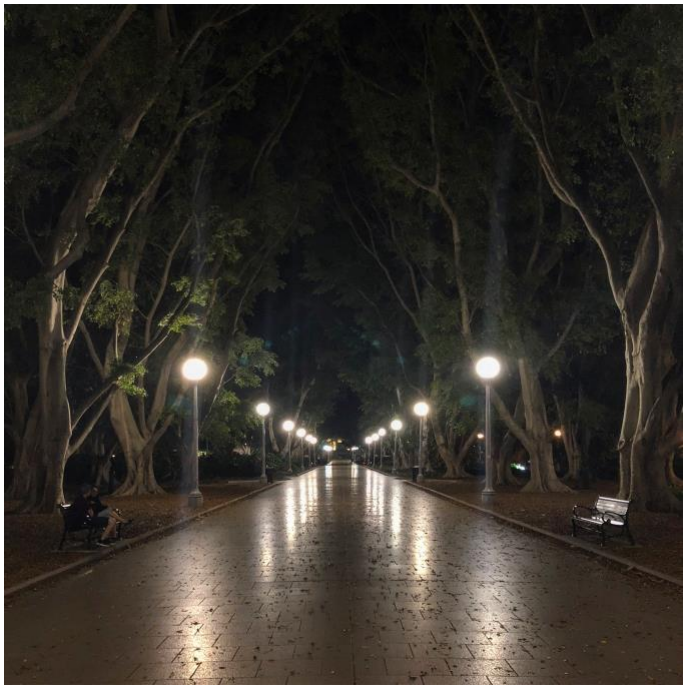
A Lifetime of Drugs

For my parents

Kane Race

In the grounds of Sydney Hospital, behind the twisting boughs of a Gingko tree, lie the offices of the Sydney Sexual Health Centre where I first learned I had been infected with HIV.[1] It was 1996—the same year that the possibility of using combination therapy to "eradicate the virus" had been announced to the world with much fanfare and hype. HIV was no longer a death sentence but "a chronic manageable illness" predicated on lifelong treatment with heavy-duty pharmaceutical combinations. Taking charge of the virus—"hitting hard, hitting early"—was the order of the day. Useful as this tough-guy slogan was for shrugging off the psychosocial overtures of the counsellor given the unenviable task of delivering me post-diagnosis support, I wasn't quite sure where it left me, also hit hard, hit early. What did it mean? How should I feel? How long do I have? *What just happened?*

I was twenty-five, in my final year of law school, trained to believe I had my *whole life ahead of me*. But with HIV infection so recently and dramatically converted to the enigmatic status of a non-event, I found myself at a loss for words, unsure what to think. I can't remember feeling anything. Whatever recourse I might have once had to the melodramatic script of fatal diagnosis seemed to have been pulled from under my feet. The only script available for handling this situation positioned me as a biological citizen dependent on powerful combinations of antiretroviral medications or the new "drug cocktails," as they were called at the time. No longer a death sentence, I found myself confronted with a life-threatening illness that was said to demand an indefinite commitment to ongoing self-dosing with gruelling antiretroviral drugs on a daily basis. The temporality of this long-term drug regime was particularly evasive, however, in the sense encapsulated by Ross Chambers when he describes antiretroviral drugs as "medications whose toxicity is able, for a time, to hold the virus at bay" (a deceptively simple formulation).[2] Withholding any approximation of how much time one had left, this was less a prognosis than a special sort of paradox that replaced the presumptive decade once invoked around HIV's progression with a great big question mark. On leaving the clinic, I made my way down the central avenue that cuts through Hyde Park towards the golden mile of Oxford Street in a state of mind so impassive it must have been a daze. The tree-lined avenue that arched before me was generous enough to extend some semblance of structure, shape, and purpose to a situation I couldn't begin to make sense of, let alone begin to know how to respond to, suspended as I was between optimism and desperation. This I what I remember most about that day; this positively meaningless *walk in the park*.



A walk in the park

The Protease Moment

The Vancouver International AIDS Conference of 1996 is widely considered a hallmark event in the history of the HIV epidemic. Within a week of the conference, over 75,000 patients commenced combination antiviral therapy hoping to reduce the rate of viral replication in their bloodstreams to undetectable levels.[3] The fact that ninety percent of the world's population of people living with HIV/AIDS (PLWHA) had no hope of accessing the expensive new drugs tempered universal enthusiasm for the new biomedical breakthroughs to some degree, redirecting activist energies towards grappling with the geopolitics of treatment access. But in wealthier countries, treatment advocates exhorted HIV-positive people to get with the pharmaceutical program with Highly Aggressive Antiretroviral Therapy (HAART).

It is difficult to convey the affective intensities—the mix of dogmatism and vacillation—that pervaded gay community discourses around new treatments at this time as medical knowledge morphed into community imperatives. In 1997, a man who had written to a PLWHA community newsletter expressing reservations about early initiation of HAART was met with a harsh rebuke from another reader:

> [The correspondent] is under a very serious misapprehension. He says that he has been HIV positive for four years and has "never been sick" (sic). I guess he means he has never felt sick. The truth is that the virus is replicating voraciously and, as a direct consequence, is placing an enormous burden on his body's immune system. [He] is deluding himself if he thinks that being HIV positive is not cause to act immediately to attempt to suppress viral replication.[4]

Prominent HIV treatment advocates in Australia rallied around this purported "truth," describing plans to delay treatment as "crazy," "stupid," and even a "let-down to the community."[5] But considering the lack of clinical data on the long-term efficacy of these new pharmaceutical compounds at the time—not to mention their long-term safety—some clinicians were not so adamant about the imperatives of early intervention. While viral suppression had been demonstrated to be a remarkably accurate predictor of disease progression, drugs can have unintended mechanisms of action and work through causal pathways that are independent of the disease process.[6] Thus, despite the intransigence of community advocates, it was precisely the length of this long-term commitment that eluded precise calculation or clinical certainty.

