangible forms of intimidation, such as, rejection, humiliation, abandonment, shame, disgrace, et cetera that result in emotional or psychological scars – for example, the chastisement that some of the research participants reported receiving as a consequence of their recreational practices. Unfortunately, because such actions do not leave marks of physical violence, they are often dismissed as normal group interaction, rather than being recognized as forms of non-physical violence. In effect, Deleuze and Guattari's[46] concept of *microfascism* helps to explain this process because the methods of social regulation that are used to enforce the observance/continuation of traditions, conventions, and rituals, which are ascribed to an elevated authority, although not written formally in law or scripture and by which individuals

are trained and moulded as good citizens,[74] are as subtle, invisible, and pervasive as the covert violence described above.

As an adjunct to Deleuze and Guattari's[46] theory of *microfascism*, Foucault's[58] theory of bio-power proves apt for providing further insight into the external-impulse internalization that was uncovered during data analysis because this latter theory portrays the specific methods by which individuals acquire information. The first relevant point is that power is not invested in one group/individual as an absolute, but rather, it is a dynamic process between individuals.[58] From this perspective, power is understood as an agreement between two groups that allows one to become, or remain, dominant, and the other to be submissive.[58] However, the accord between the two groups is neither conscious, nor explicit, and is often transferred from older to later generations through methods of anatomo-politics, the term Foucault[58] used to describe an amalgam of mechanisms (identified as hierarchical observation, normalizing judgement, and examination – see Chapter Two for further detail on this concept), aimed at politically training the anatomical individual to acquire normalized behaviour patterns. To achieve this goal, hierarchical observation is used to rank behaviour; normalizing judgment compares specific actions to social ideals or to statistically calculated norms, and examination thoroughly scrutinizes individuals through the lens of the former two mechanisms.[58] In other words, examination encompasses a multiplicity of methods that can be used to acquire information about an individual, a group, or a culture, and allow authorities (scientific, public health, religious, legal, etc.) to first construct hierarchies, and then to rank each group accordingly.

When based on the premise that the limitation of desire is actually a self-imposed process constructed on the internalization of repressive external impulses, the results of this research reveal that the research participants themselves were the greatest limiting factor on their own behaviour. This demonstrates that while the interactions of the impulses that ultimately result in self-policing may have originally arisen from a variety of external sources

(such as law, religion, and/or custom), the ultimate agent of their enforcement was the individual himself: written in a different way, this could be stated as, "I, and no one else, can stop me from doing for myself what I want, and, therefore, there is no longer a need for you to stop me from such unregulated self-indulgence". In this way, external agents are not required to violently enforce propriety because each and every individual ensures that they maintain their actions within prescribed limits – neither too timid, nor too outlandish. Within the research results of this dissertation, this finding was considered the territory between the relative and absolute limits. However, at this point, it must be acknowledged that some of the research participants did not acquiesce to the subtle or overt control of the public health discourse (external impulse), or to the dictates of social propriety; these individuals did surrender to their desires.

Major Finding Two: The Relationship of Drug Use and GCPs to Unsafe Practices

This very act of surrendering to one's desires constitutes the second major finding in need of discussion within this dissertation – precisely as this indulgence in desire relates to the research participants willing, wilful, and intentional engagement in unsafe activities, such as, unprotected sexual practices, illicit or experimental substance use, and GCP attendance. The fact that, during the interviews, the research participants repeatedly reported motives for these practices that were at variance with the findings of pre-existing research, such as, that by Semple, Patterson, and Grant[6] who argue that drug use and attendance at GCPs often occur as coping mechanisms, highlighted a major incongruity between the latter and the findings of this study (as discussed above): that desire is not necessarily related to previous negative occurrences.[44,49,77] In fact, it quickly became evident that this incongruity was much more than a simple difference between research findings; it was a major area in need of further discussion because it begs the following question: why would anyone wish to risk their lives, or desire to jeopardize their health if there were no

material rewards for doing so? Please note the difference between finding one and finding two; this second finding is about the effects of drug use and GCP attendance as they relate to extreme indulgence in desire, not a discussion of desire itself.

Nevertheless, the answer to the latter, which surfaced during this project is that, for some individuals, desire is driven to extremes by the intensity of the experience itself,[89] or within the language of this dissertation, individuals strive to achieve their absolute limit because they desire to encounter the abyss without falling into it. This absolute *limit experience* is an exposure to an edge, or to the boundary of one's physical, emotional, or psychological being; it is an experience that is actively involved in pushing one's personal boundaries and can be understood as an example of Deleuze and Guattari's[45,46] *becoming* process. Each and every *limit experience*, each and every encounter with the absolute limit, redefines the individual, thus illustrating how they are *becoming* rather than *being*.[218] In fact, these edges or margins that the research participants endeavour to encounter could be defined in numerous ways: for example, the boundary separating life from death (e.g., the narrow therapeutic range between insufficient drug effect and overdose), or the line dividing pleasure from pain. As a consequence, *limit experiences*, or the processes of achieving one's absolute limit, are often located in non-traditional spaces where individuals "resist the imperatives of emotional control, rational calculation, *routinization*, and reason in Modern society"[89] (p. 6). Thus, the absolute limit is the point toward which the *limit experience* strives; furthermore, it is neither a stable, nor an objective limit, but rather, a context-dependent boundary. For the research participants involved in this study, they were engaged with the *limit experience* through drug use, unprotected sexual contacts, and marathons of partying.

To begin this discussion effectively, Emile Durkheim's[219] work regarding the nature of transgressive practices and deviance will be used because it provides a starting point for understanding these desires, which have been classified by the majority of current health

care literature as irrational. According to Lyng,[89] what is most useful about starting with Durkheim's[219] work is that he clearly defines the source of "deviant practices" as the "inevitable flip-side of a rationalized ... culture, one that produces by its own structural logic radical extremes of wealth and poverty, power and powerlessness – and the emotional contradiction of arrogance and humiliation that accompanies these extremes" (p. 7). Thus, for this author,[89] deviance is not a natural, or objective, state, but rather, it is an inevitable outcome of the dominant societal structure. Furthermore, the preceding quotation also reveals Durkheim's proposition of dualism (note his contrasts of wealth versus poverty; power versus powerlessness), and therefore his unexpressed assumption that deviance and normalcy are co-dependent for their existence and definition. The One and the Other are (and must always be) born simultaneously.[77] In the realm of sexuality, for a sexual practice to be labelled as an act of deviance (i.e., unsafe), there has to be some previously created benchmark against which this act can be compared.[46,49] In this case, it is the standard of the public health discourse on safer sex that compels the individual to adhere to practices that reduce the chance of STI/HIV transmission, while concurrently avoiding all of types of sexual expression that would be judged as risky/unsafe.

However, Durkeim's[219] work on deviance is not enough within the context of this discussion because it does not move beyond the analysis of deviance as a construct arising from the binary structure of language, and, therefore, fails to provide the depth needed to understand the research participants' desires and practices of engaging in deviant (outside mainstream public health acceptability) sexual practices. To address this shortcoming, Foucault's[88] work regarding the processes of crossing over and transgressing limits will be added because he argues that such indulgence and surrender to desire constitute a *passage obligé* in the complex process of self-creation – that is, in the production of one's own subjectivity. His analysis of deviance is not limited to discussing it as a contrast term for normalcy; rather, it is about understanding the role and purpose of deviance for the

individual. To paraphrase Foucault: because of their complicity in their own oppression and domination by various state structures and their affiliated agencies, which employ a vast array of sovereign, disciplinary, and pastoral techniques, individuals are in a perpetual process of finding extra-marginal avenues of resistance to the stratifying effects of external impulses to achieve *de-subjectification*. In other words, it is the process by which an individual begins to escape the imposed limits of their definition as an individual. *Limit experiences* provide a way of putting this process of *de-subjectification* into concrete practice because they are not only locations or states of mind, but also include the objective of discovering new possibilities of embodied existence.[89]

Within this research project, the concept of the *limit experience* is highly important because it helps to explain the relationships between drug use, GCP attendance, and unsafe practices. In fact, this concept can be used to address the processes that the research participants undertook when they transgressed their boundaries, and transferred to a state in which the previous state of existence no longer continued; examples of which range widely from the discovery of new states of ecstasy through drug use to the acquisition of HIV during unprotected sexual contact. In both cases, personal definitions are irreversibly changed (i.e., new understandings of pleasure arise in the first example, while in the second example, the individual is forced to assimilate HIV into their self-definitions). Before continuing with this discussion, however, it is important to emphasize that, within this context, the term *limit,* does not signify the end, or the furthest that one can go. Rather, it is a process for reaching beyond any given limit, a method of "pushing the limits" to the point of their being surpassed. Simply put, the *limit experience* is reached when the subject is torn from itself.[88] In fact, Foucault once wrote: "I think the kind of pleasure I would consider real pleasure would be so deep, so overwhelming that I could not survive it"[220] (p. 378). This means that during Foucault's *limit experience*, his subjectivity would be pushed to the point

of death, which might be either real or metaphorical (i.e., his actual death, or the death of the individual that he and others previously thought him to be).[90]

With this understanding, the next logical step in applying the concept of the *limit experience* to this discussion is to delineate some of the elements of stratification, such as, disciplinary technologies and normalization processes that force the body to conform to a given set of standards. That is, the next step is to employ the concept of the *limit experience* in understanding the external and internal impulses, which construct those same *limits* that this *experience* aims to surpass. For Foucault,[58] this would be the process of overcoming socially imposed ideations of appropriateness because "the soul is the prison of the body" (p. 29). While this quotation is theoretically fruitful, it, however, falls short in relation to the results of this research project. In fact, within this dissertation, this statement would need to be expanded to read as follows: the impulses of the individual's body and his desires limit one another in dynamic and interactive ways. Thus, in contrast to Foucault's[58] statement quoted above, it is not a simplistic equation of the soul limiting the body. First, the quasi-religious term "soul" must be removed, and, secondly, it is a threefold relationship encompassing, impulses of desire that limit other impulses of desire (internal interference), impulses of desire that limit impulses of the body, and impulses of the body (physical impulses) that interfere with and limit impulses of desire. These three options can be understood in practical terms as follows: (1) desire limits desire – some of the research participants' desires to have unprotected sex interfered with other desires to avoid activities that are unsafe); (2) desire limits the body – the research participants' desire to be safe prevented them from engaging in specific activities; and (3) the body limits desire – the research participants desired to have multiple partners, but were unable to do so due to the physical limitations of their bodies. Therefore, desires, which are continually modified and stratified by social norms, come into conflict (impulses interfering with one another) and thus

prevent the individual from satiating some desires, and the body, due to its physical limitations, limits the possible range of desires that can be experienced.

However, it is important to remember that many of the participants in this research did report overcoming some of the desires that limited other desires, and that they usually reported doing so by means of drug use and party attendance. In other words, drug use and party attendance did not induce unsafe practices, rather, they were deliberately used to enable the participants to engage in a *limit experience*, and transform themselves into something and someone new. Thus, because these activities create an immanent sense of danger that both pushes the individual beyond their usual limits, and, after the experience is over, leaves the individual changed, these practices exemplify Deleuze and Guattari's[45,46] *becoming* process par excellence. What all of this signifies (that is, the combination of drug use, party attendance, *limit experiences*, and *becoming*) is that as an essential aspect of the *limit experience*, certain impulses of desire and the body (either alone, or in combination) must be deactivated in order to overcome a proscribed barrier (regardless of whether it arises from internal or external impulses) and that drug use and attendance at GCPs is one means by which desires to limit desire can be overcome.

Deleuze and Guattari's[45,46] concept of *becoming*, however, indicates that overcoming limiting desires is not a single process to complete, but rather, a process to continue, and that, consequently, the *limit experience* is neither predictable nor scientifically measurable. In fact, no *becoming* could ever be. Therefore, *limit experiences* most closely resemble art – the *ars erotica* which allows and requires learning to be experiential, thus enabling the creation of alternatives.[60] In this way, an activity such as extreme drug use (as defined by quantity or duration) becomes a means of pushing one's partying practices, one's physical capabilities, and one's self-definition to the limit, and in doing so, is a perpetual process of resisting desires to *be* a stable subject.

