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Publication Date

2013

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UNIVERSITY OF CALIFORNIA, SAN DIEGO

**Risky Subjectivity:
The Effects of Cultural Discourses of Addiction on
Methamphetamine Using HIV+ Men Who Have Sex with Men in San Diego**

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy

in

Anthropology

by

Theodore Karwoski Gideonse

Committee in charge:

Professor Janis H. Jenkins, Chair
Professor Suzanne Brenner
Professor Norman Bryson
Professor Steven Parish
Professor Thomas Patterson
Professor Nancy G. Postero

2013

The Dissertation of Theodore Karwoski Gideonse is approved, and it is acceptable
in quality and form for publication on microfilm and electronically:

Chair

University of California, San Diego

2013

Dedication

This dissertation is dedicated to the man who in the text I call Sam.

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Acknowledgements

The research and writing of this dissertation has been the most rewarding intellectual experience of my life, and it would not have been possible without the intellectual, moral, and practical support of a community of scholars, friends, and family.

The members of my committee provided me with the tools I needed to develop a theoretical position, formulate an ethnographic project, and perform the research, and then go about the strange process of turning all that into something resembling a book. My chair, Prof. Janis Jenkins provides me with the theories, approaches, and concerns that inspired this project. She gave me the light bulb that appeared over my head and blinked on in 2008 when I figured out what I wanted, and needed, to write about. That light bulb is still shining. Prof. Nancy Postero guided me back into the field of anthropology after 10 years away, giving me a political and moral understanding of the discipline that I had not appreciated or understood. Prof. Suzanne Brenner, over many hours in the homes of many of San Diego's gay couples, taught me how to do fieldwork and to think like an ethnographer. Prof. Steve Parish helped me to transform my journalistic skills into anthropological methods, and his encouragement of this project and my work helped me to believe that I might actually be doing something worthwhile.

If I had not met Prof. Tom Patterson, I doubt I would have done this particular project, and I also doubt that I would have had such wonderful, enlightening conversations about its specificities, oddities, and importance. And finally, the last addition to my committee, Prof. Norman Bryson, will always be the teacher who now 20 years ago assigned me Foucault for the first time, changing not only my interpretation of art and literature at the time, but eventually my entire understanding of the world and

how it works. It is wonderful that I am able to end my formal academic career with the person who helped spark it two decades ago.

Several other professors have been very important. Two former committee members provides needed assistance early on. Prof. Elisa Sobo helped me to understand the massive literature on the anthropology of AIDS, while Prof. Meg Wesling gave much needed bureaucratic help at the most important moment. Prof. Keith McNeil, who was one of my master's thesis advisers, was the person who introduced me to psychological anthropology, which, honestly and wonderfully, changed my life. I also filled my intellectual toolbox in the particularly enlightening classes of Professors Elana Zilberg, Joe Hankins, and Tom Csordas at UCSD, as well as in classes at Harvard taught by Professors Byron Good, Arthur Kleinman, Salmaan Keshavjee, Kaila Compton, and William Fisher.

Of course, if not for my junior colleagues, in the Department of Anthropology, in other UCSD departments, and at other institutions, I would have been lost. In particular, I single out the other medical and psychological anthropology students Whitney Duncan, Charlotte van den Hout, Allen Tran, Bridget Haas, and Jess Novak. The advice of Eli Elinoff (particularly), Julia Klimova, and Erica Fontana in the department's dissertation practicum was invaluable. I do not think I would have survived graduate school without the love, humor, and friendship, and brilliant scholarship of Jason Farr, Dr. Eun Jung Park, and Dr. Marion Wilson. Prof. Adia Benton has never wavered in her support of me and my work since we met in a panel at the meetings of the American Anthropology Association in 2008. And Dr. Timothy McCajor Hall has encouraged me since 1993. Dr. Alison Miller, my dissertation coach, taught me how to work.

Edward De Anda, my research assistant during a key 18 months of the project and now a PhD student in clinical psychology, provided needed help transcribing interviews, managing the flood of research, and providing a soundboard for me initial analyses. Later in the process, four of my best students at UCSD provided needed help: David Lam, Timothy Sargis, Sairah Khan, and Janelle Brown. Thank you.

None of this would have happened without my family. My partner Dr. Hank Green, who has had to suffer the most arduous parts of this process, has championed me and my work all over the world while also challenging me to learn how to describe my analysis in ways that other disciplines can understand. My brother Hendrik has been on the other side of some of my most profound discussions about addiction. My ex-husband Rob Williams encouraged and joined me for the first six years of the process. And my parents, Drs. Hendrik and Sarah Gideonse, not only made it possible for me to do the research, but they also raised me to be curious, moral, loving, and honest. I did it by watching you.

And finally, I owe a debt of gratitude to my informants, from the men in my central sample who told me their life stories to the people in the apparatus who gave me their time and energy when they certainly did not have to.

Vita

Education

- 1996 BA in Social Anthropology, Harvard University
- 2005 MFA in Creative Writing, The New School University
- 2007 MA in Anthropology, University of California, San Diego
- 2013 PhD in Anthropology, University of California, San Diego

Employment

- 1997-1999 Reporter-Researcher, *Newsweek*
- 2002-2005 Literary Agent, Ann Rittenberg Literary Agency, Inc.
- 2002-2005 Instructor, Gotham Writers' Workshop
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Selected Writing

Books and Monographs:

- Bad Things Happens to Bad People: Stories*. MFA Thesis. Department of Creative Writing, The New School University, 2005.
- From Boys to Men: Gay Men Write About Growing Up*. Edited with Rob Williams. New York: Carroll & Graf, 2006.
- Hybridity as Cultural Capital on the US/Mexican Border*. MA Thesis. Department of Anthropology, University of California, San Diego, 2007.

Academic book reviews:

“The Anthropology of AIDS: A Global Perspective by Patricia Whelehan,” *Medical Anthropology Quarterly*, March, 2010, pp. 133-135.

Conference papers:

“‘Yes, I’m a practicing homosexual. And practice makes perfect!’: imagining, narrating, and constructing gay male identity,” presented at the meeting of the Society for Psychological Anthropology, March 10, 2007.

“‘If you don't like the fact that I am POZ, hold on and I'll change profiles’: Identifying as HIV+ on the Internet in San Diego,” presented at the meeting of the American Anthropological Association, November 23, 2008. Revised version presented at Dialogues in Sexuality Studies, University of California, San Diego, February 23, 2009.

“‘But are you going to do meth, too?’ Empathy, Ethics, and Epiphanies in Insider Ethnography,” presented at the meeting of the American Anthropological Association, November 19, 2010. Draft version presented at UCSD-UCLA Conference and Workshop Series on Culture and Mind, University of California, San Diego, October 22, 2010.

“Shame and Pride and Addiction and Recovery under American Neoliberalism,” presented at the meeting of the Society for Psychological Anthropology, April 1, 2011.

“Meth and Moral Communities in San Diego,” presented at the meeting of the American Anthropological Association, November 16, 2011.

“Productive Members of Society: Tactics and Strategies of HIV+ MSM Who Use Meth in San Diego,” presented at the meeting of the American Anthropological Association, November 18, 2012.

“Narrating the Psychopathology of Meth Addiction,” presented at the meeting of the Society for Psychological Anthropology, April 5, 2013.

Abstract of the Dissertation

Risky Subjectivity:
The Effects of Cultural Discourses of Addiction on
Methamphetamine Using HIV+ Men Who Have Sex with Men in San Diego

by

Theodore Karwoski Gideonse

Doctor of Philosophy in Anthropology

University of California, San Diego, 2013

Prof. Janis H. Jenkins, Chair

Methamphetamine use and HIV disease are large and intertwined problems in American gay communities. This is particularly so in San Diego, where both meth and HIV have been endemic for three decades. Because meth use is associated with not just the spread of HIV and other STDs, but also with petty and violent crime, the public health and law enforcement agencies have responded with substantial, but sometimes ineffective efforts. The effects of these efforts on meth-using HIV+ men who have sex with men (MSM) have been studied in hundreds of publications, but little of it is qualitative, and rarely in the literature are political and economic forces discussed, except in relation to demographic categorizations of study participants. Thus an examination of the subjectivities of men in three major HIV risk categories – HIV+, MSM, meth using – helps to understand their experiences and the results of the institutional response to their problems. After doing 14 person-centered ethnographies of HIV+ MSM who use meth

and spending two years doing participant observation in the institutions charged with focusing on this population, I have concluded that the efforts to stop HIV infection and meth addiction among gay men has had an unintended consequence: the social abandonment of HIV+ meth addicted MSM to an underfunded, ineffective, but mostly well-meaning healthcare system, in addition to a moralistic, hostile, and deeply flawed law enforcement system the goals of which are at odds with the health of addicts and the results of which are at odds with both public safety and law enforcement. This is neither the fault of the addict nor the fault of the institutional response, but rather a complex and chaotic interaction between destructive behavior of the addicts and a morally confused, haphazard, and under-funded neoliberal collection of organizations that comprise anti-meth apparatus. The subjectivities of these men have been constructed in a fraught environment of pity, anger, fear, and loathing, which has led them to a lived experience of suffering and constant struggle.

Introduction:

Problems, Questions, Claims, Theories, Methods

I first met Sam when an outreach worker at the clean syringe exchange in San Diego introduced us. Leo, the outreach worker, knew that I was looking for subjects for my dissertation research, and Sam fit the parameters: he was HIV+, used methamphetamines, and was a man who had sex with men. Leo pointed him out on a bright sunny Friday morning in June, a few months after I had started volunteering at the exchange. Sam was wearing cargo shorts and a baggy blue t-shirt that, up close, I could see was stained and smudged with dirt. He had blue eyes and a receding blond hairline that was cut close to his skull, and he had the crisp, slightly wrinkled skin of many fair Southern Californians in their 40s. But he also had the random sores and scratches and the dilated pupils and shifting gait of the men and women I'd see in the neighborhood who I assumed were homeless and either addicted to something or suffering from mental illness, or both. When Sam spoke to me in the mumbling, somewhat distracted fashion that I became used to over the next year and half, I could see that one of his upper front teeth was dead, a brownish-gray piece of calcium and enamel that seemed to hang by a precarious piece of gum; I often thought it would fall out during one of the numerous time we talked.

I briefly explained my research project, that I was studying HIV+ men who have sex with men and use meth, that I was interested in his life story. He nodded and muttered in the affirmative. I told him that I would pay him \$15 an hour to talk to me

about his life, that I would like to do seven or eight interviews over several months.

“If I talked to you for two hours at once, can I make \$30?” he asked.

“No,” I said, “that’s not how I’ve set it up.”

“Okay, where will we do this?”

“Well, you can come to the office I have downtown or I can come to your home.

Where are you living right now?”

“I have a home!” he said indignantly. After a pause, he added, “But it’s a mess. You don’t want to come there.”

I gave him the address of my office and made a plan to meet him the upcoming Monday. I thanked him, and he grunted a “You’re welcome” as he put his arms through his backpack straps. As he walked up the street, I thanked Leo, who told me that Sam had an interested story. Unfortunately, I did not get to hear the story for a while. He did not show up for the interview, and he did not show up when we rescheduled. The third time, he did show up, and he was a half hour late. By this point, I had started interviewing seven or eight other men, and I was used to active addicts being late or otherwise erratic. And when he was in my office, he gave perhaps the most trying interviews. Much of this had to do with his mumbling, which I initially thought was caused by his inebriation; but after I spent time with him when he was sober, I discovered he is just a mumblor. The other problem was that when he was high, which he was for the first five interviews I did with him, he had difficulty focusing on answering my questions or completing a story in a linear fashion. During one interview, I prompted him three times, and he talked for an hour about everything from his mother’s death and stealing money from his father to

witnessing a murder in a residence hotel and his frustration with the terrible quality of meth right now.

In addition to the half dozen interviews we did, I saw Sam every week at the syringe exchange, and Sam grew to trust and to like me. And I grew to like him, to appreciate him as something more than an extremely interesting research subject. Even though he had spent many years incarcerated and had been homeless off and on for two decades, both which seem to harden most people, Sam was surprisingly empathic, a trait that not only was clear during our conversations but also in his dealing with other addicts and homeless people. We became friends, and when he was sent to jail the spring after I met him, I was one of the two people who ever visited him, and the only one who visited him more than once.

While he was in jail for being under the influence of a controlled substance (which he could have avoided if he had completed a recovery program), he was placed in the psych ward because of his dual diagnosis of HIV and addiction, and because of his long history of mental illness. I was relieved, because while the psych ward sees its share of outbursts and disruptions, it is nothing like being in the general population in jails and prisons in California, which the participants in my study all claimed are rife with race-based gang violence. Sam was able to have time to read, to make friends, to think, and to write letters; he sent me over 60 pages of hand-written notes in the three months he was in jail's psych ward.

In these letters, Sam repeated several of the stories he told me in our interviews from the summer before. But he did not remember telling me because he was high. His letters were also full of descriptions about books he was reading and what he wanted to

do when he was released; he wanted to go to a recovery program, he wanted to work as a tow driver again, he wanted to get over his ex-lover Michael, he wanted to have a normal life, where he could go to the movies and out to eat and have friends who do not live in a canyon and spend their life looking for drugs. I encouraged him. I put in a good word with the director of a recovery program, and I asked a case manager who knew him to write to him. When he was released, he was accepted into a sober living job training program in a bleak industrial section of the southern suburbs of the city. A few days after he arrived there, I visited and gave him a few books I thought he would like. He was thrilled to see me, and I was happy to see him sober and headed towards both the physical and existential places he had written to me about.

A week later, I was checking in clients at the syringe exchange when I saw Sam walking down the street towards the camper out of which we operate the syringe exchange. I said to one of my co-workers, "I wonder why Sam is here." I went to greet him, and the look on his face could only be described as shame.

"I couldn't do it," he said. "I left the program on Sunday, and I'm back in the canyon."

"Oh," I said. "Okay." My face belied my feelings: surprised, sad, angry.

"It was too hard. It wasn't right."

"It's okay," I said. "You can't beat yourself up about it. You weren't getting the help you need."

"I only feel awful because I'm telling you."

"Please don't."

When he went into the camper, I swore. When he was done in the camper, we spoke briefly again and I told him that I would see him the following week. I was cold; I was angry, disappointed, embarrassed, upset, and Sam could tell, making him more ashamed. Two hours later, I was sitting in a restaurant two blocks away, having a beer with two friends and sitting by an open window. Outside, Sam walked down the sidewalk and past the window, catching my eye for less than a second and then looking away. His shame made me ashamed of my position, literally sitting above him and looking down.

The problem

This was the most profound moment of intersubjectivity that I experienced during my fieldwork. In the year and half I had been doing participant observation at various HIV and drug abuse prevention organizations, working two days a week at the largest agency, I had been subsumed into their culture¹, and with Sam, I had done what I was critiquing: I had made him feel shame, I had compounded his suffering, simply by encouraging a pathway he was unprepared to take, a pathway cluttered with roadblocks set up by what I came to call the anti-meth apparatus. Stigma itself is intersubjective, “produced and experienced in the interactive spaces between individuals in culturally defined social worlds” (Jenkins and Carpenter-Song 2008:382), and I had become part of the problem. Sam’s “failure” to become and remain a sober and productive member of

¹ I use Jenkins’s definition of culture as “a context of more or less known symbols and meanings that persons dynamically create and re-create for themselves in the process of social interaction. Culture is thus the orientation of a people’s way of feeling, thinking, and being in the world—their unself-conscious medium of experience, interpretation, and action. As a context, culture is that through which all human experience and action—including emotions—must be interpreted. This view of culture attempts to take into consideration the quality of culture as something emergent, contested, and temporal, thereby allowing theoretical breathing space for individual and gender variability and avoiding notions of culture as static, homogenous, and necessarily shared or even coherent” (1996:74).

society saddened and angered me, and despite knowing that both external (economic, political, cultural) and internal (biological, cognitive, psychiatric) reasons were mostly to blame for his situation, part of me blamed Sam for simply not being strong enough.

More than at any time during my fieldwork, when Sam turned his eyes from mine and continued down the sidewalk, I could see how meth addicts could be abandoned by the community, how easily their addiction, disease, and presence could be too frustrating, problematic, and embarrassing for a particularly conservative community like gay San Diego's to handle. Some social problems – like homelessness, obesity, drug addiction – are so massive so endemic that the community finds them easier to ignore than to engage. And both meth and HIV are large, increasing, and intertwined problems in American gay communities; this is particularly so in San Diego, where both meth and HIV have been endemic for three decades (Associate Press 1985; Warth 2007; County of San Diego 2012). HIV has not had the same presence, in numbers or cultural effect, in San Diego as it has in Los Angeles, San Francisco, New York, and Washington DC, but San Diego's large gay community nevertheless has, according to public health officials and HIV doctors, a 20% infection rate, though it may more likely be closer to 6%². Meth is proportionately much more of a problem: More than 20 years ago, a spokesman for the Drug Enforcement Administration declared San Diego “the meth capital of the world,”

² In 2012, the State of California reported that 5,032 people were living with HIV in San Diego County (Office of AIDS 2012). In San Diego, 90% of those cases are men (HIV/AIDS Epidemiology Unit 2012:25), and 90% of those MSM (31), which leaves 4,076 MSM with HIV. If, as estimated by the CDC that 20% of people with HIV do not know their status (U.S. Statistics 2012), this means that 5,095 MSM are probably living with HIV in San Diego. In a well-regarded study, Gary Gates of UCLA's Williams Institute estimated that San Diego County had 163,961 gay, lesbian, or bisexual residents, based on 2,992,915 total residents, or 5.5% (Gates 2006); if the 2013 estimated population of the county is 3,177,063 (San Diego County QuickFacts from the US Census Bureau 2013), then based on the same percentage, that means 174,738 residents are gay, lesbian, or bisexual. Split in half, 87,369 residents are gay or male bisexual; 5,095 of that number is 5.8%.

and the only reason it cannot still claim that title is that other cities have since developed similarly high rates of meth use. Meth use dramatically increased from the mid-1980s to the 1990s, with meth-related emergency room admissions in California rising 366% from 1982 to 1993 and the number of meth lab seizures in Los Angeles County growing more than 150% from 1993 to 1996, to 267 (Reback 1997:1).

By 2005, according to the United States Department of Health and Human Services, 1.4 million people were using meth in a given year, and 130,000 met the criteria for abuse or dependence, up from 63,000 in 2002; in 2010 in San Diego 30% of people seeking treatment for substance abuse have problems with meth, while the national average is just 5% (Methamphetamine Strike Force 2010). And meth had become the most popular drug among men who had sex with men (MSM) in the Western United States (Mausbach et al. 2007:249). In 2008, 50% of MSM in California had done meth in their lifetime, compared to 5% of the general population (Fisher and Quintanilla 2008; Engel 2008). Men who have sex with men have the highest rate of meth use of any demographic other than Native Americans, with 15% of MSM 18-50 claiming to have used the drug in the last six months, according in state report from 2008. Along with numerous physical sequelae associated with meth use, including major neurological and cardiovascular problems, MSM who take meth are much more likely to exhibit sexual behavior that puts them at high risk for contracting HIV (Reback 1997; Halkitis, Parsons, and Stirratt 2001; Semple, Patterson, and Grant 2002; Boddiger 2005; Shoptaw, Reback, and Freese 2001). San Diego is home to at least hundreds and possibly a few thousand of men who have sex with men who both use meth and are HIV+.

Because meth use is associated with petty and violent crime as well as the spread of HIV and other STDs, and because of a moral panic inspired by these problems (see Chapter 1), public health and law enforcement agencies responded with substantial, but sometimes ineffective efforts. These range from increased and aggressive policing (Garriott 2011) to restrictions of precursor ingredients for the manufacture of meth (Reding 2009) to advertising campaigns devoted to demonizing the use and the users of meth. I first became interested in meth and HIV in San Diego's gay community in the spring of 2008, when three separate (and conflicting) public health advertising campaigns were waged in Hillcrest and North Park, the city's two gay neighborhoods. Most famous was the statewide "Me, Not Meth" campaign, which involved extensive signage and TV ads featuring starkly lit men saying, "I lost me to meth" (see Chapter 1). The other two campaigns were locally produced and involved several community health organizations. During my preliminary field research, I discovered that hundreds of people worked in what I came to call San Diego's anti-meth apparatus. Each agency and office would claim to be underfunded, but the combined budgets for the anti-meth efforts in San Diego – from policing to addiction services, from research to prevention efforts – is in the tens of millions of dollars. This "double" (Halkitis, Parsons, and Stirratt 2001) or "intertwined" (Stall and Purcell 2000) epidemic has been researched extensively by academic researchers in San Diego, most of whom work at my home institution, the University of California, San Diego. From 1990 to the middle of 2013, according to Google Scholar nearly 500 peer reviewed journal articles about meth use and HIV have been published with data from San Diego.

Despite the ever-increasingly number of publications on HIV infection and meth use among MSM, from San Diego and every other major American city with a large population of MSM, very little of it is qualitative. Semple et al. (2002), Halkitis et al. (2005), and Mimiaga et al. (2008) provide invaluable insight into motivations for and experiences of meth use, but their descriptions are brief and their goals are in intervention and behavior change. The only ethnography of meth use in a gay community, Reback's ethnography of meth use among MSM in Los Angeles, written for the City of Los Angeles and published in 1997, was conducted before HIV became a manageable disease in the United States and before the sea-change in gay rights and acceptance over the last decade. I see this dissertation as a sequel and an expansion of Reback's monograph; since its publication 16 years ago, rarely in the literature are political and economic forces like government austerity, race relations, or gay political debates discussed. Similarly, because of the nature of research methods used by the above mentioned authors, rarely are study participants seen outside researchers' offices, in social settings like their homes or when spending time with friends, let alone in situations where the subjects are enacting the studied behavior (and this is particularly true when it comes to risky sex and drug use). Hence, Sam's subjectivity, and the subjectivities of men like him, are missing from the social science record.

Aside from filling this gap in knowledge, there are both intellectual and practical reasons for recording the subjectivities of HIV+ men who have sex with men and use meth. Some critical medical anthropologists – in particular Frankenberg (1994) and Glick-Schiller (Glick Schiller, Crystal, and Lewellen 1994) – have argued that risk categories created and utilized by epidemiologists dehumanizes the people in the

categories, transforming them into mechanical objects that are believed to behave in orderly, predictable ways. This is a somewhat vague analysis, and an examination of the subjectivity of people in three major HIV risk categories – HIV+, MSM, meth using – would help to understand the rich experience of what is simplistically described as reification. In addition, despite 20 years of public health, social psychology, and biomedical research on meth and HIV, little progress has been made on developing effective interventions, neither at preventing meth use among MSM, treating people addicted to meth, nor preventing HIV infection when meth use involved. An ethnography of the men in these multiple risk groups should help other researchers to understand the population whose lives they are trying to improve. It will also help researchers and the people working in public health and law enforcement to recognize and understand the unintended consequences of these two decades of efforts. That Sam has survived 25 years as an HIV+ meth addict is odds defying for sure, but his life story is perhaps more valuable than his longevity is interesting.

The argument and key findings

What I witnessed during my three years of fieldwork was often profoundly upsetting, but it was also sometimes inspiring. I argue that the efforts to stop HIV infection and meth addiction among gay men has had an problematic unintended consequence: the social abandonment of HIV+ meth addicted gay men to an underfunded, ineffective, but mostly well-meaning healthcare system, as well as to a moralistic, hostile, and deeply flawed law enforcement system the goals of which are at odds with the health of addicts and the results of which are at odds with both public

safety and law enforcement. Contrary to political arguments and the arguments expressed in popular and academic discussions of addiction and HIV, I contend that this situation is neither the fault of the addict nor the fault of the institutional response, but rather a complex and chaotic interaction between destructive behavior of the addicts and a morally confused, haphazard, and under-funded collection of neoliberal³ organizations that comprise anti-meth apparatus. In turn, the subjectivities of these men have been constructed in a fraught environment of pity, anger, fear, and loathing, which has led them to a lived experience of suffering and constant struggle.

My key findings are as follows:

- The moral panic about AIDS in the 1980s dwarfs the meth-HIV moral panic of the 2000s. The latter moral panic, however, has created moral and medical discourses that have profound effects on both the agents of the anti-meth apparatus and the subjectivities of the meth-using HIV+ MSM that the apparatus focuses on.
- The healthcare providers and health researchers have strikingly different moral opinions HIV+ people and meth users from those of law enforcement. In the simplest terms, the providers and researchers believe that they have a moral imperative to help meth addicts while those in law enforcement have a moral duty to protect the community from meth addicts.

³ “Neoliberalism is ... a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. ... It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world” (Harvey 2005:2–3).

- All of my informants in my central sample used meth to cope with depression and the stress of their lives. However, meth exacerbates these problems; depression is both a cause and an effect of meth use
- In the life narratives my informants reflected not just the broad and old American hopes and goals of economic individualism, but also the desire to become neoliberal subjects.
- The men in my central sample survived addiction and poverty by utilizing sometimes haphazard and inefficient, sometimes strategic and calculated practices and performances.

Theoretical context

Rationality

I see this dissertation as adding to ongoing discussions in psychological and medical anthropology, particularly in the studies of the HIV/AIDS epidemic and how healthcare is delivered in the neoliberal nation state. The questions I posed and the analysis of my fieldwork data are based in anthropological, sociological, and historical discussions of rationality, biomedicalization, and subjectivity. The bookends of my theoretical context are Didier Fassin and Ruth Benedict. Fassin recently argued that “past facts are inscribed in the subjective experience of the present” (2007:29) and this is problematized by our cultural and “political anesthesia” (2007:xi); because of our inability to remember, we are unable to help enact the needed political and social changes that will alleviate suffering. Three-quarters of a century earlier, Benedict took the then-daring position that the categories of normal and abnormal are culturally defined.

Benedict points out that all cultures have normal and abnormal types, and in most cases, what is normal tends to be considered good, and what is abnormal tends to be seen as bad (Benedict 1934:73). Behavior that is “moral” that which is standard and accepted, and so immorality ends up describing behavior that is different, that is not “habitual.” She referenced lepers, the insane, and homosexuals as prime examples of people whose behavior were not habitual and therefore became seen as immoral. In the contemporary United States, the homeless, the addicted and the HIV+ fill similar roles; their abnormality is a moral problem, which Fassin and others would argue become embodied in their persons, the reasons and histories of their abnormalities forgotten by those who are normal.

At the time Benedict’s article was published, “No society [had] yet achieved self-conscious and critical analysis of its own normalities,” and if it did, the results would be “momentous” (1934:77). Many would say that Benedict was right; the post-structuralist deconstruction of many central tenets of what has been considered normal in Western civilization was, in fact, momentous, and not only in academic circles. Anthropology is an Enlightenment science, its goal being to codify, categorize, and explain the wild and strange cultures of the world. The most insidious use of anthropology, and the reason for its spread and development in the 19th century, was the “rational” analysis of the conquered “savages” for the purpose of controlling them. From the minds of these scientists, magic and seemingly ineffective medical practices were among the most bizarre practices of the savages; they were proof of the West’s superiority.

In his critique of anthropological studies of medical and magical beliefs, Byron Good claims that the “emergence of ‘belief’ as a central analytic category was a fateful

development, and that use of the term continues to both reflect and reproduce a set of conceptual difficulties within modernist anthropology” (1994:7). Most problematic was the Health Belief Model (Rosenstock 2005), which held that *correct* health beliefs would lead to salvation from illness and that those who did not subscribe to such a belief were, bluntly, inferior. W. H. R. Rivers (1922), E. E. Evans-Pritchard (1937), and Claude Lévi-Strauss (1958), three of the most important figures of 20th century anthropology, all exemplify the paradigm in which rationalism as not just preferred but hegemonic. This medical model is a taken-for-granted way of thinking in their texts and was not problematized until the post-modern turn in the 1970s.

Good cites Geertz’s assertion (1988) that the confidence with which Evans-Pritchard and Lévi-Strauss analyzed and wrote is not viable in today’s academy. “Anthropology’s great contribution to 20th century sociology of knowledge,” Good says, “has been the insistence that human knowledge is culturally shaped and constituted in relation to distinctive forms of life and social organizations” (1994:21). After the critiques of the post-structuralists, feminists, and sociologists of science, “rationality” emerges as a problematic term. There are three factors that contribute to the positivist view that science is an empiricist foundation for progressive advancement: 1) the problematic power of empirical medical language, 2) the status of Western medicine as the normative control from which all other systems must be compared, and 3) the idea that researchers have unbiased standpoints. These are no longer tenable assumptions (22–23). Nevertheless, while the critical position Good argues has a strong impact in anthropology, Enlightenment form of rationalism still largely dominates scientific and popular analysis in Europe and North America. The subsequent dilemma of the

anthropologist is endemic, Good claims: “Medical anthropologists sometimes feel ... [like tiresome skeptics] among physicians and public health specialists” (182). Tiresome, but necessary.

Foucault's analysis

Deep skepticism of the rationality of science and medicine is well-known in the writings of Michel Foucault that range from the Renaissance to the modern era (Foucault 1961; 1963; 1963; 1975; 1976; 1991). This body of work provides the foundation for my own genealogy of the medical rationality of the anti-meth apparatus. Foucault described the process through which madness became key to the West's understanding of itself as rational. As the Age of Reason flourished, the mad came to represent unreason, and the 18th century birth of the asylum, which was a medically informed, seemingly more humane version of confinement, introduced numerous methods of controlling, treating, and punishing madness and unreason; it also created psychiatry and the psychiatrist. He writes, “In the patient's eyes, the doctor becomes a thaumaturge; the authority he had borrowed from order, morality, and the family now seems to derive from himself; it because he is a doctor that he is believed to possess these powers...” (1961:275). Foucault argued that “the gaze” – the viewing of, and in turn, the describing of, a patient by a doctor – always implies a power relation, for “the gaze that sees is a gaze that dominates” (1963:39). The confrontation of the gaze and its object was not only the locus of the doctor's power over his patient, but when writ large, it became the singular method for the state's control over its citizens. Political ideology and medical technology converged, creating the hospitals, professional medical associations, and the faculties of medicine, all

of which formalized the integration of medicine with the state's structure and aims. The state's gaze, and thus the doctor's, Foucault asserted, "was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating" (1963:89). The gaze, then, categorized, predicted, and expounded. The subsequent development of medical discourse (of medical writing, language, and codes) then constructed a seemingly rational, amoral language of the body and of disease that was actually deeply influenced by the state's ideology of population control.

The development of the prison apparatus is another method of control; "a corpus of knowledge, techniques, 'scientific' discourse" was formed and became "entangled with the practice of the power to punish" (1975:23). The prison examination expands the medical gaze beyond the interaction between the doctor and patient and into that of the disciplining state. It is essential to the state's method of surveillance, and whether the exam is medical, military, or judicial, it exercises the state's power, partly by normalizing it. But what is the desired result of this relentless examination? Part of the goal, Foucault claims, is the creation of "docile bodies," bodies that "may be subjected, used, transformed, and improved" (136). Docile can also mean malleable, and that was what served the 19th century Western state which needed industrial workers to run the mills and dig in the mines, regimented soldiers to expand and protect empires, controlled masses that would not threaten the state's legitimacy, and healthy breeders who can make more bodies to use. Numerous scholars have claimed that the effort to create and control docile bodies is one of the key tasks of the modern nation state, and I believe that this is evident in not just public schooling and military training, but also in the ways that the

state attempts to gain control of those who refuse to be docile, from the criminal, to the addicted, to the infectious, to the simply rambunctious.

As I will explain in subsequent chapters, the anti-meth industry's main objective is securing the health of the community, both biologically and economically. When addicts are rehabilitated, it is to remake them into "productive members of society." This "biopower," which Foucault asserted was vital to the evolution of capitalism, was how the state "focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health... *regulatory controls: a biopolitics of the population*" (1976:139). This particular interest meant that the control of sexuality – kept normalized through "continuous regulatory and corrective measures" (1976:144) – would be increasingly important. Through the confession, which started as a religious practice but became essential to the practice of medicine and psychiatry, confessors opened up their lives to the codification, interpretation, and medicalization of the listener (1976:65–67). The confession, both forced and voluntary, is just one of tools of what Foucault termed governmentality, or the "ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy and as its essential technical means apparatuses of security" (1991:102). The governmentality of enforcing both medical and economic rationality is one of the key sources of power that my central sample of HIV+ MSM meth users interact with in the construction of their subjectivities. During my fieldwork, I was particularly concerned with observing the ways that the microphysics of

governmentality's power (Foucault 2006) were involved in the quotidian experiences of my central sample, and I traced how seemingly mundane interactions were meaningful in the construction of their subjectivities.

But management of the body is not simply about social control; it is also leads to the transformation of bodies, which in turn leads to a transformation of identities and subjectivities. These “technoscientific identities” are defined by such things as risk, epidemiology, and DNA markers (182). The medical imaginary has produced new ideas about truth and science, all of which intensify our progress-based opinion of medicine. “Enthusiasm for medicine’s possibilities arises not necessarily from material products with therapeutic efficacy,” Mary-Jo Good writes, “but through the production of ideas with potential but as-yet-proven therapeutic efficacy” (Good 2007:367). The experience of medical positivism seems to erase, or ease, the interior moral battles of health seeking. There is no conflict, just a desire to be healthy and a belief that medicine can do anything. Good calls this the “biotechnical embrace.”

The flipside of this embrace is that, as Ulrich Beck (1992) has argued, we live in a society obsessed with risk. Mary Douglas (Douglas 1978; Douglas 1994; Douglas and Calvez 1990) has contended that risk is the Western tactic for dealing with threats to the body and the body politic. Douglas “sees risk as a socially constructed interpretation and response to a ‘real’ danger that objectively exists, even if knowledge about it can only ever be mediated through sociocultural processes” (1999:39). Mark Davis has argued that the rationalities of risk as presented by the public health and government discourses about HIV infection use the “health belief model” and assume “a general model of human action: people will act to preserve life and avoid death if adequately informed, if barriers

to rational action are removed and if people are otherwise supported” (2002:281). Thus, risky behavior by people who have been informed is seen as irrational, and therefore, in the logic of the biomedical era, immoral and dangerous. All of this assumes a Cartesian mind-body binary and ignores other, more complex, reasons for behaviors, such as “emotions, the ‘unconscious’ and cultural responses to danger and risk” (284). This has caused many gay men and those who work with gay men in HIV/AIDS research and services to moralize about behavior, focusing blame and stigmatizing those who behave irrationally and praising those who take on rational “risk identities” (2002:286). But considering risk as a moral arbiter is contested, with some seeing risk as sexually exciting or politically subversive (Warner 1999; Halperin 2007; Race 2009).

HIV and AIDS

If, as Fassin contends, history is inscribed on our bodies and our subjectivities, then the history of the AIDS epidemic – and all of moral, intellectual, symbolic and affective debates therein – can be seen in the subjectivities of people with HIV/AIDS today. The dominant narrative of the first five years of the AIDS epidemic is Randy Shilts’s *And the Band Play On* (1987). Shilts explains how AIDS exploded in the early 80s in San Francisco after a decade of post-Stonewall exuberance, during which gay men began to define themselves and their community around their unbridled sexuality, not simply around which gender they were oriented towards. One of the central themes of the book is the conflict between this sexual politic and what seemed to be commonsense precautions needed to avoid infection. When public health officials and their gay allies asked gay men to stop doing the things many of them had used to construct their

identities, the result was a chaos of anger, fear, malaise, and guilt. Unlike most social scientists who attempt to present themselves as unbiased, Shilts takes a clear side, vilifying those who ignored the advice of those whom Shilts saw as heroes, damning the irrational and sainting the logical: “And people died while gay community leaders played politics with the disease, putting political dogma ahead of the preservation of human life...A handful of gay leaders withstood vilification to argue forcefully for a sane community response to the epidemic and to lobby for the funds that provided the first breakthroughs in research. And there were many victims of the epidemic who fought rejection, fear, isolation, and their own deadly prognoses to make people understand and to make people care” (xxii-xxiii). Shilts’s moral positioning of the events of the early history of the epidemic is mirrored in the current moral ethos of both AIDS, Inc. and the anti-meth apparatus: only rational, sane behavior leads to progress and health. While there have been numerous non-academic histories, memoirs, and historically oriented fiction about these first years of the epidemic (Kramer 1985, 1989; Feinberg 1989; Callen 1991; Preston 1995; Monette 1998; White 1998; Finn and Lapine 1989; Sherwood 1986; René 1990; Friedman 1993; Ashley 1995), Shilts’s 646-page bestseller is the account that has prevailed; it can be found on the syllabi of numerous college classes about AIDS, for example. It is not without criticism. Steven Epstein, for instance, faults the book for its teleology, writing that Shilts projected “the ‘certainties’ of 1987...onto past moments in the epidemic” (1996:38). Douglas Crimp, however, did not base his criticism of Shilts in postmodern critique but rather in identity politics: “The fact that Shilts places blame for the spread of AIDS equally on the Reagan Administration, various government agencies, the scientific and medical establishments, *and the gay community*, is reason enough for

many of us to condemn the book” (1988:239, emphasis in the original). Crimp believed that *And the Band Played On* was, simply, homophobic.

Crimp’s criticisms of how AIDS was discussed and represented joined complementary analyses by Cindy Patton (1985; 1996; 1998), Dennis Altman (1986; 1994), Susan Sontag (1988), and Paula Treichler (1999), who wrote that AIDS brought on an “epidemic of signification” (1999:1). Much of the initial academic, non-biomedical analysis focused on AIDS as discourse. “AIDS and HIV are not simply labels,” Treichler writes. “They exist in material spaces, that is, quite distinct from but as real as those inhabited by the entities to which they are presumed to ‘refer’” (1999:328–329). Patton focused on the use of AIDS by the American Right to demonize gays, lesbians, and sexuality in general. She asked, “How does anyone remain sex-positive when the newspapers and passersby see homosexuals = AIDS = death?” (4). Echoing the critic and novelist Susan Sontag (1978) and the sociologist Mary Douglas (1978), Patton says, “Illness is not only an individual experience, it is a cultural metaphor...Dirt is chaos, cleanliness order. Disease-stricken people are immoral, healthy people righteous” (11). Her argument was straightforward: “AIDS is double jeopardy: it endangers life through both disease and political persecution, and it increases the likelihood that the at-risk population will be considered guilty (infected) until proven innocent (disease-free)” (35-6).

In describing the various metaphorical structures in which AIDS and people with AIDS were trapped, Sontag argued that the structures always creates Others who are demonized and persecuted as if they themselves were the disease (see also Nelkin and Gilman 1988; Frankenberg 1992; Farmer and Arthur Kleinman 1989). “The effect of the

military imagery on thinking about sickness and health is far from inconsequential,” Sontag wrote. “It overmobilizes, it overdescribes, and it powerfully contributes to the excommunicating and stigmatizing of the ill” (1988:182). Her well-intentioned call for avoiding metaphors of disease and embracing rational, scientific vocabulary was naïve, says historian Alan Brandt. “Despite her pleas that illness is not a metaphor, the process by which disease acquires meaning and value is ubiquitous,” Brandt argues. “Disease is simply too significant, too basic an aspect of human existence to presume that we could respond in fully rational or neutral ways” (Brandt 1988:416). Expanding on this idea, Epstein explains that rationality and neutrality are both culturally situated, socially constructed ideas, and in the early years of the epidemic, who was rational, who was fair, and whether they were credible were subject to intense debates. “AIDS has... been a politicized epidemic, and that political character has had consequences,” Epstein writes, “it has resulted in multiplication of the successful pathways to the establishment of credibility and diversification of the personnel beyond the highly credentialed” (1996:3). In addition, these fights led to fights about the words used to talk about the epidemic and the categories where people with AIDS were placed.

Ultimately, the metaphorical structures of the AIDS epidemic combined with the discourse of modern epidemiology in problematic ways. In her appraisal of the discourse of epidemiology, Nina Glick Schiller pointed out how biomedically oriented AIDS researchers and anthropologists have significantly different interpretations of “how culture is to be understood and interpreted” (1992:238). For instance, Glick Schiller claimed that biomedical researchers believe that drugs users, gay men, and certain ethnic minorities were at risk for HIV-infection because “they belong to subcultures that deviate

in practices and life-style from the behavior and values of the general population” (1992:238–239). Since they seemed to believe that culture was as distinct and “natural” trait as age and sex (Glick Schiller, Crystal, and Lewellen 1994:1337), their risky practices, therefore, were the “product” of their culture. Anthropologists, Glick Schiller contends, see culture as the *context* for the behaviors: “. . .the behavior that puts people at high risk for HIV infection must be understood in relationship to the structure or power and wealth within the larger society” (Glick Schiller 1992:239). Because the biomedical researchers have more authority and power in creating categories of risk, disease, and danger, their use of “culture” is part of hegemonic processes (Williams 1977) that separate and subjugate groups like users, gay men, and certain ethnic minorities, Glick Schiller writes.

The tendency to stereotype cultural behavior within ‘risk groups’ has reified the concept of culture, and has identified the cultural behavior of internally diverse categories of persons with that of conspicuously extreme sub-groups at one end of a behavioral continuum. Stereotyping and reification provide a misleading backdrop for policy formation. This tendency to distance the ‘general population’ from ‘risk groups’ has acted as cross-purposes to public health goals, facilitating public definitions of the HIV epidemic as a problem which concerns others, not oneself and one’s own ‘group.’ (1994:1344)

These epidemiological practices also reified the people placed into “risk” groups, Ronald Frankenberg pointed out. Transformed into mindless, medical things, the people in risk groups are then thought to behave in orderly, mechanical ways. But they do not. As Frankenberg argued, reification makes biomedicine possible, but it also makes it dehumanizing. “Risk groups are, of course, merely categories in disguise,” he wrote, “and their members are denied both subjectivity and paradoxically, individuality” (1994:1334).

The influence of Marx, Gramsci, and Foucault's analyses of political economy can be seen in both Glick Schiller's and Frankenburg's approach to the creation and reification of risk groups. Anthropologists interested in AIDS have asserted that "not just cultural, but also structural, political, and economic factors shape sexual experience (and hence constrain the possibilities for sexual behavior change) to a far great extent than had previously understood" (Parker 2001:168). As Merrill Singer, one of the central figures in this approach, writes, "Political economy... constitutes not just the context of but also part of the context of human social life. Consequently, there can be no accurate analysis of AIDS in the absence of a consideration of the role of political economy" (1998a:28). In particular, Singer, Brooke Schoepf, and Paul Farmer developed this approach through several articles in the late 1980s and early 1990s (Schoepf 1988; 1991a; 1991b; 1992; 1993; Farmer 1988a; 1988b; 1990a; 1990b; 1991; 1992; 2001; Farmer and Kim 1991; Farmer and Kleinman 1989; Singer 1994; 1998a; 1998b; Singer et al. 1990). While describing the symbolism of AIDS and recording the suffering of their research subjects, Singer, Schoepf, Farmer and the other practitioners of the approach also exposed the historic and political forces that acted on gender, race, and class divisions. For example, Schoepf explained that in order for HIV prevention campaigns to function, structural forces like gender inequality needed to be addressed. "Because social structures circumscribe the choices people make," she wrote, "eradicating AIDS requires the elimination of the barriers that deny women control over their own sexual decisions" (1993:70).

