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Governmentality/Animacy/Mythology: A Biopolitical and Rhetorical Mosaic of HIV Stigma in a Time of PrEP-eration

Abstract

Since 1981, roughly 35 million people have died from the Acquired Immune Deficiency Syndrome (AIDS), the end stages of the Human Immunodeficiency Virus (HIV), and an estimated 39 million are living with HIV today. While various factors such as poverty, lack of education, and poor access to treatment and healthcare compound the epidemic across the world, the endemic in the industrialized west faces specific communication-based challenges to slowing the spread of HIV. Now classified as a "chronic manageable condition", an HIV diagnosis is no longer the death sentence of the early outbreak in the 1980's. A major factor in the continuing endemic of HIV in the United States is stigma surrounding the HIV virus, modes of transmission (anal sex and injection drug use), and a pervasive belief that HIV and AIDS remains a gay white man's disease despite increasing the increasing burdens HIV holds on communities of color where the virus does not discriminate by sexuality.

While much Communication scholarship has explored the reasons why people do not talk about HIV, talk about it in specific ways, feel stigmatized because of HIV, and do or do not disclose their HIV status--among other topics--very little research has been done to examine the rhetorical nature of HIV stigma as it connects with stigmatization of gay and bisexual men's sexuality. This project argues that in order to understand the reasons why HIV remains a medical problem for gay and bisexual men because of a complex network of reasons, a complex rhetorical understanding of the contextual mosaic of HIV and stigma must be explored.

Using rhetorical methods of governmental analysis, viral/biocriticism, and mythic criticism this project proposes a new perspective on rhetorical criticism as a mosaic approach. The project explores: the Federal discourses by President Obama and prevention campaigns created by the CDC; perspectives of HIV Neutrality as proposed by social media campaign organization The Stigma Project in (conversation) with blogger Renato Barruco's proposed HIV status continuum as a form of animatic hierarchy of HIV risk; and the final two seasons of HBO's popular television show True Blood's use of Hepatitis-V through AIDS-as-allegory.

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Governmentality/Animacy/Mythology: A Biopolitical and Rhetorical Mosaic of HIV

Stigma in a Time of PrEP-eration

A Dissertation

Presented to

the Faculty of Social Sciences

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Brendan G.A. Hughes

August 2017

Advisor: Dr. Christina R. Foust, PhD

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Key words: HIV and AIDS, stigma, gay and bisexual men, rhetorical criticism, *True Blood*.

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1. Proposing A Rhetoric of Mosaics in a Time of PrEP-eration

In June of 1981, five deaths from *pneumocystis* pneumonia, which occurred in Los Angeles, were reported by the Centers for Disease Control (CDC) in *Morbidity and Mortality Weekly Report*. Prior to this, hospitals in New York had been chronicling deaths of otherwise young and healthy men who suffered from WOGS, or “Wrath of God Syndrome.” The causes for these deaths were mysterious cancers and the sudden failing of the human immune system among a specific population—gay men. Before this, around 1979, many gay men in New York and California began noticing their friends mysteriously falling ill and dying. Paula Treichler describes these moments as the beginning of an epidemic that would move from being called WOGS to GRID (Gay-Related Immunodeficiency), to its official name in 1986: AIDS, the Acquired Immune Deficiency Syndrome (Treichler 26-27). Along the way, a cacophony of medical discourse grew about a mysterious disease that held no similarity with many other diseases of the time. As the evolution and/or discovery of new diseases is a rare phenomenon among medical science, the appearance of AIDS on the medical scene in the 1980s was a fascination for the industry (Treichler). This was the beginning of a new plague; the start of a pandemic that would sweep the world and grow from a mere handful of cases in 1981 to more than 35 million in 2015, and claim a further 39 million lives in the process (UN AIDS).

However, the arrival of AIDS on the medical scene was not just a curious phenomenon for scientists. The new disease could not also be separated from the sociological and cultural implications of the populations that were at greatest risk: gay and bisexual men and a collection of other people, who the CDC and other medical organizations named “the 4 H’s”—homosexuals, heroin-users, hemophiliacs, and Haitians (Treichler, 20). As Carol Reeves notes, an outpouring of medical theories and knowledge did not assuage people who wanted answers about Human Immunodeficiency Virus (HIV), but actually made issues of homophobia, serophobia (or the fear of people infected with HIV), and the mythologies surrounding AIDS worse (Reeves 2).

Specifically, journalists promulgated outlandish theories from scientific discourse that AIDS was caused by the use of amyl nitrates (an inhalant and sexual stimulant commonly referred to as “poppers”), that it was a variety of syphilis, or that it was caused by semen itself not being deposited within the rugged vagina that was biologically built to withstand semen’s potency (Reeves, 2; Treichler, 25). Further, scientists demonstrated homophobia through their inability to fathom how a man could infect another man with an infectious disease. In response, many in the gay community expressed anger that the scientific establishment first dismissed, and then delayed, attending to the crisis. The after effects of this delay can still be felt today.

The epidemic continues, with the CDC reporting around 50,000 new infections every year, as prevention campaigns continue to rely primarily upon methods targeting behavior change rather than addressing knowledge or perception change (CDC; Noar et. al.). Different strategies for addressing the epidemic, specific to cultural or ethnic groups,

have become a recent shift in prevention rhetorics, but their introduction may be too little too late to stave off the spread of HIV into wider minority communities. It may be surprising to revisit the earliest days of the HIV epidemic following the advancement of medication in the 1990s, but the homophobic and conservative narratives and discourses about HIV echo today.

However, as I consider throughout the dissertation, the systemic nature of HIV stigma is at its most vulnerable moment since the 1980s; the opportunity for real change to contest the promulgation of stigmatizing discourses has never been more possible. With the advent of advanced pharmaceutical intervention that suppress the virus in a positive body through treatment as prevention (TasP) or a single pill regimen can prevent seroconversion (or HIV infection) in a negative body through Pre-Exposure Prophylaxis (PrEP), rhetorical and critical scholarship has the ability to produce a discursive intervention that crafts key interrelationships between bodies at risk for a virus and language using bodies that participate in and perpetuate systems of stigma. Given the nature of HIV stigma as a contemporary and shifting, vulnerable assemblage, rhetorical critics can provide new directions to study, contest, and halt stigmas in the current endemic. Previous studies have looked at what stigma does rhetorically, or how stigma is a communicative act, or the social and psychological implications of it—but not enough of these scholarly discourses have shown the importance of linking language use and the deployment of performative meaning making practices to the body at risk in a contemporary system of homophobic endemic.

In this chapter, I lay out my project, one that examines the perpetuation of a stigma surrounding the end-stage condition (AIDS) and those who carry HIV. However, this stigma is not just pervasive and ever-present in discussions of HIV today, it is much like the virus itself—always shifting, subtly mutating, and reinserting itself back into new discourses about prevention and opportunities for action against the endemic. Building from Goffman’s definition of stigma, explored below, I define HIV stigma as the rhetorical construction and deployment of the perception of discredited social value placed upon specific bodies, political identities, and group affiliations enmeshed within a social context of institutional homophobia, which seeks consciously or subconsciously to perpetuate systemic social inequity through a continued state of *endemic*.¹

In order to rhetorically explicate this complex sea of meaning, I reformat rhetorical criticism in an approach I call a *rhetorical mosaic*. A drawing together of textual tiles/fragments and arrangement of them in such a way that their contradictions and complimentary meanings allow for the viewer/critic to step backward and rhetorically see a larger, complex social text and the relationships of power and rhetorical force that travel along the gatherings of tiles. I create this mosaic approach by merging previously discussed research, or the tiles of others, into conversation with tiles that

¹ As Foucault notes in *The History of Sexuality*, the turn toward biopower is characterized by a significant shift between epidemic toward endemic—the former is characterized by the unexpectedness of death that sweeps down on life, where the latter manages and minimizes the constant state of potential death, which has economic and/or political ramifications. As I argue in this dissertation, key to the HIV endemic is understanding that modern stigmas surrounding HIV are connected to the evolution and complexity of inherited social homophobia. As medical knowledge, or biomedical technology, has created a vast array of treatments, detection tools, and procedures by which those at risk are identified and (potentially) provided care, more rhetorical work is needed to explore who and how people may come to—or perhaps are rhetorically failing to—understand their risks and the current state of the HIV endemic.

create the chapters of my project. I ground this rhetorical perspective through Michael McGee's understanding of texts as collections of cultural fragments drawn together by critics, through contexts made apparent and put in conversation with each other. In short, for McGee, "rhetoric is what rhetoricians do" (279). Critics that "do" rhetoric as mosaic examine the ways that fragments are not separate and discrete "taken-for-granted cultural imperatives," practices, and beliefs; but become, through the mosaic, "implicated in every instance of discourse" (281). However, McGee's approach to criticism is not without flaw, and has been recently critiqued for its Western, normative bias (Wanzer). As such, I affix three theoretical threads to forge a more socially just version of criticism: Nathan Stormer's articulation, Darrel Wanzer's decolonial approach to fragmentation grounded in the silenced voices, and Jasbir Puar's intersectional assemblage theory.

Stormer's approach to articulation follows the performative turn in rhetorical theory, underscoring that "the relations of language to bodies within discourse" matters and impacts the meaning of "the world performed by participants in [rhetorical] practices" (263). Articulation here refers to the linguistic or rhetorical practices that simultaneously join together discourses while also separating them and communicating (263). Stormer's articulation is the performance of creating a body of texts through rendering visible the "connections" or "joints" which "delineate form and establish the boundaries and substance of a body, whether textual, corporal, institutional, social, or natural, by arranging its elements" (264). Articulation places bodies of texts into *performative space* which is dense, dynamic, and heterogeneous in its relationship to textual meaning-making (270). As "space is not empty" and no space is "ready-made and

self-contained,” Stormer argues that rhetorical spaces are both formed and reformed; they move through and inside performative discourse (270). This builds with McGee’s notion of the text as a collection of fragments as Stormer notes that spaces are remade, and I argue that this remaking is done through the use of fragmented textual pieces by the critic. However, Stormer’s approach differentiates from McGee by paying attention to how rhetorical spaces are filled and arranged (articulated) by critics, where McGee would focus more on what critics are using to fill the space they are (re)creating.

This focus on space merges with Wanzer’s criticism of McGee’s fragments. Wanzer argues that the nature of McGee’s fragmentation thesis is a modern/colonial perspective that does not comprehend that for the non-First World, fragmentation has long been the reality of colonized peoples (650). Fragmentation of culture is a consequence of First World rhetorical practices: “first world people are finally having to deal with the conditions they created and that enabled their assertions of superiority” in relationship with the colonized others (651). In contrast, Wanzer’s approach re-centers the colonial Other’s ability to be inside/outside the dictates of the modern/colonial regime of power.

While this project does not specifically address the challenges faced by non-First World peoples and people of color, I posit that LGBTQ folk exist within a similar relationship of modernism/coloniality that dictates sexuality and gender performance within a proscribed modernist and colonial order. Gay and bisexual men, arguably, exist within this inside/outside voice of the Other perspective. Wanzer asserts that the de-colonial perspective seeks to “*listen to what has been silenced*” in the contexts from

which rhetorical discourses are mobilized and come to be (653, italics original).

Rhetorical mosaics merge these perspectives of *space* and *silence* as the critic arranges the rhetorical texts/tiles to enable viewing and understanding rhetorical force along the connections, joints, or spaces between the tiles. Such spaces and joints articulate the spots of silence where the Other voice is often relegated through modernist and colonial assumptions of discourse. Though gay and bisexual men, specifically those who are cisgender white and masculine performing, have seen increasing access to mainstream discourses, gay and bisexual men in general are still regularly rendered as Other in discourses of sexuality or sexual health where their own decisions about in what what ways and how to have sex. Sexuality discourses often become framed through a sanitized colonial, heteronormative, and patriarchal model where medical expertise supersedes the experiences and desires of gay and bisexual men.

Further, rhetorical mosaics address contemporary movements within rhetorical studies that adopt a perspective of rhetorical assemblages. In responding to criticisms of intersectionality in her book *Terrorist Assemblages*, Jasbir Puar notes that contemporary rhetorical approaches to assemblages can be reframed as a type of grid system that enables the understanding of layout, organization, arrangement, and relations as arrangements of (rhetorical) matter that is its own “actor” (57). Drawing from Karen Barad, who describes matter as a type of “doing,” Puar explains that “event-spaces” enable the articulation of moments of complex relationships between the body’s relationship to itself and the “patterns within which they are arranged with each other” (60-61). If we view bodies as more than animal/human, we see formations such as bodies

of water, cities, literature, discourse, or institutional practice, or simply *texts*. From here, it is possible to theorize a rhetorical mosaic as a rhetorically crafted body of texts that enable the critic to view the spaces and silences between tiles as pregnant with meaning. So the grout, the joint, the connection, becomes as much a focus for criticism. The critic's responsibility here is in the performative rendering of the tiles into a larger con/textual culture-system, she or he must account for the choice of placing specific tiles. As Burke notes, the role of the critic is to use whatever means are available at her or his disposal to address the problem being explicated; in creating this perspective of rhetorical mosaics, I am furthering Burke's perspective to criticism by following Wanzer's call of rehabilitating fragmentation and I reforge this perspective by tempering it with Stormer's articulation and Puar's approach to assemblage.

But how does one create a mosaic out of current discourses of HIV and stigma? The three methodologies I present in this dissertation (Governmental criticism, Biocriticism, and Mythic critique) show the ways in which a critic may fill or arrange their rhetorical space through rhetorical and textual tiles that lead toward and away from specific understandings of contextual knowledge and perspective (re)mapping. Such assemblages are strengthened by a diversity of critique as they show how a multiplicity of knowledge and criticism can be drawn together in order to reveal new subjectivities (such as the Stigma Project's HIV Neutrality) or revive older ways of approaching critique (such as the Mythic approach to criticism).

The remaining chapter surveys the tiles available, through a review of relevant scholarship: foundational research on stigma, with special attention to communication

research related to HIV and stigma; LGBTQ identity and its relationship with HIV and/or stigma (which is troubled with intersections regarding economics and racial identity); and the current state of rhetorical scholarship in theory or criticism that explores HIV.

Throughout this assemblage, I am guided by a grand question: *What possibilities can critical and rhetorical interventions that confront HIV stigma across a range of discourses offer the current movement against the endemic of HIV among gay and bisexual men in North America?* I conclude the chapter by introducing the remaining dissertation, which addresses this question by exploring the rhetorical intricacies of prevention materials in well-meaning but off-putting CDC campaigns, popular monster media, and the emergence of social media campaigns that target stigma as a rhetorical construct.

Stigma and HIV in Communication

No discussion of stigma as a product of social discourse, rhetorical construction, or discursive practice with material impacts on the lived realities of symbol using humans would be complete without a discussion of Erving Goffman's 1967 sociological study, *Stigma: Notes on the Management of Spoiled Identity*. In his text, Goffman describes stigma as an evolution of the ancient Greek meaning to mark someone as unusual or as less moral, to a modern usage referring to evidence of both the disgrace *and* the disgrace itself—with a stronger focus at the time of his writing on the latter (Goffman, 1-2). A stigma is therefore *a relationship* between an attribute—either a visible trait/mark, an invisible deficiency, and/or a socially undesirable characteristic—*and a stereotype about that attribute* (4). Such stereotypes construct the stigmatizing identifier as a failing, a

shortcoming, and a handicap that creates distance between virtual and actual social identities (3). The deficiency or stereotype is almost always brought into social situations when the stigma is apparent, but Goffman describes that stigmas shift and change over time. A contemporary and discursive reading of Goffman's construction of stigma would see that his understanding of stigma's application to lived experience is greatly influenced by historical and cultural flows—meaning that it is difficult to pin down how stigmas evolve and change over time. More detail about stigma's ephemeral and shapeshifting qualities will be described shortly.

Goffman provides three basic categories for the relationship between a stigma and the attribute to which it is connected: abnormalities of the body (such as disability or deformity), perceived “blemishes of individual character” (such as homosexuality, mental disorders, infidelity, criminal behavior, or addiction), and tribal stigmas (such as race, nationality, and religion) (4). Building from Goffman's distinction of homosexuality within the second category, I posit that stigmas of HIV transcend Goffman's original schema and include elements of all three groupings. Since HIV destroys the immune system, and manifests in its final stages as a highly visible, distorting and deforming condition, the distinction of HIV stigma being an “abomination of the body” and its natural immune system fits (4). Second, as previously mentioned by Treichler and apparent throughout much of the literature surrounding HIV, many people—despite gains in medicine and endless awareness campaigns about HIV—still view the infected individual as having breeched a code of morality, such as practicing safer sex, being heterosexual, or not using drugs. As such, from the moralist's perspective, the HIV

positive person is deserving of unequal treatment. Third, since Goffman was writing right before or during the early days of the gay liberation movement of the 1960s and 1970s, when homosexuality was still considered a mental disorder by the American Psychiatric Association, his placing of homosexuality within the area of “flawed moral character” should be revised. Modern stigmas associated with LGBTQ identity are more directed at a counter-culture or tribe of people who practice a different sexuality than the hegemonic heterosexual “normals” that Goffman contrasts the stigmatized against (5). That HIV stigma represents all three of Goffman’s types of stigma underscores its complexity and its sinister effects.

Unfortunately, Goffman leaves little space for stigmatized people to have agency in addressing stigmatization to effectively end the practice. As Goffman notes, the stigmatized individual often internalizes the identity or standards of the *normals*, opening the door for powerful narratives and feelings of shame that progress a series of performances with an intended goal of “acceptance” by the outside or normal world (8-9). As such, the individual takes steps to correct, minimize, or hide the obvious or objective characteristics that set him or her apart. S/he may fall prone to victimization by those who take advantage of the individual’s desire to, for instance, lighten her skin, correct a physical deformity through surgery, or be cured of a socially unwanted behavior (such as alcoholism or gay-ness) through faith (9). If these means fail, the stigmatized

individual may attempt to master a skill or trait that may be perceived as impossible based upon his specific stigma—Goffman calls this “tortured learning”² (10).

While Goffman focuses specifically upon those with limiting physical disabilities learning to swim, fly airplanes, or ski, tortured learning could be expanded to include any means of survival that allows for easier access to the mainstream. Tortured learning and tactical compensation could include LGBTQ people focusing on academic or professional achievement as a means of having social or economic capital to protect themselves from persecution and social stigma. Additionally, people of color may perform Goffman’s “tortured learning” by performing traits and actions associated with middle-class white society as a means of accessing the mainstream and economic opportunity. It is an understatement to say that such responses to stigma come with intense psychic costs.

Goffman’s distinction about the ability of stigmatized peoples to lead full or complex lives, and their (lack of) agency to affect change rhetorically, is highly problematic. Goffman suggests that the individual may use his or her stigmatized identity as a means of organizing her life. However, he also states that such a life only exists within a “half-world,” which pens the individual into organizing his life based upon this stigmatized category. Goffman’s half-world conceptualization completely dismisses the possibility that someone may occupy multiple stigmatized identities (as will be described further, below) or that the stigmatized person is a holistic composite of characteristics and

² Gust Yep’s concept of “soul murder”, or the systemic oppression of LGBTQ people in heteronormative society seems also to fit here, to a degree.

identities that makes a full person. Additionally, Goffman states that though group members may consider themselves a collective “we;” and that “normals” may designate the stigmatized people within the sense of a “group;” stigmatized identities ultimately lack a “capacity for collective action or” or a “stable and embracing pattern for mutual interaction”—completely ignoring the ability of marginalized or stigmatized individuals to create change.³

Expanding the Study of Stigma through Social Scientific Research

From Goffman’s germinal book, many other scholars have explored and expanded the humanistic study of stigma, helping address the key flaws in his original theorizing (i.e., missing the possibility for someone to be stigmatized in multiple ways; failing to inquire into the “normals” who stigmatize; and discounting stigmas as a basis for collective organizing). Meisenbach defines stigma as “an identity discrediting mark of questionable moral status,” breaking stigmas into three types: physical, social, and moral (268). Meisenbach states that most humans will experience stigma at some point in their lives since it helps coalesce in-group and out-group identities—as such, it may not be eliminated, but only managed (269). Meisenbach provides three axioms to assist in the

³ Interestingly, Goffman considers relationships between the “normals” and the stigmatized. Goffman’s conceptualization of stigma also contains a unique ability for stigmas to create an empathic connection between stigmatized individual and a person who does not see the attribute negatively. The “wise” person, with whom a stigmatized individual may be themselves, serves as a place of refuge (28). Goffman borrows from homosexual vernacular, where a “wise person” undergoes a “heart-changing” personal experience by which she sees the stigmatized person as ordinary, a person whose faults or failings are no different than his or her own. However, the final discerning characteristic of being a “wise person,” is acceptance by the stigmatized group, who permit her or him access and pseudo-membership. Wise people usually come in two varieties, those who work with or spend a great deal of time around stigmatized individuals and those who are part of a social structure, such as family relationships or romantic relationships that binds the two people together.

management of stigma: stigmas are discursively constructed and managed via both non-stigmatized and stigmatized individuals' perceptions; stigmas shift and are shifted by discourse and material conditions; and stigmas may vary. More concretely, Meisenbach suggests that stigma may be managed through acceptance, avoidance, evading responsibility, or denial (278).

The flaw of Meisenbach's theory however, is its *inability to eliminate* stigmas or transform perceptions with a goal of eliminating them. To reduce stigmas to an unavoidable facet of human life suggests that they are impervious to change, that they may not shift or be removed over time. Further, as Goffman asserts, a stigma is not the attribute but the *response to the attribute* that is significant in how stigma is perpetuated. Meisenbach focuses on the management of the stigma by those stigmatized, not the ability for viewers to change or shift perceptions that create/maintain stigma. This is a key intervention that a humanistic, rhetorical perspective might bring.

In attempting to rehabilitate stigma messaging and the nature of stigma in Communication Studies, Rachel Smith describes that stigmatized individuals are first distinguished, then separated as a social entity, then ascribed as having a social peril (477). Smith concludes that specific stigmas carry more weight than others, specifically those related to sexually transmitted infections (STIs) and communicable disease (478). While she applauds Goffman's view that stigma is a relationship and not specific attributes, Smith loses sight of how social systems perpetuate inequity through stigmatization and fails to address how stigmas may also overlap or may be addressed effectively (versus managed).

Similarly, Frable, Platt, and Hoey discuss the ways in which cultural stigmas are associated with negative self-perceptions. They note how members of the stigmatized group may help others perceive themselves differently or may provide guidance about how to negotiate social interactions (909). However, pervasive social isolation is a common theme for people with concealable stigmas, which may include a slight deformation or social characteristics which may be covered through dedicated, tortured performance. Similarly, Frost notes in a study of stigma associated with same-sex relationships that many individuals experienced stigma as “ever-present” and “negative weights” on their relationships though some also shared stories about stigmatizing experiences that had generative possibilities for their lives (5, 7).

Fife and Wright note that folks diagnosed with HIV and cancer face similar stigmas.⁴ However, they conclude, people living with HIV face a heavier burden, as the stigma is connected to homosexuality and intravenous drug use, and is additionally viewed as the responsibility of the individual, acquired by immoral behavior, and is perceived as a danger to the community (Fife and Wright). Furthermore, a prominent “blame-the-victim” ideology is associated with HIV, where people living with HIV face prevalent social rejection, economic discrimination, internalized shame, and social isolation based on the social dimensions of their illness (52). Indeed, as Fife and Wright

⁴ Fife and Wright’s initial comparison of lung cancer caused by smoking and HIV is not, in my reading, appropriate. Though someone may “survive” cancer, someone with HIV never ceases being HIV Positive. Even with successful medical therapy and a viral load beneath the limit of detection, often referred as being “undetectable” or a suppressed virus (Fife and Wright, 53).

conclude, participants reported viewing HIV as a punishment for their actions after the fact (53).

This builds on Gilbert and Walker's discussion of HIV related stigmas in South Africa, where pervasive shame and stereotypes about HIV may interfere in drug adherence. In this case, the perceptions of the attribute of stigma have high impact upon lived, daily experiences. However, despite this, the prevalence of ART, or Anti-Retroviral Therapy, has the promise of showing that HIV may be a "life-limiting chronic disease" and that successful provisions of ART may help reduce stigma and the myths surrounding it in South Africa⁵ (Gilbert and Walker, 145).