In fact, exploring limits (edges or margins) in such a way creates a project of perpetual self-creation that enables individuals to continually explore and identify new possibilities of being and doing.[89] While this can be related to resisting social mores and constraints (see Crossley[221]), it is more about experimenting with new ways of being. Therefore, the criss-crossing of barriers is the essence of the *limit experience* that permits, in return, the development creation (i.e., the *becoming* process) of the each individual *BwO*.[46,88] Put in another way, the principal focus of *limit experience* is perpetual self-creation through the examination and exploration of the lines that separate the concepts of normality and deviance – that is, the requirements of external impulses. However, both Foucault[88] and Deleuze & Guattari[46] asserted that for transgression to be effective, one must play with these limits without destroying them. This highlights that the *limit experiences*, which cause the most disturbance within the social realm are those which unbalance the normative ways of the system, without doing so to such an extreme that the transgression cannot be understood within the models of understanding that comprise mainstream social comprehension (see Deleuze and Guattari's[46] discussion regarding "extreme" lines of flight).

This helps to explain the role of drug use as an excuse for proscribed behaviour, *ex post facto*, because drugs act as the vehicle that transports individuals beyond social limits, and then diminish the disapproval associated with this transgression of boundaries; thereby, allowing this individual to re-enter the boundaries of mainstream society with less condemnation. Drugs, then, provide both a means of increasing one's probability of experiencing and playing with the limits, and extenuating circumstances to mitigate blame after the fact. In this way, drug use is related to the *limit experience* in at least three ways: recreational drugs are illicit within current society, and therefore their use constitutes a breech of societal limitations; drugs permit individuals to move beyond their typical experiences and ways of being; and drugs can function as an excuse, after the fact, for why certain practices occurred. In relation to this last item, drugs become an excuse, and

assume much of the blame for the individual who engaged in a *limit experience* while under their influence. This latter respects Deleuze & Guattari's[46] warning that transgressions (*limit experiences*) should not be too extreme; while drugs enhanced the research participants' ability and likelihood of engaging in potentially excessive, non-mainstream behaviour, the resulting actions were often understood as an effect of the drugs, thus transforming the appraisal of the transgressive behaviour from irrational, deviant, or insane acts into dangerous or risky ones. Therefore, the true relationship between drug use and non-mainstream party attendance is that it allows individuals to attain their *limit experiences* both directly (through the physiological effects of the drugs) and repeatedly (because the individual is then allowed to continue this practice that challenges the mainstream social structure without his transgression causing the social body to exclude him absolutely). These transgressive actions then function as a virus within the social structure – corroding its structure from the inside.[222]

Moreover, Lyng[89] proposes that these acts of playing with boundaries and transgressing them may, at times, be the sole remaining form of resistance available in what Deleuze[223] calls the modern "society of control". A *limit experience*, thus, provides an opportunity to resist hegemonic regulations and is, therefore, an adventure, a *chassé-croisé* (an intricate criss-crossing dance) between the margins of the norm and those of excess and self-intoxication. It is a method by which the repetitious nature of life (i.e., the individual's stable self-definition) can be torn from itself. Therefore, it is, not only an accomplishment of the Self (through self-creation and perhaps self-destruction), but also a political manoeuvre created to subvert the omnipresent hierarchies that govern everyday life: a method of resisting one's assigned socio-temporal location through the act of movement beyond that confining space into the realms beyond the absolute limits.[224] Through the *limit experiences* of unsafe sex with anonymous partners of unknown HIV serological status, illicit drug use, and prolonged physical stimulation, GCP attendees

engage in a form of rebellion against the constraints of everyday life – a rebellion that is initially instigated by the repressive external impulses that manifest through public health surveillance apparatuses and media campaigns that demonize targeted subgroups within society. Thus *limit experiences* are part of a political process that is manifested by individuals exceeding their absolute limits.

However, exceeding one's absolute limits (that is, the furthest and closest points to which one feels comfortable going) need not be accomplished by engaging in extreme activities. In contrast to the *limit experience* proposed by Foucault, for whom the quintessential method of exceeding this limit is sadomasochism,[90] this research project identified that the process of doing something completely out of character also constitutes a surmounting of these limits. In fact, for an individual who perpetually breaks rules, following the rules would constitute an infringement of absolute limits, and thus, a *limit experience*. For example, for the participants who always engage in drug use while at GCPs, a clean or sober GCP experience would in fact constitute a *limit experience*. Thus, the limit is not just the furthest point, but also the closest; it is a set of parameters that bounds an individual, and when breeched, instigates growth/change. In other words, exceeding any absolute limit (which may not constitute an extreme practice) may result in a Foucauldian *limit experience.*

Therefore, the experimental works of creation attempted by the research participants are not random and aimless, but rather, are often highly regulated, structured, and carefully planned.[57] What this means is that deviance is not irrational. Bataille's[57] work helps to locate this logic in research participants' narratives. In situations where the options of fight and flight have both been eliminated by a pervasive society of control, inwardly directed violence serve to re-establish a sense of autonomy: the participants consciously chose to purposively engage in substance use and unsafe sex not only to maximize their pleasure, but also to resist control. In a society where most of the control is both subtle and invisible, personal control still remains over self-destruction (i.e., "you may control me, but I can still destroy

me"), and resistance is still possible in relation to external impositions, which may be physical, personal, or political. Thus, for the participants, the outcomes of their drug use were not accidental; they were sought out as a form of resistance through *limit experience*. In this regard, this Bataillean[57] form of eroticism follows a seeming "death-drive" logic[225] that actually has nothing to do with death; instead, its goal is escape and resistance.

Indeed, such practices may culminate in a new form of eroticism precisely because they transgress, not just personal, but also societally established boundaries, and thus may exacerbate feelings of shame motivated by social, religious, and public health mores. Hence, to push the limits beyond the pale of social norms constitutes not only a transgressive act,[57] but also a counter-power, a form of resistance to that norm (a *becoming*), that is generated by an eroticization of the forbidden. Furthermore, such *becomings* may embody the act of *becoming minor* (i.e., removing oneself from the majority status of middle-class, white, heterosexual, Western male), provided that the aim, methods, processes, et cetera, are not repetitive, but rather, constitute one method among many for resistance. Thus, to *become minor,* by breaching the confines of ordered and normative society (stratification) in order to reside in the margins, the participants must continually explore (through engagement, not through political scheming) the novel strategies of resistance that are offered to them by drug use, unsafe sex, and GCP attendance.

Limitations of the Study

As with all research, limitations that imposed restrictions on the results occurred within this study. In this case, the main restriction stemmed from the fact that the researcher was an outsider to the GCP subculture. While such an external or removed perspective can provide fresh insight into areas overlooked by group members, it is limited by the fact that the validity of the results is dependent on the level of success that the researcher has in gaining the trust (and, therefore, the level of openness) of the research participants. In this

specific case, the organizers of the targeted GCP had already had previous experiences with researchers who had reported negatively on the GCP subculture. Consequently, these organizers were reluctant to be forthcoming, or supportive of this particular study, which may have resulted in limited observation of the less socially acceptable aspects of the GCP. Furthermore, despite efforts to acculturate the observational, surveying, and interviewing data collection and analysis methods, because the researcher remained separate from (external to) the party activities, ultimately, only an emic perspective could be achieved.

In addition, the data collection methods employed restricted direct observation to the capabilities and perspective of the individual undertaking data collection. Thus, the findings of this study were all influenced by the effects of the observer, including the observer's paradox, which states that the act of observing changes the behaviour, or qualities of the entity being observed, a phenomenon, which occurs primarily because of a desire for social acceptability (social desirability bias), or due to observer expectancy effects. Social desirability bias ensues when individuals under observation change their behaviour to reflect what they believe the observer will find most desirable, or wishes to see; observer expectancy effects are the self-fulfilling prophecies of the observer, who expects certain observations before they happen, and then interprets the observations to make them match the original expectations. In other words, the pre-conceived ideas of the researcher undoubtedly influence the results. However, to what extent this occurs is highly variable, and thus, is impossible to determine. Furthermore, the interview process also created limitations because it excluded from the data collection process individuals who did not feel confident regarding their verbal communication skills. Thus, only individuals who felt that they were articulate enough to participate in a semi-structured interview would have self-selected to contribute to this data collection method, thereby, eliminating all others from the findings. In addition any interview process is subject to social desirability bias because

during face-to-face interactions subjects may be more likely to report what they feel the interviewer would like to hear than what they actually feel, or have done.

Moreover, observer expectancy effects may have occurred during the analysis phase, (again, unquantifiable). In addition, analysis was limited to theoretical positions pre-selected by the researcher as informed by previously undertaken research. However, as a response to the latter, the critical approach used to carry out this study allowed for additional theoretical works to be added, as dictated by the collected data. This permitted additional models to be used if the previously selected models proved insufficient, or inadequate for explaining a particular result.

Above and beyond the foregoing, a major philosophical limitation of this study is that it served as a method of anatomo-politics by engaging in the investigation of an otherwise under-represented population within scientific and health care literature. In doing so, a marginalized subculture was scrutinized in order to produce a public document that could now be used to rank and normalize GCP attendees. From a political perspective, any identification of a group might lead to self-fulfilling prophecies, stereotyping, and blatant inaccuracies about this group.[226,227] For example, any examination of a particular group could lead to political attack, as occurred in the early 1980s in relation to gay men and immigrant Haitian populations.[196] To this day, being self-identified as gay is an exclusion criterion for blood donors in Canada.[197] Moreover, the production of a cultural portrait can isolate those individuals within the group who do not identify with the portrait that has been constructed.[195]

Future Directions

The findings of this research project are relevant for nurses who provide direct clinical services and for those working in public and population health environments. In addition, these results may also serve as a guideline for future research and education.

Clinical

First, the findings of this research project are relevant to nurses who practice within specifically designated sexual health environments, including birth control and STI clinics. The reframing of desire that occurred within this dissertation signals that nurses working within these milieus should reframe their attitudes to accept that sexual practices and behaviours, which may seem contrary to current scientific wisdom, as positive impulses that form interpersonal connections rather than reactions to the effects of a psychological deficit. As a consequence of this shift in focus, it is suggested that nurses should expend less time and effort attempting to discover, or to help patients discover their *true* inner desires, a process, which ultimately serves to achieve little more than the application of an anatomo-political (disciplinary) strategy through the application of external interference under a caring guise. Furthermore, in cases where patients present with specific health concerns in which their actions are producing dissonance and where veritable psychological distress is present, this new conceptualization of desire could help nurses and patients to understand the nature of desire, and allow them to accept that "non-mainstream" desires are not necessarily reflections of deviance.

Moreover, the findings presented in this dissertation focus on the culturally specific, but ultimately, individualized nature of internal interference, thus highlighting the importance of nurses remaining non-judgmental of patients who have different standards of propriety. In addition, by reformulating desire in a positive light, health care issues related to what is currently labelled as non-compliant may then be approached as the externalized *becomings* of an individual, rather than as problems to be controlled or eliminated. This, in turn, would allow the health care practitioner the freedom to modify his or her approach according to the particular needs of the individual presenting for care. At the clinical level, the findings of this research project may also provide some guidance for nurses who must address non-compliance issues in non-sexual health-care settings.

Lastly, the findings of this research could be incorporated into recommendations for direct nursing services to be offered at GCPs. Services, such as, on-site testing, counselling, and overdose treatment should be made available. It must be clarified here that this does not mean that the nurses need knowledge in order to "educate" individuals, but rather, that the nurses themselves need to be educated to understand the complexity of the physiological and psycho-social events that they may encounter. In practice, this would result in the need for front-line nurses to be armed with the knowledge that is required to treat individuals who engage in drug use and unsafe sex, regardless of mainstream prohibitions, and thus minimize the possible negative outcomes that could occur. Specifically, this knowledge would include precise information about drug interactions, the signs and symptoms of developing overdoses, requirements for physical preparation prior to the onset of sexual contact, and the distinct properties and uses of lubricants.