Similarly, Sobo (1995) shows how "past afflictions and current poverty" (Farmer 1992:253) are profoundly implicated in the decision-making of some Black women in

Cleveland in the 1990s who did not practice safe sex. “Denying risk allows a person to preserve self-esteem and status,” Sobo writes, “just as admitting risk by using condoms can lower self-esteem” (1995:34). Sobo’s psycho-social explanation for risk-denial disrupts the sexist and racist analyses that have blamed unbridled Black sexuality for increasing HIV rates. Denial here is not simply a covering of the ears and a closing of the eyes, but rather the situationally logical result of status-seeking behavior within a field of power structured by political and economic oppression. In discussing the epidemic in Haiti, Farmer described both the macro historical forces that shaped the racial and economic oppression of Haiti and the individual experiences of suffering of the three residents of the village of Do Kay who died of AIDS while Farmer was in the field. “HIV,” he writes, “has run along the fault lines of economic structures long in the making” (1992:9). Writing about HIV/AIDS in Tanzania, Philip Setel sees a political economy of stigma production. Focusing on the paradoxes of the epidemic, Setel writes, “In its fullest sense, the paradox of AIDS is that this *new* disease is enmeshed in *historically shaped* social environments” (2000:4).

Since I am interested in the effects that historically shaped environments and discourses have on the discourse of my study participants, Didier Fassin’s *When Bodies Remember: Experiences and Politics of AIDS in South Africa* (2007) is of great relevance for this dissertation. Fassin focused on how the memory of apartheid and the experience of disease intertwined. Fassin explains “we,” the rich west, cause suffering and then ignore it, just as South African politicians have; we suffer from both cultural and “political anesthesia” (xi). Because of our inability to remember, we are unable to help enact the needed political and social changes. Fassin’s approach, like others, is based

clearly in a political economic analysis of South Africa in which he takes “a critical vantage point that requires thinking of our shared humanity less in terms of difference than inequality, less a matter of culture than history” (xv). But his attention to history and inequality is not focused on only politics and rhetoric, but also, in an unusual turn for the anthropology of AIDS, on the phenomenological experience of both AIDS and the memory of apartheid. The lives of so many people in South Africa are defined by memories of oppression and violence, so their current experience of, say, AIDS will be as well. His central example is the story of Puleng, an impoverished woman dying of AIDS in a slum. In her story, she expresses anger at the political and economic reasons for her illness. In his response to her story, Fassin writes, “AIDS is taking her life, but what life has it been? Her protest is not a biological fact, but against a political fact” (24). She is a victim of political violence, Fassin contends. “Beyond the experience of the disease as suffering, it is Puleng’s experience of politics as violence – historical, social, gendered, ordinary – that I believe she was seeking to transmit to us. In this sense, her account is profoundly political” (25). These feelings are expressed as interpretations of memories, and Fassin sees memory-as-history inscribed and embodied in two ways. One is how “past facts are inscribed in the objective realities of the present... the other consists in the way past facts are inscribed in the subjective experience of the present” (29). Part of this subjective experience is how these memories, traumas, and joys are embodied. Following Mauss, Merleau-Ponty, Bourdieu, and Csordas, Fassin writes that “the body is...a past embodied in the present” (178). Fassin connects this embodied past to the memories of quotidian experiences as limited by the political economy both of South Africa and of AIDS. Finally, Fassin argues that the “history of AIDS [is] a web of meaning that extends

well beyond country borders and the disease itself. It recounts a political world order composed of both social configuration and symbolic arrangements, relations of knowledge and power, representations of the self and discourses of the other” (275). This is why South Africa matters; we, and the rest of the world, are implicated in the suffering of Puleng. This is also why Sam matters; we are all implicated in his struggle to survive on the streets of San Diego.

A brief history of methamphetamine

Virtually every description of the origins of the methamphetamine problem starts with the synthesis and manufacturing of amphetamines at German and Japanese pharmaceutical firms in the late 19th century. While the chemical combination that evolved into crystal methamphetamine may trace its origin to these labs, the desire for and love of stimulants has existed in humans since before recorded history. Ephedra, the plant from which ephedrine was isolated (which in turn allowed for the synthesis of amphetamine and methamphetamine), appears in the records of the Chinese emperor Shen Nung from about 2700 BCE (Lee 2011:78). So does tea, but the earliest clear evidence that the Chinese were drinking stewed tea leaves is from literature of the Tang Dynasty in the 7th century CE (Fredholm 2011:5). The Abyssinians chewed and brewed the leaves, bark, and unroasted beans of the coffee plant for probably thousands of years before someone decided to roast and grind the beans and make what we know as coffee in the 16th century (Pendergrast 2000:5). Myths and legends from the ancient Sumerians to the Greeks to the Mayans describe the experiences of mind-altering substances – hallucinogenic, sedative, and stimulating.

This may be the result of our mammalian brains, in which neural mechanisms developed to mediate incentive behaviors. One neurotransmitter, dopamine, is greatly affected by drugs from heroin and caffeine; the drugs cause the false belief that we are happy, and happiness is one of key emotional pushes for survival, in a Darwinian sense. But the rub is that drug use can be maladaptive: “The pursuit of emotion-associated goals tends to move organisms up a hedonic and adaptive gradient, but neurobehavioral systems are designed to maximize Darwinian fitness, not happiness, so our pleasures are often fleeting, and we experience much unnecessary suffering” (Nesse and Berridge 1997). Despite the potential for addiction and other sequelae – violence, crime, and diseases like HIV and cancer – the desire for something that will bring positive emotions or the absence of negative ones is so deeply wired into our brains that demand for psychoactive drugs will never disappear. In turn, discovering the psychoactive side effects of everything from fruit to leaves, from the backs of toads to cold medicine, seems to be universal. This is what led amphetamine to go from being a useful remedy for bronchial problems like asthma and sinus congestion to, after cannabis, the most abused illegal drug in the world (United Nations Office on Drugs and Crime 2011).

In 1893, the Japanese chemist Nagayoshi Nagai first synthesized methamphetamine from ephedrine, which he first isolated from the *ephedra* plant in 1885, a year earlier than the German pharmaceutical firm Merck (Nagai 1893; Lee 2011). Ephedrine and its relatives – amphetamine, pseudoephedrine, and methamphetamine – were little used until 1927, when American doctors started prescribing ephedrine to treat bronchial complaints like asthma, allergies, and colds. When supplies of *ephedra* became scarce, drug makers began looking for a synthetic version, and they rediscovered

amphetamine, which had been synthesized in Germany shortly after Nagai's findings were published. As scientists did more research on amphetamine, they discovered that it was an incredibly effective stimulant; it woke dogs from anesthesia and successfully treated narcolepsy. There is very little doubt that the Germans, Japanese, and Americans all gave amphetamines and methamphetamines to their soldiers during World War II, and this widespread use led to addiction problems among Japanese ex-soldiers during the post-war period (Yudko, Harold V. Hall, and McPherson 2003).

Used for so many ailments and so effective at keeping truckers, housewives, students awake and alert, amphetamines were ubiquitous in the 1940s and 1950s in the United States. By 1946, the pharmaceutical industry had listed 39 different conditions amphetamines could be used to treat, including "schizophrenia, morphine and codeine addiction, tobacco smoking, heart block, head injuries, infantile cerebral palsy, radiation sickness, low blood pressure, and persistent hiccups" (Miller 1997:114). In the 1960s, 20 million prescriptions, mostly for weight loss, were written every year, with 31 million written in 1967 alone. In the 1950s, a liquid form of metamphetamine was marketed as a treatment for heroin addiction. This was quickly abused, and by the early 60s, San Francisco became the center of the liquid meth addiction. While tens of millions of people were legally prescribed amphetamines, production of its various forms was disproportionately large based on their medical use; by 1971, when the federal government started placing quotas on amphetamine production, between a third and half of what was legally manufactured was illegally diverted to the black market (1997:115).

Meth in San Diego

Shortly thereafter, the biker gang the Hell's Angels, as well as others, began to manufacture their own meth from relatively easily obtainable ingredients. Little knowledge of chemistry was needed, and meth labs sprung up first in the San Diego area and then all over the West Coast. No one seems to know definitively why San Diego was the first center of illicit methamphetamine manufacturing, though one of the more popular theories I heard in San Diego, which was also referenced in a recent popular book on meth (Owen 2007), is that the biker gangs learned how to make the drug from Navy veterans who had been involved in making amphetamines for American soldiers during World War II. Until the end of the Cold War, San Diego County had largest Marine base and one of the largest Naval bases in the United States and today still has one the largest veteran population in the United States (California Department of Veteran Affairs n.d.). Subsequently, of the county's 9,000 homeless, 25% are veterans, and many have mental or substance abuse problems (Reno 2010).

My former father-in-law, who was an undercover police officer and then an agent of the Drug Enforcement Administration would drive around San Diego and point out numerous places where he had busted meth labs in the late 70s and early 80s. In 1989, a spokesman for the DEA referred to San Diego as the "meth capital of the world" (Zamichow 1989). The biker gangs who dominated the meth trade were hobbled by both the intensive attention of law enforcement and by the internet revolution, which enabled anyone to share and download meth recipes that had been closely guarded secrets for decades. In the 1990s, meth was being cooked by anyone with the will and some secluded space; the barren mountains and desert canyons in the eastern part of San Diego

County were perfect places to build meth labs, but labs were found in the much more densely populated areas of the western part of the county, too.

The dramatic rise in meth labs, meth addicts, meth crime, and the healthcare costs associated with meth use was the impetus for the creation of the San Diego County Methamphetamine Strike Force in 1996, two years after statistics showed that 53% of people arrested in San Diego testing positive for meth (Rother and Jones 1996). The somewhat violently named organization brings together law enforcement, treatment, and prevention organizations. While the goal of the Strike Force is to foster cooperation between these three branches of the anti-meth industry, the name of the group makes it less surprising which segment of the anti-meth industry dominates the organization and its meetings. The government organizations that send representative to Strike Force are primarily concerned with decreasing the crime associated with meth use and the healthcare costs involved in meth use and manufacture, and the amount of money spent on policing meth use in San Diego over the nearly two decades years the Strike Force has been in existence is well into the hundreds of millions of dollars. The city and county subcontract all of their treatment and prevention efforts; these costs dwarf the budgets of law enforcement in the county.

In 2000, the voters of California passed Prop 36, which clarified and expanded on a 1972 law that encouraged treatment over incarceration for nonviolent drug offenders. Prop 36 broadened the scope and power of the decade-old drug courts, and it profoundly changed the way that drug users are treated by the state (Porter 2007). While the new law dramatically decreased the number of drug users being jailed, it placed them in treatment facilities, both in-patient and out-patient, that were wildly different in quality.

(Nevertheless, California still has the largest prison population in the country, and in 2011 was more than 75% over capacity, and it is court-ordered to decrease its population from 143,000 to 80,000 (Dolan 2011)). Prop 36 also placed these users in lengthy parole and probation periods, during which they were forced to waive various rights, most famously the 4th Amendment. At any point, their homes, bodies, and cars could be searched. The expansion of probation and parole in the United States is just one of the extension of police power under narcopolitics; American policing is now focused as much on the potential threat of crime as it is with actual crime (Garriott 2011).

In the mid 2000s, meth lab seizures decreased dramatically not because they became better hidden but rather because the ingredients needed to make meth became much more difficult to obtain in large quantities. Various laws, from the extension of the Patriot Act to numerous state laws around the country, made one of the key ingredients, the cold and allergy medication pseudoephedrine (better known as Sudafed), difficult to purchase in large quantities. In order to buy a box, you have to ask at the pharmacy counter, show your ID, and sign your name. Determined meth cooks have been able to work around these new laws, using “smurfers” who go from store to store buying small quantities, but amateur meth labs have still begin to vanish. While 15 labs were seized in San Diego County in 2005, and only 6 were seized in 2009. While this is considered a significant victory, the result is that most of the meth coming into San Diego now is being smuggled over the Mexican border; multinational drug cartels are making most of the meth being bought and used in San Diego. The purity of the drug was between 70% to 90% in San Diego in 2005, and it now swings from 25% to 80% (Methamphetamine Strike Force 2010). One of my study participants described shooting up the meth that is

most easily found on the street to be “like injecting yourself with lighter fluid.” And because the purity is so low, more people are injecting meth in order to get the high that smoking a weak batch cannot achieve.

At the end of the 2000s, the economic crash and the California budget crisis nearly crippled the anti-meth industry, which in turn created problems for meth users. Numerous treatment programs either lost much or all of their government funding; several closed down or were pared down substantially. People on Prop 36 or voluntarily in treatment were left to fend for themselves. Money for prevention programs vanished. And the surviving non-profits began to cannibalize each other. Family Health Centers took treatment contracts from several other agencies. Counselors were laid off, and others left the area for good. The syringe exchange where I met half of my study participants was operating without a budget for a year after their funding disappeared. At the writing of this, the exchange’s only funding comes from a small grant from the AIDS foundation run out of MAC Cosmetics. Injection drug users are not given enough syringes per week. Often we are unable to give them rubbing alcohol, and we longer are able to give them antibiotic ointment. San Diego County refuses to fun the exchange because, in the words of the county supervisor who founded the Methamphetamine Strike Force, “It sends a message to our kids that as county government, if we gave out clean needles for illegal drug use, that we condone illegal drug use. And we don't. And it's wrong” (Goldberg 2009).

Subjectivity

What has been produced by this history and this history-in-practice? Many of the public health researchers studying the intersection of meth and HIV have done so while under-emphasizing the social, cultural, structural context (key exceptions include Reback and Garriott). For the most part, the anthropologists and sociologists studying the AIDS epidemic have been describing structural processes, not personal experiences (key exceptions include Fassin, Farmer, and Sobo). While these researchers have often referred to the new “subjectivities” that are created by these socio-historical shifts, they do not describe, dissect, or explain these medically and biomedically informed subjectivities beyond what is offered by the broad languages of sociology and history. Both groups only offer half of the analysis I think is needed. Biehl, Good, and Kleinman ask for new methods for the analysis of subjectivity, which they see as the place where we can how the grand social, historical, and moral changes of the recent era have united and transformed humanity. They implore anthropologists to “find new ways to engage particularities of affect, cognition, moral responsibility, and action” (2007:1). Subjectivity has come to stand for “inner life processes and affective states” (6), or, more elaborately:

The subject is at once a product and agent of history; the site of experience, memory, storytelling and aesthetic judgment; as agent of knowing as much as of action; and the conflicted site for moral acts and gestures amid impossible immoral societies and institutions. Modes of subjectivation are indeed determined by the vagaries of the state, family and community hierarchies, memories of colonial interventions and unresolvable traumas, and medicoscientific experiments and markets. Yet subjectivity is not just the outcome of social control or the unconscious; it also provides the ground for subjects to think through their circumstances and to feel through their contradictions, and in doing so, to inwardly endure experiences that would be otherwise outwardly unbearable.

Subjectivity is the means of shaping sensibility. It is fear and optimism, anger and forgiveness, lamentation and pragmatism, chaos and order. It is the anticipation and articulation of self-criticism and renewal. (14)

The analysis of experience is central to the anthropology of subjectivity, Kleinman writes. “Experience... has as much to do with collective realities as it does with individual translations and transformations of these realities. It is always simultaneously social and subjective, collective and individual” (2007:53). Social and historical changes lead to changes in our inner worlds, from our stated identities to our private selves, from schematic processes to our affect and embodied experience. Earlier, Kleinman and Kleinman described experience as the medium by which intersubjectivity occurs, and more specifically, that “experience is the *felt flow* of that intersubjective medium” (1991:277). Importantly, experience is not what is produced by “human nature... but the condition for its emergence as both shared and culturally particular” (278). The analysis of subjectivity involves, therefore, deep description of experience, but also of emotion, embodiment, and the “orchestration of the self” (Biehl, Good, and Kleinman 2007:15) . These three concepts, which I will discuss in reverse order, are central to how I have analyzed the subjectivities of HIV+ MSM who use meth.

Perhaps the most important contribution psychological anthropologists have made is their explanations for how culture and the self are co-constitutive. Hallowell writes, “the self is a social product – more accurately characterized as, also, a cultural product” (1955:81). He rejected the idea that we can have can ever have complete objectivity from which our initial understanding of reality – and ourselves – springs. “The psychological field in which human behavior takes place is always culturally constituted,” he says (84). Taking this further, Hallowell contends that we do not live in a social or a cultural

environment, but rather a “culturally constituted behavioral environment” (87). Hallowell considered his approach to be phenomenological in that the sense that it is through basic, socially constrained orientations that we construct and maintain self-awareness: self-orientation, object orientation, spatio-temporal orientation, motivational orientation, and normative orientation. The last is particularly important for the construction of the moral self. “Values, ideals, and standards are intrinsic compounds of all cultures,” Hallowell writes. “Without normative orientation, self-awareness in man could not function in one of its most characteristic forms – self-appraisal of conduct... [The] individual must be motivated to consider whether his acts are right or wrong, good or bad. The outcome of this appraisal is related to attitudes of self-esteem or self-respect and to the appraisal of others” (105–106). With the population I have studied, a population that is the focus of intense efforts to change their behaviors and subjectivities, their orientation to what is normal in the behavioral environment is central to development of their identities, their emotional discourses, and the experience of their bodies.

My preferred theory on the construction of identity is put forth by Holland, et al, who synthesize theories from Vygotsky, Bakhtin, and Bourdieu. For Holland et al, identity and society are both historical products and intricately intertwined. They are constantly in dialogue: *Identity is practiced*. Holland et al. point to one of Vygotsky’s late essays that describes how children, for the purpose of play, suspend the standard, everyday meaning of objects and ascribe different meaning to them (50). When they play, they react to different, imagined meanings to objects: the bathroom is a beauty parlor, a stick is a gun, or a hairbrush is a microphone. An object can then become a “pivot” that the child uses as a mediating device to transport him- or herself into the play world. (A

hairbrush, for example, can be picked up and held in a certain way, a child pivots into a world where he is a pop star.) As the child grows older, however, the object may not be needed to enter the imaginary world, and games become less pure fantasy, but being able to travel to the land of make-believe is still needed to play. This ability to play is linked to the ability to function in an institutional world, where you are given a role to play, and the game is much more serious. Thus, play is linked also to culturally figured worlds “peopled by characters from collective imaginings,” worlds like academia, the military, or Alcoholic Anonymous (51). These are

socially and culturally constructed realm[s] of interpretation in which particular characters and actors are recognized, significance is assigned to certain acts, and particular outcomes are valued over others. Each is a simplified world populated by a set of agents... who engage in a limited range of meaningful acts or changes of state... as moved by a specific set of forces. (52)

These “figured worlds” are not only thoroughly imagined (with roles given, defined, narrativized, and embodied), but also constantly practiced. All of this is done within structures of power and position that Bourdieu referred to as a “field of power” or “structure-in-practice” (58). The field is basically a game—it is performed, practiced, and played by better and worse players—and that is why Bourdieu referred to the *habitus* (see below) as the “feel for the game” (Bourdieu 1990 [1980]:67). Every game has rules and game pieces, the latter of which Holland et al. refer to as “artifacts”—or to use Vygotskian terminology, they are pivots. In AA, the pivots would be both the chips that members earn with each completed step as well as the stories that members tell of their alcoholism. The pivots enable the actor to enter the figured world, “to shift the perceptual, cognitive, affective, and practical frame of activity” (Holland, et al. 1998:63).

Pivots are also means of self-control, because they help to frame our emotions and experiences, and to narrate our history-in-person.

The concept of *habitus* helps us to understand the ways that culture is inscribed on the body. Mauss was the first to use the term, defining the *habitus* as physical habits, actions, and ways-of-being, and in them “we should see the techniques and work of collective and individual practical reason rather than, in the ordinary way, merely the soul and its repetitive faculties” (1973:73). These are “techniques of the body,” transmitted by tradition and operationalized with the body, “man’s first and most natural instrument” (75). Bourdieu greatly expanded on and complicated Mauss’s *habitus*, defining his version as “systems of durable, transposable dispositions, structured structures pre-disposed to function as structuring structures,” all of which is produced by “conditionings associated with a particular class of conditions of existence” (1990:53). The *habitus* is the foundation for “perception and appreciation” (54) of every experience, “acting as a system of cognitive and motivating structures” (53). While personal style, strategy, and subjectivity are still personal, and singular, personal invention is controlled; the range of options is limited by the *habitus* of a particular culture, class, and period. For Bourdieu, *habitus* is not simply repeated physical actions, habits of the body, but also habits of the mind. It can allow you to be controlled, but it can also allow you to rebel, to be agentive, to make change, though how is not ever fully explained by Bourdieu.

Similar to Bourdieu, Foucault’s “docile bodies” are inscribed with meaning; both Bourdieu’s and Foucault’s bodies seem to be passive. But in synthesizing these theories with those of the French psychologist Maurice Merleau-Ponty, a more active, and interactive, theory of embodiment arises. Crossley contends that by synthesizing Foucault

and Merleau-Ponty, it is easier to see how the body can be both “active and acted upon: a locus of action and a target of power” (1996:104). Crossley points out that for Merleau-Ponty, “Meaning is not produced by a transcendental or constituting consciousness, but by an engaged body-subject” (101). Foucault, on the other hand, believed that the body was not the subject *of* but rather subjected *to* historical forms of conduct. These are not opposing, but rather complementary, positions: order and control is accomplished through “direct and active attempts to control, direct, and delimit, and co-opt the actions of the body,” these attempts are only possible through agency: “It requires a person who acts and person who acts upon those actions” (105). In turn, synthesizing Merleau-Ponty and Bourdieu, Csordas is interested in how the body becomes informed. Merleau-Ponty claims that the body projects itself into the world, and so perception begins in the body. Csordas claims that the concept of the *habitus* collapses the body-mind duality by focusing on “the psychologically internalized content of the behavioral environment” (1990:11). The *habitus* is constructed by the body’s relation to the mind, and vice versa. For Bourdieu, Csordas writes, the body is “both the original object upon which the work of culture is carved out, and the original tool with which that work is achieved” (11). While any anthropology of subjectivity should involve an analysis of embodied experience, I believe it is particularly important in the ethnography of my study participants, whose bodies are hypercognized because of both drug use and biomedicalization,

Similarly, emotional experience is central to subjectivity, but the emotional discourses expressed by my study participants are particularly intense, not only because drug use is often caused by the desire to feel particular emotions but also because they are

constantly being told what emotions they should be feeling by various segments of the anti-meth industry. One of my goals in this dissertation is to describe the process by which these emotional expressions are constituted. As Catherine Lutz writes, “Emotion can be viewed as a cultural and interpersonal process of naming, justifying, and persuading by people in relationship to each other. Emotional meaning is then a social rather than an individual achievement – an emergent product of social life” (1988:5). Emotions, she argues, are neither innately biological nor completely personal and idiosyncratic. They are social: “Emotional experience is not precultural but preeminently cultural” (5). Emotions are created both through the complex interaction of interpersonal negotiations and the subjective experience of social structures and Foucaultian microphysical power relations. Thus, the ideas, descriptions, and discussions of emotions are laden with ideology, history, and “ethnotheoretical ideas about the nature of self and social interaction” (10). This interactivity also helps to explain some of the power of morality; this interactionist model of emotion provides an explanation for why people feel as they ought to feel: “The force of emotion is to a great extent the sense of moral or pragmatic compulsion, the sense one must do what the emotion ‘says’ one will do” (Lutz 1988:213).

Emotions almost always bring forth imagery that is social in nature, involving relationships between people. For example, in Jenkins’s (Jenkins 1991a) analysis of “expressed emotion,” which is the “criticism, hostility, and overinvolvement” by family members towards their relative with schizophrenia, Jenkins showed that families can construct a particularly troubling, awkward, and unhealthy environment for an ill person. The methods of criticism are culturally variable, both in the content of what

is said or signified as well as in linguistic manner that the criticism is made. These “vocal markers... are observed to function as what Goffman termed ‘keying devices’ to mark specific activities, distinguishing, for example, between teasing and criticism” (398). This is precisely the sort of orienting behavior that Hallowell would point to as that which constructs normalcy or that Foucault would say slowly constructs subjects. This emotional construction can quickly become political, for as Abu-Lughod (1986) points out, emotions and emotional discourse are political. The state has a vested interest in controlling them, if not reconstructing them, in creating a political ethos (Jenkins 1991b).

Ultimately, the feel of morality, the correct emotional reaction to social events, leads, after a cascade of power relations, to cultural norms. Emotions, and emotional discourse, is then inherently political – on both the local and national levels – and the state has a vested interest in controlling them, if not reconstructing them. As Good and Good write, “the state, along with other modern social structures may play a profound role in organizing emotional life and in defining legitimate interpretations of affective behaviors” (1988:59). For example, the creation of Post-Traumatic Stress Disorder was part of the United States’ attempts to control emotional discourse; it turned the trauma of the Vietnam War into a disease, and it not only freed soldiers, but also the state from guilt. The debate over whether someone is actually ill has profound moral and political consequences, as Janis Jenkins writes: “Someone who is distressed might still deserve that distress, but... someone who is sick is relieved of culpability” (1991b:155). This tension, between what is a disease (like addiction) and what is a moral failing (like criminality), leads to the confusing and erratic emotional discourses expressed by both my study participants and the anti-meth industry.

Questions

What is the lived experience of HIV+ men who have sex with men who use crystal meth? In addition to the need for thick description, my interest is what is structuring the experience. So, I also asked how the subjectivities of these men were shaped by the political, scientific, and moral discourses about HIV, meth, risk, and healthy behaviors. I can also see profound effects of biomedicalization, neoliberalism, and the Drug War. If, as Holland et al. contend, identity is practiced, then I wanted to understand what those practiced processes were that my study participants experienced. This involved not only a life history of each participant, but also a detailed understanding of their lives as meth users, as HIV+, as men who have sex with men.

These men were the focus of anti-meth industry because they had been determined to be a risk to the community, so I wondered if they saw themselves and their behavior as “risky”? How did they perceive risk? How did they resist, accept, perform and embody these discourses? How did they see their behavior in terms of morality, of right and wrong? Did they believe they were deserving of their experience? What did it mean to them that they were the focus of so many forces, so many institutions and individual people?

I was also curious about how the diversity of men who have sex with men affected their interactions with these discourses. Did their political, economic, and ethnic subject positions affect how they experienced, internalized, or resisted these discourses and ideologies? How did educational levels, class positions, and access to different strata of healthcare affect their subjectivities – their identities and emotional and embodied experiences?

Since subjectivity is not simply an interpolation, but rather the product of interactions, I wanted to complement my study of the lives of HIV+ MSM who use meth with an examination of the organizations and agencies charged with stopping HIV infection and meth use. I came to call them the anti-meth apparatus, using apparatus as Foucault did, referring to “a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic proposition” (1980:194).

Primarily, I wanted understand how public health, biomedical, and law enforcement organizations reacted to and tried to reshape the subjectivities of HIV+ MSM who use meth. In what ways did public health and healthcare providers embody or resist popular and academic discourses about HIV, meth, and risk? In what ways did morality and moral conflict structure the ways that agents of these organizations, agencies, and institutions approached these men? How did academic researchers approach these discourses and ideologies? How did law enforcement differ in the ways that they dealt with the problem of HIV+ MSM who use meth, and how did they talk about the difference in their approach? How did the political economy of health and medicine in the post-industrial United States affect the ways that the agents of biomedicine attempt to treat, shape, and interpolate HIV+ MSM who use meth?

Unsurprisingly, some of these questions were easier to answer than others. Using grounded theory (Strauss and Corbin 1990), I allowed my research processes and questions to shift as issues on the ground shifted or revealed themselves in new and different ways. Some questions were less relevant for certain study participant. Similarly,

as newly discovered issues became more salient for me, other questions became more important.

Methods

The overall research aim of my research was to describe and deconstruct how various cultural discourses are involved in constructing the subjectivities of HIV+ MSM who use crystal meth and live in San Diego. My goal was to complement the extensive quantitative research on MSM who use crystal meth in the United States (Wohl, Frye, and Johnson 2008; Halkitis, Moeller, and Pollock 2008; Halkitis, Fischgrund, and Parsons 2005; Semple et al. 2006; Mausbach, Semple, Zians, et al. 2007; Shoptaw, Reback, and Freese 2001; Shoptaw et al. 2005; Reback, Larkins, and Shoptaw 2004) and to contribute to the limited qualitative data that characterizes the contemporary predicament of risky subjectivity and precarious health status (Mimiaga et al. 2008; Díaz, Heckert, and Sánchez 2005; Semple, Patterson, and Grant 2002; Reback 1997). I used a mixture of person-centered ethnography, participant observation, semi-structured interviews, and archival research. I mixed these methods in order to see how the behavioral environment was constructed and, in turn, how the subjectivities of my research subjects were formed in interaction – in micro-physical power relations – with their environment. I see this methodology as a way to operationalize and synthesize Hallowell, Bourdieu, and Foucault.

Person-centered ethnographic interviews

The centerpiece of my research was person-centered ethnographic interviews with 14 HIV+ MSM who use crystal meth. (Thirteen men sat for full cycles of interviews,

while one only came twice; he died before I could do follow-up interviews.) Hollan describes person-centered ethnography as the anthropological attempt “to develop experience-near ways of describing and analyzing human behavior, subjective experience, and psychological processes. A primary focus... is on the individual and on how the individual’s psychology and subjective experience both shape, and are shaped by, social and cultural processes” (1997:219). In order to examine what my subjects said about their experience, what they did that reveals and is constitutive of that experience, and how they embodied their experience (Hollan 1997; Bourdieu 1990; Csordas 1990), I conducted in-depth interviews – between five and eight hours – with my central sample. In addition, I observed a six of them in social, home, and healthcare settings, all based on the methodology as put forward by Levy and Hollan (Levy 1973; Levy and Hollan 1998). This methodology is greatly influenced by psychiatric interviewing (Sullivan 1970), and the interviews resemble the therapeutic encounter with the key difference being that my goal was not change but rather intensive information collection. (For a discussion of the ethical problems of person-centered interviewing, see the conclusion to this dissertation.)

The goal of these interviews were two-fold. First, I wanted to record and describe the subjectivity of my sample. Second, I wanted to understand how and why their subjectivities came to be, looking for causes in the phenomenological dialectic between political economy and personal psychodynamics. For the orchestration of the self, I collected the life narratives of each member of my sample, including explanations of their identity formations and their experiences with their personal health, drug use, education, and sexuality. I wanted to understand how the men in my sample were oriented to the world (Hallowell 1955), and importantly, why. I paid particularly close attention to how

their individual classes, ethnicities, and other subject positions affected their narratives and their orientations to the behavioral environment. Similarly, these positions played roles in how the men in the sample experienced and expressed their emotions. I asked about their emotions, and I also tracked the emotional discourses in their narratives. During participant observation with the subset, I recorded how emotions were communicated and expressed (Abu-Lugod 1986; Lutz 1988; Jenkins 1994). Finally, I also paid keen attention to how these experiences and self-concepts were physically expressed and mediated (Fernandez and Herzfeld 1998; Csordas 1994). I asked them to explain how they understand their physicalities, not only in relation to their drug experiences, but also their sexual and medical experiences as well. With permission, I audio recorded all of the interviews using a Zoom H2 digital recorder. In addition to the interviews, I also asked for extensive biographical data that included such family, employment, income, educational, and medical histories.

I recruited my study participants from several sources. I gave fliers to and asked for referrals from healthcare providers, case managers, and addiction counselors, and two-thirds of my sample came to me through these contacts. The other third were recruited through study participants; they were friends or acquaintances of early members of the sample. One was referred by friend and neighbor of mine. My sample was stratified and reflected the racial diversity of previous studies on MSM who use crystal meth in Southern California (Shoptaw et al. 2001; Shoptaw et al. 2005; Semple et al. 2002; Mausbach, Semple, Strathdee, et al. 2007). However, because of where my referrals were originating, many of the men who joined my sample were in case management, in a rehabilitation program, or recently in recovery. Only one of the 14 was

fully employed, and only one was a full-time student. The rest were either living off public assistance, through petty crime, or were homeless or some combination of all of these. So, while the socioeconomic statuses of their childhoods were diverse, most of my sample were similarly economically strapped.

The demographic breakdown was as follows:

Name (Pseudonym)	Place of birth	Race	Age at first interview	Age tested HIV+	Age of first meth use
<i>Adam</i>	Coldwater, MI	White	31	31	22
<i>Brandon</i>	Poway, CA	White	22	20	12
<i>Charles</i>	Placerville, CA	Native American	41	17	15
<i>Darrell</i>	National City, CA	African-American	36	34	17
<i>Eric*</i>	Johnson City, TN	White	46	22	25
<i>Glenn</i>	Burbank, CA	White	42	31	34
<i>Jonathan</i>	Santa Monica, CA	White	50	30	25
<i>Jorge</i>	Guadalajara, Mexico	Hispanic	47	28	42
<i>Matthew</i>	San Francisco, CA	White	32	26	12
<i>Max</i>	Philippines	Pacific Islander	38	37	34
<i>Richard</i>	Stockton, CA	Hispanic	49	34	42
<i>Sam</i>	Berkeley, CA	White	43	23	13
<i>Walter</i>	Los Angeles, CA	African-American	49	36	49
<i>William</i>	San Francisco, CA	African-American	43	23	17

* Eric sat for two one-hour interviews in 2010 and did not return. He died the next summer in an altercation with police.

Figure 1. Demographic breakdown of central sample.

I paid each of these informants \$15 in cash for each hour of interview time. I chose this payment after a discussion with another researcher focusing on the population from which my sample was pulled. He told me that their economic situations were likely to be such that an iTunes or Amazon gift card, my original idea for remuneration, would be much less useful than cash, which could be used to buy food or drugs. The ethics of paying drug-addicted research subjects has been addressed by IRB boards and other scholars (e.g. Ritter, Fry, and Swan 2003). That said, it was clear to me that the payment I

offered my informants did create a power relationship that affected the data I collected in some way, though it was different for each interviewee. The most salient moments are addressed later in the dissertation.

I conducted the vast majority of my interviews with the sample of meth-using HIV+ MSM in a one-room office in downtown San Diego, two blocks from the Thursday night location of the clean syringe exchange where I volunteered. The office was simple, just tables and chairs and a desk; I shared it with my husband, who used it to teach writing workshops. While I was offered space in the offices of some researchers and providers, I decided that my more anonymous office would be at least slightly intimidating than those of the anti-meth apparatus.

Semi-structured interviews of community and institutional actors

In addition to person-centered ethnography of HIV+ MSM who use crystal meth, I also performed semi-structured interviews with community leaders, medical professionals, public health officials, and academic researchers. I was interested in how cultural discourses about HIV, drugs, gayness, etc. influenced the construction of the subjectivities of my central sample, so in order to understand how local actors were involved in the productions of these discourses, I interviewed various agents of the institutions in the anti-meth industry: Family Health Centers of San Diego, the San Diego Methamphetamine Task Force, the School of Medicine at the University of California San Diego, and various rehabilitation and recovery centers. Each semi-structured interview lasted on average about an hour, and I asked these interviewees their experiences with, feelings about, and opinions concerning HIV/AIDS, crystal meth, the

gay community, politics, public health, and medicine. I used a snowball method to find most the subjects for these interviews, beginning with key informants that I met at UCSD and Family Health Center, asking them for suggestions, and then asking those subjects for more suggestions. My status as a UCSD researcher made interviews among healthcare service providers, researchers, and community leaders easy to obtain, but not among law enforcement officials. In Chapter 2, I explain in more detail the processes and problems by which I found these interviews.

Interviews with the different groups of institutional actors had different focuses. Doctors, nurses, and psychotherapists are charged with encouraging healthy behavior in their patients, and their authority and power is particularly powerful (Foucault 1963; Parsons 1951). Thus, the ways that health care professionals in San Diego conceptualized and communicated discourses about HIV/AIDS and meth use had profound effects on their patients. My interviews with these people focused on their memories of and opinions about treating HIV+ MSM who use crystal meth, their beliefs about risk and risky behavior, and both medical and moral ideas about HIV/AIDS and homosexuality.

Several multi-million-dollar research projects focusing of meth use among MSM are currently running in the San Diego area, and their data is being used in public health campaigns in San Diego and the rest of the country. I was interested in how the research was performed, how the data was operationalized, and the discourses created by and within these processes. I asked these actors about the philosophies behind their research and health campaigns, the ways that their data is created and used, and their moral and political opinions about the data.

The meth epidemic in the United States is largely considered a law enforcement problem, with treatment and prevention important but less funded and less visible. Those involved in the enforcement of drug laws, from politicians to prosecutors to members of the sheriff's department, are directly responsible for the governmentality that structures the quotidian experiences of my central sample. I asked the interviewees in this group about how they conceptualized of MSM who use meth, their moral and political opinions about HIV/AIDS and drug use, and how they constructed and utilize discourses about gayness for political purposes.

Following Mishler (1986), I considered the interview to be both an event for the gathering of information from an informant as well as a cultural event in and of itself, as productive of discourse. I was self-reflexive in my role in helping to produce ideas and ideologies about HIV+ MSM who use crystal meth (Levy and Hollan 1998:347-348); this was particularly important as I was an analyzer *and* an agent of one of the central knowledge-producing institutions in the region, UCSD. All of these interviews were audio-recorded.

Participant observation

During the research, another central method was participant observation, which Taylor and Bogdan define as “research that involves social interaction between the researcher and the subjects, in the milieu of the latter, during which data are systematically and unobtrusively and collected” (1998:24). There were two key domains for this research. First was in the daily activities of HIV+ MSM who use crystal meth. In addition to the person-centered interviews of the men in my central sample, I joined six

of the participants in their day-to-day activities, spending time – as allowed – in social, home, and healthcare settings. I wanted to understand both their habitus and the behavioral and ideological environment that was helping to structure their subjectivities. I paid particular attention to how my study participants talked about their drug use, sexual experiences, medical statuses, and their emotional states with friends, acquaintances, and health care professionals.

The other major domain was the anti-meth apparatus. I did participant observation in community clinics, research conferences, community meeting, political events, and gay meeting places, from cafes to dance clubs. Observing and participating in scientific meetings, public forums, outreach work, and research subject recruitment helped me to develop an understanding of the production and utilization of technoscientific, governmental, and moral discourses about crystal meth use, HIV/AIDS, and behavioral modification in the service of public health. For two years, I worked at the county's only clean syringe exchange, participating in the most visible harm reduction program in the area. In addition, for a year, I was a HIV testing counselor, where I learned how to discuss HIV and risk reduction as mandated by the state and county. I regularly attended meetings of the HIV Planning Council, the Community Advisory Board of the Antiretroviral Research Center, the Methamphetamine Strike Force, as well as public events, community programs, and outreach efforts planned or hosted by members of the anti-meth apparatus.

Plan of this dissertation

In the first chapter of the dissertation, I analyze the discursive structures of the moral panic concerning the “double epidemic” of HIV and meth, the “world’s most dangerous drug” (Biega 2006). Stanley Cohen argued nearly 40 years ago that moral panics are fueled by the media and by people in positions of power; they are discursive, political events. While the use of psychoactive substances is a cultural and historic universal, drugs are used, discussed, and imagined in socially and historically specific ways, and meth use in the gay community is no different. I base the argument of this chapter on the theories of Stuart Hall, who argues, via Foucault, that culture is shared meanings, meaning comes through language, and “representation through language is therefore central to the processes by which meaning is produced.” These meanings are in turn what become the normal that, Halliwell argued, the self becomes oriented towards, and this normal is what is interacted with in the, as Foucault would say, microphysical power relations that develop subjectivity. After a discussion of Cohen and Hall’s theories, I provide a history of the meth epidemic, including a history of the association of meth and HIV and the moral panic this connection wrought. I will then analyze three discursive events: an episode of the hit television drama *Law & Order: SVU* about an AIDS activist accused of murdering two meth addicted gay man who were spreading a super strain of HIV; the \$17 million “Me, Not Meth” anti-meth public health campaign in California; and the press coverage and reader reaction to the death of HIV+ San Diego gay man on meth in the custody of the police in Palm Springs, California.

In the next chapter, I argue that American anti-meth apparatus, which partly arose as a result of the moral panic described in the first chapter and partly was created by the

Drug War and the AIDS epidemic, is not only heterogeneous, but also inefficient, confused, and at odds with itself. The people working in the apparatus's disparate branches all want meth to be gone from their community, but none can agree how or why. Either they see meth use as morally wrong, or they see the suffering caused by meth addicts as morally wrong, or they see the desire for healthy living as a moral imperative. The apparatus arose from what has been called an epidemic of meth addiction, what is believed to be a crisis of public health, public safety, and morality. The different wings of the apparatus have responded in different, often contradictory ways, and this dissonance is representative of the ethical and moral confusion that American culture has about addiction. I argue that all the branches of the anti-meth apparatus are trying to create the same thing: not just a meth-free community, but also individualistic, self-disciplined subjects primed for late capitalism. First, I contextualize the anti-meth apparatus within both the historical trend of biomedicalization and Michel Foucault's analysis of the prison and the clinic as instruments of social control. Next, using Steve Parish's discussion of the development of moral consciousness and Jarrett Zigon's theory of how moral breakdowns lead to the construction of ethical practices, I explain that moral underpinnings of the methods of the various branches of the anti-meth apparatus. Using ethnographic vignettes from participant observation and semi-structured interviews, I describe the moral positions of the four main branches of the anti-meth apparatus: law enforcement, medical treatment and care, academic research, and public health and prevention.

The effects of the apparatus's efforts on the lives of my central sample are the focus of the next three chapters, which focus on three key domains of their experience:

self-medication, the desire to be and the frustration with trying to be normal, and the strategies and tactics for survival. In Chapter 3, I discuss how self-medication is the dominant reason that the men in my study used meth. They started to use meth as way to escape depression, fear, and anxiety; or they started for other reasons, like pleasure or curiosity, and they continued because of the depression, fear, and anxiety engendered by meth addiction. Pleasure for pleasure's sake is sometimes the initial reason these men first used the drug, but self-medication is what kept their use going, even when they did not experience the sort of physical addiction that a quarter of meth users have. When my study's participants described their highs, they almost always included the joy of being free from problems, anxiety, and sadness. Similarly, when they told me about the withdrawal from meth, they described it as a physical return to the emotional and psychological discomfort, bodily pain, and the fear of a hostile environment.

All of my participants wanted to be normal, as I discuss in Chapter 5, and what constituted normalcy was an American – and both the last 20th century neoliberal and “homonormative”⁴ ways – ideal of self-reliance, employment, health, marriage, and home-ownership. This desire for normalcy was not just the product of living in the United States at the particular historical moment, but also it was also influenced greatly by the men's experiences with recovery programs, the prison system, and healthcare providers, all of which were trying to shape them into a particular kind of normal, moral subjects. Specifically, they were being shaped into addicts, either active or in recovery.

⁴ Lisa Duggan describes homonormativity as “A politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption” (2004:50)

They were taught to narrativize their addiction as moral and medical stories, and their stories tended to end with dreams of a normal future, a future free from pain, frustration, and the gaze of the apparatus. But in their struggle to make that future happen, their emotional options were limited by the anti-meth apparatus: those who failed felt profound shame, and those who succeeded expressed great pride in their abilities.

Importantly, normalcy is not just a goal or a dream; in Chapter 5, I explain it is also a survival mechanism. In attempting to shape, construct, and interpolate these subjects, the men and women who work in the anti-meth industry pull from moral discourses of good and right behaviors that operate to define bad and wrong behaviors: which synthetic substances are allowed in the body, how good and productive citizenship is defined, what responsible health behaviors are expected. In turn, those who are able or willing to develop the correct subjectivities are rewarded with services, care, and entry into the fold, while those who cannot or will not are cast, somewhat literally, over the walls, behind the fence, and into the canyons that line San Diego's landscape like cracks in a broken windshield. I watched my research subjects negotiate complex and fraught practices in order to access the care, services, and shelter they needed to survive: whether it was by transforming themselves into recovering addicts in the structures of 12 step programs, learning how to manage the physical and discursive presentations of their addictions so that they could pass as a sober when in the normal world, or developing a network of charitable assistance through strategic recitation of prohibitionist discourses.

