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Research Paper

Constructing a 'target population': A critical analysis of public health discourse on substance use among gay and bisexual men, 2000–2020

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ABSTRACT

Background: Gay and bisexual men (GBM) have higher substance use prevalences than general population samples – often attributed to stigmatisation of sexual minority identities. We examined how influential public health research on substance use among GBM interprets this behaviour and what GBM-specific identities emerge through the discourses employed.

Methods: We searched Web of Science for publications on substance use among GBM, selecting 60 of the most cited papers published during 2000–2020. We studied the language used to describe and interpret drug-using behaviour using critical discourse analysis, focusing on interpretive repertoires and subject positions.

Results: Three distinct discursive tendencies were identified. First, in *constructing a target population,* GBM who use illicit drugs are positioned as deficient, socially irresponsible, and maladapted to dealing with stigmatisation and HIV risks. Second, in shifting the focus *beyond the individual,* the gay community is conceptualised as offering a safe space for socialisation. Nonetheless, gay community spaces are problematised as promoting substance use among vulnerable GBM through aggravating loneliness and normalising drug use as a form of maladaptive (avoidance) coping. Third, *counterdiscursive movements* add nuance, context, and comparisons that relativise rather than generalise substance use and focus on pleasure and self-determination. Such discourses centre the need for interventions that disrupt homophobic socio-structures instead of individualising approaches to limit non-conformity.

Conclusion: 'Expert' assessments of substance use among GBM perpetuate pathologising understandings of this behaviour and promote abject subject positions, contributing to perpetuations of intergroup stigma and social exclusion based on drug and sexual practices. Our findings highlight the need for deliberate and critical engagement with prior research and a conscious effort to disrupt dominant discourses on GBM's substance use.

Background

Academic and public health interest in illicit substance use among gay, bisexual, and other men who have sex with men (GBM) is substantial. Researchers have shown particular interest in the complex relationship between substance use and sexual risk, investigating drug use as a health issue for GBM (Pienaar et al., 2018). Their publications, spanning at least five decades (Fifield et al., 1977) and all regions (Drysdale et al., 2021; Lisboa Donoso & Stuardo Ávila, 2020; Rich et al., 2016; Schmidt et al., 2016; Vu et al., 2017; Williams et al., 2016), identify higher prevalences of substance use among sexuality and gender diverse populations worldwide than in general population samples (Bourne & Weatherburn, 2017; Rosner et al., 2021; Roxburgh et al., 2016). Explanations range from 'minority stress' due to coping with a stigmatised social identity (Goldbach et al., 2014; Lowry et al., 2017; Meyer, 1995, Meyer, 2003) to the historical significance of bar and dance culture for sexual identity and gay community formation (Lea et al., 2013; Race, 2011; Stall & Purcell, 2000). Across the range of explanatory frameworks, stigmatisation is identified both as a driver and a consequence of substance use and as harming GBM health.

Critiques of the 'mainstream' public health research dominating this field has centred on the privileging of biomedical styles of research which foreground 'risk' paradigms and fail to generate understandings of

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the real-life scenarios in which drug use emerges (Møller & Hakim, 2021; Bryant et al., 2018; Hopwood et al., 2016). Views of drug-using GBM as undisciplined and out of control permeate this literature (Bryant et al., 2018), and of drug use confirming the presence of some deep-rooted suffering and 'social victimhood' (Race, 2009 p.168). Such understandings legitimise increased scrutiny and authoritarian treatment of particular social groups (Herzog, 2016; Karasaki et al., 2013; Race, 2009), and the continued sexuality-based exclusion and marginalisation of some GBM (Race, 2009; Bryant et al., 2018).

In this article, we do not assess the 'truth' of the extant literature. Rather, we are interested in peer-reviewed publications as sites where social meanings are formed and reproduced, social identities are shaped, and social facts are established (Foucault, 1972). Specifically, our concern is for the differing ways in which GBM's substance use is problematised, and how GBM are characterised in influential publications. We assume a social constructionist/critical realist understanding that views language not as a neutral medium for communicating information, but a domain in which people's knowledge of the social world is actively shaped and social realities are made (Willig, 1999).

As a discursive formation, expert language has force, because it 'marks out a field of knowledge', confers membership, and bestows authority (Tonkinss, 2012). It is possible that the language used in the literature on substance use among GBM unintentionally (re)produces discourse and empirical 'evidence' that exacerbates stigmatisation based on sexual identity and/or substance use practices (Race et al., 2016; Bryant et al., 2018). To understand this point, consider the issue of 'problematisation', which means:

> *the totality of discursive or non-discursive practices that introduces something into the play of true and false and constitutes it as an object for thought.* (Foucault, 1988, p. 257)

Research processes typically commence with the 'problematisation' of a research object and culminate in the dissemination of research findings through peer-reviewed publications, thereby constructing and organising the terms in which particular social issues are understood. In shaping political, community and health service responses to the 'problem' under study, academic discourse influences individuals' ways of being and forms part of the culturally negotiated process of identity formation and transformation (Bamberg et al., 2011; De Fina et al., 2006; Sibley et al., 2020). In the case of substance use, these discourses delimit the range of available interpretive repertoires and may constrain the possible self-hoods that can be assumed by individuals who use drugs.

This paper examines the language used in influential peer-reviewed articles on substance use among GBM. We analyse the linguistic choices made to describe GBM who use drugs and consider what these choices reveal about conceptions of individuals and communities. By illuminating implicit assumptions and interpretive repertoires employed in discourse, we demonstrate the power of language in meaning-making and identity construction. We argue that this contributes to broader society's views of GBM, shapes and is shaped by cultural narratives of drug use, and consequently impacts on GBM's social realities. Implications of these discourses for the perpetuation of inter- and intragroup stigma are discussed.