In contrast to Fife and Wright, Crandall and Coleman consider the stigma surrounding AIDS (and HIV as the first phase of the disease) as doubly complex because the condition is associated with already stigmatized groups, and associated with disease and death. Crandall and Coleman expand and complicate Goffman's theory of stigma in interesting ways. For instance, they determine that stigma is the most significant psychological aspect of the disease, and that individuals may keep their stigma a secret or hidden. Those who "pass" are still discreditable, but are not yet discredited as long as they keep the stigmatized identity secret. Crandall and Coleman thus build on Goffman's

⁵ The dominant medical term for biochemical medication today is "Highly Active Anti-Retroviral Therapy" or HAART. Often this is simply shortened to ARVs for antiretrovirals or ART for antiretroviral therapy. HIV in the United States is classified as a "chronic medical condition" with access to medical care and antiretroviral therapies. However, it is important to note the distinctions made in Gilbert and Walker's discussion of the challenges people living with HIV in South Africa face considering that they routinely discuss "tablets" and "pills" in the plural form and the debilitating and life-interrupting effects they have; such medication is not the standard in the USA and much of the West, where single tablet cock-tails with limited side-effects are the norm. This may indicate a larger, postcolonial issue or questions of access and quality of older, generic medications or the passage time between their publication and today.

two groups of stigmatized people: the discreditable, who are not yet openly identified, and the discredited, who have lost the ability to hide their stigmas. However, Crandall and Coleman note the “catch” that Goffman describes: specific parts and aspects of our social lives provide moments in which disclosure of a stigma may be necessary within intimate contexts, and to not do so would leave the individual feeling quite guilty. An example of this is the disclosure of an HIV positive status to new sexual partners. Within many states, failure to disclose is technically criminal and is not unknown to result in prosecution even today.

Crandall and Coleman explored the influences of negative affect, feelings of stigma, alienation, and social relationships of people who are HIV positive. A diagnosis of AIDS makes visible a potentially double-stigmatized identity, such that individuals are potentially both living with AIDS *and* a homosexual or IV drug user (170). However, they also identify a distinct group that is infected with HIV but does not report feeling much stigma and does not show effects of stigmatization. They claim that, based on Goffman’s assertion that stigmatized and normal people are not two distinct groups but roles that people play, that knowledge about the “marking” of HIV may reduce or shift stigmatizing perspectives—making stigma not a matter of material reality, but a perspective about a role played or identity performed (173). In other words, if people living with HIV understand that they are playing a stigmatized role, and the stigma is not about them specifically, it may not be internalized to such an extent that it impacts social relationships, leads to isolation, and feelings of alienation. The opposite is also possible. Dan Brouwer notes that some individuals choose to mark their bodies with tattoos that

disclose without uttering a word. This is, in some ways, a rebuke of Goffman's concept of "half-worlds," and will be described in more detail later in this chapter.

Agne, Thompson, and Cusella note the difficulty of disclosing one's HIV status to a primary-care health provider, since the primary-care provider is often not the person making the diagnosis ordering testing for HIV. Writing in 2000, shortly after the introduction of protease inhibitors as a method of treatment, people were expecting to live longer and be forced to disclose multiple times to their providers in order to protect their providers from exposure and be prescribed adequate medications. Their research noted that most people living with HIV in 2000 were comfortable disclosing their status to their providers when the patients felt comfortable with the previous interactions with their provider (256); additionally, disclosure was not seen as a loss of face, a critical aspect of stigma according to Goffman's germinal discussion. However, Agne, Thompson, and Cusella's research gathered to support their claims of social impacts on stigma and perceptions of people living with HIV or AIDS is dated. Have perceptions of disclosure to medical providers and other individuals shifted in the now three and a half decades since the discovery of HIV and even greater advancement in treatment since 2000? Clearly, more empirical work, informed by a critical, humanistic analysis of stigma, is needed.

A selected body of literature has addressed HIV stigma in relationship to non-majority populations, or as a burden pushed onto minority communities. Pittam and Gallois note the perceptions of heterosexual Australians in the HIV epidemic and found that often many young Australians did not see themselves at risk because HIV was not a

problem on an isolated, island country—which is baldly untrue—and that the disease only affects homosexuals, which is also false. Additionally, Pittman and Gallois argue that people of color in Australia continue to be falsely perceived as responsible for HIV because prevention rhetorics and campaigns do not contest this assertion (41-42).

Additionally, stigma related to homophobia and same-sex sexual activity within minority communities in the United States is important in understanding how HIV stigma operates. Brooks et. al., in their study of Latino and African-American men, noted that stigma within both cultures was either a weakness, an embarrassment, or that it hurt the family; as such, many gay and bisexual men in these communities identified as heterosexual while having sex with men secretly (738). Such a performance is highly connected to the social stigma attached to homosexuality, whereby participants mitigated multiple levels of stigmatization (e.g., being black, a man, and gay or bisexual) by rebuffing a gay or bisexual identity in such a way that reasserted heterosexuality (Lapinski et. al., 611; 622). Mirroring the concerns raised by Agne, Thompson, and Cusella, Lapinski et. al. address that for many African American men on the down low, discussing their sexuality or sexual acts with a health care provider may be the first time they are discussing this to another person not also on the down low.

Additionally, authors note the role of religion in being an obstacle in tackling homophobia and HIV in both minority groups. Brooks et. al. address that since many African-American churches do not wish to discuss homosexuality, sex in general, or HIV, this silence may make access or participation in testing services by those on the “down low” much less frequent, while Lapinski et.al. note that the silence of the African-

American church to address homosexuality may be perceived as an endorsement for gay or bisexual African-American men to be on the down low (623). The Catholic Church's stance on condom usage and homosexuality also creates barriers for gay and bisexual Latino men in access to health care or testing services. However, the authors do note that beauty salons and barber shops may offer an alternative space in which to distribute condoms or have conversations with trained prevention staff since these spaces are often place of information dissemination and discussion in both communities (Lapinski et. al, 741).

Another body of research that deserves mention is the study of women living with HIV and other STDs and their management of stigma. Wagner et. al, note that the life expectancy and shift in perspective brought about by HAART has shifted the outlooks of many women who are living with HIV in developed countries, specifically since the medical advancements allow them to have biological children who are HIV negative (208). However, these women still face an abundant stigma that prevents them from feeling completely integrated into their society. This stigma may also be exacerbated by the prevailing stigmas associated with other demographic issues, such as the association of HIV with ethnic minorities and poverty. Wagner et. al.'s study revealed that psychological distress and anxiety—common symptoms of HIV stigma—were common occurrences when women who are living with HIV wish to discuss becoming pregnant. As such, research on treating such anxieties might address the needs of women who wish to become mothers or have more children while also on treatment for HIV. In a study of mothers with HIV and seronegative children, Murphy, Roberts, and Hoffman found that

many mothers believed that their serostatus was a family secret that needed to be kept private, and most feared repercussions of stigma and ostracism for themselves and their children, including the suspicion that the child was also HIV positive.

In Nack's study of the disclosure practices and emotional management of women with STIs, the dominant response from many women was that the risks of revealing or disclosing an STI outweighed possible benefits of acceptance or discussion, and as such, their sexual self-concept began to falter. Nack's study also revealed, though, that through disclosure of a stigmatized condition (an STI) the women she studied were able to revise the narrative of their sexual self-concepts and prevent the conceptualization of a "dirty" or tainted sexual-self from spilling over into their whole self-concepts.

However, Nack's study focused primarily upon non-lethal chronic STIs, such as the human papilloma virus (HPV) and Herpes, and not HIV; since these diseases are not lethal or deal with potential death, the identity of these women was open to compartmentalization of the "spoiled" identity to just one sector, rather than their whole self-concept. These studies also show that stigma related to HIV transcends stereotyped assumptions about who is at risk for the disease, but the associations of HIV and gay male and IV drug use transfers over to women who are living with HIV. Additionally, as Murphy, Roberts, and Hoffman noted, the intersection of poverty, minority identity, and HIV may also provide a crippling level of stigma. In their study, 50% of the studied population identified as African-American, and a majority were unemployed (Murphy, Roberts, and Hoffman 194). Additionally, many of the above sources are, for lack of a better term, medically dated.

While the social scientific literature addressing HIV stigma has much to offer, this review leads us to ask: How do social scientists perceive stigma as a variable that may be distinctly measured? While such epistemologies are useful for pointing at specific utterances that are stigmatizing and quantifiably measuring them or qualitatively exploring their discursive power, these studies leave questions about social structures and issues of power open for further study by different epistemological methods. Where Meisenbach's and Smith's studies described above attempt to rehabilitate stigma communication for social scientific or qualitative communication study, they often undervalue the power of social systems, historical and cultural inequities, and means by which stigmas may overlap or impact one another. To underscore, the three flaws of Goffman's conceptualization are: treating stigmas as though they do not overlap, using an unquestioned definition of normal, and refusing to acknowledge the potential for stigmas to create communities or resistance. I believe that the benefit of a rhetorical and critical study of HIV and stigma may reveal the way in which different types of rhetorical discourse respond to, (re)create, contest, and perpetuate stigma related to HIV. By studying how homophobia, or the anxieties created by queer people, impact stigmas associated with HIV, a complex relationship between stigmas and their discursive impacts on larger systems may be teased out.

Additionally, the field's understanding of HIV stigma is, medically speaking, dated. In a time of advanced medical technology that may arrest the virus within a human body for decades and may also prevent new infections from occurring, returning the lifespan of a person with the virus to nearly normal, what are the intricacies of a social

marking of bodies by the sociological and communicative attributes associated to the epidemic's continuation at a rate of 50,000 new infections every year in the United States? Since the stigma surrounding HIV specifically is linked to homophobia, as Treichler mentioned, explicating the nature of stigma related to an LGBTQ identity is also necessary. A brief tracing of literature within Communication Studies that addresses LGBTQ identity and media, with attention to implications for stigma, is explored below, with additional focus on the new attention paid to specific subcultures within this community tied intimately to the HIV epidemic.

Stigma and LGBTQ Identity in Media: Old Stigmas, Same Homophobia, New Trajectories

Homophobia, as an institutional entity, is a problem for nearly all LGBTQ identified individuals at nearly any, or every, major period in their lives. For many, anecdotes about negative treatment prior to the realization of sexuality reveal that homosexual or non-heterosexual identities are often ascribed to queer-perceived children who do not meet the standard behaviors of gender expression for their assigned sex (Fox, "Tales of a Fighting Bobcat"). As such, experiences within a society that by its very nature exists to reproduce a specific subject, create material conditions of oppression for bodies who are realizing they do not fit into the social mold of the dominant narrative (Fox, "Auto-Archeology of Homosexuality").

Ragan Fox's work on unpacking the various intersections of homophobia within society serves as a distinct point of origin for this section of literature which addresses how LGBTQ identity cannot be separated from homophobia and the ascriptions that are

often placed upon LGBTQ⁶ identified bodies (Fox, “Auto-Archeology of Homosexuality”). Fox discusses that in his educational experience prior to higher education, the only discussion of gay men he experienced was in health courses, where the bodies of gay men were “causally linked with the AIDS pandemic” and that often, gay male bodies bore the brunt of homophobic and uneducated opinions about HIV and AIDS (Fox, “Tales of a Fighting Bobcat,” 129; Fox, “Skinny Bones,” 12). Fox additionally notes that the narratives of LGBTQ identity or their absence within specific educational and identity formation periods results in the construction of “blueprints” for living as LGBTQ people, specifically for his work with “HIV serostatus performativity”—the methods and performances that people enact in their subjectivity as either HIV positive, negative, or uncertain (Fox, “Skinny Bones”, 5).⁷ Such blueprints are often sought by gay men, many of whom may or may not know their status. And, as Fox also notes, the narratives of gay bodies as bearers of AIDS (“Tales of a Fighting Bobcat”; “Skinny Bones”) permeates popular culture, specifically this message is reinforced within educational settings that are imbued with institutional and systemic homophobia—which manifests in such instances as the “after-school specials” recounted by Fox in his health classes that depicted blatant heterosexuality and left same-sex interactions mysteriously absent in class-content but always present among the violent vernacular of his classmates.

⁶ While many would use the word “homosexual” to describe these ascriptions, I instead use the LGBTQ identifier for Lesbian, Gay, Bisexual, Transgender and Queer identifying individuals. The use of the medical term “homosexual” continues the violence that psychology and normative society inflicted upon LGBTQ bodies, which Fox discusses.

⁷ I insert “uncertain” as a category to question the situation that Fox addresses within “Skinny Bones” how specific gay men go years without testing due to fear of a positive result. In such situations, these individuals cannot easily give a truthful or definitive answer about their serostatus.

Fox's primary texts are recollections of his own experiences as a student in an institutionally homophobic educational system in a small town in Texas. Though Fox does provide details from his time within graduate school ("Queering"), he does not address his experiences as an undergraduate student—which is a primary location for identity development in LGBTQ identified individuals who manage to escape institutionally homophobic educational institutions within their hometowns for higher education's own liberal interpretation of institutional homophobia⁸. If such an institutional system of homophobia is experienced by LGBTQ people in the educational and employment systems, the ability of media systems to permeate and promulgate stigma in these situations is significant for understanding how bodies-at-risk and language-using-bodies are connected.

Farrell notes that many undergraduate students, specifically young gay men (like those in her research), are exposed to LGBTQ topics primarily through television.⁹ Farrell's study addressed how young gay men read the popular television show *Queer as Folk*, which provided a window into the lives of a group of middle-class white gay men in Pittsburgh. Unlike previous depictions of HIV on television throughout the 1980s and 1990s, HIV was a recurrent topic and was not relegated to a "special issue" faced by just one episode or a short made for television film (Farrell). Farrell's study also revealed the

⁸ The levels of institutional homophobia in high-school and college are very different, and an intricate dissection of these levels could be its own dissertation subject for a PhD candidate in higher education studies or education fields. It is, however, outside the scope of this project.

⁹ Similarly, Mary Gray argues that the experience of watching television representations of LGBTQ characters helped expand the understanding of LGBTQ identities for teens and young adults who grew up in rural areas.

fear that permeates popular culture discussions of HIV, since many of the participants in her focus group study did not understand that HIV is considered a chronic illness and not a fatal condition (provided one has access to treatment). Additionally, all focus group members believed that a HIV diagnosis was something that changes lives “completely,” building on HIV prevention materials and understood the mass media’s relegation of HIV to something “extraordinary, negative, and frightening” (Farrell, 201-202).

Farrell additionally notes that the focus group members of her study all felt “disappointed” when, in their viewing of *Queer as Folk*, a conventionally attractive, smart, and successful character was revealed to be HIV positive, and the group members were uncertain about a central character continuing his relationship with the HIV positive character (202). While the college students did empathize with the main character’s crisis, they were more focused on his feelings than the supporting character’s feelings of anxiety toward potential rejection. Yet, how does the development of LGBTQ characters in media shape the individual understanding of HIV in modern society? As Fox addressed, for at least two generations of gay men during and following the epidemic of AIDS in the 1980s, the only exposure to the pandemic was news stories of death and the lacking discussion of same-sex issues in schools—this creates a prime environment for systemic and ongoing HIV stigma.

Larry Gross further castigates the media and press system for its systemic homophobia and squeamishness that producers and owners assumed their audiences shared (99). Gross notes that when reporters and journalists proposed stories related to the mysterious disease not-yet-called AIDS, they were often met with the accusatory

question of “why are you interested” (101). Following the 1985 death of Rock Hudson, America’s masculine (glass-closeted and gay) film darling, to AIDS, reports and media about the disease exploded—and with it, the existence of LGBTQ characters (already few and far between) became wedded to AIDS for the foreseeable future. And yet, even homosexuals who were disproportionately affected by the AIDS crisis were not spared the indecency of media bias when there were opportunities to privilege heterosexual “victims of HIV” such as Arthur Ashe, Kimberly Bergalis, and Ryan White. This is not to say that these individuals did not suffer (there is a reason why the primary legislative victory for providing government backed treatment in the US is called the Ryan White Care Act); but, as Gross argues, the media privileged heterosexuals who were affected by HIV as a means of making the disease “respectable” (102). As Gross states: “by emerging among groups that are largely despised and rejected, AIDS proved once again the truism that the importance of an event may be determined less by what happened than to whom it happened” (97). The AIDS crisis revealed a distinct level of homophobia and political disdain for gay life that had always been just beneath the surface.

This was made apparent and critiqued by Mary Fisher, a Republican Mother and HIV Positive activist, stated to the Republican National Convention in 1992 in her speech “A Whisper of AIDS”:

[AIDS] does not care whether you are Democrat or Republican; it does not ask whether you are black or white, male or female, gay or straight, young or old... We may take refuge in our stereotypes, but we cannot hide there long, because HIV asks only one thing of those it attacks. Are you human? And this is the right question. Are you human? Because people with HIV have not entered some alien state of being. They are human (Fisher).

Fisher's speech makes clear what is well known today about HIV: that it can impact anyone, despite its prevalence among specific populations. However, her appeal to the equal nature of humans as susceptible to HIV, while powerful and empathetic, is dangerously reductionary—particularly when considering the layered nature of stigma I advocate in this introduction. Populations at high risk for HIV experience a distinct set of additional stigmas: LGBTQ people experience homo/queerphobia for not being heterosexual; Black, Latino, and Native Americans deal with racism that is also institutional in our culture; and injection drug users deal with the stigmas that come with addiction. These stigmas may also overlap on each other. It is important to note, therefore, that a complex intersectional reading of stigma is necessary because every distinct population experiences the epidemic differently, and each member of these populations is impacted by systems outside of his/her individual control.

Since the national media was slow to address the crisis, Gay media had to lead the charge. In 1983, Larry Kramer published the essay "1,112 and Counting" in the *New York Native*. Bonnie Dow, following Kenneth Burke's theoretical perspective by incongruity, states that Kramer's call to action proposed a shift in identity away from sex and toward one of self-worth through the use of shock, guilt, and anger (236). Dow further notes that activism shifted the focus of Gay identity and media away from sex-related and sexual liberation to survival and the protection of life. The end of gay liberation and the dawn of AIDS, ironically, parallels an explosion of LGBTQ characters in media in the 1990s. Though limiting in scope, that representation-as-presence went

from “nothing” to “prevalent” in almost every media form, from newspapers and magazines to television and the internet.

Writing in 2001, Walters notes the explosion of LGBTQ characters on primetime television dramas, the success of Broadway productions that focus on LGBTQ characters, such as *RENT* and *Angels in America*, and the prevalence of LGBTQ entrepreneurs and family oriented organizations and businesses that cater to LGBTQ people. Compared to Fox’s discussion of growing up in the 1990s, where gay lives were highly absent and secrets about gay community members kept quiet (Fox, “Auto-archeology”), Walters contends that gay life, identity, and the performance of these two are public spectacle. Visibility becomes a necessity for equality, Walters argues, but the question must be raised, at what cost? New forms of visibility, such as LGBTQ characters as central focus on television, gay days at Disneyworld, and the explosion of LGBTQ centered legal protections has also created new forms of homophobia that are quickly becoming mainstreamed along with the fundamentalism of the far right in American culture (Walters, 8-13). Quoting Urvashi Vaid, Walters notes that the mainstreaming of LGBTQ people at the advent of the new millennium, while the fundamentalist right-wing additionally gained legitimacy, created a repetition of the same problem: that some face the quandary of if coming out is safe, that some have mainstream access but still face challenges explaining their lives to straight friends and family, and experiencing uncertainty about how to live openly as a gay person (51). The gay movement, Walters argues, has come into its own at the same moment that technology has made everything from banking to entertainment to health information instantaneous—we truly are in a

place we couldn't have imagined in the 1990s and have only now begun to understand, and this still holds true 10 years after her writing (290-291). As such, a rhetorical-critical updating of stigma is needed.

New Directions? Bareback Subculture and the (Re)Turn to Condomless Sex

But not all aspects of gay culture from the 1970s and 1980s from the past have quietly faded away. Following the explosion, pandemic, deaths, and eventual medical discoveries to treat AIDS, the predominant rhetoric surrounding sex among men who have sex with men (MSM) has been one of militant condom usage, regular testing, serosorting, and abstinence as methods of preventing the spread of HIV in Western countries. As seen above in Farrell's study of young college aged men, this rhetoric has reduced AIDS and HIV to be something that is rare, negative, and that "happens to someone else." Körner, Hendry, and Kippax's study of seroconversion among gay men in Sydney echoes this characterization, whereby the absence of knowledge or the presence of it did not provide a simple narrative for prevention materials (141). As Gacoin notes, the theories of behavior change that permeate most prevention approaches fall into the traps of focusing on the "rational individual" who will make specific choices when provided with accurate information about the risks of HIV (169), or do not take into account poverty, education, comprehension, or homophobia. Or, to go in a slightly different direction, such theories neglect desires that run counter to the narratives and rhetorics of safer-sex that dominate the gay media sphere.

Dean's 2009 book *Unlimited Intimacy* argues that the emergence of bareback subculture, or the intentional practice of casual sex without condoms by gay men, is

intimately tied to the evolution of same-sex marriage victories and spread across the United States (ix). Dean notes that this subculture that had no name or collective conceptualization prior to 1997, re-emerged during the turn of the millennium as advancements in antiretroviral therapies sharply reduced the deaths from AIDS related illnesses (2); and that barebacking as a behavior is the next step in the evolution of sexual promiscuity for gay men (5). Elwood, Greene, and Carter, describe that bareback culture relates to bathhouse sex culture, which has re-emerged after the mass closure of the cruising spaces during the 1980s (Elwood, Greene, and Carter, 278). While there is dissent as to how widespread “barebacking” is in the gay male community (see Elwood, Greene, and Carter, 278; Haig, 872; Dean 7), as Haig notes, the practice is gaining popularity alongside neoliberal practices of individual choice and behavior (Haig, 863). Dowsett et al. argue that the practice of bareback sex meets the search for performances of intense masculinity that are privileged within gay male culture; but that bareback sex operates under the possibility of queering contemporary masculinity in ways that were previously unthought of (Dowsett et. al, 130). This follows the explosion of such content online, as entire websites and subgenres of pornography have allowed for the expression of a once/still taboo desire.

Bareback subculture prospers underground in the silence of an HIV closet. Since 31 states have legal statutes that make the transmission of HIV a felony—laws all enacted well before the advancement of antiretroviral therapy, and many of which are now under review—the practice of barebacking exists in its own form of silence and “don’t ask,

don't tell" (Dean, 6-7).¹⁰ Barebacking perpetuates the "open secret" of the closet where everyone "knows" the other person's status, or at least assumes they do (Eve Kosofsky Sedgwick, quoted in Dean, 7). That such a subculture exists is a clear refutation of Goffman's conceptual "half-worlds;" the individuals in bareback subculture often pass unnoticed or un-assumed in daily life—their sexual practices, of course, are their own private business. In bareback subculture, the attributed perception of the "bareback" attribute, that one practices condomless sex acts, is almost interchangeable for HIV positive—the two are read as practically the same—so the stigma carries little weight among members. This creates a unique relationship between moralistic stigmas related to "unsafe"/condomless sex acts and stigmas related to HIV. However, Dean wrote *Unlimited Intimacy* before the FDA approved Truvada, a protease inhibitor, for market as Pre-Exposure Prophylaxis in 2012. The advent of PReP has the potential to dramatically change the relationship between bareback subculture and HIV stigma since, for the first time in decades, condomless sex does not always equal HIV risk.

Bareback subculture is, in a way, not just a response to a stigma—that of sexual practices deemed unsafe—but the dual rebuke and reclaiming embrace of the stigmatized identity. As Mitropolous argues, the silent passing of viral threads among consenting adults, creates new relationships and formulates oikonimic connections and threads of

¹⁰ Dean does, however, reveal his own serostatus (HIV negative) while also confirming that he has participated within the bareback subculture, implicating himself in his own research. Ragan Fox addresses the extreme intimacy of HIV testing and the connection of gay male bodies to the plague, discusses his best friend's positive home-testing, but ends the ethnographic section of "Skinny Bones" right before his own test results are revealed. Both Dean's book and Fox's essay are contemporaries; the intricacies of the anthropologist disclosing but the ethnographer hiding behind ambiguity is not lost on this author.

(re)production that exist outside the mainstream, which Walters may argue LGBTQ people are now being included within (Mitropolous 110-112). Even as the CDC prepares to abandon the terminology of “safe versus unsafe” in favor of sex with condoms versus sex without condoms, the dominant official discourse still privileges condoms over, and regular testing alongside, open conversation. As medical science converts HIV into a long-term, manageable condition for those who can afford treatment, how is the historical stigma of HIV changing? Scholarship on bareback subculture reinforces that Goffman’s stigma must be updated to account for multiple intersecting stigmatized identities; a more robust understanding of normalcy; and the potential for stigmatized people to have agency beyond simply managing the shame and guilt accompanying stigma.