The possibility of suppressing the virus was received by some as an opportunity to return to a "normal" life with a new sense of energy, vitality and agency.[7] In Western countries, sociologists began describing "the normalization of HIV."[8] But for others, viral management presented as an onerous task, with medication manifesting as a sign of illness and a "constant reminder" of HIV status.[9] The prospect of ongoing treatment posed difficulties for those already dealing with grief and loss who now found themselves having to consider the prospect of returning to work and re-shaping relationships in the context of unexpected and uncertain futures.[10] A new sense of isolation began to characterize some people's experience of living with HIV, especially those who found themselves grappling with a range of noxious treatment side-effects in their efforts to remain "undetectable." These side-effects ranged from serious complications such as liver-damage, fat redistribution, diabetes, high cholesterol, and heart disease to mundane irritations such as nausea, fatigue, and persistent diarrhea—a cluster of symptoms succinctly characterized by one community educator as "low-level chronic ickiness."[11]

The conflicted nature of this situation produced tensions between different measures of health and well-being, as one of my research participants explained:

> My feeling of well-being is shit-house. Um, really bad. Um, actual health—like going to the doctors—is fabulous. There's a nice contradiction for you. I feel awful, but my actual health is very, very good.[12]

Here the term "health" refers to the results of his viral load test, which he uses to account for his persistence with treatment despite a range of distressing side-effects. If antibody testing and CD4 counts created the historical possibility of being diagnosed as sick with HIV while feeling perfectly well, viral load testing created the possibility of being diagnosed as acceptably healthy while feeling or appearing otherwise.[13] Some treatment advocates tried to rationalize this situation by drawing analogies with gay men's enthusiasm for other kinds of drugs. In a community newspaper, HIV treatment advocate Martyn Goddard conceded, "These drugs have side-effects. People take ecstasy because they like the side-effects. HIV drugs are not like that. These are all serious, toxic chemicals. They're not as toxic as the virus though."[14] Perplexingly, Goddard's remarks classify the effects consumers seek in ecstasy as "side-effects." The passage appears to fumble on a major fault-line that emerged for many people living with HIV at this time. The classification of drugs and drug effects as "therapeutic" and/or "toxic" appeared a

somewhat arbitrary but indisputably onto-political determination with material consequences for patients, consumers, and practices of self-administration in general.

Whatever improvements in health and well-being became possible for those with the geopolitical and economic good fortune to have access to the powerful new pharmaceuticals, these new drug cocktails were also taken to spell a major problem for HIV prevention. Prevention specialists went into damage control: contrary to what the imagery of pharmaceutical advertisements might have consumers believe, living with a "chronic manageable illness" was "no picnic" and "hardly a walk in the park," they declared.[15] Countering glossy depictions of fresh-faced, smiling PLWHA engaged in healthy, active, sporting pursuits—"taking charge" of their disease—critics objected: "We don't think it's a sexy disease. It's not about climbing mountains. It's about IV poles, wheelchairs and pain."[16] In their bid to tackle increases in sexual risk-taking among men who have sex with men, San Francisco's Stop AIDS project even plastered confronting images of people suffering from some of the more gruesome side-effects of protease inhibitors on bus shelters and restroom walls throughout the city as part of their *HIV is No Picnic* campaign. The posters depicted PLWHA suffering night sweats, sporting distended abdomens and pronounced facial wasting, and sitting on the toilet with diarrhoea.[17] The campaign illustrates how representations of the intimate experience of HIV infection were becoming hostage at this moment to the collective imperatives of public health and disease prevention.

As overblown and instrumental as these images appeared to anyone lucky enough to have been spared such complications, there was no doubt the new treatments made living with HIV into a different kind of problem. "Going the Distance"—an advertisement for Merck's new protease inhibitor—instructed consumers:

> Focus on the rest of your life. Learn all you can about HIV therapy. Talk with your doctor. Stay informed and stay with the course. With viral load below the limit of detection and an increase in CD4 T-cells, it's easier to look forward to the future with confidence.[18]

This passage produces treatment as a kind of marathon or high-endurance sport that requires commitment, focus, and the motivation to achieve one's personal best. But as Michael Flynn spelt out, the daily grind of treatment was not quite so blithe or glamourous:

> We have all had to rearrange our daily living schedules to fit the drugs in at the right time and dosage. Our whole life is now regimented by our intake of drugs. Going out to dinner, meeting friends for a drink, staying away from home or partying all night long have now to be carefully planned like a military operation.[19]

HIV may have transformed from an inevitable death sentence into a chronic manageable illness, but it was generally agreed that HIV infection was still a serious issue involving the dismal prospect of a *lifetime on drugs*.[20]

Personally, I was quite eager to sign on to the treatment bandwagon. However regimented these medical prescriptions, the idea of "taking charge" was irresistible. "The basis of optimism is sheer terror," Oscar Wilde once quipped, and this might as well serve as a description of what was going on

for me.[21] My sense of the future was unstable enough to render nonsensical the idea of slaving away as a trainee solicitor in a law firm for five years (quite possibly the rest of my working life), so I applied for a job at the national HIV social research centre. I was employed to research understandings and experiences of the new treatments among people living with HIV in the interests of "improving patient compliance." At the time I joined the centre, most of its research team were working on questions of HIV prevention, busily devising statistical measures to scrutinise the pernicious effects of "treatment optimism," releasing their findings under titles as foreboding as "HIV treatments optimism is associated with unprotected anal intercourse with regular and causal partners among Australian gay and homosexually active men."[22] The dubious status of treatment optimism in my new workplace was not enough to derail my own optimistic attachment to the daily rigours of treatment, however. When interview participants tried to explain to me how they found the pills to be a "constant reminder" of HIV, all I could do was blink and stare, reassuring myself that I was "taking charge" and things would be okay and secretly wishing they would just get over it.

In order to be effective and prevent drug resistance, the new treatments were said to demand a very high level of "patient compliance." The question of "treatment readiness" was often framed in super-conscientious terms: people were not ready to start treatment, so the maxim went, until they had "thought and talked it through and [were] ready to make the commitment to stick with it religiously."[23] Since the discourse on treatment adherence prominently foregrounded, what Jack Halberstam has called, the "normative scheduling of daily life," it might be understood to be "upheld by a middle-class logic of reproductive temporality."[24] But these pharmaceutical regimes lacked any of the self-surety associated with reproductive futurity, and there was nothing "natural" about some of the bodies they were producing. With their uneasy temporality, the new treatments seemed to demand a long-term commitment to "living in the moment," with each of these moments suspended on an arc of indefinite deferral. Sociologists working on the "normalization of AIDS" in Western countries conveyed some of the paradoxes of this predicament:

> The gain in time and the greater latitude to shape one's life face [*sic*] the challenge of also having to fill the same, i.e. having to normalize one's life, so to speak. . . . If [before 1996] maximum priority was attached to a search for ways to continue living, problems of living with and despite HIV and AIDS now have a far higher standing: a diagnosis of HIV no longer appears to be tantamount to an early end of life. . . . Not all PWA are in a position to cope with this situation in adequate fashion and deal with the medicalization of their life: many have problems adhering to therapy and cannot handle the challenges of coping with the medicalization and normalization of their life, challenges that are, by nature, contradictory.[25]