Finally, in the conclusion, I revisit and tie together the claims made in the introduction and the previous five chapters: The efforts to stop HIV infection and meth addiction among gay men has had an unintended consequence: the social abandonment of

HIV+ meth addicted gay men to an underfunded, ineffective, but well-meaning healthcare system and a deeply flawed law enforcement system at odds with the health of the addict. In turn, the subjectivities of these men have been constructed in an environment of pity, anger, fear, and loathing, which contributes to lived experiences of suffering. The problem of witnessing suffering and injustice through person-centered ethnography in clinical settings is also explored. I examine the realization of becoming a member of the anti-meth apparatus by virtue of conducting research. Practicing that identity, requiring the need to set “boundaries” to alleviate my own suffering was challenging. Using discussions of counter-transference in anthropology, I will show how this sort of witnessing can cause a moral breakdown – as it did to me – that must be repaired through a new ethics: the obligation of the anthropologist to alleviate suffering. Finally, I make recommendations for how the apparatus, however fraught, can alleviate suffering through both policy and cultural change.

Chapter 1:

The “Double Epidemic” As A Moral Panic



Figure 2. Billboards warning against meth and encouraging disclosure of HIV status.

A dozen billboards on the three-mile stretch of University from Hillcrest east through North Park almost always feature public health campaigns directed towards men who have sex with men. In seven years I lived in San Diego, the campaigns featured exhortations to know your HIV status and post it in your profile on hook-up sites, to get tested for syphilis and look out for chancres on your partners’ hands and feet, to ask your partners’ HIV status and tell them your own, and to take the Early Test for HIV, which detects HIV’s RNA a week after exposure. In the winter and spring of 2008, the billboards in San Diego’s gay neighborhoods featured two separate campaigns about the dangers of methamphetamine. One campaign featured stylized drawings comparing partying with meth and going to jail for meth, and it was sponsored by Family Health Centers of San Diego. The other was California’s Department of Alcohol and Drug Programs’ “Me, Not Meth” campaign, the billboards for which had “I lost me to meth” scrawled over black and blue images of gaunt sad-eyed young men. One of those was

looming over the McDonald's on the corner of University and Richmond, glaring down at the line to get into the city's largest gay nightclub, Rich's. These two advertising campaigns followed the December, 2007 showing of the documentary-length anti-meth public service announcement *Crystal Darkness* on five local TV stations simultaneously.

These three campaigns marked the end of the most intense period of the moral panic about crystal meth in San Diego (1996-2008), which also comprised within it, a secondary moral panic about crystal meth in the gay community and its connection to the spread of HIV and a possible super-strain (2005-2008). Moral panics, as Cohen (2011) and Goode and Ben-Yahuda (1994b) argue, are disproportionate, extreme social reactions to threats that create “‘folk devils’ ... deviant stereotypes identifying the enemy, the source of the threat, selfish, evil wrongdoers who are responsible for the trouble” (Goode and Ben-Yehuda 1994b:156). In this chapter, I analyze the discursive structures of the moral panic of the “double epidemic” of HIV and meth, the “world’s most dangerous drug”⁵ (Biege 2006). While the use of psychoactive substances is a cultural and historic universal, drugs are used, discussed, and imagined in socially and historically specific ways, and meth use in the gay community is no different. However, the way that meth and HIV became epidemiologically and socially intertwined led to a specific kind of cultural milieu.

I base the argument in this chapter in the theories of Stuart Hall, who claims, via Foucault, that culture is shared meanings, meaning comes through language, and

⁵ Whether meth is actually the world’s most dangerous drug is of course arguable, considering what crack and heroin addictions are capable of doing to both individuals and communities. Part of the moral panic process is an amplification of deviance, making what may be a debatable superlative into an undebated, taken-for-granted truism.

“representation through language is therefore central to the processes by which meaning is produced” (1997:1). These meanings are in turn what become the normal that, Hallowell argued, the self becomes oriented towards, and this normal is what is interacted with in the, as Foucault would say, microphysical power relations that develop subjectivity. After a discussion of moral panic theory and Hall’s theories of representation, I provide a history of the meth epidemic, including a history of the association of meth and HIV and the moral panic this connection wrought. I will then analyze three discursive events: an episode of the hit television drama *Law & Order SVU* about an AIDS activist accused of murdering two meth addicted gay man who were spreading a super strain of HIV; the \$17 million “Me, Not Meth” anti-meth public health campaign in California; and the press coverage and reader reaction to the death of HIV+ San Diego gay man on meth in the custody of the police in Palm Springs, California. Finally, I will conclude with a description of the normative morality concerning meth, HIV, and MSM in San Diego.

Moral panics, representation, and meaning

Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solution; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorate and becomes more visible. Sometimes the object of the panic is quite novel and at other times it is something which has been in existences long enough, but suddenly appears in the limelight. Sometimes then panic passes over and is forgotten, except in folklore and collective memory; at other times it has more serious and long-lasting repercussions and might produce such changes as those in legal and social policy or even in the

way the society conceives itself. (Cohen 2011:1)

Stanley Cohen opened his book *Folk Devils and Moral Panics* (2011 originally published in 1972) with this description of the moral panic. The book, which was a sociological examination of how British culture reacted to a series of riots involving mods and rockers in 1964, was responsible for entering the term “moral panic” in both the popular and academic lexicon. Other moral panics that Cohen identified in the original and the 2002 edition included the Teddy Boys, childhood sexual abuse, heroin, crack, and marijuana epidemics, false asylum seekers, welfare cheats, and so on. It is my contention that the HIV-meth connection that became salient in the early 2000s, peaked in 2005 with belief that a super strain of HIV had partly because of rampant meth use among gay men, and ended in 2008 with the “Me, Not Meth” campaign comprised a moral panic. It was not on the same nationwide level that, say, the crack addiction and child molestation panics were in the 1980s. But in gay communities and their environs in the United States in the 2000s, the meth-HIV panic held an equivalent role as an object of fear, anxiety, and fraught discussion.

The theory of moral panics comes from the sociology of the 1960s, in which deviance and deviance amplification were major concerns. In particular, Cohen sides with the transactional theory of deviance, which, instead of holding that deviance is what leads to social control, holds that, quoting Becker, “social groups create deviance by making the rules whose infraction constitutes deviance and by applying those rules to particular persons and labeling them as outsiders... deviance is not a quality of the act the person commits, but rather a consequences of the application by others of rules and sanctions to an ‘offender’” (2011:5). Thus, as Cohen writes, “the societal reaction is thus

conceived as the ‘effective’ rather than ‘original’ cause of deviance: deviance becomes significant when it is subjectively shaped into an active role which becomes the basis for assigning social status” (2011:7). Over the four decades since Cohen’s first edition was published, the media and other powerful institutions have increasingly focused not only on deviance but the threat and risk of deviance. In the risk society (Beck 1992), the “social anxieties, insecurities, and fears” (Cohen 2011:xxx) create for a nearly constant low level of panic about all sorts of dangers. Thus, the fear of SARS or bird flu led to fear – a panic – about those who may be carriers, from East Asians to Mexicans. And the connection between meth use and HIV infection, the risk that meth use will lead to HIV infection and then possible into a super strain, was what fueled the moral panic in the 2000s.

In Cohen’s formulation of the moral panic, the media is the driving force behind these panics’ definition and its spread: “The student of moral enterprise cannot by pay particular attention to the role of the mass media in defining and shaping social problems” (2011:9). He quotes Erikson, who noted that “a considerable portion of what we call ‘news’ is devoted to reports about deviant behaviour and its consequences” (2011:10). The media of the late 1960s is obviously vastly different from the media of the first decade of the 21st century; our media is diversified, diffused, fractured, confused, and more interactive than what could even be imagined when Cohen was theorizing the moral panic of the mods and rockers. However, the representation, and in turn the cultural understandings, of moral panics now may be more complex and conflicted, but they are still mediated. Television, radio, and print still dominate, but they are now joined

by social media and web-based news and commentary to complicate the ways that the representations of the moral panic are produced.

Cohen's moral panic theory became particularly influential after the initial publication of his book, with Goode and Ben-Yehuda's expansion of his initial ideas (1994a) even more so. They provide a clear schematic for what constitutes a moral panic. First, there must be greater and increasing concern that the behaviors of a certain group of people will lead to problems for the larger, general society. This can be seen in opinion polls, media attention, and social action. Next, hostility develops; the group that is concerned about becomes a folk devil, a them counter to an us. Below, I explain in detail the process of how HIV+ MSM who use meth became first a concern and then were turned into folk devils. Consensus occurs in the next step. This is not by any means the majority agreeing, but rather a sizeable group in a particular place, for a moral panic does not need to be nationwide but can occur in a small, discrete community. This, too, is addressed below. The fourth attribute of a moral panic is disproportionality, in which the reaction to the phenomenon is either statistically exaggerated (such as the claim that anorexia kills 150,000 American women a year), nonexistent (such as the fear of satanic ritual abuse), comparatively more focused upon than the same problem at a different time (such as heroin in the 1990s, when rates were the same as the 1980s), comparatively more focused upon than a similar but just as or more problematic phenomenon. It is the last that the panic of meth and HIV is disproportionate, since alcohol abuse, lack of safer sex information, the arrival of anti-retroviral drugs, and condom fatigue are as great if not great reasons for the increase of HIV infection rates in the mid 2000s. Finally, these panics are volatile, arising and disappearing just as quickly, which is not to say that they

do not have structural or historical antecedents. ... Likewise, describing a given concern as volatile does not mean that moral panics do not, or cannot, leave a cultural and institutional legacy. Indeed, elements of panics may become institutionalized during panics, organizations and institutions may be established at one point in time that remain in place and help stimulate incipient concerns later on, at the appropriate time. (Goode and Ben-Yehuda 1994b:158–159)

This can be seen in the aftermath of the some moral panics, such as those about pedophilia and childhood sexual abuse, which lead to sex offender registries, which are now embedded in the American legal system.⁶ Similarly, the panic about HIV and meth has led to numerous institutional and cultural changes, from federal funded interventions and research projects to the omnipresent “No PNP”⁷ that appears on gay dating profiles.

While Goode and Ben-Yehuda stress that moral panics can be generated by elites, interests groups, or the grassroots public, I do not think the role of media in furthering the panic can be underemphasized. In the introduction to the 2011 edition of his 1972 book, Cohen has pointed out that the media are involved in three stages of the moral panic drama “(i) *Setting the agenda* – selecting those deviant or socially problematic events deemed as newsworthy, then using finer filters to select which of these events are candidates for moral panic; (ii) *Transmitting the images* – transmitting the claims of

⁶ Other moral panics, such as those in response to comic books in the 1950s (Hajdu 2008), horror films or “video nasties” in the early 1980s (West 2010), violent or obscene music lyrics in the 1980s and 1990s (Wright 2000), fade away and become mostly forgotten, their institutional after-effects, like the comics code stamp of approval or the parental advisory insignia of CDs, remaining toothless reminders of a historical oddity. Still other events that perhaps could benefit from a panic, like sexual assault in the military or climate change or the Rwandan genocide, fail to take hold in the popular imagination, despite righteous attempts by interest groups to create moral panics in response to them. As Cohen writes, “Sometimes... the media try to create moral concern, but struggle against palpable audience denial” (2011:xliv).

⁷ The term PNP refers to “party ‘n’ play,” and it is used on gay hook-up sites indicate a desire to take meth (party) and have sex (play). While seeing it was common in first half of the 00s, “No PnP” became vastly more common following the moral panic; it is now an option to be checked on many profiles, along with race, build, and whether one is looking for dating or just sex.

claims-makers, by sharpening up or duymbing down the rhetoric of moral panics; or (iii) *Breaking the silence, making the claim*. More frequently now than three decades ago, the media are in the claims-making business themselves” (2011:xxviii–xxix). For example, shows like Dateline NBC catch sexual “predators” by seducing and then filming their shame, and many newspapers print the names and addresses of people on the sex offender registries, ostensibly as a public service. The media is the central source for the representation of the moral panic and the folk devils at its center. Perhaps more nefariously, these representations amplify deviance by labeling groups of people as deviant, and this labeling leads people to behave in a deviant fashion because their self-concept becomes formed in part around rejecting social and cultural forms (Denham 2010).

Representations of these moral panics create and implicate the subjects of panics and define their role – their subject position – within a culture. Stuart Hall (1997), in his expansion of Foucault’s theories on power and discourse, argues that culture is shared meanings and that meaning is exchanged and produced through representations in language, signs, and images. “We are able to communicate because we share broadly the same conceptual maps and thus make sense of or interpret the world in roughly similar ways,” Hall writes. “That is indeed what it means when we say we ‘belong to the same culture.’ Because we interpret the world in roughly similar ways, we are able to build up a shared culture of meanings and this construct a world which we inhabit together” (1997:18). Hall connects the notion of shared meanings and shared codes, mostly following Saussure and Barthes, with Foucault’s theory of discourse and discursive

formulations in order to express how representations are historically situated and embedded in webs of power relations.

As Hall explains, Foucault's project was to "analyse 'how human beings understand themselves in our culture' and how our knowledge about 'the social, the embodied individual and shared meaning' comes to be produced in different periods" (Hall 1997:43). All of this is done through the analysis of discourse, "a group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment. ... Discourse is about the production of knowledge through language" (1997:44). When the multiple discursive events all refer to the same subject and do so in similar ways, they are part of a discursive formation; when they are part of an intuitional strategy, they become an apparatus. These formations are historically specific and the production of power relations; knowledge about something or someone is always a product of power. In this way, what we know to be true about something or someone is not an indelible universal truth but rather a historical specific discursive formation "sustaining a regime of truth" (1997:49). Why Hall prefers Foucault's theory power over that of Marx's ideology and Gramsci's hegemony is that Foucault did not see power as always top-down but rather a web, "many, localized circuits, tactics, mechanisms and effects through which power circulates – what Foucault calls the 'meticulous rituals' or the 'microphysics of power'" (Hall 1997:50).

While much of western philosophy has privileged the agentive subject who believes that he or she is the source of meaning and source of discourse, Foucault's radical position is that the subject does not exist outside of discourse because it must

always be subjected to discourse. Discourse produces subjects, not the other way around. Subjects have free will, but their options to exercise that are limited by the constraints of the reality that exists within the web of power, within a specific historical context and framework. Discourse produces subjects such as, in Foucault's work, the madman, the prisoner, and the homosexual, or in the case of this dissertation, the tweaker. But discourse also produces a "reader or a viewer, who is also 'subjected to' discourse ... It is not inevitable that all individuals in a particular period will become the subjects of a particular discourse... But for them – us – to do so, they –we – must locate themselves/ourselves in the position from which the discourse makes most sense, and this becomes its 'subjects' by 'subjecting' ourselves to its meaning, power and regulation. All discourses, then, construct subject positions, from which alone they make sense" (Hall 1997:56). These subject positions, as I contend, can have profound effects on behavior and subjectivity. You can become the subject *or* the object, depending on who are determined to be in the discursive formation. For as Cohen points out, this can further solidify their status as deviants. After deviants are identified and responded to punitively, "The deviant or group of deviants is segregated or isolated and this operates to alienate them from conventional society. They perceive themselves as more deviant, group themselves with others in a similar position, and this leads to more deviance. This, in turn, exposes the group to further punitive sanctions and other forceful action by the conformists – and the system starts going round again" (2011:11–12). The discursive construction of the tweaker pushed the HIV+ MSM who use meth further from the community, from services and support, and closer to behaviors that only law enforcement were allowed to handle, furthering and exacerbating suffering.

Popular media like network television and Hollywood film play particularly powerful roles in this amplification of deviance. In Denham's synthesis of moral panic theories and social and cognitive psychological understandings of film watching, he argues that movies "help to construct media-driven panics by identifying and reifying internal enemies and external enemies, with 'folk devils' bearing responsibility for 'skyrocketing' use of substances such as heroin, crack cocaine, and methamphetamine" (2010:485–486). This can also be applied to popular television as well as to advertising. These moral panics are constructed, either willfully or haphazardly, by "moral entrepreneurs" in the forms of politicians, pundits, editors, and producers who bind deviant behaviors with "shame, disrespect, and irresponsibility" (Ben-Yehuda 1990:84), which, in turn, encourages audiences to have particularly emotional responses, usually anger or "moral indignation." Citing Ericson, Baranek, & Chan (1987), Denham writes, "By definition, deviance does not exist without calls for social reaction, and when those appeals are made in concert with powerful imagery, reaction becomes increasingly intense" (2010:486). The depictions of these moral panics – of the folk devils and their deviant behaviors – help audiences form cognitive frames through which to view events and attribute blame. But emotions become frames in and of themselves, and Denham cites Nabi (2003), who argued that repeatedly viewing pairings of emotions like fear and anger with certain narratives and images shapes the way that people read and react to those narratives and images.

In short, emotional reactions stand to influence behavioral attributions. On a conceptual level, disposition theory suggests that media enjoyment tends to increase when disliked characters experience negative outcomes and liked characters prevail, consistent with the moral concerns of audience members... When one links disposition theory with social identity and

attribution theories, out-group deviant behaviors, the result of an apparent proclivity for wrongdoing, must be stopped. If, as Critcher (2006; 2003) suggested, mass media “map” issues and events onto existing discursive frameworks, then dramatic film representations might provide recurring foundations for drug-issue constructions by creating antagonists and protagonists based on characteristics such as race, social class, gender, and nationality... Such characterizations may generate affective responses, which stand to normalize responsible reactions to the perceived reality. (2010:489)

Meth, HIV, and the superstrain: “A wake-up call”

Arguably, the beginnings of the moral panic about the connection between HIV and meth can be traced back to 1997, when a young San Diego man named Andrew Cunanan, supposedly HIV+ and high on meth, went on a killing spree. He first killed two men in Minneapolis, an ex-boyfriend and one the ex’s friends, before driving to Chicago and murdering the real estate mogul Lee Miglin. He stole Miglin’s car and then dumped it in New Jersey, killing a cemetery caretaker and stealing his truck. The night after the body of the gravedigger was discovered, I was working late at *Newsweek*, and Jon Meacham, then the editor of the national affairs section, paced the halls, repeating, “This is a cover. This is a cover.” He meant that the story was going to be big; it had all of the sex, violence, and mystery needed to sell magazines. And Meacham was right. Six weeks later, Cunanan shot and killed the world-famous Italian fashion designer Gianni Versace in South Beach, Florida, on the steps of Versace’s mansion. The combination of a murder of a major celebrity and the unexplainable criminal behavior of a young, ethnically ambiguous, sexually aggressive, drug-addicted social climber was a marriage made in tabloid heaven, and the media – from the TV newsmagazines, to the weekly print newsmagazines, to the actual tabloids – were obsessed with Cunanan for two weeks.

Under a pseudonym⁸, I wrote the cover story for gay and lesbian magazine *The Advocate* about the media's construction of the story. "The media are supposed to hold up a mirror to reflect whom they're reporting on," I wrote. "In the Cunanan case, however, the mirror seemed to reflect the media's own confused perceptions about who gay men are... In the end, the story wasn't about a crazed killer and his five victims. For much of the news media, it was about giving Americans a glimpse into a world they've never understood – and perhaps understand even less now" (Crowley 1997). As with many mass murders, from Columbine to the Boston Marathon bombing, the reason for the killing becomes a media obsession; with Cunanan, his homosexuality, drug use, and HIV status, all of which had been panicked about in the past, were central to the discussion.

Cunanan was a classic folk devil, one of the "visible reminders of what we should not be" (Cohen 2011:2). He was irrational, liminal, infectious, and dangerous; he was risk personified. The coverage of the story focused on Cunanan's sexuality and sexual behavior, whether it was as prostitute, a habitual user of cocaine and meth, someone interested in kink, or as a person with AIDS. *Vanity Fair's* Maureen Orth titled her book on Cunanan *Vulgar Favors*, in which she wrote, "Lurking just beneath the charm a sinister psychosis was brewing, aided by Andrew's habits of watching violent pornography and ingesting crystal meth, cocaine, and various other drugs so prevalent in circles of gay life today — but not spoken of" (Orth 2000:2). Tom Brokaw, the anchor of NBC News in 1997, called Cunanan a "homicidal homosexual," while CNN asked a panel of experts whether or not serial killers often suffer from sexual dysfunction. Joe

⁸ As a *Newsweek* reporter, I could not criticize *Newsweek* under my own name.

Walsh, the host of *America's Most Wanted*, made perhaps the most telling statement: “[Cunanan] crossed the line from killing gay people for revenge and started killing innocent bystanders.” Finally, though there was scant evidence that he was HIV+, let alone had AIDS, *The New York Post* ran a story with a headline reading “AIDS Fuels His Rage,” and *Newsweek's* Evan Thomas more subtly claimed that Cunanan was initially taking revenge on people who may have given him HIV. There was some pushback: In the *Washington Post*, the executive director of Washington, DC's Whitman-Walker Clinic, which provides healthcare for people with HIV and AIDS, said that AIDS being the cause of the killing spree was “as conceivable as saying he has a sixth toe.” And in the *Miami Herald*, the health writer wrote sadly, “It was a naked reminder that 16 years after AIDS seeped into the national consciousness, the virus is still seen through a prism of fear and misunderstanding.” After Cunanan killed himself, the autopsy showed that he was negative for HIV. No one has ever been able to identify Cunanan's motive. The communication professor Matthew Soar writes that “the singular lack of any concrete explanation for Cunanan's actions – which could only conceivably only have come from him – gave the media the freedom to make all manner of claims” (Soar 2000). In the vacuum of knowledge about who Cunanan was and why did what he did, the space was filled with negative, occasionally hysterical, assumptions about drugs, HIV and AIDS, homosexuality, and what happens in gay enclaves out of the sight of “innocent” people. These assumptions would eventually return.

While there was a certain amount of panic concerning where Cunanan might strike next – wanted posters hung in gay bars all over the Eastern seaboard between Versace's death and Cunanan's suicide – Cunanan's story was not clearly connected to

the concern that was developing about the increase in meth use among gay men that California public health researchers were just then identifying. But he fit into the homicidal homosexual category and narrative that had been at work for decades before AIDS, in which gay men were seen as more likely to kill children and each other, and became even more pronounced during the AIDS epidemic, in which every gay man was a potential Typhoid Mary (Herek 1991). The moral panic about AIDS in the 1980s dwarfs the meth-HIV moral panic of the 2000s; the fear of AIDS has become so integral a part of the collective memory, it is so salient, that AIDS-based stigma is still the most important reason for not getting testing for HIV and for not revealing one's status to a sexual partner. While the outright panic that was palpable in the mid to late 1980s died down to a low boil after the advent of HAART, flare-ups continue in the form of Cunanan's HIV-based motives, the MRSA outbreaks in the mid 2000s (Diep et al. 2008; Burroway 2008), and in the arrival of the so-called super strain of HIV in 2005.

While these flare-ups were, in most ways, the constructions of for-profit mass media organizations earning viewers and readers by wittingly or unwittingly playing into fears of the homicidal homosexual, the "double epidemic" of meth and HIV was structured and fueled by public health researchers and AIDS activists. As Cohen writes, moral panics feature "socially accredited experts [who] pronounce their diagnoses and solutions" (2011:1). These accredited experts did not initially encourage a panic, nor the creation of folk devils. A month before Cunanan started his murder spree, Cathy Reback presented to the Los Angeles City Council her ethnography on meth use and gay and bisexual men in Los Angeles, noting that use had increased dramatically in the previous decade. Reback found that in her sample, meth usage was not just a self-medication to

“manage certain AIDS-related conditions or effects, both physical and psychological” but also a coping strategy for dealing with “emotional and/or physical pain associated with their lives such as boredom, senses of isolation and hopelessness, grief, and mourning” (1997:xi). The report, titled *The Social Construction of a Gay Drug*, also focuses on how meth “complements” parts of gay culture that are “valued” by gay and bisexual men, from the focus on sex to weight and mood control. In the section on “Crystal-facilitated sexual decision-making,” the ways that crystal encourages irresponsible behavior around protecting oneself and others from HIV are detailed. Recommendations for intervention were, compared to later and recent discussions in the media and in public health campaigns, focused much more on cultural and emotional context of gay and bisexual men and less on the stigmatization of “irrational” health behavior. In hindsight, Reback’s analysis almost reads as radical: “HIV interventions for gay and bisexual crystal users cannot be understood outside the historical context of AIDS... Interventions must address the impact of AIDS on both the individual user and the gay communities and must acknowledge that, for many, crystal use is historically and socially relevant” (1997:65).

In the context of the Drug War and the neoliberalization of health behavior, describing drug use as culturally “relevant” is taboo. Nick Reding, whose bestselling and award-winning book *Methland* detailed the meth epidemic in the small town of Oelwein, Iowa, took a similar tact in describing the impetus for using meth. Not only was meth not a surprising drug for people to take, it was also a sensible reaction to American labor conditions – as a reaction to the American dream.

For eight decades, from the time Nagayoshi Nagai first synthesized meth in 1898 until the early 1980s, meth was a highly acceptable drug in America, one of the reasons being that it helped... “the salt of the earth” –

soldiers, truck drivers, slaughterhouse employees, farmers, auto and construction works, and day laborers – work harder, longer, and more efficiently. It’s one thing for a drug to be associated with sloth, like heroin. But it’s wholly another when a formerly legal and accepted narcotic exists in a one-to-one ratio with defining ideal of American culture... So much so that [sociologist] Patricia Case calls meth “the most American drug.” ... [The] ability to make something in your basement that promised work, success, wealth, thinness, and happiness was not necessarily too good to be true. (Reding 2009:54)

But as Reding details, it *was* too good to be true. Addiction and the criminal, medical, and social results of the spreading addiction led to a social suffering in especially rural America that compounded the economic conditions that Reding claims encouraged its use. Reding is outraged not by the meth users, who he has compassion for, but for the state’s confused and disastrous response, from allowing pharmaceutical companies to lobby away restrictions on precursor chemicals to failing to treat addicts adequately and instead send them to jail, where they would receive no treatment. But like Reback’s ethnography, *Methland* was read and lauded by those intellectuals in the culture who resist moral panics. The discussion with Reding on San Diego’s local NPR station included two local treatment experts of meth treatment who agreed with Reding on most of his arguments, though they did not share his outrage (Cavanaugh 2009). This was, however, several years after the peak of the panic, when such positions, outraged or not, were rarely taken.

As meth spread from the West Coast and into both eastern gay enclaves and the rural Midwest in the late 1990s and early 2000s, meth became an “epidemic.” Each community affected and infected by meth were astonished by the level of crime, the number of addicts, and suffering that followed. Meth was doing to some communities what crack had done to some inner city neighborhoods in the 1980s. As Cohen explained,

while some moral panics are based on nearly non-existent problems, as the hysteria about satanic child murders in the late 80s was, others were based on tangible, even catastrophic problems, like the crack and AIDS epidemics in the mid to late 80s. However, the proportionality of the response is the issue, because “some disparities are so gross, some claims so exaggerated, some political agendas so tendentious that they can only be called something like, well, ‘social injustice’” (Cohen 2011:xliii). While the panic about meth did not result in anything as extreme as the law that treated crack as 100 worse than a similar weight in powder cocaine and was used wildly disproportionately against African-Americans (Protass 2007), the discursive construction of the meth addict was not dissimilar to that of the crack addict. Skinny, crazed urban blacks were simply replaced by prematurely aged, toothless, pockmarked rural whites. This can be seen in newspaper, television news, and documentary reports, and it is even more pronounced in the anti-meth public health campaigns in which the arguments against meth use are the most concentrated. “[By] 2005,” Reding writes, “thousands of stories across the country blaming meth for delusional violence, moral depravity, extreme sexual perversion, and an almost otherworldly, hallucinogenic dimension of evil” (Reding 2009:43).

Reding’s colorful language notwithstanding, the descriptions of meth use in the press focused greatly on the worst case scenarios, from the horrible burns caused by meth lab accidents to abandoned children of meth addicts. The public health campaigns focused on the so-called meth mouth, in which meth addicts lose their teeth because of incessant grinding, or on family violence, like the ad from the Montana Meth Project that depicted a bloodied woman on the floor of a kitchen with the slogan, “My mom knows I’d never hurt her. Then she got in the way” (Mother 2011). Gay men were referred to as

careless as they partied in denial, spreading meth and HIV. Their behavior was called “sexual roulette” (Cheshes 1999), and it was leading to a “rebound epidemic” (Torassa 2001). In the *Village Voice*, the moral outrage came in the form of near mockery of the hedonism of gay men: “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” (Owen 1999). The pathologically narcissistic pleasure-seekers that provided the petri dish for AIDS in the 1970s, depicted in the not just the speeches of anti-gay politicians like Jesse Helms but also in histories like *And the Band Played On*, were back, this time the folk devil of the meth-HIV moral panic.

In 2001, the sympathetic tone of Reback’s report was not apparent in Halkitis, et al’s extremely influential article – cited 274 times in other peer-reviewed articles, according to Google Scholar – that cemented meth and HIV as a connected, dual, intertwined problem. “A Double Epidemic: Crystal Methamphetamine Drug Use in Relation to HIV Transmission Among Gay Men” describes a looming specter of an increase of HIV in the gay community due to meth use. Halkitis, et al’s article covers much of the same ground as Reback’s, bringing in additional support from more recent research, but the language includes more emotionally laden terminology and a focus on stigmatized kinky sexual behavior, all of which ratchets up the panic level of the discourse. Meth is a “substantial threat to HIV/AIDS prevention,” and the combination of meth and sex is “disconcerting” because meth encourages “risky” behavior. All of this

means that there is a “potential for an epidemic of methamphetamine,” which would be “destructive” (2001:18–19). They point to the use of the drug in the creation of “instant bottom” and in facilitating sexual marathons, group sex, fisting, and “a greater likelihood of having 50 or more sexual partners ... as compared to their heterosexual counterparts” (2001:25). The language of Halkitis, et al was more clinical and technical than the popular press accounts, but the goal was the same; while it is doubtful they were attempting to titillate the reader, they were certainly trying to alarm.

They conclude that meth is at the center of behaviors that will exacerbate the AIDS epidemic: “Methamphetamine use by gay and bisexual men may, therefore, work to perpetuate the AIDS epidemic among this population by creating a patchwork of complex, interrelated behaviors related to sexual risk taking within its users” (2001:28). However, while this conclusion is similar to many of the articles they cite, Halkitis et al go further to speculate on an even worse outcome of this double epidemic, that increased unprotected sex among HIV+ men on HAART will result in drug-resistant strains of the virus: “With the development of new treatment regimens for HIV infection such as protease inhibitors, methamphetamine-related risky sexual behavior among HIV+ gay and bisexual men presents the likelihood that newer seroconversions will occur with antiretroviral-treated and potentially mutated HIV virus (Halkitis 1998). The spread of drug-resistant strains of HIV will further complicate and prolong the HIV/AIDS epidemic” (2001:28). While at this point the science of how HAART was affecting the mutations of the virus was somewhat unclear, the suggestion that too much sex by people on HAART would lead to a super-strain and to another, even greater public health

emergency was founded only in theory. But that did not stop it from being repeated by gay pundits and AIDS activists (for example Ehrenstein 2004).

And then the feared super-strain actually arrived. The hysteria of AIDS reports from the 1980s returned, and combining the increasingly moralistic and angry tone of the anti-meth public health campaigns and the copious amount of academic research showing that meth use was increasing and implicated in new HIV infections, the media helped create a small moral panic in the spring of 2005. A man who was recently infected with HIV developed full-blown AIDS in mere months, and he was resistant to three out of four classes anti-retroviral drugs. On February 11, 2005, health officials in New York City put out a press release announcing that situation, with the city's health commissioner quoted saying, "This is a wake up call to men who have sex with men." Major AIDS researchers including David Ho, who developed combination therapy, and Aaron Dobkin, the director of Columbia University's AIDS program were quoted in the release to give it weight. The writer of CNN's article wrote that the situation "raises the *possibility* that a hard-to-treat variant of the virus could be spreading among gay and bisexual men who use the drug methamphetamine" (Drug-resistant HIV Strain Alarms Officials 2005, emphasis mine). Other initial news reports repeated the "wake up call" quote and dwelled on the patient having been infected during unprotected anal intercourse and while using crystal meth (Rovner 2005; Dobnik 2005; Santora, Altman, and McNeil 2005; Talaga and Star 2005).

In the string of newspaper, magazine, and web articles and TV news stories that followed, the restraint of the initial wire news stories disappeared. The always incendiary *New York Post*'s headline read "New AIDS Super Bug – Nightmare Strain Shows Up In

City” and its lead sentence was even more hysterical and inaccurate: “A frightening, never-before-seen ‘superstrain’ of the AIDS virus - unimaginably aggressive and resistant to nearly all treatments - has been found in New York City, alarmed health officials announced yesterday” (Edozien 2005). *The New York Times* headline was finger-wagging and accusatory: “Among Gays Grown Complacent And Often Careless, Fear Returns” (Confessore 2005). Halkitis is quoted in the article saying that his prediction had come true; “This is what we were fearing all along,” he says. Only Walter Armstrong, the editor of the *Poz*, doubted that the hysteria was warranted, saying, “A handful of cases does not an epidemic make.” But this kind of doubt is described as “indifferent” in a handwringing, accusatory article for *The San Francisco Chronicle*, “No panic over report of new HIV strain; Infection back East worries some here, others indifferent.” Each person quoted is clearly concerned, but only one 28-year-old gay man doing his laundry says he would wait to see whether panic was warranted; he must have been the “indifferent” one (Fulbright 2005). In a third *New York Times* article, the lead quote is similarly used to highlight the stupidity and indifference of so many gay men: “I have spoken to young kids, sometimes here, who say, ‘If I get it, it's no big deal. I can just take a pill,’” he said. “I'm like, ‘Are you stupid?’ It is so disgusting. I find it really disturbing” (Perez-Pena and Santora 2005). An article that ran the next day focused on how little gay men were discussing the superstrain (Cave 2005).

Four days after the initial report, in the *Times*' fourth front page article on the super strain in as many days, gay reporter Andrew Jacobs quoted AIDS activists and pundits who were “advocating an entirely new approach to the spread of unsafe sex, much of which is fueled by a surge in methamphetamine abuse. They want to track down

those who knowingly engage in risky behavior and try to stop them before they can infect others” (Jacobs 2005b). But more than discussing the details of how such an epidemiological project would work, the article is mostly a collection of statements about the irresponsible evil of gay men who use meth and spread HIV. Charles Kaiser, author of *The Gay Metropolis* and brother of the Associate Editor of the Washington Post, is given the lead quote, comparing condomless sex with murder: “Gay men do not have the right to spread a debilitating and often fatal disease. A person who is H.I.V.-positive has no more right to unprotected intercourse than he has the right to put a bullet through another person's head.” (In a subsequent op-ed in the *Washington Post* about the “juvenile” irresponsibility of some gay men, Richard Cohen says his “guru” on the subject is Kaiser (Cohen 2005).) Larry Kramer, the playwright and founder of ACT-UP, had recently given a suddenly legendary speech titled “The Tragedy of Today’s Gays,” and Jacobs quotes from it, “You are still murdering each other. Please stop with all the generalizations and avoidance excuses gays have used since the beginning to ditch this responsibility for this fact.” Gabriel Rottello, another longtime activist, was similarly Chicken Little about the future. “You can't have a core group of people having sex with large numbers of people without amplifying any sexually transmitted disease that enters the system. I don't have any doubt that a resurgent H.I.V. epidemic will hit the gay population in the near future. People are not going to modify their sexual habits in ways that are difficult or unpleasant until they see their friends dying again. And to me that's just an unbelievably depressing thought.”

Balancing Kaiser, Kramer, and Rotello, Jacobs quotes people working in HIV care and advocacy, who point to the danger of hunting down people who might be

spreading HIV. Jon Givner, the director of the HIV Project at the Lambda Legal Defense and Education is quoted, saying, “We don’t want public health vigilantes going out and taking matters into their own hands, particularly if it means breaching the confidentiality and civil rights of people with H.I.V. Frankly, I find it pretty scary.” To counter Givner, Jacobs then describes how gay men “strenuously opposed efforts by health officials to trace those infected with the virus. Until now, those advocates, driven by concerns about privacy and the stigma associated with the disease, have successfully fought off efforts to impose a traditional public-health model for tackling the spread of the virus.”

In the days and weeks that followed, newspapers and televisions newscasts all over the country – and in Canada and the United Kingdom, as well – repeated the messages and tropes that appeared in the *New York Times* (Honigsbaum 2005; Resnick 2005; Carry 2005; Connection Between Methamphetamine Use and Unprotected Gay Sex 2005; Allen 2005; Jacobs 2005a; Kusel 2005; Ramsey 2005; Specter 2005; Chung 2005; Turner 2005; Moore 2005). *The New York Daily News* railed, “Such reckless foolishness is the most extreme manifestation of a complacency toward AIDS” (Deadly Disease, Deadly Behavior 2005). The influential sex columnist Dan Savage spoke out in favor of tracking down HIV+ gay men having unsafe sex in an interview on National Public Radio (AIDS and Personal Responsibility 2005), while the Village Voice gossip columnist found such ideas “alarmist” (Musto 2005). And “alarmist” is perhaps the best way to describe the opening of a *Newsweek* article than ran at the end of February; the lead was a detailed description of meth-fueled orgy in a hotel room across from Ground Zero. David Jefferson, who like Jacobs is gay and who would eventually pen the famous *Newsweek* cover story about meth titled “America’s Most Dangerous Drug” (Jefferson et

al. 2005), constructed an image of the object of the moral panic more explicit than anything that had yet appeared in the mainstream press:

It's Saturday evening in Manhattan, and three dozen men are crammed into a one-bedroom suite in an upscale hotel across from Ground Zero. After shelling out \$20 apiece to the man who organized tonight's event over the Internet, the guests place their clothes in Hefty bags for safekeeping and get down to business and pleasure. A muscular man in his mid-30s sits naked on the sofa and inhales a "bump" of crystal methamphetamine. Within minutes, he's lying on the floor having unprotected sex with the host of tonight's sex party, whose sunken cheeks, swollen neck glands and distended belly betray the HIV infection he's been battling for years. In the bedroom, a dozen men, several of them sweaty, dehydrated and wired on meth, are having sex on the king-size bed. There's not a condom in sight. "It's completely suicidal, the crystal and the 'barebacking' [unprotected anal sex]," says one of two attendees who described the scene. "But there's something liberating and hot about it, too." (Jefferson and Williams 2005)

Jefferson then repeated much of what the *Times* had reported in the previous weeks, and while he was sure to place doubt in the theory that meth was the reason for the super strain and would be the reason if the strain created a second epidemic, he furthered moral panic succinctly with such stories like John's: "Decimated by the endless partying, he would crawl into the bathroom at his office and curl up around the toilet, still wearing his business suit, to steal an hour of sleep. 'You get tunnel vision,' John says. 'Your world gets smaller until it's just you, a pipe and the Internet. And, for a growing number of users, HIV.'

As the spring and summer of 2005 wore on, articles like Jefferson's appeared in newspapers in Canada, Australia, Britain, and in smaller American cities. But none reported what the *Daily News* reporter Jason Shin did: that the man who supposedly had the super strain was responding to treatment (Shin 2005). But Shin did not report on the July presentation by Gary Blick at an international AIDS conference that explained that

the epidemiology of the man's strain, that it was contracted from a man from Connecticut whose virus had become resistant to anti-retroviral drugs after many years of taking them. While meth had been a key factor in the condomless sex that led to the infection of the New Yorker, the strain had not spread further than the New Yorker, the Connecticut man, and the Connecticut man's partner; there was no new epidemic. In the paper on the case that was finally published in 2007, Blick wrote that it was possible mutations and resistance to drugs could lead to a "disastrous" super strain or to "superinfection" – in which someone infected with one strain of HIV can be also infected with a separate a distinct strain – the 2005 case was an interesting aberration, if a worrisome one (Blick et al. 2007). A recent meta-analysis of HIV superinfection studies show that while it is possible, there is very little evidence that superinfection happens more than extremely rarely (Waters and Smit 2012).

While the panic that the superstrain garnered may have increased vigilance about HIV and meth and certainly was a factor in increased spending on anti-meth public health campaigns, interventions, and studies, it was not, in hindsight, something worth panicking over. However, the media response was not surprising: as in original AIDS panic of the early 1980s (Patton 1985), the discourse focused on the irresponsibility of gay men, on out of control sexual behavior, on the danger that what gay have wrought will lead to an second epidemic, and implicitly, this would be yet another epidemic that threatens the "general" and "innocent" population. When it turned out that the drug-resistant HIV was not real, virtually nothing was mentioned by the media outlets that had promoted the threat, but the demonization of gay men as lawless and hedonistic remained. While traditional moral panic theories and analyses (Denham 2010; Goode and

Ben-Yehuda 1994a; Morgan, Wallack, and Buchanan 1989) focus on how people who seek or already in elected and appointed places of power benefit the most from these sorts of panics and crises – because they activate attribution biases that focus on individual moral failure rather than of socio-economic problems that should be bailiwick of those in power – the panics also, and perhaps most insidiously, benefit those conservative communities and classes that feel threatened by the Other in the form of the folk devil. Readers and users of conservative web forums like FreeRepublic.com and Townhall.com posted many of the mainstream media’s panicky articles as fodder for their readers’ commentary, usually as confirmation of their beliefs that gay men were dangerous to American society (Colson 2005; Party, Play and Pay: Inside New York’s Meth Fueled HIV/Internet Sex Parties 2005). Online communities have achieved an out-sized influence on political rhetoric in the United States in recent years, particularly on the right (Carty 2011; Williamson, Skocpol, and Coggin 2011; Raisinghani and Weiss 2011).

But what made the meth/HIV panic different from the original AIDS panic was that it was created and supported by gay men in positions of power in academia and the media. Gay men had made enormous progress in the 25 years since the beginning of the AIDS epidemic, not only structurally within institutions like large media conglomerates and research universities, but also in winning unprecedented healthcare for people with HIV and AIDS and in the shockingly swift adoption of same-sex marriage in several states. At a time when these rights and gains were threatened by ballot initiatives and an emboldened conservative movement in Washington DC, gay meth users threatened the hard-fought image of gay men as respected and responsible members of society. In turn, gay men crafted messaging that differentiated good gays from bad gays. As Denham

writes, “In the context of moral panics, when groups that have attained power sense external threats, they may characterize specific out-group behaviors as deviant and morally reprehensible; mass media facilitate these characterizations through narratives of heroes and villains” (2010:488). One of the commenters on FreeRepublic.com astutely wrote, “This story is the homosexual civil union proponents’ worst nightmare.”

Discussions of how to reach out to and help meth users who were having unsafe sex were present in the reporting, but the dominant, both emotively and in placement in the actual stories, message was that meth users practicing unsafe sex were stupid, childless, criminal, suicidal, dangerous, and insane. By building a discursive prison cell for these men, the authors of these discourses were able to retain their privileged and empowered place in American society. The discursive stigmatization of meth use and condomless sex in discourse succeeded in making “No PNP” a fixture in online profiles for gay men seeking sexual and romantic partners, which in turn succeeded in shoving men who wanted to PNP and have condomless sex into both actual and virtual venues that would cater to them without stigma.