Public Health

Beyond the scope of front-line service delivery, the findings of this project are also relevant for nurses engaged in public or population health. Most importantly, it is crucial that nurses who construct large-scale interventions incorporate the concept of desire into their campaigns because disregard for this factor may produce two-fold consequences: either the message will be judged as having no relevance or practical applicability, or it may signal ignorance or indifference on the part of health authorities. Specifically, when addressing sexual health concerns for MSM, nurses need to understand desire as a positive force, not as a deficit that signals inherent psychological dysfunction. In fact, propagating the notion that the sexual behaviour of MSM is problematic or deviant achieves little more than the maintenance of social biases. In contrast, the concept of interference provides public health nurses with a tool that, in part, explains why and how current campaigns are incorporated

into the erotic practices of those who use them as focuses against which to rebel – the very opposite of what is intended.

At a practical level, these research results indicate that public health nurses should advocate for the provision of free water, pragmatic drug awareness information that is not abstinence-based, candid information about drug interactions, effects, and benefits, and drug purity testing. Currently illegal in Canada, purity testing would provide a means by which GCP participants could ensure that the substances they are consuming are the intended drug and that it has not been mixed with other, toxic chemicals. This open approach would allow for a constructive dialogue to begin between public health authorities and those whose health they are mandated to protect. It may also diminish the lack of trust that arises when health sequelae are predicted, but do not materialize and ideally, might counteract the gateway effect that occurs when individuals begin to wonder what other potentially pleasurable experiences (especially those related to drugs) public health authorities are proscribing, or suppressing. In addition, such an open-minded attitude might facilitate a constructive and cost-effective response to the issues that arise from trial and error experimentation with drugs, especially since the majority of health problems result from such uninformed substance use.

Research

First, from a research perspective, the findings of this project present a new conceptualization and theoretical understanding of desire and its expressions, but still requires further investigation to see if these findings are also applicable/transferable to other groups, such as, women, teens and heterosexual men, et cetera. Thus, future directions for research must include the incorporation of the conceptualization of desire, impulse, *becoming*, and interference, and require that each component be further explored to expand the current understanding of these concepts. Secondly, this research demonstrates that it is

possible to utilize a poststructuralist perspective to construct research that does not provide *the* answer, but rather, which provides outcomes (i.e., many answers) that can be drawn upon by marginalized, minority, and disenfranchised groups for their own political goals. Thirdly, a future direction of this research is to return the results to the GCP organization and its participants that/who were studied, and to do so in a clear and coherent manner. The reason for this is, one, to transmit the information that was gathered on and about this group and organization back to them, and, two, to do so with the goal of restoring some faith in the public/sexual health system, while also lessening previously mentioned feelings of resentment and persecution that are experienced by this group at the hands of the health care system.

Education

As the final section of future implications, the understanding of desire that is depicted in this research project is one that could have a future impact on education. It is important that future nurses be educated regarding, not only the wide variety of desires, but also the contextually and culturally situated nature of these desires. In this regard, education about this topic may provide nursing students with a greater appreciation of the nature and power of desire, while providing a perspective from which to deal more successfully with so-called "non-compliant" behaviour. In addition, the findings of this research, in relation to how they contrast (and resist) mainstream scientific discourses, need to be transmitted through the education system to illustrate the political nature of knowledge, science, and of each and everyone's personal desires.

Chapter Seven – Conclusion

In addressing the public health concerns related to desire, drugs, and unsafe sexual practices within the milieus of GCPs, it is essential that reformulations of the entire philosophical perspective of public health nursing occur to overcome the gaps that have been left thus far by the strictly, traditional, quantitative methodologies. As a starting point for this undertaking, this research project was based on an exploratory research design, which was employed in conjunction with a complex theoretical model that derived from the combination of the poststructuralist works of Bataille,[57] Deleuze and Guattari[45,46], Foucault,[58-61] Grosz,[62,63] and Lupton[18,19]. The resulting theoretical framework, coupled with a critical ethnographic methodology, allowed a reformulation of the questions regarding the motivations of MSM who use drugs and engage in risky sexual practices and about how the GCP environment affects drug usage and sexual practices.

Put simply, the findings of this research revealed that while the mathematical correlations between substance use and unprotected sexual contacts are valid, statements or suggestions indicating that substance use is a causative factor for unprotected sexual contact are invalid. In fact, this relationship is far from simple (as is promulgated by much current public health care literature); in-depth exploration of this confirmed that there is a relationship between drug use and risky sexual practices, but also indicated that it is not causative as previously surmised. Conversely, the results of this project suggest that individuals (particularly, those who attend GCPs) use alcohol and drugs as a means by which they can enable their pre-existent desires and impulses to materialize. As such, substance use is the mechanism by which desires and impulses for unsafe sex are realized; it is an impulse that facilitates engagement in other impulses. In other words, drug use results in unsafe sexual practices (because it is used intentionally and purposively to

engage in these practices), but it does not *produce*, or cause, these behaviours. For example, this research found that a generalized social belief that substance use causes individuals to engage in atypical behaviours that they would not otherwise, actually functioned to provide an excuse for the research participants to indulge purposively in proscribed activities while intoxicated (drugs or alcohol) because substance use can then be employed to justify how and why the proscribed activities occurred – to support the argument that without substance use the offending actions would not have occurred – and, thereby, to diminish the negative consequences associated with the breech of societal norms. In this way, this research sheds light on how substance use and unsafe sex have a complex, but non-linear, relationship.

Furthermore, the findings presented in this dissertation reveal that men's desires for drug use, partying, and unsafe sex are impulses that are based on, and modified by, context. However, as with all the attributes of desire and impulse described thus far, context is not a stable phenomenon, but rather, it is the culmination of multiple impulses, multiple desires, and the perpetually changing outcomes associated with these two forces. In this way, GCPs are understood, and are created to be understood, as havens of drug use, dancing, and (homo)sexuality. Thus, it is the impulses, which create the GCP that make it function in this role, and it is this assumed role that helps to maintain the commonly held perceptions about it. Consequently, the findings of previously undertaken studies, which employed statistical and traditional epidemiological methods, identify GCPs as particular settings where drug use occurs and sexual contacts are possible. However, the findings of this study add depth to this uncritical scientific research due to the discovery that, while unsafe sexual activities and drug use do occur, within GCPs, these environments do not cause these behaviours. In other words, GCPs represent the synergistic combination of men's desires to engage in these practices; they are not their cause. Again, this finding demonstrates that correlation does not equate to causation.

In summary, the findings of this dissertation, which warn against ascribing causation to correlation when it comes to desire, drug use, and unsafe sexual practices are:

1. Desire is not always a response to restriction; (Major Finding One)
2. Desire for unsafe activities is not an outward representation of deviance or other psychological or emotional deficits; (Major Finding One)
3. Desire is a representation of individuals because it forms connections between the desirer and the desired; (Major Finding One)
4. Drug use does not cause unsafe behaviours; rather, drug use is purposively engaged in to ensure that unsafe sexual activities occur; (Major Finding Two)
5. GCPs do not cause unsafe behaviours; rather, GCPs provide locations for many unsafe behaviours to occur, and are attended by individuals, many of whom, desire to engage in these unsafe practices. (Major Finding Two)

Consequently, these findings indicate that the motivations of MSM who use drugs and engage in risky sexual practices within the GCP subculture are not deficit driven, and that, therefore, knowledge will not deter these individuals from engaging in behaviour that is considered harmful by health-care professionals. The findings of this research project signify that individuals will undertake whatever actions they wish (i.e., that they will pursue their desires), regardless of warnings, although not necessarily because they are biologically impelled toward these actions, or because they have an underlying deficit that needs to be satisfied. Individuals do not necessarily use drugs, drink alcohol, or have unsafe sex due to depression, loneliness, or isolation. Substance use and unsafe sex occur as a result of desire, and individuals come to be created, defined, and seen as stable entities based on the external and internal perceptions of the expressions of these desires in thought, emotion, and/or action. Desire is an impulse toward objects, but not necessarily because these were previously lacking. In contrast to the Freudian[65,67] belief – that desire is the result of negative underlying problems – which underpins many current public health interventions

involving MSM who use drugs and attend GCPs, the research participants did not define their desires in these negative terms. Therefore, this research questions the rationale for continuing to base prevention campaigns on this Freudian subtext. In fact, the research findings point to the idea that the individuals who attend GCPs, engage in unsafe sex, and use drugs, base their rationales for doing so on a set of beliefs, which are completely different (and perhaps even alien) to those beliefs held by many health care professionals. In this way, the findings of this research make it possible to see GCPs not only as sites of pleasure, excess, substance use, sexuality, and desire, but also as potential sites for renewed preventative health care and direct public health service deliver.

Appendix A: Relevant Tables

STI Transmission (Table 1)

In the table below, some of the more common sexual practices are evaluated regarding the chance of transmission and the effect of protection for each of the abovementioned STIs. The Risk Level comprises three categories: No Risk, Possible Risk, and Known Risk. While No Risk and Known Risk are straightforward, Possible Risk indicates that transmission has occurred, but is not fully understood scientifically, or that theoretically transmission could occur, but a case has not yet been isolated to illustrate this transmission. In the Effect of Protection category the evaluations of Not Applicable (N/A), Significant Decrease, Limited Decrease, and Unknown have been used. N/A signifies, either a lack of protective measures (kissing), or that the definition of the activity is based on a lack of protection (Skeet). Skeeting is the process of randomly dispersing ejaculate onto the epidermis of a sexual partner. Such actions have been speculated as a reaction to the danger HIV/AIDS, where ejaculating inside a partner is now considered to be an irresponsible and risky sexual practice.[160] The term, Significant Decrease, indicates that research has identified that barriers are successful – correct condom use decreases the chlamydia acquisition; and Limited Decrease represents a less than significant drop in transmission rates (herpes simplex virus type II).

Sexual Practice	*STI*	*Risk Level*	*Effect of Protection*
Kissing	Gonorrhea	Known Risk	N/A
	Chlamydia	Known Risk	N/A
	Herpes (HSV)	Known Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	Known Risk	N/A
	Hepatitis B	Known Risk	N/A
	HIV	No Risk	N/A

(con't)

Oral			
Oral-penile Aka: oral sex, blowjob, fellatio, head,	Gonorrhea	Known Risk	Significant Decrease
	Chlamydia	Known Risk	Significant Decrease
	Herpes (HSV)	Known Risk	Limited Decrease
	Genital Warts (HPV)	Possible Risk	Unknown
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Possible Risk	Unknown
Oral-vaginal Aka: cunnilingus, oral sex	Gonorrhea	Known Risk	Significant Decrease
	Chlamydia	Known Risk	Significant Decrease
	Herpes (HSV)	Known Risk	Limited Decrease
	Genital Warts (HPV)	Possible Risk	Unknown
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Possible Risk	Unknown
Oral-anal Aka: feltching, rimming, anilingus, tossing salad	Gonorrhea	Known Risk	Significant Decrease
	Chlamydia	Known Risk	Significant Decrease
	Herpes (HSV)	Known Risk	Limited Decrease
	Genital Warts (HPV)	Possible Risk	Unknown
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Possible Risk	Unknown
Vaginal-vaginal contact Aka: tribadism, bumper-to-bumper,	Gonorrhea	Known Risk	Significant Decrease
	Chlamydia	Known Risk	Significant Decrease
	Herpes (HSV)	Known Risk	Limited Decrease
	Genital Warts (HPV)	Known Risk	Limited Decrease
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Possible Risk	Unknown

(con't)