If this "protease moment" presented the possibility of normalizing one's life, living "with and despite" a virulent pathogen nonetheless altered the experience of normality and normative temporality.[26] To achieve some chance of longevity, those affected had to incorporate into their everyday lives drug cocktails whose experimental, toxic, and indefinite outcomes prompted persistent personal and cultural

anxieties. Moreover, sex did not seem to offer much critical resistance to this process of "normalization," notwithstanding the claims and investments of some queer critics.[27] Indeed, more typically sex emerged as an outcome or element in the effective restoration of normal life. As one review article on the topic discusses, HIV patients commonly report a loss of libido in the first stages of going onto antiretroviral therapy, but:

> . . . at thirty months on ART, many participants considered themselves as "normal" and said that as "normal people" one of their healthy functions was to have sexual desires. They also reported that drugs had increased their desire for sex, contrary to what many had mentioned at three and six months about the drugs having diminished their sexual desire.[28]

And yet, for every scientific article that problematizes sexual dysfunction among antiretroviral users in the name of health and medical normativity (and there are many) several more fret about the increased sexual behavior and erotogenic activity the new treatments were said to engender among this population.[29] These conflicting citations of normative health within different strands of sociomedical research might be taken to exemplify what Robyn Wiegman and Elizabeth Wilson describe as the "dispersed, consociating nature of normativity"—its "dependencies, differentiations, clashes."[30]

Drug Cocktails

One of the most widely circulated accounts of the changing landscape of the epidemic at this time was a piece called "When Plagues End" which appeared in the *New York Times* in 1996.[31] Penned by prominent US homo-conservative Andrew Sullivan, the essay inspired the wrath of some of the most radical and astute queer critics working at the time.[32] But to my mind, it remains one of the most phenomenologically textured and insightful accounts of the experience of the changing epidemic among gay male populations in relatively affluent settings. Combining descriptions of community events with personal anecdotes and reflection, Sullivan develops a detailed account of the many complications associated with new treatments for gay men of his class and generation, ranging from treatment failure to the experience of toxic side-effects; from the challenges associated with resuming a "normal life" to emerging anxieties about a return to "unsafe sexual behaviour" caused by the "abatement of pressure" associated with the new treatments.[33] However, Sullivan's nuanced and generally empathetic account of the vexations associated with antiretroviral therapy soon gives way to another set of ruminations about another kind of "drug cocktail" doing the rounds among his peers and contemporaries. It is striking that a substantial portion of an essay devoted to gay men's cultural responses to the new HIV treatments concerns the seemingly unrelated topic of "the increasing numbers of circuit parties" catering to gay men of the time, all of which involve "the ecstatic drug-enhanced high of dance music." As Sullivan reports:

> These events are made possible by a variety of chemicals: steroids, which began as therapy for men wasting from AIDS and recently spawned yet another growing sub-subculture of huge body builders; and psychotherapeutic designer drugs, primarily Ecstasy, which creates feelings

> of euphoria and emotional bonding, and ketamine, an animal anesthetic that disconnects the conscious thought process from the sensory body.[34]

While "on the surface the parties could be taken for a mass of men in superb shape merely enjoying an opportunity to let off steam," Sullivan advised that "underneath, masked by the drugs, there is an air of strain." He concludes that "these are not mass celebrations at the dawn of a new era, but raves built upon the need for amnesia."

"When Plagues End" went on to supply a narrative template for innumerable accounts of gay men's social and cultural responses to HIV medical developments in various different locations and contexts from the time it was published right up until the present. In this genre of HIV storytelling, concerns about the disinhibiting effects of treatment optimism invariably give way to breathless discussions about gay men's use of recreational drugs in a narrative formula that seems carefully designed to reprimand gay subjects for their reckless sexuality, complacency, and unbridled hedonism. A 1997 article entitled "The Lethal Liberator" kicks things off in *The Guardian* newspaper by linking "the cocktail of protease inhibitors and other powerful pharmaceutical drugs" with "misplaced complacency" about safe sex.[35] The story's main focus, however, is what it terms "the looming public health crisis" of methamphetamine abuse among gay men, a substance whose "disinhibitory effects" are said to make "users temporarily forget about safe sex."

A 1999 news-piece in the *New York Times* is just one of many to repeat this formula. "With new drug therapies showing remarkable success in controlling HIV," it reported, "some gay men have grown disturbingly complacent about safe sex in recent years."[36] Again, the main fixation of the story is what it frames as "another alarming trend," namely "the use of inhibition-relaxing drugs." The report goes on to cite anecdotal evidence from community groups that "much of the increase [in HIV infections] had been among young gay men and that many had become careless about sex while high on libido-enhancing drugs." Similarly in Australia in 2000, gay journalist Steve Dow attributed a small increase in HIV infections to gay men "partying on as though illicit drugs will make them forget the world outside, while prescription drugs will save them from the threat of the virus."[37] Under the menacing title "Dancing with Death," Dow writes:

> Many will not be surprised. Recent surveys in Sydney and Melbourne have shown a greater incidence of sex without condoms. Health promoters believe it is not just casual unsafe sex, but problems with people getting into relationships and having unsafe sex before both partners are tested. . . . More to the point, however, a nexus has been found between drug use—ecstasy and speed, inextricably linked to the dance party circuit. Young gay men are taking risks because, like other young men, they believe they are indestructible. In this case, however, gay men have had their minds altered by illicit drugs, and they assume the new protease inhibitor drug combinations will save them.

Accounts such as these are typical of the time in their finger-wagging eagerness to attribute increases in sexual risk-taking to the "misplaced optimism" they associate with various forms of prescribed and non-

prescribed drug consumption. Where credible alternative explanations for new infections do make an appearance, they are typically subordinated to the narrative requirements of this cautionary tale about gay over-step and pharmacological over-enthusiasm. "More to the point," Dow writes, "a nexus has been found between ecstasy and speed," as if this explained what exactly? It is as if the only conceivable reason people might want to have sex without condoms at this time must involve some sort of drug impairment or pharmaceutical slippage.[38] Hit hard, hit early.

The most imaginative and capacious example of this genre I am aware of is an article entitled "Higher and Higher: Drug Cocktails—Pleasures, Risks and Reasons" that appeared in 1999 in *The Village Voice*.[39] The piece introduces us to Dormil, an HIV-positive gay man who "takes four different AIDS medications, including AZT. For recreation, he goes to dance clubs where he gets high on a nocturnal medley of Ecstasy, Special K, and crystal methamphetamine." "It's therapeutic. It's a stress-reliever," Dormil is quoted as claiming. "It allows me to accept the fact of my disease and get on with my life." Dormil's main narrative function is to serve as a gateway informant, an individual case study devised to give a human face to a sensationalized scene of illicit activity and collective experimentation. The following passage cuts to the chase:

> This weekend, and every weekend on dance floors across the city, thousands of teeth-grinding subjects like Dormil engage in an underground research project. Amid flashing lights and pounding music, untutored freelance pharmacologists conduct experiments on their own bodies to determine what happens when one consumes a bewildering array of pills and powders in the confined and humid setting of a nightclub. The results are not always pretty.[40]

The article proceeds by reeling off a cautionary list of dangers and casualties associated with the polypharmaceutical mentality it takes as its main concern. As if testing the gullibility of readers, the article goes on to quote a "veteran drug dealer" who exclaims, "it's crazy! . . . the entire New York club scene revolves around drug cocktails."