Methodology

Searches/data collection

Our object of analysis was influential peer-reviewed publications on drug use and sexual minority men published during 2000–2020. Using number of citations as a proxy for 'influence' and likelihood of contributing to intertextuality in discourse (i.e., the shaping of future texts through selective reading and integration of prior research (van Dijk, 1993; Moore, 2008; Bryant et al., 2018), we systematically searched the Web of Science database to identify the most cited publications on this topic.

A detailed description of our search strategy and iterative approach to article selection is provided in the Supplementary materials. Briefly, search strings included medical subject headings and free text relating to GBM and recreational drug use. To capture dominant discourses, we then narrowed our focus to those research areas contributing the most publications. We therefore limited the results to publications indexed under 'Substance Abuse', from which we selected 30 articles, and 'Social Sciences Biomedical' AND 'Public, Environmental and Occupational Health', from which we selected another 30 articles, to transcend genre or discipline-specific variations in public health discourse.

Upon stratifying the results by number of citations, the first author screened titles, abstracts and full-texts and sequentially selected articles meeting our selection criteria (see Table 1) until sufficient publications of historical and geographical diversity were identified to detect variability and changes in discourse, while limiting the data volume to afford the necessary attention to detail. We selected the 30 most cited articles published during 2000–2020; the 20 most cited articles from research groups outside the United States (to mitigate the overrepresentation of US-based studies); and the 10 most cited articles from 2010–2015 and 2016–2020 to ensure inclusion of recent publications (given citations build with time). Ten publications were duplicated in subsequent searches, which we chose to remove but not replace. Using this strategy, we identified 60 articles for analysis as listed in the Supplementary materials.

Data analysis

Data were analysed using discourse analytical approaches (Fairclough, 2003; Jorgensen & Phillips, 2006; Tonkinss, 2012), oriented towards critical discourse analysis (van Dijk, 1993). Discourse analysis is an umbrella term for methodologies that treat language itself as the unit of analysis. In line with social constructionism, discourse theory rejects positivist assumptions of a static and singular reality and instead conceptualises (social) reality as multiple, emergent, and produced in practice (Davies & Fisher, 2018; Sims-Schouten et al., 2007). Language is understood not as a transparent medium, but a value-laden and culturally prescribed social practice, used (consciously or unconsciously) to accomplish particular objectives (Wetherell & Potter, 1988).

We instrumentalised discourse analytical methods described by Fairclough (2003) and Parker (1992) to analyse the content of the interpretive repertoires, and the structure of language and how this functions to create particular understandings of the phenomenon. Two primary research questions directed the analysis:

(1) What subject positions are made available to GBM who use drugs?
(2) What interpretive repertoires are used in the literature on drug use among GBM?

Discourse analysis urges reflexivity upon a researcher or reader, achieved by continually asking: What is not explicated but implicit in the text? Why was this said and not that; why was it said using these words; and how do they fit the various ways of talking about the world? (Parker, 1992). The search for patterns then gives way to the formation of 'themes' or 'hypotheses' about particular patterns of language use (Wetherell & Potter, 1988). To this end, preliminary coding focused on the *content of discourse;* we developed codes that defined the *materialities* of drugs (i.e. their properties and characteristics identified in the data); *actors* and their identifying attributes; and *practices* produced by discourse to respond to the problematisation of the research object (Herzog, 2016). Subsequently, we designed thematic codes to capture interpretive repertoires and the distinct lexical or syntactic features of the text that produce a particular meaning/interpretation (Wetherell & Potter, 1988). We then compared and contrasted these codes to generate higher-level thematic categories; the resultant three themes are presented here.

Table 1
Article selection criteria.

	Inclusion criteria	Exclusion criteria
Search 1	Published between 2000 and 2020; Published in English;	Exclusively investigating alcohol, tobacco or cannabis; No data disaggregated by sexual minority status;
30 selected	Empirical (qualitative or quantitative) research; Review articles; Reporting on illicit substance use; Reporting disaggregated data for sexual minority men; Highest ranking by citation	Clinical drug treatment trials
Search 2: Repeating search 1 //AND not USA	Studies conducted outside the USA (n=20); Highest ranking by citation	Studies conducted in the USA
20 selected		
Search 3: Repeating search 1 //AND Timespan=2011–2015	Studies published 2011–2015 (n=10); Highest ranking by citation	Studies published before 2011 or after 2015
10 selected		
Search 4: Repeating search 1 //AND Timespan=2015-2020	Studies published 2016–2020 (n=10); Highest ranking by citation	Studies published before 2016 or after 2020
10 selected		

Results

Details of the 60 publications we examined are given in Appendix 1, Table 2 Supplementary material. Briefly, they mainly describe quantitative methodologies, observational cohort study designs and cross-sectional analyses. Four papers are based on qualitative interviews, and two are (non-systematic) reviews. They predominantly problematise substance use among GBM in the context of HIV epidemics – as a target of prevention efforts – within epidemiological risk frameworks.

We identified three critical themes (discussed below). (1) By *constructing a target population,* discourses produce limited subject positions that diagnose GBM who use drugs with multiple interrelated deficiencies. (2) Problematisations of drug use among GBM mobilise gay-specific factors *beyond the individual* and ascribe certain roles and attributes to LGBTQ+ communities. (3) *Counterdiscursive movements* disrupt hegemonic discourses on the causes and consequences of drug use, thus enabling alternative responses to the research 'problem'.

In the illustrative quotes that follow, we retain original spelling and punctuation; in-text citations demonstrate how evidence is 'made' through narration and how language is perpetuated through intertextuality in academic writing.

(1) Constructing a 'target population'

In public health research, 'target population' is used to refer to a group of people with certain attributes (typically, behaviours that increase risk of adverse health outcomes) that can be used to guide strategic public health responses. Participants are selected based on these attributes (the 'sample population') to understand relationships between variables of interest (e.g., substance use and HIV) and to make inferences about the target population, often in the context of informing intervention design or policy responses. In the reviewed papers, such attributes include identifying as male and having sex with men. Age, race, ethnicity, residence, HIV status, substance use patterns, venue attendance and other attributes are also used to define the target population, although, as we will demonstrate, many discourses conflate the target population with GBM populations as a whole.