This section has drawn broad connections between homophobia, media representation, LGBTQ identity, and the new subcultures of the gay and bisexual wings of the LGBTQ population, as a point of departure for composing the rhetorical mosaic. We are now prepared to re-engage the driving question: With the approval of Truvada as a PReP which studies show is equally as effective as condom usage in preventing HIV transmission, and the growing number of medical studies that show TasP additionally reduces HIV infection to being nearly medically impossible while on successful medical treatment, what does this mean for the shifts and changes within society toward HIV and stigma? I explore a final set of tiles before composing the mosaic.

Rhetorical Study of HIV: Criticisms Past, Criticisms Ongoing

The central book for rhetorical studies, specifically rhetoric of science, which addresses HIV is J. Blake Scott’s 2003 text *Risky Rhetoric: The Cultural Practices of*

HIV Testing. Using a Latourian approach, he “unblackboxes” the technoscientific narratives and discourses about HIV that are often considered discrete and coherent (5). Testing practices have the powerful effect of judging bodies as “risky or clean, vulnerable or invulnerable, deviant or normal” (7), and benefit established power hierarchies by controlling the “topos of identity-based risk” which dominates HIV prevention services. The side effect, ironically, has been the continuation of stigma upon certain bodies deemed to be at high risk for HIV, which can lead these populations avoiding testing services all together, for they risk incurring mandatory testing and losing insurance (87).

The original and dominant national pedagogy for HIV prevention was written to heterosexual people so they could understand the medical discourses of the virus, but not the cultural milieu of those at high risk—IV drug users and gay men, who were also the dominant populations targeted for testing. Bearing the brunt of the heightened anxiety this created were bisexual men, who were thought to be dangerous for the potentiality of spreading HIV among heterosexual women (97). As such, Scott argues, “choose your partner carefully” became the national mantra. Prevention materials in the 1980s stated that one of the best ways to prevent transmission was to simply not have sex with someone who is HIV positive (serosorting) or at high risk for becoming HIV positive; for anyone who had a partner with HIV, the best option became abstinence.¹¹

Testing practices—specifically, home testing and the testing of newborns shortly after birth—complicated this pedagogy. As Scott notes, the system of newborn testing for

¹¹ I can already hear modern psychiatrists and sexologists screaming and recoiling in shock about the psychic damage such tactics had/have done to people living with HIV; having one’s sexuality stripped from them in this way is damaging beyond words.

HIV antibodies may seem like it seeks to protect newborns and the crisis of pediatric HIV and AIDS, but it also is a kairotic intervention for public health officials to find and diagnose at risk populations through deployment of a knowledge enthymeme toward specific ends. These ends place the (sero)status of women and children as innocent and vulnerable and in need of protection by the state (“Newborn HIV Testing” 66). However, these discourses continue the previously mentioned conflation of stigmas that assume a baby born with HIV is immediately dying of AIDS; such stigmas are not placed directly upon the infant, but primarily upon the state for not testing and treating, and the mother for then allowing the infection to occur. The assumption that a newborn may be immediately dying from AIDS is dramatic, yes, and newborns are susceptible to infection and disease whether negative or positive, but this relationship between attribute and perception is startling. This possibility, that the newborn is immediately dying, rather than needing urgent pharmaceutical intervention, shows a complex relationship between stigmas that are assumed to be inherent with a complex medical condition.

Further developing the power of testing to perpetuate stigma, Scott reads the arrival of home testing as a part of the movement to “privatized, market-driven health care and growing cultural emphasis on personal healthcare and responsibility” that followed the political agenda of Newt Gingrich (Scott, “Extending Rhetorical-Cultural Analysis”). Importantly, Scott notes that the advent of the home testing kit has the ability to reach specific audiences or consumers; ones that are often more affluent, educated, and proactive in their health, but who also fear being singled-out at a clinic for asking about testing (361). The privacy of these tests, however, is matched in the lack of immediacy in

counseling or connection to care; and a shift to a more individualist testing practice may reduce funding for public screening and testing of populations at high risk who cannot afford private, home testing.¹² Augmenting Scott's work, Reeves notes that the battle over patenting and licensing the early blood tests to detect HIV by scientists and the United States government delayed significantly the production of medical technology that could have changed lives (16-17).

A second major touchstone in critical-rhetorical work on HIV is Paula Treichler's *How to Have Theory in an Epidemic*, which was first published in 1999. Treichler does not shy away from connecting the AIDS epidemic to homophobia, arguing that the inattention paid to the pandemic's early days was specifically was a response to gains made by the Gay Liberation movement. The challenge, according to Treichler's 1998 introduction, is that it is still unclear whose story will become the "official narrative" of HIV and AIDS. However, from nearly twenty years on, it appears that the answer to this question sits with the official and homophobic narratives that have abandoned the HIV epidemic in the developed world in favor of creating the abject subject in Africa or Asia—all the better to continue the best means of targeting specific politically unwanted populations (34). Such rhetoric can be seen clearly evolving from the diversity of First World versus Third World AIDS discourses that evolved during the 1980s (116), and the inadequacy of conservative responses following the "just use a condom" narrative that

¹² It should also be mentioned that Fox's test which he describes taking in his autoethnographic account of HIV testing is a home-test kit; which Fox states he chose for its ease but also its privacy, revealing a fear and shame of stigma associated with a positive result in a public clinic. Fox ends the piece right before disclosing his results.

failed when aid agencies notoriously distributed in Africa condoms that were both too small and not stretchy enough for durable use (117). Rhetorical-critical analysis helps reveal the means by which the institution benefits or may engineer the continuation of the pandemic.

Building on Treichler's approach, rhetorical critics have critiqued neoliberal approaches to HIV policies and response, for instance, as illustrated by Luis Sullivan, Secretary of Health and Human Services for the George H. W. Bush Administration. Secretary Sullivan shifted attention from MSM as the primary victims of HIV to African-American and Latino populations (Roth, 237). Roth notes that Sullivan's non-intersectional approach is built upon four fantasy themes called the "mosaic of misery". This mosaic created out of neoliberal solutions to pull one's self up by the bootstraps is meaningless when one does not have shoes, cannot afford shoes, or does not even have access to purchasing shoes.

Mackey-Kallis and Hahn note that similar rhetorics were predominant during the Reagan administration, where the "Just Say No" drug campaign expanded to other social ills of the era, including HIV. The Reagans never really addressed what should replace the thing (drugs, abortion, or sex) that one was saying "no" to (7); as such, without an alternative even offered by a moderate voice, the rhetorical approach reinforced institutional discriminations that resulted in abortion, drug use, and sex that lead to seroconversion. More recently, Phu attends to how the Product (RED) campaign functions as a means by which individuals attempt to assuage their guilt through shopping. The Product (RED) campaign fails to address a larger systemic issue about

AIDS worldwide and instead just draws attention to the nations in Africa which The Global Fund, a medical NGO, sends supplies to support prevention. Using a critical rhetorical approach, Phu localizes the desire inherent in the “We can make a difference, you can help” message that Product (RED) uses to manipulate consumers into thinking their consumption of goods equals stopping the spread of HIV across the planet.

Rhetorical critics have also analyzed texts related to HIV as they circulate among populations, with more particular implications for updating Goffman’s notion of stigma, because they give voice to those stigmatized by HIV, or rhetoric grappling with stigma in critical ways. Daniel Brouwer and Thomas Long study the self-published print media that many gay men created in order to spread knowledge or communicate their frustrations about HIV and AIDS. Long argues that the ‘zines *Infected Faggot Perspectives* and *Diseased Pariah News* constituted an audience and interpellated them into a subjectivity devised of the rage and anger the authors composed (409). Evolving from 1970s punk culture, such compositions were mostly collage art, self-made imagery composed of cut-outs copied and pasted, and the use of self-published poetry, conveying an excess of feeling as their “cultural immune systems” became overwhelmed. Brouwer argues that the zines composed a counterpublic against the dominant media narrative that unsexualized the positive body (Brouwer, “Counterpublicity and Corporeality”).

Brouwer analyzes a more interpersonal response to HIV stigma, following *POZ* magazine which, in 1994, started including imagery of individuals who had obtained tattoos, consciously and willfully marking themselves as “tainted.” The tattoo “announces the invisible even when the bearer is silent” (Brouwer, “Self-Stigmatization”, 115),

perhaps subverting Goffman's original characterization of stigma as a mark of shame attributed to someone and creates a sense of control—the bearer has agency to decide the look of their mark and to reveal or cover the mark at their will. Though the tattoos have the power to be communicatively subversive and transform meaning for the bearer and the community embraced by them, Brouwer notes that the tattoos may invite surveillance and repressive violence (129). As such, Brouwer holds that such tattoos have the potential to be individually empowering and to show courage, but also that they are a mark of privilege. Brouwer's analysis echoes Goffman's insights that some individuals may use the stigma or marking to their advantage through humor or control. Much like the one-legged woman who announces, "I've never noticed!" when told she is missing a limb, the tattooed individual may turn inquiry into sarcasm or humor by quipping, "Oh, it's good that you noticed; I might have forgotten about it otherwise."

Published in 2009, Jeffery Bennet's book *Banning Queer Blood: Rhetorics of Citizenship, Contagion, and Resistance* explores the existential challenge of citizenship rituals that are/were denied gay and bisexual men under the Food and Drug Administration's ban of blood donation by any man who has had sex with another man since 1977. Bennet notes that the FDA admits that it is committing discrimination that has a negative impact on the community being targeted, but reveals their actions are being framed toward a "greater good" of a safe blood supply (150). Further, despite the attention the ban receives, many people (including openly homosexual men) did not believe the ban actually existed and volunteers were unaware the ban was still in place (152). In the book's conclusion, Bennet predicted the (practical) continuation of the blood

ban in name only; currently the FDA only allows for men who have sex with men who have not had sex for 12 months to donate blood. Further protest to contest the ban and to reframe the benevolent nature of promoting blood donation as discriminatory toward gay and bisexual men is necessary, he states. Bennet implicates how stigma can travel through citizenship rituals, and undetected by contemporary citizens who see their institutions as somehow “above” stigmatization.

Charles E. Morris III’s *Remembering the AIDS Quilt* frames the AIDS pandemic as a loss of life, as well as a loss of understanding the history of gay culture which had suffered the brunt of the epidemic. Morris and the other authors grapple with whether or not the quilt actively helps prevent the spread of HIV today, or if it places the epidemic within the past (li). Bryant Keith Alexander negotiates the addition of new panels to the quilt and uses performative writing and narrative ethnography to contrast the past by creating performances of possibility that offer the means to restory the past and bring the margins of the narrative into the center. Erin Rand similarly argues that through the reconstitution of memory surrounding the events of the quilt, the modern viewer can understand how the mourned subject of the quilt came to be, and as such, may understand how the anger that was addressed during the tidal wave of death and dying can help make sense of new names being added to the quilt—which marks the United States’ problematic relationship with AIDS and homosexuality—and reinscribes the mourned subject into the present (253).

Along with new directions in engaging public memory with HIV rhetoric, recent critical-rhetorical work approaches health communication from a Postcolonial

perspective. This recently emerged theoretical body of work seeks to rid health communication as a sub-discipline of its “derivative, paternalistic, and narrowly focused version of health education” specifically through decolonial cultural and rhetorical work that engages constructions of the “modern” versus the “primitive” (Shastry and Dutta, “Postcolonial Construction of HIV/AIDS,” 437). Shastry and Dutta provide two excellent examples of this praxis when they critically interrogate the mass media print representations of HIV in India, and examine the neoliberal “common sense” drive behind the PEPFAR program (“Postcolonial constructions of HIV/AIDS,” “Global Health Interventions”). In the former case, they explore how India is constructed as the Third World and is controlled through the biomedical apparatuses of the United States, which plays out the international drama of the Indian state as “other” and in need of saving. In the latter case, they note how PEPFAR frames the cost of HIV and AIDS not primarily through lives lost but through damaged economic output and that it is, again, framed as an African problem and not a global problem.

Proposing a Rhetorical Mosaic: HIV, Gay/Bisexual Identity, and Stigma

HIV stigma appears in 2017 as complex, mobile practices, that perpetuate fears of others (notably, gay, queer, and bisexual men, MSM, people of color, poor folks, and IV drug users), and continue to affect policy, health, and quality of life for many in the US and around the world. Additionally, with the advent of technological and pharmaceutical intervention for both the treatment and prevention of infection, HIV stigma appears at its most fragile. *What possibilities can critical and rhetorical interventions that confront HIV stigma across a range of discourses offer the current movement against the endemic*

of HIV among gay and bisexual men in North America? Through the remaining chapters, I endeavor to perform a complex arrangement of discourses that exist within discussions of HIV prevention or the present state of the endemic that, when placed together in a mosaic, reveal investments, movements, and shifts in the landscape of the endemic. As such, this project seeks to render through rhetorical critique new connections or “joints” that discursively bring together rhetorical meaning from previously discrete areas of scholarship (Stormer). Thus, a second question guides my research: *What does the conceptualization of rhetorical mosaics offer rhetorical criticism as a reconceptualized paradigm for the critic’s relationship with the textual tiles that she places into conversation and contradiction in order to rhetorically see larger movements of communicative meaning?*

The rhetorical mosaic derives from three specific areas of focus and rhetorical critique: official and governmental messages (from the CDC), special interest campaigns from non-governmental organizations (like The Stigma Project) and pop culture/mythic discourse (from the popular HBO series, *True Blood*). In Chapter Two, I study the CDC’s recent HIV prevention campaign, “Start Talking. Stop HIV” (CDC, “Act Against AIDS”). While the CDC operates a large survey of HIV prevention campaigns under their “Act Against Aids” project, I specifically choose this campaign because it is more narrowly focused at gay and bisexual men by “encouraging open discussion about a range of HIV prevention strategies.” While other campaigns target a general (multi-racial/cultural) audience or a specific demographic (such as Latinx Americans in the US).

“Start Talking” focuses upon gay and bisexual men as a risk group, and addresses the challenges surrounding disclosure of status and conversations about prevention that often accompany discussion about HIV among MSM. The campaign features slick YouTube style PSA ads that depict romantic same-sex couples at various stages of the life cycle, and claims that conversations about prevention must occur often. Additionally, this campaign also provides sample “conversation starters” for a variety of situations, such as: “I don’t care whether you are positive or negative, it is not going to change how I feel about you, but we need to talk about it so we can come up with ways to keep each other healthy. What’s your HIV status (“Conversation Starters”)?” Unfortunately, HIV stigma is absent from important parts of this campaign, and the conversation starters do not equip the reader for what to do should the conversation not turn out well. As I argue, the CDC’s ability to meaningfully impact change through the campaign is rhetorically limited, because it does not address stigma or homophobia.

Chapter Three explores how a social media campaign, The Stigma Project, addresses the issues of stigma alongside awareness and a focus on testing for HIV. The Stigma Project’s primary method of addressing HIV stigma is through the use of poster-style informative images that are designed to circulate quickly on the Internet. Significantly, The Stigma Project is co-managed by a person living with HIV, creating a unique perspective for the campaign as it contests stigma within the movements—HIV Neutrality. Further, The Stigma Project aims to span racial and economic lines. . Interestingly, the Stigma Project proposes not awareness or behavioral change, but complete perception change about HIV as their method of reducing stigma. Since

immunity discourses are couched in creating a binary, The Stigma Project radically shifts the attention away from positive/negative binaries to other modes of understanding life in a post-AIDS era, that of HIV Neutrality. As I construct in Chapter Three with the aid of Renato Barruco's continuum of HIV statuses, Chen's animacy, and critical attention to health rhetorics, The Stigma Project offers new possibilities for undoing stigma and altering HIV risk discourses.

In Chapter Four, I consider how popular culture, and more specifically, cultural myths related to monstrosity, might perpetuate or challenge HIV stigma. Following recent work that considers lycanthropy in *Harry Potter* as a metaphor for HIV (Hughes), I analyze the HBO series *True Blood*. Called "Hepatitis-V," a variant super-strain of hepatitis D, designed in a Louisiana state-run lab to kill Vampires in the virus' final stages, the television show drips with allegory about HIV. From the black spidery veins that are reminiscent of AIDS related Kaposi's sarcoma, to the medical industry's anxieties about creating a treatment that seems all but lost, to the awareness posters stating "silence equals true death" (a play on ACT UP's signature motto), to the very nature of the testing process to find out if one is a "carrier," to disclosure scenes, and countless other possible moments, the HIV metaphors abound. Chapter Four addresses how fantasy, horror, and monstrosity address critical social issues in ways that might circumvent the emotional reactions of many people to a traditional HIV message or approach; such messages also serve as dramatic transformative texts for conversation and attitude-shifting. At the same time, though, through mythological criticism, I argue that the representation of a viral apocalypse (rhetorically emerging from Frankenstein and

Frontier myths) transforms into a myth of a collapsed frontier, to re-inject conservative, individualistic appeals, and thus, bolster HIV stigma and reify heteronormative modes of understanding HIV and AIDS.

I should make it very clear here that these claims I make regarding *True Blood* (and by extension, President Obama's speech) are not measurements of intent. Rhetorical intent matters very little in the study of what rhetorics do and how they are enacted or taken up by audiences and rhetorical actors or agents of change. While many sections of this project may be read as ideological in nature, they are invested heavily within the materialist approach to rhetoric: that rhetorics create and sustain systems of discourse with lived and material consequences—both for good and ill. In seeing how Obama's speech outlines policy to create a regime of health, or a network of intersecting practices and ways of being, it is possible to connect/see the need created by popular culture's understanding of what the AIDS pandemic was like through *True Blood's* AIDS-as-allegory approach. In drawing these two rhetorical tiles together, the "joint" of possibility they create allows us to see Stormer's concept of arrangement and assemblage as ways of brining materialist critique to life.

Finally, this project draws together (in Chapter Five) the major offerings of each chapter and addresses the future trajectories in 2017 as the United States descends into political upheaval in the Trump administration and an anti-LGBTQ resurgence spreads among conservatives. Calls for critical praxis in health communication are not new; however, the lack of rhetorical study addressing stigma's relation to gay male sexuality and HIV, with intersections for culture-centered health communication, shows a real need

to be filled by the present dissertation. By creating a rhetorical approach of mosaics, this project enables critical scholarship to see the ways in which discourses may come into contact with each other as forms of “assemblage” drawn together by the connecting “joints” (or grout) of a mosaic text rendered visible by a skilled rhetorical critic.

The conclusion reminds readers that stigma surrounding HIV may be reduced, as Goffman explains, or even eliminated through shifts and changes at specific historical moments within society, but that it cannot go quietly into historical memory without us understanding how power relations shift global terrains and spaces. The VICE documentary “The PrEP Revolution” is introduced as a clear example of the challenges faced as the fight against HIV moves from just external prophylaxis (condoms) to internal, chemical prophylaxis and external as well. Further, and of specific notoriety, is how now Vice-President Mike Pence survived the 2016 political election season with very little attention paid to the HIV outbreak that occurred in southern Indiana as a direct consequence of a raging opioid epidemic and his cutting funds to Planned Parenthood and needle exchanges. Additionally, within the Western and developed worlds, the advent of PReP creates a unique opportunity for activism about new and advanced prevention strategies. One method of resistance, titled a “PReP walk” and based on the now controversial “slut walks,” contests stigmas about HIV risk and sexuality that are aimed at gay and bisexual men.

In conclusion, while most social scientific studies of stigma explore how stigma functions to dominate bodies and impact lives, very few studies actively show how stigma may be resisted or where to find its most subtle and pernicious iterations.

Rhetorical interventions bridge this gap. They allow the critic to view amalgamations of social scientific or prevention rhetorics as evidence of the state of the HIV endemic within the United States and patch up the holes that allow for implicitly stigmatizing practices or discourses to be questioned.

2. President Obama and the Regime of Health: Federal Governmental Rhetorics of (Empty) “Awareness”

In his germinal volume *The History of Sexuality*, Michel Foucault explicates the means by which sex became a tool of managing populations, and how sexuality evolved as a means by which populations were encouraged to grow or not grow, expand in certain ways, but not others. In one of his most salient passages, Foucault describes the means by which sex and the desire for it serves as a temptation for which the cost is the exchange of life itself. Sex, he states, “is worth dying for.” This passage catches the eye 30 years after Foucault’s death from AIDS rendered the epidemic more a matter of urgency for the academy, as well as the Gay Liberation Movement and the French government. However, the systemic HIV endemic of today is quite different from the mysterious plague that AIDS was in the 1980s and early 1990s—the epidemic of signification that Treichler discusses in *How to Have Theory in an Epidemic*. As Foucault writes in his lecture, *Society Must be Defended* modern Biopower and biopolitics must be concerned with endemics, which are “the form, duration, and intensity of the illnesses prevalent in a population” which are “difficult to eradicate” and are treated as “permanent factors” that decreased economic participation and production (65). Though often framed as an epidemic, which connotes widespread and active infectious agents moving through a population, the contemporary crisis of HIV is instead best described as an endemic, since

the virus is largely contained within populations of gay and bisexual men, Black and Latino Americans, and intravenous drug users.

The US federal government represents an important rhetorical actor for understanding contemporary HIV stigma. As I considered in Chapter One, and following Treichler, homophobia is intrinsic to understanding how the response to HIV played out in the early days after the virus was discovered. So powerful was this homophobia, that when Rock Hudson lay dying from AIDS in a French hospital, the Reagan administration refused to acknowledge his request for diplomatic intervention, effectively continuing their distinctly anti-gay, family values platform. Responding to the ongoing HIV and AIDS epidemic each president¹³ since Reagan has taken specific steps to halt, slow, or prevent the spread of HIV. This raises the central question of this chapter: *how does contemporary federal discourse about HIV and AIDS address the ongoing endemic as a consequence of stigma toward both the virus and, by extension, sexuality?*

As a starting analysis in the rhetorical mosaic, Chapter Two offers an exploration of how US governmental agencies *rhetorically engage an endemic that is perpetuated as a consequence of stigma*. The federal government, as the head and central manager of a multitude of issues, shows a distinct preference for using numerical, quantifiable data and the allocation of resources to address crises that are new or ongoing—such as the HIV endemic. Such a preference makes sense from a large scale, managerial standpoint.

¹³The Trump administration has not yet made clear its approach to slowing the spread of HIV in the United States or worldwide.

However, the intricacies of everyday life lead this critic to ask how the federal government's approach to HIV allows stigma to become sidelined, understated, overshadowed, or repositioned in texts, practices, and rhetorical discourses. While modern discourse, representation, and legal victories would lead an individual toward the belief that views on sexuality are much evolved since the outbreak of HIV, this may not be entirely true. Drawing from the intricacies and implicit privileging of some bodies over others in federal discourse, I argue that stigma—though masked with good intentions—still occupies a subtle and pervasive place in the highest levels of federal HIV discourses. The legacy of homophobia subtly codes discourses about HIV today by positioning specific bodies—those who know that they are positive—as the ones chiefly responsible for slowing the spread of HIV.

Along with rendering individuals living with HIV as responsible for managing the endemic, this chapter's rhetorical examination of government (building on the work of Mitchell Dean and Foucault) considers how federal discourse sidelines stigma as a single, couched variable. I build the rhetorical mosaic through three main tiles of federal discourse: the remarks of President Obama during the 2010 announcement of the White House's initiative to reduce HIV and AIDS in the USA; the policy document that describes the White House's approach to preventing HIV in the USA—the National HIV/AIDS Strategy; and the Center for Disease Control and Prevention's "Start Talking. Stop HIV" campaign, part of the larger "Act Against AIDS" initiative. This collection of texts/tiles reveals a distinct challenge that government discourse faces as a means of

controlling conduct and molding citizens as actors of proper behavior—*the inability to directly challenge stigma as a cultural force*. Even in campaigns directed at men who have sex with men, the communicative nuances of stigma and the mental and psychic implications of it are lost to the governing body. Finally, this chapter frames the implications of the structure of governance that is enacted through the policies of the Obama administration. Though the Trump administration currently holds the reins of HIV prevention, little has been done by the Trump Whitehouse to pick up where the Obama administration left off. As such, a detailed examination of the Obama administration’s approach yields key insights about what could be done by the current administration¹⁴ or future presidents.

Theorizing Governmentality in Federal Rhetoric

Throughout the chapter, I take “government” to reference both the process of self-governance and behavior in relation to HIV prevention (a code of conduct), and the governing discourse created by federal actors with capabilities in decision making positions. Specifically, the latter in this case will be the Obama administration and its Office of National AIDS Policy (ONAP), the Centers for Disease Control and Prevention (CDC). The method of self-governance or behavior deployed here is a *regime of health* and governmental system that has been thought out and enacted by the US federal government, state agencies, non-governmental organizations, community groups, and

¹⁴,The Trump administration has said little to nothing about HIV and AIDS policy, but proposed cuts of large amounts of funding from the NIH and the attempt to repeal the Affordable Care Act do not bode well for HIV prevention in this administration.

activists ranging from the ONAP and the CDC to ACT UP and the AIDS Healthcare Foundation (among many, many others). The deployment of governmentality in the examples provided here also has vast biopolitical implications, with biopolitics as the means by which the very domain of life itself becomes the realm of political inquiry and control.