To its credit, the story goes further than the standard moralistic fare, attributing the lack of reliable knowledge about the effects of various drug combinations to the dearth of clinical research on the interactions between prescribed medications and club drugs which it names as an outcome of the War on Drugs. Polydrug use need not be synonymous with immoderation, the article concedes, since "some club patrons go to great lengths to figure out what each drug does individually and in combination." But the challenge of working out what to mix with what and when—replete with innumerable tricky questions about drugs synergies, interactions, timing, and dosage —clearly demands careful planning in an exercise that is uncannily reminiscent of the military operation Michael Flynn conceives in order to convey the regimented nature of antiretroviral treatment compliance.[41]

With its anxious but nonetheless productive focus on the complexities of drug effects, "Higher and Higher" repeatedly returns to the fuzzy distinction between therapeutic and recreational logics of drug consumption. Where some of the informants interviewed for the article attribute these

"underground research experiments" to consumers' desires to escape from reality, others describe certain illicit combinations as capable of delivering other benefits when safely self-administered.

> Disco polypharmacy involves risk. Nobody knows how safe some of these mixtures really are. Some say that not necessarily all combinations are bad for you—for instance, partygoers claim that swallowing Ecstasy followed by LSD (known as "candy flipping") can be extremely therapeutic.[42]

Rather than concluding with another hapless indictment of gay men's complacency or reckless behaviour, the article wraps up with a practical set of guidelines on "Doing Polydrugs Safely" complete with an informative "Polydrug Glossary."

In "Higher and Higher," Dormil's use of illicit substances is tentatively depicted as enabling him to normalize his life by accepting the fact of HIV disease. That is to say, chemical experimentation emerges as an activity that makes possible a long-term commitment to living "with and despite HIV."[43] While Dormil's everyday life already teems with a veritable pharmaceutical cornucopia on account of his HIV status, the various illicit drug cocktails he is said to depend upon appear to contribute to his ability to get on with a relatively normal life. This is a markedly different conception of what counts as normal (and its relation to illicit activity) than the reproachful narratives of pharmaceutically induced optimism that make up the mainstay of this archive. Indeed, perhaps it is the normalization of experimental drug cocktails within the field of HIV treatment that precipitates a degree of systemic and discursive play around the variable taxonomies of pharmaco-activity, their contingent relations, historicity, and speculative possibilities. Drug use is encountered on the whole as a sphere of experimentation *and* normalization shot through with "differentiations, comparisons, valuations, attenuations, skirmishes."[44]

Against Pharmaceutical Amnesia

Another prominent voice in popular discourses of gay men's relation to HIV in North America at this time was that of HIV activist and community organizer Tony Valenzuela, one of the first gay porn stars to come out as HIV positive. With his naked arms wrapped around the dark mane of a horse that had clearly been chosen to accentuate his swarthy Mexican–Italian features, Valenzuela first came to the attention of a wider public when he appeared on the cover of *POZ* magazine beneath the alluring headline "Tony Valenzuela and the boys who BAREBACK take you on a ride inside."[45] Extending and expanding upon his celebrity persona, Valenzuela's creative fiction provides insights into gay sex, HIV, and recreational drug use that are more self-reflexive than the standard fare encountered in gay journalism and health advocacy discourse. His 2004 short story, "The Day We Didn't Quite Manage to Smuggle Some K," tells the story of group of gay friends who travel to Tijuana to stock up on drugs for the White Party in Palm Springs, one of the circuit parties that Andrew Sullivan first brought to general public attention.[46] The narrator of the story describes the experience of living with HIV through the Protease Moment in terms that corroborate its queer temporality.

> Being forced to think, over a prolonged period, that I might die sooner rather than later, was like dying over and over again, taking stock of my achievements, saying my goodbyes in a sentimentally overwrought imagination, until the notion sat with me, worn and familiar. Now, not dying was the resurrection, the survival day by day.[47]

These remarks are followed immediately by a sequence of dialogue that conveys the appeal of the drug among a group of guys who have gone so far as traveling all the way to Mexico to scour veterinarian outlets in order to source it:

> "I heard that ketamine produces 'near-death' hallucinations. No wonder I love it so much."
>
> "I knew that already," Alex says . . .
>
> "It's so obvious," I say, shaking my finger at a man holding a tree of glass wedding-cake crowns. "The drug that's made me intimate with death has helped me to reconcile it."[48]

Earlier in the piece, the narrator discusses the "solace" he and his HIV-positive friends seek in recreational drugs. But where Sullivan's exposé attributed gay men's use of this "animal anesthetic that disconnects the conscious thought process from the sensory body" to a collective "need for amnesia" and others point to a "desire for escape", Valenzuela's story rebukes such characterizations with deft precision:

> To call drugs an escape from HIV was, for us, the opposite of the truth. Getting high became a meditation and dialog on figuring things out. Shirtless and sweaty, in the midst of our other party-boy friends, we dropped E and snorted ketamine from tiny bumpers and screamed into each other's ears over the blast of disco: "Our generation has a different relationship to HIV!"; "AIDS prevention lies about the meaning of real sex!"; "Circuit parties are about survival as much as celebration!" The dance floor, the drug trips, and our friendship became a dark, lush terrain for this merciless self-awareness.[49]

I remember the burst of recognition I felt when I first read this passage, and how well it captured aspects of my own experience of gay dance parties over the late 1990s. As with Dormil, who says his recreational drug use allows him "to accept the fact of my disease and get on with my life," in Valenzuela's account recreational drugs emerge as psychoactive elements in a process of collective self-experimentation that produces subjects who become capable of confronting and producing truths about living with HIV that might otherwise remain unbearable. Rather than blocking out the possibility of imminent death or operating as a mere anaesthetic, these substances appear to emulate and magnify that apprehension precisely to discharge its terror.