As well as being research subjects, research participants and their attributable target population become *discursive* subjects (Foucault, 2018). Across the reviewed literature, GBM who use drugs are repeatedly positioned as morally irresponsible or juvenile; as blameworthy individuals whose self-destructive tendencies pose a liability to innocent others as well as themselves; and as abject 'others' whose drug use aetiology (situated in a drugs-as-disease framework) is explained by vulnerabilities attributed to individual biographies (e.g., childhood sexual abuse) and psychopathologies (e.g., depression or compulsivity).

These discourses instrumentalise a 'war on drugs' language, effectively presenting psychoactive substances as malevolent agents whose unique properties compromise and corrupt the behaviours of their consumers. Of the psychoactive substances discussed, methamphetamine is portrayed as particularly insidious because its ascribed properties (e.g. promoting sexual disinhibition, increasing euphoria and impulsiveness, producing loss of control) feed directly on the vulnerabilities and insecurities of GBM 'struggling' with their sexualities. For instance, in interpreting their research findings, Halkitis et al. (2005) conclude that:

> *Methamphetamine use is clearly related to issues of sexuality and sexual coping among gay and bisexual men. This link signifies the ultimate challenge in dealing with and treating this drug addiction, which because of hypersexual qualities induced by methamphetamine, is clearly a concern with regard to the transmission of HIV and other sexually transmitted pathogens.*

Halkitis et al.'s representation of their findings as an incontestable truth is noteworthy; *'clearly'* is used to describe both negative antecedents and consequences of drug use, namely coping with sexuality and sexually transmitted infection, respectively. The reader is guided towards considering methamphetamine use as a generalised problem for all populations. However, the capacity ascribed to methamphetamine – to *'induce hypersexual qualities'* – make GBM particularly prone to its negative effects. This, in turn, is *'clearly a concern'* because of exceptional risks of disease transmission inherent to male-to-male sex (a taken-for-granted understanding).

In the reviewed literatures, it is common for the research background and rationale to instrumentalise alleged synergies between GBM's sexual lives, high prevalence of HIV (which demands that GBM alter their sexual behaviours), and the properties ascribed to substances. For instance, Kipke et al. (2007) cites the following consensus regarding methamphetamine's power to override GBM's volition:

> *Methamphetamine is believed to encourage risky sexual behaviors by intensifying and prolonging sexual encounters, increasing the subjective pleasure of sex, increasing a sense of euphoria and confidence, and encouraging impulsivity that may in turn lower one's inhibition to engage in unprotected sex.*

Here, the choice of the word 'encourage' positions methamphetamine as an independent agent that can overpower individual volition. Moreover, positioning methamphetamine-induced impulsivity as a precursor for disinhibited, unprotected sex implies a natural preference for unprotected sex among GBM, which can only be overridden with sufficient willpower. Collocating pleasure with risk and impulsivity gives pleasure a negative connotation that is amplified by framing it as subjective, but as an embodied experience, pleasure can only *be* subjective! Inclusion of 'subjective' may therefore be interpreted as a (deliberate or unconscious) reference to methamphetamine impairing a person's judgement. Implicitly, the lesson is that someone who achieves pleasure through methamphetamine use cannot assess pleasure accurately.

While discourses portray drugs in general as dangerous, drugs are also construed as primarily corrupting the corruptible. Some authors' lexical choices construct their research subjects as multiply deficient. In addition to being seemingly maladapted (as 'evidenced' by GBM's self-destructive tendencies and preponderance to avoidance coping, which exacerbates underlying 'issues') some publications portray GBM who use certain drugs in certain ways as lacking the skills to action what they know is better – to exercise willpower and restraint. Drug use allows GBM to intentionally and rationally override their sense of responsibility as a means to ignore the need to *'restrain their sexual activities'* and to productively cope with *'uncontrollable desires for sex'* (Parsons & Halkitis, 2002). For instance, in discussing HIV, McKirnan et al. argue that '*awareness of personal risk requires that one forgo highly desired activities'*, which may induce *'coping burnout'* among identified risk groups, notably GBM (McKirnan et al., 2001). It is implied that GBM use substances strategically to yield to their sexual desires, which in the context of HIV is inadvisable:

> *Substance use may constitute an active strategy to decrease painful self-awareness of the larger health implications of behavior, in this case regarding anxiety about HIV. Attending to the concrete 'here and now' … allows one to escape awareness of longer-term or more abstract concerns, such as personal health or social obligations. Substance use, of course, is effective in narrowing attention to the immediate (Steele & Josephs, 1990).* (McKirnan et al., 2001)

Their cross-sectional analysis is discursively constructed as evidence of a temporal relationship between substance use and sexual risk that exists *because* GBM turn to drugs to avoid anxiety associated with same-sex behaviour and self-awareness of HIV risk. Describing this relationship as bound by *'painful self-awareness'* disregards the possibility that GBM are acting on personal evaluations of risks and rewards (e.g. implementing HIV serosorting as a risk reduction strategy and seeking enjoyment). Instead, the supposed self-loathing tendencies associated with their sexualities are foregrounded. Likewise, the suggestion that GBM want to escape awareness of social obligations through drug use implies that GBM who use drugs are socially irresponsible citizens. There is a notable lack of nuance in the excerpt above, which culminates in the interjection *'of course'* as, again, presenting a universal truth, as well as giving off an air of condescension.