Penetration			
Penile-vaginal	Gonorrhea	Known Risk	Significant Decrease
	Chlamydia	Known Risk	Significant Decrease
Aka: sex, fucking,	Herpes (HSV)	Known Risk	Limited Decrease
balling,	Genital Warts (HPV)	Known Risk	Limited Decrease
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Known Risk	Significant Decrease
Penile-anal	Gonorrhea	Known Risk	Significant Decrease
	Chlamydia	Known Risk	Significant Decrease
Aka: anal sex	Herpes (HSV)	Known Risk	Limited Decrease
	Genital Warts (HPV)	Known Risk	Limited Decrease
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Known Risk	Significant Decrease

(con't)

Other			
Fisting	Gonorrhea	No Risk	N/A
	Chlamydia	No Risk	N/A
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	Known Risk	Significant Decrease
	Hepatitis B	Known Risk	Significant Decrease
	HIV	Known Risk	Significant Decrease
Scatophilia Aka: shit play	Gonorrhea	Possible Risk	Unknown
	Chlamydia	Possible Risk	Unknown
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	Possible Risk	Unknown
	Hepatitis B	Possible Risk	Unknown
	HIV	No Risk	N/A
Urolagnia Aka: watersports, urine games, golden showers	Gonorrhea	No Risk	N/A
	Chlamydia	No Risk	N/A
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	No Risk	N/A
	Hepatitis B	No Risk	N/A
	HIV	No Risk	N/A
Sado-machocism Aka: S&M	Gonorrhea	No Risk	N/A
	Chlamydia	No Risk	N/A
	Herpes (HSV)	Possible Risk	Limited Decrease
	Genital Warts (HPV)	Possible Risk	Unknown
	Syphilis	Possible Risk	Unknown
	Hepatitis B	Possible Risk	Unknown
	HIV	Possible Risk	Unknown

(con't)

Skeet			
On face Aka: facial	Gonorrhea (Ocular infection)	Known Risk	N/A
	Chlamydia (Ocular infection)	Known Risk	N/A
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	Known Risk	N/A
	Hepatitis B	Known Risk	N/A
	HIV	Possible Risk	N/A
On chest	Gonorrhea	No Risk	N/A
	Chlamydia	No Risk	N/A
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	No Risk	N/A
	Hepatitis B	No Risk	N/A
	HIV	No Risk	N/A
On vagina	Gonorrhea	Known Risk	N/A
	Chlamydia	Known Risk	N/A
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	Known Risk	N/A
	Hepatitis B	Known Risk	N/A
	HIV	No Risk	N/A
On anus	Gonorrhea	Known Risk	N/A
	Chlamydia	Known Risk	N/A
	Herpes (HSV)	No Risk	N/A
	Genital Warts (HPV)	No Risk	N/A
	Syphilis	Known Risk	N/A
	Hepatitis B	Known Risk	N/A
	HIV	Possible Risk	N/A

Table 1: STI Transmission

Summary of Drugs (Table 2)

The following table (2) provides a summary and comparison of the four drugs: crystal meth, ecstasy, ketamine, and GHB commonly used within the GCP subculture. Items included are the slang terms used to identify each drug, the source of these drugs, the pharmaceutical classification, the medical use, the usage method, the effects sought, and the adverse effects.

Drug	Methampethamine	MDMA	Ketamine	GHB
Slang terms	speed, meth, Tina, Yaba, Gak, chalk, fire, ice, jib, crystal, crank, crack and glass	Love drug, XTC, adam, "E", doves, disco biscuits, echoes, hug drug, eccies, burgers, fantasy	Special K, K, vitamin K, cat valiums, ket	Sexual assault drug, Date rape drug, Grievous bodily harm, Easy lay, Gook, Gamma 10, Liquid X, Liquid E, Liquid G, Georgia home boy, Soap, Scoop, Salty water, Somatomax, GG-rifflick, Cherry meth, Fantasy Organic Quallude, Nature's Quallude,
Source	Synthetic	Synthetic	Semi-synthetic	Synthetic
Pharmaceutical classification	Stimulant	Amphetamine-based hallucinogen	Analgesic	CNS depressant
Medical use	Bronchodilator; mood improvement; energy pills	Appetite suppressant; adjunct to psychotherapy	Veterinary analgesic	Sold as performance enhancing additive to body builder formulae; analgesic effects plus amnesia
Abuse form	Powder, crystal, liquid, tablet	Tablets or capsules	Powder or liquid	Capsules; grainy, white to sand-coloured powder
Usage method	Orally, intranasally, IM, intravenously, rectally, vaginally, sublingually, smoking	Orally	Snooted, smoked, or IM injection	Orally or dissolved in liquids like water and alcohol
Effects sought	Euphoria, energy increase, mood elevation, sexual enhancement, improved focus, improve self-esteem	Insight, distortion of senses, exhilaration, mystical/ religious experiences	Euphoria (causes dream-like states/ hallucinations), has been used in rape	Intoxication, deep sedation
Adverse effects	Psychosis, tachycardia, dyspnea, dysphoria, palpations, cardiac failure, liver/ kidney failure	Neurotoxic, particularly to serotoninergic neurons	Delirium, amnesia, impaired memory / motor function, hypertension, depression, respiratory failure, heart failure	Chemical burns to esophagus, mouth and throat; amnesia; seizures; respiratory depression; coma and possible death with overdose

(Cited from Hamid, El-Mallakh & Vandeveir[228])

Table 2: Summary Table of Common Circuit Party Drugs

Appendix B: Ethnographic Data Collection Grids

Ethnographic Data Collection Grid 1

Date: ___________

Time (Vol.)	# within group	Dress	Activity level	Physical appearance	Interaction

Ethnographic Data Collection Grid 2

TIME: ___________

Location type	
Club design	
Party layout	
Colours	
Lighting	
Bathrooms	
Bar	
DJ/ Stage	
# of people	
Type of music	
Volume of music	
Types of dancing	
Size of dancing groups	
Description of groups	
Clothes worn	
Themes	
Additional items	
Other	

Appendix C: Qualitative Interview Guide

Interview Probes

General

What are your reasons for attending gay circuit parties?

What are your motivations when you are at the gay circuit party?

Sexual Practices

When attending gay circuit parties, is it your intention to have sex?

What type of sexual practices do you wish to engage in at the gay circuit party?

Within the location and elsewhere.

Do you engage in different sexual practices with non-circuit party partners?

Do you meet people to have sex with at the gay circuit party?

Drug Use

Do you use drugs at the gay circuit party?

What are your reasons for using drugs?

Which drugs do you use?

Do your sexual practices change if you use drugs?

What are you motivations for using drugs at the circuit party?

Do you use drugs when not at the circuit party?

Do you feel that drug use is an aspect of the gay circuit party?

Environment

What is your favourite aspect of the gay circuit party?

What are your feelings upon the effects of the music? The lights? The crowd?

Knowledge of Risk

What do you know about STIs and HIV?

-Acquisition, testing, treatment, reoccurrence

What do you know about the effects of drug use?

-Adverse effects, signs of overdose, effects of combination

Appendix D: Self-Administered Questionnaire / Questionnaire Auto-Administré

Self-Administered Questionnaire

Information Letter

Title of Study:

THE INTERSECTION OF DESIRE, DRUGS AND UNSAFE SEXUAL PRACTICES: AN ETHNOGRAPHIC STUDY OF THE GAY CIRCUIT PARTY SUBCULTURE

Funding agency: Canadian Institutes of Health Research

Researcher:
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School of Nursing
451 Smyth Road, Ottawa, Ontario, K1H 8M5
Ph. 613-562-5800 ext. 8433
Fax 613-562-5443
Email: kwoodend@uottawa.ca

1. Research objectives

a. To understand the motivations of males who have sex with males (MSM) who use drugs and engage in risky sexual practices within the gay circuit party subculture.
b. To understand the effects of the circuit party environment upon drug use and sexual practices.

2. Contribution of participants / participation

Should you accept to participate in this research, you need to allocate the time needed to complete a 10-minute self-administered questionnaire in order to answer the required questions. Only one questionnaire will be necessary. At any time, you may withdraw from this research by not continuing with the questions.

3. Risks associated with your participation

The researcher is well aware of the intrusive nature of this study concerning your drug use and/or sexual practices. As such, certain questions may evoke some distress or even suffering on your part. Therefore, the researcher is committed to referring participants to appropriate counselling resources available in your city of residence, should you express this need.

Montreal:	Ottawa:	Toronto:
Action Sero-Zero	AIDS Committee of Ottawa	AIDS Committee of Toronto
C.P. 246, Succ. C.	1 Bank Street, Suite 700	399 Church St, 4th Floor
Montreal (Quebec)	Ottawa, Ontario	Toronto, Ontario
H2L 4K1	K2P 1X3	M5B 2J6
514.521.7778	613.238.5014	416.340.2431

4. Confidentiality and anonymity

The confidentiality of information obtained will be respected for all participants taking part in this research. All participants will be attributed an alphanumerical code preventing any possibility of links between their real identity and their responses given.

5. Conservation of information and communication of research results

The questionnaires will be kept in a locked file cabinet in the researcher supervisor's office at the University of Ottawa for 5 years. To ensure confidentiality, all data will be identified by an alphanumerical code. The final stage of the research involves communicating the results in the form of scientific articles or conferences. By agreeing to participate in this research, you accept that the results obtained from analyzing your questionnaire may be used for scientific or teaching purposes.

6. Main benefits anticipated and related to research

By accepting to participate in this research you are promoting the advancement of knowledge in a domain of nursing that is poorly developed. This research constitutes a novel response to a gap in this area that it may allow a better understanding of your experiences with gay circuit parties and, ultimately, will provide various avenues for developing interventions that are non-stigmatizing and adapted to your needs.

7. Voluntary participation

You are under no obligation to participate and if you choose to participate, you may withdraw from the research at any time. You may also refuse to answer questions. If you choose to withdraw, all data gathered until the time of withdrawal will not be used and will be destroyed.

8. Additional questions or comments related to this research

The researcher is available for answering questions you may have regarding this research project (pjobyrne@uottawa.ca). If you have any ethical concerns regarding your participation in this research, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, room 159, Ottawa, Ontario, K1N 6N5.: 613.562.5841, email: ethics@uottawa.ca.

Questionnaire

Part 1: Sociodemographic data

1) What year were you born? ____________

(If you are born after 1988 please do not continue with the questionnaire)

2) Do you have sex with men, women, both?

- ❑ Men
- ❑ Women
- ❑ Men & Women
- ❑ Other : ______________________

3) What is highest level of diploma or degree you have attained?

- ❑ No Diploma
- ❑ High School Diploma
- ❑ College Diploma (general or professional)
- ❑ Bachelor Degree
- ❑ Master's Degree
- ❑ Doctoral Degree
- ❑ Other, please specify ___________________

4) What was your income last year? (before taxes)

- ❑ Less than $10,000
- ❑ $10,000 - $19,000
- ❑ $20,000 - $29,000
- ❑ $30,000 - $39,000
- ❑ $40,000 - $49,000
- ❑ $50,000 - $59,000
- ❑ $60,000 - $69,000
- ❑ $70,000 - $79,000
- ❑ $80,000 - $89,000
- ❑ $90,000 - $99,000
- ❑ More than $100,000

5) Ethnic origin:

- ❑ Caucasian
- ❑ African Canadian
- ❑ Latin
- ❑ Asian
- ❑ Aboriginal
- ❑ Other, please specify ___________________

Part 2: Sexual Practices

1) In the last six (6) months, how many different sexual partners have you had? (All types of sexual contact.) Approximate number:

____

2) In the last six (6) months, during sexual contacts, how often were you on the influence of DRUGS?

- ❑ Always
- ❑ Most often
- ❑ Half of the time
- ❑ Sometimes
- ❑ Never

3) In the last six (6) months, during sexual contacts, how often were you under the influence of ALCOHOL?

- ❑ Always
- ❑ Most often
- ❑ Half of the time
- ❑ Sometimes
- ❑ Never

4) In the last six (6) months, how often did you ask your partners about their HIV status before having sex with them?