In "Dosed," a short story published two years later, Valenzuela depicts a scene of home-based sex-partying to explore how the drugs crystal meth and GHB may be used to remediate and recreate temporality, this time in the different setting of gay sexual encounters between men.[50] Dubbed PnP in North America and chemsex in the UK and Europe, the practice of using the internet to arrange drug-enhanced sex has been subject to recurring waves of moral panic in Western countries for over two

decades now.[51] In this scene of sexual activities, even the anticipation of certain cocktails of psychoactive drugs can interrupt what some queer critics term the logic of reproductive temporality.[52] As soon as the narrator of the story clinches a desirable hook-up online all he can think of is getting high on crystal meth:

> I want to get twisted, gnarly high on Tina where I don't care about tomorrow and yesterday and time is reduced to an acute yen for body parts.[53]

Here the appeal of crystal consists in how it allows the narrator to escape the pressures of the normative scheduling of everyday life. As the narrative proceeds, however, things start to get more complicated. The storyteller describes the experience of sexual desire on crystal meth in the following terms:

> On crystal, all that remains of me is my body with its moist orifices, ravenous as summer tornadoes. I am, otherwise, held in glorious suspension from the nuisance of the day's worries. I am erased of complicated history, like high school textbooks in the South. There is only lust here now, an empire of prurience whose frontier plots against the horizon: orgasm is defeat, is desire's drowning.[54]

Insofar as this passage conveys a sense of escape from inconvenient histories that cast shadows on the present it might be taken to reflect the "need for amnesia" Sullivan discusses in "When Plagues End." But it also does something more or other than that: in particular, it evokes an experience of dilated temporality that resonates with the structure of feeling I earlier associated with the prospect of long-term HIV therapy beyond the Protease Moment. Crystal is invested in this scene with the specific value of enabling users to eroticize a suspended state of indefinite deferral. In other words, it enables the sexual subject to be "in the moment" where each moment gains its specific erotic charge by suspending users indefinitely on some intensified point in the normative arc of impending teleological resolution or climax. Here, the "long-term" is effectively relocated from the scene of normative temporality to what Valenzuela characterizes as the "acute yen" of the moment. Rather than *escaping* the realities of HIV, being high on crystal seems to replicate and magnify a prehension that constitutes a temporal reality of HIV for those subject to this feeling, recreating it as a source of excitement, ongoing desirability and desiring-continuity.

The vast and growing empirical literature on gay and HIV-positive experiences of crystal methamphetamine suggests that Valenzuela's account of the effects of this drug is far from idiosyncratic or isolated. "How to say this?" one participant asks in a 2006 qualitative study, "what I find on crystal, I kind of enter into a special space. A particularly sexual, sensual space" in which "every touch is enhanced."[55] Notably, this experience of a sensuously dilated temporality—of getting lost in the moment—is not confined to sexual activity for all users. In a 1997 study, a self-identified transgender participant claims that "99 percent of drag queens who inject crystal use it to "sketch on their face. They do their make-up, they tweak on their face":

> Like I could get stuck in my bag, you know, stuck, for hours, in my bag—in my make-up bag. Just sitting, putting my make-up on. For hours. And keep putting it on. And leaving it on. Taking it off. Putting it back on.[56]

This is not the only thing crystal is good for, on the account of this informant. She describes how the drug makes a range of other activities she periodically engages in more possible, from walking to "cleaning the house until it's spotless."

Some of the most careful studies of gay men's methamphetamine consumption reveal specific affordances of the drug among gay guys living with HIV. As one participant in a 2002 study puts it:

> When I found out I was HIV +, I didn't know what was going to happen. I didn't know what to expect with HIV. I didn't know where I was going. But after I started using [crystal]—I started making some positive choices in my life. And actually I think I did some pretty good things. It helped me. I don't know how I would have ever got started again.[57]

The drug's capacity to enhance energy, mood, focus, confidence, motivation, and sexuality becomes all the more significant in the context of a condition whose most commonly reported symptoms include fatigue, depression, anxiety, inability to concentrate, loss of libido, and lack of energy, focus, and motivation. The finding that HIV-positive people constitute the majority of gay male users of the drug starts to make sense, even from a therapeutic perspective.[58] This is unsurprising if one considers the use of this substance historically: clinicians and pharmacists prescribed methamphetamine as a treatment for depression for a good part of the twentieth century (1920–60).[59]

My purpose here is not simply to reduce the activity or meanings of this substance to the normatively acceptable frame of "self-medication" on the basis of its pharmacological properties. The protease moment invites us to go further and query the porous, arbitrary, and contingent nature of drug taxonomies more generally: the identification, coding, ranking, delegation, and prioritization of certain drug effects over those others deemed "side-effects" or else "pleasure" (in which case their legitimacy comes into question, both normatively and, I think, perversely).[60] But I have also been trying to explore the queer resonances that appear to consociate between the practical logics of antiretroviral therapy and those that inform the use of certain illicit substances among a population that has been disproportionately affected by HIV since the beginning of the epidemic. Exhorted to persevere with the historically alarming side-effect profiles of early combination antiretroviral therapy—their toxicities, both known and unknown—in the name of a greater good, this subpopulation has had to grapple with the complex multiplicities of living with toxicity over the long term in both personal and collective efforts to normalize their day-to-day existence and realize their hopes of longevity. Through our collective experiments and "underground research projects" we have learnt that some combinations of psychoactive drugs have the capacity to reproduce and constructively re-enact some of the contingencies of living with the virus.

One source of appeal of some of the most popular recreational drug cocktails (such as ecstasy, ketamine, and crystal meth) on this analysis is their imputed capacity to magnify and discharge the

distinctive temporalities of living with the protean experience of the virus and its treatment. Rather than escaping reality, recreational experiments with drug cocktails have helped some of us confront the difficult realities of a temporality whose prolongation is at once normatively desirable and precarious. Indeed, in a curious way drugs such as crystal meth (use of which has been roundly condemned within gay community HIV prevention discourse) would appear to make good on the promise of restoring a sense of vitality, agency, confidence, and erotic possibility first associated with combination antiretroviral therapies when they initially became available in the West. The purported capacity of crystal meth to suspend temporality renders its use generically intelligible as a psychoactive substitute for "medications whose toxicity is able, for a time, to hold the virus at bay" (*pace* Chambers). But in an odd twist of fate, where pharmaceutical advertisements for protease inhibitors once depicted the dosing requirements of the new drug cocktails as a high-endurance sport that demanded of their consumers a commitment, focus, and stamina to "stay with the course" if they wanted to "face the future with confidence," today the figure of the pharmaco-athletic gay man has become a source of moral panic as hundreds upon hundreds of scientific articles and media reports fret about the "72 hour drug-fuelled sex sessions" [sic] said to be sweeping the nation, and the "sexual marathons . . . among HIV-positive men who have sex with men" that researchers and commentators pin on the confidence, energy, stamina and overactive sexuality that crystal meth is said to induce among this cohort.[61]