While the literature highlights the stressors GBM experience as part of a sexual minority and facing deadly health risks, discourses foreground that GBM who use drugs are maladapted to these rather static conditions. Drug use is commonly presented as one of multiple deleterious health behaviours, benefiting the stereotype of individuals unable to self-regulate effectively or conform to societal expectations that GBM limit their risk of contracting and 'spreading' HIV. For instance, in a cross-sectional study from the US, Greenwood et al. (2001) linked correlates of 'heavy' substance use to never learning one's HIV serostatus, writing:

> *The failure to ever get HIV serostatus results — given the elevated risks of HIV infection among this sample – may reflect a susceptibility to engage in other health-compromising behaviors (e.g., drug use), a limited set of coping strategies to deal with such stress (i.e. avoidance coping), or an inclination toward 'magical thinking' or denial.* (Greenwood et al., 2001)

Noteworthy in this excerpt is the consistency with which deficits are attributed to the study population in a moralising and shaming manner. Not learning one's HIV status is defined as a failure. Using parallelism as a rhetorical device, this failure is linked to drug use (here defined as a consequence of someone's *'susceptibility to engage in (…) health compromising behaviours'*), suboptimal coping, delusional tendencies and immaturity (evoked by *'"magical thinking" or denial'*). As a rhetorical device, parallelism is particularly effective in establishing equivalence between these three separate elements; drug use is equated to avoidance coping and delusion, conveying that a person engaging in one is likely to engage in all three – hence their likelihood of 'failure'.

In other publications, GBM who use drugs are portrayed as exhibiting particular personality dispositions, such as *'sensation-seeking'* (Vu et al., 2017), *'sexual compulsivity'* (Pitpitan et al., 2016) and *'romantic obsession'* (Parsons & Bimbi, 2007) – psychopathologies that are construed as posing a danger to others and warranting urgent intervention. Repeated links between such attributes and HIV spread marks them as personality dispositions that threaten community wellbeing and social cohesion. In establishing these links, GBM who use drugs are deemed irresponsible citizens, therefore legitimating institutional governance.

GBM who use drugs are thus effectively constructed as a target population in need of intervention due to multiple, interrelated deficiencies that they are unable or unwilling to overcome. The population is portrayed as lacking in, for example, a sense of responsibility to protect others from HIV (Parsons & Halkitis, 2002), impulse control (sexual compulsivity is exacerbated by drug use) (Semple et al., 2006), and the skills to manage health risks (Minichiello et al., 2003).

> *Given the substantial body of research on the link between meth use and high risk sex among gay and bisexual men, it is not unreasonable to suggest that those who have higher levels of sexual compulsivity will potentially engage in even more frequent or more risky sexual behaviors as compared to their less sexually compulsive counterparts. Furthermore, if a meth user is sexually compulsive and HIV-positive, the risk of HIV transmission to uninfected sex partners may be significantly increased, thereby contributing to the growing number of new cases of HIV among gay and bisexual men in the United States.* (Semple et al., 2006)

Here, the authors construct an argument based loosely on previous research and framed within the realm of reason and logic. Their superior knowledge claims are solidified in words (*'it is not unreasonable to suggest'*). On further scrutiny some of this reasoning is questionable: it privileges etic (scientific) perspectives and does not consider the motivations of the study population beyond selfish desires and self-destructive tendencies. The phrase *'will potentially engage'* (as opposed to 'might engage') and the modal verb *'may be significantly increased'* demonstrate a commitment to the 'truth' described – as high as can be afforded without direct proof. Describing sexual practices as *'even more frequent or more risky'* assumes a high baseline level of undesirable activity, again implying GBM embody multiple deficiencies. While 'may' and 'potentially' grant possible alternative interpretations, this section concludes by mentioning increasing HIV incidence among GBM in the USA (a measurable reality) and effectively reaffirms the relationship between methamphetamine and risky gay sex; only an unreasonable person would dare to suggest otherwise. This shift between authoritative truth statements and authoritative moral statements, which assumes the power to tell others what is and what should be (i.e. the reasonable and the unreasonable) is a prime example of academia 'governing at a distance' (Foucault et al., 1991).

(2) Beyond the individual rests a misguided gay community

Another critical theme encompasses the various ways in which problematisations of drug use among GBM expand the focus *beyond the*

individual onto the 'gay community's' enabling and encouragement of (harmful) drug use. Here, the previously illustrated deficits ascribed to GBM are oftentimes extrapolated to gay communities, or seen to be reinforced by gay-specific environments.

For instance, a qualitative study of methamphetamine use among GBM in Miami concludes that the study population was motivated to use methamphetamine because they felt sexually unattractive, inhibited, lonely and unlovable. And while attributing the *'pervasive drug use among gay men'* to the '*social difficulties in homophobic culture'*, the authors propose that:

> … *drug use serves as an escape from an unshakeable sense of being alone, unacceptable, and unloved; crystal emerged on the Miami scene as the* newest *way to avoid those realities [emphasis added].* (Kurtz, 2005)

This sentence construes an established history of avoidance coping among GBM and critiques the Miami scene for dealing with the social difficulties of living in a homophobic culture by seeking an escape. Gay culture becomes complicit in reproducing loneliness by enabling *'pervasive drug use',* rather than encouraging productive ways of 'shaking it off' (akin to delegitimising someone's experience of depression by suggesting they 'snap out of it'). Critically, *'avoiding those realities'* implies that study participants are, in fact, *'alone, unacceptable and unloved'* and that drug-enhanced sociality is a futile way of addressing these negativities. The underlying notion is that as individuals, GBM might not become 'risky' if left to their own devices and internal motivations, but collectively they form communities that promote and practise risk.

A cross-sectional study of alcohol and drug use among urban MSM contends that *'it is drug rather than alcohol use that most distinguishes MSM substance use patterns'*. In addition to supporting associations between traumatic experiences, depression and substance use reported elsewhere, GBM participants' social and sexual practices are represented as consistently determining *'heavy or problematic'* substance use. While cautioning against the design limitations for understanding causality, the authors conclude:

> *An understanding of heavy or problematic substance use among MSM requires an understanding of MSM sexual cultures, perhaps as an expression of a conjoined 'high-risk' or 'sensation-seeking' life-style.* (Stall et al., 2001)

Depression and 'sensation-seeking' are not unique to GBM. In suggesting that GBM-specific sexual cultures are critical to the aetiology of problematic drug use and insinuating the link is a lifestyle of excess, a conflation fallacy construes problematic drug use among GBM as extraordinary and inextricably linked to GBM sexual cultures. Arguably, such generalisations are typical for this genre, because quantitative approaches tend to decontextualise individual behaviours in their data collection and analysis, only to then recontextualise findings that confirm conventional wisdom and unconscious biases. (It should also be noted that authors highlight that gay community affiliation is protective against harmful alcohol use.)