- ❑ Always
- ❑ Most often
- ❑ Half of the time
- ❑ Sometimes
- ❑ I never ask about HIV status

5) In the last six (6) months, how many of your sexual partners were HIV negative?

- ❑ All
- ❑ Most
- ❑ Half
- ❑ Some
- ❑ None
- ❑ N/A (I never ask about HIV status)

6) In the last six (6) months, how many of your sexual partners did not know THEIR OWN HIV status? (You asked and they did not know.)

- ❑ All
- ❑ Most
- ❑ Half
- ❑ Some
- ❑ None
- ❑ N/A (I never ask about HIV status)

7) In the last six (6) months, how many of your sexual partners were HIV positive? (Have HIV.)

- ❑ All
- ❑ Most
- ❑ Half
- ❑ Some
- ❑ None
- ❑ N/A (I never ask about HIV status)

8) Have you previously had an HIV test?

- ❑ Yes   If YES,**What was the result?**   ❑ **Positive (You have HIV)**
  ❑ **Negative (You do not have HIV)**
- ❑ No

9) If you have previously had an HIV test, was it a confidential test (you used your name), or an anonymous test (you used a number/code instead of your name)?

- ❑ Confidential (You DID use your name)
- ❑ Anonymous (You DID NOT use your name)
- ❑ N/A (I have never been tested for HIV)

10) If you have previously had an HIV test, did it make a difference if the test was confidential or anonymous?

- ❑ Yes
- ❑ No
- ❑ N/A (I have never been tested for HIV)

11) Do you regularly get tested for HIV?

- ❑ Yes   If YES, **How often?** ____________
- ❑ No
- ❑ N/A (I have never been tested for HIV)

12) Have you previously had an STI (sexually transmitted infection)?

- ❑ Yes   If YES, **WHAT?** __________
- ❑ No
- ❑ I have never been tested for STIs

13) Do you regularly get tested for STIs?

- ❑ Yes   If YES, **How often?** ____________
- ❑ No
- ❑ N/A (I have never been tested for STIs)

Part 3: At the Circuit Party

1) Do you attend circuit parties with the intention of being intoxicated with ALCOHOL?

- ❑ Yes
- ❑ No

2) Do you attend circuit parties with the intention of using DRUGS?

- ❑ Yes
- ❑ No

3) Do you visit circuit parties with the intention of having anonymous sex?

- ❑ Yes
- ❑ No

4) Do you have anonymous sex (either at party or after leaving) with partners you meet at the circuit party?

- ❑ Yes
- ❑ No

5) If yes, what types of sexual activities do you engage in with these partners? (Please check all that apply)

- ❑ I do not have sex with partners at/from the circuit party (please skip to the next question)

❑ I suck with condoms	❑ I get sucked with condoms
❑ I suck without condoms ❑ I take loads in my mouth ❑ I take loads on my face ❑ I take loads on my chest	❑ I get sucked without condoms ❑ I give loads in the mouth ❑ I give loads on the face ❑ I give loads on the chest
❑ I fuck with condoms (anal sex) ❑ I give loads in the ass (with condom)	❑ I get fucked with condoms (anal sex) ❑ I take loads in the ass (with condom)
❑ I fuck without condoms (anal sex) ❑ I give loads in the ass ❑ I give loads on the ass	❑ I get fucked without condoms (anal sex) ❑ I take loads in my ass ❑ I take loads on my ass
❑ I rim	❑ I get rimmed
❑ Other, please specify: ____________	

6) If you meet partners at circuit parties, do you have sexual contacts while under the influence of alcohol?

- ❑ Yes
- ❑ No

7) If you meet partners at circuit parties, do you have sexual contacts while on DRUGS?

- ❑ Yes
- ❑ No (Skip to question 10)

8) If you use drugs, which drugs do you use? (please check all that apply)

- ❑ I do not use drugs (please skip to question 10)
- ❑ Crystal meth (Tina, crystal)
- ❑ Viagra, Cialis
- ❑ Gas, Glue
- ❑ Marijuana (hashish, pot, grass)
- ❑ Poppers
- ❑ Amphetamines, stimulants, speed
- ❑ LSD (acid), mescaline
- ❑ Other, please specify ____________________
- ❑ GHB (Gamma-Hydroxybutyric acid)
- ❑ Special K (Ketamine)
- ❑ Ecstasy
- ❑ Cocaine, free base
- ❑ Crack
- ❑ Heroin

9) If you use drugs, what is your drug of choice and why? (please specify)

____

10) Indicate the degree to which the following statements apply to you:

❑ I do not use drugs (You are now done the questionnaire)

Please provide an answer for each statement.

	do not agree	agree a little	agree moderately	agree a lot	agree totally
a) I prefer having sex while on drugs	❑	❑	❑	❑	❑
b) I prefer partying while on drugs	❑	❑	❑	❑	❑
c) I prefer having sex while under the influence of alcohol	❑	❑	❑	❑	❑
d) I prefer partying while under the influence of alcohol	❑	❑	❑	❑	❑
e) I use drugs/ alcohol to maximize my party experience	❑	❑	❑	❑	❑
f) I am dependent on drugs to have fun	❑	❑	❑	❑	❑
g) I am not dependent on drugs, but use them to have fun	❑	❑	❑	❑	❑
h) I use drugs so that I won't remember what happens	❑	❑	❑	❑	❑
i) I use drugs to lose control	❑	❑	❑	❑	❑
j) I use drugs to forget about my problems	❑	❑	❑	❑	❑
k) I use drugs to fit in	❑	❑	❑	❑	❑
l) I use drugs/ alcohol to over come shyness	❑	❑	❑	❑	❑

Invitation to participate in "in-depth interview" with the researcher

For this research, the researcher is looking for individuals who are willing to do an in-depth interview of approximately 60 minutes. This interview will be done by Patrick O'Byrne, RN, PhD(c), outside the party. Please contact the researcher if you are interested (contact information on attached business card). Anonymity is assured.

Questionnaire auto-administré

Lettre d'information

Titre de la recherche:

INTERSECTION ENTRE LE DÉSIR, LES DROGUES ET LES PRATIQUES SEXUELLES À RISQUE: UNE RECHERCHE ETHNOGRAPHIQUE DANS UN « CIRCUIT PARTY » GAI

Organisme subventionnaire: Instituts de recherche en santé du Canada

Chercheur:
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Candidat au Doctorat
Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières
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Superviseurs:
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451 Chemin Smyth
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613.562.5800 ext. 8341 (P)
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Kirsten Woodend, Inf, PhD,
Professeur agrégée
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451 Chemin Smyth
Ottawa, Ontario, K1H 8M5
613-562-5800 ext. 8433 (P)
613-562-5443 (F)
Adresse courriel: kwoodend@uottawa.ca

1. Objectifs de la recherche

a. Comprendre les motivations d'hommes ayant des rapports sexuels avec d'autres hommes qui fréquentent les « circuit parties », qui utilisent des drogues et qui ont des rapports sexuels à risque.

b. Comprendre les effets de l'environnement des « circuit parties » sur l'utilisation de drogues et sur les pratiques sexuelles.

2. Contribution of participants / participation

Si vous acceptez de participer à cette recherche vous devez être disponible pour répondre à un questionnaire auto-administré de (10) dix minutes. Un seul questionnaire est nécessaire. En tout temps vous pouvez vous retirer de cette recherche en refusant de répondre aux questions.

3. Risques associés à votre participation

Le chercheur est bien conscient du caractère intrusif de cette recherche qui porte sur votre consommation de drogues et/ou sur vos pratiques sexuelles. Certaines questions pourraient susciter chez certains d'entre vous une certaine part de détresse, voire de souffrance. Le

chercheur s'engage donc à orienter les participants vers les ressources de *counselling* appropriées disponibles dans les villes où ils résident, si le besoin est exprimé comme tel par certains.

Montreal:	Ottawa:	Toronto:
Action Séro-Zéro C.P. 246, Succ. C. Montreal (Quebec) H2L 4K1 514.521.7778	AIDS Committee of Ottawa 1 Bank Street, Suite 700 Ottawa, Ontario K2P 1X3 613.238.5014	AIDS Committee of Toronto 399 Church St, 4th Floor Toronto, Ontario M5B 2J6 416.340.2431

4. Confidentialité et anonymat
La confidentialité des données sera respectée pour tous les participants à cette recherche. En effet, tous les informants se verront attribuer un code alphanumérique empêchant ainsi les rapprochements entre leur identité réelle et les réponses qu'ils donnent aux questions posées.

5. Conservation des données et diffusion des résultats de la recherche
Les questionnaires seront conservés pendant une période de 5 ans dans une armoire verrouillée dans le bureau du directeur de recherche sur le campus de l'Université d'Ottawa. Tous les questionnaires porteront un code alpha-numérique afin de protéger l'identité des participants. Enfin, la dernière étape du processus de recherche implique la diffusion des résultats sous formes d'articles scientifiques ou de conférences. Vous acceptez donc que les résultats de l'analyse faites à partir de vos réponses soient utilisés à des fins de communications savantes ou d'enseignement.

6. Bénéfices anticipés de ma participation à cette recherche
En acceptant de participer à cette recherche vous participez à l'avancement des connaissances dans un domaine très peu développé par la recherche en sciences infirmières. Cette recherche vise donc à palier à cette lacune dans la mesure où elle permettra une meilleure compréhension de votre expérience en regard des « circuit parties » tout en permettant la mise en place d'interventions infirmières adaptées à vos besoins en matière de santé publique.

7. Participation volontaire
Votre participation à ce questionnaire est volontaire et vous êtes libre de vous retirer en tout temps, et/ou de refuser de répondre à des questions. Si vous choisissez de vous retirer de cette recherche, les données recueillies jusqu'au moment de votre retrait ne seront pas utilisées et seront détruites.

8. Questions supplémentaires ou commentaires en regard de cette recherche
Le chercheur est réputé pouvoir donner suite à toutes les questions que vous auriez en regard de ce projet de recherche (pjobyrne@uottawa.ca). Si vous avez des questions concernant l'éthique relativement à votre participation dans ce projet, veuillez communiquer avec la Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550 rue Cumberland, pièce 159, Ottawa, Ontario, K1N 6N5, tel. : (613) 562-5841, courriel : ethics@uottawa.ca

Questionnaire

Partie 1 : Données sociodémographiques

1) Quelle année êtes-vous né ? __________
(Si vous êtes né après 1988, SVP ne continuez pas à remplir le questionnaire)

2) Avez-vous des rapports sexuels avec des hommes, des femmes, les deux ?
- ☐ Hommes
- ☐ Femmes
- ☐ Hommes & Femmes
- ☐ Autre : ________________________

3) Quel est le plus haut diplôme obtenu ?
- ☐ Aucun
- ☐ Études secondaires
- ☐ Études collégiales (général ou professionnel)
- ☐ Baccalauréat
- ☐ Maîtrise
- ☐ Doctorat
- ☐ Autre : ____________________________

4) L'an passé, quel était votre revenu personnel avant impôts ?
- ☐ Moins de 10,000$
- ☐ 10,000$ - 19,000$
- ☐ 20,000$ - 29,000$
- ☐ 30,000$ - 39,000$
- ☐ 40,000$ - 49,000$
- ☐ 50,000$ - 59,000$
- ☐ 60,000$ - 69,000$
- ☐ 70,000$ - 79,000$
- ☐ 80,000$ - 89,000$
- ☐ 90,000$ - 99,000$
- ☐ 100,000$ et +

5) Origine ethnique :
- ☐ Blanc
- ☐ Noir (Africain – Canadien)
- ☐ Latino
- ☐ Asiatique
- ☐ Amérindien
- ☐ Autre : _____________________________

Partie 2: Pratiques sexuelles

1) Dans les derniers 6 mois, combien de partenaires sexuels différents avez-vous eu?
(Toutes formes de rapports sexuels) Nombre approximatif : ________________

2) Dans les 6 derniers mois, pendant vos rapports sexuels, quelle proportion de vos relations sexuelles ont été sous l'influence de drogues ?