Of course, concern about the long-term psychological and bodily impacts of methamphetamine is warranted and understandable. My intention is certainly not to gloss over these potential harms. But it is surely revealing that one of the recurring tropes to feature prominently in this series of moral panics is the specter of gay men using drugs "in combination to facilitate sexual sessions lasting several hours or even days with multiple sexual partners."[62] In other words, it is precisely the prolonged and extravagant temporality of the sexual activities facilitated by the practice of experimenting with drug combinations that alarms moral commentators and incites condemnation, ultimately serving to produce these scenes of gay sex as excessive, deviant, and exceedingly problematic. Gay sex was never meant to last so long, nor be so uninhibited.[63]

A Condition of Silence

Soon after receiving my HIV diagnosis I made an appointment with a general practitioner with years of specialist experience in HIV care and a loyal caseload of inner-city gays right in the middle of Darlinghurst. "Don't tell your parents," was the first piece of advice he offered me, followed shortly by a script for the antidepressants he suggested I go on. I remember finding both suggestions pretty outrageous. What did he know about my relationship with my parents, or my general state of mind, for that matter; especially given the pains I had taken to present myself as unfazed and optimistic? I never filled that prescription, but I did hold off on telling my parents for some time. And though it irked me at the time, in retrospect I can see that my doctor's advice was well-intentioned. It was no doubt informed by years of clinical experience with traumatized patients whose pain stemmed as much from

the drama of family rejection as the mere biological fact of HIV infection. With an HIV-positive boyfriend and friends and colleagues in the sector, I was fortunate enough to have access to a support network that made it possible to avoid a painful family drama during the early stages of learning how to live with this disease.

But living in constant fear of imminent exposure with a stigmatized, sexually humiliating condition takes its toll. Though I was relatively open about my status with friends and colleagues, my sexuality had already severely strained my relationship with my parents and family. It was only a matter of time before they discovered my dirty secret, I figured. In the narrative that dominated my parental imaginary, HIV operated as vindicating proof of sexual depravity: conclusive evidence of the wrongness of homosexuality and the foolish lifestyle I was leading. I imagined my parent's anger, disappointment, and deep shame on discovering that their only son had succumbed to the logical outcome of the homosexual lifestyle they had warned me against repeatedly. I had wasted my life, wasted everything, betrayed every hope they had invested in me. This apprehension of a wasted life filled me with a sense of impending catastrophe, the guilt-ridden intensities of which I felt most acutely—fittingly enough—while "*getting wasted*" on the dancefloors of Sydney's party scene. Intensely conscious of the shameful disappointment I had become, I lived in constant fear of public humiliation and unwanted exposure at such events. In these spaces I often thought people were laughing at me—talking, whispering, pushing past me, pointing, smirking—as though everyone were in on some elaborate collective joke at my expense; a conspiratorial plot that singled me out for ridiculing attention. The dancefloor sometimes struck me as a chaotic swarm of reckless figures who were not only oblivious to their wayward ways, but manifestly out to get me. On more than one occasion, the partygoers around me grew devilish-horns right before my eyes. It was a nightmare, a terrifying nightmare, that frequently recurred in such situations.

Over time I learned that the drugs I was using to party intensified whatever apprehensions and feelings I was experiencing with a force that was powerful enough to make those apprehensions a reality. This was true of both positive and negative apprehensions, affective states whose qualitative intensities could switch without warning according to circumstance. Psychoanalysts will squabble with psychopharmacologists over whether these psychotic episodes were caused by the recreational drugs I was consuming at the time or the intense sexual shame that the possibility of having my HIV status outed to my parents unwittingly provoked in me. Psychoanalysts would likely interpret the hellish apparitions I experienced on these occasions as drug-induced paranoid-schizoid delusional episodes stemming from the morbid fear of the social humiliation associated with the prospect of having my sexual turpitude exposed for all to see: the "I told you so" narrative of HIV infection I felt and projected so keenly.[64] But it is impossible for me to dissociate the sexualized nature of the guilt and shame I felt in relation to my HIV status from the stigmatized status of illicit drug use more generally.

Elsewhere I have discussed how the fear of a "wasted life" overwhelms popular conceptions of illicit drug use and its dangers in the neoliberal–aspirational parental imagination.[65]As a phrase of

disdain, "What a waste!" is as familiar to gay men of my generation as it has been to many so-called junkies, a pejorative exclamation that takes its cue from normative determinations of what counts as a valuable or productive life, revealing the sexual, insidiously biopolitical nature of the economic investments that motivate and project it. As I have indicated, the regular use of drugs (both licit and illicit) was part and parcel of my sexuality and the practice of living with HIV in this time and location. For a time, there seemed to be no chance of escape from this wicked psychosocial alchemy.

At the risk of being dubbed a "freelance pharmacologist," what I can say now with some certainty is that these paranoid episodes were not an inevitable or intrinsic effect of these psychoactive substances, as pharmacological determinists would have it, but intensively conditioned by the social stigmatization and devaluation of homosexuality and illicit drug use historically. I base this claim less on any rigorous engagement with psychoanalytic theory than over a decade of disco-pharmacology: "underground research" involving careful experimentation with the relevant variables. These experiments have equipped me with a degree of intimate and practical expertise about their various combinatorial possibilities and affective contingencies.

It took me a decade to muster the courage to finally come out to my parents about my HIV status. My doing so was, importantly, not motivated by any sense of moral obligation, political valour, or hand-wringing guilt about having been dishonest with them: it was entirely in the interests of self-care that I came to this decision. Years of critical reflection about the enforced silence surrounding my condition, and growing indignation about its deeply sexualised nature no doubt also played an important part in this process. Had I been diagnosed with cancer or diabetes or any other chronic illness, I would have shared the news with my family without hesitation. Moreover, I might have expected to receive the sort of care, sympathy, and support about my situation that conventionally emerges as an expectation and entitlement among family members insofar as such care and support is normatively considered one of the principal obligations of kinship. Whatever the case, I had nothing to lose: by this stage of my life, not only was I economically secure and socially independent enough to handle a bad response from them, I was convinced that living in constant fear of humiliating exposure—of trying to remain socially as well as virologically undetectable—was having such corrosive effects on my mental well-being that I was already losing my mind. In this situation, telling my parents emerged as a risk worth taking, whatever the consequences.

As it happens, my parents' response was unexpectedly generous and immensely reassuring. "You poor bastard," my father said without the slightest hint of moral judgment. "What a terrible thing to live with, what a terrible accident." By 2006 the long-term effectiveness of antiretroviral therapy had been well enough established to make a new script for HIV disclosure normatively available. After thanking me for telling them (they acknowledged and conveyed their appreciation of my bravery in doing so), the discussion quickly turned to the topic of available treatments; they were eager to learn more about their effectiveness and my experience of them. Thank goodness for drugs, thank goodness for treatment optimism.