As with doubts about the methamphetamine addiction moral panic (Shafer 2006; Ahrens 2010; Armstrong 2007a), some activists and academics pushed back against both the taken-for-granted facts about and the discursive structure of the meth and HIV epidemic. The activist Tony Valenzuela’s lengthy article (2008) about the 2005 superstrain panic in the magazine *Poz* (edited by Walter Armstrong, the voice of caution in the *New York Times* articles mentioned above) featured not only an interview with the (still living) man, the “New York Patient,” whose drug-resistant virus led to the panic and a detailed analysis of how HIV prevention efforts and HIV prevention discourse

stigmatize gay men, but also a damning explanation about how the man's virus was not new, not exceptional, and had not been likely to lead to a new and worse epidemic. In a resigned critique of the New York Patient's response to being the carrier of the superstrain, Valenzuela points out that politics have left AIDS. "The New York Patient's anger is not externalized," he writes.

... it's directed at his virus, at his tainted blood, at himself. What he is reflecting is a state of affairs of being a gay man today, in particular one with HIV. Anger is not allowed. It barely seems to matter that he, like others with HIV, is stigmatized, or that gay men's sex practices are pathologized, as long as they keep HIV-negative men uninfected. Gay men's very existence is equated with disease in a call to protect the "general public" while our national LGBT leaders are more inclined to call gay men "complacent" than to indict a health establishment that has built an entire industry around the so-called deficits of gay men. How have we arrived at this place where in the interest of health, stigma has become institutionalized?

The moral panic theorists would answer simply: This is how many moral panics end, with the folk devil cemented into both intuitions and discourses.

As the panic subsided, the stigma hardened. "Moral panics often seem ephemeral," Garland writes, "but over time their cumulative effect can be to create social divisions and redistribute social status as well as building infrastructures of regulation and control that persist long after the initial episode has run its course" (2008:16). The general public and most gay men stopped paying attention; the anti-meth ads and messages became rote, omnipresent, like wall paper. The mediated discussions, pop culture depictions, and public health campaigns solidified the ideology of the out of control tweaker, but few of them caused much commotion or commentary. A *Law & Order: Special Victims Unit* episode that expressed moral ambivalence about the murder of gay meth addicts spreading a superstrain of HIV made barely a ripple. The largest anti-

meth campaign in the country, California's \$17.5 million "Me Not Meth" campaign, barely registered in the mainstream media and the gay media was only slightly concerned. And in 2011, an HIV+ gay man who was under the influence of meth was killed in the custody of the Palms Spring police, and the online commentary about his death focused on whether or not he deserved his fate because of his choices. While the panic died down, ideology that fed the panic remained, as did the folk devil the panic created, an object of scorn or of fear.

Ripped from the headlines

On October 18, 2005, NBC aired an episode of *Law & Order: Special Victims Unit* (often referred to simply as *SVU*) called "Strain," and the plot followed Detectives Olivia Benson and Fin Tutuola as they looked for the killer of two meth addicted gay men. According to the Nielsen Company, which monitors ratings for television shows, "Strain" was seen by 14.4 million people that night alone, and it was highest rated show of the night; it was the 13th highest rated show of the week (The Associated Press 2005). With repeats of *SVU* episodes running on multiple channels multiples times a day every day of the year, it is possible that another 50 million people have seen that episode by now. Like many police and law procedurals such as *CSI* and the original *Law & Order*, *SVU* has helped influence how Americans interpret justice, perceive policing, and attribute guilt. While there is spirited debate about the existence of the "CSI effect," in which the show about high-tech forensics has made juries more critical of the real-world, much less perfect forensic skills of police departments (Schweitzer and Saks 2006; Tyler 2006), the rise and spread of television media portrayals of the police has improved the

image and the public's trust of the police (Callanan and Rosenberger 2011); logically, this also means that the public is more likely to trust the police's decision over who is guilty. Law enforcement has helped to make this happen. Denham, in explaining how visual media like film and television have the capacity to "amplify deviant behaviors among subsections of the population," notes that "government agencies appear to possess the ability to legitimate and reify film characterizations. As an example, the National Institute on Drug Abuse (NIDA) sponsors annual Prism awards for films that offer the most 'accurate' depictions of drug use in society" (2010:497). *SVU* has been nominated for 21 Prism awards, winning five (Prism Awards n.d.). While "Strain" was not nominated, the depiction of meth, HIV, gay men, and what constitutes a rational response to a public health problem were all in line with both the moral panic that had been generated in the previous year by the combined efforts of the news media, public health authorities, and gay men in positions of power.

Like most episodes of *Law & Order* and its spinoffs, "Strain" begins with the discovery of a body. We see a young man and woman walking down a street in Manhattan's West Village late at night. The woman stops to look in the window of a shoe store and exclaims that the store has a pair she has been looking for; her boyfriend says he will buy them for her. Then they both realize that it's not a naked mannequin around which the shoes are displayed. It's a dead body, and above is painted "KILLER." The woman screams. In the next scene, we see the Detectives Tutuola and Benson and the

investigator decide how the crime was committed. In a subsequent scene, the police psychiatrist Dr. Huang says of the crime, “It’s theatrical. He wants attention.”



Figure 3. The first victim.

The detectives first begin looking into the club where Robin had his wrist stamped. It was gay club, and the night of the murder it was packed for “a circuit party.” This is when Benson and Tutuola realize Robin was gay, and the queer signifiers in the previous scenes – the theatricality of the murder, the victim being the manager of a women’s shoe store – are confirmed. The club manager shows the detectives a computerized list of everyone who had been at the party; all of their driver’s licenses had been scanned and saved. While perusing the list, Tutuola realizes that his son Ken was at the club. This sets up the parallel depictions of good gays and bad gays, with Tutuola’s son representing the former.

Next, Benson and Tutuola speak to Robin’s father Liam, who is upset but seemingly unsurprised. After he agrees to let the police search Robin’s apartment, the police discover other gay signifiers. They find photos of Robin at “all of the gay hotspots,” and Benson remarks about how old he looks for only being 30. Then they find a box full of pills. Benson recites the names, all anti-retroviral medications: “Robin had AIDS!” Robin’s father had also taken out a \$500,000 life insurance policy on his son.

Benson insinuates this as motive, he responds that Robin's rehabs and medical bills had bankrupted him, and, crying, he says knew that "it would only be a matter of time" before Robin would die of drugs, AIDS, or at the hand of his boyfriend, who beat Robin. Immediately, the police jump to this stereotypical motive, that when a gay man is murdered, it is usually during a lover's quarrel.⁹ When the police go to see Robin's boyfriend Lydon Grant, they find him dead, naked and shot in the head, "KILLER" painted on the wall, and what turns out to meth all over the floor, as if it had just snowed. The crime scene investigator calls meth "the sex drug of choice." The detectives decide that it must the murders must be drug related.

The detectives initially suspect a gang called Manhattan Killer Squad, which targets gay meth users, steals their drugs, and sells them to gay meth dealers. In the precinct the detectives discuss meth, and offer key information, that "meth ages you fast," that it "makes you violent and paranoid." After staking out a club called Euphoria –



Figure 4. The detectives watch the protest on their surveillance monitors.

⁹ Homosexual domestic violence is the plot of such famously homophobic movies like *The Detective* and *Cruising* (Russo 1987). Additionally, the assumption that Jeffrey Dahmer and Konerak Sinthasomphone, one of his eventual victims, were simply having a lover's quarrel prevented them from investigating, leading to the Sinthasomphone's death. This event has been used by activists as an example of the police not taking gay life seriously (Potoczniak et al. 2003).

which is being picketed by people with signs that say “Meth Equals Death” – the police capture one of the gang members, who has a tattoo that says “Killer” on his arm. But the medical examiner, Dr. Warner, interrupts, and saying that she knows what “Killer” refers to. Robin and Lydon both had the so-called “Killer Strain” of HIV, a drug-resistant strain of the virus that progresses to AIDS in six months. They could have been spreading the virus, “making them both killers.” The rational truth of her statement is cemented by her cold delivery. Dr. Huang says that the murderer wants people to “wake people up,” repeating the phrase used in the real-world press release about the super strain. They deduce that the murderer is tracing the infection chain. They go to the Department of Public Health and discover that a list of infections and their sexual partners was stolen, though the list was encrypted. The detectives find out the person who stole the list was Gabriel, the man who runs the group that had picketed Euphoria, the Rainbow Army. The Army is clearly a stand-in for ACT-UP, which was found by Larry Kramer. Like ACT-UP’s members, the Rainbow Army’s members wear identical branded black t-shirts and spouting militant, angry phrases.

The detectives decided to have Tutuola’s son Ken infiltrate the group. He shows up to volunteer, he says the right thing to get in Gabriel’s good graces: He sees gay men “being stupid,” and it “makes me want to do something.” After evidence is collected, Benson discovers that Gabriel’s brother had died of the Killer Strain. The detectives show up at one of the Rainbow Army’s protests and arrest him for murder. Gabriel admits that he killed Robin and Lydon, and he says he did it because they were spreading the Killer Strain. He admits that he knew who had infected his brother, and he saw Robin at the circuit party, came on to him, and killed him in the shoe store. “What are two lives

compared to the thousands could be lost?” he asks. Watching the interrogation, Dr. Huang says that Gabriel has a “messiah complex”; he seem to be a violent, young crossbreed of Charles Kaiser and Larry Kramer. Gabriel’s lawyer pleads self-defense, that by killing Robin and Lydon, he was saving the lives of gay men. Arguing for her defense strategy, Gabriel’s lawyer, parroting Charles Kaiser’s comments in *The New*



Figure 5. At Gabriel's arraignment.

York Times, says that “two men with HIV having drug-fueled sex puts other gay men in danger,” that Gabriel was “defending the entire gay community from two men whose behavior threatened thousands.” When Assistant District Attorney Novak calls an expert witness from the Centers for Disease Control to explain what the super strain is, the expert says. “We may be on the verge of a disaster, another world-wide epidemic,” either mimicking or echoing Perry Halkitis in his “double epidemic” article and his *New York Times* quotes. When she is cross-examined, in another echo of the *Times* article on the need for radical measures, the CDC expert says, “We have no way to stop them.” Under redirect by the prosecution, however, expert says, smiling, that murder is “of course” not the answer. While accepting as a truth the words of a fictional CDC official is not rational, audiences have been greatly influenced by the science fiction of *CSI*'s forensics

and the morality of shows like *COPS*; it would not be surprising if they accepted the epidemiology of *Law & Order: SVU*.

In her closing argument, Gabriel's lawyer doubles down on the self-defense argument. In an analogy that could have come from the playwright Larry Kramer, she compares these two carriers of the super strain to Osama Bin Laden arriving on the courthouse steps with a dirty bomb. "Wouldn't you kill him if you could? Desperate times require desperate measures." Novak has her own comparison: "Would it be okay to kill tobaccos CEOs?" Still, Gabriel is convicted, and Novak is confident that Robin's father's statement at the sentencing hearing will ensure that Gabriel goes to jail for life. But Robin's father says, "I don't approve of what Gabriel did, but I understand why he did it." Gabriel is in tears as Liam continues, "I didn't think I'd feel this way. I thought I'd want revenge. Don't punish him too harshly."



Figure 6. "Don't punish him too harshly."

In most American police procedurals bad guys go to jail, and the police and the prosecutors, while flawed, are the lauded arbiters of who is good and who is bad. *Law & Order* and its spin-offs do not exist outside this modus operandi, but the shows do revel in the gray areas before referencing, not surprisingly, law and order. These gray areas are usually considered tragic, such as when a lawyer bends the rules to convict a bad guy or

when a good guy does something bad for the right reasons. As with most “naïve psychologists” who suffer from attribution bias, crimes are the result of individual moral failings, and very rarely are the social, cultural, or psychological explanations for behavior detailed. In “Strain,” for example, the resident psychologist explains that Gabriel has a psychological disorder called a “messiah complex.” He knows that murder is wrong but what he did was right and justified. By the end of the episode, his crime is nearly justified, and his extremist activism is, while not lauded, is given a pass because, clearly, Robin deserved his fate. Robin’s use of meth, however, seems to be based at least partly on the fact that his father rejected him for being gay. This is still the result of one individual tragedy, and not because of structural or cultural homophobia. But Robin’s behavior – infecting hundreds, getting even more hooked on meth – is never explained, nor even verified. He is just presented as the worst kind of Typhoid Mary, callous, hedonistic, and deserving of his fate. Addiction is partly to blame, it seems, but this is seen as his failure of character. In addition, that meth addiction can lead to this sort of murderous behavior is presented as a given, even though it is farfetched to say the least.

While the HIV+ gay meth addict is presented as the folk devil of a moral panic, *SVU*’s script seems to strain not to be considered either AIDSphobic or homophobic. But in presenting “good” gays and “responsible” behavior, the opposite becomes just as clear. Even Gabriel is presented as “doing good work,” and when asked how he feels about the general apathy about AIDS and the super strain, he says, “lonely, afraid, hopeless.” While the prosecutor wins by pointing out Gabe’s hypocrisy – that he would not have killed his brother if his brother had spread the super strain – she is depicted as bullying him and as overconfident. Robin’s father’s statement in support of Gabe, in which he asks the judge

“Don’t punish him too harshly,” is the last word. Gabe is good; Robin is bad. The victim is blamed for the crime. Folk devils, after all, are devils, and they do not deserve sympathy. Denham notes, following Pizarro (2000), that “film [and television] amplify deviant behaviors by drawing attention to those most inclined to commit deviant acts, in effect teaching audiences about “others” by casting out-group members as antagonists who have an apparent predisposition for wrongdoing. Across time, these dramatic narratives stand to affect the cognitive frames on which audience members draw in reasoning about social issues” (Denham 2010:490). While in the past, all homosexuals were out-group members, in newer narratives, homosexuals are placed into two categories, saints or sinners. Ken is a saint, Gabriel has saintly intentions, while Robin and Lydon were the opposite: predatory, violent, theatrical, superficial, and interested only in their own pleasure.

The contradictory, some would say “balanced,” depiction of gay men is less an attempt to counteract potential criticism than an example of post-1960s critique of mass media depictions of minorities that were simplistic and one-sided stereotypes. But instead of a nuanced explanation of how these complexities come to be, why sex and drugs are, as Reback says, “relevant” to the gay community, *SVU* simply shows two sides of a coin, preferences one, and demonizes the other. It is similar to the problematic created when *The Cosby Show* attempted to counteract *What’s Happening* and *Sanford & Son*. The newer model minority depiction does not complicate the negative stereotype; it simply contradicts it, making those who exist in the stereotype even worse off because they are not the ideal.

Losing me to meth

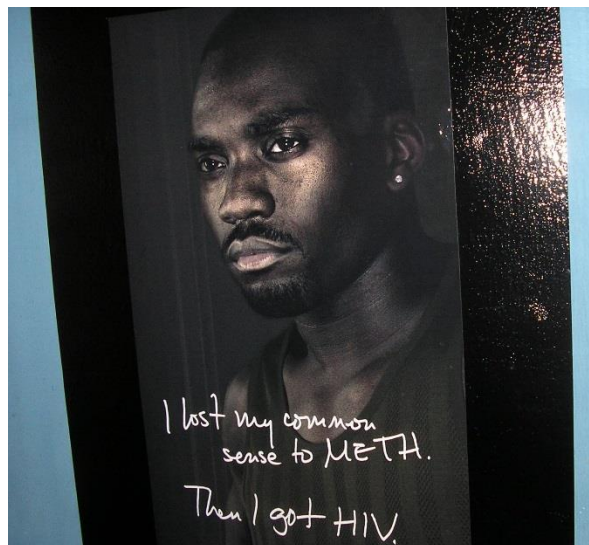


Figure 7. A "Me, Not Meth" poster in a Hillcrest gay bar.

In the March, 2008, billboards through Hillcrest and North Park, the gay neighborhoods of San Diego, depicted grainy, shadowy pictures of grave-faced men. There were multiple versions, depicting men of every race and a variety of ages between late teen and early 40s. The slogan, written in a rough but clear scrawl, always said, "I lost me to meth." Below was the website address menotmeth.org and the insignias of various state public health agencies. The ads appeared on about dozen different billboards in the neighborhoods, and smaller poster versions hung in almost every gay bar and in numerous restaurants, which also served drinks on cardboard coaster versions of the advertisement. I saw Spanish language versions in City Heights, the mostly Hispanic neighborhood adjacent to North Park. In other California cities, the ads were even more omnipresent; in San Francisco, for example, they appeared on the sides of buses and in the subway stations. In the spring and summer of 2008, it was nearly impossible to enter any gay neighborhood in California without being exposed to the "Me, Not Meth" campaign. In San Diego, because the gay community is so concentrated in two

neighborhoods, the campaign had perhaps an even more pronounced presence. But you would not need to set foot in Hillcrest or North Park to see the campaign, since the “Me, Not Meth” television commercial ran for six weeks on television shows known for their gay audiences: *Project Runway*, *Desperate Housewives*, and various shows on Logo, the cable network catering to LGBT people.

“Me, Not Meth” was the largest and most expensive publicly funded anti-meth public health campaign in the United States, and it was quite different from other anti-drug campaigns. A project of California’s Department of Alcohol and Drug Programs, their press release and the initial news reports of the campaign said that it was costing \$13.5 million, though a muckraking activist blogger determined that the actual cost was somewhere closer to \$18 (Petrelis 2008; Engel 2008). Originally, the MSM-focused ads were supposed to be the first phase in a larger campaign, with another phase focused on other, heterosexual communities, but after massive budget cuts following the 2008 recession, this plan was junked. In addition to costing as much as several times the annual budgets of some of the cities’ local HIV service organizations and involving some of the biggest players in public relations and advertising including Edelman Public Relations, Better World Advertising, and the film director Joel Schumacher, the messaging and tone of the campaign were markedly different from other anti-meth campaigns in both California and around the world. The Montana Meth Project, which was the best known before “Me, Not Meth,” was explicitly fear-based, and the images were gruesome and terrifying. (That campaign cost \$20 million over several years and was funded by one private foundation (Kemnick 2009).) These ads, like Oregon’s “Faces of Meth” campaign (Faces of Meth n.d.), depicted the physical degradation of meth users in the

ways similar to how anti-smoking and anti-heroin campaigns had, by depicting “embodied deviance,” in which images of the body’s destruction act “as a kind of symbolic map not just for the social significance of drug use and addiction but for broader notions of deviance and social and bodily disorder” (Huggins 2010:384). The famous, privately funded anti-meth campaigns that appeared in New York in 2003 did not use fear but rather irony and mockery; the ads, which, while controversial because of their tone, were successful in promoting awareness of the issue, looked like ads for household products and the slogan read “Buy Crystal Meth, Get Syphilis and HIV free!” (Nanín et al. 2006). Campaigns that ran in San Diego were less blunt, but they were also based in fear. One campaign running at the same time as “Me, Not Meth” was sponsored by Family Health Centers and it showed the consequences of using meth, often in a split image. Half showed a stylized cartoon of man partying and happy, while another half shows him in jail, his head bowed. The Crystal Mess campaign also focused on the seedy, descent-into-madness imagery that anti-drug campaigns have been using for decades, that have inspired and been inspired by film depictions of drugs in such works as *Panic in Needle Park*, *Less Than Zero*, or *Requiem For A Dream*, films that could all be said to have been involved, as Denham (2010) contends, in the amplification of deviance. The most well-known harm reduction campaign, Tweaker.org encouraged users to learn how to use the drug carefully by using sexy and well-designed instruction materials. It also provided forums on their website for discussion and encouraged treatment for those who were ready.

The “Me, Not Meth” campaign had three components: television ads, the billboards, and the website. Unlike a television show like *SVU*, which features subtle

arguments about morality that use melodrama and genre conventions to draw in and keep viewers, public health campaigns are clear arguments for behavioral change and use much blunter rhetorical tools. The television spots were 30 seconds long, and they were based on video diaries that were then booming on such sites as YouTube. The men who would eventually appear in the billboards spoke to the camera, and to their viewers, about their experiences with meth. The images are slightly grainy, and the lighting is dark, harsh, and tinged blue; stylistically it is reminiscent of Schumacher's work in the thriller *Flatliners*, about medical students who figure out how to die, experience the beyond, and then come back to life. All of the men in the ad are actors, though according to producers, some of them had some experience with meth either through their own use or by friends. The actors are also good-looking, much less haggard than the images of meth addicts in the Montana Meth Project and the "Faces of Meth" campaign.



Figure 8. *Lost*.

The ad begins with, in succession, a handsome Latino man ("Lost"), a skinny young white man ("Skinny"), and a handsome white man in his forties ("40s") sitting down in front of cameras. The man in his forties adjusts the camera. A young black man ("Family") is not in this series, but appears later in the ad. Lost, addressing the camera,

says, “People think you can do meth without it ruining your life.” Skinny appears, and shaking his head slightly, says, “And it was amazing at first and then...”



Figure 9. Skinny.

40s is suddenly on the screen. He is angry and resigned and says, “Everything went to hell.” Lost, emphatic and slightly choked up, says, “I lost my job. I lost my man.” Skinny, nodding, says slowly, “I lost my common sense and got HIV.” Family appears, and he is ashamed and seems angry at himself: “My family was okay with me being gay but I lost them because of meth.” 40, looking away from the camera for a moment before returning his gaze, says, “I lost everything I cared about.” Lost, looking down and away from the camera, says, “I lost myself.” The screen goes back and Skinny says, “I lost me to meth.” The word “Me” appears and becomes “Meth,” and then the web address and a hotline number appears: MeNotMeth.org 866-787-METH.

The billboards, smaller posters, and cardboard coasters uses the pictures of “Skinny” and “Lost,” as well as several other men who did not appear in the ad. In the print advertisements, the imagery is similar to the television spots, with the coloring more gray and less blue. The expressions of the men are similarly wan. The website that the posters and television commercials advertised was ambitious. Not only was there information about meth addiction and treatment, but there were also places for people to

discuss meth, to tell their stories. Video testimonials were encouraged and posted. After the budget cuts, the original site was taken down, and a barebones collection of information sits at the site's URL.

The intent of the ad is clear: If you do meth, no matter your age or race or intent, your life will fall apart. You will lose your job, your family, your man, and your health. Losing "me" is the ultimate disaster, and what constitutes "me" in the ad is not explicit, but the implicit definition is a combination of not only your occupation, familial relationship, and health but also common sense, happiness, pride, and happiness. All of the actors in the ad express regret and shame, and the 40something and the black men are also angry, at themselves, at their own stupidity. While the ad is tonally different from many drug abuse prevention messages in that it elicits empathy from the viewer rather than disgust, it follows the argument of many HIV prevention messages targeting gay men in which rational behavior is the advertised goal. As Davis writes about such campaigns, "The application of rationality to risk assumes a general model of human action: people will act to preserve life and avoid death if adequately informed, if barriers to rational action are removed and if people are otherwise supported" (Davis 2002:281). By arguing that those who are rational humans will avoid meth and stay HIV-negative, it implies that those who use crystal meth or contract HIV are irrational and, in some ways, inhuman, deviant, and Other.

The American gay community has long had conflicted opinions about public health imagery, whether complaining that images of people with AIDS were too negative (Sturken 1997) or complaining the ads for HIV medications depicted people as too healthy (Salyer 2001). So, it was not surprising that the images in the "Me, Not Meth"

images were contested, with many men I discussed the ads with claiming that the mostly healthy looking men were unrepresentative. However, their easy attractiveness was also a draw for the audience. It created identification, sympathy, which kept the viewer watching. The lighting and the physicality of shame and anger keep the men in a state of sadness; there was no glamorizing of meth. In fact, since so much of meth use by gay men is by middle class, socially and sexually active gay men, the men in the ad are appropriate spokesmen for this addiction. In addition, the use of peer warning against the drug is rare in anti-drugs ads, though common in HIV prevention and medications advertising. While many anti-drug ads focus on the harm you will cause the community, this ad focuses on the harm that can be done, not to your physical brain like in the old “This is your brain on drugs” ads, but to something arguable much more important: the self. The selves that were presented and performed in these ads acted as cautionary examples to men who had not yet used meth or for whom meth was not yet a problem. For men who were still using meth, had become HIV+ because of meth, the selves in the ads were exemplars for narratives of recovery (Carr 2010). But many viewers were unsure to whom the advertisement was directed – users, potential users, HIV- men, or HIV+ men – so how the viewers were supposed to react was, to them, unclear.

The response to the campaign was mixed. Many men were simply confused by the ads. At one gathering of gay men, I heard numerous questions along the lines of, “How would that stop people from doing meth?” While discussing it with a health educator, he told me that some of the meth users he knew found the ads “empowering” because they seemed allow users to talk about, and to own, their own experience rather than being told what that experience was supposed to be. While another health educator,

an expert in social marketing, found the message more more unclear: “I don’t know what it’s supposed to be saying.” During the months the posters and billboards were up, meth was a major topic of conversation. Some people were amazed that they saw the ads on TV shows like *Desperate Housewives*, while others joked about the ads. But the discussion of the ads also led to discussion of meth and how terrible the drug was, how terrible it was for the community. The ads were mocked, too, with parodies posted on YouTube, and the posters defaced in San Francisco, where bloggers critiqued the earnestness of the messaging and doubted the effectiveness (I Lost Me--and Faith In Drug Awareness Campaigns--to Meth: SFist n.d.). The sardonic San Francisco blog SFist posted photographs of the defaced – or “tweaked” – posters. One had the slogan crossed out and “Stop meth ads!” written on it, and another added “but I learned to fucking clean house!” (Tweaked Anti-Meth Campaign Posters: SFist n.d.). But while there was lighthearted fun poked at the campaign, which mostly attests to its success at becoming iconic, it was a punch line for a joke on the TV show *Ugly Betty* the next year (Nelli 2009).

San Diego’s local gay newspaper did not find the campaign amusing. In an unsigned editorial, the paper argued that “meth addiction doesn’t discriminate. It doesn’t single out a gender, race or community – but this ad campaign does.” The paper claims that the ad perpetuates an “ugly stereotype of the gay community,” and it claims that “meth is a problem in the gay community, as much as it’s a problem in the straight community, the Latino community, the Native American community, the black community – the risks are as monumental for us all.” While it is statistically not true that meth is “as much” a problem in the gay community as it is in the straight community –

15% of gay men in California in 2008 claimed to have done meth in the last six months compared to 1% of the general population – what is clear is that the paper does not want the gay community’s dirty laundry presented to the general population. “The important question that must be asked is: does this ad campaign do more harm than good? For the vast majority of heterosexual TV viewers, what message does the campaign send about our community?”

What message indeed. It continues in less blunt fashion what *SVU* did. It presents a version of what it means to be good: clean, sober, employed, happy, healthy, responsible. And it presents an image of what is bad: irrational, diseased, dangerous. The *Gay and Lesbian Times* editorial makes it clear what version is preferable for public consumption at the precarious moment in gay rights that was 2008, when Prop 8 was on the ballot and Barack Obama and Hillary Clinton were trading “Who’s more gay friendly?” barbs. The argument of the ubiquitous ad is clear what is preferred, what is right, and what is good. The dark place where “me” is enveloped by “meth” is the void where the gay meth addict will end up.

“Naked Man Scuffles With Police And Later Dies At Hospital”

On the night of August 20, 2011, the police were called to a clothing-optional gay resort in Cathedral City, one of the towns in the Palm Desert resort area, two hours northeast of San Diego. Apparently, a “a naked man” was causing a disturbance at the Cathedral City Boys Club, also known as CCBC. Scott Routh, who was 47 and acquaintance of mine, was escorted from the lobby of the hotel, but an hour later police were called again; a few blocks away, a passing driver saw a man wearing only shorts

was lying on the sidewalk, and another man was trying to get him to stand up. When the police arrived, the man who had been on the sidewalk ran and tried to hide. The police officers pursued Scott and when he resisted arrest, they tackled him. According to the police, shortly after he was handcuffed, Scott had trouble breathing. He was pronounced dead shortly after midnight. Scott's partner told *The Desert Sun* that Scott seemed to having a breakdown of some sort that night, that he seemed to be having panic attacks and unaware of what he was doing. His version of the events also portrayed the police as being responsible for Scott's death. "I could hear my partner say, 'Get off me. You're hurting me,' and they never got off him," he said. "They crushed the life out of him" (Indrelunas 2011).

While it is not clear whether Scott was high when he died – his partner did not “rule out the possibility that Routh's behavior was “somehow chemically induced” – the descriptions of his behavior, the report that he was recovering addict, and his presence at a somewhat notorious resort, led many of the commenters on the news story on *The Palm Desert* website¹⁰ to assume that he was high on meth. (One commenter wrote, “That would be a hoot to have drug dogs sniff the property at CCBC.”) While some of the commenters were focused on the potential police brutality, many were focused on Scott, as a drug user who didn't do as was told by the police, either deserved or should have

¹⁰ There were numerous stories about Routh's death, in the *The Palm Desert* (McGinty 2011; Goolsby 2011; Police ID Man Who Died after Arrest 2011), *The San Diego Union-Tribune* (Davis 2011), news sites based in Los Angeles and Riverside County (Naked Man Scuffles With Police And Later Dies At Hospital 2011; Pedroza 2011; Brooks 2011), and one national gay issues blog (Beauchamp 2011). Commenting was most active in the Union-Tribune and Palm Desert papers, but because both papers shifted their commenting programs between the events and the writing of the chapter, the comments vanished from the papers' website. After emails to the writer of the story and then to web editor of *The Palm Desert*, I was able to gain access to the comments just from their first story on Routh. When I asked for all of the comments to all of their articles, the web editor refused.

expected his fate. One simply commented, “My guess is METH.” One person, who witnessed the altercation at CCBC and said that two men had been arguing: “No idea which one died, but if it was the older one, it could have been from a heart attack (meth combined with the stress of the whole drama). If the younger, almost certainly a meth related death.” Another was certain that Scott’s death was substance-related, writing, “Drugs are a MF'r and I would almost guarantee that's what the cause of death will be.” Another, seemingly having medical knowledge, wrote, “Thanks for the info. With the actions and breathing issue it sure does sound like an meth OD.”

The assumption that Routh’s death was meth-related because he was behaving irrationally and because he was at a space marked as gay and sexualized is most likely the result of the moral panic concerning gay men, HIV, and meth. Of course, as Foucault argued, both irrational behavior and sexual deviance have long been othered, but the moral panic helped to define the specific folk devil and the devil’s specific behavioral traits. It framed the event, the man, and, it could be argued, how the police responded to Routh when they encountered him again on the street. If American TV viewers are told that HIV+ meth users are so dangerous to the good gay men that their murderers are justified, if Californians are told that use of meth erases identities, then it does not seem to be much a leap to think that many of the commenters of *The Palm Desert* might not think Routh was human any longer; he was just a meth user. Assumptions, accurate and inaccurate, about meth and how it affects behavior – criminal, sexual, economic, moral – guide the institutional response to meth users. In the next chapter, I examine the moral positioning of the anti-meth apparatus, which is so powerful in structuring the behavioral environment where my informants live, or, rather, struggle to live.

Conclusion

In this chapter, I traced the moral panic of the “double epidemic” of HIV and meth, focusing on the how the seeming appearance of a meth-fueled super strain of HIV helped usher in an extreme discursive response in the popular media, public health messages, and, finally, local crime stories. First, I explained the moral panic theories of Cohen, Goode, and Ben-Yehuda, related them to the analysis of representation by Hall and Foucault, and then, using Denham, explained how the negative, hostile depictions of deviance can amplify and solidify discrimination. I then provided a history of the “double epidemic,” from the hysteria over the spree killer Andrew Cunanan, to Halkitis’s coining of “double epidemic,” to the super strain scare of 2005. I analyzed an episode of the popular television drama *Law & Order: SVU*, which created a murder mystery about the super strain scare. Then, I discussed the massive “Me, not meth” public health campaign in California in 2008, critiquing its creation, execution, and meaning. Finally, I looked at how these mass mediated discourse affected the response to the death of an HIV+ meth-using gay men in Palm Springs, pointing to the hostile moralism in online commentary. In the next chapter, I will focus on how these discourses about the “double epidemic,” along with the historical processes of medicalization and biomedicalization are iterated in ideologies, actions, and morality of the anti-meth apparatus.

Chapter 2:

The Moral Ethos of San Diego's Anti-Meth Apparatus

In this chapter, I argue that the branches of what I term the anti-meth apparatus are trying to create the same thing: not just a meth-free community, but also individualistic, self-disciplined subjects primed for late capitalism. I begin with 1) an ethnographic vignette depicting the moral conflicts at the clean syringe exchange. Then I 2) contextualize the anti-meth apparatus within the historical trend of first medicalization and then biomedicalization. Next, 3) using Parish's concept of moral consciousness and Zigon's theory of moral breakdowns, I discuss the construction of the apparatus's ethics that govern the methods of the various branches of the anti-meth apparatus. Finally, using ethnographic vignettes from participant observation and semi-structured interviews, 4) I describe the moral positions of the four main branches of the anti-meth apparatus: law enforcement, medical treatment and care, academic research, and public health and prevention.

The moral exchange

The man appeared to be in his late 40s, he was Hispanic, and he wearing grubby khakis and a thick plaid shirt that indicated that he had either come from a construction job or had not washed his clothes in some time. He had a slightly sheepish look on his face; his dark eyes and thick mustache perhaps accentuated this. He was standing just inside the door of the small camper that houses San Diego's only needle exchange. I was sitting in what would be normally be a breakfast nook. The table was covered with a

stack of our clients' order forms, a laminator, a bottle of hand sanitizer, and various piles of business cards and flyers for research studies, free clinics, and detox centers. I was charged with reading off the list of items the clients had requested when they checked in outside -- twenty 28 gauge 50 cc hypodermic needles ("50s"), a bleach kit, some tourniquets, small cottons, condoms, flavored lube, etc. -- while Gretchen pulled the items from boxes and drawers and cans, filling a brown lunch bag. Gretchen also counted out the syringes, or "points," that the clients brought in for disposal. While the accoutrements were free, we only gave out as many needles as the clients brought it. The man was nervous and embarrassed because he had no points.

"The cops took them," he said. We heard this often. The police would profile a drug user, stop them either as they were driving or walking down the street, and search their car or body for drugs. If they did not find drugs, they might find syringes. As of January 1, 2012, possession and sale of up to 30 syringes without a prescription was legal (Access to Sterile Syringes 2012). Before that date, the limit for possession of syringes without a prescription was 10 (Nonprescription Sale of Syringes (NPSS) in Pharmacies 2011). In the two years I worked at the exchange, I never heard of a police officer in San Diego, the city or county, let a client of the needle exchange keep his or her needles or escape a citation.

What I found to be particularly ironic was that if a client brought the ticket to the exchange, one of the staff members would write a letter confirming the client's membership to the exchange and the citation would be voided by a judge. While the possibility exists that having your needles taken by the cops might drive you to seek the services of drug treatment, the likelihood is much higher that you will have continue to be

addicted to the drug you are injecting, and you will need to reuse, borrow, or steal needles. Old needles are blunt and dirty and lead to abscesses; shared needles are by definition old and are easy vectors for transmission of HIV and Hepatitis C. After a good bleaching, needles will not spread HIV, but they can still pass along Hepatitis C. The Chief of Police of San Diego and the City Council are both aware of these issues and have publicly supported the exchange. The Chief of Police even sits of the exchange's board of advisers. Still, the police harass the injection drug users. Not only are the police ignoring their chief's stated policies and the state's clearly defined law, but they are also abusing their authority at the expense of the health of an already vulnerable population.

While our clients were often harassed by the police throughout San Diego County, the police avoided the exchange.¹¹ At the exchange's Friday midday location, on a side street in North Park, police cars were never visible except down the street, passing by along the busy University Avenue. At the Downtown location on Thursday night, a police car may drive by on its way to the police department's headquarters a few blocks away, but they did not park and write down license plates of all of our clients, as some of our more paranoid clients tended to imagine. But on the night that this man told Gretchen and me that the cops had taken his points, the police officer had stopped, searched, and cited the man only two blocks from the exchange. As with most tales of woe that seemed believable, his earned him five free syringes and a bag of supplies. As the night wore on, we heard from other clients that the same police officer had been profiling and stopping

¹¹ In one major exception, the manager of the Bank of America that sits across the street from the North Park site called the police when an employee reported that her car had been broken into by one of the exchange's clients. Six police cars arrived at the scene and question the exchange's workers and volunteers; the clients ran away. The break-in was not verified, and the police on the scene had no knowledge of the exchange or the Chief of Police's approval of its operations.

other clients. I was furious, but Gretchen and the other employees of Family Health Centers, which operates the exchange, were resigned. It was par for the course.

In San Diego, as in many other places in the United States, the organizations engaged in harm reduction approaches to drug use have waged a guerilla cold war with the forces of law enforcement that had been organized around the strident, prohibition-based, four-decade-old Drug War. The conflict between harm reductionists and prohibitionists is sometimes described as policy disagreement based on different interpretations of evidence and research. Considering the copious amount of research showing that zero-tolerance prohibition policies are considerably less effective than harm reduction methods in lessening drug abuse and addiction (Bluthenthal et al. 1999; Kerr, Small, and Wood 2005; Wood et al. 2003), this description has become a canard. The difference is moral; on one side, the use of an illegal drug is moral error, on the other, the moral error is in treating using illegal drugs as a moral error. The cultures of the organizations operating on the different ends of the spectrum are similarly distinct, as the glaring difference between a uniformed police officer and an outreach worker for a syringe exchange would indicate.

However, this conflict belies the goal that both sides share: the creation of a healthy, drug-free, law-abiding subject. Kane Race has written that this

distinction between criminal and medical approaches to drug use ... misunderstands the broader political and economic forces that invest this site. It is not a rational preference for medical or criminal approaches that accounts for the selection of strategies at a given juncture, but *the political investment in self-administration as a node of social control*. Power never knows whether it wants to punish or save the drug user, incarcerate or treat this figure. Instead, both strategies are kept in reverse as mutually reinforcing alternatives. (2009:69)

Who is subject to the two strategies tends to be structured along socioeconomic lines, with the better off finding their way to treatment and poor into prison. But the goal is the same: to become “productive members of society,” in the words of several of my interviewees.

Producing these productive subjects is the job of what I have termed the anti-meth apparatus, which is the collection of government and non-government organizations that focus either partly or exclusively on meth use and its sequelae like HIV, homelessness, addiction, and crime. I use the term “apparatus” as Foucault did, referring to “a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic proposition” (1980:194). The American anti-meth apparatus is not only heterogeneous, but also inefficient, confused, and at odds with itself. The people working in the apparatus’s disparate branches all want meth to be gone from their community, but none can agree how or why. Either they see meth use as morally wrong, or they see the suffering caused by meth addicts as morally wrong, or they see the desire for healthy living as a moral imperative. The apparatus arose from what has been called an epidemic of, and the moral panic about, meth addiction: a crisis of public health, public safety, and morality. The different wings of the apparatus have responded in different, often contradictory ways, and this dissonance is representative of the ethical and moral confusion that American culture has about addiction, a confusion that has led to a heteroglossia of attitudes about meth among my central sample of meth users (as I discuss in the next three chapters).

Creating a moral subject

Foucault and biopower

As discussed in the Introduction, to Foucault the “biopower” that the medical and law enforcement organizations regulate is vital to the evolution of capitalism. This is a major concern in the first volume of *The History of Sexuality* (1976 [1978]). In *Discipline & Punish*, Foucault focused mostly on the docile body for use as an industrial machine; in *The History of Sexuality*, he was especially concerned with how the state “focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health... *regulatory controls: a biopolitics of the population*” (139, emphasis in the original). This particular interest meant that the control of sexuality – kept normalized through “continuous regulatory and corrective measures” (144) – would be increasingly important. But the state, and the culture, could not suddenly impose this sort of control without a solid understanding that sexuality was something that could be controlled. This was achieved by treating sexuality as a rational, medical thing within the *scientia sexualis*, the polar opposite of which was the *ars erotica*, which dominated in other cultures (at least in Foucault’s categorization). The dominant method of the *scientia sexualis* is the confession, which started as a religious practice but became essential to the practice of medicine and psychiatry, as well as to the justice and penal systems.

The confession worked in numerous ways, but vitally important, it is clear, was that confession was the result of the dominating gaze of the doctor or psychiatrist. In being induced to speak, the confessors opened up his life – his story – to the codification, interpretation, and medicalization of the listener (65-67). As medicine, psychiatry, and

the *scientia sexualis* evolved and amassed their power in the 18th and 19th century, four mechanisms for control became particularly important: “a hysterization of women’s bodies,” “a pedagogization of children’s sex,” “a socialization of procreative behavior,” and “a psychiatrization of perverse pleasure” (103-5). While much of this began with an ever-lengthening list of behavioral and ideological prohibitions in the 17th century, and was loosened with the so-called Sexual Revolution in the mid to late 20th century, these four mechanisms are still deeply embedded in various discourses in the modern West, from debates about the morality and rationality of contraception, sex education, family values, addiction, and sexually transmitted disease. The focus on controlling the sexual behavior of gay men, either as a way to prevent disease transmission and drug abuse or as a way to encourage homonormativity, is clear descendent of this Victoria era discourse of sexuality. All public health campaigns are about the harnessing of biopower, even if the focus of the campaign does not procreate. And all public health campaigns, whether through billboards on one end of the spectrum or aggressive policing on the other, are exercises in the micro and macro-physical power of “governmentality,” Foucault’s term for modern apparatus of the state (1991).

Medicalization and biomedicalization

What we recognize as modern medical rationality solidified in the United States after World War II, in particular in the roles and behaviors of the sick and stigmatized. Talcott Parson’s description of “the sick role” (1951), while unsurprisingly dated in some ways, describes a deeply familiar formation. When Parsons was writing, medicine was more collectivist and idealist than it is in today’s profit-driven medical culture, but the

role of the sick person still has a “set of institutional expectations and corresponding sentiments and sanctions” (436). They are exempt from normal social responsibilities and roles, cannot be expected to heal themselves but must instead be taken care of. That said, they must want to get well, and they must cooperate and comply with professionals and the professional help who the sick must seek out. Not following these rules is considered to be moral failure; you become a deviant. Parsons covers deviance for the norm in broad terms, but he avoids a discussion of stigma, and this was taken up by Erving Goffman (1963), who explains how the stigmatized construct and manage their identities. Goffman contends that the key conflict of the stigmatized is whether or not they are, or can be, accepted by the rest of the society, by the “normals.” The stigmatized have a “moral careers,” during which “persons who have a particular stigma tend to have similar learning experiences regarding their plight, and similar changes in conception of self... that is both cause and effect of commitment to a similar sequence of personal judgments” (32). Though Goffman does not call it as such, this cultural information includes how to pass, the control of social information (including sight of “stigma signals”), the intricacies of etiquette, the limits of social mobility, and other strategies for concealment and protection.

During the post-war period, stigma was transformed from a moral to a medical failure through medicalization (Conrad and Schneider 1980). Continuing the historical trajectory the Foucault’s histories traced, the bad were now simply sick: “In the wake of a general humanitarian trend, the success and prestige of modern biomedicine, the technological growth of the 20th century, and the diminution of religion as a viable agent of control, more and more deviant behavior has come into the province of medicine”

(Conrad and Schneider 1980:34). Treating the disease became the method of “returning sick individuals to compliance with health norms and to their conventional roles, adjusting them to new (e.g., impaired) roles, or, short of these, making individuals more comfortable with their situations” (242). This medicalization had both positive and negative ramifications for those who were once bad and now sick. For instance, by medicalizing alcohol and drug abuse, addicts can be more optimistic about being “cured,” and they also receive a “secondary gain” of being at least partly blameless for their behavior. Medicalization, Conrad and Schneider claim, can be a more efficient and flexible method of social control since “medical controls circumvent complicated legal and judicial procedures and may be applied more informally” (248). The rationalism of the medical model seems to make judgments of medical practitioners morally neutral. However, their decisions are still socially and politically resonant (35), for, as Parsons notes, a refusal of the role imposed by medicine is considered a moral crime.