Mitchel Dean defines “government” as:

any more or less calculated and rational activity undertaken by a multiplicity of authorities and agencies, employing a variety of techniques or forms of knowledge, that seek to shape conduct by working through the desires, aspirations, interests, and beliefs of various actors for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects, and outcomes. (18)

Here, Dean is indebted to the work of Michel Foucault in *Security, Territory, Population*, where Foucault first conceptualized the process of governmentality as both “the conduct of conduct” as a practice of morality and deployment of power/knowledge. Specifically, Foucault notes the evolution of government’s three areas: the self, the family, and the state (93-94).

This conceptualization of government is a technology of power that deploys itself in order to create docile bodies—the “various actors” that Dean states above—through methods of self-governance along a continuum from the top down or the bottom up based upon a precedence of morality; what is good governance for the state is also good governance for the family and the self. Further, if one is not a good governor of the self, how could one properly manage a family or a territory (93-94)? Methods of self-governance are therefore often deployed en masse to populations as a politic of bio-

power, or a set of functions and mechanisms deployed toward a specific end and political strategy that sees the human species as the object of power's manipulation (1-2). Part of Foucault's larger theorization of power, a set of procedures that create in circular cause and effect, both their (re)creation and their continuation through enactments, rituals, and relationships of human interaction via "mechanisms" or *dispositifs* (2-3).

In *The Birth of Biopolitics*, Foucault further claims that a state has no true essence: that a state and its government is constructed of the relationships between central and local powers and the forms and types of control that mediate investment, sources of finance, and the location of decision making centers (77). The adherence to the state's governmentality creates a permanent condition of economic well-being through the continual generation of surplus value (wealth) through adherence to the regime (economic, social, political) which the state uses as its legitimization (85). Part of Foucault's larger project, these brief moments reveal the creation of a system of analysis, which Foucault claimed was only the beginning of a theory, that can examine the three forms of government.

Dean further outlines the steps and processes for performing an analysis of government (or, as I will occasionally term it, governmental analysis) along multiple axes: "forms of visibility and ways of seeing or perceiving"; "ways of thinking and questioning," which "rely upon specific vocabularies for the production of truth" and the procedures of making sense of it; "ways of acting, intervening, and directing based upon specific rationalities" positioned in practicality that "relies upon definite mechanisms or

techniques, or technologies;” and “characteristic ways of forming subjects, selves, persons, actors, or agents” (Dean 33). Dean additionally notes that the primary way in which a governmental analysis must begin is “problematization” or the examination of specific situations or moments where and when government becomes a problem—where we must ask “how we conduct government and govern conduct” (38). To summarize and synthesize Dean’s statements, there are issues or problems where government—the conduct of conduct—must become questioned or questions must be asked toward what conduct becomes appropriate. To understand that a problem even exists, there must first be the ability to see or perceive that a problem exists outside of the current conduct system. Second, a vocabulary of truth, or the judging of the problem’s sincerity or social relevance, must be constructed in order to formulate and disseminate the question of conduct that has arisen. Finally, these vocabularies of truth allow for the enabling and creation of rhetorical actors (broadly theorized as individual or larger groups) that act out the vocabulary of truth’s answer to the question that is constructed.

Such problems are defined by “grids” that are composed of “particular techniques, languages... methods of evaluation, forms of knowledge, and expertise” that create the possibility of asking *how* the way of conceptualizing a problem and its connections creates a way of *thought* regarding the problem (39). The series of ritual performances (techniques, methods of evaluation, qualities of expertise) done following a correct form of behavior enable the imagining of an approach or *way of thought* about the problem. Ways of thought construct and identify a set of objectives that are aimed at the contesting

of social ills, the creation of a schemata of evaluation, and the unification and rationalization of these techniques in order to preserve the regime. A regime, here, is the ways in which we do things such as “cure, care, relieve poverty, punish, educate, train, and counsel” toward specific visualizations and illuminations of a problem (40-41). In other words, the way in which a problem is addressed, and the actions that are taken by rhetorical actors to address a problem, are understood through the connection between how the problem is conceptualized as an issue (via the vocabulary of truth) and then thought about in order to disseminate the question and create rhetorical actors. For this chapter, the grid that becomes apparent is the creation of a regime of knowledge about HIV and populations at risk that is created by specific rhetorical actors (the President, the CDC, the ONAP), disseminated through statistically collected data, problematized along specific characteristics, and approached through a nebulous rhetoric of “awareness.” This process does not exist as a linear formation from the top-down, but instead from many directions reinforces its own perspective and regime. By asking how a regime of knowledge comes to exist through grids such as the one explained above, we see the various webs of connection that play through.

Governmental analysis not only concerns itself with asking “how” a regime and its practices and mechanisms create thought, but also about how these systems provide light that falls in specific ways and illuminates specific ills or problems as deserving of attention by governmental actors—which begs the further question of what gets left in darkness that is not worth of attention? By focusing upon the way in which a problem

becomes “illuminated” the critic may expose the way in which a problem has been conceptualized, and then consider how this conceptualization focuses the directions and actions of rhetorical actors toward specific ends. Such methodologies require the attention to the technologies of government—what models and forms are used, what procedures, tactics, vocabularies, and techniques back up this system? All of these tools create the means of illuminating a conceptualized problem.

Along with ways of knowing and guiding conduct, then, government creates identity and forms subjects. These are the “actors” that make possible both government and the governed who must conduct themselves. Dean leads with questions of “what form[s] of person, self, and identity are presupposed by different practices of government and what transformation do these practices seek” (43)? What are their positions, capacities, and orientations of those in authority and those who are governed? What forms of conduct are expected and what rights do they have (43)? Specifically, government does not create or determine subjectivity, it instead facilitates, fosters, and promotes various capabilities, qualities, or statuses among the particular agents who govern and are governed. (44). To clarify what I mean here, it is important to note that the Federal organization of bureaucratic structures, practices, and policies that create and disseminate specific codes of conduct—or government of the self—through labeling what is a series of idealized performances and practices toward specific rhetorical ends. In this case, the Obama administration sought to reduce the spread of HIV and thus had to dictate what bodies and practices must be targeted, channeled, and corrected in order to

reduce the rate of new infections and keep those currently living with HIV from progressing to AIDS.

As such, this chapter will first problematize the situation that rhetorics of HIV prevention in the Obama administration found themselves in before examining a snapshot of the governing “grid” of language and discourse created by the federal government, identifying the ways in which the mechanisms of this regime provide(d) light to illuminate specific codes of conduct and ways of behavior and then leaves others to shadow, and finally exploring discourses that create specific actors of specific qualities or capabilities. The essay concludes with an exploration of how a transformation of this regime may take place along the bottom rung of the governed who are challenging old forms of regime knowledge that are now technologically out of date but perniciously sticking around in social circles.

Governing Discourse: President Obama’s Address on the National HIV/AIDS Strategy

Federal efforts to manage the endemic of HIV in the United States have required multiple different systems of rhetorical deployment among countless agencies and organs—the White House, the CDC, the ONAP, the National Institute of Health (NIH), the Food and Drug Administration (FDA), Congressional law and State government action—with complex levels of interplay, interruption, and interference upon the political playing field. One area that is routinely under-scrutinized is the role that stigma plays in prevention efforts or in how people understand HIV. In fact, rarely, if ever, do governmental agencies within the sphere of HIV prevention and discourse admit that

stigma—both as a consequence of and perpetuated by rhetorical action—is a primary factor in the HIV endemic among specific minority populations (i.e. gay and bisexual men) in the United States. When stigma is described, it is usually in print material available on the Internet and rarely ever is approached verbally or in spoken address—which only perpetuates stigma. A hesitancy to speak verbally about the stigmas of HIV by our national government, and the preference for writing about it only, is off-putting to say the least.

For example, during the 2010 version of the White House National HIV/AIDS¹⁵ strategy, President Obama’s comments fit the standard trifecta of prevention, treatment, and service for communities that need it most. Obama’s comments regarding the treatment of women and the vast inequities of wealth and development across the world further complicated Obama’s message about who is most vulnerable to HIV and the scourge of its final stage—AIDS—across the planet. The rhetorical aim of this approach is to address the needs of those outside the United States as well as those within; but the rhetorical cost is significant in that it does not address both the specific causes of stigma (homophobia and mythology), or name those who are at risk domestically (gay and bisexual men). To be clear, Obama’s address was a broad, sweeping message aimed at creating a dialogue about what the governing executive of the US is doing to confront HIV at home; and how his administration is approaching the complex relationship

¹⁵ This is the name of the federal program, and I break from my intervention of “mending the slash”—or separating HIV and AIDS in discourse without a “/”—for this instance only. The reasoning of this decision will be explored in this project’s conclusion chapter.

between state actors and non-state actors within mechanisms of controlling and creating sexual subjects.

A generic analysis of this speech would claim that Obama needed to meet certain requirements, for instance, related to administration goals for confronting HIV across the globe; however, such an analytic approach would fail to address the complex relationship that stigma and HIV have in regards to the global crisis by instead focusing on the President's rhetorical approach to the issue, rather than how the issue is made salient through the rhetorical approach of the rhetor. A government analysis instead shows how an influential state actor, at the top of the governing hierarchy, is restrained in method of directing action through the mechanisms at his disposal and the vocabulary of truth it must wield. In this instance, President Obama continued a line of rhetorical appeal that crafts HIV and AIDS as a global, overarching problem—a macro issue of social inequity—rather than a problem made manifest by a *relationship of stigma*.

If, as Dean notes, government is form of conduct transfers from top down, Obama needed to convey his understanding and position as exemplary of not only how subjects who are governed must behave; he needed also to model the role of liberal, progressive leader who is taking a bold stance on HIV. As such, his message connected the international elements of the health regime with other regimes charged with reducing poverty and addressing women's rights across the planet. His literal regime positioned itself as oppositional to other (also literal) regimes that oppose the rights of women and perpetuate systems of poverty that allow the global pandemic to continue. Such rhetoric

functions as part of a “way of knowing” that makes sense of a separate problematization (world poverty) and draws these regimes together through a vocabulary of truth. Obama thus framed HIV as a problem that can be tackled on a macro scale through poverty reduction and addressing cultural issues of misogyny, not through directly de-stigmatizing HIV or eradicating homophobia.

It is significant that never once did Obama say the word “stigma”—though he alludes to stigmatizing rhetoric and the implications of stigmatizing practices:

In the beginning, of course, it was known as the “gay disease” — a disease surrounded by fear and misunderstanding; a disease we were too slow to confront and too slow to turn back... *When a person living with HIV/AIDS is treated as if she’s done something wrong, when she’s viewed as being somehow morally compromised, how can we expect her to get tested and disclose her diagnosis to others? When we fail to offer a child a proper education, when we fail to provide him with accurate medical information and instill within him a sense of responsibility, then how can we expect him to take the precautions necessary to protect himself and others? When we continue, as a community of nations, to tolerate poverty and inequality and injustice in our midst, we don’t stand up for how women are treated in certain countries, how can we expect to end the disease — a pandemic — that feeds on such conditions...* So fighting HIV/AIDS in America and around the world will require more than just fighting the virus. *It will require a broader effort to make life more just and equitable for the people who inhabit this Earth. And that’s a cause to which I’ll be firmly committed so long as I have the privilege of serving as President.* (“Remarks by the President on the National HIV/AIDS Strategy” italics for emphasis)

While the president’s rhetoric was admirable in its tone, it failed to address stigma directly by name; and stigma quickly evaporated into the larger issues of women’s equality and economic development.

This opens up the problematization of federal discourse about HIV: “government” becomes a problem because individuals and regulatory bodies must be given both ways

of conduct and attention to prevent the continued spread of HIV. But such ways of conduct require first perception and visibility, as Dean states, a process made complex by the indirect ways of addressing stigma (41). Obama's address reminded Americans that HIV and AIDS are both still problems, thus focusing audience perception and ways of seeing/knowing HIV as a problem. In his remarks, Obama alluded to the direct stigma that people living with HIV face which makes the individual feel "spoiled" or "wrong;" drawing straight from Goffman's vocabulary. Where Obama cultivates sympathy for the individual who feels stigmatized, he does not address why such stigma is persistent. So Obama promoted a way of thinking that connects a person living with HIV back into the society that treats him or her as wrong or spoiled by asking the question "how can we expect" in regards to testing and disclosure. This directs us to a new form of knowledge, through which the citizen is aware of stigmatizing beliefs, but not to the practices that continue to enable stigma to flourish. Simply put, Obama reiterated rhetorics of vaguely defined awareness without tools or tactics for prevention. If Obama wished to direct us toward a new set of tools in which awareness was *part* of the modes of seeing and preventing HIV and AIDS, perhaps adjusting the question from "how can we expect" to "what can we do better" would meet this challenge?

Obama next appealed to how stigmas regarding HIV and sexuality complicate sexual education, or the absence of its effective and inclusive nature, in the United States. Part of a broader regime of health, sexual education is often a highly contested topic—with different sides of the discourse claiming that teaching young adults and children

about sexuality falls into either a parent's or public institution's domain of responsibility (though framed as an either/or, the productive and healthy choice for young adults would be a both/and decision for sexual health and wellbeing to be taught holistically in multiple intimate domains of their lives). *HIV* education within the US is an even more controversial subject, due to the powerful mental association that connects AIDS and gayness. Many people do not wish to discuss or address HIV, and these feelings often carry over into other community spheres and school systems. Though Obama didn't specifically allude to gay and bisexual men in his comment, the specific gendering of the individual "him" in regards to sex-education creates the possibility (at best) that he was referring to the dearth of comprehensive male same-sex sexual education in American classrooms—a dearth that is a direct consequence of homophobia and heteronormativity. At worst, he switched pronouns from female to male, and same-sex sexual education has been rendered an afterthought in an area where it should be central and historically salient. If an HIV endemic is perceived as a problem of government in Obama's address, here we see the first way that his policy questions an established "vocabulary of truth:" that the mechanism (*dispositif*) used for teaching sexuality and sexual health, the instruction and way of understanding sexuality and sexual behavior as taught in schools, is woefully underperforming specifically for gay and bisexual men in regards to HIV education or representation, and further under-informing heterosexual men of the risks faced by their gay and bisexual cohort mates.

The challenge of Obama's remarks, however, are that he never *explicitly* addressed the sexuality of the individuals in his speech text. While we are familiar with the sex of the boy who is undereducated or the woman who feels she has done something wrong, *their sexuality is rendered absent in the text*. For the boy who is uneducated, this is an absence that is very glaring considering Obama's comment about the history of AIDS as a "gay disease." Removing the sexuality of those for whom HIV and AIDS is a crucial issue, specifically for gay and bisexual men for whom sexual education is still clearly lacking. Obama's speech suggested and implied that contemporary sexual education that is inclusive is necessary, but in not naming this specifically he did a grave disservice to the cause for which he was speaking. As the head of the federal system dictating the United State's approach to HIV and AIDS, he served as the top of the governmental system that is assembling the grid that constitutes a regime of health and vocabulary of truth.

Foucaultian critique would see the normalization and mainstreaming of sexual orientation teaching for sexualities once deemed far too deviant for public discussion as a new frontier, something that had once never been considered possible. However, it would further question the relationship that Obama was constructing between the technologies of "accurate medical information" that are deployed to make sense of these sexual behaviors and risks, and further would question what was meant by a "sense of responsibility" that Obama raises. But again, *sexuality is rendered absent in this speech*, so the audience is left only to assume that Obama was speaking of same-sex male

behaviors through the absence of clarification and the association of HIV and AIDS with myths that must be dispelled through “accurate medical information”—in short, Obama used a queer “dog whistle” approach to speak of homosexuality without addressing it.¹⁶ The approach offered for mainstreaming same-sex male behaviors folds it into the governmental codes of conduct that are expected of all sexual-citizens, for whom this speech assumes as a general audience. This form of conduct, “sexual responsibility,” is further constructed a way of thinking that forms the subject—the individual at risk for HIV, most likely a gay or bisexual man—as an actor in his own sexual health. As we shall see below, this mechanism reinforces a specific part of the regime that focuses upon individual action and decision making and paramount to preventing HIV infection rather than seeing the endemic as a systemic problem. This systemic problem, which requires a specific way of directing action to address, was brought up in Obama’s next point.

However, the clear problem with Obama’s address needs to be stated and critiqued in detail: it did not approach *in concrete terms*, the role that stigma plays in the endemic at home, and the pandemic across the world. This flaw has dramatic implications. By not addressing stigma as its own piece of the larger grid or assemblage, Obama’s discourse failed to make visible a distinct possibility within the situation and moment that calls government into question. In a single paragraph, he addressed how an

¹⁶ This speech was delivered well before President Obama voiced his support for same-sex marriage in his second term. In many ways, by linguistically avoiding explicit statements about homosexuality, he avoided making any sort of comment for or against same-sex marriage in his first term. This provides context for his “inference and absence” approach to homosexuality here.

individual is not to blame when society stigmatizes them, or makes them feel “wrong,” but never did he ask why our cultures does that or how we could address this error—or better, *how it came to be* in the first place. This is a clear failure despite the honest appeals of the federal approach to stopping HIV and stigma: the approach adopted by President Obama did not account for the difficulty in openly challenging the stigmatizing cultural quagmire that is HIV stigma. In not doing so, this sets a dangerous precedent for the documentation of the United States policy documents and policy actions.

Government analysis, as a way of seeing how conduct operates across a grid in relationship to specific nodes of rationality that make possible action and intervention by actors and subjects, requires that such questions of how something comes to be are essential to understanding the operation of the governed and governing. While stigma is a shifting, hard to pin-down conceptualization today, it is important to remember that stigmas are always associated *as a relationship* (Goffman, Smith, Meisenbach) between the stigmatized and the associated marker that a stigma is placed upon. In this moment, Obama’s appeal to a larger audience and the call to reduce inequity, a compassionate aim, actually created a missed opportunity: here, the President had the opportunity to address how homophobia, as a pervasive social force, was still particularly powerful at home and abroad through myths and falsities often accompanying HIV. However, the notion of homophobia as specific for larger-scale approaches to HIV prevention did not fall into this vocabulary of truth; instead it was/is left out, as if it were a relic of the past. The failure to name homophobia as a specific piece of the continuing epidemic, which is part

of the general absence that sexuality plays in this speech, is a significant omission. Whether this was done to avoid discussion of *any* sexuality in the speech or to avoid potentially controversial commentary about homosexual behaviors, the absence of homosexuality or gay and bisexual men specifically created a problematic regime of knowledge for the address.

This project, however, does not concern itself *only* with the rhetorical appeals of one rhetorical actor in a prestigious, powerful position, but rather with how a distinct formation—stigma associated with HIV—operates as an assemblage that *manifests* in this moment. So Obama’s Remarks were but one piece of the federal discursive production about HIV. The ONAP, the White House’s arm of enacting AIDS policy, created a document that describes in greater detail the federal approach to combating HIV across the globe and in the US. Unlike the President’s address, this document does address stigma, but not in ways that directly and productively challenge stigma. Instead, the document shadows it in an ambiguous rhetoric of awareness that fails to be adequately defined.

The Federal (Revised) HIV/AIDS Strategy: Where Stigma Appears

Stigma *does* appear as an issue in the published version of the National HIV/AIDS Strategy in both its 2010 and updated 2015 versions. In the updated version, a full two pages are dedicated to the role that stigma plays in the endemic and how the ONAP perceives it to be an issue. ONAP determines stigma to be a confounding variable, or a piece of an issue that correlates to dependent and independent variables. Translated,

this view further reveals the primary flaw of the national approach—that stigma is not seen as *the* contributing factor, or variable, that perpetuates the endemic/epidemic and as such becomes part of “the soup” that national organizations must tackle in order to fight HIV.

The updated 2015 document defines stigma as “an attitude of disapproval and discontent towards an individual or group from other individuals or community and public institutions because of the presence of an attribute perceived as undesirable.” The document asserts that stigma may impact larger institutional forces (possibly including such social institutions as education, place of employment, and one’s family). This definition meshes nicely with Goffman’s. Further, when brought together, the social and cultural nature of Goffman’s stigma realms open up to the “larger institutional forces” mentioned by the federal government. Additionally, the document does suggest that research is needed to address structural interventions and reducing HIV stigma (“NATIONAL HIV/AIDS STRATEGY: UPDATED TO 2020” 22). Further, the updated policy for 2020 does actually address the necessary goal of reducing stigma through education and awareness (24). However, this claim is dropped into the bottom of the paragraph about “education and awareness.”

The ONAP thus couches HIV messages in a more prevalent rhetoric of *awareness*, a state of being greatly lacking in concrete description of the HIV endemic. How is one “aware” of HIV? What comes after awareness? Is it possible to be aware of HIV one day and forget the next (how convenient!)? These questions raise important

implications about the broader approach for confronting the spread of HIV. By positioning the primary approach for stigma reduction as part of a drive for “awareness,” the means of making stigma and HIV visible are impacted. By constructing the rhetorical appeals in “awareness” the ways of knowing what HIV both is and how it exists within the sexual environment of the United States is made intelligible via a larger part of the regime of health. This regime of health places the responsibility of understanding risk and “appropriate behavior” as governed subject within the individual. The subject, a sexual being at risk for HIV (in various contexts) is rendered responsible through the mechanisms and technologies of the regime—such as sexual health propaganda and sexually transmitted infections (STI) testing. Thus, awareness becomes a central part of the vocabulary of truth that is established in this form of knowledge-regime that creates the possibility of agency within the system. To be “aware” is to become both an agent of one’s own health and subject to the regime’s dictates of sexual health. Agency here allows the individual to act, but also requires that he or she be *acted upon* within the dictates of the regime’s systems of subject creation—who is and is not at risk for infection and requires what forms of information to become “aware.” This rhetoric of awareness is not without its drawbacks.

Most pernicious, the rhetoric of “awareness” creates a potential double standard for those who find themselves on the wrong side of the prevention campaign: should one test positive after having been rendered “aware” of their risks, where does this position the subject? Did he/she fail to behave as an appropriate sexual being? “Awareness”

cascades outward into other areas of prevention, where “awareness” rhetoric becomes central to HIV prevention campaigns. We hear as an echo from Obama’s speech the phrase of the young man in need of proper education about HIV for his own responsible behavior. Such a method of intervention creates a specific subject position in this failed health actor—the same individual who sees themselves as “spoiled” or “wrong” which Obama addressed. I expand upon this double bind in the conclusion.

To understand how “awareness” functions as a vocabulary of truth operating within a regime of health, the role of governing institutions must be explored. In an early excerpt from the updated National Strategy, the role of the government in constructing a productive conversation about HIV is expanded into a job that must be tackled by specific/all communities:

Educating the public about HIV is not simply the job of governments or schools. Over the past three decades, communities have taken it upon themselves to educate people in their areas about how HIV is and is not transmitted, and how to successfully utilize prevention tools—using destigmatizing and culturally appropriate methods. Especially in places where it is not feasible for the Federal, State, Tribal, and local governments to act, it remains the role of community-based organizations, faith-based leaders, constituent organizations, national associations, trade associations, and peer networks to provide educational materials, trainings, and digital tools for their specific community’s needs.
(NATIONAL HIV/AIDS STRATEGY: UPDATED TO 2020)

Recall from Dean that the role of proper governing and self-governance translates to three specific levels: that of leader, province, and citizen. Here, the role of middle-ground, province, becomes important. While the ONAP’s message shows the importance of a multi-faceted approach, the rhetoric falls apart when it attempts to explain that the responsibility of educating populations about HIV requires “destigmatizing and culturally

appropriate methods” which are not adequately described. They are specific to the community/province in question, and the role of “awareness” remains couched somewhere ambiguously between government actors (the leader’s arm) and non-government institutions (the arm of the province). This is not to denigrate the gains and efforts of communities of color, queer activists, or health advocates who have fought against HIV for the past three decades, but it instead attempts to render visible the ways in which responsibility for managing populations transfers from levels of governance at the detriment of clarification for whom and to whom these dictates are being delivered.