Generalising is common even in the selected qualitative papers, which are usually regarded as providing better context for behaviours and 'giving voice' to research subjects (Jack, 2010). The following extract proposes that some GBM's selfishness is not a trait, but a habit made possible by a shared culture of avoiding responsibility for others:

> *The anonymity of [Public Sex Environments] buffers individuals from full responsibility and accountability toward their sexual partners. Participants tacitly signed onto the social contract that states the primary responsibility to disclose HIV status is placed on the sexual partner. Many claimed to operate from the assumption that people are responsible for their own bodies, and that feelings of responsibility toward another are not obligatory.* (Reback et al., 2004)

Interestingly, by referring to a 'social contract', the authors employ a moral and political discourse to infer moral culpability in GBM who engage with these cultures. Going further, Kurtz problematises the '*strong focus on physical appearance and sexual performance [which] is destructive of men's self-esteem, intimate relationships and enjoyment of a wide range of life activities'* permeating the gay community in Miami, and concludes:

> … *the sex-on-crystal subculture reveals more fully what the circuit party subculture was better able to hide – that many gay men feel isolated, often use drugs in an attempt to bond with others, and find that connectedness and intimacy remain elusive.* (Kurtz, 2005)

GBM's subcultures are thus implicated as part of the research 'problem' being investigated.

More recently, in Australia, Roxburgh et al. (2016) argued that substance use disparities are in part due to a *'different set of shared values, including a "normalisation" of substance use within LGBTI communities'* (p. 76). Similarly, in Europe, Sewell et al. (2017) instrumentalise cultural mechanisms to make their point:

> *The 'gay scene' … can represent a culturally endorsed 'time-out' from stresses common to the gay community (and other sexual minority men). Drug use often plays a key role in escaping self-awareness of social and sexual norms. For many men, the 'scene' is an important social nexus (Crowe & George, 1989; McKirnan, Ostrow, & Hope, 1996) where gay sexuality is sanctioned and celebrated.*

Here, a noticeable change in discourse positions gay sexuality not only as permissible ('sanctioned') but something to be proud of ('celebrated'). Nonetheless, in positing that gay communities abide by alien norms and distinct value systems, and integrating notions of escapism and maladjustment, discourses of non-conformity and othering persist.

The 'scene' is also central to an Australian study of gay venue attendance and associations with substance use among same-sex attracted young people. Due to the social and psychological stressors related to sexual minority group membership, Lea et al. suggest, *'the social world of same-sex attracted people [is] largely situated in venues of the lesbian and gay scene'*. To the authors (and – seemingly – their intended audience), it is unquestionable that such venues propagate substance use:

> … *it is unsurprising that substance use is often considered a central feature of lesbian and gay sociality across the developed world.* (Lea et al., 2013)

This paper exhibits a more consistent focus on harmful societal processes that produce social isolation of sexual minorities. In contrast with other publications' implicit criticism of GBM who use drugs, here *society* has negative attributes (hostility, judgment):

> … *the lesbian and gay scene has traditionally functioned as a space for same-sex attracted people to congregate without fears of judgment and hostility from wider society.* (Lea et al., 2013)

Yet, the authors proceed to suggest that this safety causes young GBM to feel more comfortable in *'letting go'*, and that this enables drug use - demonstrating the difficulty of a complete departure from dominant interpretive frameworks. The 'problem' of elevated drug use among non-hetero-identifying individuals is therefore not only born from society's heteronormativity and hostility, but from GBM's regular engagement with the 'scene', which catalyses drug use.

While discourses that move *beyond the individual* have explanatory power and are less centred on individual deficits, some consequences of these discursive formations must be noted. The 'normalisation' of substance use becomes interpretable as a negative social process, and the 'scene' (despite being a safe space for GBM) is portrayed as unequivocally contributing to health disparities by enabling disinhibition and risk. The reader is led to understand that gay community affiliation perpetuates risk and compromises the health (and conduct) of GBM.

(3) Counterdiscursive movements

Discourse is influenced by intertextuality (Fairclough, 1992), context-dependent, and bound by time and space. *Counterdiscursive movements* disrupt hegemonic discourses on the causes and conse-

quences of drug use, thus enabling alternative responses to the research 'problem'.

Much has changed since the HIV epidemic began (Granich et al., 2010) and in the harm reduction and advocacy space (Rhodes, 1997, 2009). As the accessibility and effectiveness of HIV treatment and biomedical prevention have increased, improving prospects for people with HIV (Bor et al., 2021), as societal attitudes towards drug use have liberalised (Nielsen, 2010), and as same-sex relationships have become increasingly normalised, so too have discourses evolved in their conceptualisations of gay communities, drugs, sex and sociality (Bryant et al., 2018).

The transformation of previously generalising discourses that profile GBM as inherently risky or dispositioned to excess (as exemplified by 'problematic' drug use) are examples of *counterdiscursive movements*. Attempts to disrupt this interpretive repertoire have focused on differentiating between strata, segments and subcultures of the gay community. For instance, an Australian study (Prestage et al., 2007) cautions that only 'aspects' of the gay community foster higher rates of drug use:

> *Involvement in 'sexually adventurous' subcultures and sexual networks … may be an important factor in understanding risk among certain gay men.* [These subcultures] *may play a key role in unsettling some men's usual practice of safe sex, and may also encourage heavier use of illicit drugs.*

Here, several linguistic choices function to create nuance and weaken the claim to truth. Firstly, the modal word 'may' (in contrast to previously highlighted adverbs like 'clearly') permits alternative interpretations or truths. Furthermore, the authors limit their argument to 'certain' or 'some' gay men, rather than a collective concept of gay community. Finally, they contextualise their findings about associations between drug use and sexual risk with men's 'usual practice of safe sex', characterising GBM's sexual lives as predominantly 'safe'. It is a 'sexually adventurous' subculture, not the individual per se, from which heavy drug use and accelerating HIV incidence rates emerge.