- ❑ Aucune
- ❑ La minorité
- ❑ La moitié
- ❑ La majorité
- ❑ Toutes

3) Dans les 6 derniers mois, pendant vos rapports sexuels, quelle proportion de vos relations sexuelles ont été sous l'influence d'alcool ?

- ❑ Aucune
- ❑ La minorité
- ❑ La moitié
- ❑ La majorité
- ❑ Toutes

4) Dans les 6 derniers mois, dans quelle proportion avez-vous demandé le statut sérologique VIH de vos partenaires avant les rapports sexuels ?

- ❑ Aucune
- ❑ La minorité
- ❑ La moitié
- ❑ La majorité
- ❑ Toutes

5) Dans les 6 derniers mois, quelle proportion de vos partenaires étaient VIH négatif?

- ❑ Aucune
- ❑ La minorité
- ❑ La moitié
- ❑ La majorité
- ❑ Toutes
- ❑ N/A (je ne le demande pas)

6) Dans les 6 derniers mois, quelle proportion de vos partenaires ne connaissaient pas leur statut sérologique en regard du VIH ?

- ❑ Aucune
- ❑ La minorité
- ❑ La moitié
- ❑ La majorité
- ❑ Toutes
- ❑ N/A (je ne le demande pas)

7) Dans les 6 derniers mois, combien de vos partenaires étaient VIH positifs ?

- ❑ Aucune
- ❑ La minorité
- ❑ La moitié
- ❑ La majorité
- ❑ Toutes
- ❑ N/A (je ne le demande pas)

8) Avez-vous déjà passé un test de dépistage du VIH ?

- ❑ Oui Si oui, quel était le résultat ? ❑ **Positif (Tu as le VIH)** ❑ **Négatif (Tu n'as pas le VIH)**
- ❑ Non

9) Si vous avez subi un test de dépistage du VIH, était-ce un test confidentiel (utilisant votre nom), ou un test anonyme (utilisant un numéro au lieu de votre nom)?

- ❑ Confidentiel (utilisant votre nom)
- ❑ Anonyme (n'avez pas utilisé votre nom)
- ❑ Je n'ai jamais passé un test de dépistage du VIH

10) Si vous avez déjà passé un test de dépistage du VIH, le fait que le test était confidentiel ou anonyme a-t-il influencé votre choix de passer le test ?

- ❑ Oui
- ❑ Non
- ❑ Je n'ai jamais passé un test de dépistage du VIH

11) Vous faites-vous tester régulièrement pour le VIH ?

- ❑ Non
- ❑ Oui Si oui, à quelle fréquence ? _________
- ❑ Je n'ai jamais passé un test de dépistage du VIH

12) Avez-vous déjà eu une ITS (infection transmise sexuellement) ?

- ❑ Oui Si oui, quelle ITS ? ___________
- ❑ Non
- ❑ Je n'avais pas déjà passé un test de dépistage pour une ITS

13) Vous faites-vous tester régulièrement pour les ITS ?

- ❑ Oui Si oui à quelle fréquence ? _________
- ❑ Non
- ❑ Je n'ai jamais passé un test de dépistage pour une ITS

Partie 3 : Au « Circuit Party »

1) Allez-vous à des «circuit party» dans l'intention de vous intoxiquer avec de L'ALCOOL?

- ❑ Oui
- ❑ Non

2) Allez-vous à des « circuit party » dans l'intention de consommer des DROGUES?

- ❑ Oui
- ❑ Non

3) Allez-vous à des « circuit party » dans l'intention d'avoir des relations sexuelles anonymes ?

- ❑ Oui
- ❑ Non

4) Est-ce que vous avez des rapports sexuels (après ou pendant le party) avec des partenaires anonymes que vous avez rencontré à des « circuit party » ?

- ❑ Oui
- ❑ Non

5) Si oui, quels types de pratiques sexuelles avez-vous avec vos partenaires ? (Cochez toutes les réponses qui s'appliquent).

❑ Je n'ai pas de rapports sexuels à des «circuit party» ou suivant ceux-ci. (Sautez à la prochaine question)

❑ Je suce avec condom	❑ Je me fais sucer avec condom
❑ Je suce sans condom ❑ Je prends le sperme dans ma bouche ❑ Je reçois le sperme sur mon visage ❑ Je reçois le sperme sur ma poitrine	❑ Je me fais sucer sans condom ❑ J'éjacule dans la bouche ❑ J'éjacule sur le visage ❑ J'éjacule sur la poitrine
❑ Je pénètre avec condom (sexe anal) ❑ J'éjacule dans l'anus (avec condom)	❑ Je me fais pénétrer avec condom (sexe anal) ❑ Je reçois le sperme dans l'anus (avec condom)
❑ Je pénètre sans condom (sexe anal) ❑ J'éjacule dans l'anus (sans condom) ❑ J'éjacule sur les fesses	❑ Je me fais pénétrer sans condom (sexe anal) ❑ Je reçois le sperme dans l'anus (sans condom) ❑ Je reçois le sperme sur mes fesses
❑ Je « rim »	❑ Je me fais « *rimmer* »
❑ Autres: ____________________	

6) Lors de votre participation à des « circuit party », avez-vous des rapports sexuels anonymes sous l'influence d'alcool ?

- ❑ Non
- ❑ Oui

7) Lors de votre participation à des « circuit party », avez-vous des rapports sexuels anonymes sous l'influence de drogues ?

- ❑ Non
- ❑ Oui

8) Si oui, laquelle/ lequelles ? (Cochez toutes les réponses qui s'appliquent).

- ❑ Je n'utilise pas de drogues (sautez à question #10)
- ❑ Crystal meth (Tina, crystal)
- ❑ Viagra, Cialis
- ❑ Gas, Glue
- ❑ Marijuana (hashisch, pot, grass)
- ❑ Poppers
- ❑ Amphétamines, stimulants, speed
- ❑ LSD (acide), mescaline
- ❑ GHB
- ❑ Special K
- ❑ Ecstasy
- ❑ Cocaïne, free base
- ❑ Crack
- ❑ Héroïne
- Autres: ____________________

9) Si vous utilisez des drogues, laquelle est votre préférée et pourquoi ?

____

10) Veuillez indiquer dans quelle mesure les phrases suivantes vous concernent :

❑ Je n'utilise pas de drogues. (Vous avez terminé)

Veuillez répondre à chaque question	En désaccord	Peu d'accord	Moyennement d'accord	Très d'accord	Totalement d'accord
a) Je préfère baiser sous l'effet d'alcool	❑	❑	❑	❑	❑
b) Je préfère faire le 'party' sous l'effet de la drogue	❑	❑	❑	❑	❑
c) Je préfère baiser sous l'effet de la drogue	❑	❑	❑	❑	❑
d) Je préfère faire le 'party' sous l'effet d'alcool	❑	❑	❑	❑	❑
e) J'utilise de la drogue pour maximiser le « party »	❑	❑	❑	❑	❑
f) Je suis dépendant de la drogue pour avoir du fun	❑	❑	❑	❑	❑
g) Je ne suis pas dépendant de la drogue, mais je l'utilise pour le fun	❑	❑	❑	❑	❑
h) J'utilise de la drogue afin d'oublier ce qui s'est passé	❑	❑	❑	❑	❑
i) J'utilise de la drogue pour perdre la contrôle	❑	❑	❑	❑	❑
j) J'utilise de la drogue afin d'oublier mes problèmes	❑	❑	❑	❑	❑
k) J'utilise de la drogue « TO FIT IN »	❑	❑	❑	❑	❑
l) J'utilise de la drogue car je suis timide	❑	❑	❑	❑	❑

Invitation à participer à une entrevue en profondeur avec le chercheur

Dans le cadre de cette recherche, le chercheur est à la recherche des gens qui veulent se porter volontaires pour une entrevue d'une durée de 60 minutes. Cette entrevue sera réalisée avec Patrick O'Byrne, Inf, PhD(c) à l'extérieur des « circuit party ». Veuillez communiquer avec lui si cela vous intéresse (voir coordonnées sur la carte d'affaire qui vous a été remise). Cette portion de la recherche est aussi confidentielle et l'anonymat, quant à votre identité, sera assuré.

Appendix E: Consent Forms / Formulaire de Consentement

Consent Form

Title of Study:
THE INTERSECTION OF DESIRE, DRUGS AND UNSAFE SEXUAL PRACTICES: AN ETHNOGRAPHIC STUDY OF THE GAY CIRCUIT PARTY SUBCULTURE

Funding agency: Canadian Institutes of Health Research

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Kirsten Woodend, RN, PhD,
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451 Smyth Road, Ottawa, Ontario, K1H 8M5
Ph. 613-562-5800 ext. 8433
Fax 613-562-5443
Email: kwoodend@uottawa.ca

1. Research objectives

a. To understand the motivations of males who have sex with males (MSM) who use drugs and engage in risky sexual practices within the gay circuit party subculture.
b. To understand the effects of the circuit party environment upon drug use and sexual practices.

2. Contribution of participants / participation

Should you accept to participate in this research, you need to allocate the time needed to complete a 60 minute interview in order to answer the required questions. The interview will be audio-recorded. Only one interview will be necessary. At any time, you may withdraw from this research by not contributing to the questions.

3. Risks associated with your participation

The researcher is well aware of the intrusive nature of this study concerning your drug use and/or sexual practices. As such, certain questions may evoke some distress or even suffering on your part. Therefore, the researcher is committed to referring participants to appropriate counseling resources available in your city of residence, should you express this need.

Montreal:	Ottawa:	Toronto:
Action Sero-Zero	AIDS Committee of Ottawa	AIDS Committee of Toronto
C.P. 246, Succ. C.	1 Bank Street, Suite 700	399 Church St, 4th Floor
Montreal (Quebec)	Ottawa, Ontario	Toronto, Ontario
H2L 4K1	K2P 1X3	M5B 2J6
514.521.7778	613.238.5014	416.340.2431

4. Confidentiality and anonymity
The confidentiality of information obtained will be respected for all participants taking part in this research. All participants will be attributed an alphanumerical code preventing any possibility of links between their real identity and their responses given.

5. Conservation of information and communication of research results
The interview materials will be kept in a locked file cabinet in the researcher supervisor's office at the University of Ottawa for 5 years. To ensure confidentiality, all data will be identified by an alphanumerical code. The final stage of the research involves communicating the results in the form of scientific articles or conferences. By agreeing to participate in this research, you accept that the results obtained from an analysis of your interview may be used for scientific or teaching purposes. By signing this document, you accept to be quoted. The researcher will utilize an alphanumerical code in order to protect your identity.

6. Main benefits anticipated and related to research
By accepting to participate in this research you are promoting the advancement of knowledge in a domain of nursing that is poorly developed. This research constitutes a novel response to a gap in this area that may allow a better understanding of your experiences with gay circuit parties and, ultimately, may provide various avenues for developing health interventions adapted to you.

7. Voluntary participation
You are under no obligation to participate and if you choose to participate, you may withdraw from the research at any time. You may also refuse to answer questions. If you choose to withdraw, all data gathered until the time of withdrawal will not be used and will be destroyed.

8. Additional questions or comments related to this research
The researcher is available for answering questions you may have regarding this research project (pjobyrne@uottawa.ca). If you have any ethical concerns regarding your participation in this research, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, room 159, Ottawa, Ontario, K1N 6N5.: 613.562.5841, email: ethics@uottawa.ca.

I read and fully understood the conditions of this form of consent and I accept them. I also accept to be audio-recorded.