Today I regard this action as one of the best things I have ever done for my health and well-being. My paranoia gradually abated; an enormous weight had been lifted from my shoulders. What did it matter if my social life involved associating with a bunch of horned-up partygoers? With a mix of relief and just a whiff of disappointment, I came to realize that their horniness generally had nothing whatsoever to do with me. *Quel surprise!* What a relief! But more to the point: what sort of self-absorbed, self-serving conceit had persuaded me to think otherwise? People had other things to worry about, better things to concern themselves with. There was no elaborate conspiracy against me. This was a disappointment I could live with.

Conclusion

In *Homosexual Desire*, Guy Hocquenghem argued (contra Freud) that paranoia illuminates the operations of homophobia rather than homosexuality.[66] In my own experience, the apprehension of homophobia has been inextricably bound up with HIV infection and the stigmatization of illicit drug use. But where I have had the rare good fortune of being able to come out to my family about my HIV status relatively painlessly—enabling me to move from a paranoid to a reparative position—the same opportunity cannot be taken for granted by a great many people living with HIV, nor indeed those whose practices of drug consumption remain criminalized. Those who feel they have to hide these dimensions of their intimate experience have far less hope of accessing the care they need should they run into trouble. Dismantling these forms of enforced silence, stigma, and fears of exposure should remain an urgent priority on this basis.

Of course, the consumption of a range of drugs has been a conspicuous part of gay world-making practices since the days of disco. But as I have argued, the emergence of combination antiretroviral therapy to treat HIV disease in 1996 brought a new kind of anxious attention to questions of drug use and the transformative possibilities associated with the experimental use of drug cocktails within and among this population. The moralistic tenor of the bulk of this discourse can be traced to cultural anxieties about the return of increasingly active expressions of gay sexuality at this point in the HIV epidemic, which sociomedical and public health discourses now pinned on the medical and recreational use of drugs. But the association of drug cocktails with the maintenance of "normal life" now made it possible to query a series of distinctions long deployed in the medicolegal classification of drugs: therapeutic/recreational, benign/toxic, medical/pleasurable, proven/experimental. The protease archive I have assembled here suggests a more capacious perspective on experimental drug use might be possible—one that expands the bounds of normativity to incorporate a range of drug futures, such that the use of certain drugs—currently deemed illicit and irrational—emerges in alternative terms: as both intelligible and experimental.

When experimentality is foregrounded a different story can be told about sex and drugs that is particularly pertinent for the age of biomedical prevention. This term refers to the present paradigm of HIV prevention which is largely predicated on the repurposing of antiretroviral drugs to optimize their

capacity to prevent HIV infection. Though rarely acknowledged, this is something gay men started experimenting with almost as soon as these drugs became available and the possibilities of viral suppression became apparent to them. Figuring that undetectable viral load could be taken to mean minimal risk of passing on the virus, some men began to change their sexual practices accordingly.[67]

Almost two decades later, the underground experiments of these 'freelance pharmacologists' received the imprimatur only *clinical* experiments are deemed capable of conferring. Their optimism, it turns out, was warranted. This has led to a high profile overhaul and redesign of HIV prevention services around the world to maximise the preventative capacities of these drugs ('the prevention revolution'). But the preceding labour of 'freelance pharmacologists' is rarely acknowledged in official accounts of this moment. From the outset, our team at the national centre were among the handful of researchers internationally who were prepared to take these underground experiments seriously enough to propose changes to the definition of safe sex. Other colleagues brought the same approach to the use of recreational drugs, arguing that attending to the 'folk pharmacologies' circulating within gay dance culture might generate new concepts and practices of harm reduction.[68] Most scientists took what we approached as potential innovations to be unprotected sex and substance abuse, plain and simple, with the effect of disqualifying the subcultural experiments in question.

Today, most of the drugs that gay men and their communities began experimenting with on the dancefloors of the late millennium are being investigated for various 'therapeutic' applications. Ecstasy, marijuana, LSD and ketamine are among the drugs being tested for their use in addressing conditions such as Post-Traumatic Stress Disorder, anxiety and depression in largescale clinical trials. Of course, there are differences between clinical experiments and the collective, subcultural experiments that take place on dancefloors. The former are far more controlled, have the luxury of quality control, are randomised, documented and closely monitored. But despite all these controlling measures, they miss something important. One only need imagine how the experience of taking ecstasy or ketamine would differ in the white padded cell of a clinic to the 'flashing lights and pounding music' of a party or nightclub. All the contingencies, particularities and historicity of a given night – those mediating conditions that Zinberg once referred to as drug, set and setting.[69] Perhaps clinical researchers have something more to learn from these underground research projects after all.

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Notes

[1] This piece reworks and develops previous work from "The Undetectable Crisis" and *Pleasure Consuming Medicine*.

[2] Chambers, *Facing It*, 48.

[3] Engel, *The Epidemic*, 246.

[4] *Talkabout,* the newsletter of People Living with HIV/AIDS Inc. NSW, Australia, May/June 1997, 9.

[5] Dominic O'Grady, "AIDS Groups: Hit Early, Hit Hard," *Sydney Star Observer*, July 1996, 3. Martyn Goddard, "Half in Love with Easeful Death," *Sydney Star Observer*, May 1997, 8.

[6] Pozniak, "Surrogacy in HIV-1 Clinical Trials."

[7] Race, "The Undetectable Crisis."

[8] Rosenbrock, et. al., "The Normalization of AIDS."

[9] Race, "The Undetectable Crisis."

[10] Bartos and McDonald. "HIV as Identity, Experience or Career"; Flowers, "Gay Men and HIV/AIDS Risk Management."

[11] Race, "The Undetectable Crisis," 178.

[12] Race, "The Undetectable Crisis," 183.

[13] Navarre, "Fighting the Victim Label."

[14] Martyn Goddard, "Time for a Nice Cold Shower," *Sydney Star Observer*, July 18, 1996, 10.

[15] Lugliani, Greg. "Last laughs," *POZ* magazine, October 1, 1997. This trope of living with HIV endures well into the epidemic's third decade. See, for example, Cynthia Poindexter's *Handbook of HIV and Social Work*: "Living long term with HIV is possible, but it is not a walk in the park. Side effects of medication can range from serious to mere nuisance. Accepting a lifetime of popping pills on a regular and consistent basis can be challenging and tiresome" (108).

[16] Laurie Garrett, "Eyeing an Ad Ban: Critics say HIV Drugs' Claims Paint Too Rosy a Picture." *Newsday*, March 13, 2001.

[17] Stop AIDS Project, "HIV is No Picnic" campaign, San Francisco, 2002.

[18] Race, "The Undetectable Crisis," 181.

[19] Michael Flynn, "Compliance Ain't Easy," *Body Positive*, July 1997, 214.