Such nuancing is helpful in disrupting previously established stereotypes. However, increasing fragmentation and delineation of 'high-risk' groups into smaller outgroups may contribute to alienation and, ultimately, intragroup stigma (Stephan, 1977; Stephan & Stephan, 1996) and dividing GBM who conform to societal values and those who continue to lead 'maladapted' lives.

Counterdiscursive movements are effective in contextualising and relativising GBM's drug use and sexual risk by exploring situational characteristics. Subject positions within these discourses afford GBM agency to make choices about their health and lives that other dominant discourses preclude:

> *Although many aspects of substance use are unhealthy, these decisions reflect the participants' concerns about maintaining their health even while engaging in harmful activities.* (Reback et al., 2003)

Other texts emphasise that high prevalence of drug use does not imply high levels of 'dysfunctional' use (Cochran et al., 2004). Counterdiscourses on resilience, pleasure, connection, and (self-)care are also traceable in the reviewed studies (Lea et al., 2013; Melendez-Torres et al., 2016; Minichiello et al., 2003; Pitpitan et al., 2016; Reback et al., 2004) but more common in sociology-based publications not reviewed here (Race et al., 2016; Race et al., 2021). Notably, it is not uncommon for multiple and sometimes conflicting discursive formations to be circulating within the same text. Within our sampled literature, positively connotated sentiments and concepts were often overshadowed by their context, chiefly hazardous drug use and sexual risk-taking:

> *There is evidence in this study that illicit drug use and risky sexual behaviours are associated with one another via the search for sexual pleasure, and that sexual risk behaviour, particularly within certain gay community subcultures, also predicts the escalation of illicit drug use.* (Prestage et al., 2007)

This extract falls just short of granting the *'search for sexual pleasure'* intrinsic value and construing drug use as a rational, pleasure-based pursuit. Instead, associating it with *'sexual risk behaviour'* and an *'escalation'* of illicit drug use reminds the reader that hedonism – at least, if linked to debauchery – is devalued in our societies. Interestingly, within this single utterance is an obvious hierarchy of acceptability, whereby sexual pleasure is permissible while an 'escalation' of illicit drug use (for whatever reason, and whatever that entails) is not.

Similarly effective in relativising drug use, a study conducted in 38 European countries highlights that drug use and sexual practices are unrelated at the population level, disrupting historical notions of homosexuality as distinctly related to substance use (Israelstam & Lambert, 1983):

> *… that city of residence is so strongly associated with drug use should point us towards structural drivers for drug use and hence structural interventions, rather than solely psychological explanations and psychotherapeutic interventions, if we wish to change drug use patterns at the level of populations of MSM.* (Schmidt et al., 2016)

Addressing the audience with an inclusive 'us' and 'we' removes the barrier between expert and audience; truth becomes something owned and observed by society as opposed to a matter uncovered by research alone. Paired with the word 'should', this excerpt produces an immediate call to action amongst the research community and society at large. The desired outcome remains a change in drug use patterns among GBM populations, but GBM are not blamed for undesirable patterns, but societal structures that disproportionately affect GBM. Furthermore, this extract subtly but skilfully criticises the dominant tendency to individualise and pathologise drug use among GBM.

Within such counterdiscourse, wellbeing interventions operating on societal-level conditions become possible, even mandatory. Traditional health promotion seeks to improve self-regulation among GBM by equipping them with sufficient knowledge to reduce sexual and drug risks (Herbst et al., 2005; Huan et al., 2013). Although many research rationales instrumentalise social exclusion processes (e.g. homophobia, stigmatisation, discrimination) as causes of harmful drug use, the health promotion *practices* enabled by academic discourse are focused on behaviour change in affected individuals (Golden & Earp, 2012), thus alleviating the need for society and non-GBM-identifying individuals to alter their attitudes and behaviours towards sexual minorities. Some exceptions include Mustanski et al. (2017), who concentrate on the immediate social environment and call for interventions that increase parental acceptance of homo- and bisexuality to improve wellbeing trajectories. Similarly, Leliutu-Weinberger et al. (2013) quote prior research that identified improvements in social policies toward sexual minorities to predict mental health betterment in gay/bisexual men, suggesting that facilitating connectedness is an important avenue for HIV prevention efforts.

Discussion

We conducted a critical analysis of discourses instantiated in 60 highly cited public health research papers on drug use among GBM, focusing on the interpretive repertoires employed and the subject positions made available. We identified discourses that construct GBM as a *target population* for intervention by attributing select characteristics to GBM who use drugs, and to GBM and their communities at large. Subject positions profile drug-using GBM as multiply deficient and exhibiting psychopathologies; displaying maladaptation to the reality of being gay in a heteronormative world; and inherently hedonistic, delusional, and lacking essential qualities of responsible citizenship. Within HIV prevention frameworks, such discourses associate drug use with impulsivity, disinhibition and lack of self-control, and portray GBM who use drugs as untrustworthy and a threat to others and themselves. Similarly, drug use is itself construed as a morbidity, caused by stressors of belonging to an identifiable minority in a homonegative society. 'Drugs-

as-escapism' is a popular interpretive repertoire that supposes an inability to conform to responsible citizenship (Weber, 1930; Karasaki et al., 2013). GBM who use drugs and/or engage in 'risky' sex practices (with variability of 'risk' definitions ranging from oral sex without a dam to fisting without gloves) are thus part blamed, part pitied and always 'othered' (Stephan, 1977).