If we view this problematization as a grid, we see the illuminated light from a leader’s discourse render visible communities at risk in soft focus, leaving the viewer unsure of what he or she actually sees; in the movement from leader to province, or governor to system of governance, specifics appear to be lost along the way. Not until later in the document, in the section specifically addressing stigma and ways that the government is planning on reducing it in order to combat the endemic, do significant options for creating interventions among specific levels of government become better illuminated. The role that “awareness” plays in fighting stigma and enabling the process of destigmatization is not made clear by the ONAP. As part of the regime of health outside, we are left with a simple “yes” or “no”—someone is aware, or is not.

“Awareness” cannot exist in a vacuum; the regime of knowledge constructed to address HIV and AIDS must understand the interplay of forces that enable an endemic, notably, cultivating fear and hatred for men who have sex with men. Simply, the grid

must have its own awareness of the reasons for its own existence. Without defining what constitutes “culturally appropriate methods” for destigmatization, readers are left to wonder what cultures and groups are in need of “awareness.” What spaces exist outside the jurisdiction of Federal, State, Tribal, municipal, and community organizations where the rhetoric of “awareness” cannot permeate? Without naming such spaces or providing examples, the ONAP critically limits itself by closing off specific, unnamed groups who exist outside the scope of governmental space and cannot be reached by the grid of the “awareness” vocabulary of truth. Perhaps ironically, then, the ONAP further stigmatizes those who are “unaware” (or perhaps those living with HIV) as being incapable of (or left out of) self-governance within the terms set forth by the federal government. Further, such rhetorical closure raises issues of contesting systemic homophobia that serves as a confounding variable to HIV prevention. Do these spaces of rhetorical closure create untouchable homophobia? If the federal system has decided that there are areas where itself, state, or community agencies cannot act, the restriction of agency by the federal government’s actions is disconcerting to say the least.

However, in two significant pages the national HIV and AIDS strategy policy document offers a great look into what could serve as a unique way of combatting HIV stigmas and the myths that surround them—directly contradicting its previous “awareness”-centered rhetorical approach. The document calls for three significant implementations of merit: the re-examination of criminal laws, the enforcement of civil rights laws, and the promotion and public leadership of people living with HIV. These

areas serve as half-answers to what constitutes “awareness” and enables some areas of possible change, but shuts out others. The first two options presented are very significant; most laws that are written about HIV exposure and criminality were written during the early days of the epidemic before much scientific knowledge about the virus was known. These laws are inheritances of previous administrations and provincial understandings of the problematization of AIDS, a time period in which the perception of an HIV diagnosis was death—this is no longer the case, and this renders these mechanisms and rationalities highly problematic. Previous research has shown that these laws actually inhibit people from getting tested because they can create criminal liabilities and establish a fear of one’s status—creating a way of knowing that actually benefits not knowing one’s status (Brouwer). Further, HIV criminalization laws are slow to change. One state that has dramatically altered their laws to fit scientific advancement is Iowa, who was compelled to perform such a change after a successful lawsuit (Iowa Scraps Harsh HIV Criminalization Law in Historic Vote). The revision is not perfect, however, as it requires individuals to still be placed on a sex-offender registry that discloses their status for at least six years, as opposed to a lifetime on the registry.

Second, the fact that HIV is protected under the Americans With Disabilities Act (ADA) is not common knowledge; the ONAP here argues that people with HIV have a right to protection from discrimination and to have accommodations made. By implementing the ADA and rendering it visible for citizens, this law (a form of technology) should remind many Americans that people with HIV exist all around them

and are subject to fair and equitable treatment. A complication arises, however, because pursuing civil rights laws doesn't acknowledge the emotional cost that may come from filing legal disputes based on HIV discrimination, which touches upon those confounding issues of race, sexuality, and drug use. Much like one finds themselves on the wrong end of the health regime following an HIV diagnosis, individuals who choose not to file charges of discrimination are open to being blamed for their own self-preservation behaviors. Being able to manipulate the law in one's favor after being wronged for an HIV status is easier if one does not have to deal with being black in a white society, gay in a homophobic world, or admit to using injection drugs in a society that continues to demonize addiction. This solution conflicts with the previous solution where criminality laws must be re-examined because the intersectional nature of the lives of many people living with HIV creates a complex, contesting sphere when laws become involved—stigmas related to race and sexuality could inform legal decision making, justifying the creation of the laws in order to control those deemed as Other who bear a greater burden for the HIV endemic. This complicates the vocabulary of truth established by the federal government, who posits that as subjects and actors empowered to make decisions, their citizens should think and know themselves as well-governed subjects—never mind that the governing system seems a bit ungovernable.

The final intervention tactic presented by the document is the promotion of HIV positive people as exemplary actors in HIV service organizations and non-governmental organizations (NGOs). This solution is simply provided at the end of the section on

stigma, and no explanation for it is given in the text of the sub-section, but its implications are big. The argument for having people living with HIV in visible, leadership positions in advocacy and governmental organizations dedicated to HIV shows that the government cares about how people living with HIV are involved in its organizational structure, and that these people become examples for other people living with HIV. However, this argument also has a flaw—it requires that people living with HIV invest in a larger system which had failed them previously. For gay and bisexual men who would become involved in HIV prevention in governmental agencies, this argument would imply that they are responsible for educating a homophobic system rather than the system changing itself to meet the needs of its constituents. Though the argument could be made that this solution does not require one to *openly* identify as HIV positive, this possibility furthers the serocloset (the silence about one's HIV status) and perpetuates the traveling nature of stigma that marks bodies who are stigmatized by association.

Additionally, this solution to stigma is actively complicated by the stigma itself. To be openly HIV positive in a leadership position or in public draws attention that many people with HIV do not want directed at them; the dearth of openly positive role models in high profile positions—government or otherwise—was underscored recently when Charlie Sheen revealed his HIV status on the *Today Show*. Sheen's disclosure, which will be addressed later in this project, was accompanied by questions of whether the entertainer would be the new face for HIV in the United States. This creates a powerful

implication in governance. The individual who suddenly finds themselves under the scope of the public eye is, for many intents and purposes, now a “leader” for the movement and sits at the level of virtuous governor. His/her behavior now is expected to serve as exemplary to the organization he/she works for or with and then to the general population at large. The question of who should or should not be the face of HIV is beyond this project and for another style of inquiry, but the implication that someone should “represent” people living with HIV comes with this cost—the virus and the stigmatizing affects of its assemblage takes a giant psychic toll on anyone who makes their status known and steps into the spotlight. Further, the restrictions of agency become important for this individual as well; a celebrity may be more inclined to take this role though it may cost his or her career many roles or guest appearances. Activists and educators who make their HIV status known lack the amount of social capital and face-recognition that many celebrities may have, which raises specific questions of who and what can protect them from slander and defamation or other forms of professional and career related pressures and prejudices that may arise. This method of forming a subject as exemplar within the US regime of health overlaps with specific consumerist regimes and ways of knowing which are important to explain.

This discussion has served as a snapshot into government discourse on HIV at the executive level in two parts. By reviewing President Obama’s speech in the unveiling of the 2010 White House National HIV/AIDS strategy, the problematization of his administration’s approach to HIV becomes apparent, but his failure to voice stigma

openly became a catch in the system. Obama alluded to the issue that stigma creates in his address—but refused to say the word, and this has sincere implications. He alluded to the way in which the American education system has failed, dramatically, young gay and bisexual men, but did not voice that they have already been failed and inherited a situation that is largely outside their control. Instead, the discourse framed them as individual actors who must behave “responsibly” (i.e. “use a condom”) as the government takes steps to control the endemic. “Awareness”, then, also masquerades as “personal responsibility” in opportunities for HIV transmission; “awareness” is further muddled by the implication that one must be “aware” of their personal responsibility in addition to being “aware” of the realities of HIV. Obama proclaimed that solving inequity around the world is the best way to reduce the prevalence of HIV abroad, but doesn’t seem to address how fighting inequity at home could fix this as well.

Further, the document that outlines the approaches to addressing HIV in the United States—the National HIV/AIDS Strategy: Updated for 2020—fails to adequately see stigma as something integral to how HIV functions as an endemic, which Treichler notes by calling it an “epidemic of signification” rather than a “confounding variable.” While the document addresses how stigma overlaps and adds to the plights faced by many people with HIV in the US (poverty, racism, mental health and addiction struggles), it mentions that homophobia is a significant issue facing the endemic among gay and bisexual men *only once*. While the document further argues that laws must be reviewed to reduce criminality of HIV and should be based upon science, the document

fails to acknowledge that doing so requires the state legislatures to shift their opinions and education and “awareness” about HIV—something easier said than done. As part of the contemporary problematization of HIV, this approach fails since it doesn’t consider homophobia as part of its way of perceiving the crisis. This is made more complex as other laws which serve to protect people living with HIV from harm are misunderstood, underutilized, or are not enforced adequately. If “awareness” is the central part of this vocabulary of truth, and the laws and policies meant to protect LGBTQ people and people with HIV and/or AIDS serve as methods of deploying this vocabulary in order to create subjects that exist within the governmental structure, critics are left wondering what are the technologies of acting and being “aware” outside of regular testing and participation within the medical establishment that performs testing?

If the mechanisms designed to protect and serve people living with HIV are not capable of intervening due to an incomplete understanding of the problematization, a new way of exploring this challenge must be theorized and offered in its place. The honest appeals that the National Strategy makes are an acknowledgment that there is a problem with the system, but they fail to concretely grasp the nature of the cultural quagmire that is HIV stigma among a not-at-risk population in addition to at-risk populations. This is evident in the documents failure to address homophobia as a confounding stigma alongside HIV, which Paula Treichler made explicitly clear in *How to Have Theory in an Epidemic*. The governmental rhetoric of the ONAP is couched within a discourse of “awareness”-centric strategies that *imply* that rendering HIV visible through increases in

testing and holding people within HIV in positions of leadership can serve alongside culturally salient discourses of prevention and stigma deconstruction. And yet, the ability of those existing within this structure to have agency in making choices outside of testing is not addressed. Again, one is either “aware” or one is not—with no room for ambiguity or clear definition of what constitutes awareness, the position of the subject and his/her agency is left unanswered. If the ONAP would follow its own guidelines, and see that its own position would benefit from an increased holistic and multifaceted awareness of the cultural problem of homophobia and the complex nature of what is “awareness,” perhaps this approach would be more deployable and concrete.

Finally, the document offers an interesting proposal of highlighting and promoting people living with HIV in the organizations that address HIV within communities—however the document doesn’t address the psychic toll that openly wearing the stigma in a spotlight would have on people. As such, I highlight the problems facing government discourse that addresses HIV, though well-meaning and highly invested in by various executive agencies, as a form of empty rhetoric—an appeal that makes excellent show about what needs to be done or grasps a problem well, but falls far, far short on understanding the needs of how to fix the problem and upon whose shoulders the burden to address the problem should fall. To put this in terms of critical rhetorical practice, these appeals create a basic understanding of a problem of power—that HIV is in epidemic/endemic because of specific intricacies of power and action, and places a high burden on some populations more than others—but fails to critically and fully

interrogate how the machine of domination affects the populations. Stigma is not a “confounding variable,” it is a variable that can be contested if only the regime of health for this administration seriously undertook a critique of its institutional homophobia.

Thankfully, however, the executive branch of the government is not the only agency or governmental organ that attempts to address the HIV endemic. The CDC works in tandem with the White House to also create rhetorical discourse and artifacts that allow for an examination of governmental approaches to reduce HIV infection and, to a lesser extent, confront stigma. This is the third piece of this analysis, and it provides an excellent opportunity to examine how individual actors are created as subjects by ways of government.

Acting Against AIDS through Discourse: Awkward Conversation Can Save Lives?

Specifically titled “Act Against AIDS,” the CDC hosts a multi-faceted program that attempts to reduce HIV through education, with various campaigns targeted at raising awareness, pushing for testing, and prevention campaigns aimed at lowering infection rates. The campaign is a joint initiative by both the Obama White House and the CDC that seeks to “combat complacency about HIV and AIDS in the United States”—though the website fails to account for where this complacency originates (“About Act Against AIDS”). This may, perhaps, be the closest thing to a definition of “awareness,” as that which constitutes being “vigilant,” the opposite of complacency. This differentiates President Obama’s address on the initiation of the new strategy, where the goal of reducing stigma was implied through his language use. The difference between

cosmopolitanism, or the acceptance of a variety of HIV statuses, and vigilance against the spread of HIV is a marked contrast.

Additionally, the larger campaign is broken down into multiple sub campaigns appearing on the Internet, radio, television, newspapers, and magazines—technologies deploying the mechanisms of governance from the regime of health. Specific testing campaigns, which encourage people to get tested for HIV, address specific dual minority populations such as African-American women, African-American gay and bisexual men, and Hispanic gay and bisexual men—addressing specific forms of subjects who are at heightened risk for HIV exposure. While one “awareness” campaign exists to bring the way in which HIV impacts all Americans to light (“Lets Stop HIV Together”), only one prevention campaign is provided on the Act Against AIDS website. The “Start Talking. Stop HIV” campaign aimed at gay and bisexual men declares a goal of “encouraging open discussion about a range of HIV prevention strategies and related sexual health issues between sex partners” (“Start Talking. Stop HIV”). The “Start Talking. Stop HIV” campaign specifically places itself as a communication-centric campaign that argues “[e]ffective partner communication about HIV can reduce HIV transmission by supporting HIV testing, HIV status disclosure, condom use, and the use of medicines to prevent and treat HIV”. This rhetorical move seems to create “awareness” and being “active” as part of the act of talking about sex and risk. Since the rhetoric of “awareness” is serving as a vocabulary of truth, and the technologies of for acting within this vocabulary include both testing and disclosure, the health regime begins to coalesce

around the campaigns the CDC creates, but does not adequately confirm what “awareness” means; this critique is apparent throughout. This regime attempts to move from theoretical to visible within the discourses of the campaigns, described below. The movements here add up to a regime of health that is structured around “awareness” that is never adequately or concretely defined. Ways of being within this regime are further relegated to one’s own perception of ‘personal responsibility’.

“Start Talking. Stop HIV” frames itself as a conversation and communication based campaign which posits that before sexual encounters, men who have sex with men should discuss HIV testing, status disclosure (or revealing one’s status), and talking about safer sex options. The website begins the conversation starters section by admitting that talking about HIV can be awkward. However, these offerings for “breaking the ice” do not also include how to gauge a correct moment, how to read body language, or what to do should the conversation go wrong. Further, many of the conversation starters “drop the ball” half-way in and seem unrealistic. For example, the website suggests looking at the web-page together and watching the videos contained on the website together if one partner is unsure about how to talk about HIV. While this seems like great advice, it feels quite surreal to imagine that two people would sit and look at an informative website and campaign youtube video prior to sexual intercourse (“Conversation Starters”). Though the website specifically frames that it is important to not wait until the heat of the moment to discuss HIV statuses, the website also doesn’t offer any advice to have the conversation in such a way that does not potentially ruin the moment, since, right

underneath the point about showing a partner the website, the next piece of advice is to not force it into the conversation. Significantly, the nuances of interpersonal and romantic interaction are lost to the government mindset of the regime of health. Further, the “aware” individual who has adopted the vocabulary of truth is positioned within a challenging agency situation: to act upon the regime of health and enact the vocabulary of truth via “awareness”—he or she must address HIV preferably before or the act of sex and intimacy is initiated. Commonly, this rhetorical trope is channeled through language such as “bring it up before you get it up.” Such linguistic phrasing acknowledges, awkwardly, that government and proper conduct is not inherently sexy.

By supporting a range of efforts to reduce infections that include disclosure, testing, condom use, and medications (or as I term this, “pharmaceutical intervention”), the campaign actively attempts to combat the continuing endemic among gay and bisexual men by recentering life and its value in the regime of health. This can be seen in the single-sentence tag on the website’s cover page: “*Your life matters and staying healthy is important*” (italics for emphasis, “Start Talking. Stop HIV”). Linguistically, this appeal is complicated by the “and” that splits the phrase in two: is the reader supposed to question that being healthy is important? Is the placement of “your life matters” a means of addressing a social system that still devalues gay and bisexual lives? The positioning of the “and” renders the second half of the sentence an afterthought—“oh, I matter, and I should be healthy, too.” But what exactly does the website address as

“health?” As the backbone of the underlying regime, health is rendered a nebulous construction.

To answer the question, the “Start Talking. Stop HIV” campaign jumps back to the “Act Against AIDS” campaign which dances around defining “health” in any format until the page of “Living with HIV” where “health” implicitly is defined as either being on successful medical therapy or anti-retroviral (ARV) medications. Further, the “Prevention” page never outwardly declares that “healthy” is defined as being HIV negative, but sloppy language in its first sentence (“today, more tools than ever are available to prevent HIV”) leads a critical reader to question whether the page is intended to provide information to negative individuals or to also inform positive individuals how to protect their sexual partners. Only two of the twelve example questions offered on the web page¹⁷ are directed at people living with HIV: for people to protect their partners (#10) and for mothers to protect their babies (#12). These further back up the rhetoric of “health” as being on drug therapy and seeing doctors regularly. Further, this rhetoric of health is buttressed by the same governance behaviors that are repetitive throughout both campaigns: taking medication *correctly*, using a condom *the right way*, and *choosing* less risky *behaviors* for sexual intercourse (“HIV Prevention,” italics for emphasis).

As a sexual health campaign, these articulations of “correct behavior” create a specific opportunity for understanding the “proper subject” who sees themselves as an

¹⁷ The option for drug use (#11) is remarkably stigmatizing, as it begins with the “stopping injection drug use” appeal, as if the reader hadn’t heard it before.

empowered actor in their own health. Such a rationality positions those who fail to perform adequately lower on the hierarchy of visibility: in each section of the “Act Against AIDS” campaign page dedicated to HIV facts, information for people living with HIV is positioned after or below information for people who are seronegative. The positioning of such information cannot be unintentional and raises serious questions about whether the CDC actually seeks to completely halt the endemic by using a holistic approach and reducing stigma or if it still privileges older systems of behavior change or control. This analysis of the governing discourse in the regime of health seems to suggest the latter.

In returning to the “Start Talking. Stop HIV” campaign, the technologies which deploy the vocabulary of truth, part of a larger regime of health set out by the “Act Against AIDS” campaign, begin to manifest. “Start Talking. Stop HIV” begins with the statistical information that in 2011 “a study in 20 U.S. cities with high AIDS prevalence found that 18% of gay or bisexual men had HIV”. The website further breaks down this prevalence, or 1 in 6 gay or bisexual men being HIV positive, by noting that of those 18%, one-third did not know their status. Further, the website does return some sexual agency to gay and bisexual men by noting that multiple strategies of prevention exist, and that through communication “the right prevention strategy that works for you and your partner” can be found (“Start Talking. Stop HIV”).

I elaborate next on what the campaign does well—its inclusive and wide-appealing posters—and what it could do better—talking and conversation starters that

actually sound like human conversation. Unlike the larger “Act Against AIDS” campaign, the “Start Talking. Stop HIV” campaign embraces first explaining why HIV is such a problem for gay and bisexual men, and one category includes stigma as a barrier for engaging in health care and testing and from seeking support through friends or family members. However, this approach does not address how structural homophobia may impact the perception a gay or bisexual man has of himself, such claims are systemically absent from the larger regime of health. Though a greater and more culturally nuanced explanation would be beneficial, this rhetorical tactic that begins by explaining some reasons why gay and bisexual men are at higher risk evolves out of the ONAP’s approach for culturally appropriate means of preventing the spread of HIV.

One area that the campaign succeeds in doing well is its vast array of campaign materials. Specifically, the posters that are constructed from the governmental vocabulary of truth (staying negative, protecting others) are dramatically inclusive of gender identity, age, ethnicity, and ability. Each poster addresses the viewer with an appeal to discourse such as “talk before you play,” “talk can be the perfect foreplay,” and “talk before you...” (“Start Talking, Stop HIV” Posters). Of the ten posters, seven position the action between two men in an intimate setting (the bathroom, a restaurant, on a walk) and three show the use of technology (a phone) with an intimate other. While each poster has a different headline, the text below is generally the same: “Protect yourself and your partner. Talk about testing, your status, condoms, and new options like medicines that prevent and treat

HIV. Get the facts and tips on how to start the conversation ...” and then links to the CDC website.

While overall very reflective of many people’s experiences (including one poster that shows two people interacting via smart phone), one of the posters does touch upon one of the major flaws of this entire campaign: the verbiage leaves something to be desired. One poster specifically states: “Before sweet nothings, whisper something that can keep him safe.” Such a claim seems contradictory to the campaign’s method, which seeks to have people living with HIV be able to disclose their status easily, which would not imply a whisper. Further, by positing that the individual must whisper something to “keep him safe” the poster implies that the individual himself is dangerous and the implied need to protect “him” positions the masculinity of the dangerous individual at risk as well. Aimed at creating specific types of health actors, the engaged, healthy, and “aware” individual, the governance of these posters clearly follows the regime of health initiated by the CDC which can miss the mark on stigma and reinject it into the discourse, even in instances where many other forms of communication are done well, such as being inclusive and mentioning multiple strategies for prevention including condoms, ART, and PreP.

Much like the “Act Against AIDS” campaign appeared to use hierarchical placement to favor HIV-negative readers on its web-space, the “Start Talking. Stop HIV” campaign appears to favor discussion of testing and asking about status. Further, a sincere disparity in quantitative offerings is made for how to approach conversations

about HIV. Divided into six areas, nine conversation starters are dedicated to testing, seven are dedicated to talking about one's status, nine again to talking about safer sex, three each for both revealing one's HIV-Positive status and learning that a partner is HIV-Positive, and a paltry two conversation starters are dedicated to discussing living with HIV (which is somehow separated from disclosing a positive status). With such a mathematical imbalance in addressing negotiating HIV once a partner reveals their positive status, the burden of negotiating the complexities and awkwardness falls, apparently, on people living with HIV to make up the difference in their conversations. As such, it can be hard to imagine people living with HIV having much of the one thing the website suggests will make the difference: confidence.

Chances are if you're confident and bring it up without judgment, your partner will be open to the discussion. For all you know, he could be just as worried as you to bring it up. Just remember, nearly everyone who is having sex will have this conversation at some point, and many other guys before you have already done it ("Conversation Starters").

The sum total of problems in this section of the campaign is staggering, and this disconnect reveals the major flaw of the campaign: a dearth of attention paid to the mental, affective costs that HIV and the stress/fears of it place on men who have sex with men. Specifically, the imbalance of materials aimed at men who know they are HIV+ despite statistical documentation that argues that it is people who do not know their serostatus which fuels the endemic, creates critical issues that this critic cannot ignore. It is no wonder, then, that men who know their HIV+ status fear disclosure since the

discourse of necessary disclosure as part of the “awareness” regime is positioned within a precondition of rejection and uncertainty by those to whom he is disclosing his status.

As such, this environment of fear fuels the stigma that perpetuates the endemic of HIV. Much like how the “Act Against AIDS” campaign attempted to explain the disproportionate risk faced by men who have sex with men but failed to address how homophobia fit into the epidemic, the “Start Talking. Stop HIV” campaign doesn’t problematize issues of mental and psychic trauma that gay and bisexual men carry in a society that still wields heteronormativity as the disciplinary norm. Such traumas create the problematic lack of confidence that creates the possibility for gay and bisexual men to fail to adopt the rationality of a vocabulary of truth that places them as actors within the larger regime of health. Simply put, conceptualizing gay and bisexual men as agents who should “just do it” in regards to having conversations about HIV as part of the national HIV strategy fails to connect how the lives of gay and bisexual men are separated and disconnected from the larger society that creates the strategy to begin with.

Conclusion: Governing Bodies, Governing Health

As a campaign of government, specifically aimed at instilling proper behavior or conduct that a government regime establishes into health conscious subjects, such campaigns are often challenged to adequately address human interpersonal challenges in their materials. By tracing the movements of government analysis through first President Barack Obama’s speech regarding the National HIV/AIDS Strategy, a rhetorical critic can first admire the President’s nuance in attempting to cover a large range of policy

needs and to connect his administrative approach to HIV to a larger geopolitical war on poverty, but such an approach specifically left something to be desired since the President failed to utter the word “stigma” once during this speech; further, his failing to address how homophobia plays into the endemic both nationally and internationally leads to the questions raised specifically by the document which outlines the National HIV/AIDS strategy that references homophobia only once, and as an offhand remark. This document further offers an interesting way of conceptualizing stigma, but fails people living with HIV who it places in a unique double bind of having to reveal their status or toe the line of stigma. Finally, the “Start Talking. Stop HIV” campaign created by the CDC appears to adopt a more human approach to getting gay and bisexual men to discuss their HIV statuses, but underneath the surface it replicates some of the same governmental rhetoric that is enacted by the “Act Against AIDS” initiative that, drawing from the regime of health, perpetuates a vocabulary of truth which largely omits stigma from methods of intervention and creates subjects that are woefully underprepared for confronting it.