However, despite its political and spiritual problems, medicalization has only intensified, becoming “biomedicalization,” which Clarke, et al. describe as “the increasingly complex, multisited, multidirectional processes of medicalization, both extended and reconstituted through the new social form of highly technoscientific biomedicine” (2003:162). Biomedicine has been transformed in its economics, organization, and focus, and revolutionary medical discoveries, advances, and methodologies – epidemiology, in particular – of the last quarter century have expanded the influence of medicine to cover not just illness and injury but also health. Clarke et al. write that “the proper management of chronic illnesses are becoming individual moral responsibilities” (162). The reach of biomedicine is now broader and deeper than ever

before, and the expanded use of surveillance, testing, and risk identifiers, in addition to the enormous commodification and valuation of health, has produced new biologically defined segments of society. Key is that many of these new identities are self-defined through “technologies of the self,” through self-governance (165). As Foucault pointed out in describing the birth of medicine and the state’s new modes of discipline, surveillance and risk are not restricted to the clinic or the prison: “Rather, they implicate each of us *and* whole populations through constructions of risk factors, elaborated daily life techniques of self-surveillance, and the management of complicated regimens around risk and chronic conditions” (172). But management of the body is not simply about control; it is also about the transformation of bodies, and this leads to a transformation of identities and subjectivities. The segment of the anti-meth apparatus particularly focused on HIV transmission by MSM are clear agents of biomedicalization, as it is not only focused on the molecular aspects of its subjects but also on encouraging technologies of the self that will control and survey these molecules.

Moral consciousness, moral breakdowns, and ethical positions

The morality of these techniques of governmentality, biomedicine, and the self are not self-evident, but rather, as anthropologists have shown over the history of the discipline (Csordas n.d.), constructed in a complex cultural processes in which people determine right and wrong, good and evil, normal and abnormal. This process is not sublimated; it is active. As Parish writes, “The ‘must’ and ‘should’ meanings attached to them do not attach themselves – people do. Moral values and meanings are active within life... We cannot detach ‘the moral’ from cultural life, which is where people have something ‘at stake,’ and expect to understand moral consciousness” (1994:289). He

explains that moral consciousness comes, at least in part, from experience of powerful moral emotions like shame, embarrassment, or, in Parish's fieldwork among the Nepalese Newar, *lajyā*, which "combines feeling and evaluation; it is an emotion and a moral state" (1994:199). Americans do not tend to see evaluation as an emotion, but in the face of pain, fear, grief, and anxiety, evaluation is often the result.

This evaluative state is central to Zigon's theory of the moral breakdown. He describes morality as "a kind of habitus or an unreflective and unreflexive disposition of everyday social life... [it] is not thought out beforehand, nor is it noticed when it is performed. It is simply done" (2008:18). Morality is noticed when "some event or person intrudes into the everyday life of a person and forces them to consciously reflect" upon an appropriate response (2008:19). Following Foucault, Zigon describes ethics as the conscious engagement with this moral habitus, when one is "reflective and reflexive about her moral being the world and what she must do, say, or think in order to appropriately return to her nonconscious moral mode of being" (2008:165). This ethical debate arrives during a moral breakdown, and Zigon argues that the "ethical moment brought about through the moral breakdown... should draw the most attention of anthropologists of moralities. For it is by studying ethics and the ethical moment that we can see the intersection of the various spheres of morality in the daily lives of individual persons, and also the multifarious ways in which human person works on themselves not only to enact, but also to alter the moralities of their social worlds" (2008:165–6).

The meth and AIDS epidemics provoked moral breakdowns on both the individual and institutional level, as the interviews with the agents of the anti-meth apparatus show. The ethical response to the epidemics has structured the actions of both

the gay community and the anti-meth apparatus. Moral panics can be the social response to masses of moral breakdowns; moral panics in turn help to create ethical structures, in the forms of laws, policies, procedures, and treatments. Race points out that drug policy has the “capacity to conjure up a moral state—suggesting, if only fleetingly, the possibility of an alignment between the state command and the contents of that space carved out for personal variation. It instates as a vision of control a regime of the personal—installing the self as the medium of liberation and control” (2009:68–9). In San Diego, the explosion of both the meth trade and of the number of addicts meant that nearly half of arrests involved meth in 2002, and tweakers and meth dealers became the primary public enemies for police and prosecutors. As I have explained elsewhere, the connection between meth and the post-HAART rise in HIV infections terrified many health providers and prevention experts, and the result was a string of moralistic public health messages that advocated strict ethics about meth use and sexual risk. Researchers responded by developing and testing ways to encourage this ethical behavior. And all were focused on ideal moral subjects: the result, the fruit of ethical behaviors.

Enforcing the law, exercising governmentality

The dominant branch of the anti-meth apparatus is inarguably law enforcement. It wields hegemonic ideological and discursive powers through its sheer breadth: its quotidian street presence, its involvement in structuring public education, its extensive mediated representations, and its role in enforcing the United States’s governmentality, which has grown more and more pervasive since the declaration of the War on Drugs in 1971 to the suturing of anti-meth laws to the Patriot Act in 2005. In San Diego, just as

across the country, there are multiple and overlapping agencies responsible for waging the drug war: the San Diego Police Department, San Diego County Sheriff's Department, the police departments of the county's other cities like El Cajon and Chula Vista, the Drug Enforcement Administration, The United States Customs and Border Patrol, The Department of Homeland Security, San Diego County District Attorney, San Diego's Drug Court, San Diego Parole Department, San Diego Probation Department, San Diego County Department of Corrections, among others. While I hypothesized that my sample of HIV+ MSM who use meth would hypercognize their HIV status and their bodily experience on meth, I found that they instead hypercognized law enforcement. With the tentacle-like breadth of its presence, it should not be surprising that my sample would feel that their mostly antagonistic interactions with law enforcement structured their lives more than any other branch of the apparatus.

Compared to the other branches of the apparatus, doing research in law enforcement was difficult for me. Interviews were hard to come by; sometimes the interviewees' superiors would not allow them to talk to me, and other times, even after repeated requests, I would not receive a response to a request, or interviews were scheduled, canceled, and never rescheduled. The interviews that did occur were with people who either had a personal connection to another key informant or were predisposed to understand my project and my methods. One was a UCSD graduate, another had majored in Sociology in college, and another met with me as a favor to a mutual friend. I suspect that the law enforcement actors who met with me also carefully presented their opinions of their work and the focus of their work in such a way not to offend me or not to present themselves as lacking empathy; this was confirmed when I

discovered two such interviewees spoke about meth users in distinctly different ways to law enforcement audiences as they had to me. While my formal semi-structured interviews were limited, I tried to make up for it by collecting the extensive media (both press and law enforcement created) coverage of law enforcement activities and two years of participant observation at meetings of the San Diego Methamphetamine Strike Force, the somewhat violently named organization that brings together law enforcement, treatment, and prevention organizations.

The morality of the law enforcement branch of the anti-meth apparatus is not surprisingly the most rigid in what is determined to be right and wrong. It is decidedly conservative: Individuals are responsible for their actions whether or not cultural or structural forces have greatly influenced the environment in which the actions were taken. Change is resisted, unless it is mandated from a force or an actor in substantial power. Prop 36, the law that mandates that nonviolent drug “offenders” be given the option of treatment instead of incarceration was opposed by most law enforcement agencies when up a statewide vote in 2000. Voters passed it, forcing drug courts to be created. One of the first drug court judges in San Diego, Bonnie Dumanis, became District Attorney and mandated the creation of Reentry Court, which was initially resisted by the rank and file attorneys in her office. Despite these seemingly liberal structures – which are favored by such reform and legalization advocate as the Drug Policy Alliance and NORML, the National Organization for the Reform of Marijuana Laws – the individual at the structures’ mercy is expected to exhibit both classic American individualism and modern neoliberal subjectivity (Rose 2007; Beck 1992). Since law enforcement is told and then repeats the mantra that treatment works, any

failure to recover is seen as an individual and moral failure. Because harm reduction inherently means a tolerance of drug use and a deliberate admission that policing is not always an effective method of controlling drug use, it is declared to be either immoral or impossible to justify as moral to the public. Because profiling potential criminals based on risk categorizations – gang colors, erratic bodily movement, presence in criminal areas, being a racial or ethnic minority – leads to mostly justified arrests of those risky subjects, those who are not profiled – white, middle and upper class – remain uncriminal, preventing any change in the moral or structural order. When it comes to drug use and abuse, the morality of law enforcement is based on the premise that rational and docile individual behavior is right, while irrational, resistant behavior is wrong.

The MSF was founded in 1995, when meth-related crime in San Diego was at an all-time high, with 43% of people arrested in San Diego testing positive for meth. While some writers have pushed back on meth being “epidemic” (Armstrong 2007b; Shafer 2006), in San Diego in the 1990s, it caused more problems than any other drug except, arguably, alcohol, and these were both tangible and moral problems, fairly earning comparisons to the crack epidemic. (Moral panics are often responses to empirically large problems – like crack and AIDS – but it is the extremity and volatility of the discourse that earns the moniker.) In addition to increased property crime and possession arrests, the rates of both general assault and battery and domestic violence were dramatically higher than ten years prior. And meth labs in the county were plentiful; about 40 labs were seized and cleaned up every year from 1995 to 2005, when the number dropped to a quarter of that because of laws tightly controlling the sale of precursor chemicals. While it was politically correct to say that, like AIDS, meth does not discriminate, meth use was

concentrated in the white working class areas of San Diego County, which is where much of the county's law enforcement and its most conservative and religiously devout residents lived. The moral panic about meth in San Diego that lasted from the mid 1990s to the mid 2000s coincided with a moral breakdown, and the MSF was part of the structural response, which in turn helped to develop the moral ethos of San Diego's law enforcement concerning meth. While the goal of the Strike Force is to foster cooperation between law enforcement, treatment, and prevention, I think the name of the group indicates which segment of the anti-meth apparatus dominates the organization and its meetings. Law enforcement members are the loudest and most vocal members and their efforts receive the vast majority of the press coverage touted at the quarterly meetings. Many of the people I know and interviewed who have attended MSF meetings but who do not work in law enforcement have been frustrated, if not enraged, by the group's focus on policing, crime, and the morbidity, mortality, and immorality of meth addicts.

These meetings are held in large meeting rooms in different county buildings; once we met in the county health department, once in a police station in the north part of the county. There is always a spread of expensive muffins and bad coffee, and the crowd is full of conservatively dressed, mostly white people, many of whom are wearing badges and guns. When everyone in attendance introduces themselves, usually two-thirds in attendance are in law enforcement, from county police to the DEA, from probation to the District Attorney's office. The other third tends to be a smattering of county public health officials, treatment program managers, and the occasional researcher. At each meeting, the attendees sit at conference tables while presentations are made. The coordinator, a middle-aged woman who was a psychotherapist before going into public health

communications, always organizes the panel discussions in order to show the diversity of the MSF, making sure to include all the various factions. As the timekeeper and mediator of the discussions, she focuses on comparing comments and linking questions. In this way, she encourages teamwork and integration, since she is aware of both moral and professional conflicts among its members. She reminds the attendees that as members of the MSF, they “of course” recognize the need for and success of treatment and should examine “evidence-based” models of policing and prevention. The yearly “report cards” she presents to the membership focus on simple data points: numbers of arrestees who test positive for meth, meth lab seizures, deaths from meth, treatment admissions, and results from surveys that ask how easy meth is to obtain and for what price. For several years in 2000s, the report card only listed statistics on meth-related deaths. The goal of the MSF is to improve the numbers in the report card, and in the technocratic language of the meetings, the procedures and policies developed and discussed sound both scientific and sanitized, which in turn sublimates the moral underpinnings of the MSF.

At a meeting in December, 2010, the featured panel was titled “Collaborative Models for Integrated Drug Treatment for Offenders” and speakers focused on the innovative ways that drug offenders (drug users who have been arrested) are handled in special drug courts in San Diego where treatment is favored over incarceration. The panel included two drug court judges – one who worked with adults, one who worked with juveniles – an assistant district attorney who worked with the parolee reentry court, and a mental health social worker who worked with drug offenders. The discussion focused on punitive behavior change, on using tools of both the courts and psychotherapy to construct better citizens.

The first speaker was a middle-aged, graying veteran drug court judge who admitted that the collaborative nature of drug court was quite “different from what we’re trained to do.” But, he pointed out, “studies have shown that interaction with judges are critical components of success” in rehabilitation of drug offenders. Based on this evidence, things should be done differently: “We can’t keep doing what we’ve always done if it doesn’t work.” Because most addicts fail on their way to success, if they ever succeed at all, “we have to define success differently” and focus on “harm reduction for the community.” To these offenders, he says he is “trying to sell common community values. They are outside the system, [expressing] flagrant disregard for the values we all share.” As a judge, he said, he is a role model and, differently from a trial judge who is adversarial, his function is to engage, motivate, care, and express compassion. Getting the offenders to buy back into these values involves a different skill set than from what most judges have. “Nothing in law school prepared me for drug court,” he said, “but an awful lot of being a parent did.” It is through a paternalistic court system that the offenders can be “reintegrated” back into the community. As an example of the court’s success, the judge talks about how the court’s staff and its clients, the offenders, have played softball against each other. During the question and answer period, a man who worked in drug treatment in the northern part of the county (who often speaks out of turn, without raising his hand) claimed that drug court judges are too soft, that they refuse to punish parole violations: “Our police officers are doing a great job, but the judges aren’t.” The judge’s response was tempered; police are not supposed to exercise discretion, but that is the role of the judge.

The second speaker was an assured, blonde, coiffed assistant district attorney, who worked at the parolee reentry court. Echoing the previous speaker, she said that when she was first asked to work on the special court focused on the helping parolees reenter the community after incarceration, her response was, “We’re not social workers!” And she does not believe that “there’s something called a victimless crime,” a push back against an absent voice for drug law reform who might claim that illegal drug use did not create victims. After presenting her law and order credentials, she told the story of how she ended up working with the parolee reentry court. The District Attorney had told her and her staff that “Prosecutors can do more than react to crime. They can be proactive.” And this is needed because “the criminal justice system is not working.” The ADA then listed a number of statistics: 70% (actually 67.5%) of parolees go back to prison, 42% need alcohol treatment but only 7.5% get it, 56% need treatment for drug abuse but only 9% receive it (Petersilia 2006; Office of Research 2010). Because of this failure, the parolee reentry court was set up to assist post-incarceration treatment and rehabilitation. The goal, she said, is to create “productive members of society.” She called the process “cognitive behavioral therapy,” which she explained was encouraging offenders to “rethink how they can be successful.” As an example she compared an offender seeing a pen left on a desk and stealing it to, post therapy, seeing the pen and then pointing out that its owner should not forget it. During the question and answer period, the MSF facilitator asked the ADA how the reentry court had changed her, and the ADA responded that it made her a better prosecutor. In the same response, she also said that when discussing her work with her young daughter, she refers to the offenders as “the

bad guys,” and tells her daughter not to repeat that description her father, since the ADA is married to a public defender. This anecdote is met with laughter from the room.

Following the ADA was an actual social worker, a drug abuse counselor who worked with the reentry court. Decidedly less at ease speaking in front a crowd, she also described her work through a different lens; the offenders “are human beings” and “we need to meet them where they’re at.” After explaining that treatment focuses on co-occurring illnesses, gender, and culture, and that in order for treatment to work it needs to be holistic, she echoed the ADA and the drug court judge, stating, “It is all about behavior modification.” The social workers seek to “engage them on many levels,” by connecting the parolees with housing, vocational training, and, with luck, a job. And they utilize motivational interviewing (“a directive, client-centred counseling style for eliciting behaviour change by helping clients to explore and resolve ambivalence” (Rollnick and Miller 1995)), which is carrot version of cognitive behavioral therapy to the ADA’s stick. Seeming almost defensive in the room of law enforcement officials, the social worker asserted that “nice, warm and fuzzy things really make a difference.” Offenders need to be bold “they’re worth something,” and key is “treating them as important.”

The fourth speaker was the judge who presided over a juvenile drug court. Similar to the judge who worked at the adult drug court, this judge spoke of her work in both paternalistic and paternal ways. “The kids,” she said, “come from some pretty miserable circumstances. It is important to assess the family. What sorts of family problems are there?” But sometimes, she admitted, “we’re not going to affect them that much. What do we do with a parent who is excited their 13-year-old daughter is pregnant because it will be their first grandchild?” The room laughs. Using the language of 12-step programs, she

said that “kids typically have not hit bottom yet. They’re not grasping that connection and link between substance abuse and negative consequences. It’s still fun, still an escape.” Locking the kids up, however, is not the answer, she claimed: “We can do more harm to the kid than good.” Compassion for these kids comes “naturally,” she also claimed. As an example, she told the story of her own teen-aged son meeting one of the juvenile offenders while waiting for the judge to get off from work. He watched the other teen being unable to use the pay phone, and he helped him make a call, and then offered him a ride home, and then offered to take him to lunch. “And I said, ‘Wait, we don’t know who this kid is!’” she said, in mock exasperation to the audience’s laughs and headshaking. Finally, continuing the theme of careful compassion, she states that juvenile drug court “graduation brings tears to your eyes [when you hear] what they have to say about how drug court has changed their lives.”

After a brief question and answer period and an update on the new Prescription Drug Abuse Task Force, the audience is presented with an update about Operation: Tip the Scale, which is the name for the Strike Force’s semi-regular targeted sweep of known drug offenders. The sweep involves a great deal of fanfare: an large cohort of uniformed officers, a festival of lights and sirens, and the local press corps, which dutifully reports on the sweep with images of people in handcuffs and quotes from police spokespeople saying, as one did in 2009 to a local TV station: “What we’re trying to do here is say, this is wrong, and as an offender, you need to take a step back and see the effect you’re having on other people” (Muddaraj 2009). What makes this a collaboration with treatment is that the offenders, after being arrested, are given the option to talk with an addiction counselor for a brief moment before spending the night in jail. As one social

worker told a local newspaper, “When they’re coming to you in handcuffs, defensiveness and denial about the reality of what’s going on in their life is washed away and they’re more receptive” (Cook 2011). The public relations consultant from a local non-government organizations introduced the clips from one of the local stations after thanking the “more than a dozen agencies” for being part of the sweep. He said that they had written off the media coverage for that day’s operation because “we had a tragedy that day when an officer was killed doing the kind of routine check that the officers did during Tip the Scale.” However, at least one station covered both. The news story referred to an “army” of police officers. As the audience watched the video, several people recognized themselves, and the sheriff’s deputies smiled wide when they saw their faces. One was quoted in the video, “We’re here to send a message that drugs are not allowed in our community.”

This meeting of the MSF was representative of the law enforcement branch of the anti-meth apparatus, but I found it particularly interesting because of its specific discussion of the methods of governmentality used to control, regulate, and transform addicts. Without using the word “docile,” they were all discussing ways that they could produce docile bodies, to encourage addicts to submit to the will of the anti-meth apparatus. Some of these methods were quite deliberate, from court-ordered carrot-and-stick measures to encourage good behavior to the use of motivational interviewing by social workers and psychotherapists, from policing behavior through lights, sirens, and handcuffs to broadcasting images of raids on the local news to encourage both vigilance and stigma. But other methods were more subtle; the paternalism was both metaphorical and actual. The adult drug court judge saw himself as a parental disciplinarian, while both

the ADA and the juvenile drug court judge not only parented offenders but also taught their children to distrust offenders or see them as bad guys. The nervousness of the social worker stuck in the middle was not surprising, considering the moral ethos of her branch.

Treating the tweakers

Because of the Ryan White Care Act, people with HIV in the United States have access to free healthcare involving the treatment of the virus and its sequelae. This means that visits to your HIV specialist are free, but if you get into a car accident, your broken arm is not paid for by the state. In California, which matches the federal Ryan White grants at one of the highest rates in the country, no one with HIV is placed on a waitlist for care or for the AIDS Drug Assistance Program (ADAP); in addition, what ADAP and Ryan White covers in California includes services and treatments not always covered in other states, from acupuncture to nicotine cessation. HIV+ people are treated in three ways in San Diego. If you have private insurance, you go to a private HIV specialist at places like Scripps Mercy or Kaiser. None of the men in my study had private insurance, so their doctors were at the two other options: UCSD's Owen Clinic, one of the best HIV/AIDS clinics in the United States; and Family Health Centers, whose Ciaccio Memorial Clinic has been treating uninsured people with HIV since the mid 1980s. In addition to primary care, people with HIV are also eligible for numerous services, from housing assistance to mental health care. More than once, I have heard homeless or near-homeless clients at the needle exchange say, after hearing about what is available for people with HIV, "I should get AIDS."

Addiction services are somewhat easier to access for people with HIV, as there are specific facilities and programs for people with HIV. But “somewhat easier” still means that it is difficult. While numerous addiction service programs exist in San Diego, very few are affordable, even for people with insurance. The programs that are free or operate on a sliding scale include places with names like Stepping Stone, Crash, and Choices; these are programs that receive extensive funding from the county and the Ryan White program. One program at which half of the men in my study lived lost most of its funding in 2011. All of its residents were scattered to various sober living residences and other programs; several men relapsed during the process. In stark contrast to HIV care in San Diego, many of the people who work in addiction services in San Diego are under-educated and poorly trained. For each MCSW or PsyD or PhD in these programs, there are maybe three or four counselors who have received minimal training and whose only experience is that of being a recovering addict. While the imprimatur of a degree does not always or necessarily mean that a person is competent, the number of under-trained staff members working for \$10 an hour is an indication that the service is woefully underfunded and undervalued. It is also, potentially, one of the reasons that so many addiction treatment programs fail. The funding differential is just one of the reasons that, I believe, meth is hypercognized for the men in my study and HIV is hypocognized. HIV care is not something one needs to struggle for, while meth addiction is a constant, fraught, and frustrating struggle (see Chapters 3-5).

The service providers’ views of HIV+ people and meth users are strikingly different from that of law enforcement. The treatment branch of the anti-meth apparatus is much less antagonistic. Instead of referring to “offenders” and “bad guys,” the doctors,

nurses, psychologists, social workers, and counselors talk about their “clients” and “patients.” As copious as they are, the drug addiction counselors and HIV clinicians are much less visible to the general community, and they have a great deal less discursive power in the general community’s ideology about HIV and meth. But because of their direct and intense contact, they have an enormous amount of influence over the subjectivities of my research subjects.

Because of human subjects review board concerns about healthcare privacy laws, I was unable to witness actual interactions between treatment providers and their clients and patients. But unlike with law enforcement, I had a much easier time interviewing healthcare providers: HIV specialists, drug counselors, social workers, and mental health professionals. This was clearly because of the personal and professional connections I had with them. My connection to UCSD, which has been so long involved in HIV and meth research, indicated to them that I was unlikely to be antagonistic to their work. Also, my lengthy volunteer work at Family Health Centers created a rapport with many of the staff, making the interviews easy to set up and much more candid than would be otherwise. What follows are analyses based on interviews with treatment providers, their own descriptions of interactions with HIV+ meth users and on my research subjects’ descriptions of their interactions with their providers.

More often than not, with my interviewees, the impetus for providing care to people with HIV or with addiction problems was moral, and it was as often based on personal experience with the AIDS epidemic or with addiction. Many of them talked about “making a difference,” “giving back,” and in other clichés that Americans use to discuss their good deeds. But these clichés were not used to justify giving to charity but

rather to devoting their working life to helping others. Witnessing suffering, of other or of oneself, influenced the altruistic ideals that were commonly expressed. One doctor told me about caring for people with AIDS at the height of the epidemic in the late 1980s. “I developed a real passion,” she said. “The number of people who had been disowned by their parents – I can't imagine. They've already lost their family. They had no one to talk to. I felt that [we] had to be there for them.” A counselor, who is HIV+ and works with addicts and with people with HIV, expressed that the work was “spiritually fulfilling: Being able to assist someone with their quality of life, being able to empower people who don't have that kind of knowledge, to manage, to know about the program. Those things matter to me. I'm giving back to the community. It's more personal for me.”

However, it was not always so cleanly and clearly felt. One man who had run an HIV services program told me, “I started out trying to save myself. Then the altruistic motivation came later.” With him, as with many of these providers, the ethical view of his work arose out of the moral breakdown experienced during his profound struggle with what he had witnessed. In his case, it was witnessing his own suffering, and with the doctor and counselor, it was witnessing the suffering of others; in repairing their breakdown, they all saw their work as ethical imperatives.

While most providers expressed a general work ethic of doing what needs to be done to prevent or alleviate suffering, many were specific about how they saw their work as part of a political project to fight homophobia and reform “the system.” These actors were aware of how structures of power – in relation to gender, class, and racial ideologies – made health and health-seeking difficult for men who have sex with men. In turn, they saw themselves and their work as both political and moral; the system that they were

fighting was complicit in creating the suffering of people with HIV, people with addictions, and men who have sex with men, and the works these actors did was an attempt to fight, undermine, and reform the system. One drug counselor, who is HIV+, told me about how difficult it was to see a doctor when he was an active meth addict, how the doctors encouraged the stigma he already felt. “When you present like that to a medical provider, there's a lot of stigma, a lot of shame,” he said (see Chapter 4 for a discussion of shame among my informants). “[One] doctor said, ‘You should find another doctor.’ Another doctor actually had compassion. Someone cared for me despite... Some of the clients are self-loathing, defeated. It feels like I'm giving back what was given to me.” One doctor who was an early HIV specialist said that one of the reasons for places like the Owen Clinic and Ciaccio was that medical culture prior to 1980s was often extremely homophobic, not just against patients but against doctors and nurses as well. “I had an obligation to be involved with the gay community as a doctor,” he said. “I witnessed horrible encounters – the remarks doctors and nurses would make about gay patients. I believe this was the only way to confront this kind of homophobia.” An administrator of an HIV service program saw his involvement in AIDS services and gay health as connected all the way to his anti-war efforts in the 1960s. “I was profoundly shaped by witnessing” the brutality against protesters, he said. “It made me realize where the power is.”

Even those who came to HIV medicine or addiction services without missionary zeal – one doctor went to work at an HIV clinic because its director just “pulled at my heartstrings” and one recovery administrator was just looking for “a new population” to focus on – their ethical and moral positioning was starkly contrasted to that of those

working in law enforcement. Those in the anti-meth apparatus's law enforcement branch see their roles as the keepers of public order and promoters of public safety, as protectors of institutions and unquestioning enforcers of the law; the ethics of their work focuses on protecting the community from those who would disrupt its nostalgic utopian peace. But those in the healthcare provider branch see their work as opponents of the many of the institutions and moral positions that the law enforcement branch is charged with protecting, from the healthcare system to the Drug War to capitalism, all of which are seen as inherently, even catastrophically, flawed. The healthcare providers value compassion and the health and empowerment of their patients and clients over all else, while law enforcement values order, discipline, and the criminal version – not the social version – of justice. These differences belie both branches' goal, which is to create self-disciplining and economically productive subjects, but their different moral positions are key influences on the vastly different methods that are used to shape these subjects. Law enforcement focuses on fear, punishment, and reward; meanwhile, the healthcare providers, for the most part, believe in harm reduction, motivational interviewing, and various forms of cognitive behavioral therapies.

The methods of the healthcare providers are seen as not only more compassionate and less adversarial, but also as “pragmatic,” “effective,” “evidence-based,” and “non-judgmental.” Harm reduction, the goal of which is to reduce the physical and social injury caused by “high risk” behaviors, is based on the idea that no judgment is made about the drug use or the drug user by the provider. Harm reduction is defined by one the largest advocacy organizations as “a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a

movement for social justice built on a belief in, and respect for, the rights of people who use drugs” (Principles of Harm Reduction - Harm Reduction Coalition n.d.). Motivational interviewing (MI) eschews judgment in favor of subtle, pragmatic encouragement. In the words of its developers, MI “focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally-driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns” (A Definition of Motivational Interviewing n.d.). Cognitive behavioral therapies are central to the recovery programs such as Crystal Meth Anonymous (and AA or NA), the Matrix program (which merges 12-step programs with other methods), and SMART recovery (which eschews 12-step ideology in favor of CBT). Both Matrix, which is the dominant method used in recovery programs in San Diego, and SMART, a newer method that unlike Matrix does not encourage 12-step programs, cloak all of their methods in the language of science. Sites for both the programs promote peer reviewed articles and literature written by credentialed professionals. Several of my interviewees pointed out that while the AA model has moralistic and religious, they still recommended 12-step programs because researchers had shown it to be successful because of various cognitive and social benefits (Morgenstern et al. 1997).

Despite the focus on supposedly amoral scientific methods that are officially operate without judgment placed on client and patient behavior, providers indicated in their discussions of these methods and their implementation that moral judgments of clients and patients were difficult to resist. For example, one veteran HIV doctor, when

discussing how he approached patients with drug problems, he said, “We’ve all had a lot of training in motivational interviewing. It’s better than moralizing. We let them know they can come back even if they’re not ready to go into [addiction] treatment. And when they come back for medical care, we try to do a brief clinically based intervention in a non-judgmental way.” In the same interview, just several minutes before, however, the doctor expressed frustration with drug addicted patients, complaining about “drug deals in the waiting room, sex in the bathrooms,” complaining about how one patient “refused to hear about consequences.” Drugs made his patients “lose control,” he said, shaking his head. One drug counselor who works mostly with HIV+ patients did not separate his moral judgments from his motivational interviewing, particularly at moments of frustration. He described how he dealt with active drug users:

Sometimes I'm really direct and abrupt. I'll say, 'Well do you think that sounds sorta dumb?' Because nobody's has ever asked them that because everybody tries to be nice and professional and this stuff. And sometimes, I just figure, Well, that's just dumb. Don't you think that's dumb? What's the matter with you? And then they're kind of like shocked. Ohhh, you're not really supposed to ask me that! I do that *sometimes*, especially when they're, like, in denial. Or if they're being jerks, you know, during the talk, something like that. There's a reason why they're being jerks; there's something there.

In virtually all of my conversations with providers, they expressed but did not usually articulate a conflict between their personal morality about right, correct behavior and the official amorality of their methods. (The exception was with some drug treatment program managers who believed in harm reduction and motivational interviewing but were not allowed, because of who was funding them, to use any other method that did not mandate zero-tolerance on drug use.) While numerous academics have shown how health is considered a moral problem, among the healthcare providers I interviewed, helping

people was a clear moral good, but health seeking by patients was not cognized as a moral good, even though behavior that harmed health was looked down upon. While it is hypocognized, all of their methods used to decrease risk are laced with moral discourses, and in fact, they work or do not based on the desire of the addict to follow a moral path. I believe that this is an issue of competing schemas, in which ideological discourses about health and politics exist side-by-side but are not, or are very rarely, integrated (Strauss 1997). As I have explained, the moral discourses about drugs and HIV are confused and internally conflicted; in later chapters, I show how this is internalized in the subjectivities of the men in my sample.

Research and development

Research on HIV is a multi-billion dollar business, and research on meth addiction is keeping several thousand researchers in the United States employed. The overlapping research, that which is focused on meth, HIV, and high risk sex, has produced nearly a thousand scholarly articles and books, and San Diego is one of the main centers of that research. UCSD has been continually running studies on several hundred HIV+ or at-risk MSM meth users since the turn of the century, and studies associated with HIV and meth have helped to fund the world-renowned Antiviral Research Center at UCSD. Research from UCSD and the other centers for research on the intersection of meth and HIV, which include UCLA, UCSF, and NYU, among others, has produced most of the knowledge that is used by the healthcare providers and prevention professionals. (While law enforcement in San Diego rarely discusses any use of academic research in their methodologies, it is clear that James Q. Wilson's "broken

windows” theory (Wilson and Kelling 1982) is behind some of the community policing done by the county.) For this reason, I was interested in the impetus for the work, how the researchers decided to do the research and what their goals were. I interviewed a dozen of the researchers involved in the production of knowledge about HIV and meth use among MSM, including several whose research helped to define the problem and several who helped develop treatment programs used in San Diego and around the United States. These “evidence based,” “pragmatic,” “non-judgmental” methods, not surprisingly, were made by people with specific moral goals in mind.

Most of the researchers see their work as having explicit moral purpose to it; like the healthcare providers, they want to improve the health of the people they are focused on. But unlike the healthcare providers, the researchers did not usually come to their work as part of moral project. Four of the most cited researchers who work on HIV and meth all told me that they arrived at the focus of their most impactful studies haphazardly. Only one came to his research out of a personal, activist desire to help, born from his experiences during the height of the AIDS epidemic. For the rest, meth was where the grant money was; they saw opportunities to do work that was desired by funding institutions. The phrase, “I never intended on doing this” was common. However, it was also common to develop a strong moral position while doing the work, eventually to see the work as not just morally right but personally imperative. One, who expressed guilt at benefitting professionally from recording and analyzing the stories and suffering of so many people, became directly involved in creating housing services for indigent meth addicts. The failure of the healthcare system and the political culture to find humanistic solutions sparked moral outrage among the researchers, more so than the

providers. One told me that the attitude that ““These are drug users who shouldn’t be valued’ -- It makes my blood boil that we don’t have a more gentle and caring society.” He followed this statement with, “These people can be productive. Why not put them in a position so that they don’t fail?”

The goals of the research on meth and HIV are clearly stated, so it is easy to determine what sort of healthy person – what sort of subject – these researchers are trying to produce. The researchers, like the providers and law enforcement, are trying to figure out ways to create productive citizens, but the specificity of the studies exposes both the psychological and behavioral specifics of what healthy and productive entails. In the studies focused on interventions, various forms of behavior modification were tested to see which method could return someone to being a rational actor. The goal is to save these men from their behavior and in turn, to save the community. This imaginary healthy, rational, economically efficient person is the golden ring.

Preventing and reducing harm

I spent the bulk of my participant observation volunteering at Family Health Centers of San Diego, working at their syringe exchange and at their gay men’s clinic, where I was an HIV testing counselor. During the period of my fieldwork, virtually all prevention efforts involving HIV and meth in San Diego were consolidated at Family Health Centers. Federal and state contracts were moved to FHC (or they were “stolen,” in the words of an employee at another agency), and FHC’s HIV services division was running, in addition to the exchange and the gay men’s clinic, an out-patient program for addicts, numerous support groups for gay men at risk for HIV infection, and various

public health campaigns around sexual health, much of it encouraging HIV testing and disclosure. FHC, despite or maybe because of its increasing size and breadth, is an inefficient agency that performs some work well (such as primary care for people with HIV) and some work either poorly or haphazardly (such as HIV and STD prevention). This is not the fault, I believe, of its employees or even its management, but rather in how HIV service programs are developed, contracted, and implemented; this is the case internationally, not just in San Diego. But poor management and extraordinarily low pay is mostly to blame for the staff's low morale. To wit, in the three years I worked at the syringe exchange, I outlasted every single staff member but one.

I also believe that the low morale is also the result, at least partly, of the difficulty in doing HIV and drug abuse prevention, both practically and morally. Prevention is notoriously difficult (Campbell 2003; Sobo 1995; Sumartojo 2000; Rotheram-Borus et al. 2009), and since the advent of effective medications for HIV suppression, HIV prevention campaigns have failed to achieve the kinds of behavior changes that the safer sex campaigns of the 1980s did. Some studies have shown that the most aggressive, moralistic, and visually violent anti-meth campaigns have had some success (Erceg-Hurn 2008), but several public health officials told me that it was not clear whether meth use was actually going down or if it was just so stigmatized that people are lying (even more than before) on surveys.

This deliberate stigmatization of meth, heroin, and “unsafe” sex has affected the prevention workers, whose opinions of their clients are much more conflicted than the opinions of that law enforcement, researchers, or doctors have of meth users. Only one of the FHC employees I worked with expressed a specific interest in harm reduction as a

philosophy. (When she encountered in a college class on public health, she was “fascinated” by idea of examining health behavior without judgment. This led her to start working at the syringe exchange.) Most of the others came to their work for a host of differently moral and personal reasons. A number of the gay men and lesbians who worked at FHC are old enough to remember the AIDS epidemic before the cocktail, and they told me that they that they felt a moral duty to prevent suffering from HIV, AIDS, and the substance abuse and depression that is endemic to the gay community. In turn, they had trouble refraining from negatively judging clients who seemed to be unable to avoid behaviors that put them and others at risk for HIV. Several others were in recovery from heroin or meth addiction, and they were making the 12th step, to carry the message of Alcoholics Anonymous (in the form of Crystal Meth, Heroin, or Narcotics Anonymous) to other addicts. Because of 12 step ideology of complete abstinence from drugs and alcohol, these recovering addicts seemed to have trouble simply reducing harm; they were often pushing, some more blatantly than others, abstinence and recovery programs.

During the three years I worked at the syringe exchange, I became particularly close to one outreach worker named Roger. A former meth addict, he has been clean about two years when I met him, and his first job after rehab was as a case manager at the agency. He is gregarious, with a witty sense of humor and bounding laugh. As an outreach worker, he has few peers; he can talk to and charm anyone. But when he is overwhelmed and frustrated, like at the end of a shift at the exchange and the line is too long for us to accommodate, just like anyone would, he can get cranky.

During one such day, an exasperated Roger muttered to me, “Fucking entitled junkies.” As a contrast, he told me a story of someone who was late and had explained his tardiness as, “I’m sorry. I’m an addict. I can’t get it together,” Roger said, “See? That’s cool. He owns his shit.” Roger, a veteran of 12-step recovery programs, values acknowledgment of the bad behavior of being addict, of owning the disease and admitting the problem. The junkie who is self-aware is more likely to see that his behavior as wrong; the entitled junkies who are outraged when they can’t get the right size syringe are not getting clean any time soon. And for Roger, this is frustrating. Both of comments to me were asides, whispered to me not just because he did not want to anger the clients, but also because he knew that his thinking – his judgments about addicts and their behaviors – was running counter to the institutional ethos of the syringe exchange and the agency that runs it. The exchange and the agency are supposed to be free from judgments about drug use and addiction and life choices, but it is a rare occurrence to meet people who work in prevention and harm reduction who do not express contradictory opinions about drug use and sexual risk, proclaiming harm reduction theories in one breath and castigating irresponsible client behavior in another.

The mantra is harm-reduction; behavior is morally neutral. All we ask is that clients think about ways to reduce the physical harm caused by their actions. To say the least, being morally neutral when confronted with some addicts and their behaviors is difficult for some people.¹² But that is what you must do when you put on the agency’s

¹² I found it particularly so when clients came to the exchange with their children in strollers. When the state mandated that all University of California employees became mandatory reporters of child abuse, the syringe exchange workers used my status as a mandatory reporter as a motivational threat for these clients to leave their children at home. Of course, this was problematic, especially when I considered the likelihood that the clients could afford babysitters.

badge. The contradiction behind harm reduction is that it is considered a moral imperative to be nonjudgmental but that it is also a moral imperative to be healthy; in reality, the nonjudgment is a smokescreen, a lie used to draw in the risk-taker, earn their trust, and ready them for action – risk reduction, behavior change, recovery. This almost totally unspoken and unrecognized deception can lead to counselors react in anger or confusion or despair, rarely if ever at a client, but rather about a client when only in the company of other agency workers.

Sometimes this confusion is expressed publicly. As mentioned before, I became interested in the topic of this dissertation in the spring of 2008, when San Diego's gay community was the target of three separate anti-meth public health campaigns. Billboards, ads in bus shelters, placards in restaurant bathrooms, and even coasters at the gay bars were emblazoned with slogans like "I lost me to meth," "It's not a game!" and "Know Crystal." The first was part of the state-wide "Me not meth" campaign paid for by the California's Alcohol and Drug Services office that claimed that meth stole one's individualism. The second was a campaign managed by Family Health Centers, paid for by county money, that warned people of the dire consequences of meth use, from depression, to jail, to death. The third was promoting a harm reduction website (that was focused on a recovery readiness) paid entirely by private donations and run by a local public relations professional.

That particular spring saw competing messages from competing – though not deliberately so – agencies. Several public health officials and workers complained to me about the gross mismanagement of that spring, how even though representatives from all of the agencies and organizations met with each other, were friendly with each other, and

agreed, in theory, with each other's messaging, it was still, in the words of one person involved in the process, a "clusterfuck." The messages were not coordinated, money was dumped in one place at one time and then gone, and no agency or organization followed up its campaign with research or another campaign. Since 2008, no one has produced an anti-meth campaign in San Diego, leading one official to tell the MSF in 2011 that "gay men are claiming in surveys that meth is less stigmatized now. This is probably because we haven't reminded them."

Leading the way

Since the disappearance of the anti-meth billboards, the two campaigns that held the largest amount of visual real estate (on billboards, posters, and ads in the gay press) for the longest time were a syphilis campaign¹³ and UCSD's campaign for Lead the Way. The latter was a research study that appeared to be a testing and prevention campaign, and it was run by a UCSD researcher named Susan Little. In the winter of 2011, Little twice visited the Community Advisory Board meetings of the Antiviral Research Center to present the study that would eventually be called Lead the Way. Dr. Little presented a polished and persuasive argument that showed, statistically and theoretically, that if everyone in a community was tested for HIV and those who were found to be infected

¹³ The syphilis campaign was one of the stranger ones that I saw waged in San Diego. It was implemented because of a striking increase in syphilis diagnoses in TK. While the number of cases was no astronomical, the rise was. The campaign features billboard, posters, and print ads featuring community members with slogans such as "I want my man to be clean" hovering above a drawing of hands or feet covered in secondary syphilis lesions. Not only were the billboards asking men to diagnose their own sex partners based on one vague drawing, they billboards were impossible to read or decipher from a car; they were only clear from sidewalks. During the summer of 2009, one such billboard was erected directly across the street from another billboard advertising the popular gay hook-up website, Manhunt. When I asked about the billboards, several officials told me that they were erected simply to please county politicians who wanted to appear to be making an effort. The money, the officials claimed, would have been much better served as funding for expanded and mobile testing sites.

were treated, then the amount of the virus in each person – the “community’s viral load” – could be reduced to undetectable. If this were to happen, no more infections would result, which in turn would eventually eradicate HIV from the community. The goal of her study, which she stressed was underfunded, was to test whether or not testing and treating a community was possible. She and her team were focusing on two zip codes in San Diego, 92103 and 92104, which are the two zip codes with the largest number of gays and lesbians, people with HIV, and people who vote for liberals. The idea, she said, was that if anywhere, it would be possible in these zip codes. There were two ways that the testing would happen. The first was the set up in a prominent place, a storefront HIV testing center; the Lead the Way storefront is on the corner of Park and University, basically at the center of the two zip codes.¹⁴ The second was to send a team of testers door to door to 20% of the addresses in the zip codes. Going to door to door was the most controversial part of the study at the CAB meeting, and it has been in the community as well.

When presented to the CAB, the study was justified with charts, graphs, and citations to the seminal study (Granich et al. 2009) that showed how mathematical modeling of viral loads and populations presented a theoretical justification for this “test and treat” method of HIV prevention. But when the study was underway and was being presented to the public – being *sold* to the public – the science was much more vague. The study is posed as an attempt to answer the question “would you or wouldn’t you take an HIV test this year?” and the shorthand for the question, which is how it is posed on

¹⁴ This is a block from my apartment.

billboards throughout the two zip codes, is “would you?” Artful, cheerful photos of various opinion leaders from 92103 and 92104 are shown and the words “they would” or “he would” and “she would” are written by them. While the billboards do not include “HIV” anywhere on them, the website explains:

We want everyone in 92103 + 92104 – yes, everyone – to answer the question “Would you or wouldn’t you take an HIV test?” If you would, we offer a free, confidential HIV Rapid Test that will give you your results in 10 minutes. If you would not, we’d like you to fill out a short, confidential survey.