Alternatively, drugs are construed as having distinctive, agentic qualities with effects felt far beyond the individual consumer and the consumption event. Of these, methamphetamine is typically described as particularly dangerous to GBM because it overrides personal volition to consider HIV risks and perform health behaviours prescribed by public health advice. In encouraging GBM to give in to their sexual urges and disrupting any sense of responsibility for sexual partners, methamphetamine is made directly responsible for perpetuating the HIV epidemic. Previous analyses of the association between methamphetamine use and risky sex as interpreted in mainstream public health literature observe that their directionality and nature has been assumed rather than specifically investigated (see e.g. Bryant et al. 2018; (Hopwood, Cama, & Treloar, 2016; Race et al. 2016). This 'drugs-as-malevolent-agent' discourse is thus a relic of intertextuality, drawing on and advancing existing cultural and political narratives surrounding drugs and their effects (Bryant et al., 2018; (Race, 2009). Elsewhere, it is identified as an instrumental strategy in the US-led 'war on drugs' for its effectiveness in eliciting socio-political practices of policing and punishment (Herzog, 2016; Tupper, 2012).

In terms of public health interventions, even publications that identify societal factors such as inequity and stigma as the underlying causes of negative (health) outcomes largely deflect the responsibility for harm reduction away from society onto affected individuals. The practices made possible through such discourse involve equipping drug-using GBM with the tools to improve self-regulation and self-efficacy, and to ultimately achieve abstinence from drugs or 'risky' sex. Thus-targeted individuals are called to conform to expert advice, based on evidence that has been 'made' (Rhodes & Lancaster, 2019) within the logics of dominant social norms and moralism.

We do not deny the validity of the research findings, but highlight the narratives that imbue these findings with meaning. Here, the tendency to decontextualise individual behaviours at data collection and analysis only to then recontextualise findings based on conventional wisdom and unconscious biases is critical, including for its contribution to the studied social practices. As Race (2009) notes:

> *'what drugs "do" is an effect in part of the cultural narratives we have around drugs – narratives that are reproduced in scientific discourse'. (Race, 2009, p.175)*

Scientific assessments of 'good' and 'bad' behaviours carry (and entail) a moral judgment of the people and behaviours under study. The reviewed discourses on 'target populations' indicate that individuals are free to follow their personal desires, so long as these desires represent socially sanctioned behaviours and acceptable notions of pleasure – which exclude pleasures achieved through drug use. Where personal desires are non-conforming and surpass conservative ideals of moderation, the right to self-expression – ordinarily promoted and valorised in neoliberal societies (such as the USA (Emerson, 1963), where most studies originated) – becomes a transgression of citizenship (Race et al., 2016).

Othering of GBM communities occurred by highlighting their alien norms and values. While discourses described the gay community space as safe for GBM to be themselves – thus absorbing some of the negative effects of homophobia experienced elsewhere – the pervasiveness of drug use 'perpetuated' within these communities was highlighted as unsafe, and undesirable. Likewise, discourses represented gay culture as lacking in depth, and failing to provide gay or bisexual individuals with the connection they craved and the protection needed to mitigate risk of drug use. Such discourses mirrored a shift in health promotion research away from individualising/behaviourist approaches towards models of social ecology (Golden & Earp, 2012) centring on GBM's social lives. Our analysis found that othering occurred here by distinguishing GBM's approach to sociality as being based around sex, drugs, bars and places of leisure. These are devalued in heteronormative societies, and while discourses highlight their centrality to GBM identities, positive attributes are typically eclipsed by negatively connotated, moralising evaluations of this phenomenon. Unequivocally, drug use is framed as demanding monitoring, surveillance and timely intervention.

Finally, counterdiscursive movements provide more positive viewpoints of the motivators and consequences of drug use among GBM, including community, care, connection, pleasure and resilience. Such discourses are characterised by critical engagement with previous research findings (even though uncritical perpetuation of 'truth' is more typical); the promotion of emic perspectives through giving voice to participants; and removal of expert–audience barriers. Importantly, this discourse affords agency and 'normalcy' to individuals who might engage in behaviours elsewhere defined as esoteric, adventurous or deviant – thus moderating social exclusion processes. Employing counterdiscourse shifts the weight of responsibility away from the study populations onto society. It demands public health policy considers broader societal interventions to mitigate marginalisation instead of furthering social exclusion by promoting individualised risk management.

Our claim is not that public health researchers aimed to manipulate the meanings of drug use and gay sexuality to serve their own ends. Instead, we suggest that the ways in which authors use language to conceptualise GBM and interpret their relationship with drugs are effects of wider socio-political discourses, as well as of a particular genre of discourse formation influenced heavily by intertextuality (Fairclough, 1992). In this regard, it is important to reiterate the context in which much of this literature emerged, which may explain their high citation counts; namely, that HIV exceptionalism (i.e. the Western response to the originally terrifying and lethal nature of the virus that disproportionately affected specific groups) had mobilised huge investment in HIV research (Smith & Whiteside, 2010) that supported many of the studies described in our sampled publications. Hence, the examined discourses are shaped by the moralised climate surrounding ongoing HIV transmission among GBM (Race, 2009) and the various theoretical frameworks influencing addiction research, policy, and service provision (including cognitive-behavioural, psychological, psychoanalytical, biomedical, social, and biopsychological models), across which individual responsibility remains a contentious issue (Karasaki et al., 2013).

Implications

Our discourse analysis does not suggest that drug use is harmless, or that GBM are not socially excluded and affected by homophobia and minority stress. However, we contend that the prevailing discourses stereotype GBM and may foster prejudice against GBM who use drugs – particularly when drugs are used in the context of sex – and drive inappropriate or ineffective responses that are based on erroneous assumptions about the antecedents or consequences. Likewise, although research on GBM population health has long abandoned the view that non-heterosexual orientation is in itself pathological and causative of substance use disorders (Israelstam & Lambert, 1983), the exceptionalism ascribed to GBM relative to substance use in our data begs the question of whether, unconsciously, such biases have been inherited. If clinical practice and educational material for harm reduction continues to be informed by a narrow focus on risk and negative health outcomes, even well-intended discourses can become alienating (or as Roe (2005) puts it: 'Is better than bad good enough?'). People engaging with such educational material might consider it overly negative and irrelevant to their experience (Moore, 2008) and thus dismiss attempts to preserve wellbeing based on expert advice.