Specifically, the prevention strategies adopted are predominantly aimed at preventing people from getting exposed, but the campaign also address the 12.8% of people who are HIV+ but do not know it. According to their own documentation, these individuals constitute a majority of new infections and those infections which stem from them. However, this group is completely left out verbally of the CDC’s explanations on the “Act Against AIDS” page as a significant contributing factor of the epidemic.

Whether intentional or not, this is a rhetorical shifting of blame over to people who know

they are HIV+ rather than saying that the most important tool in prevention is regular testing, which isn't even addressed on the "Testing" page of the CDC's website. If regular testing is an issue of governance and following the acts of the "awareness" vocabulary of truth, then the why does the repetitive message of "1 in 8 people with HIV don't know they have it" keeps coming back? The absence of a collective statement in this endemic, that one can reduce their risk *to others* by getting tested regularly, is disturbing. Even though the one-in-eight message is usually banded about prevention and testing materials, why isn't that one person's risk to others ever seriously addressed? If this analysis makes but one thing clear, it is the inability of the "awareness" centered rhetoric of the CDC's vocabulary of truth, and the campaigns constructed around it, lacks in one thing: the danger of being not "aware" and its impact on others. While the danger of HIV prevalence and proper behavior is made clear through "awareness" centered rhetorics of agency toward prevention of HIV contraction in oneself, the rhetoric fails to go the other direction and clearly poses the threat one may be to others by being not "aware."

A qualitative review of the suggestions put forth specifically by the CDC could be exhaustive, but such a review does not address the governance rhetoric that is the focus of this chapter; further research is needed (from many paradigms) to explore the communicative nuances of this campaign. However, this chapter raises an important question: *if the CDC doesn't address stigma well, then who does?* The next chapter in this project moves from government analysis into biopolitical analysis, specifically

biocriticism, and explores how texts and artifacts that are created as consequences of the government rhetorical approach, specifically NGOs and blogger activists, may actually confront stigma in nuanced ways that governance discourses cannot. The opportunities for intervention contained in such approaches cannot be underestimated.

3. “We’re Not in 1984 Anymore, To+o”: The Stigma Project’s Conceptualizing of HIV Neutrality Through a Critique of Personal (Bio)Insecurities and the Possibilities of New HIV Animacy Hierarchies of Risk

In recent years, countless governmental agencies and global bodies have proposed a dramatic challenge to the global pandemic that is HIV: the creation of an AIDS-free generation. As then Secretary of State Hillary Rodham Clinton stated in 2011, the very notion of an AIDS-free generation “is possible with the knowledge and interventions we have right now. And that is something we’ve never been able to say without qualification before. Imagine what the world will look like when we succeed” (PEPFAR Blueprint). Similarly, Carla Bruni Sarkozy greeted a UNAIDS delegation in Deauville, France, with the aspirational challenge of ending mother-to-child HIV transmission by 2015 (“G8 Summit”). Sadly, this reality did not come to pass. Meanwhile, South African President Thabo Mbeki is deservedly and repeatedly criticized for his intense AIDS denial during his presidential term, drawn from influence by scholars and AIDS denial activists such as infamous Dr. Peter Duesberg, by claiming that HIV doesn’t cause AIDS, but that poverty does. This rejection resulted in the deaths of around 300,000 people from AIDS during Mbeki’s presidency (Boseley).

Each of these three prominent, global incidences raise specific questions about dominant governmental approaches to addressing change from policy down, rather than

through contextualized, cultural interrogation of how HIV pandemics/endemics continue. As I addressed in the previous chapter, governmental bodies and agencies often approach issues of global and biopolitical significance in ways that miss cultural and rhetorical nuances that perpetuate endemics and contagions among specific populations. Specifically, the previous chapter demonstrated how President Obama's administration did not adequately confront cultural and interpersonal stigma through the Office of National AIDS Policy and Centers for Disease Control and Prevention campaigns.

Though the examples given above address a world stage, this project specifically examines the effort within the United States to end or limit the ongoing endemic of HIV among gay and bisexual men. Unlike parts of the world where HIV is in pandemic, the advanced medical infrastructure and access to life-saving medications within the United States frames HIV as a chronic manageable condition, rather than a pervasive, serious illness that will result in death¹⁸. Though access to, and quality of, care and medication remains an issue, advancements such as the Affordable Care Act and the Ryan White Act before it specifically address the challenge of getting care and life-saving medication to people who need them. The goal of such efforts is not just the stemming of the infection and the slowing of the endemic within the United States, but ending the scourge of AIDS completely. An example of one state-actor doing this is Governor Cuomo's AIDS-free

¹⁸ This is, of course, dependent upon access and management of a series of barriers within the health insurance world. Under the Affordable Care Act, access to health care for people living with HIV is dramatically improved. Whether this breakthrough law will remain under the Trump administration remains to be seen.

New York 2020 campaign. Using testing, anti-retroviral access, and increased adherence to Pre-Exposure Prophylaxis (PrEP), the campaign seeks to end AIDS deaths and HIV infections in New York state by 2020. Obviously, such an undertaking is quite a challenge, and the myriad logistical needs created by such an endeavor are the domain of governing bodies.

But with such a framework of providing care and interventions in place, another major challenge can be tackled: changing cultural practices and beliefs that strengthen stigma surrounding HIV, a consequence of the epidemic of signification surrounding AIDS that continues to result in myriad material consequences for people living with HIV or those at highest risk to contract HIV. Many people in the US who do not feel themselves to be at risk for HIV or who are very disconnected from the endemic often are surprised when they are reminded that HIV is still a major issue for gay and bisexual men in the US and/or that HIV is re-approaching pandemic among populations of color.

Thankfully, the United States Government and its federal agencies do not tackle this challenge on their own. Various charities, grassroots organizations, cultural groups, and citizen collectives—otherwise known as Non-Governmental Organizations (NGOs)—assist in the ongoing struggle to reduce HIV prevalence and continue conversations about HIV (often using the word “awareness”). However, where governmental agencies are often challenged to negotiate and shift cultural rhetorics and behaviors that continue stigma in favor of non-stigmatizing behaviors, these NGOs often create more diverse and rhetorically complex methods of addressing the ways in which

stigma discursively moves through populations. One such organization, The Stigma Project, furthers an ideal known as “HIV neutrality” as a way of moving beyond stigmatizing beliefs about HIV with a goal of “reduc[ing] the HIV infection rate through knowledge, awareness, and effective marketing and advertising. Ultimately we see a future where the world is free of HIV/AIDS” (The Stigma Project, “About Us”).

Creating an AIDS free or HIV free world is no small endeavor, and the biopolitical and rhetorical implications of such a goal are tremendous. Further, the possibility conceptualized by a subject position of HIV neutrality is deserving of critical attention. This chapter explores the intricately complex notion of HIV neutrality by first framing various understandings and articulations of immunity discourses in biopolitics before synthesizing Lisa Këranen’s notion of biocriticism and Mel Chen’s notion of Queer animacy. The importance of the immunity paradigm in biopolitical discussion cannot be understated, but it is also a foundational piece of the project of biocriticism, a movement of rhetorical critique in the sub-discipline of rhetoric of health and medicine proposed by Këranen. As I demonstrate, this nuanced constellation of theory provides an excellent foundation for framing the implications of and possibility for an HIV free world. After drawing together such a framework, this collage of theoretical perspectives provides an interesting vantage point for critiquing The Stigma Project’s concept of HIV neutrality. Having applied the theory to HIV neutrality, the application of neutrality as a subject position becomes a challenge. However, this application is made possible by the rejection of the contemporary HIV positive/negative binary in place of a larger, more medically

nuanced continuum of HIV statuses that is proposed by blogger Renato Barruco. As such, this chapter is framed as an exercise in the exploration of biopolitics or biopower and the application of Käränen's notion of biocriticism in two parts. The exploration of these two areas creates an interesting rhetorical tile for the mosaic of this project: how do NGO/Grassroots organizations create new ways of understanding HIV and AIDS in a way that is different from, but not antagonistic to, federal rhetorical discourses? The Stigma Project addresses a discursive lack that is created by this, and when combined with Barruco's new animatic hierarchy of risk, inadequacies in the previously discussed tile (federal discourses of a regime of health through "awareness") can be addressed through a radical subject position of HIV neutrality. This textual tile is perhaps the most significant of the three addressed in this project.

Immunity and Biopolitics

Drawing from the definition Foucault's biopower, biopolitics considers as its domain the overlap of life and politics, or when "life itself" becomes the topic of political discourse with vast, diffuse implications for what qualifies as the realm of politics within life's sphere (Foucault, "Security, Territory, Population"). Esposito notes that the immune paradigm becomes central to discussions of life and biological reality in the moment when rhetors stop talking about specific life forms and their interactions on a grand scale. Instead, the rhetorical focus falls on the intricacies of biopolitical interaction—specifically the challenges and anxieties of biology and politics (Esposito, "Biopolitics"). Esposito abstracts the body away from something that we inhabit with a

mind, to something that is dependent upon being kept alive; that the moment it becomes “*touched by death*” it ceases to endure (Esposito 316, italics for emphasis). In such a way, the body also serves as a metaphor for the national body, the larger social system that defines that national discourse (“body”) of politics itself (318). Central to Esposito’s positioning of the body and its immunological characteristics is the acknowledgment of that which is outside the body—the environment that the body comes into contact with, which is rife with agents of death (325). The biocritical perspective developed in this chapter begins with work that specifically explores immunity as it relates to biopolitics.

To understand how immunology functions biopolitically, a reader must see bodies/the national body as being both always connected to something inside and something outside of itself—the rendering of this separation and the regulation of what comes in and heads out of these spaces is central to an immunological paradigm of biopolitics. The immunity paradigm speaks to “the need...for immunity barriers, protections, and apparatuses, aimed at reducing, if not eliminating, the porosity of external borders against contaminating toxic germs” (327). Esposito writes introduces the concept of *pharmakon*, from the Greek word for both poison and cure, as a means of balancing the immunocological system. Thus the body (personal or political) comes under attack by something that is both outside and a foreign element to it (such as a disease or social discord), rendered inside by something integral to the bodies’ processes (such as sex or social interaction with human others of another culture).

Drawing from Paracelcus, Esposito posits that the way to heal is not to work in opposition to antagonism from outside the body, but instead to incorporate pieces/parts of its principles into the body to prevent against total failure of the system, similar to inoculation of vaccination. The cure is dialectical: “the way to remedy a disease is by administering it in forms and doses capable of bringing about permanent immunization” (329). When barriers and protections (walls and rubber gloves) are not enough, the answer is then to vaccinate socially and biologically against people and/or disease.¹⁹ But immunity does not just reference dialogic relationships between antagonistic parasites and populations. Since one of Esposito’s clear implications about immunity systems is that human interactions spread disease, the nature of human economic interaction must also take into account the spread of disease and social ills/ideas.

Much like the Middle Ages, when warfare spread plague, today we have to understand movements of leisure, trade and labor as being part and parcel with the movement of disease and toxic conceptualizations from place to place. However, this shift from warfare to economics and leisure as primary spreaders of disease does not change the means by which we conceptualize the immune systems of the body or social systems. Donna Haraway writes of the immunological paradigm being the model for understanding late capitalism as a network of symbolic and material difference. This network is informed through vast matrices of belief, knowledge, and practice that account

¹⁹ This is not meant to be glib, and I recognize that it comes with distinct problems and consequences for very specific populations, as this project shows.

for the self and the other, and is based on systems of military force (275). Haraway's thesis, that the immune system serves as an "icon" for how knowledge about society is understood, shapes the way that "other" bodies are experienced, recognized or misrecognized in postmodern discourses that are becoming highly biopolitical—discourses where life itself becomes the subject of political discussion and the realm of immediate concern. She argues that the body serves as a "highly militarized" strategic and symbolic system that is built upon the biomedical recognition and misrecognition of complex meaning (283)—opening the door for the spread of disease and contagion.

Haraway's claims expand the concept of immunology from simple discussions of contact with death (and the avoidance of such contact) to a militarized system that *reinforces* our defenses against contact with death. This "coded text" must be read through the interrelated movements in humanistic discourses that exist during moments of decolonization, worldwide militarization, and multinational capitalistic drives that push into new frontiers of profit and identity (283). Where Esposito focuses on the nature of cure, Haraway addresses how difference codes these interactions of economic significance through a metaphor of competition and militarization, which perpetuates immune discourses (broadly conceived) in postmodernity. The challenge, however, is that social understandings of the biological immune system of the human body are dependent upon reflections of this metaphor.

Within this paradigm, Haraway notes that disease serves as an "information malfunction" where transgressions or misrecognitions of the self occurs among bodies

that are “marked” by difference. Treichler’s *How to Have Theory in an Epidemic* and the epidemic of signification that surrounds AIDS infuses the power for marking bodies. Drawing from Nobel prize winning immunologist Niels Jerne’s theory of the immune network, Haraway constructs the concept of communicative immunity as the process of always already reacting to the world outside. Much like an immune system T-cell, communicative immunity must always be both an antibody against an outside force it has recognized, and the ability to replicate/reproduce itself in other locations of the body (291). The immune system does not operate under a self-other paradigm, for it “mirrors internally” the necessary responses to the outsider that it has recognized—this creates an *internal image* of what the immune system should look like, what it should respond to and how such responses should occur.

Haraway’s dense reading of immunology creates a potential opening for biopolitical theory: communication systems that are performative and human created mirror the bodily processes created by the immune system as it has been understood/theorized through a metaphor of economic and human competition. While Haraway’s reliance on science at first seems to suggest that human interaction may be entirely pre-ordained, it actually opens up a rich possibility for communicative analysis of critical, humanistic problems. Haraway creates the matrix for a system of self and non-self recognition: the possibility of accepting, under specific circumstances, the semi-permeable self to engage with others in moments of “finite consequences” and “specific possibilities” or “fusions and dangers” which helps the process of visualization of the

semi-permeable self in contexts of biomedical technology and the everyday life (290-291). Following the explosion of scientific discourse in biomedical science and popular culture, the immunological system recreates itself within and provides metaphor for the ways human understand the immune system. She specifically describes how media depictions and explanations of AIDS mirror the political discussion of war and colonialism that engaged the “other” in complex relationships of power: The body fights an “invasion” it does not recognize; the immune system falls to the mass-produced HIV virus. Haraway raises the essential question: “when is the self enough of a self that its boundaries become essential to entire institutionalized discourse in medicine, war, and business?” (297).

While Haraway was focused on how the understanding of the immune system was similar to that of a militarized system, Peter Sloterdijk instead focuses on how our understanding and focus on immunology reflects anxieties surrounding trade and the migration of bodies. Current understandings of immunity systems disconnect from contemporary cultural contexts, creating a paradox: older variations of homogenous immune-systems made of specific ethnic or political identities are falling apart in modern social interaction, creating the need to admit new ideas, new blood into once closed societies. Globalization specifically threatens the immune paradigm of those who believe a national container may protect them from outside contagions.²⁰ As such, it is necessary

²⁰ There is an opportunity here to discuss HIV and AIDS in Asia as originally being something China, Hong Kong, and Japan did not feel a need to “worry about” because they were “separated” from the problems of the west by geography and politics. This turned out to be, obviously, false.

to allow in a small part of the contagion to train the immune system to rebuff the contagion's advances, a form of social vaccination similar to herd immunity, operating in what Sloterdijk calls "thin-walled" societies—social groups that are strong, reflexive, but also vulnerable to outside influence.

The immunity paradigm dovetails with recent work from communication studies that falls under the umbrella term *rhetorics of health and medicine* (Scott, Segal, and Këranen, 1). This work discusses the broad array of health publics, the discursive practices, and the intersection of these practices within or outside of medical institutions. People interact with a vast number of health related texts on a daily basis, and that a constellation of symbolic and material rhetorics impact the daily lives, public meanings, and practices of global populations (Scott, Segal, and Këranen 2). As with all rhetorical criticism, the rhetorics of health and medicine aims to allow us to "see" or "question" differently a practice, culture, or problematic. The specific method aiding this pursuit is biocriticism, which Këranen describes as the rigorous study of "artifacts, texts, discursive formations, visual representations, and the material practices positioned at the nexus of disease and culture" ("Addressing the Epidemic," 225). Biocriticism evolves out of a movement within the study of science, specifically rhetoric of health and medicine, uniting "disparate fields...around the pressing problem of biological 'security' and, to borrow a Foucault inspired phrase from Nickolas Rose, 'the politics of life itself'" (226). Biocriticism studies how discourses connect humans, politics, and medicine as part of making live or letting die.

Providing an example of biocriticism, Këranen writes that the creation of a national program for biosecurity and counterterrorism represents the very visceral fear of bioterrorism that accompanied a world post 9/11 (“Review Essay”). Specifically, the perception that humanity is vulnerable to biological agents, either augmented or naturally occurring, creates a very real exigence for crafting some sort of preparedness or response system to biological attack—which Këranen terms bio(in)security, or the perceived risk of biological catastrophe. Bio(in)security creates “linguistic and cognitive bridge[s] uniting public health to national security through a vision of bioterrorism and catastrophic risk” (455), as in the funding/attention “bonanza” following anthrax laced letters arriving in Washington, DC, or the (false) pretenses of an Iraqi biological weapons program in the early 2000s. The dramatic portrayals that a few spores or one outbreak of a viral agent could result in catastrophe, despite assurances that such a possibility was highly unlikely, helped promote a biosecurity apparatus that created its own problems in the 2000s.

First, the massive amount of funding being redirected toward biosecurity creates an imbalance in national priorities, which is mirrored by the movement of scholars and scientists toward national defense instead of pressing, high-mortality problems—specifically HIV and the global AIDS crisis. Second, the possibility that augmented viral agents are being created in order to defend against such attacks creates the possibility for their use as weapons; inviting the potential that, bioterrorism be damned, these pathogens and viruses may simply be “mishandled” at one of the growing number of biosecurity labs or sites where toxic and highly contagious materials are stored in order to study or

keep safe a population. Such problems create a fear of viral outbreak that results in the end of civilization: the notion of “viral apocalypse,” which will prove significant in Chapter Four’s discussion of how popular culture representations help spread the endemic of HIV stigma.

The fear of “the plague” and ensuing casualties and collapse is fodder, as Këranen notes, for popular culture to back the rhetorical appeals of government and biological agencies. Films and television programs such as *28 Days Later* and *The Walking Dead* reinforce the apocalyptic imaginary, whereby “economic and cultural life terminates, cuing audiences to interlinking of pathogenic risk and international stability” (461). Rhetorics of viral apocalypse simultaneously capitalize upon the national insecurities of social, political, and economic life that promotes fears of the Other outside. Such fears and anxieties provide the means of social destruction—positioning viral apocalypse rhetoric and bio(in)security as a complication for and oppositional to immunity rhetorics and discourses. Viral apocalypse is the result of a failure of the national immune system to defend against some sort of biological rupture.

In the previous chapter, I discussed how governmental rhetorics required the conduct of rhetorical actors to follow a horizontal continuum along national to individual lines: what one actor, either citizen or governor, does to govern themselves along a regime of health, so, too, should the nation or province. What causes fear in the national body also, realistically, scares the personal and individual body, so it follows that national and institutional moves based on apocalyptic fear, mirrors a psychological and

interpersonal insecurity about germs, viruses, or infectious diseases. As noted above, the “drain” of resources and labor power from emerging pathogens and contemporary “plagues” such as HIV and AIDS toward civilization-ending catastrophe further mirrors a governmental and social move that follows national priority away from underserved and needy populations elsewhere.

Stigma is a critical way of advancing fear-mongering around viral invasions and ruptures in the body politic’s immunity. Such hierarchies of attention need to be addressed in order to understand how attention paid to one area impacts or affects the attention paid to others. If a national attention for bio(in)security mirrors personal bio-insecurity about one’s immune system or health, how then can such insecurities be reconfigured in order to address stigmas that perpetuate inequity, insecurity, and biopolitical Othering? To help address this question, I turn next to the notion of animacy hierarchies developed by Mel Y. Chen. Reconceptualizing animatic hierarchies of risk and calling into question the rhetorical power of anxieties surrounding personal insecurity creates possibilities for the national discourse about HIV and risk, thus providing an important tool for biocritics and the ongoing rhetorical mosaic constructed in this dissertation.

Animacy Hierarchies and our Personal (Bio)Insecurities about Sex (Acts)

In her book *Animacies: Biopolitics, Racial Mattering, and Queer Affect*, Mel Y. Chen discusses recent movements in sexuality, race, environment, and affect to consider how differences between living and perceived inanimate matter illuminates differences of

power in cultural life (2). As Chen writes in the book, her permanent challenges caused by lead poisoning directed her to examine the linguistic need of structuring what bodies matter and what ones do not based upon the measure of wrongness society attributes to it. Chen states that the goal of her critique is to explore the biopolitical reasoning behind who or what “counts as human” and “who does not.” The policing of this relationship maps out important political “consequences and distinctions” that are volatile within culture (Chen 2).

Chen argues that animacy, the attribute of liveliness and ability to affect change, is defined often by the *opposite* of the person or object under scrutiny: the primary object is defined against the lowness, deadness, or abject and /or animalistic nature of what the item/object is not. Chen uses the phrase “I don’t want to be a vegetable” in relation to the popular case of Terry Schiavo, a woman kept alive with advanced technology and severely diminished brain function who was medically termed “vegetable”—or not human (42). This animatic ordering, of Schiavo’s body as “wrong” by being “vegetable” called upon society to re-conceptualize what an assemblage of “liveliness” specifically “counted” as a living body that ontologically matters in the worlds humans inhabit. The argument about what is and is not “human” is not new in rhetorical studies, but this dissertation questions the power of rhetorical stigma as affective communicative force given to the human immunodeficiency virus. Those bodies marked by HIV, as much as any permanent sexual infection or other condition/disease, may be read through a dominant lens of having “less liveliness” or having been “touched” by an agent of death.

I parallel Chen's troubling of the "human-vegetable" hierarchy with the phrase "I do not want to be a statistic" or "you do not want to be a statistic"—rhetorical appeals within HIV prevention discourses that reduce the life and being of a gay or bisexual man from human to mathematica, living to abject number. Key to both examples is the idea that animatic hierarchies, or the ranking order of specific actors, create or affect change. Chen's "hikers that rocks crush" example seems linguistically absurd because it applies agency to non-living matter—rocks. Chen's own example of her experience with lead poisoning and the panic caused by lead tainted toys shows the anxieties that non-living matter may cause humans. I take Chen's argument a step further to argue that the lowest forms of life, viruses, can in fact have similar animatic power. It should go without saying that HIV's ability to infect and spread causes anxiety and fear; actions taken and behaviors of prevention (such as "low-risk" sex acts) serve as a means of reducing the chances of the virus to exercise its limited agency. Thus, an animatic hierarchy of HIV can be conceptualized via perceived behaviors and risk factors—from low risk to high risk—with each movement along the hierarchy increasing the possibility of transmission.

Animacy hierarchies allow people to count what things or beings matter more/most, permitting individuals and/or societies to dehumanize or render life and agency away from a subject, object, or thing. In the case of Schiavo, it was her contested medical subjectivity as "vegetable" and inability to function within any agency-centered human capacity that dehumanized her; in my example, it is the rendering of the seropositive individual as number, rather than human, which allows the conceptualization

of a previous animacy hierarchy to be developed further with the seronegative individual defined by the absence of the HIV virus framed against the abject, seropositive individual. This framing becomes empowered by the dehumanizing, or animatic theft, of rendering the seropositive person as “statistic” rather than a rhetorical agent. This rhetorical movement further is strengthened by conceptually rendering the seropositive person as a number instead of a HIV carrier—denying two forms of agency, the human’s ability to control his or her infection via medication and the virus’s ability to spread. As a consequence of sex-acts, a seroconversion (or an infection/movement of HIV to a new host) opens the possibility of exploring how sex and its consequences create the possibility for re-establishing animatic hierarchies built upon stigma and the rhetorical deployment of sex as technology of power.