By participating in this study, you can help us better overcome barriers to HIV testing. Because if we can get everyone to test, we can get treatment to everyone who wants it. And effective treatment can reduce the chances of HIV transmission by up to 90%. That’s how we stop HIV in its tracks.

Following this extremely simplified version of Little’s scientific justification, Lead the Way then gives five reasons for why they are doing the study.

1. Impatience: It’s been over 30 years since the first case of AIDS was diagnosed in the U.S. and we still don’t have a vaccine. So while the research continues, we’re going to do something about it ourselves.
2. Curiosity: By participating in our research, you help us better understand why people choose or don’t choose to take an HIV test. If we can understand that, we can make more effective campaigns to promote testing.
3. Common Sense: Since it’s already been proven that regular HIV testing is integral to curbing the spread of HIV, more effective testing campaigns mean more people testing regularly.
4. Strength in Numbers: If someday everyone tests, anyone who needs treatment can get it. Effective treatment can reduce the chances of HIV transmission by up to 90% and that’s how we curb the spread of HIV.
5. Karma: So, we are asking you to give us just 15 minutes of your time to take our HIV Rapid Test or take our survey. Either way, you’re helping us with some very important research and that’s going to score you some major karma points.

All advertising campaigns appeal to various needs, and the public relations executives who were hired by the AVRC to promote the campaign wrote the reasons in such a way to trigger specific emotional reactions. Using Maslow's hierarchy of needs, which is often used to analyze advertising messaging and is often used by advertisers to develop their messaging (Walker, Churchill, and Ford 1977; Pringle and Thompson 2001; Brierley 1995), it would seem that the entire list is appealing to safety, the second lowest need. But focusing on impatience (and the need for a local group to go it alone), on strength in numbers, and on karmic morality appeals to esteem, the second highest need. The use of the opinion leader models, who include scientists, chefs, media personalities, and personal trainers, also appeals to esteem, to need for acceptance of others. But the focus on common sense appeals to the highest need, self-actualization. Thus the ads themselves are attempts at not just recruiting subjects for a study but creating the kind of people who would want to become part of such a study, a biomedicalized neoliberal subject par excellence.

The morality of the messaging is therefore rather clear. According to the leaders of most pervasive scientific study in the Hillcrest and North Park neighborhoods, testing and treating HIV is not just a common sense action, it is a morally correct one; rational health behavior gives you points in a vulgar depiction of karma. This is not as much individual morality as it is community morality. By using "strength in numbers," the Lead the Way campaign is merging a kind of collectivist power with immunological power. The numbers refer not only to people in a population working together but also to the viral count in both individuals and the community at large. By banding together as bodies and with bodily, molecular, immunological power, the community will be able to

protect itself from the threat known as HIV. Being part of this project, according to the campaign literature, is a moral good; according to the scientists behind the campaign, it is a moral imperative. This morality fits within the trends of biomedicalization that Clarke, et al. identified: “Health itself and the proper management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment, the treatment of risk, and the consumption of appropriate self-help/biomedical goods and services” (2003:162).

Lead the Way, like most AIDS education and prevention programs, is explaining that certain specific behaviors are moral and others are not. But unlike previous campaigns that successfully argued that unprotected sex was unsafe and thus immoral (piggybacking on widespread American and Puritan attitudes about sex), Lead the Way is arguing for the morality of getting an HIV test and assisting in creating a sort of herd immunity. Outside the gay community, this argument is not well received. And based on my conversations with some associated researchers, early data has shown that Lead the Way is having great difficulty in persuading people in 92104 and 92103 to take an HIV test beyond people who already normally seek one out. And based on my discussions and observations in the community, a small but vocal minority has expressed that the campaign seems like Orwell’s Big Brother. They doubt both confidentiality and the scientific argument. Whether the resistance to Lead the Way is active or passive, it shows yet another rift in the morality of HIV. Many of the researchers, at Lead the Way and throughout the research profession, see treating and eradicating HIV as a moral imperative that implicates the entire community, from HIV+ MSM meth addicts to monogamous middle-aged heterosexual couples. However, like the mothers who refuse

to vaccinate their children because of the minute chance of complications from the virus and claim that the herd immunity of others will protect them (Mnookin 2011), most San Diegans in 92104 and 92103 seem to think that another person's risk for HIV is not the responsibility of anyone but that person. This individuality is profoundly American, but it makes the work of American public health researchers and providers very difficult.

Conclusion

In this chapter, I have describe how – at the exchange, at the Meth Strike Force meetings, at the HIV clinics and recovery centers, and at the meetings where public health messaging is developed – the anti-meth apparatus is slowly, messily, and but clearly trying to form a certain kind of person and a certain kind of community. The apparatus is the result of the AIDS epidemic, the meth epidemic, and the “double epidemic,” as well as the historical processes of medicalization and biomedicalization. Each branch of the apparatus responded to the moral breakdown of the meth epidemic with a particular set of ethics. Law enforcement has focused on capturing, punishing, and, they hope, rehabilitating drug offenders. And the goal of law enforcement is to convince the offenders they have not caught and the people who might become offender to abide by community values. The community health agency that runs the syringe exchange is ostensibly encouraging a nonjudgmental position on drug use, ostensibly subverting the ethics of law enforcement, but their “harm reduction” is, out of the earshot of the drug users, referred to as “recovery readiness.” The goal of the agency is, after all, community health. Roger's reactions to the entitled junkies and to the self-aware junkie are representative of the kind of health that is envisioned: responsible, knowledgeable, and

self-reliant – the prototypical values of late capitalism in the United States. In the subsequent chapters, I investigate how the ways that the apparatus, in its inefficient but nevertheless great power, influences the subjectivities of the meth-using HIV+ MSM in my sample.

Chapter 3:

Using Meth for Pleasure and to Escape Pain

When Cathy Reback was hired by the City of Los Angeles to conduct an ethnography of gay meth users, it was 1997, and the anti-retroviral drugs that ushered in the post-Holocaust period of the AIDS epidemic in the United States had not yet changed the culture. Meth's meaning, and the reasons for its use by gay men in Los Angeles, were, according to Reback, powerfully connected to their identities, as gay men, as people living under the aegis of HIV/AIDS, and as functional drug users: they "constructed their crystal use to counteract the social stigma attached to any or all of these identities" (1997:62) Meth made sex extraordinary, and it helped these men forget the trauma of the AIDS epidemic, not only by creating euphoria but also by allowing them to feel the unbridled sex that fear of HIV had ended. My fieldwork began 12 years later, well after HAART and government funding had made HIV a mostly manageable disease. The historical and social relevance (1997:65) of meth was different for my informants; they were using for themselves, for their immediate social group.

Contrary to the assertions of some queer theorists who place drug use and bareback sex within the realm of resistance and "counterpublic health" (Warner 2005; Dean 2009), none of my informants told me of conscious efforts, or seemed to me to be making unconscious efforts, of using meth in a practice of agentive resistance. Evidence that meth is used for the experience of using meth, for the hedonistic thrill, and for that reason alone is often sought by researchers, but finding it in the real world, outside the offices of professors of cultural studies and queer studies, has proved elusive. At the same

time, in the psychological, medical, and epidemiological literature that followed Reback's initial work, the use of meth is almost always the pathological result of various mental pathologies, from attention deficit hyperactivity disorder to post traumatic stress disorder. But for my informants, meth use is not just a sequelae of mental illness. It is also fun, at least for a while. None of my informants would say that the use was worth it, as the suffering that followed was more severe than the pleasure was ever fun. The suffering was never just the result of internal, personal processes. These experiences of the use, reuse, and continued use of meth are structured with cultural, political, economic forces, deeply influenced by the discourse of both the meth moral panic and the moral ethos of the anti-meth apparatus.

In this chapter, I examine the reasons my informants use or used meth, continued to use it, and why they were able or unable to stop. I place the data from my person-centered interviews within the varying explanations from the quantitative research of biomedical and public health researchers, who contend that self-medication is a prime reason for use. I argue that the experiences of and ramifications of the use are structured by cultural, political, and economic forces, discourses, and scripts; specifically, they inform us of the human reactions to the unforgiving Drug War and America's neoliberal healthcare system. My informants describe the use of the drug in both phenomenological and philosophical ways, and often see meth as a means to an end rather than for a physical experience in and of itself. I focus on vignettes from Adam, whose use of alcohol and drugs as self-medication for mental illness began when he was a teen-ager, who turned to drug dealing and prostitution, developing a belief that he useless and doomed and stuck; Jonathan, who became addicted to meth after using it with his lovers

but whose recovery was difficult and agonizing because of policies that served the drug war more than the drug addict; and Glenn, who used meth as self-medication but also for fun and release and an imagined ecstasy, but whose addiction led him to poverty, a rocky road of recovery, made more painful as he internalized the moralistic language of 12-step programs.

Theories for meth use among MSM

According to hundreds of studies done by health researchers, the reasons for using meth are varied, but most MSM seem to use meth to self-medicate for emotional problems, to enhance sexual experiences through “disinhibition,” and to improve and facilitate socialization (Halkitis 2009:85). These are not mutually exclusive, of course, as most men are likely to have multiple and overlapping reasons. Depression, self-esteem problems, anxiety, and stress are all indicated as precursors to meth use, with robust findings that of co-morbidity of meth use and depression. As Halkitis writes, “Not only may methamphetamine directly impact depression by alleviating the mood disturbances engendered by this condition, but it may also mask feelings of fatigue as well as lack of concentration, both characteristic of a depressive state” (2009:92). Since people with HIV are more likely to be experience depression – for numerous reasons – meth is often used as a coping tool, particularly after seroconversion (Halkitis, Fischgrund, and Parsons 2005; Reback 1997). Unfortunately, meth exacerbates these symptoms; depression is both a cause and an effect of meth use (Rabkin 2006).

As researchers have shown in other populations of meth users (Ross 2004; Looby and Earleywine 2007; El-Bassel et al. 2001), all of my informants used meth to cope with

depression. While not all of them described themselves as depressed prior to using meth, either using the term “depressed” or by describing emotional states that sounded to be depressive, during periods of abstinence from use or recovery from meth addiction, those who returned to meth did so to treat, alleviate, or mask their depression. Adam, whose experience I describe below, discovered as an adolescent that alcohol and drugs were the most effective tools for helping him survive his severe depression and anxiety. Meth was even better. “When I’m not high, actually,” he said, “I feel really uncomfortable. I hate it because I’m bored, nothing to do. There’s many people that don’t do drugs that live everyday like that...But I don’t want to do that because it’s boring. It’s a messed up world. Too much hurt and too much sadness.” After Charles’s partner died of AIDS, Charles went on a meth binge that last several years, all to forget and numb himself from the grief: “Greg said that he loved me no matter what, but then he died. I didn’t have it in me to deal with it.” Glenn, as I detail below, had a long history of using drugs and alcohol to self-medicate his emotional distress before he began to use meth, and at the lowest points of his recovery, it was meth that he turned to for help. Jonathan, whose story I also tell below, was enormously depressed and distressed by recovery and relapsed repeatedly. Sam was probably the most negative about his chances for recovery and the most depressive in his statements, saying during one interview, “I often think I should kill myself. But whenever I have enough heroin to do it, I forget.”

It is also likely that there are biological impetuses as well. Methamphetamine can alleviate symptoms of attention-deficit/hyperactivity disorder (ADHD), and this may draw some users (Khantzian 1985). In addition, recent research has indicated that genetic variations in the dopamine system may make some people more prone to addiction than

others (London et al. 2004). The majority of my informants described being much clearer and focused on meth and recalled diagnoses, formal and informal, of ADD or ADHD.

Sam was given Ritalin as a child for hyperactivity, while Glenn, Charles, and Eric were never ever given actual diagnoses as children, but in interviews, they all claimed to have ADHD and to find that meth focused them. Sam explains, “You know, I used to be down, and you put me on speed, I usually get calm. I mean, it depends on the deal, but ... really, it's pharmaceutical.” Charles was always acting out as a child, and was not treated well because of it. “When I was 12, I went on a crazy rant – ADHD stuff – and one of the teachers slapped me.” On meth, his mind is quieted. “Meth calms me down; I can focus.”

Numerous other studies have indicated that gay men use meth and other drugs as a means for coping with the stress of homophobia, loneliness, HIV disease, and social situations. Post-traumatic stress disorder is also associated with drug abuse and addiction; long-term sufferers of HIV who also have many AIDS related losses have shown signs of trauma, PTSD, and existential crises (Nord 1998; Machado 2012). Reback's ethnography of meth use in among gay and bisexual men in Los Angeles, which is the only one of its kind in the literature, showed that crystal helped some men manage their physical, psychological, and social effects of an HIV/AIDS. For men who had AIDS and lowered energy, crystal gave them vigor. Crystal helped others forget that they were grieving the loss of friends and lovers. Or to simply deal with their existence. One informant explained, “Sometimes when I'm down and out and I feel like I don't like myself any more, the things I'm doing for hustling and living in the streets, I take drugs and it falsely portrays a new person in myself. It's my moment of time to escape from reality” (Reback 1997:24). In their study of HIV+ men who used crystal, Semple et al. found similar

motivations. They quote one informant who used meth to escape HIV: “Everywhere you go, you’re reminded of HIV. Can I have one day when I’m not reminded that I’m HIV+? Meth gives me that” (2002:153). Halkitis et al. adds, “It may be that HIV+ men engage more frequently in methamphetamine use and sexual risk behaviors in an effort to cognitively disassociate themselves from their serostatus, enabling them to withdraw from the emotional and psychological stress they endure as a result of living with HIV” (Halkitis et al. 2005:714).

I interviewed my informants 13 years after Reback’s ethnography was published, and none of them talked about HIV being the main stressor in their lives, at least not in 2010 and 2011.¹⁵ I found it hard to untangle stress from anxiety and depression in my informants’ narratives, but several of them described the joys of using meth after a stressful week, as a way to take away their worries, or to disassociate from the “real world.” Richard, who worked as administrative assistant at a local university, constantly described his weekend meth binges as antidotes to stress of his job. When I was interviewing him, he was in recovery, not working, and living in a sober living facility. He was calm and happy and was planning for the future. When he went back to work, within a month, the stress of the job, he said, had led him to relapse. Similarly, when I asked Charles to describe the feeling of meth, he focused said on its ability to take away his worries. “Oh, it’s like every care in the world is just gone,” Charles said. “You’re not worried about anything. For that moment, it’s just perfect.” Adam, who had begun using

¹⁵ Eric and Jorge, both of whom contracted HIV in the 1980s and identified greatly with being gay and with the gay community, would have been the most likely to provide me with data that would match Reback’s, but they did not describe their meth use as having such meaning. William was old enough and has had HIV long enough, but he did not identify himself as part of the or a gay community.

meth partly because of its successful masking of depression, also used meth to cope with the stress and anxiety of his life, from not knowing where he will sleep or how he will eat to dealing with an emotionally abusive boyfriend or his needy sex work clients.

These reasons are individualistic, and many of the researchers who have described them underplay the role that social and environmental influences have in encouraging meth use. Halkitis argues that the composition and processes of the family can influence meth abuse, citing the work by Hawkins, et al (1992) that connects to meth use by children meth use by family members, poor family management practices, heightened family conflict, and weak family bonds. Both Brandon and Matthew had family members who used meth; Dylan's mother was a dealer and his father had spent time in jail for possession. After his mother abandoned him, Glenn grew up in numerous foster homes, several of which were either or both physically and emotional abusive. Charles, Richard, William, Jonathan, and Jorge had missing parents, either dead, estranged, or far away. Max and Eric had enormous amounts of conflict within the family; Max ran away, and Eric was beaten. However, Sam and Adam, two of the most troubled of my informants, had intact nuclear families with parents who were not drug users not abusive.

Of course, peer influence is incredibly important, particularly among gay men, whose feelings of difference as a child often lead to social insecurity as an adult. Brandon, always worried about being abandoned, used his drug connections to make and keep friends as a teen-ager and used with friends as an adult. Darrell's gay friends in high school encouraged him to take meth to lose weight. Richard was introduced to meth by men he met in West Hollywood. Eric first used meth when men he met online raved about the sex they had on it. He went to a hotel room to meet one of them and the man

had a syringe full of meth ready for him. Max's boyfriend persuaded him to smoke meth with him before and during sex.

Sexual experiences that seem impossible while not high are commonplace on meth. Since meth is such a powerful stimulant that intensifies the senses, the physical experience of sex is enormously powerful. One of Reback's informants described the sex: "All your senses are ascending, suddenly awakened and not dormant. Like being born; really cool, warm, everything is new and exciting, like the first time." Another echoes, "It's just every nerve in your body is standing attention" (Reback 1997:25). In addition, meth enables many men to have anal sex more easily, to experiment sexually, or to have sex for longer durations of time. Semple et al. quote one man for whom meth was "about pushing my limits. It's about seeing how far I can take it. The nastier sex, the better. Nastier being multiple partners, a lot of exchange of body fluids. I have to have multiple partners, one right after the other for hours and hours, and sexual marathons up to 20 hours of rough sex" (Semple, Patterson, and Grant 2002:152). Jonathan told me, giggling, "I would do the craziest things on meth." Jorge said, "Oh, yes, all I wanted to do was bottom. And I would do it forever."

In the introduction to Reback's ethnography, the Los Angeles AIDS Coordinator Ferd Eggan, who commissioned the study, suggests that the "outlawry" inherent in the mythos of gay sex is partly to blame for this destructive behavior. He argues, "[My] readings of the narratives provided by the men in this study is that the lives they have constructed and had constructed for them involve internalization of stigma, a sexualized definition of self, and mechanisms to resist the internalized negative feelings" (Reback 1997:ii). Meth use may not simply increase risk-taking in otherwise risk-averse men.

Rather, their work suggests that “methamphetamine attracts a hypersexual risk-taking group of men who engage in unprotected sexual behaviors regardless of their methamphetamine use” (Halkitis, Shrem, and Martin 2005:703). This possibility is echoed by another study that shows a correlation between meth use and both impulsivity and sexual compulsion (Semple et al. 2006a; Semple et al. 2006b; Semple et al. 2008). It is not surprising that since self-control is so valued in American culture many gay meth users feel shame about their drug use and sexual behavior, and those who quit rarely have anything but extremely negative memories of their meth use (Reback 1997; Mimiaga et al. 2008; Menza et al. 2007). Several gay cultural critics (Halperin 2007; Warner 1999) have argued that this shame, which comes from pathologizing both gay sexual adventure and the use of illegal psychoactive drugs, is precisely what many men are resisting, probably more unconsciously than consciously, by using meth and having sex that is called “risky.” Many of the men in my study described themselves as rebellious as children and cited their drug use as evidence of that rebelliousness, but it was never clear to me whether rebelliousness was an external description of their abnormal behavior by parents and teachers or a self-aware, agentive state of being in opposition to oppression.

Glenn

Glenn had grown up in and around San Diego, bouncing from foster parents to an uncle who touched him inappropriately, then to more foster parents. His father was gone and his mother had been incapable to taking care of him; his temporary families were only slightly better. Some were violent. Many he cannot remember. One family stuck the longest, and he refers to the other boy his age who lived there as his brother, still, more

than 30 years after he left the system. When he was younger, he was always getting into trouble, either because of his anger or sometimes, because he made passes at father figures. “I thought that that’s how you loved a father figure,” he told me. “I was a kid. I just wanted to be loved.” The chaos and emotional violence Glenn experienced as a child would be the first thing I would point to when he said that when he is high, he is most sexually turned on by degradation and humiliation (as I explain below). But: “I don’t see that as a reflection on my childhood.”

In his late teens, Glenn found himself in Kansas, engaged to a woman, even though he had long before realized he was gay. He married anyway, had two children in quick succession – a boy and a girl – but was divorced by 22. Constantly looking for stability and for family, he found a boyfriend and, long before it was both politically possible and socially banal, had a commitment ceremony at a branch of Metropolitan Community Church in Wichita. They were together for two years, and it was his addiction to crack that split them apart. He moved to Texas, and he was drugged in a club and raped, and he believes this is when he was infected with HIV. He’d always had trouble with substances, using them, he says with hindsight honed by 12-step programs, to masquerade his anxiety and loneliness, to fill the hole ripped out when his mother abandoned him. This is not a completely logical explanation, of course, and jumping over that disconnect, he also says he took drugs, “to get higher and higher. I don’t ever think I’ve been high enough. I’m hooked on the idea of not looking at reality.”

When his kids graduated from high school, he saw his responsibility to them lessened, and he and his brother decided to get a fresh start back in San Diego. They packed everything up, and without jobs or a plan, just an imagined belief that San Diego

really was American's Finest City, they drove west. But like the wannabe starlet who arrives on a bus in Hollywood and is promptly introduced to sex, drugs, and rock and roll, Glenn's return to San Diego was also his arrival to meth. The night they arrived, Glenn went to Montage, a gay club not far from San Diego's airport, and he drank and danced, thrilling to his new old home. He met two men on the dance floor, roommates who invited him back to their apartment for an after party of more booze and assuredly sex. When they got to the men's home, the roommates disappeared into one of their bedrooms, and while Glenn waited in the living room, they injected meth. Then, they opened the door, revealing themselves to Glenn both naked and in ecstasy. Glenn looked at them, at what he saw as freedom from care and constraint, from sadness and anxiety, and he said, "I want to feel like that."

So, he did. And he did it over and over again, though he would never feel like he did that night. Shortly after Glenn became addicted to meth, his brother returned to Kansas. Left completely to his own devices, Glenn devoted his time to meth and to sex, to finding money to pay for meth, to finding people who might give it to him, ever for money or for sex. He spent time in motels and hotels and flop houses with other men who were also doing meth. He asked men to act out rape scenes with him, to rape him. "That's what I was pursuing in all of my addiction, pursuing hurtful sex. The idea of being held down and injected, it turns me on. In my addiction, I wanted hands around my neck, to be spit on, spanked. I wanted to be hurt and to be loved."

Glenn had sex with men who he'd never have looked twice at while sober, he crashed on couches, he spent his savings, and he started finding and reselling junk to make ends meet. After four years of this, after a couple fits and starts attempting

recovery, he says he hit bottom in an SRO, crying all night long because he knew he was killing himself, destroying his children, ruining his life. When he came to our first interview, Glenn was crashing on a friend's couch and applying to sober living housing, for social security, and making plans for the future. He went to meetings every day, volunteered at Family Health Centers, and said he wanted to become an addiction counselor. He was positive, focused, full of goals. He was also dishonest, both with me and with himself and with the sober living programs. He told me one life story over three interviews, and then during the fourth, he read the addiction narrative he had written for San Diego's Crystal Meth Anonymous Book, and the tale was different. In the addiction narrative, he had been a crack addict in Kansas, and to me, he'd told that he'd tried cocaine once. I asked about the discrepancy and he told me, off-handedly, that he probably had wanted me to like him.

Glenn had been so excited about his future and his recovery, had thrown himself so fully into the recovery community, repeating their mantras in our interviews, volunteering at meetings, and declaring his desire to make a career as a former addict. He acted like a veteran of 12-step programs, but he was barely two months into his sobriety when he started sitting for interviews with me. He would also beat himself up after every set back, blaming himself for his failure to recover more quickly. After six interviews, we took a break; I had planned on doing two or three follow-up interviews after six months. But a couple of weeks after our sixth interview, one of my other interview subjects, who was living in the same recovery housing for people with HIV, told me that Glenn had left the complex. He had relapsed; he left one night, shot up meth, and returned a few days later to pick up his stuff. Within a week, he was back in Kansas, out of contact of his

friends at the complex. Brandon, a 22-year-old who Glenn had suggested for my study, who was in love with him, was livid: “He just gave up. He couldn’t handle it. He couldn’t be sober.”

Aside from never having been arrested and never spending time incarcerated, Glenn’s story was typical among my subjects, who were in turn typical of HIV+ MSM who use meth, at least in epidemiological terms. Before using meth, he had a long history of emotional trauma, depression, instability, and substance abuse. He was drawn to meth not only for purpose of pleasure, but also because of the freedom from earthly worries, from anxiety and sadness and unease. It also allowed him to feel things he’d never allow himself to feel sober. The ecstasy of sex and meth provided just that freedom. For a while. When he had tried to stop using, he had received minimal counseling and treatment by either experienced psychotherapists or addiction specialists. He relapsed not because of lack of willpower, morality, or ethics, but because he had neither the cognitive nor practical skills to manage the depression, anxiety, rootlessness, and insecurity of being an indigent addict.

Adam

“Well, my balls dropped and I rebelled. That was pretty much how it started,” Adam told me during our first interview. He turned 13, and his idyllic childhood ended.

I met Adam at the syringe exchange on a bright Friday morning in July. Carlos pointed him out; down the block, I saw a tall, lanky man in his late 20s, wearing a tank top and shorts and eyeing me suspiciously while smoking a cigarette. I walked over to him and introduced myself and briefly explained my research project. He nodded and he

said, “Well, I can certainly tell you stories about HIV, meth, and having sex with men.” While he didn’t smile, weary irony laced his voice. (Later, he would say, “My priority is to have sex with men and do meth, or the other way around.”) We made an appointment to meet at my office downtown, and he cinched his backpack up his shoulder and walked down the street. He took a bus to the trolley, which he rode without a fare ticket back to East County, risking another arrest; he has been arrested and incarcerated more than 20 times. Then, he was living with a couple who were allowing him to sleep on their couch for free, or rather, for no money. He told me that it was clear that he was expected to do meth and have sex with them. When he had demurred, they had gotten angry. They were not violent like other men had been, but Adam had gotten the message about what constituted rent.

During our first meeting, Adam told me that he was living with friends, was working for a landscaper, and was looking into going back to school. These were not exactly false statements. In a way, the men he lived with were his friends, but they were friendships forged in drug use and had numerous strings attached. Adam was thinking about working: one of his other friends had said he could help him get a job assisting a landscaper. As for school, this was a goal, or rather an idea of a goal, that he had been told over and over again to have, by drug counselors, case workers, and probation officers. Because of who I resembled – a researcher, a therapist, part of the anti-meth apparatus – I seemed like the kind of person who wanted to hear that Adam was thinking about going back to school.

Adam did not contemplate the future very much. He was more concerned with where his meth would come from, where he was going to sleep the next time he decided

to sleep, where he was going to be able to find money, who was going to give it to him and what he would have to exchange for it. Adam had been doing meth for more than a decade.

As a child, Adam had felt disconnected from his family.

I just never felt really connected to my family – to my parents and my family, really – because I'm not their blood, you know? I'm not their biological son. I'm adopted. So, that kind of threw me off. It made me feel like, you know, I don't have parents. Ever since I was little, I've felt that way. So, that kind of made me feel like I was less than. I think. It kind of screws... I don't know. It screwed me up.

He thinks it led him to look outside for social kinship. He grew up upper middle class, the son of a prosecutor and a doctor in suburban Michigan. His parents, he said, were obsessed with being good at being parents. But when he was 12, he became fascinated with the other side of the tracks – literally. The kids from that side of town smoked cigarettes before school, they drank a lot, and they did whatever they wanted to. By 14, Adam was getting arrested, and he was using all kinds of drugs and copious amounts of alcohol to self-medicate for severe depression, anxiety, and ADHD. His parents paid for psychiatry, rehabilitation, and lawyers, and they pulled strings to keep him out of jail multiple times, he told me. But no treatment, no prescription psychopharmacological substance worked to soothe him the way that the drugs and alcohol did. Finally, his parents put their feet down: If he would not cooperate, they would not take care of him anymore. He left Michigan when a warrant was issued for his arrest for writing bad checks.

Adam and his then-girlfriend decided to come to San Diego. They spent days on buses and arrived at her father's door expecting a bed to sleep on. But her father did not

want to see her or help her, and they spent the next couple of weeks sleeping on sidewalks downtown before cobbling together enough money to rent a unit at an SRO. It was in the lobby that he met his first boyfriend, who introduced him to meth.

And this guy asked, "Do you party?" and I was like, yeah. Then he was like "You want to come up to my room later?" And I'm like, yeah sure. Well of course I liked men so I was like, of course. And he pulled out a glass pipe. I didn't know what it was and he was like, let me show you how. We start smoking meth and then we had sex. So on that night I had sex, anal sex for the first time. And smoked meth. He was a drug dealer and he liked me, and shortly after that I moved in. And I had a really bizarre fun time for about, a couple years. So that was my introduction. Selling meth, unprotected sex. I got warned of like HIV or something like that. I don't even know if that was true or not. But obviously it didn't infect me because I was negative up until last January.

When I get real far out like on meth, shooting meth, what happened was I thought [my boyfriend and I] were so close and everything and maybe I just didn't care. At one point I thought it was cool to have a full syringe of meth, have him do half of it and take it right from his arm and put it in my arm. When you shoot meth, when you register your needle, blood shoots into the syringe. So it's full of his blood. I did that sort of thing. But it never came up [a positive HIV test result] until that January, and that was years ago. Yeah, I don't know man. I had unprotected sex with him so it could either happen – well, I was having sex with everybody so, well, yeah it could have happened with him. I don't know when it happened with him but I think it did. I mean as far as I know I was positive and he's been positive, and I was having unprotected sex, but I just figured that was like the direct line. I just didn't care, that is really sick. That is how I was thinking. You know?

I didn't care. And like another part of me was like, well at least this time now I'll have an excuse to destroy myself or have people feel sorry for me. Yeah, right! Oh, they'll feel sorry for me, so I can use that as an excuse to keep from destroying myself on meth, pretty much. Or no maybe my parents will help me now because I'm you know, I'm stupid.

After that relationship ended, Adam discovered that his good looks and mostly mellow demeanor gave him an advantage; he could easily trade sex for drugs, for a bed, for cash. Some of the men were nice, many were not. Some would get him involved in

the drug trade. He found himself carrying drugs for dealers, selling some on the side, and one day, at a Wal-Mart in East County, he was arrested with a duffle bag full of meth, ecstasy, marijuana, and cash. He had been high when he went into the store, and paranoid and agitated, and he easily piqued the suspicions of the security staff. This was not the first time he ended up in jail, but it did lead to his longest stay.

As with the vast majority of people who are incarcerated for drug offenses in California, Adam received no drug counseling while he was in jail. When he was released, he was sent to an in-patient rehabilitation program in North County. Understaffed by under-educated and under-paid drug counselors, the program was useless for Adam. After learning the vocabulary of recovery, after learning that only he has the power to end his addiction using drugs, he walked out, violating his parole; the prescription drugs meant to quell the agony of his emotional state were no comparison to the illegal, “recreational” ones. This repeated itself more than a dozen times: He would wander the city, couch hopping and scrounging for drugs and money, before eventually doing something – shoplifting, loitering, just looking weird -- that caught the attention of the police. After an arrest or a conviction, he would be funneled to treatment that failed to stick, and Adam would leave, violating probation or his parole.

During the months that Adam and I met, he would discuss his depression frequently. This was the depression that even the meth couldn't mask. He often said he didn't see any point in trying, that he expected failure, that he didn't see anyone interested or willing or able to help me. One day Adam came to my office covered in bruises and dried blood, and he was incredibly agitated and terrified. His boyfriend, who he called Psycho, had crossed a gang in a check-kiting scheme, and the gang had held

them and Psycho's brother hostage for two days. They were beaten and tortured before, for no seeming reason, they were released. Adam seemed to have a concussion; he needed medical attention. But he was terrified to go to the hospital because the last time he went – for bronchitis – he ended up with \$50,000 in bills. He repeatedly stopped himself from crying, which was most difficult for him when I told him I wanted to help him.

He told me, "I can't go on like this. I really feel bad. I don't know what to do." I spent the rest of what was to be our interview convincing him to go with me to see Leo, who had introduced us, at Family Health Centers. I knew I could get him into crisis housing. Adam agreed to meet me there in an hour. But he never showed up. For a week, I thought he might be dead, and I was in agony. I dreamt about him, and I couldn't stop talking about him. Then he showed up for our next appointment as if nothing had happened. He told me he had gone to get some meth to calm himself down before meeting me and Leo. One thing led to another and he was back sleeping at Psycho's apartment. After that week, I tried repeatedly to convince him to try to get into crisis housing, to get him to go see his doctor's appointments, to get him to find some method of excising himself from Psycho's home and grasp. And he simply could not.

During this period, as I contemplated why Adam would refuse help I was reminded not only of Reback's conclusion, that meth made sense to the lives of meth users, but also of the stack of studies about meth users using the drug to treat their clinical depression and their existential dread, as well as the knowledge that meth was not actually helping relieve the depression (Looby and Earleywine 2007). Adam was addicted to meth, and that physical need was the most powerful drive to his using, but

when he was sober, he didn't utilize the resources, however weak and ineffective, that could have helped him. Those are the resources that told him that he was a failure, a criminal, that his struggle was deserved and necessary. Being sober didn't make sense to Adam. Sobriety meant hating himself and panic attacks and efforts that seemed Herculean when high and even more difficult when coming down. Even though staying on meth would have similar consequences, from self-loathing to physical pain, it made sense to Adam to continue to.

Jonathan

I never found out how Jonathan found me. He was the only one of my informants who called me out of the blue with neither a referral nor a flier. I asked him and he said, "I did my own research." Like most of the men in my study, he was keen on the \$15 I paid them for each hour they were interviewed. But unlike most of them, he was eager. He loved to talk to me, and stated repeatedly that our conversations were very helpful to him. I reiterated that I was not a therapist. He understood this, but he also understood that my methods felt very similar to psychotherapy. When I asked him leading questions and followed them up and pushed him to explain, he was forced to organize his thoughts. This reflection led them to insights that he claimed he had not have before. On the New Year's Day after our initial meetings, he left me a voicemail thanking me for all the help I had given him in the previous year. All I had done, I believe, was ask him questions that no one else was asking him.

When Jonathan first came to see me, he was living in one of the sober living complexes that doubled as a recovery program. Because of space limitations and bad

timing, Jonathan was not living in the part of the complex that was mostly populated with HIV+ gay men. He was in the part that was serving as a halfway house for HIV+ men with histories of drug abuse who were on parole. It was a much rougher area, and Jonathan was slight, sweet, slightly effeminate white man who had just turned 50. He was scared, unnerved, and as a recent meth addict, he had very little control over his anxiety. He received a call from his family in Los Angeles that he overreacted to, and without permission to leave for the weekend, he left. When he returned, he had been kicked out the program; their “zero tolerance” for failure to follow the program’s rules was common. This zero tolerance for failure ensured that Jonathan would relapse. His options incredibly few, he was offered the couch of a friend, an active meth user whose roommate was also an active user. In addition to providing the drugs that he would relapse with, his roommates were so emotionally erratic and volatile that they encouraged the anxiety and rootlessness that meth helped Jonathan temper.

Jonathan had grown up in suburban Los Angeles, living at times with his mother and, when she was institutionalized after a suicide attempt, with a rough foster family. He was scarred by his mother’s mental illness and his foster care experience: “I would always wonder why she didn’t love me enough? Why would she give me up?” He was also a hyper active child, which caused much consternation among his teachers and social workers. He would get into fights, go into rage. “I had the attention span of a gnat.” His unstable and confusing family life as a child probably encouraged him to focus much of his energy, after coming out at 19, to find, build, and hold on, occasionally desperately, to relationships. It was in one of those, when he was about 40, that he first did meth. “After a year together, when we’d get high together, we’d fuck. It was really not based on

getting high but it was a part of it.” It progressed, however, to it being based on getting high.

On Fridays, I’d pick him up at his office in Sorrento Valley. We’d get a motel room, lay out the pipes and needles, and we’d have sex until Monday morning. It was rough. I’d usually go into work just dragging. Finally, I got fired, for using, for being high. They didn’t say it, but that’s what it was. I had started doing [meth] during the week.

Jonathan did not describe and did not seem think of his initial meth use as self-medication or the result of peer pressure, but rather as a distraction and an aphrodisiac. He giggled when he talked about all of the “dirty” things he did when he was having meth-fueled sex.

God knows I’ve done some nasty shit... Unfortunately I couldn’t have done it sober. It gave me a different mental attitude. I get more turned on more easily. Physically, sex was the same, I was just doing it for longer. I could push the envelope, do something different. Meth makes me more intrigued... all without coming too fast.

As fun as the sex was, Jonathan also told stories of taking meth and just sitting at his window staring at the street for hours and hours on end. After he broke up with this partner – who got arrested, got clean, and then convinced himself he was straight – he and his mother moved to Hillcrest, in central San Diego. He found another boyfriend who also did meth, who he would do meth with, but it wasn’t until his mother died that he started doing meth by himself.

After my mother died, I went into a serious, serious depression. I was simply denying everything around me. I’d just do \$100 of dope, take off, go to the casino, to take my mind of everything. I had a great time until I had to deal with reality. I was so out of touch. Then I needed the dope just to get motivated. I’d get distracted, and I’d need the dope. When I found myself with nothing to do, I would go to the storage unit [where all of his mother’s stuff was] and just cry. I was crying all of the time. I was constantly isolating myself.

In some ways, Jonathan was a functional addict: he had a roof over his head, he knew how to access his medical benefits, and he had never been arrested or incarcerated. But he could not keep a job or stay in a recovery program for longer than a month or so. And every time he was fired or kicked out for using, he was placed in a situation that made him want to use. Introspective and optimistic, he was an excellent candidate for treatment, for a program that mixed some sort of psychotherapy and cognitive behavioral therapy. The anti-meth apparatus functioned in such a way that made treatment for him nearly impossible. Shortly after we first met, he was kicked out of own sober living facility because he went to LA for the weekend to see his father. This seemed to him, and to me, to be an extreme reaction to a family emergency, but at recovery facilities, rules are part of the treatment. "It's hard for me to adapt to these rules. All of a sudden, you have a curfew." After living with the two meth addicts for two months, in the middle of the night one of them manically became enraged with him, kicking him out the apartment. In order to get back into the recovery program, Jonathan had lied about being in physical danger and about how long he had been clean. The irony that he had been kicked out for doing nothing inappropriate except for not asking for permission to visit his father but had been readmitted through lies was not lost on him.

During the time that I knew Jonathan, he stopped using meth not because of what it did to his mind, his friendships, or his health. He stopped so that he could not only improve his self-esteem, but so that he could have a roof over his head. And he did not just stop using; he also bought into the dictates of the anti-meth apparatus's idea of recovery. He discovered that if he followed the rules, he was safe. "I know if I do the right thing, I'll get my way. So far, all I've gotten are negative repercussions. But now

the good stuff is coming to me.” He applied to become a paid staff member at the program, and he was unanimously accepted by the staff and residents. “How do you think I’d feel? It’s been a super powerful growth thing. It makes me feel – it just boosts my self-esteem. I’m impressed with myself. I know I just have to trust the program. It’s worked for the best. It’s gotten me where I am now.”

Glenn, again

“If I had never had consequences, I’d do meth again. But it will kill me.” Glenn told me this a few weeks before the relapse that led him, first, to leave the recovery program where he lived, and second, to leave San Diego and return to Kansas, where he lives as of this writing. It did not kill him. We are friends on Facebook, and in the last two years since we last spoke, he has posted numerous mantras from recovery programs, photos of him and his children and grandchildren, a series of updates about a visit with his estranged mother, and then this month, a number of updates about his first weeks as a freshman at the University of Kansas.

Today is "New Student Orientation Day" at the University of Kansas. I'm up, showered and ready to go. There is a "little" voice in my head telling me that I'm too old to go back to school, people are going to laugh at me, I can't do this and so on. It's the same "little" voice that said I wasn't good enough and so I spent years of my life running from that belief with drugs and alcohol. So, today I'm not going to listen to that voice. Today I'm going to hear the voices of all those who are supportive and encouraging to me (and let me just say that there are several of you that believe I can do this). I will let you know how it goes. :) Have a great day everyone~

Glenn’s path to recovery was a long one. He told me during one interview that he’d introduced himself as a new member of Alcoholics Anonymous eight times; he’d relapsed seven times so far. This time, it seems, the program, both as a series of meetings

and exercises and a series of cognitive scripts and behavior modifications, has worked. He has stopped using.

Like Adam and Jonathan, and the other men in my study, Glenn's addiction has been powerfully individualistic experience. As they describe it, the desire for the drugs is theirs alone, the triggers are theirs to avoid, the use of drugs is theirs to end. The discourse of addiction promoted by the anti-meth apparatus expresses drug use as an individual choice; you can choose to follow the path of recovery or the path of addiction. Failing to follow that path can have disastrous consequences, from Adam's assault and torture to Jonathan's near homelessness, from Glenn's self-loathing to the structural violence suffered by all of my informants for whom the choice of recovery was nearly impossible to make. With few exceptions, my informants describe walking their paths to addiction as being done under their own power. Glenn does not see the state's failure to provide him with a safe foster family, to treat his mental health problems as a child, as having anything to do with the trauma he is still dealing with. He does not see how state-sponsored recovery programs push 12-step ideologies on him not because they are the most effective, but because they are the cheapest. (And as Carr explains, "...by prescribing talk that can only reference the inner states of speakers, addiction counselors effectively, if not intentionally, enervate clients' institutional critiques and discourage social commentary" (2010:5).) He does not see how the shame, guilt, sadness and despair that he felt during his recovery is partially determined by these programs, not because one needs to feel these things in order to overcome an addiction but rather because the Drug War, and the cultural, political, and economic processes that started and perpetuate it, need the shame, guilt, sadness and despair in order to prop itself up.

As Glenn said, in describing his rapes at the hands of men who drugged him, “I didn’t deserve it. But it happened because I put myself in that situation.”

Conclusion

In this chapter, I connected the experiences of my informants with the theories about the reasons for meth use argued in the extensive health research literature. Several patterns emerged among the men in my research. All of them used meth to cope with depression, anxiety, or other mental health issues, like ADD or bipolar disorder. Often it was combination of issues that my informants self-medicated for, and often, after they became addicted and new issues emerged, they used meth to self-medicate for those as well. This became a vicious circle. Meth was also important to my informants’ sexuality; it was used to increase pleasure, inhibit inhibitions, and create connections with other men. In three person-centered ethnographic vignettes, I described the cultural, historical, and emotional context for these pushes and pulls: Glenn, who used meth for both sexual adventure and emotional medication; Andrew, who could not cope with his mental illnesses without using meth, which only increased his suffering; and Jonathan, whose need for connection and love became profoundly entwined with his need to be high. In the next chapter, I explain in more detail the process by which the apparatus helps to construct these sorts of subjectivities.

Chapter 4:

The Trouble With Trying To Be Normal:

Pride, Shame, Frustration, and Risky Subjectivity

One morning in March of 2011, my phone vibrated as I was getting into my car to go to the syringe exchange where I have volunteered every Friday morning for about a year. The “Hey, Ted” that I heard was instantaneously familiar; it was Sam, a funny, sweet, crafty, and homeless 43-year-old meth addict I had met at the exchange the previous summer. For three months last summer and fall, I had interviewed Sam, paying him \$15 for each hour he talked to me. More so than any of the other 12 men I worked with, Sam became my friend, and I became his friend.

I had not heard from Sam since he sent me a text on Christmas, and I had hoped that this was because he had, as he said he wanted to, gone into a rehab program. The exchange worker who had introduced me to Sam had said, “No, he’s probably in jail.” But I’d checked, and according to San Diego’s very handy “Are they in jail?” website, he was not, at least not in the county.