The discourses we identified are evidence of ideological hegemonies, because GBM – especially if using drugs – remain othered in a society that promotes conformity to the 'social order' through exercising productivity, rationality and sexual inhibition. Discourses are impor-

tant tools for 'governing at a distance' (Pienaar et al., 2018; Rose & Miller, 1992) by censoring self-expression and shaming those who use the dangerous drugs people had been warned against, whilst contributing little to disrupting HIV stigma.

Understanding how dominant discourses of pathology, deprivation and maladaptation evolved does not imply that the lived experience of GBM (whether they use drugs in harmful ways or not) is any less compelling or worthy of consideration. However, it does invite attention to the ideological contractions of public health discourse which advocate for equity and social justice whilst negating the 'social' in matters of justice by rendering individuals responsible for 'their own' risk. On the one hand, there is a humane warrant for social inclusion, the provision of equitable health care and social services, and critique of societal practices that valorise certain social identities over others. On the other hand, the positioning of drugs as malevolent agents that cause HIV transmission, and calling for treatment of substance use as a form of HIV prevention (Parsons & Bimbi, 2007; Shoptaw et al., 1998), legitimise repressive drug policies.

Debates about politicisation of the sexual lives of GBM exist (Race et al., 2016; Race, 2003). While the public health community continue to strive for evidence-based health and the rational use of evidence to inform policymaking (Parkhurst, 2017; Smith, 2013), greater acknowledgement of the creative and interpretive processes involved in the making and narration of such evidence is needed (Kippax & Stephenson, 2005). Generating compelling evidence through a rigorous, scientific process (involving triangular methods, sound theorising and openness to re-interpretation), can assist in challenging prevailing moral and scientific orthodoxies instrumentalised in these debates (Race, 2018). Discourses are powerful political tools because they assist in defining the nature of a social 'problem' and justifying an 'appropriate' response (Herzog, 2016). Due to the relative power bestowed upon academia as a site of knowledge generation, legitimate expertise and truth, its texts can effectively transform historical texts and restructure existing conventions (genres, discourses) to generate new ones. This paper is a conscious attempt to apply and advocate for more reflexivity in research data description and knowledge dissemination practices. Importantly, we caution against the reproduction of unconscious biases by relying too heavily on conventional wisdom and cultural narratives as interpretive repertoires.

Discourses can undergo substantial transformations in a relatively short time. We identified some such transformations in our analysis, including shifting the focus away from individual deficits and drugs-as-disease discourses towards socio-cultural context and an acknowledgement of the diversity of sociocultural norms and value systems that influence human behaviour. In recent years a strong shift towards destigmatising population health research has occurred, for example, by promoting person-centred language (in the case of people with disabilities (Nicks et al., 2022), people who use drugs (Traxler et al., 2021) and people in contact with the criminal justice system (Harney et al., 2022)) to reduce stigmatisation and marginalisation (Christiansen & Ebscohost, 2020). This gives hope for disruption of discursive echo-chambers that may generate more holistic and considered conceptions of drug use among GBM. However, as our analysis shows, it is not just words that perpetuate stigmatising notions, but rhetoric and discursive formations taken together.

In addition to moves towards inclusive language in research, our findings highlight the need for more deliberation in the use of language to constitute realities. Representing knowledge as uncontested truths is misleading and may exacerbate the distress experienced by people classified as pathological due to their drug use. The research community must make a collective and conscious effort to continue to change the way we describe 'facts' and problematise our research areas, which could make a sustainable difference in minority communities' social standing.

We acknowledge the difficulties of disrupting discourse, which can mean professional isolation, less likelihood of publication in more conservative (often prestigious and high-impact) journals, and reducing the chances of support from major funding bodies. These difficulties highlight the need for a sustained, collaborative approach to discourse generation in research.

Ultimately, it is our hope that marginalised typologies of human behaviour are no longer considered and written about as abnormalities, but rather as varying expressions of the human condition. By continuing to recognise, articulate and critique biases in research development and dissemination, public health researchers can become more accountable towards the externalities produced by their discourses (Ayo, 2012). In acknowledging that research is inherently political (Parkhurst, 2017), the academy can recommit to a values-based pursuit of public health as a social good (Friedli, 2013; Nurit Guttman, 2001).

Limitations

Our specific claims and insights are limited to the particularities of the analysed texts, and we do not make claims about discourse in other publications directly. We do believe, however, that aspects of this work are broadly generalisable to other publications or public health texts on substance use and sexual minorities, to the degree that they are discursively alike and ideologically aligned.

In our selection of illustrative quotes, we demonstrate commonalities or particularly noteworthy utterances from across predefined categories and sub-categories. As discussed previously, we are not implying that the selected extracts represent conscious lexical choices to achieve a particular ideological end. We concede that these excerpts and our interpretations thereof might be considered extreme, but they align with our critical research paradigm. It is important to reflect on these utterances not just as isolated incidents but as part of emergent patterns, because collectively, their othering effects become salient.

Conclusion

Researchers' expert role holds tremendous power. In defining a target population and their risks and harms, the publications reviewed in our critical analysis present evidence in a way that shapes the lives of research participants and their constituent populations. As our analysis demonstrates, stereotyping and othering exist in influential public health texts, representing behaviours as gay-specific and interpreting drug use as an extraordinary and generalisable health threat. Understanding how the dominance of discourses of pathology, deprivation and maladaptation occurred does not imply that the lived experience of GBM experiencing harms associated with substance use is any less compelling, nor do we deny the reality that drug use can have adverse individual and community health outcomes. Our findings invite attention to academic discourse and its ideological elements, and to interventions that valorise certain social identities over others.

Ethics approval

The authors declare that the work reported herein did not require ethics approval because it did not involve animal or human participation.

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