[20] For example, a 1997 news report headed "Survival Means Drugs for Life" stated: "Powerful drug combinations being taken by many people with AIDS do not eliminate the virus from the body, scientists have found—but neither does the virus develop resistance to the drugs in people who follow the dosage instructions. . . . The findings mean people who benefit from the drug combination therapy cannot safely discontinue their medication, as had been hoped, and may need to stick with the costly treatment indefinitely." Denise Grady, "Survival Means Drugs for Life," *Sydney Morning Herald*, November 15, 1997, 28.

[21] Wilde, *The Picture of Dorian* Gray, 54.

[22] Van de Ven, et. al., "HIV Treatments Optimism."

[23] Walt Senterfitt, "The Message from Vancouver: The Hope is Real and the (Reality) Check is in the Mail," *Aegis*, August 1996.

[24] Halberstam, *In a Queer Time and Place*, 4–7.

[25] Rosenbrock et al., "The Normalization of AIDS," 1617.

[26] This is the term I used to explore the impacts of the medical news broadcast during the 1996 International AIDS Conference in Vancouver in my essay "The Undetectable Crisis."

[27] See for example Bersani, *Homos*; Edelman, *No Future*; and Berlant and Edelman, *Sex, or the Unbearable*.

[28] Wamoyi et. al., "Changes in Sexual Desires."

[29] For a review of this literature, see Crum et. al., "A Review of Hypogonadism and Erectile Dysfunction"; Elford, "Changing Patterns of Sexual Behavior"; and Sullivan et. al., "Prevalence of Treatment Optimism-Related Risk Behavior."

[30] Wiegman and Wilson, "Antinormativity's Queer Conventions," 18, 15.

[31] Andrew Sullivan, "When Plagues End. Notes on the Twilight of an Epidemic," *The Independent*, February 16, 1997, https://www.independent.co.uk/arts-entertainment/when-plagues-end-notes-on-the-twilight-of-an-epidemic-1278905.html.

[32] See Harper, *Private Affairs* and Crimp, *Melancholia and Moralism*.

[33] Sullivan characterizes this behaviour as "manic," its practitioners "terrified by the thought that they might actually survive." "When Plagues End."

[34] Sullivan, "When Plagues End."

[35] Frances Anderton, "The Lethal Liberator," *The Guardian*, September 15, 1997.

[36] Kevin Sack, "HIV Peril and Rising Drug Use," *New York Times*, January 29, 1999.

[37] Steve Dow, "Dancing with Death," *The Age*, October 4, 2000.

[38] I take the concept "pharmaceutical slippage" from the work of Marsha Rosengarten, who presented a paper at the 2000 *HIV/AIDS & Related Diseases Social Research Conference* in Sydney with the title "Prophylactic Slippage." See generally Rosengarten, *HIV Interventions*.

[39] Frank Owen, "Higher and Higher: Drug Cocktails—Pleasures, Risks and Reasons," *The Village Voice*, July 21, 1999.

[40] Owen, "Higher and Higher."

[41] Flynn, "Compliance Ain't Easy."

[42] Owen, "Higher and Higher."

[43] Owen, "Higher and Higher."

[44] Wiegman and Wilson, "Antinormativity's Queer Conventions," 18.

[45] Cover page, *POZ* magazine, February 1999.

[46] Valenzuela, "The Day We Didn't Quite Manage to Smuggle Some K," n. p. A pre-publication copy of this story was given to me by the author.

[47] Valenzuela, "K."

[48] Valenzuela, "K."

[49] Valenzuela, "K."

[50] Valenzuela, "Dosed," n. p. A pre-publication copy of this story was given to me by the author.

[51] See Race, *Pleasure Consuming Medicine*, Chapter 9; Race, "Party and Play"; Race, *The Gay Science*, Chapter 7; Gideonse, "Framing Samuel See"; Hakim, "The Rise of Chemsex"; and Kagan, *Positive Images*.

[52] Halberstam, *In a Queer Time and Place* and Edelman, *No Future*.

[53] Valenzuela, "Dosed."

[54] Valenzuela, "Dosed."

[55] Isaiah Green and Halkitis, "Crystal Methamphetamine and Sexual Sociality," 323.

[56] Reback, "The Social Construction of a Gay Drug," 38.

[57] Semple et. al., "Motivations Associated with Methamphetamine Use," 153.

[58] In recent Australian gay community samples, three times as many HIV-positive men report using crystal methamphetamine as HIV-negative and untested men. See Lea et. al.,

"Methamphetamine Use among Gay and Bisexual Men in Australia" and Shoptaw, "Methamphetamine Use in Urban Gay and Bisexual Populations."

[59] Rasmussen, *On Speed*.

[60] See Race, *Pleasure Consuming Medicine* and Keane, "Pleasure and Discipline."

[61] Mitchell, Laura. "The Rise of 'Chemsex': Craze Sees 72 hour Drug-Fuelled Sex Sessions Sweep UK," *Daily Star*, December 13, 2015; Semple et. al., "Sexual Marathons"; Bourne et. al., "The Chemsex Study." For a critical analysis of chemsex discourse see Race, *The Gay* Science, Chapter 7.

[62] See McCall et. al., "What is Chemsex and Why Does it Matter?"

[63] Critiques of the popular narrative which produce the AIDS crisis as a sexual morality tale can be found in Crimp, *Melancholia and Moralism*; Race, *Pleasure Consuming Medicine*, Race, *The Gay Science* and Warner, *The Trouble with Normal*.

[64] In his essay on the case of his patient Schreber, Freud claimed "the strikingly prominent features in the causation of paranoia, especially among males, are *social humiliations and slights.* But if we go into the matter only a little more deeply, we shall be able to see that the really operative factor in these *social injuries* lies in the part played in them by the homosexual components of emotional life" (10, my italics). But Freud's theory that paranoid delusions emerge as a defence against latent homosexuality is slim on convincing explanatory detail, and has been re-asserted and contested since the time it was first published. See Freud, "Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia."

[65] In neoliberal discourses of illicit substance use, the main problem associated with drug use is the threat drugs are said to pose to the lives, dreams, and futures of middle-class aspirational subjects. See Race, *Pleasure Consuming Medicine*, Chapter 3.

[66] Hocquenghem, *Homosexual Desire*. See also Sedgwick, "Paranoid Reading and Reparative Reading"; and Morrison, *The Explanation for Everything*, Chapter 6.

[67] Rosengarten et al., *Touch Wood, Everything will be Ok*; Susan Kippax and Race, 'Sustaining Safe Practice'

[68] Erica Southgate and Hopwood, 'The Role of Folk Pharmacology and Lay Experts in Harm Reduction'; Race, 'The Use of Pleasure in Harm Reduction'; Race, *The Gay Science*, 10-19.

[69] Zinberg, *Drug, Set and Setting*, 1984.