“I fucked up,” Sam said. “I really fucked up.”

“What happened?” With Sam, the possibilities were not quite endless, but they did involve dangerous and illegal activities. He did a lot of shoplifting, and he used steal a lot of cars.

“I was clean for two months, and I walked out of Choices at 9am this morning,” he said. “And I just drank a whole Four Loco, and I’m drunk.” Choices is a free, non-profit, heavily state-subsidized recovery program in northern San Diego County, and

Four Loco is a malt liquor beverage that is intensely caffeinated. Because of the power for the price, Four Loco has become popular among college students and the poor.

Sam went on to tell me – between talking to and yelling at the friend who had picked him up at Choices – that he had gone into recovery on January 3rd, that he had been doing really well, that he had held his grand-niece and grand-nephew for the first time, that he had been *clean for two months*. But the man who Sam was in love with, who he had been in love with for three years, worked at Choices, and he had told Sam that did not want to get back together with Sam. And Sam could not take seeing the man, a recovering heroin addict, every day.

“I’m not patient enough,” Sam said. “I couldn’t take it. And now I’m drunk. I fucked up again. I just can’t do it.”

He went on to tell me that he was spending the weekend with his friend and then going into another program on Monday. I asked if this friend would keep him away from the hard stuff.

“Oh, we already scored some speed.”

A week later, he called and asked for \$20. When I went to meet him, he was thankful, but he was also, clearly, ashamed of his predicament. He was back sleeping in a tent in Camelot. He kept saying that he’s not strong enough, not patient enough, that this was all his fault. “This is all on me,” he said.

Sam, clearly, is ashamed that he is unable to be clean and sober, to be able to work, to be able to avoid hustling, stealing, and asking people like me for \$20. In the fall, at one interview, Sam told me, “I always feel like shit after I talk to you.” I immediately felt guilty and asked why. “Because you have your shit together and I’m such a fucking

mess.” I told him I do not want to him to feel like shit, and it is not as if I’ve faced the same problems. He said that he knew that, but my existence made his predicament all the more clear. This was one of the moments in my fieldwork that most clearly showed me how emotional experience is an interactive cultural experience structured by power relations. Even in my concerted effort to be non-judgmental, to just prod him to tell his story, my existence as an educated, housed, and seemingly happy academic researcher paying him \$15 for his tales of woe threw into relief those tales of woe.

Sam’s shame arises from his inability to become what the anti-meth apparatus wants to its objects to become, the productive member of society, a “normal” American. This focus on the construction of normal citizens is fraught with complexities, inefficiencies, and confusions. In this chapter, I will examine how, once they became identified and hailed as HIV+ MSM meth users, my informants’ subjectivities were formed within a behavioral environment focused on making them normal: How they are made to narrativize their identities as meth addicts, how this shapes their desire to be normal, what normal ideal looks like, and how the success or failure to be normal leads to pride, shame, and frustration in both their quotidian lives and their more broad, existential situations. The, legal, and biomedical structures set up to prevent or control meth and HIV are trying to create a normal subject that is an American and neoliberal ideal of individualism and self-reliance: employed, productive, healthy, married and settled in a home (as discussed in Chapters 1 and 2). Both those who are using and recovering all attempt portray normalcy in their dress, walk, and physicality, all to communicate to the world and to themselves that they are not abnormal, dangerous, or risky to those around them, to the greater community. The data I will use will focus on interviews with all of

my informants, focusing on the vignettes of frustration, shame, and, occasionally, pride felt in their quest for normalcy.

Normal, abnormal, and subjectivity

In 1934, Ruth Benedict published her influential essay “Anthropology and the Abnormal,” in which she took the then-daring position that the categories of normal and abnormal are culturally defined. Benedict points out that all cultures have normal and abnormal types, and only rarely do societies agree on what belongs in either category, and, in fact, in some societies, abnormal people are honored and are even key components in the social structure. In most cases, however, what is normal tends to be considered good, and what is abnormal tends to be seen as bad. Behavior that is moral that which is standard and accepted, and so immorality ends up describing behavior that is different, that is not habitual. “A normal action,” she writes, “is one which falls well within the limits of expected behavior for a particular society. Its variability among different peoples is essentially a function of the variability of the behavior patterns that different societies have creates for themselves” (1934:73). Throughout the essay, Benedict cites the example of homosexuality; while it is considered immoral, deviant behavior in the modern West, in certain indigenous American tribes, homosexuals were given honored places in society, and in ancient Greece, homosexual behavior was morally neutral. Nearly 80 years later, while homosexuality was not yet considered a normal way of being in the United States, it is approaching that status in many segments of the culture. However, as homosexuality has become normalized, it is only certain kinds of homosexuality, only certain ways to be gay that are hopes to become normal.

This has not been without both debate and conflict, with criticism of what is known as homonormativity coming particularly and powerfully from practitioners of Queer Theory in the academy. In *The Trouble With Normal* (1999), for example, Michael Warner attacks the notion that normal is something that is actually good and that normal is something that should be aspired to. The problem with that argument is that only those who can thrive, or even survive – socially or economically or psychologically or physically – while resisting the normal can actually benefit from abnormality. For my informants, men who exist outside the boundaries of acceptable behavior, trying to be normal is the only option. And it is a fraught process.

Perhaps the most important contribution psychological anthropologists have made is their explanations for how culture and the self are co-constitutive. Hallowell writes, “the self is a social product – more accurately characterized as, also, a cultural product” (1955:81). He rejects the idea that we can have can ever have complete objectivity from which our initial understanding of reality – and ourselves – springs. “The psychological field in which human behavior takes place is always culturally constituted,” he says (1955:84). Taking this further, Hallowell contends that we do not live in a social or a cultural environment, but rather a “culturally constituted behavioral environment” (1955:87) Hallowell considered his approach to be phenomenological in that the sense that it is through basic, socially constrained orientations that we construct and maintain self-awareness. The normative orientation is particularly important for the construction of the moral self. “Values, ideals, and standards are intrinsic compounds of all cultures,” Hallowell writes. “Without normative orientation, self-awareness in man could not function in one of its most characteristic forms – self-appraisal of conduct... [The]

individual must be motivated to consider whether his acts are right or wrong, good or bad. The outcome of this appraisal is related to attitudes of self-esteem or self-respect and to the appraisal of others” (1955:105–106). My informants have been the focus of the anti-meth apparatus’s efforts to change their behaviors and subjectivities, and their orientation to what is normal in the behavioral environment is central to development of their risky subjectivities. For what is normal is not often what is actually experienced; the ideal of normality for my informants becomes, for some, not the comfort of acceptance and conformity but rather a symbol of shame and frustration.

Both the purveyors of addiction treatment and critics of their methods understand that the transformation from an active addict to a recovering addict often involves the development of an entirely new identity. Holland et al argue that identity is practiced. They point to one of Vygotsky’s late essays that describes how children, for the purpose of play, suspend the standard, everyday meaning of objects and ascribe different meaning to them (1998:50). An object can then become a “pivot” that the child uses as a mediating device to transport himself or herself into the play world. As the child grows older, however, the object may not be needed to enter the imaginary world, and games become less pure fantasy, but being able to travel to the land of make-believe is still needed to play. This ability to play is linked to the ability to function in an institutional world, where you are given a role to play, and the game is much more serious. Thus, play is linked also to culturally figured worlds such as Alcoholic Anonymous (1998:51). These “figured worlds” are not only thoroughly imagined (with roles given, defined, narrativized, and embodied), but must be constantly practiced. All of this is done within structures of power and position that Bourdieu referred to as a “field of power” or

“structure-in-practice” (1998:58). The field is basically a game—it is performed, practiced, and played by better and worse players—and that is why Bourdieu referred to the *habitus* as the “feel for the game” (Bourdieu 1990:67). Every game has rules and game pieces: pivots.

Narrativizing addiction and psychopathology

In AA, Narcotics Anonymous, Crystal Meth Anonymous, recovery programs, and sober residences, the pivots would be both the chips that members earn with each completed step as well as the stories that members tell of their addiction. The pivots enable the actor to enter the figured world, “to shift the perceptual, cognitive, affective, and practical frame of activity” (Holland, et al. 1998:63). Pivots are also means of self-control, because they help to frame our emotions and experiences, and to narrate our history-in-person. As E. Summerson Carr writes in his ethnography of a recovery program *Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety*, the constant communications between treatment counselors and recovering addicts are

semiotic entanglements: clients worked to effectively represent themselves and their problems, and therapists worked to script, or set the terms of these representation. Because of the institutionalized ties between . . . therapists and other social service professionals, a variety of resources – from temporary housing, transportation vouchers, and job training to medical care, legal protection, and therapeutic acknowledgement – hung in the balance of these intensive verbal transactions. (2010:2)

Addicts must accept the hail of addiction treatment in order to access services needed for survival. Not only is this a profound example of micro-physical governmentality, but it also is an explanation for the development of my informants’ stories explicating the origins of their addiction.

Carr's ethnography focuses on a Midwestern treatment program in which the interaction between addicts and therapists is localized in one clinic and is specifically focused on psychotherapeutic language. My informants, on the other hand, are being scripted and are scripting themselves in a much more diffuse behavioral environment, interacting with a heterogeneous anti-meth apparatus comprised of not just addiction counselors but also doctors, case managers, outreach workers, police officers, district attorneys – a discursive milieu constructed by the Drug War and self-help ideologies. Carr writes that “there is a distinct clinical logic to the theorization of addiction as a disease of insight” (2010:123), and this focus on an insightful understanding of an inciting incident appears in the narratives my informants constructed when explaining their addictions; they were especially well-structured, well-plotted even, among the older addicts more experienced with recovery programs and addiction ideologies. This is not surprising. The more time spent using meth led to more court orders for treatment, more time in sober living complexes, and a greater likelihood that therapy paid by the Ryan White Care Act was utilized. The more interactions with these arms of apparatus, and the more intense the interactions, the more likely the coercive nature of the apparatus's agents will succeed in scripting the meth users life stories.

In their narratives, my informants almost always focused on psychodynamic or traumatic reasons for the creation of the needs that meth helped them fill. With this moment identified, the story then followed the informant as he looked for situations that might make him feel better, to feel the correct way, with correct usually meaning content and safe. This quest often leads the informant away from family and old friends and into the gay community, usually the segment more focused on sex, partying, and physical

experiences of pleasure. It is in this milieu that the informant first takes drugs; sometimes this is meth, sometimes it's another drug that eventually leads to meth. They each described a honeymoon period during which the informant is taking a lot of meth, having a lot of sex, making a lot of friends. Sometimes this period lasts months, sometimes years, but for each of my informants, it ended with some sort of personal disaster: an HIV and/or AIDS diagnosis, jail or prison, homelessness, estrangement from friends and family. After a period of recovery, a few stayed sober (at least during the period of my fieldwork), while the others started the cycle again, with most blaming their own personal failings for their situations. If addiction is, as many contemporary psychological theorists contend, a disease of denial that affects the sufferer's insights, these insights are supposed to be part of the treatment. They can also lead to self-loathing, and without further treatment, a return to active addiction.

While it is possible, as Carr explains, to "flip the script" and use the language strategically just to gain approval from agents of the apparatus who control resources, William, a 45-year-old African-American man, was the only one of my informants who discussed doing this knowingly. But William still had internalized the psychodynamic, psychopathologized cause-and-effect narrative, just as had the rest of my informants. These narratives, as discussed above, became pivots for their identities, which were centered on their addiction, their HIV status, and the burdens they placed on the community, their friends, and their families. William, for instance, saw his early adolescent exposure to Oakland's red light district, and the sexual and moral corruption he experienced there, as a prime cause for how he became "fucked up," which is what would lead to the addiction that came in college. Adam did not blame an actual event, but

rather on the mental illness that he self-medicated for beginning in high school, first with alcohol and eventually with meth. Eric, Sam, and Brandon recounted being molested and connected it to later feelings of shame and depression that drugs helped treat. Glenn connected his need to belong and to be wanted, as well as to be free of his memories and emotions, to his affection for drugs and his use of them as a crutch-like self-medication. For Richard, a Latino man in his early 40s, “HIV just derailed me,” and it took him ten years of what he calls denial to admit, or rather to accept the hail of, his addiction. “I wanted to use it to have some fun on the weekends,” he told me. “And the therapist said, ‘You’re an addict.’” After he was told this enough times, Richard believed it.

For Max, a Filipino-American in his late 30s, the process worked as designed. His HIV diagnosis was when he, in 12-step parlance, hit bottom. He was told and he came to understand that if he did not find housing, get into medical treatment, and beat his addiction, he would die. “I fucked my life, my job, just being homeless,” he said. It was though embracing recovery, both practically and ideologically, that he was surviving. (See Chapter 5 for more on Max’s, and others’, survival strategies.) But it also transformed his identity. “My mind I’m all about being a new person,” he said. “Getting a new job, a new place. I know I’m healthier. Before I didn’t check on my health. I need vitamins, nutrition, food, psychiatry – everything. [At the recovery program] you talk about your past. You’re going to find [the answer to your problems] there. I learned a lot about myself, about learning to say no, about taking more responsibility. In 12-step, your mind is getting more cleared up.” In the process of clearing his mind, of learning why he needed the approval of men and of his new gay friends, he was transformed from an addict into a recovering addict. The procedures of recovery programs constantly

reinforced this new identity. He practiced it not just in Bourdieu's sense of the term, but in its more literal meaning, that practice makes perfect. As Max said, reciting the script, "I just follow the tools."

Of my informants, Charles had the most extensive therapy, and his scripting was a flawed and haphazard process. As with most of my informants, the apparatus's scripting did not produce the subject desired. During my fieldwork, he was the only one who saw a psychiatrist every week. (The others saw drug counselors, had medical doctors prescribing anti-depressants, or were members of at least one support group. He did all of these, as well as psychotherapy.) He seemed to have the most insight of anyone in my study, but at no point did he stop using meth for longer than a few months. He and William were the only high-functioning active addicts I interviewed; they had their own apartments, picked up their monthly federal disability checks, and always made their appointments. But despite being the focus of the apparatus for so long, and despite having analyzed his past and his emotions so thoroughly, and despite being on numerous psychotropic medications, Charles had an almost exclusively negative, if not depressive, analysis of his psychodynamic narrative.

When I asked about his earliest memories, he told me about being left at his grandparents' house often. "I would sit and stare out the window," he said, "waiting for my parents to come pick me up. They would never show up." He told me that is why he is always waiting for me when I arrived for our interviews. "Now I have to be early, or they won't wait." He links this fear of being left behind with his fear of his family discovering that he was gay; they suspected it early on because of his effeminate mannerisms: "To my dad's parents, who were dumb rednecks, I was devil spawn."

Instead of disappearing into himself and hiding, he became an extrovert. “I was afraid of being found out and afraid of being forgotten, so I would be as obnoxious as I possibly could.” In his analysis, he sees this extroversion, much of which was a clown-like performance, as a defense mechanism. “They could never know how depressed I was,” he said. “It takes so much effort to put on that happy face. I have a hard time attaching myself to people. That’s why I had to be outlandish.”

What he refers to as a pathological fear of abandonment is his explanation for two key moments in the narrative of his illness. He found out he was HIV+ in his early 20s and he told no one after the day he got the results. “I never talked about it until I was 35,” he said, not even his partner of many years, Greg. “I never told him. I knew for sure he would leave me.” The cruel irony was that when Greg was dying of Hepatitis C, which he did not tell Charles about until it was killing him, Greg revealed he also had HIV. When Greg died, Charles’s fear was realized: “Greg told me he loved me no matter what. He told me he would never leave. And then he died.” In response, Charles says, he focused on a combination of denial and self-destruction: He spent all of his money and all of the money Greg left him on drugs, eventually becoming homeless and finding himself in jail.

As he explained his behavior, he repeated the various analyses offered him by his therapists and counselors. (Even though some of the therapists he found to be unhelpful, even cruel, he has continued therapy. One, he said, “tormented me.”) His current therapist told him, “You’re not crazy, you just do crazy things.” In one support group, which used an intervention curriculum designed at UCLA, he said, “We were trying to figure out why a lot of us have underlying reasons for using. You’re supposed to be responsible to yourself.” This responsibility means that, as Charles believes, “I made my life this way.”

In analyzing himself, both through years of psychotherapy and in various interventions, from groups to one-on-one sessions of motivation interviews, he has learned to narrate his life as a mentally disordered rake's progress. But unlike the rake in Hogarth's iconic moralistic paintings, he feels shame for letting these events and situations make him – and others – suffer. He told me: "I have to stop using my past as an excuse for being bad." Repeating

Of course, these stories are not the only pivots that send Charles into a self-aware identity as bad, as a meth addict, as HIV+, as mentally ill, problematic, as the object of public health risk discourses. There are also the syringes he uses, the anti-retroviral combination therapy he takes, the cocktail of psychopharmaceuticals: trazedone, seroquel, abilify. But the narratives that he developed in concert with the agents of the anti-meth apparatus are what give all of these aspects of his quotidian existence meaning, making his subjectivity cohere. Unfortunately, what has cohered is not all what was intended by the anti-meth apparatus, unless daily, guilt-ridden suffering is their goal.

Hoping for a homo/normative future

In the life narratives my informants recited, the future plans, the unwritten, unscripted sections, were remarkably similar. They reflected not just the broad and old American hopes and goals of economic individualism, but also the desire to become a neoliberal subject (Ong 2006; Harvey 2005) and what Lisa Duggan (2002) calls "homonormative." This is not surprising since central to the 12-step process is the focus on self-management and individual responsibility, and the dominant issue in gay culture, the central topic of the cultural discourses surrounding gay culture, during my fieldwork

was marriage, both the political fights over and the decisions of many gay couples to wed. Duggan and Warner (1999), among others (Halperin 2007; Wharton and Philips 2004), criticize the political prioritizing by gay rights organizations of marriage rights over economic justice issues as well as those organizations' willingness to underplay and even condemn the radical sexual politics of the Stonewall generation. Race (2009) connects these politics to the world-wide drug war, arguing that drug use has become considered the antithesis to the family and to morality. Putting aside the debates over the ethics of same-sex marriage both politically and practically, the presence of the most conservative of these discourse in the hopes and dreams of HIV+ MSM addicts is testament to their pervasiveness.

In the future, my informants want to be not just be free from meth addiction, working and self-sufficient, but also settled down with a husband, owning a house, and focusing on family.

While these futures varied in the specifics, they were primarily economic and secondarily affective. Darrell said he wanted to "go with flow. Hopefully get married, settle down, working a stress free: living." That these are done by "going with the flow" seemed to me to say that he was following the path of least resistance, not that it would be easy to achieve but that it would be the most expected, the place the "flow" would send him. Max was following the CMA rules and was waiting a year before looking for a boyfriend, though he was thrilled when men at his meetings asked him out. While he worked the steps, he said, he would look for friends: "I need to focus on my career." Afterwards his career and sobriety were established, he would find a partner. During our interviews, Eric was a year clean and going to school to earn his teaching certificate and focusing on his

relationship with his new partner, a community organizer. Brandon told me wanted to go to school to become a lawyer, while Glenn's dual focuses during his sobriety was earning his degree and being a present father and grandfather. William, despite his politically oriented reasons for refusing sobriety (see Chapter 5), realized that in order to be a member of his nuclear family, he had to be sober and at least act the part of a self-sufficient heterosexual man. Sam, in his letters to me from jail, told me that working would give him worth.

I'm 44 and I'm not really going nowhere. What do I have to lose [by going to] one more drug program? It's a way to get back on my feet and off the streets. I want to go back to work so bad. I love to drive and tow car so possibly towing or delivery driver or something like that. At - least I would be doing something that I enjoy therefore chances are I would stick with it. I know that I'm worth more than living in that damn canyon in Hillcrest.

Extremely wistful for the year that he was sober, working as tow-truck driver, and living with his boyfriend Michael, his ideal future is a recreation of that time. When Sam was at the recovery program where Michael worked, Michael refused to be part of future; this is one of the reasons Sam relapsed.

Matthew, who had been dishonorably discharged from the Marines and incarcerated several times for meth use and sales, saw work, family, and his relationship as his key to success; success would leave him to these things, and these things would ensure his success. During our interviews he was newly clean and living at one of the sober living complexes. His daughter from a high school relationship lived in Northern California and his boyfriend was living in Florida, where the boyfriend's father had taken him to get him sober. "I never wanted to stop [until now]," he told me. "I like who I am today. I have a dream: I got tired of hurting my family, myself. Not just physical, but

internal, emotional, physical. James woke me from the darkness, showed me how to love again. If I didn't meet him, I'd still be lost in my addiction. I learned to love myself and somebody else. If you find true love, never let it go." In order to this, he was working at a convenience store and going to school, both at a community college and at a vocation school. In his vision for the future, he would work and then come home to his boyfriend and to his daughter. The hypercognized ideology was affective, but the hypocognized one was economic.

An idealized middle-class gay future was expressed by Richard, who perhaps more than any of my informants was focused on work, both as the result of his sobriety and as the cause of his addiction. He repeatedly said that it was the stress of work that he was escaping on his weekend meth binges, that it was dreading his stressful job that made him not want to return after a weekend of drugs and sex. But during our interviews, when he was living at one of the recovery programs, he was focused, almost obsessed, with going back to work. His addiction was not technically what was keeping him from work but rather a hand and wrist injury that had allowed him to go on disability from his administrative job at one of the local universities. Richard, who had been sober longer than most of the other residents in his program, was bored, antsy because he was not being productive. "Obviously, I want to do things to be productive," he said. But he had to be patient. "I just try to work one day at a time." In the last interview before we took a four-month break, I asked him about his plans. "In six months, I want to be back to work, looking about getting into a nursing program. After one year, I want to be getting my own place, moving on to other things. In the future, I want to moving back to LA. I want to be living in LA working at a hospital, working in an HIV clinic. I would like to settle down,

working and feeling stable.” I asked about the far future: 15 years from then. He told me, “Fifteen years is so far in the future...” but within 15 seconds, he pictured what he wanted: “having a house in West Hollywood, where I can go have coffee downtown. That would be nice.” This image could have been plucked from a gay fashion magazine, or from the “No on Prop 8” advertisements that famously depicted the homonormativity critiqued by Duggan and Warner and aspired to so many urban gays and lesbians. In order to get there, Richard said, “I need to be trying to work towards my goals and working on my action steps.”

Pride, shame, and emotional subjectivity

Six months later, Richard called me several times in one afternoon. He had relapsed and he told me he needed to talk to me. We met for coffee; he was driven to the cafe by one of the men he had spent the weekend with. He was sweaty, jittery, and he had lost his belt, which was making it hard for him to keep his shorts on his waist. He was ashamed, mortified, scared, and very nervous. Richard told me that he had first relapsed a few weeks before, and then this past week the stress at work had been too much for him. The pressure to do everything right and do it all on time activated all sorts of panic and anxiety that Richard thought a weekend of meth and sex would be able to quell. He was wrong, as it turned out. Worse, in leaving his sober living apartment for the weekend without providing notice, he had been kicked out. He was homeless, had none of his belongings, and had no clean clothes. I spent the afternoon with him; I took him to Target, then to a motel, and I put in a good word for him with a new case manager. Throughout, he was terrified of admitting what he did, not just to his boss (to whom he

called in sick), but also to the case manager, the director of the sober living complex, and to me. As he came down from the meth, the shame mixed with paranoia. He called me a half dozen times from the motel, convinced that the front desk manager knew that he had been high and was going to call the police.

Richard's storm of emotions that day was not atypical among my informants. Emotional discourses expressed by my study participants were particularly intense, not only because drug use is often caused by the desire to feel particular emotions but also because my informants are constantly being told what emotions they should be feeling by various segments of the anti-meth apparatus. As I discussed in the Introduction, emotional experience is cultural, and it is central to subjectivity. As Catherine Lutz writes, "Emotion can be viewed as a cultural and interpersonal process of naming, justifying, and persuading by people in relationship to each other. Emotional meaning is then a social rather than an individual achievement – an emergent product of social life" (1988:5). Emotions are created by both the complex interaction of interpersonal negotiations and the subjective experience of social structures and Foucaultian microphysical power relations. Thus, the ideas, descriptions, and discussions of emotions are laden in ideology, history, and "ethnotheoretical ideas about the nature of self and social interaction" (10). This interactivity also helps to explain some of the power of morality; this interactionist model of emotion provides an explanation for why people feel as they ought to feel: "The force of emotion is to a great extent the sense of moral or pragmatic compulsion, the sense one must do what the emotion 'says' one will do" (Lutz 1988:213). Ultimately, the feel of morality, the correct emotional reaction to social events, leads, after a cascade of power relations, to cultural norms.

Emotions, and emotional discourse, is then inherently political – on both the local and national levels – and the state has a vested interest in controlling them, if not reconstructing them. The debate over whether someone is actually ill has profound moral and political consequences, as Jenkins writes: “Someone who is distressed might still deserve that distress, but... someone who is sick is relieved of culpability” (1991b:155). This tension, between what is a disease (like addiction) and what is a moral failing (like criminality), leads to the confusing and erratic emotional discourses expressed by both my study participants and the anti-meth apparatus. In this cacophony of emotional discourses expressed by agents of the anti-meth apparatus, by addicts, and by the community, two emotions still became particularly salient. Overcoming a disease like addiction is cause for pride, but not overcoming the disease is considered a moral failure. It is cause for shame. Both emotions are considered self-conscious emotions that arise from self-reflection and self-evaluation, with shame being the “negative evaluation of the global self” (Tangney 1999:545) and pride “generated by appraisals that one is responsible for a socially valued outcome or for being a socially valued person” (Mascolo and Fischer, qtd. in Tangney 1999:558), they were the most pronounced during my interviews and interactions with my informants.

Richard’s shame, as well as Sam’s, which opens this chapter and was also discussed in the introduction, were echoed by several of my informants. When Glenn relapsed shortly after we finished our interviews, he stopped using rather quickly, but he also stopped speaking to his friends in recovery and would not return phone calls. He was too embarrassed to return to the sober living complex and picked up his bags in the middle of night. He drove to Kansas without speaking to anyone. A few weeks before he

relapsed, he told me about being tempted by a friend he used to shoot up with. He told me, “I contemplated giving up everything. I put myself in a vulnerable place. That wasn’t taking care of myself.” As he told the story, he shrank into his chair, wouldn’t meet my eyes, and teared up; I wasn’t surprised when he did relapse that he didn’t want to speak to me or the people he knew in recovery. Speaking to us and about what happened would remind him of and reinforce his shame.

Similarly, while Eric was happy to talk to me about being a recovering addict and to tell me stories about his childhood, but when I asked about the first time he used meth, he started the story – how he met a man online who told him to come to his house, where a full syringe would be waiting – and he started sweating, avoiding eye contact, and breathing heavily. He stopped the interview and told me that he was going to find his sponsor; he never returned or responded my messages. This seemed to be to be both a panicked response to an event that led to trauma, but exposing me to this seemed to shame him. The shame can be totalizing, like Sam’s and Glenn’s, in which it is both about using meth and being an addict. With Eric and with Richard, the shame was less about meth and more about the consequences of addiction. Before he relapsed, Richard was almost defensive about not feeling shame, or even guilt. “Everybody is doing meth,” he said. “Why should I feel guilty about it? I didn’t do horrible things to people.” William, on the other hand, protected himself from shame by carefully presenting himself as sober not just to the people, like the police and social workers, who could take away his freedom or his service, but also to his family, who knew neither about his drug use or his sex with men.

One of the goals of recovery programs is instilling positive emotions that both create happiness but also protect recovery addicts from relapse. Pride does both, and it was powerful replacement for the shame my informants felt after they admitted their addiction or saw their addicted, suffering selves through others' eyes. Max, who was the proudest recovering addict among my sample, told me that initially, "I didn't want to go [to the CMA meeting], because I was ashamed. But I'm not anymore. All of my friends are so proud. You know it feels when someone says you look good. It makes me proud of myself. It makes me happy like that." At the beginning of our sessions, Glenn was enormously proud of his progress, and part of why Sam longed of his time sober was the pride he felt in being able to be sober, happy, and productive. Jonathan, the last time we talked, was thrilled by his progress. "I've accomplished a lot. I've been really diligent," he told me. "I've networked, marketed myself, and now I have a job that I like. I'm very adamant on starting school. I'm not overwhelmed by it. I have confidence." William felt proud about preventing himself from feeling shame, and even though he was not sober or in recovery, he was proud of being able to manage his addiction and disease, to be able to "maintain." Charles was not happy about his day-to-day life, but he was proud when he was not using. "I made my life this way," he said. "I do a lot of nothing. I'm just not using. Things are working. I'm proud. But if things go too well, I start having panic attacks."

Hovering in-between: Risky subjectivity

The precariousness of Charles' emotional life – hovering between pride, depression, panic, and the promise that meth could take it away (since he told me of its

experience, “It’s like every care in the world is just gone. You’re not worried about anything. For that moment, it’s just perfect.”) – is what makes him risky. He is not only risky in the minds and eyes of the anti-meth apparatus that wants to regulate his legal and illegal drug use, his viral load, his t-cells¹⁶, and how much money he can receive from the federal government; he is a risk for and to the community and thus an object of the apparatus’s many-eyed gaze. He, like all of my informants, is also a risk to himself. This is he has learned because the agents of the apparatus have told him so, and they have made sure that he suffers for not following their rules. The suffering that comes from having a risky subjectivity is somewhat like the game Operation. When you are walking the straight and narrow, when you are doing what is expected as a normal actor in a normal world, you walk freely and comfortably. When you stray from the path, you are usually pushed by someone or something back onto the path. If you continue to stray, if you wobble precariously along the path, or if you leave the path far behind, when you hit the sides of the wall, you are shocked; a buzzer sounds. The addiction narrative is the path back from the shock and the shame, and pride is the feeling of walking the path again, enjoying the life of the normal.

Conclusion

This chapter describes the process by which my informants developed what I call “risky subjectivity,” the result of trying to be normal after being hailed as abnormal.

¹⁶ Two of the key markers of the health of someone with HIV is t-cell count and viral load. The latter is the number of t-cells in cubic millimeter of blood. HIV attacks and kills these cells, which are central to the functioning of the immune system. A t-cell count of less than 200 cells/mm³ is said to indicate that HIV infection has progressed to AIDS. The former refers to the amount of viral copies found in the blood; the more there are the more likely they are going to destroy t-cells. If the amount is below 50 copies per milliliter, the viral load is considered undetectable. (HIV & AIDS Information from AVERT.org n.d.)

Using the theory of identity formation put forward by Holland, et al. (which is based on the work of Vygotsky and Bourdieu), I explain how my informants orchestrate their selves in the behavioral environment. First, I describe the ways that they narrate their addictions, following the guide put forward by 12-step and similar programs. Second, I show how they imagine a future of homonormativity and economic self-sufficiency. Third, I describe their emotional reactions to their success or failure to live up to goals of the anti-meth apparatus, how they feel pride if they are able to construct the correct self and correct subjectivity, and how they feel shame if they cannot. Finally, I define risky subjectivity as the perpetual constructing and reconstructing, the perpetual struggling and usually failing, that men like my informants experience. In the next chapter, I show how my informants attempt to survive this arduous process.

Chapter 5:

Productive Members of Society:

Tactics and Strategies of HIV+ MSM Who Use Meth in San Diego

I'm 44 and I'm not really going nowhere. What do I have to lose [by going to] one more drug program? It's a way to get back on my feet and off the streets. I want to go back to work so bad. I love to drive and two car so possibly towing or delivery driver or something like that. At - least I would be doing something that I enjoy therefore chances are I would stick with it. I know that I'm worth more than living in that damn canyon in Hillcrest.

Sam wrote this to me in a letter he sent from the psych ward of the San Diego County Jail in the Spring of 2011. In the three months he was there, he was sober and taking his HIV medications religiously, and he was also referencing religion a good deal in his letters. Each one was full of stories about his life as well as plans for when he got out of jail, how God might help him stay clean, how he would just need to take it one day at a time. I used this same quote in the previous chapter to illustrate Sam's goals for the future; they were part of a narrative he had learned and internalized during his many attempts to get off sober. His imagined future was, yes, meth free, but it was also economically viable, self-sufficient. Each time I read one of his letters, I felt such hope for him, and I encouraged him.

As I discussed in Chapter 2, the anti-meth apparatus, no matter which branch, has a clear goal: the creation of a healthy, drug-free, law-abiding subject, a "productive member of society." In attempting to shape, construct, and interpolate these subjects, the men and women who work in the anti-meth industry pull from moral discourses of good and right behaviors that contrast and define bad and wrong behaviors: which synthetic

substances are allowed in the body, how good and productive citizenship is defined, what responsible health behaviors are expected. In turn, as I discuss in Chapter 4, my informants have developed subjectivities in response to this focus. Of course, the anti-meth apparatus, as much as its agents would like it to, cannot produce identical subjects, responsible and disciplined human widgets in recovery. The process is messy, and my informants, and men like them, exercise a great deal of agency, but they do so within political ethos that encourages shame for failure to become that widget and pride for success. That said, those who are able or willing to develop the correct subjectivities are rewarded with services, care, and entry into the fold, while those who cannot or will not are cast, somewhat literally, over the walls, behind the fence, and into the canyons that line San Diego's landscape like cracks in a broken windshield. During the two years I worked with my informants, I watched them negotiate complex and fraught performances in order to both manage their stigma, express their feel for the game, and access the care, services, and shelter they needed to survive within the waving, weaving tentacles of the anti-meth apparatus.

They are waving and weaving partly because of how disorganized the anti-meth apparatus is; it is almost everywhere, but it cannot and does not capture everyone. Partly, this is a geographic problem, a problem of space. Like the Drug War itself, the apparatus is inefficient, doing a very poor job of getting into your apartment, your car, and, particularly, your head. But it does quite a good job constructing, fortifying, and controlling institutions you need to interact with, things like the police department, the department of public health, and the mass media. In *The Practice of Everyday Life*, de Certeau describes two uses of space, which can help differentiate between the apparatus's

weaker and stronger methods, tactics versus strategies. The latter refers to the “calculation (or manipulation) of power relations” that is can be made (or done) when something with “will and power” can be specifically placed and can “serve as the base from which relations with an *exteriority* composed of targets or threats (customers or competitors, enemies, the country surrounding the city, objectives and objects of research, etc.) can be managed.” Thus, the HIV clinic, the case manager’s office building, the police station, and the jail are places of strategy for the apparatus. Tactics, however, do not have the strength of place nor the power over space that strategies do. “The place of a tactic is the space of the other,” de Certeau writes. “Thus it must play on and with a terrain imposed on it and organized by the law of a foreign power. It operates in isolated actions, blow by blow. It must vigilantly make use of the cracks that particular conjunctions open in the surveillance of the proprietary powers... In short, a tactic is an art of the weak” (Certeau 2011:36–37). Tactics of the apparatus are everything from sobriety checkpoints and profiling to HIV prevention outreach events in bars and the underfunded, barely legal syringe exchange.

I think it is useful to think of the methods my informants use to live under the gaze and within the reach of the apparatus as strategies and tactics. Transferring de Certeau’s concept to human action and individual agency, we can see strategies as methods used with an awareness of power relations, both macro and micro-physics of power. They are long-ranging, usually carefully honed, and they involve probably consciousness of political economy, class, race, and general hierarchies and processes. The methods can be resistant to the broader strategies of institutional power, but they do not need to be; they can utilize, incorporate, or manipulate the other strategies. They

involve the prudent spending of cultural and social capital. They involve an awareness of the agent's place within the larger space; it is not just the feel for the game, but the knowledge of the position being played. While strategies are proactive, tactics are reactive. Tactics involve the awareness of only the micro-physics of power, with larger processes as mystifying as gravity or the weather. Tactics are methods used to survive day to day, maybe week to week, but they fail when applied to entrenched, structural problems. They are not quite Scott's weapons of the weak (1987), because they are not solely about resistance to oppression but rather about the practice of everyday life.

The three men at the center of the vignettes that follow exemplified the methods, both strategic and tactical, used by addicts to survive their quotidian existence. Max transformed himself into a recovering addict in the structures of 12 step programs. William learned how to manage the presentation of his addictions so that he could pass as a sober when in the "normal" world. And Sam developed a network of charitable assistance through strategic recitation of prohibitionist discourses. Through these, it can be seen how tactics are useful methods for evading capture, while strategies can be used to win the war.

Max

Max is a slight, broad-smiling Filipino-American in his late 30s who was referred to me by the facilitator of support group for gay, HIV+ recovering meth addicts. When I met him, he had been living in a group home for recovering addicts, and he had stopped using meth three months before. He stopped when he tested positive for HIV, an event that also led him to get off the streets, where he had been living since leaving his

boyfriend, who was also a meth addict. Max usually came to our interviews with his roommate, best friend, and “sister” Jose, who had also stopped using meth recently but who had been positive for 20 years. I would interview one and then the other, and each would sit and listen to each other’s life stories and tales of woe. They had to come together, it turned out, because they were not allowed to leave the group home alone; they had to bring a buddy to supervise their behavior.

Max was the only member of my sample who did not relapse during my fieldwork. He was not the only one whose narratives were structured by 12-step language and ideology, but he was the only one who seemed to be following steps almost exactly as they were laid out. Over the several months that I saw him regularly, he would gleefully update me on his positive progress, not only on which step he was working on, but also on his health: his weight, his T-cell count, his viral load, and the like. He also told me about his various successes at the group home. He was running support groups, manning the front desk, supervising the other residents’ work, both domestic and recovery. When he would brag about this, Jose would roll his eyes.

Max grew up in the Philippines, the son of a Filipina and an American Marine officer. His parents were in the United States through much of Max’s childhood, and his mother’s remittances, he says, spoiled him. His descriptions of his adolescence are idealized until it became clear to his parents that he was not straight. “All I wanted a Toys R Us were Barbies. I liked to dance, I liked flowers. My mom was so happy! My mom just let me go and do what I wanted,” he said, beaming. His father was not happy. “But my dad tied me up and put my head in a bucket of water. He’s very upset.” His father was determined to make him a man and forced him to move to the United States and join

the Marines. Max ran away after two weeks, and his mother was so upset that she ended up in the hospital. She told his father, "Don't do that again. I accept him no matter what." But his father made it clear that Max was no longer part of his family. "I still pray for him," he said.

At 19, aside from occasional communications with his sister, he was without a home or a family. It was also at 19 that he discovered Hillcrest. "I was so happy," he said. "This was my world. I saw two guys holding hands. I just started introducing myself." He got a job at McDonald's and moved to the neighborhood. He quickly found a boyfriend, the bouncer at one of the gay bars, and he found the gay beach in La Jolla, he went to White Party in Palm Springs, and he danced and drank and partied. His mother was helping him pay his rent, but when she died, he could no longer afford it. He made up with his father and moved home. But when his met a woman at a casino and married her over Max's strenuous objections, he ran away again; this time he was homeless, living "outside."

This begins a period in his life for which I had trouble developing a chronology. Rather willful, Max was hard for me to direct, and figuring out what he did exactly between this first period of homelessness and the period that ended a few months prior to our meeting was hard.

At some point, he met a man named Steve, with whom he lived for a long time and who taught him how to smoke meth. Max was the homemaker, and he was totally beholden to Steve. "He has the money, he buys me the shit," Max said. "He has a lot of power." The relationship fell apart when two things happened: Max discovered Steve's needles, a method of use that he was vehemently opposed to; and then Max tested

positive for HIV, which he contracted from Steve because Steve had lied about using condoms during sex outside the relationship. Max was devastated. “I was so shocked,” he said. “I was crying, and I was standing for an hour on the bridge [over Route 163]. I was so focused; I wanted to kill myself.” He left his boyfriend, and within a week, he was sleeping on the street again. The week of our second interview, Steve died of AIDS in a hospice in Los Angeles.

Family Health Centers helped Max get into a recovery program, one that provided housing and structure. When he started, HIV was taking its toll; he was down to 125 pounds and his skin was terrible. He was depressed. He took to recovery, to the 12-step ideology as aggressively as he took to the gay community 20 years earlier. He told me how the daily routine – morning meditation, life skills training, group discussions, doctor’s appointments, chores, meals, and so on – helped him feel like he was part of a family. While Jose and several of my other informants complained about how their day was over-scheduled, Max loved it. He embraced the limits, and this made him particularly popular among the staff. He was quickly running the groups and supervising other residents. “I learned a lot about myself,” he said of the classes and group discussions. “I learned how to say no. I learned more responsibility to myself than to anyone else. I learned a lot running the groups. I’m very proud of myself. The big thing is grow up: I was spoiled, a mama’s boy. I learned a lot about being mature. If I was outside, I’m not going to learn a lot. If I follow the rules and use the tools, I will get what I need.” He told me he was always on time to appointments, went to his Narcotics Anonymous meetings like clockwork, met with his sponsor twice a week. He liked his

sponsor, because “he is like a strict teacher.” Soon, his t-cells were higher, he’d gained 20 pounds, and his skin had cleared up.

Now I’m not thinking of drugs. I’m Max again. My mind now is about a new person, a new job, a new place. I have a lot of experiences that I never had. Lots of guys want to date me now. I have a new life, a new everything. I am so focused on myself, on what’s next. I’m going to school now, barbershop school. I’m going to get a certification and get a job at a barbershop. I’m going to save money and get my own place. Little by little, step one, step two. I just have to be patient, and I’m very not patient. I learned a lot at Recovery House. Good things. They talk about plans, about the past and the present. It’s nice to hear it. You have to open to things. It’s a good recovery.

Max was an enthusiastic model recovering addict. Accepting the hail of the recovering addict, and then aggressively defining himself within that identity, practicing its rituals, and preaching its benefits was strategic. He knew that it enabled him more privileges in the home, a higher status among his fellow residents, and access to the so-called “normal” world of employment, leisure time activities, consumerism, and dating. He invited me to his graduation ceremony from the recovery program that ran the group home, and when he was called onto the stage by the program’s director, the staff and the residents cheered more loudly for him than anyone else. When he accepted his diploma, he thanked the staff and his friends for helping him, but he singled out his “higher power” for doing the most to help him achieve sobriety and entrance back into the normal world. By the end of my fieldwork, he eventually made his way through barber school, was making money, had moved to an apartment, and had a large sober social network.

Max became the productive member of society that the anti-meth apparatus is trying to foster. He did this by not resisting any of their efforts and by completely internalizing the instructions and parroting the discourses of the recovery branch of the

apparatus. But in order for him to become that productive member of society, he had to leave things behind. Jose was one such thing. When I had coffee with Jose for a follow-up interview, he told me that Max had moved to an apartment without him and had stopped returning calls and texts. “He thinks he’s better than everyone else,” Jose said. When I saw Max, he told me that Jose had relapsed, shook his head, and then quickly changed the subject to Max’s new boyfriend, who he had met at a Crystal Meth Anonymous meeting. With the recovery program defunded during one of California’s annual budget crises, with Max leading a normal life and eschewing abnormality, Jose was left with a ruptured social network and only his monthly Supplemental Security Income check to survive on.