I ______________________________________ (Name of participant)
in ____________________ (city) on ____________________ (day and month) 2007.
Participant's signature: ________________________________

Formulaire de consentement

Titre de la recherche:
INTERSECTION ENTRE LE DÉSIR, LES DROGUES ET LES PRATIQUES SEXUELLES À RISQUE: UNE RECHERCHE ETHNOGRAPHIQUE DANS UN « CIRCUIT PARTY » GAI

Organisme subventionnaire: Instituts de recherches en santé du Canada

Chercheur:
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Candidat au Doctorat
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Superviseurs:
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École des sciences infirmières
451 Rue Smyth, Ottawa, Ontario, K1H 8M5
Ph. 613-562-5800 ext. 8433
Fax 613-562-5443
Adresse courriel: kwoodend@uottawa.ca

1. Objectifs de la recherche
a. Comprendre les motivations d'hommes gais qui fréquentent les « circuit parties », qui utilisent des drogues et qui ont des rapports sexuels à risque.
b. Comprendre les effets de l'environnement des « circuit parties » sur l'utilisation de drogue et sur les pratiques sexuelles.

2. Contribution of participants / participation
Si vous acceptez de participer à cette recherche vous devez être disponible pour une entrevue d'une (1) heure enregistrée sur bande-audio. Une seule entrevue est nécessaire. En tout temps vous pouvez vous retirer de cette recherche en refusant de répondre aux questions.

3. Risques associés à votre participation
Le chercheur est bien conscient du caractère intrusif de cette recherche qui porte sur votre consommation de drogues et/ou sur vos pratiques sexuelles. Certaines questions pourraient susciter chez certains d'entre vous une certaine part de détresse, voire de souffrance. Le chercheur s'engage donc à orienter les participants vers les ressources de *councelling* appropriées disponibles dans les villes où ils résident, si le besoin est exprimé comme tel par certains.

Montreal:	Ottawa:	Toronto:
Action Séro-Zéro	AIDS Committee of Ottawa	AIDS Committee of Toronto
C.P. 246, Succ. C.	1 Bank Street, Suite 700	399 Church St, 4th Floor
Montreal (Quebec) H2L 4K1	Ottawa, Ontario, K2P 1X3	Toronto, Ontario, M5B 2J6
514.521.7778	613.238.5014	416.340.2431

4. Confidentialité et anonymat
La confidentialité des données sera respectée pour tous les participants à cette recherche. En effet, tous les informants se verront attribuer un code alphanumérique empêchant ainsi les rapprochements entre leur identité réelle et les réponses qu'ils donnent aux questions posées.

5. Conservation des données et diffusion des résultats de la recherche
Les questionnaires auto-administrés seront conservés pendant une période de 5 ans dans une armoire verrouillée dans le bureau du chercheur principal sur le campus de l'Université d'Ottawa. Tous les questionnaires porteront un code alpha-numérique afin de protéger l'identité des participants. Enfin, la dernière étape du processus de recherche implique la diffusion des résultats sous formes d'articles scientifiques ou de conférences. Vous acceptez donc que les résultats de l'analyse faites à partir de vos réponses soient utilisés à des fins de communications savantes ou d'enseignement.

6. Bénéfices anticipés de ma participation à cette recherche
En acceptant de participer à cette recherche vous participez à l'avancement des connaissances dans un domaine très peu développé par la recherche en sciences infirmières. Cette recherche vise donc à palier à cette lacune dans la mesure où elle permettra une meilleure compréhension de votre expérience en regard des « circuit parties » tout en permettant la mise en place d'interventions infirmières adaptées à vos besoins en matière de santé publique.

7. Participation volontaire
Votre participation à cette entrevue est volontaire et vous êtes libre de vous retirer en tout temps, et/ou de refuser de répondre à certaines questions, sans subir de conséquences négatives. Si vous choisissez de vous retirer de cette recherche, les données recueillies jusqu'à ce moment ne seront pas utilisées et seront détruites. Le temps requis pour répondre à ce questionnaire est d'une (1) heure. Une seule entrevue est nécessaire et celle-ci est enregistrée sur bande-audio.

8. Questions supplémentaires ou commentaires en regard de cette recherche
Le chercheur est réputé pouvoir donner suite à toutes les questions que vous auriez en regard de ce projet de recherche (pjobyrne@uottawa.ca). Si vous avez des questions concernant l'éthique relativement à votre participation dans ce projet, veuillez communiquer avec la Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550 rue Cumberland, pièce 159, Ottawa, Ontario, K1N 6N5, tel. : (613) 562-5387, courriel : ethics@uottawa.ca

J'ai lu et j'ai bien compris les conditions de ce consentement. Aussi, j'accepte d'être enregistré sur bande-audio.
Je ______________________________________ (nom de participante)
Dans ____________________ (ville) le ____________________ (jour et mois) 2007.
Signature du participant: ______________________________

Appendix F : Data Saturation Table

Theme	TO-1	TO-2	OH-1	OH-2	OH-3	OH-4	OH-5	OH-6	OH-7	OH-8	OH-10	OH-11	OH-12	OH-13	OH-14	OH-15
Theme 1 – impulses (summary of involvement)	◆	◆	◆	◆	◆	◆	X	◆	◆	◆	◆	◆	◆	◆	◆	X
Mood Dictates Drug/Sex/Party Practices											◆	◆		◆		
Prefers/ Desires Sex Without Condoms (Heightened Intimacy/ Connection) / Animalistic	◆	◆													◆	
Desires produce Guilt/Anxiety, but does not Stop Sexual Practice			◆							◆			◆	◆		
Goal of Partying is Dancing				◆		◆										
Dancing as Pleasurable (Exhibitionistic, Rush, Stress Relief)		◆	◆					◆				◆				
No Conscious Intention for Sex at GCP	◆				◆						◆			◆		
Pushes Experiences to Extremes (Edge work) (Relative/Absolute Limits)	◆		◆	◆					◆						◆	
Theme 2 – purposive substance use (summary of involvement)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Alcohol/Drug Use Purposive to Achieve/Overcome Physical/Psychological Barriers	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆			◆
Alcohol/Drug Use Intended to Achieve Intoxicated/ Pleasurable Sensations/ Maximize Present Moment/ Exploration	◆	◆		◆	◆	◆			◆	◆				◆	◆	
Drug/Alcohol Use as a Social Practice		◆						◆	◆							
Use of Alcohol/Drugs to Escape / Addiction													◆		◆	
Drug/Alcohol Use is Not Addiction	◆					◆										
Theme 3 – context (summary of involvement)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	X	◆	◆
Hubs Change Sexual Practices			◆	◆												
Positive Energy at GCP/ Positive Environment	◆	◆	◆		◆	◆	◆		◆			◆				
Community & Connection / Tribal / Safe Gay Space	◆		◆		◆	◆	◆	◆	◆		◆					◆
GCPs as Surreal Sexual Environments/ Foreplay	◆		◆			◆	◆	◆	◆	◆	◆	◆				◆
GCPs as Escape from (Routine, Reality, Upset)	◆						◆			◆					◆	◆
Music Controls Crowd/ Energy Level			◆		◆		◆			◆						
GCPs as Sanctioned Environments to Indulge in Otherwise Proscribed Social Practices										◆			◆		◆	

Table 3: Data Saturation and Themes

Appendix G: Self-Directed Survey Results

Over the course of the two parties, 209 self-directed questionnaires were completed, 66.5% (n=139) during the first night, and 33.5% (n=70) the second night. Throughout both evenings, potential participants were questioned before they completed the questionnaire to ensure that they completed the survey only once. Cross comparison of the questionnaire results yielded that no one completed the survey twice. At this point, the self-reported demographic information, STI/HIV testing practices and infection history, sexual practices, and drug/ alcohol use will be presented.

Demographics

The first section of the self-directed questionnaire contained questions about age, sexual preference, education, income, and ethnicity. In addition, the requested language for survey completion is reported.

Category		Number
Age		Mean: 32.96 + 8.57
Language	French	130 (62.2%)
	English	79 (37.8%)
Sexual Preference	Exclusively men	182 (87.1%)
	Men & Women	20 (9.6%)
	Exclusively women	7 (3.3%)
Education	High School	36 (17.2%)
	College	55 (26.3%)
	Bachelor	68 (32.5%)
	Master's	30 (14.4%)
	Doctorate	14 (6.7%)
Income	<$10 000	8 (3.8%)
	$10 000 - $19 999	16 (7.7%)
	$20 000 - $29 999	30 (14.4%)
	$30 000 - $39 999	31 (14.4%)
	$40 000 - $49 999	25 (12%)
	$50 000 - $59 999	21 (10%)
	$60 000 - $69 999	13 (6.2%)
	$70 000 - $79 999	14 (6.7%)
	$80 000 - $89 999	10 (4.8%)
	$90 000 - $99 999	8 (3.8%)
	> $100 000	30 (14.4%)
Ethnicity	Caucasian	180 (86.1%)
	African Canadian	11 (5.3%)
	Asian	6 (2.9%)
	Latin	4 (1.9%)
	Aboriginal	2 (1%)
	Jewish	2 (1%)
	Greek, Algerian, Arabic, Persian, Middle Eastern	1 (0.5%) each

Table 4: Demographic information

The mean age of participants was 32.96 $\pm$ 8.57 years. Regarding language preference, 62.2% (n=130) requested and completed French questionnaires, while the remaining 37.8% (n=79) completed them in English. For sexual preference, 87.1% (n=182) reported having sexual contacts exclusively with men, 9.6% (n=20) with men and women, and 3.3% (n=7) exclusively with women. The most common education level reported was a bachelor's degree (32.5% and n=68), and 26.3% (n=55) indicated that they had a college degree, 17.2% (n=36) had a high school diploma, 14.4% (n=30) a master's degrees, 6.7% (n=14) a doctoral degree (n=14), and 2.4% (n=5) held no diploma. Income was not reported by three individuals, but otherwise, 14.8% (n=31) reported their previous year's gross annual income as $30,000-$39,999, 14.4% (n=30) made >$100,000, 14.4% (n=30) made $20,000-$29,999, 12% (n=25) made $40,000-$49,999, 10% (n=21) made $50,000-$59,999, 7.7% (n=16) made $10,000-$19,999, 6.7% (n=14) made $70,000-$79,999, 6.2% (n=13) made $60,000-

$69,999, 4.8% (n=10) made $80,000-$89,999, 3.8% (n=8) made $90,000-$99,999, 3.8% (n=8) made <$10,000. The breakdown for ethnic self-identification was 86.1% (n=180) Caucasian, 5.3% (n=11) African Canadian, 2.9% (n=6) Asian, 1.9% (n=4) Latin, 1% (n=2) for both Aboriginal and Jewish, and 0.5% (n=1) each reported being Algerian, Arabic, Greek, Middle Eastern, and Persian.

STI/HIV Testing and History

The second section of the survey contained questions about each participant's previous history of STI/HIV testing/ acquisition, and personal STI/HIV testing practices.

Category		**Number**
HIV Testing	Yes	195 (93.3%)
	No	11 (5.3%)
	No Answer	3 (1.4%)
HIV Test Results	Positive	25 (12%)
	Negative	144 (68.9%)
	No Answer	26 (12.4%)
Regular HIV Testing	Yes	130 (62.2%)
	No	65 (31.1%)
	No Answer	9 (4.3%)
Regular STI Testing	Yes	124 (59.3%)
	No	79 (37.8%)
	Never Previously Tested	4 (1.9%)
Regular Testing	3 months	11 (5.3%)
	6 months	37 (17.7%)
	12 months	25 (12%)
	No Answer	134 (64.6%)
Previous STI	Yes	112 (53.6%)
	No	93 (44.5%)
	No Answer	4 (1.9%)
Most common STI	Gonorrhea	42 (20.1%)
	Chlamydia	21 (10.0%)
	Syphilis	4 (1.9%)

Table 5: HIV/STI Testing and History

Regarding HIV testing, 93.3% (n=195) reported previously undergoing testing, while 5.3% (n=11) had not, and 1.4% (n=3) did not answer. The reported results of these previous HIV tests were that 12.0% (n=25) were HIV sero-positive, 68.9% (n=144) HIV sero-negative, and 12.4% (n=26) declined to answered. In addition, 62.2% (n=130) reported that they undergo HIV testing regularly. For STI testing, 59.3% (n=124) reported regular testing, 37.8% (n=79) indicated non-regular testing, and 1.9% (n=4) reported never having previously been tested. The definitions of regular testing were, at least once every three months for 5.3% (n=11), biannually for 17.7% (n=37), and annually for 12% (n=25). In total, 64.6% of individuals did not respond to this question (n=134), and one individual reported that he gets tested depending on his number of sexual partners. This critical number of partners, however, was not reported. Regarding previous results, 53.6% (n=112) reported having had an STI, 44.5% (n=93) had not, and 1.9% (n=4) did not answer. The most commonly diagnosed STI was gonorrhea, with 20.1% (n=42) of the sample having been diagnosed, followed by chlamydia at 10.0% (n=21), and syphilis at 1.9% (n=4).