The Foucauldian idea of “sex” as a technology of power connects to Chen’s distinction that animacy hierarchies are defined by humans’ ability to dictate who or what counts, and who or what can shape or matter in the world. For Foucault in *Right to Death and Power over Life*, 19th Century discourses defined sex as existing in both men and women, but specifically in men, and lacking in women, whose bodies were constituted in relationship of their sexual absence and “ordered” (153) through the function of procreation. Sexuality, Foucault argues, has primary “grip on bodies and their materiality, their forces, energies, sensations, and pleasures”—or as Chen puts it, the ability of humans to have “liveliness...in a richly textured world” (Foucault 155, Chen 29). Sexuality as a discourse thus creates a powerful operating principle for the idea of “sex”:

the constituting of sexual acts as desirable, liberating, and deserving of access to such acts for all peoples (156). This leads to Foucault's pithy claim that the deployment of sexuality "exchanges life itself in its entirety for sex itself," or, simply, returns us to the phrase that "sex is worth dying for." In Chen's terms, sexuality creates an animacy hierarchy around desirable or undesirable sex acts—meaning that specific sex acts are considered more favorably than others (heterosexual versus homosexual, or, through a public health lens, high versus low risk). Stigma helps situate power along the animacy hierarchy, with some sexuality being marked as desirable, and other sexuality marked as deviant. Further, the perception of being "touched" or "marked" by death via a virus—in our example, HIV—has significant potential to shift animacy hierarchies. Animacy hierarchies thus helps a biocritical approach in deconstructing the ways that stigma and sexuality discourses favor some performances, acts, and bodies performing these acts over others.²¹

Animacy as a form of agency, the spreading of infection, is integral to the abjection within and stigma attached to the sexuality of those marked by diseases such as HIV. That HIV can move between bodies makes it animatic, or agentic, especially within an animacy hierarchy of sexuality. HIV's agentic status resonates with Käränen's conceptualization of bio(in)security. Where Käränen discusses the fear and anxieties surrounding germs and viruses as being a larger-scale sense of national bio(in)security

²¹ See my previous chapter where the CDC's discourse of HIV suggests that it is only the responsibility of someone who knows their HIV+ status to not infect others.

regarding terrorism by an unseen or unknown viral agent, social HIV stigma sits specifically in an individual's fear of being infected via sex acts.²² This fear plays out most familiarly through individual's behaviors of sex acts in the aftermath of the AIDS epidemic. Though attention must be paid to the structural discourses that enable the fear of HIV, it is rhetorically important to discuss how individual actors act out these fears through behaviors that are deemed risky by the animatic hierarchy of HIV risk.

In *The History of Sexuality*, Foucault addresses how confessions of sexual acts and the explosion of discourse surrounding sex has multiplied within the past two centuries (53). Sexuality thus relates to the power of *confession*, the disclosure of (f)acts and truths regarding one's sexual tastes, preferences, and actions (62-63). Two centuries ago, this person would have been a priest or religious figure who granted penance and reduced a sense of shame or sin regarding sexual desires or behaviors, where a regime was focused specifically upon spiritual well-being and the health of one's soul. For gay and bisexual men today, this figure is often a therapist, nurse, or doctor to whom one

²²Though it is possible to contract HIV in other ways, the dominant fear of infection arises from exposure via sex followed by injection drug use. The clear difference between these two anxieties—bioterror and HIV infection—is that of locations of fear: the fear of bioterrorism in this context depends upon a fear of airborne or waterborne disease vectors that can infect thousands of people quickly in familiar public or private environments such as stadiums or the home. However, the fear of chronic sexually transmitted illnesses (such as HIV) arises from the unknown exchange of fluids during intimate sex acts. Where Kėranen's discussion of national bio(in)security talks of fear on a large scale, the argument presented here confronts the personal (bio)insecurities of individual rhetorical actors. These actors, who are acting within a preconceived notion of animacy surrounding HIV's ability to move and spread communicably from body to body, perpetuate stigma via the insecurities they play out in statements such as using the word "clean" to reference being free of STIs or seronegative. If we unpack this anxiety further, the fear of infection by sex is further based upon the discomfort created by discussing or *confessing* sexuality and sex acts—specifically the consequences of sex acts deemed undesirable or abject by the rhetoric of the animacy hierarchy of risk.

discusses their desires, behaviors, and STI risk reduction strategies. The nature of the confession is the same, the doctor—much like the priest—serves to “punish, forgive, console, and reconcile” an individual’s behaviors with the strategies deployed by a regime of health for preventing HIV or STI infection (60-61). Following confession, the doctor and patient proceed to discuss modifications for behaviors or to praise appropriate actions, these discursive acts follow the lead of a priest who would “exonerate, redeem, or purify” the confessor.

In today’s climate of STI risk, not only must one have a sexual partner with whom desires may play out, but also a confessor to whom the truths of one’s sexual behavior must be disclosed in order to reaffirm belief, safety, and continue a personal code within a regime of health. Chen’s animacy hierarchy allows us to see how the epidemic of signification following the pandemic of the 1980s (Treichler) perpetuates stigma today. Those sex acts which infringe on a regime of health are abject, complicating the nature of confessional discourse. Individual gay or bisexual men may feel uneasy about disclosing to both their partners that they wish to perform undesirable or taboo sex acts; or their doctor that they have engaged in such acts; given the abject status of a virus.

As calls for an AIDS-free generation become louder and more treatments for HIV become both less toxic and easier to access, discursive and activist rhetorics aimed at fighting stigmas are important to explore. Through the biocriticism, specifically supported by immunology and animacy hierarchies, I consider campaigns that respond to the personal (bio)insecurities surrounding HIV. The rhetorical mosaic here

demonstrates how the dominant animatic hierarchy of HIV risk can be upended by two methods, beginning with The Stigma Project.

An Exercise in Biocriticism Part 1: The Stigma Project and HIV Neutrality

The Stigma Project frames itself as a “grassroots” organization that seeks to “lower the HIV infection rate and neutralize the stigma associated with HIV/AIDS through education and awareness via social media and advertising” (“About Us”). The organization seeks to replace stigma with HIV neutrality, fostering a world that is “free of judgment and fear” related to HIV. HIV Neutrality, in the words of The Stigma Project, is

a state of mind, regardless of your [HIV] status, in which you are informed and aware of the constantly evolving state of HIV/AIDS. Living a “neutral” lifestyle is being a visible advocate in the fight to end HIV and the stigma that strengthens it. It is putting emphasis on the humanity of all people and not casting judgment because of their status, positive or negative. (“What is ‘HIV Neutral’”)

This message’s power sits within the Stigma Project’s ability to move outside the source of HIV stigma, acknowledging that a better world is made possible by living neutral. This is accomplished by emphasizing the humanity of people living with HIV, and supported further by arguing that education and awareness can help humanity move beyond stigma. Additionally, The Stigma Project rejects the popular conception that someone with HIV is sick or dying. Instead, people living with HIV are agents of social change and the standard-bearers of/for HIV neutrality. Unlike the CDC’s use of “awareness” as an empty signifier (as explored last chapter), The Stigma Project’s aim is clearly directing what the end goal of “awareness” is—neutrality. Here, the Stigma Project succeeds where the

CDC fails. They resource the possibility for radical change by placing the end goal outside of the positive/negative binary, coining a new term and social identity—neutrality. By advancing homeostasis rather than HIV’s status as a “viral invader,” HIV neutrality renders the immunity paradigm obsolete. This new subject position allows the individual to “make informed decisions about your social and sexual health” based on the reclassification of HIV as a chronic manageable condition which focuses treatment toward the ability of people living with HIV to have “full and healthy lives” (“What is ‘HIV Neutral’”). To achieve this goal, all of society must rethink the way in which HIV and AIDS is approached and shift toward a neutral position, rather than one of stigmatization. This can be done by “moving away from thoughts full of death and sadness and towards thoughts of life and hope for the future” (“What is ‘HIV Neutral’”).

The Stigma Project frames their agenda as part of a social media revolution: HIV neutrality is a way out of the conflict between the positive and negative binary, a subject position that could be inhabited by anyone regardless of serostatus. Whereas Haraway’s communicative immune system operates on the misrecognition of difference and the necessity of responding to that which is not of itself, HIV neutral creates a slightly different model of subjectivity is formed. Akin to Sloterdijk’s “thin walled society,” HIV neutrality debunks the possibility of separate societies. Instead, the social system becomes both stronger and more reflexive as it moves beyond the binary of positive and negative/inside and outside. HIV neutrality also raises the powerful question about Esposito’s notion of the incorporation of minute pieces of the antagonist: when you can

acknowledge the other, the viral invader, beyond being contagious but as something that exists alongside you, must you incorporate them into your own being in order to protect yourself? More generally, the Stigma Project contests the rhetorical appeal of a viral apocalypse and fear of AIDS that undergirds much of the rhetoric of prevention materials. HIV neutrality operates outside the fear paradigm that is often found to be central to many prevention campaigns and instead offers understanding and knowledge in the place of anxiety and stigma.

While the Stigma Project contains a collection of shareable campaigns composed of posters and images, its first campaign (titled “Live HIV Neutral”) projects the clear message of the Stigma Project: a movement beyond the current HIV binary of positive and negative and the animatic hierarchy of HIV risk. Seven of these images (see appendix 1) comprise important mosaic tiles. Cast in black, white, grey and shades of red, some of the images use a sense of camp and humor (images 2, 3, and 5) to draw out the contemporary nature of HIV stigma. In one, the viewer sees the famous quotation of Dorothy Gale, having just landed in Munchkinland and looking startled, saying “we aren’t in 1984 anymore Toto!” The popular culture reference to gay and bisexual men, and queers in general, being alluded to in slang as “Friends of Dorothy” is cheeky, and calls out the time difference that many people still do not comprehend—that being HIV positive does not always mean progression to AIDS and death.

Other slang is critiqued in an image where a rubber bath duck has the words “CLEAN UB 2” superimposed over it, followed by the tag “dirty is for laundry, not your

HIV status”. While the image of Dorothy calls to older queer cultural nuance, the duck image calls attention to contemporary stigmatizing slang that is problematically used among gay and bisexual men. Clean here refers to being HIV negative specifically or free of other STIs generally, and this discourse grew from the practice of serosorting—choosing only partners that matched one’s serostatus. The problems involved in this practice—picking only “clean” partners—become obvious upon examination of how many HIV infections occur, where one partner believes themselves to be negative but doesn’t realize they have seroconverted and are highly infectious. Another image shows an elephant being airlifted, and above it the tag “Remove the elephant,” and the caption, “You don’t have to whisper. It’s ok to talk about HIV. You might even learn something.” In each of these images, the specific “t” on the text is replaced by a “±” symbol, the trademark of the Stigma Project’s concept of HIV neutrality.

These three images provide an interesting insight into the contemporary moment of HIV stigma and discourse. One pokes fun at an older cultural icon to address the evolution of treatment and the passage of time, another calls out stigmatizing language, and the last one addresses a need for communication that may allow for education and empathy to develop. This is one of the key parts of arriving at HIV neutrality. Ironically, this last image has a powerful, implied political message: the cliché of HIV as “the elephant in the room,” for gay and bisexual men is also the mascot of the Republican party, a group that has historically made little effort to ending the spread of HIV in the US. Countless scholars have noted that the Reagan administration’s delay to address

AIDS as people lay dying, including friend Rock Hudson, was shameful. That later President George W. Bush suspended the Office of National AIDS Policy as a cost saving measure and exported American concern for HIV internationally (specifically, drawing attention to Sub-Saharan Africa) by ignoring a growing endemic at home is also significant. The expansive growth of NGO monies that flooded into the Sub-Saharan region with the goal of ending the spread of HIV by specific means, paired with specific messages toward specific political ends, reeks of neocolonialism. Thus, HIV Neutrality disrupts HIV stigma, in the form of shaming silence as well as a politics of ignorance. Where the CDC insinuated that whispering may be necessary about HIV status, the Stigma Project calls silence or quiet-talking into question. Perhaps the best way to fight stigma, according to The Stigma Project, is not to whisper but to shout about the possibilities that HIV neutrality offers?

Two more images show us an idea about what specifically needs to be changed or what life that is HIV neutral could look like. The first image (image 1) shows two white, younger men sitting on a beach, arms around each other, with the message: “Live HIV Neu+ral” superimposed. Cast in shades of gray, with a splash of red for the HIV neutrality symbol, the message at the bottom reads, “It’s time to change the way we think about HIV. It’s time for a revolution.” The second image (image 4) shows an evolutionary progression of humanity. Cast in red, the viewer follows the evolutionary shift from chimpanzee to human male, with the message “Evolve” superimposed over the

top. Above, the image is captioned “A quarter of the U.S. Population thinks HIV can be transmitted by simply sharing a drinking glass. They’re wrong.”

Much like the previous cluster of images, this set shows both the need for change and the possibility of what could be should (revolutionary) change happen. The word “evolve” is rhetorically powerful as Image 4 draws the reader to a sad reality that many people in the United States still believe myths about HIV transmission that are dated from the 1980s and have been soundly, loudly, and repetitively, debunked. At this point, the viewer is lead to believe that the reason for such a belief is a lack of education, and that such people need to “evolve” into modern subjectivities (such as HIV Neutrality).²³ It is important to also note that a follow-up image to image 1 contains the same message, but replaces the same-sex white possible-couple with an intimately connected black or African-American opposite-sex couple. Image 1 shows the need for creating a specific type of change, one that is revolutionary. That neutrality, a step outside positive or negative binary system, could be conceptualized as revolutionary is dramatic. The abandonment of negatively affective stigmas, intimately tied to the animatic potential of HIV to affect/infect living people is powerful indeed. By abandoning the pervasive

²³ However, there is some problematic elements of labeling these views and the people holding them as “primitive” or less evolved compared to the notion of HIV Neutrality. As Harriet Washington notes in *Medical Apartheid*, many people of color—specifically African-Americans—have legitimate reasons to distrust the medical establishment which has profited off the use of slave labor and impoverished bodies of color to further the development of medicine in the United States. Since the African-American/Black population of the US bears a significant burden for new HIV infections in the American endemic, the context of how a quarter of Americans (still) hold this view is significant because a clear answer for lack of proper education or fear of medical authorities cannot be given, but could be suggested through critical reading instead.

stigma toward HIV, people living HIV neutral also reduce the power that the high and low risk hierarchy toward sex acts holds on gay and bisexual men. As the conclusion of this project will note, the potential for a gay or bisexual man to have a sex life that thinks beyond HIV and AIDS is revolutionary.

The last two images provide counterpoint to each other, showing what people living with HIV are and are not. The first (image 6) shows a crowd of people cast in dark gray and black with the words, “I am not dirty, helpless, being punished, a victim, sick, an addict, a whore, dying, a stereotype, guilty, I am HIV Positive.” The other image counters with a white-cast background showing two hands reaching towards each other and the message: “I am passionate, smart, informed, sage, loving, cautious, open, politically correct, honest, stigma free, aware, understanding, kind, still learning, I am HIV Neutral.” The words “I am” and “I am Not” are cast in red. Each of these messages is followed by a red-highlighted caption: “It’s time to change the way we see, think, and speak HIV. It’s not what it used to be. You can help end the stigma.” The first image clearly moves to rehumanize the people who are living with HIV; or, in terms of animatic hierarchies, the body carrying HIV is human, and not a “statistic” (that could easily have followed or replaced the word “guilty”).

While the first poster draws strength from the HIV binary that the Stigma Project and HIV neutrality seeks to abandon, the second image reveals the utopia that the Stigma Project wishes to advance, a world where the counter to HIV positive is not “negative” but belonging in a position of neutrality instead. This position that is built upon

compassion, care, and learning. Much like Darwin's theory of evolution, this conceptualization of neutrality is truly revolutionary compared to the previous binary of positive and negative. This position also challenges the immunological position that undergirds so much of the biopolitical perspective. The advent of chemical prophylaxis and antiretroviral therapies that render undetectable persons as "no or minimal risk" for spreading HIV directly challenges the positive and negative binary that was strengthened by fear and anxiety about being "touched by death" through possible contact with HIV. The fear and anxiety surrounding (potential) contact with death as the moment the body begins to decline seems hyperbolic when medical technology and chemical prophylaxis instead keeps such "death" (HIV and AIDS) at bay. Living HIV neutral, or outside the stigmatizing binary of serostatus, allows subjects to view the world in this way.

This image pair does contain a problematic element in claiming that the individual may not be an addict or struggle with a drug addiction problem; specifically this re-stigmatizes people who have used drugs and may have been exposed through drug use and may be in recovery or actively seeking help. Currently, a large outbreak of HIV among the Appalachian region of the United States is being fueled by opioid painkillers and heroin abuse. Further, actor Charlie Sheen has made no secret about his abuse of recreational drugs in the past, though he has never specifically claimed that such were responsible for his exposure and seroconversion to HIV positivity. That the Stigma Project frames drug use this way creates a problematic element where one stigmatized identity is sidelined in favor of another stigmatized identity, and an intersectional and

inclusive opportunity is missed. The complications of this missed opportunity and the context that is evolving in Southern Indiana and post-Charlie Sheen will be discussed in greater detail in the conclusions chapter of this project.

Intersectional neutrality notwithstanding, the possibilities provided by this campaign provide further nuance to a biopolitical or biopower perspective couched in immunity and animancy. First, the perspective of neutrality actively contests the power regime of sexuality as fueled by confession, since the ability or position of neutrality moves away from the notion that sexuality is something sinful or a burden that must be lifted through confession. In an HIV neutral world, the notion of discussing sex practices and desires, a central part of sexuality and sex as a technology of control, would not come with guilt (or stigma) associated with STIs that characterize the current HIV animatic hierarchy. The absence of such an anxiety would further chain out into open conversations between gay and bisexual men, or other people at risk for HIV, and reduce new infection rates. Further, the absence of guilt or anxiety would also result in increased prominence of HIV being discussed by those who are not normally at risk for HIV—a significant piece of creating an HIV neutral environment. Additionally, HIV neutrality contests Foucault's notion that power exists in presence and absence. Where the previous binary enforced that power existed in the absence of HIV, and framed HIV presence as being abject or marked, an HIV neutral world instead casts out the binary—moving beyond even Foucault's conceptualization of power and into a neutral position where power is shared or communal.

Second, the concept of HIV neutrality contests the previous notion of animacy that was created by the positive/negative binary. As Chen argues, much of the power attributed to matter and its ability to affect the world is linked to liveliness, compared to lesser forms of matter (e.g., someone who wishes not to be “a vegetable” or a “statistic”). As the images from the Stigma Project show, HIV neutrality rehumanizes people living with HIV. Further, the imagery also contests the nature of liveliness versus death by contesting popular opinion that an individual with HIV is not sick or dying, and framing neutrality as liveliness. The liveliness of HIV neutrality is additionally supported by the fact that modern medication supports the HIV positive individual being able to live a full and productive life.

The concept of HIV neutrality offers powerful connections to Këranen’s notion of biocriticism, specifically to rhetorics of viral apocalypse and (bio)insecurity. As Këranen notes, biocritics “uncover, analyze or question the evolving symbolic and material rhetorics of disease or contagion while placing them in broader conversations of politics, security and culture” (236). HIV neutrality disarms the anxiety that often plagues and mutates into apocalypse discourse, as in suggesting that rising HIV infections could become “out of control.” Further, as Këranen notes in discussing the dramatic increase of funding surrounding bio-security and the brain-drain of funding and minds toward endemic problems, HIV neutrality does not require specialized medical training or professional degrees, just compassion and empathy—meaning it is a subject position possibly inhabited by anyone.

Finally, HIV neutrality creates the possibility to critique the individual's own personal (bio)insecurities leads to larger critiques of national bio(in)security. Këranen notes that research in biocriticism could critique, counter, or promote specific aspects or ways of understanding biological being (237-238). As voices call for the possibility of an AIDS free generation, the notion of a world that is HIV neutral becomes central to this possibility. HIV neutrality reimagines the notion of being a biological citizen or participant in a culture post-AIDS, since the social and cultural anxieties and stigmas that perpetuate the endemic are being contested. When such anxieties, built upon an animatic perspective, are removed by a society becoming HIV neutral, the cultural and political landscape of a nation or world may change dramatically. HIV neutrality echoes Jeff Bennett's call in the conclusion of *Banning Queer Blood*, specifically, for a sustained project that reframes gay and bisexual men away from being contagious and frames them toward active and valued citizens—undoing the rhetorical notions of impurity often levied against them (147).

However, this prospect of HIV neutrality remains, for the most part, a utopian dream that must be constantly strived towards in The Stigma Project's campaigns and promotional materials. The Stigma Project, in its attempt to change specific perspectives about HIV towards revolution repeats a similar mistake to the ONAP and the CDC: in arguing for cultural competency or a radical shift in perspective regarding methods of addressing HIV, a profound failure to offer concrete methods for implementation becomes apparent. However, a Huffington Post blogger, Renato Barruco, proposes a new

way of examining HIV statuses and subjectivities, providing an excellent starting point for reaching HIV neutrality. Barruco's perspective and what he terms an HIV risk "continuum" is described in the second part of this critique. This perspective offers a clear way of seeing animacy and risk replacing older models of stigma that trade in hierarchies and binaries.

"Beyond Poz and Neg": An Exercise in Biocriticism Part 2

Posted to Huffington Post's "Gay Voices" blog on May 27, 2014, Renato Barruco details the shift in HIV disclosure among gay and bisexual men, specifically that "in recent years, this conversation has gotten progressively easier for all parties involved, in many cases the exchange ends up being a useless formality made of insensitive questions, superficial acronyms, and uninformative answers" (Barruco). He further dictates that to have real and meaningful conversations about HIV statuses, gay and bisexual men must acknowledge that the age of a binary of status is over. Barruco's argument furthers the attack against the positive/negative animatic hierarchy as being both scientifically and culturally inaccurate. He then provides a "continuum" of six new statuses, or "subject positions," that allow for a cultural and material reexamination of the fight against HIV and how individual people may discuss HIV statuses. I propose that Barruco's continuum is a form of animatic hierarchy that completely alters the discussion about HIV prevention because it focuses on the *possibility* for movement of HIV based on contemporary prevention practices rather than the presence or absence of the virus.

The previous hierarchy positioned the negative against the positive, an animatic hierarchy that led to the practice of “serosorting.” Serosorting is the act of choosing sex partners that had matching HIV statuses—a practice which is no longer endorsed by the CDC as an effective method of HIV Prevention because it creates the possibility for misinformation, uncertainty, and dishonesty that led to HIV infection—or to borrow from Chen’s theory, the animatic transfer of the HIV virus performing “liveliness.” Barucco’s proposed statuses form a new animatic hierarchy based on science and possibility for transference, or movement of, HIV. Barucco arranges statuses from “safest” to “most problematic,” or the least to most likely to spread HIV. This new hierarchy shows in greater detail the various possibilities for HIV to move between sexual partners. Where the previous binary system had just two HIV statuses (negative and positive), the new system contains six different status labels or subject positions:

- “I’m HIV negative and on PreP”,
- “I’m HIV Positive and undetectable”,
- “ I’m HIV negative, test regularly, and always use condoms”,
- “I’m HIV Positive and don’t know my viral load”,
- “I don’t know my status”,
- “I’m negative (or only think I am)” (Barucco).

In an intentional move, Barucco begins describing these six HIV statuses with the second “safest” status—the second least likely to pass-on the virus—and moves his way down. He begins with “the positive but undetectable individual.” He argues that

following developments in HIV treatment and antiretroviral therapy, individuals on successful drug regimens who have suppressed their virus to levels that are “undetectable” by advanced tests have a greatly reduced risk of transmitting the virus, with recent studies suggesting that transmission may not even be possible (Barruco, PARTNER study).

The third safest status Barruco describes is the negative individual who uses condoms consistently and is tested regularly. Epidemiological and laboratory tests show that correct use of condoms is highly effective in lowering likelihood of infection. Further, the regular testing creates a safety net where the individual reduces chances of exposing others by having accurate and timely information about their status. J. Blake Scott, however, raises material and cultural implications arising from rhetorics of testing and the methods of moving bodies through testing sites. Though Barruco doesn’t address Scott’s scholarship in his essay, his placement of regular testing at the bottom of the “safer” half of the continuum reflects the uncertainty and ambiguity that often arises from senses of false-security and complications by HIV’s window period in which it will not be detected by certain tests.

Barruco moves to the lower half, the more problematic of the six statuses. The fourth status is a person who has been told they are positive, but does not know their viral load, or the number of copies per milliliter of their blood—higher viral loads are linked with a greater likelihood of infection. Most likely, this individual has also not started medication yet, either. The advantage of this position is that the individual knows their

status and steps can be taken to reduce risk of exposure (such as condoms) until the person starts medical therapy to suppress the virus. Barucco includes the lack of knowledge about one's status as being the fifth place on his list, since it comes with the possibility for being seropositive. Of the over 1 million people living with HIV in the United States, almost 20% don't know they are positive. The reasons for this lack of knowledge can sit in fear and stigma, or the misguided belief that one is not at risk.