William

William, an African-American man in his late 40s, always addressed me as “Professor,” even though I told him I was not one, that I was interviewing him as part of the project for my doctorate. One of the most educated men in my sample, he understood academia and understood my process, but he insisted on a formality that none of the rest of my informants did. An active meth user, he presented himself in our interviews as sober, as more controlled and self-possessed than my subjects who were sober. He was the only active user in my sample who never came to our meetings high; or, rather, he never appeared to be high. He presented the same measured affect that my sober research subjects did. He was always wearing clean clothes, his beard was trimmed, and he was always exactly on time. When I noted that he seemed sober despite telling me that he was used meth regularly, he told me that he made sure to be sober or near-sober for the hours

that he had to interact with doctors, case workers, nurses, court officials, and people like me, all agents of the anti-meth apparatus. I suggested that if he did not need meth to make his appointments maybe he was probably not as addicted as other members of my sample, some of whom injected the drug. He replied, “Oh, don’t let that fool you. I’m a meth addict. I just maintain very well.”

William was living on SSI, which he was able to get, as Jose was, because of a lengthy AIDS-related hospital stay that he experienced in the late 1990s before he started taking the cocktail of anti-retroviral medications. Like Max, William had figured out a way to survive as an object of focus of the anti-meth apparatus. However, William does not survive because he was willing to be interpolated and assimilated by the apparatus, as Max was. William’s method is creative and strategic resistance to the efforts of the apparatus to control his behavior and his subjectivity. He lived on SSI, had his own apartment greatly subsidized by HOPWA (Housing and Urban Development’s Housing Opportunities for Persons with AIDS), had a computer on which he watched TV and played internet-based games, and saw his HIV doctor at a community clinic regularly. He was well fed and had a good viral load and T-cell counts. He was also able to smoke meth regularly and have sex with men and women, some of whom were sex workers. While he was certainly not thriving according to those who see being a “productive member of society” as the base-line for morality, William was more than surviving. He had figured out how to stay out of jail, to maintain his government benefits, to maintain his addiction, and to stay, at least based on the eight interviews I had with him, relatively cheerful, despite having a life that was the opposite of his childhood dream of being an upper middle class mechanical engineer.

William learned how to “maintain,” to present himself as sober, respectable, harmless, and not worthy of suspicion through a lifetime of being profiled as the opposite. He grew up in Oakland during the 1970s, which was both the height of the city’s African-American population’s political radicalism and the city’s heroin and gang-based crime wave. His elementary schools were violent, and he had to learn how to fight to survive. “I knew it was a bad situation. Everyone’s going through it,” he told me. “It was the norm if you grew up with one parent. It’s the environment; everyone gets caught up in it.” When William’s mother married his stepfather – a jazz musician with a Master’s in Sociology who instilled in William his politics and respect for education – they moved to Emeryville, to safe neighborhood and school. But when his stepfather died a few years later, they moved back to Oakland, which William called, “a powder keg.” The war between the gangs and the police was brutal, with “the middle,” as William called the rest of the city, caught in the literal crossfire. The police, according to William, were particularly brutal. “They [were] over the top. They were sanctioned Klansmen. They got room in jail for every fucking thing, a crack pipe, open container, drunk in public.”

While he was learning to avoid the police by becoming as close to invisible as possible, he was also learning how to make invisible other parts of his life from his family, neighborhood, and community. In 8th grade, he started a paper route, and that was when, he says, “I was exposed to the underbelly. I was making good money. But the shit I was seeing... it was wrong.”

Porno sex shit. Some internet porno sex. First of all, it was weird. All of it was gay sex. It wasn’t normal gay sex. It was... It was scary shit. But at the same time it was enticing. Eventually they started noticing me.

Nobody had no scruples, so I was propositioned a bunch of times. There were a lot of white guys from the hills. The things I saw... It stuck in my head. Then I got propositioned by some white dude. Let me suck your dick and I'll pay you some money. And he asked me questions: Did you bust your nut? I didn't know what he was talking about. He had been to prison, and that's where they turned him out. And I developed a fear of prison. I did that shit undercover for a long time. I wasn't looking at it as a gay act. He was sucking my dick and I was getting paid for it. It was a win-win situation! It fucked my psyche a little bit. I've never really been that big into labels, this kind of sexual, that kind of sexual. I'm do what the fuck I want to do sexual...

Throughout high school, even after he stopped doing the paper route, he returned to the red light district, to the bookstore with video booths and glory holes.

I knew where all the shit was happening. And all this shit happened before I was 18. They never questioned me when I went in. I guess they knew what was happening. At the same time, I'm still going to school, and I'm doing very well in school. Now I'm leading a double life. I've got a girlfriend, I'm kicking ass in school, I'm on ROTC drill team, I'm running track, I'm wrestling... And I was going to the bookstores, and I was making money. If I went to the red light district, it was for sex or for money.

William says that no one knew he was leading this double life. Even now, "My family has no idea." Interestingly, it seems that because of how much we discussed his same-sex sexual behavior, he compartmentalized me, too; I did not find out that he has three children and three grandchildren until seven hours into our interviews.

Graduating at the top of his class, William had a choice of different California schools; he got into Berkeley and UCSD, but he decided to go to San Diego State because on his campus visit, everyone he saw was having a good time. It also, conveniently, had a good engineering program. While he did manage to get pass most of his classes, he partied a lot, discovered crack, and then discovered meth. With meth, he

found the gay culture of San Diego. He ended up dropping out of school, contracting HIV, and then almost dying of AIDS in 1997 before he was saved by anti-retrovirals.

In the 90s, I knew the shit was a problem. But I was really trying to meet it half way. I really like the shit, but I wasn't going to quit. I started feeling the ill aspects in my life. I was convinced I could do it and not suffer the side effects. With age comes wisdom. After a few stints in jail, you have to be pretty stupid... all of my charge are drug fucking related. Eventually they'll stop pussy footing around. Yeah, I'm an addict. If there weren't any consequences, I probably would not be here. Fuck, I'd be getting high. I gotta continue doing this shit, but I gotta be smarter about it. Then there's that old pride thing. I do this shit, but I try to be discreet. I can't always do it; it's gonna leak out. There's only so many times I can tell someone I took too much medication. I'm not stupid: My brother and sister, they're like, I know what you're doing. But the world at large, I don't want them to know what the fuck I'm doing. If you jump in with both feet, you're only going to look one way. And that shit is garbage. Only a fool would continue doing this shit.

TG: Do you feel like you're a fool?

Now, that's for everybody else. [Laughter.] I've lasted a lot longer than most. But I know it only ends one way.

William knows that he's been lucky to survive so long, and much of that is luck, while much of it was his decision to get smarter. And part of that is figuring out how to handle the police and the policing. While San Diego in the 2000s is not policed with the same sort of excessive verve as Oakland in the 1970s and 1980s, William still feels the pressure of police harassment. But he learned how to, if not avoid the policing, how to manage it, either through modulating his interpersonal interactions or utilizing his knowledge of the law.

I can't really beat the system. I can blend in with the system. If there's a cop who's harassing you, call him 'Sir.' The ends justify the means. The end is to walk away from his punk ass. I learned that from my uncle, who came to San Diego in the 50s. He used to shine shoes. Back then, he said, San Diego was a military town. Purely. He said, how do you get the big tips. You get them from the enlisted men. He also called them, Captain or

Admiral. Thank you, Admiral... It's the same thing with the police. If you show them the respect they are so desperately seeking they'll tend to let you go. Sometimes, I don't. But if I'm on probation, on 4th waiver or something, I'll definitely do it. If I'm clear, you can be an asshole with them. There's nothing they can do. They'll ask, Do you mind if I search you? And I say, yes I do mind. Are you high? No, but I assert my 4th Amendment rights. But if I'm 4th waiver... they are all up your ass. They can really degrade you – in public. They do too much with it. I can imagine search your pockets or patting you down. No, man, they're digging in your ass and shit. It's got to be unconstitutional. I shouldn't exist as a second class citizen.

William knew that he had little chance of succeeding in a constitutional challenge to a stop-and-frisk in Downtown San Diego. So, it was best to avoid any contact: “If you dress right...if you're going to use dope tonight, you dress like you're doing to party [at the downtown bars]. You can blend in. Because they're acting like a fool, too. But if you dress a certain way, you don't got a shot in hell. That's why I dress a certain way.”

Similarly, when his neighborhood was besieged by police trying to rid his apartment building of criminals, he moved. “I will not live under martial law,” he said, emphatically. His new apartment, a studio a few blocks from San Diego State, is near El Cajon Blvd., where he can buy meth and find sex, but his complex is small, calm, and gated.

He did not “maintain” simply to avoid being arrested and to make research interviews, which paid, but also because he needed to be his own advocate in his HIV treatment. When his concerns and his questions were dismissed by doctors because of his meth use, he taught himself how to talk to his doctors as an educated health consumer, leading his doctors, he said, to respect him more. He did his own research on supplements, refused some recommended drugs because of side effects he discovered online, and told me he talked back to doctors would did not respect him. He also figured

out how to persuade HOPWA to move him from the apartment under martial law, and he figured out ways to keep his math tutoring money off the radar of the Social Security Administration. He often spoke of his methods as political, that he was fighting racial oppression and countering the injustice of the Drug War. His resistance to the anti-meth apparatus was hypercognized, carefully considered, and successful. De Certeau referred to strategies as methods that were calculated, manipulated, and made with awareness of power relations. He was fully aware of both the tactics and strategies employed by the anti-meth apparatus, and he countered them one by one. He was able to extract the resources offered to HIV+ people without giving up the meth and the meth-related behavior that would make him the object of harassment and derision that men like my next example experienced every day.

Sam

The day before I started drafting this chapter, Sam, who I discussed in the opening pages of this dissertation, called me six times and sent me a dozen text messages. He had texted that “big changes R hapN soon” and his voicemails mentioned that he was meeting a new case worker, that he was getting his act together. I had been teaching and then working at the syringe exchange, and I texted him back saying that I would call him the next day. After that, he called me two more times and texted five more times, finally asking, “Could u get meSome food?” When I didn’t respond immediately, he texted, “Pleas I meet to talk2nite.” Then five minutes later, “have Re: Have a gond nite I bum at mc donalds loV u.” He had “bummed” a hamburger from a friend after his requests from me had not been answered. In the three years I have known Sam, I have bought him

several meals, bought him a pack of cigarettes, and twice given him \$20 after a series of desperate phone calls and texts; I also paid him \$15 for each hour I interviewed him for a total of \$90. Periodically, he would bombard me with calls and texts when he needed something, whether it was a small amount of cash, credits for his phone card, or, once, Xanax to help him come down from meth during one of many times he tried to quit. I stopped assisting Sam in material ways after a couple years, and I felt terribly guilty about setting up boundaries between us. But I recognized a pattern in his requests for help; each of his requests came after or in the midst of promises and plans for recovery, for treatment, for going to back to work as a tow truck driver.

Sam is in his mid 40s, and he grew up in East County San Diego. He first used meth when he was 13 and then began what he called “heavy” use when he was 16. He dropped out of school at 14, started running away shortly after, and left home permanently at 17, moving to Hillcrest to live with friends. He realized at 18 that his blond surfer looks made him attractive to men who were willing to pay for sex; he often hustled them, stealing from them after sex. He also made money from stealing cars, and he went to prison for the first time for auto theft. He tested positive for HIV in 1991, when he was 23 and in prison for auto theft. He is pretty sure that I contracted from one of his johns. But then, he says, “I wasn’t gay.” He married Cathy, another addict who hung out in Hillcrest, in 1991. She was also positive. They got divorced in 1996, and then remarried.

She died of AIDS in his arms in 2000, the same year he became homeless. He told me that during the spring of that year, he would lean on the railing of the pedestrian bridge suspended over the homeless encampment where he lived and stare at the window

to Cathy's room in Scripps Mercy Hospital and cry. He took me to that bridge on the day he gave me a tour of the encampment. Located in a leafy canyon between a bridge, a highway, and a ramp leading to the highway, it is called Camelot, and no one remembers why. Sam has lived there off and on for 13 years, moving out when he's been in jail, in a recovery problem, staying with a friend, or when the San Diego Police decide that they need to clear the area. For a year and half, he was sober, driving a tow truck, and living with his former partner Michael. One weekend, they won a few thousand dollars when Michael came in 2nd in a regional NASCAR race, and to celebrate they spent it all on meth and heroin. After a while, Sam always returns to Camelot.

In the three years I have known Sam, he has been addicted to meth, then to heroin, and then back to meth. During our interviews the year before, he told me that he thought his drug addiction was wrong.

Sam: I just want to do the right thing. And that is the right thing, being clean and not being on drugs.

TKG: Why is it the right thing?

Sam: Because it's just the right thing. Even if you just smoke pot. Look at all the shit that goes on. They grow it, they fuckin' got machine guns up in Oregon, Humboldt. It's different now than it was before, because they have all these gang places.

TKG: Right.

Sam: The point is you're not hurting anybody else, you know? I do speed and heroin. Drugs are bad, man. People die over drugs all the time. Whether they get in a fight, or whether they get robbed or shot, you know, people want their drugs. When you get right down to it, drugs are bad. Whether it be... an ounce of marijuana isn't bad, but you know drugs are – you know it's not good. It fucks people lives up, especially speed man. Married couples; she starts doing speed the next thing you know the whole fucking families fucked off. The kids are fucking, you know that's the

worst thing I hate man is when the kids go to fucking, you know. They come take the kids away.

TKG: Mm-hmm.

Sam: It's like what the fuck? You fucking stupid bitch. Why did you do that? Thank God I never had any kids. I'd be the worst father in the world, not because I wouldn't love my kid, but how am I going to love him from my jail cell or prison cell.

Without barely taking a breath, however, he went on to tell me how attached he is to drugs, and not just because of the physical addiction. As I mentioned in the last chapter, he is one of several of my informants who used meth both for fun and as self-medication, with the purposes merging and overlapping.

I love drugs more than anything. I don't care about money. The only thing money's good for is to get drugs. The feeling I get from meth is I don't have to worry about nothing. I don't care if I'm filthy, dirty, stinky, and whatever. I feel good and that's what counts to me. You can't tell me anything that's going to bring me down. When I don't have drugs sometimes I feel like, I get that real strong, like I don't fit in here or these people are all talking about me. When I'm high on drugs fuck it, man.

Because Sam came to the needle exchange every week and usually stayed to hang out and chat with me and Leo, I saw him more than any of my other informants, and I became closer to him than any of my other informants. I was one of the first people he called when he left one recovery program because Michael worked there, and he could not handle being around Michael but not being with him. Through tears, he told me that he was going to find another program the next day. A few days later, Sam called and asked for \$20; we met in front of the offices of Stepping Stone, one of the best recovery programs in the area, to which he told me he was going to try to get accepted. A few weeks later, one of his friends called to tell me that he was jail. Because he did not graduate from a recovery program that winter, he violated the terms of his probation, and

he had to serve 90 days in jail. He had originally been arrested for being under the influence of a controlled substance; he had been picked up because he was screaming and crying in a parking lot, caused by a mixture of meth psychosis and grief about Michael, who he thought was dying of a heroin overdose.

Aside from Sam's friend who called me, I was the only person who visited Sam in jail; she went once, and I went four times. Because of his diagnoses of HIV, substance abuse, and bipolar disorder, he was put in the psychiatric unit of the county jail. This kept him in downtown San Diego and far from main jail, which was known for its gang and racial violence. With nothing to do – no drugs to take, no need to scrounge for money for food – Sam was left to his own devices. He received no psychiatric treatment while there, despite being in the psychiatric unit, and he was wracked with anxiety. He read novels in the tiny stack of books that comprised the library. He told me he liked writing letters. To help him keep busy, I sent him prompts, and he wrote long letters detailing stories about his life. Most were stories that he had told me in our interviews but had forgotten because he had been high. He also detailed all of his plans for the future, how he was going to stay sober, to get work, to start a normal life.

When we spoke the day before I started the chapter, he told me he did not have “a habit” anymore. He was still using meth, he said, but he did not need to. He had said similar things to me several times. He wants to impress me, and he wants me to think that he is getting better. He called me from the hospital a few months ago and told me that he had had his right index finger amputated. He did not tell me that how his finger was injured. I later found out through an outreach worker at Family Health Centers that Sam had burned it on a meth pipe, that it had gotten infected, that he had used heroin for the

pain, that he had developed gangrene, and that while he was in the hospital he would sneak out and go down to Camelot to get high.

That he has survived so long, especially with a weak adherence to his HIV medications, is a marvel to him, as well as me and to several case managers at the community health agency that runs the exchange. A large factor is probably biological; his HIV did not progress quickly nor become resistant to medication, and there is something about his body that has allowed him to withstand the amounts and different kinds of drugs he has been addicted to. "According to the doctor, I should have been dead a long time ago," Sam told me. The other factor, I believe, is that he has developed a network of friends and charitable acquaintances, some of whom are also homeless or nearly homeless addicts but many of whom are not, who assist him in the belief that he is actually going to get better, get off the streets, and become a productive member of society.

Like Max, Sam knows how to converse in the mantras and clichés of 12-step programs. In my many conversations with him, he has said that he needs to take it one day at a time, that God could help him if he went to church and prayed more often, that he just wants to get clean so that he can work, and if he could work, he would have a reason to stay clean. He wants to be sober, he has said many, many times. But unlike Max, Sam has never been able to stay sober.

People say one day at a time. Even if you have 20 years it doesn't matter or twenty years to see and to add their bad choices. It's still one day at a time. They can get loaded just as easy as I can. I'm a chronic relapser. That's what I do, I do good for a while then I'll relapse. Then I'll do well for a while, and then I'll relapse. I'm so sick of that. It's like fuck, what was the point? In my head right now if I got back in there and put a little work into it, I'll do good. I'll get a job, that's not a problem. I'll do good at it like

I always do. Maybe who knows, I'm not always right. Maybe this time I'll have trouble finding a job. Fuck I don't know.

Like William, he has figured out how to get what he needs – food, shelter, medicine – from “the system.” But unlike William, Sam has no consistent method and little control over his behavior. He complains about how hard it is to get a free bus pass or to get the requisite paperwork for ADAP completed and submitted. For an addict, these straightforward but burdensome tasks can seem Sisyphean. He told me, “It’s a fucking full time job.” And sometimes he just refuses to go to work. Depending on his enthusiasm and focus, sometimes he goes to a food bank and sometimes he shoplifts. He is aware that the police are watching him and he says he needs to walk a certain way so that they will not suspect that he is high. It never works, however; in his tentative, nervous fidgeting, he is immediately suspicious to police, and so he gets stopped, frisked, and arrested on a regular basis. He does not see any of his difficulty as the result of political economic forces, as William does. Sam blames all of his hardships on himself, his lack of strength, his failure to be disciplined and responsible.

He has internalized the prohibitionist, 12-step discourses of the anti-meth apparatus, but because he cannot figure out how to become that clean, sober, and productive member of society, he can only use them in the future subjunctive tense in his arguments for why someone should help. In conversations with me, he has listed all of the things he will do tomorrow to find a bed in a recovery program before asking me for money for a phone card. He has used similar stories in order to get more needles from the needle exchange than policy would allow him to have. I have heard him call one friend and after another to ask for favors – a bed, a ride, some money – and use the possibility

of his recovery as reason for why the favor is both needed and justified. This sounds manipulative, and it is, but Sam is not doing it cynically. He is not devious. His relationships are not built simply on economic reciprocity. His capacity for empathy and for caretaking is great. He helps many of the other homeless addicts with procuring food, drugs, and other kinds of help, and when he asks them or asks me or the various outreach workers how they are, he seems actually to want to know. Many of the qualities that make him empathic also, when under the influence of meth, can make him hyper-sensitive and paranoid, but they also lead him to be more likely to be helped by his friends and by those in the anti-meth apparatus who know him best. He attributes this moral and affective subjectivity partly to his Christian upbringing and partly to the epiphany that he had during one of his stays in a recovery program that karma is real and if he does good, good will come to him.

He has internalized the same sort of morality Max has, but for a host psychological and biological and structural reasons, becoming sober, becoming a productive member of society may forever be elusive. A couple of weeks after he had texted me asking for food, a week after we had exchanged a few text messages only about pleasantries (in which he reminded me to work on my dissertation), he again sent me a flurry of increasingly desperate messages and called several times asking to see me. We agreed that he would come to the exchange that night. He arrived and I was unnerved to see how thin he was, his cheeks extremely prominent, eyes sunken, his neck swimming in the color of his sweatshirt. We talked for about 15 minutes before he started repeating himself; he told me about his frustrations with his case worker, with his paperwork, with the woman he lived with in a motel in City Heights. He told me that

when he had been in the hospital for the amputation of his finger, the doctor had told me had only 71 t-cells. Three months later, he had just found his old bottle of anti-retroviral drugs, and he was taking one every other day while he waited for his ADAP to be approved again. He told me this proudly, even though misusing the drug was worse than not using it. And his t-cell count was probably well less than 50 at that point. Then he said, “I’m dying. If I don’t stop, I’m going to die. I know.”

He didn’t ask me for anything that night, though I could tell he wanted to. I had put up boundaries over the previous months, and he seemed to know that I was not going to be able to offer him the financial assistance that he seemed to need (based on the list of the various ways he planned on getting money over the next few days). As I told one of the outreach workers, “He’s told me too many times that he’s going to get clean next week.” This did not mean that I didn’t feel guilty, sad, and sorrowful, that I did not almost cry when he told me how sick he was, how many abscesses he’d had in the past few months or that he knew he was dying. Sam’s tactic of developing relationships of assistance, sometimes mutual and sometimes simply emotional, was never going to be continually successful; they were all doomed to failure, to burn out, as long as he continued to relapse, to remain an addict, to zig zag towards death.

Conclusion

In this chapter, I use De Certeau’s distinction (2011) between strategies and tactics to explain the differences between Max, William, and Sam’s methods of survival. I believe De Certeau’s definition of strategy can be used to describe the conscious and careful manipulation of power relations in everyday life by singular agents. This is what

William is doing, and in some ways, what Max is doing, too. William is resisting and manipulating power relations, but Max has also figured out, by carefully following directions, how to escape the direct control of a drug, a disease, and an apparatus that expresses repressive governmentality. Again, tactics are reactive, while strategies are proactive. Sam's tactics are so ineffective that he often finds himself in jail and is now finding himself near death. Unfortunately, because of how inefficient, disorganized, confused, and underfunded the anti-meth apparatus, when Sam is incarcerated or hospitalized, he receives no treatment for his addiction, no psychotherapy, and no job training. When he is released, he has not developed the skills to develop strategies for long-term, healthy, productive living, so he resorts to the same tactics. And he survives, but just barely. Next, in the conclusion, I examine my reactions to the process of this ethnography, as well as the ethical, theoretical, and policy implications.

Conclusion:

Empathy, Ethics, and Applied Activism

When I was writing my application to have my dissertation research approved by UCSD's Institutional Review Board, first in my mind was creating mechanisms that would prevent any harm coming to my informants, mostly by keeping their identities hidden. I did not want anyone to discover by accident the name of one of these men, and I certainly did not want anyone in law enforcement to compel me somehow to reveal their identities. My focus on secrecy was based on the pragmatic and the idealistic: IRB's are extremely, and increasingly, wary of liability, and with HIV's history as a stigma marker, lawsuits about accidental disclosure are greatly feared. But I was also aware of and deeply appreciative of the stigma of not just HIV, but also of meth use and homosexuality. All three were things that had been kept secret from me by friends and acquaintances at various times, and I rarely questioned the reasoning. In my concern for my informant's confidentiality, by focusing on it, I ended up reifying their stigma. I also had no choice.

However, as I pondered and enacted an ethical fieldwork practice, I did not contemplate the ethical ramifications of my fieldwork, on either the micro, personal level or the macro, public level. But during fieldwork, I was forced to confront these issues. The unexpected – perhaps foolishly unexpected – counter-transference led me to reconsider the ethical witnessing of suffering. The empathy I felt, and still feel, for my informants is intense, and often distressing. I think it would be human, and maybe even professional, to find a way to turn off these emotions, and it would certainly help me to

avoid the ethical conflicts I feel that I face. However, as an anthropologist, this extraordinary, gut-wrenching empathy is perhaps the greatest tool I have. While counter-transference has been treated in psychotherapy as either a potential pitfall in the therapeutic relationship or as a powerful and necessary therapeutic instrument – and sometimes both – anthropologists and psychotherapists have very different goals, responsibilities, and ethical considerations.

I did fully expect to be distressed by the political implications of my research. I would have been surprised if I ended up becoming a supporter of the Drug War or of the underfunding of addiction treatment. But while I was aware of the policies that affected the men who would become my informants, I was astonished by the pain caused by the microphysical processes of those policies. The injustice, unfairness, and simple inhumanity of their treatment occasionally saddened me, but mostly enraged me. It also made me realize how far from my experience these men were. In this conclusion, I will discuss some of these surprises while summarizing my findings, discuss the theoretical implications of this study, and then I will then suggest several ways that anthropologists, applied and activist, can deal with these ethical quandaries before them recommending changes to the treatment of people like the men at the center of this dissertation.

When I was preparing my fieldwork proposal, I had, as all anthropologists do, said that I would collect a great deal of my data through participant observation. I thought that I would be doing insider ethnography, because I was gay and I was studying gay men. But I quickly discovered that more than HIV status separated me from my informants; meth and the social sequelae of meth addiction pushed me far outside their experiences. This first became clear to me when I was repeatedly asked whether I had

used meth or would use meth during my fieldwork. When I told some local gay men about my research, they almost all asked me how I could possibly do the research without taking the drug. And after my father found out about my planned fieldwork, he called me, very concerned, to ask if I was doing meth. My answer was always the same: “No.”

In proposing and carrying out my methodological procedures, I had to understand in what ways I was an insider and which ways I was not. I will probably never personally know the physical or emotional experience of a meth high, an HIV diagnosis, or side effects of protease inhibitors – just as I won’t truly know what it would mean to be a veteran, a Mexican-American, homeless, or a felon, as some of my informants are – but I know what it is to be a gay man in the United States and San Diego, a subject and an object of biomedical discourses, a political actor and pawn, an academic researcher and informant. I decided on my field site and came to my research questions because of my own subject position, of being gay in the eras of late capitalism and AIDS, of being taught that sex is always risky, of having friends and lovers who were and are HIV+, watching some of them do drugs like coke and ecstasy and meth, living in neighborhoods in the shadows of billboards telling me to get tested for HIV, hepatitis, and syphilis, to never, ever to do crystal or I will lose my self, and even, during the years I was in the field, to check my partners’ hands and feet for syphilis lesions. I have access to and knowledge of my field site that is unavailable to most ethnographers, even those who work in their home cultures.

That said, I discovered that what I thought would be our commonalities were hypercognized for me, but they were hypocognized for my informants. When I began my research, I assume HIV would be the most salient issue to the men in my sample. In

Reback's 1997 ethnography, it was, and it was closely associated with why her informants used. But my informants not only, because of HAART, no longer hypercognized HIV and AIDS, but they also did not bring up other issues I was focused on, like syphilis billboards or Prop 8 or the depiction of gay men on TV, unless I specifically asked them, and then, they often did not care. In Chapter 1, I discussed how the moral panic over the "double epidemic" of meth and HIV occurred, and how it could be seen in the press coverage and the community's response to the so-called super strain of HIV in 2005, how this story was ripped from the headlines and turned into a problematically moralistic episode of *Law & Order: SVU*, and the moral panic influenced the massive "Me, Not Meth" public health campaign, the message of which was that meth not was just bad for you, but it made you inhuman. Following Hall, who followed Foucault, I argued that these prolific, mass mediated images and symbols, joined with the expansive discourse on meth and HIV in the consumer and scientific media, helped to create a culture that made good gays and bad gays, human gays and inhuman gays, so clearly seen in the response to the death of Scott Routh. As angered as I was by the comments on the articles on Routh, the recovering meth users I know just shook their head. Few addicts I know, neither active nor inactive, express an interest in critiquing the mediated representations of either their lives or their morality. The representation is just too embedded into what is considered normal. Part of accepting the hail of being an addict is accepting that you deserve your fate.

They did, however, criticize the anti-meth apparatus, or at least parts of it. With the exception of Matthew, who said that they had always treated him well, all of my informants found the police, with their careless hostility, not an impediment to their fun

but rather an impediment to living. Those in law enforcement have as little understanding of and empathy for addicts as addicts have for those in law enforcement, for why they are called to do what they do. As I explained in Chapter 2, the moral breakdowns that were caused by the AIDS epidemic and by the moral panic about meth addiction led to a set of ethical positions that, while different in each branch, would lead to the same ideal goal, the creation of productive members of society. The researchers were trying to figure out the best methods for fostering these people and the healthcare providers and prevention workers were enacting those methods, with varying success. My informants appreciated their doctors and, if they were competent or kind or doting, the case managers and outreach workers focused on their well-being. They saw me as one of those researchers and outreach workers, and they appreciated my time, my ear, and, yes, the \$15 I gave them for each hour of their time. They also saw me as one of the good gays whose privileges, affect, and positioning enforced their badness. It turned out that I was, after all, doing insider ethnography, just not in the gay community: in the anti-meth apparatus.

In my person-centered interviews, particularly in the first four or five hours of interviews, I was prompting them to tell their lives stories, to talk about their experiences of being who they were. Despite reading numerous, mostly quantitative studies of this population, despite knowing that many in this population suffer from mental health problems, that many have been in jail, or that many have experience violence at the hands of both cops and criminals, I was not prepared for their stories. I guess I wasn't prepared for them, for who they are. It was, as Shweder (1997) would say, the surprise of my ethnography.

In Chapter 3, in order to explain how the research on the causes for meth use had neglected the social, cultural, and political economic context of use, I told the stories of Glenn, Adam, and Jonathan. These three men told me stories of suffering – physical, yes, but mostly existential – as they confirmed the quantitative public health research that showed that much of meth use was self-medication. They had all been drawn to the ecstatic feeling meth, on sex and off, but they also discovered that it masked their depression. Glenn had a wretched childhood of abuse and confusion, and drugs allowed him not to feel his daily sadness. Adam had been mentally ill since adolescence, and meth made him feel normal; it made his head right. And Jonathan, who started crying during our first interview when I asked him about his mother, found meth not only enabled him to have great sex but it also helped him deal with his anxiety and depression.

The centerpiece of the dissertation's argument is Chapter 4, in which I explain how the discursive construction of the meth addiction, HIV, and gayness helped form the subjectivities of my informants. They learned to narrativize their behavior as stories of addiction and psychopathology, and they saw hopeful futures of both American and homonormativity. If they could not achieve what they had been taught and they had practiced to hope for, they felt shame; if they could achieve it, or believed they were on their way, they felt pride. The problem for many of them was that few of them were able to succeed, and when they failed, they became subjects of risk to the community and themselves.

Surviving their existence under the gaze and policing of the anti-meth apparatus was not easy, and in Chapter 5, I use De Certeau's ideas of tactics and strategies to explain the different methods my informants used. Strategies were done with knowledge

of power relations both macro and micro and could lead to long-term success and survival, while tactics were about getting through the day; they were focused only on small problems and small solutions. Max's strategic embrace of 12-step ideology and practice got him his own apartment, his own job, and an entirely new social milieu, while William carefully modulated his physical and affective performance to beat, and to cheat, the system that was focused on making his life difficult. Sam, however, used the discourses of 12-step programs in order to convince people that he was going to get clean and that belief would lead to charity that would allow him to survive the day, the week, maybe the month.

Theoretical implications

To my knowledge, this dissertation is the only ethnographic study of meth-using MSM (HIV+ or HIV-) since Reback's 1997 monograph for the City of Los Angeles. It provides a sequel of sorts to Reback's work while also complementing the extensive quantitative research on meth-using MSM, their motives and experiences, and their responses to various interventions. This dissertation is also, to my knowledge, the only ethnography of meth-users to employ person-centered ethnography¹⁷. While each part of this ethnography is not in and of itself innovative, I believe that the combination of the parts has interesting and perhaps valuable theoretical implications for medical and psychological anthropology, particularly in the analysis of subjectivity.

¹⁷ Garriott (2011) attempted to do person-centered ethnographies during his study of meth policing in West Virginia but was unable to recruit informants who were willing spend the requisite time with him.

1. *Self-world and subject-apparatus co-creation.* The men in my sample are active, agentive participants in the construction of their lives. The data I present show them in microphysical tension with the anti-meth apparatus, with the agents of the apparatus attempting to mold my informants and my informants' responses, negative and positive, in turn shifting and re-shaping of the apparatus. While my methods were neither exhaustive nor perfect, ethnographic analysis of both the individual and the institutional are essential to understand the construction of subjectivities of people who, like my informants are, subjects of intense institutional attention. Person-centered ethnography should not be disentangled from macro-analyses.
2. *Connecting biographies, trajectories, and lived experience of health.* In the analysis of health behaviors, as I have noted, the quantitative data rules supreme. Successful interventions on health behavior is built from such work, but the richness of the experience of health behaviors, the existential and phenomenological understanding of that behavioral, and its cultural and political (though often not its economic) ramifications are ignored or elided. By connecting the rich quantitative data on meth-using MSM to the analysis of their subjectivities, I hope I have filled the gaps in at least one cultural situation.
3. *Risky subjectivity.* In Biehl, Good, and Kleinman's call for the analysis of subjectivity, they ask for new ways to examine "inner life processes and affective states" (2007:6). I believe that my concept of "risky subjectivity" provides an example of a particularly fraught mode of being and lived experience, one in which the orchestration of the self, the modulation of emotion, and the imagined

self-history are all in constant flux. This constant change, constant self-work and self-awareness, is not only risky to emotional stability but also to one's surroundings and communities.

4. *The ethical response to suffering.* Risky subjectivity leads to and is exemplified by suffering. While anthropologists have struggled with and written thousands, if not tens of thousands, of pages about suffering, the answer to the question “What does an anthropologist do in response?” has not yet been answered to the field's satisfaction. I did not know how to respond, either practically or theoretically, to the pain my informants both narrated for me in their life stories and showed me in their physical response to drugs, illness, and violence.

Witnessing



Figure 10. Adam's wrists after he had been bound and tortured.

Every night while I was doing fieldwork, I took these stories home and sat with them. They saddened me, angered me, frustrated me. I did not know what to do, either with the stories, or with the men who told them. As an anthropologist, I was supposed to

do nothing but record the words, analyze them, and put forth that analysis in the public sphere, hoping that someone might use it to do something good. To me, this is so passive as not to be ethical. Perhaps the most troubling event happened with Adam. When he was staying with a man he called “Psycho,” an ex-boyfriend Adam believes is a sociopath, Psycho made Adam break numerous laws to earn money to survive and to support their addiction. Adam sold drugs, shoplifted, smuggled Mexicans across the border, and worked as porn actor and as a prostitute. As I mentioned in Chapter 3, Adam once came to my office covered in bruises, dried blood. He was incredibly agitated and terrified. Psycho had crossed a gang in a check-kiting scheme, and the gang had held them and Psycho’s brother hostage for two days. The gang had beaten and tortured Adam, Psycho, and Psycho’s brother before they were released. Adam seemed to have a concussion, and he needed medical attention. But he was terrified to go to the hospital because the last time he went – for bronchitis – he ended up with \$20,000 in bills. As he told me all of this story, he repeatedly stopped himself from crying, which was most difficult for him when I told him I wanted to help him. I spent an hour convincing him to go with me to a case manager at Family Health Centers, a man I knew could get him into crisis housing. Adam agreed to meet me there in an hour. But he never showed up. For a week, I thought he might be dead, and I was in agony. I dreamt about him, and I couldn’t stop talking about him. Then he showed up for our next appointment as if nothing had happened. Since then, I have tried repeatedly to get him into crisis housing, to get him his doctor’s appointments, to get him to find some method of excising himself from Psycho’s home and grasp. And he simply cannot.

My role in this case was complex. In the United States and in the medical and legal culture my informants maneuver through, their experience with me is very much like therapy, as I have mentioned. In fact, I heard them refer to it as therapy not only to me but to people on the phone who ask where they are, and also to people who they referred to me. But I am not a therapist. I have had training as a peer counselor and I took a class on person-centered interviewing and I have done 10 years of therapy, so I can certainly sound like and seem like a therapist, but aside from the lack of training (and a license), my stated goals are very, very different. When I was in the field, I was not there to help them; I am there to get them to spill their guts, to provide me with data. In fact, part of my sales speech was telling them that I did not want to change them, just to listen to them – and few people ever listen to them. My goals are not purely academic, and I would like my work to make their lives better in some way. But my role is not to treat their depression, to help them get clean, or to teach them methods for navigating life. Nevertheless, because of the extreme empathy I felt for Adam and the rest of my informants – especially those who, like Adam, are deeply troubled – I felt the need to help. And that need to help complicates my role as a researcher, and it becomes much more problematic than my original worry, which mostly revolved around, “Oh, they’ll say stuff to me because I’m gay that they wouldn’t say to a straight person. And what does that mean?”

The intensity of my counter-transference, which is what seems to have happened and which is not, I think, terribly rare among anthropologists, is not something I believe is a comfortable or encouraged experience for even psychological anthropologists. While Crapanzano’s experience with Tuhami (1985) showed his willingness to take on a more

therapeutic role, this seems to be hardly an encouraged position particularly among practitioners of an extremely relativistic anthropology. In an essay on psychoanalytic anthropology, Robert Paul refers to work in which the ethnographer allows counter-transference to lead their analysis as “controversial” (1989:179). In my understanding of the ethnographic interview, counter-transference is something to be wary of and dealt with if encountered. However, Deveraux (1967) saw counter-transference as a thing to be confronted, analyzed, and then used to create true empathy. So, instead of defending myself from these emotions, I should embrace them? This is contrary to what several doctors, case managers, and social workers have told me. When I gave a talk about these issues, one grad student told me I should go to Al-Anon, and I was told by another that I was “too close.” The message was clear: Back off.

Those who have worked in my field site have told me that I need a much thicker skin, because without one, I won't be able to survive. But a cross cultural psychiatrist told me the opposite; it is this sensitivity that will be helping me get great data. But is this just a brilliant defense mechanism? That if I treat this experience as data, I can intellectualize it, differentiate myself from it, from them, and use it, well, narcissistically? I watched myself do just that. A couple of hours after Adam had not shown up to meet the case manager, I called my mother in a great emotional distress. I watched my brain work in almost slow motion as I said, “But, hey, I got the whole conversation on tape!” Isn't this just a way to absolve me from responsibility for what I have heard? What is my responsibility? To get Adam into rehab? To get him to turn himself into his probation officer? To call his parents? Or is it to simply make a grand theoretical statement that might be more lasting but will be decidedly less immediate, and probably less helpful?

I am sometime embarrassed to claim to be an oppressed minority, especially when compared to the level of oppression experienced by the men I work with. Nevertheless, I am oppressed as gay man; I am a “wounded subject,” in Povinelli’s words (2001). Announcing my woundedness, our woundedness, is integral to my personal identity, my identity politics, and it is a central goal in my work as an academic. American (and increasingly, global) politics cannot seem to function, at this time, outside the liberal paradigm that demands a wounded subject, and this greatly influences academic research in both humanities, social and medical sciences. In turn, Scheper-Hughes (1995) has argued that anthropologists have a duty to resist – or counter – evil. Since I see my work (and myself) as a political project done in solidarity with gay men, and, in fact, I see this project as an ethical obligation to both gay men and to the wounded in general, I have put myself in an ethical quandary.

Scheper-Hughes, because she is not an ethicist, but rather an ethically interested ethnographer, does not address what an ethnographer should do in the case of conflicted obligations. What if your informants, to whom you are politically and ethically aligned, are doing something that is hurtful – to themselves, others, to you? At what point do give up on solidarity and critiques or to blow a whistle? When do you drop everything and help? In *Death Without Weeping* (1992), Scheper-Hughes described mothers who “let” their children die. She convincingly argued that structural violence was the cause, that doctors, pharmacists, and government officials acted in bad faith, encouraging the situations in which these mothers did not mourn their dead babies. But I am not clear, and I do not think anthropology is clear, on what I am supposed to do when I witness either

bad faith or the results of bad faith in which people seemingly self-destruct. How much is Adam a victim and how much agency does he have to escape his situation?

In the summer of 2010, I went to the convention of the American Psychological Association to do fieldwork among the psychologists who study gay men, HIV/AIDS, and addiction. They have much clearer moral stance: To help. At one panel on same-sex couples, the discussant suggested, with little irony, that perhaps it would be more politically expedient to under-emphasize – “to keep to ourselves” were her words – the research that showed at least half of gay male couples are not monogamous. And at a workshop attended by several of expert witnesses who testified at the Prop 8 trial, a key part of the discussion was figuring out how to talk about and promote their research and the collective knowledge of psychology in order to promote a pro-gay political agenda.

In American gay communities, dirty laundry can only be hung in our backyard. In the gay press and in gay settings, we can be critical of each other’s behaviors, but if we make the same criticisms in places unfriendly, unsympathetic people may hear them, like national newspapers, government testimonies, or large family gatherings, we risk being treated as traitors by other gay men. So what is my responsibility as an anthropologist, an intellectual, as the person possessing Adam’s spilled guts? Edward Said wrote that I am supposed to be someone

whose place it is publicly to raise embarrassing questions, to confront orthodoxy and dogma (rather than produce them), to be someone who cannot easily be co-opted by governments or corporations, and whose *raison d’être* is to represent all those people and issues that are routinely forgotten or swept under the rug. (1994:11)

But this position is in many ways a fantasy. It assumes a place of structural privilege, emotional stability, and moral clarity that can rarely be achieved. That said, I can try.

With luck and a great deal of effort, perhaps I can help take the stories in this dissertation to the rest of the anti-meth apparatus, the people with whom I have gone native, and help make a difference.

Policy implications

That difference involves advocating for number of changes in the treatment of addicts and users:

1. *Encourage and facilitate discussions about the moral judgment of addicts and their behavior, not just in public service announcements but also among the agents of the anti-meth apparatus.* The creation of the “Me, Not Meth” campaign involved considering how meth users might receive the message, while the goal of other campaigns, particularly those from the Montana Meth Project, has been to create or enforce stigma. Since prohibitionist and moralistic anti-drug messages have done very little to decrease drug use but have done a great deal of harm to users and addicts, a national conversation about how to prevent suffering and encourage healthy behavior is needed. This conversation needs to happen in medical schools, nursing programs, and, especially, police academies. Part of this involves an honest discussion of the human costs of the Drug War.
2. *Make accessing HIV care, mental healthcare, and addiction treatment much simpler.* While these services are underfunded, they are over bureaucratized, and they involve complex red tape that prevents the most at need and the most vulnerable from accessing them.

3. *Fully fund and legalize clean syringe exchanges and other harm reduction programs.* The position of San Diego County that funding and expanding the clean syringe exchange program would only encourage children to use drugs is not only contrary to all evidence collected since the invention of similar programs, but it is also an immoral, injurious policy that guarantees the pain and suffering of people already marginalized by the community. The federal government is currently refusing to fund the exchanges because conservative, factually incorrect, dogma that any assistance to drug users equals encouragement was allowed to reverse policy (Turkewitz 2012).
4. *Fully fund Prop 36 and install effective psychiatric services in every jail and prison.* If addicts are to recover, they need effective, long-term treatment. Mandating 30 days in a recovery program as a way to escape incarceration sounds helpful and humane, but research shows that meth addicts need substantially more time in both residential and in subsequent out-patient programs. If incarceration is needed, addicts and the mentally ill should not be left to their own devices. Only one-fifth of inmates in the United States even have access to addiction treatment (Mears et al. 2003).
5. *Expand and fully fund Housing First.* Some cities are embracing the theory and turning into policy that idea that housing should be granted to anyone homeless as fast as possible and without strings attached. A key component is “A standard lease agreement to housing – as opposed to mandated therapy or services compliance” (Housing First n.d.). A policy such as this would put people like Sam

and Adam into safe, clean housing in addition to offering them the services that they need, not as a result of finishing treatment.

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