Sexual Practices

The third section of the survey contained questions about sexual practices. This included intention and expectations for sexual contact, type of sexual contacts engaged in, whether or not substance use was involved, and preferences regarding sexual contacts and substance use.

Category		Number
Intention of anonymous sex	Yes	46 (22%)
	No	159 (76.1%)
	No Answer	4 (1.9%)
Have anonymous sex	Yes	98 (46.9%)
	No	108 (51.7%)
	No Answer	3 (1.4%)
Sex at GCP	Yes	116 (55.5%)
	No	70 (33.5%)
	No Answer	18 (8.6%)
Oral Sex	Give with condom	4 (1.9%)
	Give without condom	97 (46.4%)
	Get with condom	11 (5.3%)
	Get without condom	83 (39.7%)
Ejaculate	Take in mouth	26 (12.4%)
	Take on Face	27 (12.9%)
	Take on Chest	60 (28.7%)
	Take in Anus	12 (5.7%)
	Give in mouth	35 (16.7%)
	Give on Face	40 (19.1%)
	Give on Chest	58 (27.8%)
	Give in Anus	17 (8.1%)
Anal Penetration	Top with condom	94 (45.0%)
	Top without condom	21 (10.0%)
	Bottom with condom	71 (34.0%)
	Bottom without condom	18 (8.6%)
Sex on Drugs	Yes	102 (48.8%)
	No	100 (47.8%)
	No Answer	7 (3.3%)
Sex while Drunk	Yes	54 (25.8%)
	No	149 (71.3%)
	No Answer	6 (2.9%)
Prefer sex with Drugs	Do not agree at all	86 (41.1%)
	Agree a little / moderately	59 (28.1%)
	Agree a lot / totally	15 (9.6%)
	No Answer	9 (4.3%)
Prefer sex while Drunk	Do not agree	65 (31.1%)
	Agree a little / moderately	72 (34.5%)
	Agree a lot / totally	26 (12.4%)
	No Answer	11 (5.3%)

Table 6: Sexual Practices

When the participants were asked if they attend GCPs with the intention of having anonymous sex, 22.0% (n=46) reported yes, 76.1% (n=159) reported no, and 1.9% (n=4) did not answer. However, when asked about whether or not anonymous sex occurs despite intention, 46.9% (n=98) reported yes, 51.7% (n=108) no, and 1.4% (n=3) did not answer. In a separate question regarding sexual practices that included anonymous and regular partner(s), only 35.9% (n=75) reported not having sex at GCPs. Furthermore, when asked specifically which sexual practices they engage in at GCPs, only 33.5% (n=70) individuals reported not engaging in sexual practices. Regarding these sexual practices, 1.9% (n=4) perform oral sex with condoms, 46.4% (n=97) perform oral sex without condoms. Concerning the ejaculate, 12.4% (n=26) receive it in their mouth, 12.9% (n=27) on their face, and 28.7% (n=60) on their chest. For receptive oral sex, 5.3% (n=11) reported using condoms, and 39.7% (n=83) did not use condoms. Concerning ejaculation, 16.7% (n=35) ejaculate into the partner's mouth, 19.1% (n=40) on the face, and 27.8% (n=58) on the chest. For anal penetration, 45.0% (n=94) reported performing anal penetration with condoms, and 19.6% (n=41) reported ejaculating with a condom on within the partner's anus. In contrast, 10.0% (n=21) reported performing anal penetration without condoms, and 8.1% (n=17) reported then ejaculating within the partner's anus. For receptive anal penetration, 34.0% (n=71) reported using condoms, while 8.6% (n=18) reported unprotected anal sexual practices. Lastly, 5.7% (n=12) reported receiving ejaculate within their bodies.

For sex and substance use, 48.8% (n=102) reported having sex while on drugs, 47.8% (n=100) reported that they do not have sex while on drugs, and 3.3% (n=7) did not answer. For alcohol use, 25.8% (n=54) reported having sex while drunk, 71.3% (n=149) indicated no sex while drunk, and 2.9% (n=6) did not answer. When asked if sex is preferred while on drugs, 41.1% (n=86) did not agree at all, 28.1% (n=59) agreed a little or moderately, 9.6% (n=15) agreed a lot or totally, and 4.3% (n=9) did not respond. When asked if sex is preferred while drunk, 31.1% (n=65) did not agree at all, 34.5% (n=72) agreed a little or moderately, 12.4% (n=26) agreed a lot or totally, and 5.3% (n=11) did not respond.

Drug/Alcohol Use

The final section of the survey contained questions about intent for substance use, substance use despite intent, favourite substance, preferences for substance use while partying, and questions about specific intentions for substance use.

Category		Number
Intention of getting drunk	Yes	42 (20.1%)
	No	164 (78.5%)
	No Answer	3 (1.4%)
Intention of drug use	Yes	125 (59.8%)
	No	80 (38.3%)
	No Answer	4 (1.9%)
Drug use despite intention	Yes	156 (74.6%)
	No	35 (16.7%)
	No Answer	18 (8.6%)
Specific Drugs	Crystal Meth	15 (7.2%)
	PD5-Inhibitors	43 (20.6%)
	Marijuana	37 (17.7%)
	Poppers	66 (31.6%)
	Amphetamines	66 (31.6%)
	Mescaline/LSD	4 (1.9%)
	GHB	61 (29.2%)
	Ketamine	40 (19.1%)
	Ecstasy	115 (55%)
	Cocaine	28 (13.4%)
	Crack/Heroin/MDA	1 (0.5%)
Favourite Drug	Ecstasy	62 (29.7%)
	Speed	35 (16.7%)
	GHB	21 (10.0%)
Preference for drugs while partying	Did not agree	19 (9.1%)
	Agreed a little / moderately	63 (30.2%)
	Agreed a lot / totally	86 (41.4%)
	No Answer	6 (2.9%)
Preference for alcohol while partying	Did not agree	55 (26.3%)
	Agreed a little / moderately	71 (34.0%)
	Agreed a lot / totally	33 (15.8%)
	No Answer	15 (7.2%)
Substance use to maximize partying	Did not agree	21 (10.0%)
	Agreed a little / moderately	57 (27.2%)
	Agreed a lot / totally	84 (30.2%)
	No Answer	12 (5.8%)
Dependence on drug use for fun	Did not agree	92 (44.0%)
	Agreed a little / moderately	53 (25.4%)
	Agreed a lot / totally	15 (7.2%)
	No Answer	14 (3.2%)
Drug use to forget what happens	Did not agree	131 (62.7%)
	Agreed a little / moderately	19 (9.0%)
	Agreed a lot / totally	12 (5.7%)

	No Answer	12 (5.7%)
Drug use to lose control	Did not agree	112 (53.6%)
	Agreed a little / moderately	37 (17.7%)
	Agreed a lot / totally	12 (5.7%)
	No Answer	13 (6.2%)
Drug use to forget problems	Did not agree	118 (56.5%)
	Agreed a little / moderately	31 (14.8%)
	Agreed a lot / totally	14 (6.7%)
	No Answer	11 (5.2%)
Drug use to fit in	Did not agree	117 (56.0%)
	Agreed a little / moderately	32 (15.3%)
	Agreed a lot / totally	11 (5.3%)
	No Answer	14 (6.7%)
Drug use to overcome shyness	Did not agree	104 (49.8%)
	Agreed a little / moderately	45 (21.6%)
	Agreed a lot / totally	15 (7.2%)
	No Answer	10 (4.8%)

Table 7: Substance Use

In indicating their intention of going to GCPs and getting drunk, 20.1% (n=42) reported yes, 78.5% (n=164) reported no, and 1.4% (n=3) did not answer. In contrast, the same question regarding drug use resulted in 59.8% (n=125) reporting yes, 38.3% (n= 80) reporting no, and 1.9% (n=4) not answering. However, despite the previously indicated intention, only 16.7% (n=35) reported that no personal drug use ends up occurring. When asked about specific drugs, 7.2% (n=15) used crystal meth, 20.6% (n=43) used PD5-inhibitor, 25.8% (n=54) used marijuana, 17.7% (n=37) used poppers, 32.1% (n=67) used amphetamine, 1.9% (n=4) used mescaline/LSD, 29.2% (n=61) used GHB, 19.1% (n=40) used ketamine, 55% (n=115) used ecstasy, and 13.4% (n=28) used cocaine. In addition, 0.5% (n=1) reported using crack, heroin, MDA, and mushrooms in the 'other drug use' section. Regarding favourite drug use, 29.7% (n=62) reported ecstasy, 16.7% (n=35) speed, and 10.0% (n=21) GHB. When asked if there was a preference for drug use while partying, 9.1% (n=19) did not agree at all, 30.2% (n=63) agreed a little or moderately, 41.4% (n=86) agreed a lot or totally, and 2.9% (n=6) did not respond. When asked if there was a preference for getting drunk while partying, 26.3% (n=55) did not agree at all, 34.0% (n=71) agreed a little or moderately, 15.8% (n=33) agreed a lot or totally, and 7.2% (n=15) did not respond. When asked if drugs/alcohol are used to maximize the party experience, 10.0% (n=21) did not agree at all, 27.2% (n=57) agreed a little or moderately, 30.2% (n=84) agreed a lot or totally, and 5.8% (n=12) did not respond. When asked if there was a dependence on drug use for fun, 44.0% (n=92) did not agree at all, 25.4% (n=53) agreed a little or moderately, 7.2% (n=15) agreed a lot or totally, and 3.2% (n=14) did not respond. When asked if drug use is to forget what happens, 62.7% (n=131) did not agree at all, 9.0% (n=19) agreed a little or moderately, 5.7% (n=12) agreed a lot or totally, and 5.7% (n=12) did not respond. When asked if drug use is to lose control, 53.6% (n=112) did not agree at all, 17.7% (n=37) agreed a little or moderately, 5.7% (n=12) agreed a lot or totally, and 6.2% (n=13) did not respond. When asked if drug use is to forget problems, 56.5% (n=118) did not agree at all, 14.8% (n=31) agreed a little or moderately, 6.7% (n=14) agreed a lot or totally, and 5.2% (n=11) did not respond. When asked if drug use is to fit in, 56.0% (n=117) did not agree at all, 15.3% (n=32) agreed a little or moderately, 5.3% (n=11) agreed a lot or totally, and 6.7%

(n=14) did not respond. When asked if drug use is to overcome shyness, 49.8% (n=104) did not agree at all, 21.6% (n=45) agreed a little or moderately, 7.2% (n=15) agreed a lot or totally, and 4.8% (n=10) did not respond.

Appendix H: Ethics Approval

Université d'Ottawa University of Ottawa

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATE OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board has examined the application for ethical approval of the research project entitled **The Intersection of Desire, Drugs, and Unsafe Sexual Practices: An Ethnography Study of the Gay Circuit Party (file H 11-06-01)** submitted by Patrick O'Byrne and supervised by Dave Holmes and Kirsten Woodend of the School of Nursing. The Board found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave it a Category 1a (approval). This certification is valid one year from the date indicated below.

Rita D'Alessandro
Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the
Health Sciences and Science REB

December 13, 2006
Date

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