At the bottom of the hierarchy, Barucco tackles the most problematic status—the individual who says that they are negative, but only thinks they are. This group fails to acknowledge the new animatic hierarchy of HIV statuses, believing the previous binary system to still be the norm. This group may have tested negative, but their last test was more than 6 months ago, and they still believe it to be true while their condom use is irregular and they seek out only other “neg” sex partners. As this behavior has the highest risk for exposure and infection, Barucco's placement of this group well within the realm of biopolitical discourses and interactions rendering them at higher risk for being “touched by death” cannot be understated. Additionally, the mindset that is perpetuated by the sixth status, that the only safe sex occurs between partners who (say they) are negative, is a complete antithesis to The Stigma Project's conceptualization of HIV neutrality. Barucco's positioning of this subject position at the bottom of his hierarchy reflects the challenges faced within prevention discourses about risk, because it shows the difficulty of getting accurate and non-stigmatizing messages to highly resistant or uninformed men who have sex with men. However, if viewed from the perspective of an

animatic hierarchy, the move to conceive the virus as an agent in interaction creates new possibilities for prevention discussions that focus not just on testing, but on the biopolitical implications of low-information subject positions.

In introducing the six statuses, Barruco concludes with position one, the HIV negative person who has adopted Pre-exposure Prophylaxis, often called “prep,” PrEP, or by its medical name, Truvada. Barruco places this status on the top off his continuum, stating that like the first group he described (people who are positive but on successful treatment), status one individuals see a medical provider regularly. Like the second group described (people who are negative and regularly test for HIV), Barruco says status one individuals “may” use condoms for extra protection (medical professionals recommend this as well). The linguistic strategy of choice and agency in one’s sexual desires and performances suggested by the use of “may” rather than “should” or “must” in regard to condom-use is a marked difference biopolitically from previous rhetorical strategies in prevention and the creation of “thin walled” societies.

PrEP creates an entirely new subjectivity for understanding the sexuality and risks associated with same-sex actions for gay and bisexual men. Approved only in 2012, the academic study of PrEP is still very new, with almost no humanities-based explorations for how it shapes gay and bisexual men’s subjectivities.²⁴ Tim Dean, author of *Unlimited Intimacy: Reflections on the Subculture of Barebacking*, writes in a follow-up essay that

²⁴ However, such scholarship beyond this author and project is in progress.

“chemoprophylaxis” or the use of chemicals and pharmaceuticals to function as “invisible condoms” that prevent HIV infection as a form of pharmaceutical power. Dean’s argument furthers the notion that biomedical intervention has disrupted the previous binary between positive and negative, but that the notion of an “undetectable” viral load had done this before PrEP (241). PrEP, however, serves as the opposite side of the coin; it works in the same mechanism that treatment as prevention (TasP) does to prevent new infections by using the *pharmakon* as intervention against infection. PrEP does not come without risk. As Dean notes, the public health infrastructure is noticeably worried that gay and bisexual men will not adhere to the drug and risk HIV strains that are resistant to Truvada. Further, people on PrEP face the same risk of complications that people living with HIV on medication to treat the virus (loss of bone mass and risk of liver damage)—however, the sincerity of these side effects as impacting quality of life is contested, and many specialists do not consider the side-effects severe at all. This returns to Esposito’s notion that in issues of biopolitical significance, often the poison and cure are the same, but turned toward different ends. Additionally, the switch to “invisible condoms” that are less likely to result in human error furthers a social movement within MSM populations toward a more accepting, HIV Neutral mindset that reflects a “thin walled” society that does not separate based on biological distinctions that are rendered as non-threats by science and knowledge.

Additionally, the radical possibility of Barruco’s continuum of subject positions constitutes an animacy hierarchy as Chen describes, with a lack of HIV liveliness at the

safer end and increased liveliness at the higher risk end. Barruco's statuses reveals the possibility for someone or something (in this case, HIV and pharmaceutical interventions against it) to affect or be affected by someone or something else (to prevent the a/effects of the virus at the top end, or create the possibilities for its movement and transmission at the lower end). Further, as Chen describes that animacy is always constituted by the opposite of itself—life to death, health to unhealthy—the continuum of statuses intersects further with Foucault. At the turn of the biopolitical moment, death had become “something permanent, something that slips into life, perpetually gnaws at it, diminishes it and weakens it” (“Society Must be Defended” 65). HIV neutrality, which separates the concept of life and death from negativity and positivity, in this case upsets that binary. Though HIV exists as the lowest form of life, that of a virus that hijacks living tissue, Chen's discussion of toxicity positions Barruco's animatic hierarchy to shift perceptions of HIV status discourse for a critical intervention based in theoretical perspectives of biocritique, biopower, and biopolitics. Chen discusses compounds such as lead and mercury, which are inanimate and unliving, can affect the development and functionality of bodies. Similarly, contagious toxicity and the anxiety surrounding “things that are unseen” (lead, mercury, HIV) fuel personal and social (bio)insecurities.

As I have shown through this biocritical analysis, Barruco's resituating of the animatic hierarchy by placing pharmaceutical intervention (PrEP or TasP) at the top of his continuum is rhetorically significant in multiple ways. This movement allows gay and bisexual men to reclaim their sexuality away from the previous prevention rhetorics of

Foucaultian confession and anxiety. Most importantly, this move opens the doors to the possibility for HIV Neutrality that The Stigma project theorizes. The execution of such a movement and the implementation of Barruco's six-status continuum, or what it can offer scholars and practitioners from rhetorical perspectives and in discussing or combating the endemic of HIV, will be discussed in the closing chapter of this project.

Immunity/Animacy/Neutrality: Critiquing the Personal and Bio-Insecurity

This chapter has merged discussions of biopolitics/biopower, animacy, and the call to biocriticism proposed by Lisa K€eranen in order to explore a possible movement, the Stigma Project and its offering of HIV neutrality, that supports international calls for an AIDS-free and/or HIV-free generations in the future (though the former would be possible sooner than the latter). The biopolitical and animatic possibilities offered by HIV neutrality complicate rhetorical understandings of immunity discourse and answer K€eranen's call to biocriticism as a method of exploring various ways in which discourses of viral agents or disease are rhetorically significant in material, cultural, or political ways. By addressing the personal (bio)insecurities that many people have regarding HIV, the Stigma Project and Renato Barruco's new continuum of HIV statuses propose a dramatic shift in the way people talk about HIV; one that is quite revolutionary.

While Foucault argued that endemics create permanent situations for potential death among (specific) populations; this chapter's exercises in biocriticism suggest that HIV neutrality, Barruco's animatic hierarchy, and PrEP in combination with TasP, offer the possibility of the end of an endemic, the possibility of an AIDS free generation.

However, the question arises: *at what and whose cost?* Should the solution come at the benefit of corporate pharmaceutical giant Gilead's profit margins? Not all gay and bisexual men can afford or have access to PrEP, and governmental programs that seek to expand access are often blocked or diverted at the whim of politicians who do not wish to expand medical funding to sanction behaviors they deem immoral. Distinct challenges exist for continuing to fight the HIV endemic using both behavior change and pharmaceutical strategies.

Additionally, HIV neutrality cannot take root as a discourse when the very politicians who reject PrEP and expanded access to it (along with government funded HIV therapies under Medicaid expansions) operate in a mindset anathematical to the Stigma Project's goal. The final set of mosaic tiles, laid out in Chapter Four, considers how myths and misconceptions about HIV based in old and outdated medical knowledge continue to influence public opinion in unsuspecting ways. Such "viral mythologies" operate under the radar and often manifest in the most sacred of American institutions—our media entertainment system. Scholars, critics, and activists may see that mythologies operate as distinct message paradigms that perpetuate challenges for propagating the subject position of HIV Neutrality.

4. “Silence = True Death”: *True Blood*’s AIDS Allegory, Outbreak Narratives, and the Collapsed Frontier Myth

The epic and gory final season of HBO’s popular series *True Blood* broke from traditional plotline tropes in monster or fantasy television to feature an antagonist that was not human or metaphysical, but instead viral—the Hepatitis V virus, or HEP-V, for short. A mutated strain of Hepatitis D that weakened vampires, which was introduced in the show’s first season, the HEP-V strain was developed by the show’s sixth season antagonist, the fictional Governor Burrell of Louisiana. After the virus’s introduction halfway through the sixth season, the impact and body count only grew along with the existential dread. As the final season opened, the world of Bon Temps, Louisiana—along with many parts of the globe—has seen their vampire populations ravaged by a literal plague designed to destroy all vampires and separate them from the humans who feed and care about them. The writers of *True Blood*’s final season deploy what Keränen terms the rhetoric of viral apocalypse, in which biological contagion causes social collapse, to show the paranoia, fear, and human (or vampire) suffering that comes along with bio(in)security. This rhetorical act would not have worked without the homage and grand metaphoric appeal that compared HEP-V to the AIDS epidemic of the 1980s and 1990s.

The use of HEP-V as antagonist, however, evolves beyond metaphor and into allegorical functions, as several interactions within the script and its plot are notoriously

heavy-handed and feel almost as if they are pulled from scenes of *Angels in America*, *The Band Played On*, or *The Normal Heart*—dramas or books that addressed the AIDS epidemic through evocative and emotional appeals to human compassion and endurance. As such, the use of AIDS-as-allegory in *True Blood* creates a unique opportunity to critically examine how outbreak narratives and mythic structures operate together to convey a surprisingly conservative (re)imagining of the AIDS crisis (and accompanying stigma) through viral apocalypse.

The allegory itself deserves recognition for its possibility in creating moments of mental connection and processing regarding the pandemic of the 1980s and 1990s; however, such blatant or subtle metaphor use is nothing new. HIV and AIDS has long been used as a metaphoric comparison between various plagues, especially in horror or monster literature. As an example, J.K. Rowling recently admitted that her use of Lycanthropy in the *Harry Potter* book series was an intentional metaphor for AIDS (Hughes). *True Blood*, instead of metaphor, exists as allegory for how pandemics function (Ward). Specifically, according to Ward, the AIDS crisis serves as the primary representation for contemporary outbreaks of any viral or widespread contagion. As popular culture texts are consumed by countless people across the world, monster and horror media are a rich site for the continued dissemination and reproduction of a set of “communicable” myths that are deployed as part of the rhetoric of viral apocalypse.

In this chapter, I argue that these mythologies are as viral and communicable as the diseases they describe and deploy through the monsters our society loves to fear.

Further, as Calafell notes, monsters are not *born*, they are *made* through the construction of “Otherness” as problematic difference; the unconsumable or unassimilable pieces of our diverse society that refuse to be woven into the (increasingly conservative) social tapestry of our world. Sidelined, abused, and made abject, the monster always asks the creator, “why did you make me?” (Calafell 4, 7). In this chapter, I draw together the rhetoric of viral apocalypse and the concept of outbreak narratives with insights provided by the methodology of critical virology to address stigma that undergirds *True Blood*’s final season. Originally devised as a performance methodology to study social media virality—or the way in which social media and other communicative technologies propagate messages and texts that “go viral” in social interaction online and through shared digital spaces—I further the methodology by answering a critical call within rhetoric and performance. Critical virology helps negotiate a new direction for understanding rhetoric and mythologies as domains of criticism and important social texts that deserve scrutiny.

I argue that the abandonment of the mythological paradigm at the end of the 20th century, while a logical movement in rhetorical studies at the time, was also premature. The evolution of social media virality combined with the explosion of monster texts have reinvigorated mythic forms of knowledge dissemination. As such, it is important to revisit how myth functions rhetorically in an age of viral digital communication that reveals how ideas and beliefs, specifically AIDS-as-allegory, are “communicable” like the symbolic contagions they reference. As Foust notes, many mythological forms

operate and spread analogically while simultaneously hijacking narrative structures that transcend time and place to offer identification that enables audiences to justify mythic arguments and knowledge with equal argumentative weight as observable, empirical truths (273). Mary Fisher noted in her address to the Republican National Convention of 1992, AIDS does not care if you are gay or straight, white or black, poor or rich, AIDS only asks if you are human (Fisher). As such, myths care not if an audience is versed in logical argument or historically competent knowledge, they only ask if an audience can follow a story and see themselves inside it. The ability to identify with a mythic form thus enables the merging of digitally viral discourse, contagion, and communicable stigma together for this project.

I return to Janice Rushing and Thomas Frenzt's exploration of frontier and Frankenstein myths in media and entertainment and the role of monsters and horror discourses that serve as vectors for propagating myths by property of communicative virality. Drawing from the previously mentioned perspectives and briefly from Barthes' germinal study on mythology, this chapter constructs a mosaic or lattice that explains the intersections of viral apocalypse rhetoric and outbreak narratives within popular culture. Within this lattice, texts such as *True Blood* operate as viral communicative elements of a stigmatizing mythology that hijacks elements of both the frontier and Frankenstein mythologies to propose a *collapse frontier*, or the after-effect of a viral apocalypse that causes the conceptual "frontier" to return to a formerly familiar "home." Seasons 6 and 7 of *True Blood* position AIDS-as-allegory within a narrative of a social collapse, where

the frontier(s) of science and society have left the abstract horizon and have come “home” to small town America.

Unlike previous chapters, this chapter positions neither gay and bisexual men nor AIDS directly in the limelight of the object of study per se, but instead the vampires of Louisiana, HEP-V, and *True Blood* serve as a distinct allegory for people at risk for specific viral pathogens, specifically gay and bisexual men and HIV. The vampire allegory has dire implications for today’s HIV endemic and the combatting of stigmatizing beliefs. *True Blood*’s final season serves as a powerful example: several moments of possibility exist where AIDS-as-allegory was used to communicate virality, fear, and devastating loss to a population at large without directly mentioning HIV or AIDS once, while simultaneously drawing on the epidemic of signification that surrounds it.

In this chapter, I first negotiate the challenge of resourcing mythological criticism as a method of critical study, and then accent it with scholarship that defines virality and the outbreak narrative. Following this, I formulate how horror and monster studies serve as a rich site of critique for seeing how mythological stigmas and the rhetoric of collapsed frontier addresses a public about virality and hijacks discourses of HIV and AIDS toward alternative ends. I then explore how *True Blood* hybridizes the Frontier and Frankenstein myths to create a fictitious *collapse frontier* to set up a suspension of disbelief. I use the second half of the analysis to show how this hybrid mythological form

simultaneously deploys stigmatizing rhetorical communication to reframe an AIDS allegory as a heteronormative tragedy.

Monsters, Myths, and Viral Apocalypse

Mythological Criticism and the Turn Away from Mythological Critique

As long as humans have told stories to each other to explain the world, myths have existed. Where narratives can inform about lived reality by appealing to the ability of a story or tale to “hang together” and have “fidelity” to someone’s experiences, myths operate on a broader context and speak of larger cultural movements.²⁵ “[M]yths are long enduring stories, often anonymously created, that dramatize a culture’s deepest held beliefs and dilemmas. They tell of origins and destinies, are filled with heroes and villains and educate the young into the society’s values” (Rushing and Frenz, “The Mythic Perspective” 233). Janice Hocker Rushing and Thomas S. Frenz, across many articles, describe the ways in which myths shape and move people to understand society through the myth’s perspective. However, when confronted with their mythological actions, most people retort that a “myth” is a falsity or mistruth that is perpetuated and lacking in value; this is not completely accurate. Rushing and Frenz argue that while myths are placed in opposition to science, with science telling truths about the observable and measurable world, myths tell us truths about our psyches and internal selves that we may deny (233).

²⁵ Walter Fisher’s Narrative Paradigm has been heavily critiqued by many scholars for its lack of a critical lens, or the ability to ask “whose stories are these?” While I am not attempting a narrative analysis, it would be remiss of me to not include a reference to narrative criticism since this paradigm enabled the turn to mythic criticism by Rushing and Frenz.

The argument that myths are scientifically “untrue” classifies myth as material falsity and allows the dominant power structures to perpetuate without critical interrogation of cultural psyches and their fondness for such grand structures that provide spiritual or religious meaning for those who believe them (235). Mythic critique, as part of a critical tradition of rhetoric, then, seeks to answer how myths both have the potential to liberate and to oppress when deployed as rhetorical forms (235-236).

Based on their structure and usage over time, rhetorical myths also fall into specific categories that provide critics the ability to unpack them based on form and content (Brummett). Many mythic discourses follow the monomyth structure (also called a *hero's quest*, with emphasis on the masculine hero) of departure, initiation or challenge, and return (Joseph Campbell, cited in Rushing and Frenzt, “The Mythic Perspective”). Other categories of myth are *coming-of-age* that tells of personal transformation, the *creation and rebirth* myths that explore cosmic and celestial creation, and *grail myths* that tell of redemption from evil, sin, and death (Susan Mackey-Kallis, cited by Rushing and Frenzt, “The Mythic Perspective”). Rushing and Frenzt also identify specific myths that perpetuate within popular culture media such as the *Frankenstein myth* (“The Frankenstein Myth”), *myths of romantic love* (“Singing Over Bones”), and the *frontier myth* (Rushing, “American Western Myth,” “Mythic Evolution,” “Evolution of ‘The New Frontier’”). This project draws specifically on the rhetorical myths of Frankenstein and the frontier to explore the textual fragments of *True Blood*.

While scholars have also identified *cultural myths* as a source of mythic rhetorical structure, such myths are heavily invested within the cultures that give rise to them. Foust's identification of "Tough Mother" mythology in neo-conservative parenting discourses connects the historical movement of Temperance to contemporary vice and sin prevention discourses. Cultural myths have a great currency for contemporary analysis, and this project explores the possible formation of a cultural mythic structure (fused from Rushing and Frenztz two archetypal mythic forms) for pandemic discourses. As Ward notes, the HIV and AIDS crisis became the default narrative of comparison for any possible pandemic that followed after. It could be easy to read the collapsed frontier mythic form, which I propose, as an archetypal form of myth. However, this mythic structure is heavily indebted to conservative, reactionary backlashes against movements and changes within cultural discourses such as the advancements, activism, and daily lived realities of queer, disabled, non-conforming folk—specifically people of color—who are made into monsters who either are scapegoated as the *cause* for the outbreak or collapse, or who become the monsters afterward (Calafell).

In archetypal myths, the Frankenstein structure often appears within discourses of technology and the ability of humanity to lose control over the very *things* (or, possibly *life-forms*) it creates to serve themselves or better their lives. Known and named from Mary Shelley's gothic novel, Rushing and Frenztz connect the Frankenstein myth to early Greek narrations such as Prometheus creating humans from earth and water and stealing fire from the gods for warmth of his creations and Pygmalion's creation of his wife-figure

Galatea (“The Mythic Perspective”). Drawing from Jungian psychoanalysis, Rushing and Frenz argue that science fiction, as a genre, has a habit of classifying itself into utopian or dystopian genres, and thus creates a “shadow myth” that defines the antithesis of what society should be (Rushing and Frenz, “The Frankenstein Myth”). This oppositional mythic structure of utopia versus dystopia, they argue, fails to note that a dystopian element contains dialectical tensions that allow for potential change. Myths provide the ability to create “interpretive possibilities” that “visualize the repressed [other] as precursor to social change” and enable oppositional readings of texts toward such change (Rushing and Frenz, “The Frankenstein Myth” 77). Shadow myths serve as a representation of the pieces of society that have been repressed and that need to move from unconscious and into conscious life. The relationship between human and technology serves the purpose of positioning the other as non-human and thus object of fear and anxiety.

Unlike the Frankenstein myth that describes the fraught relationship humanity has with technology, the frontier myth addresses a cultural narrative that frames conflict between humanity and nature. Within American society, there has been a strong historical and cultural obsession with “new and unknown *places*” (Rushing “Mythic Evolution” 265). Intersecting with technological progression, humanity’s push to discover new places and spaces integrates with movements across oceans, continents, and even into space. Janice Rushing, in articulating the frontier myth as being part of what was previously named the Western myth, states that public discourse “evolved” the notion of

outer space as a frontier from the *telos* of the contemporary moment. Specific to her argument is the conceptualization of rhetorical force not as persuasion, but the ability to pursue a *telos* toward the formation of a public character and moral action (Frentz). This fits into the world of *True Blood*, as the world the vampires and humans inhabit after the “coming out of the coffin” is easily paralleled to imagined romantic fantasies of the Wild West where everything was new, exciting, and dangerous. This romantic interpretation serves as a *telos* for understanding the mythic potential of *True Blood* spanning the romantic-yet-dark first season all the way to the heart-wrenching finale.

It is of specific importance that this movement and *telos* does not need to follow the Aristotelian requirement of reason, because many movements and practices in public and civic life are guided by both reason and (conscious or subconscious) bias, or overt malign intent (Rushing, “Mythic Evolution” 268). Using pentadic critique to explore the disjunction from the move in the myth from land to space, and guided by Frentz’s interpretation of rhetorical narration, Rushing argues that a “culture’s definition of itself which dictates its moral vision and guides its choices is constructed not from one [text], but from many of its popular productions” (268). From this, changes brought by shifts in cultural paradigms and technological advancements allow for critics to show that myths “shape and reflect our cultural identity and are *lived* rather than merely *produced*” which can cause a sincere crisis in social consciousness when scenes shift or change (292).

Specific to the change in Rushing’s analysis of the evolution of the mythic frontier is the nature of space as “transcendent”—or that humans are moving above and

beyond earth into a more celestial, heavenly realm. The notion that myths become reflected in lived experience dramatically impacts the ways in which individuals respond to and read mythological, rhetorical texts. This reflection becomes the currency by which a mythological narrative continually remains relevant in a society. By using AIDS as an allegory for the HEP-V pandemic, *True Blood* reminded a predominantly heterosexual audience that the AIDS epidemic was not as distant a memory—for straight and queer folk alike—as would be believed. The implications for rendering this epidemic a form of “currency” that helps us understand future outbreaks is central to Ward’s theorization of the outbreak narrative form—and the implications of this narrative on *True Blood*’s damaging sanitization of who suffers in such an epidemic.

The Rise and Fall of Mythic Criticism

In 1990, the journal *Communication Studies* published a forum about mythological study. Scholars were asked to answer for the vast interpretation of what “myth” was and how to constrain what specifically mythic critique could study. Robert Rowland’s conservative critique in “On Mythic Criticism” called into question the ability for critics to apply a wide-ranging definition of myth and mythic form to texts. Rowland instead called for a narrower and more traditional interpretation of mythology, which should (he argued) include: a serious narrative, heroism, sacred time and place, and archetypal symbols (Osborn 121).

Other scholars addressed the narrow (and oppressive) interpretation that Rowland was attempting to force onto a definition of myth. Brummett argued that Rowland’s form

of myth had an undertheorized relationship with “truth,” specifically since his claims leaned toward requiring myths to be “objectively true” (Brummett 133). Rowland’s traditionalist form of myth created an artificial distance between critic and text, requiring the critic to see the mythic speech act as a “myth” rather than “statement of reality” for study (Osborn 122). Rowland’s construction also proposed rules for discourse and forced highly conservative restrictions upon myth scholarship—namely, that mythic speech reifies and reinforces as “quasi-religious” the narratives “that one might indisputably call a myth” (Brummett 135). Barry Brummett went as far as claiming that Rowland’s restrictions were not aimed at preventing rhetorical critics from misusing myth, but instead protected myth from rhetorical critics (135). Based on the razor-sharp insights into dominant ideologies that mythic criticism had rendered in years prior to Rowland’s essay, this makes sense. Despite their attempts, the scholars who responded to Rowland were not successful in ending the attack on the rhetorical study of mythic form.

Scholars have attempted to rehabilitate the mythic paradigm before, and many of the scholars in the previous issue of *Communication Studies* continued to use the method through the turn of the new century, along with other scholars who found use in mythic approaches to criticism. David Sutton attempted to compromise Rowland’s critique by drawing a category of *mythos* for scholars that included subcategories of myths, legends, and folktales that separate stories that are sacred and held as true (myth) or secular and either held as true (legends) or not true (folktales) based on their content and rhetorical deployment (212). Much like Brummett, Sutton’s attempt focuses on the way in which

categorization of stories serves political ends, but instead of making categories “slippery,” these categories allow for scholars to talk about different types or forms of *mythos* (Brummett). Sutton’s interpretation, however, capitulates to Rowland’s conservative requirements by admitting that myths are “sacred stories” that must be believed or held as true and are held at arm’s length from critics.

In many ways, this debate between allegorical, children’s story and Aesop’s fable style mythology repeats the debate between rhetorical critics that address entire, discrete texts or fragmented, composited discourses.²⁶ Sutton’s interpretation places the realm of *mythos* as an in-between of both realms, but does not provide a theoretical framework to construct *mythos* as a form of critique in looking at complex texts. Christina Foust addresses this problem through a different means by focusing on how cultural repetition and narrative identification with myths as “larger than life” enables viewers and audience members to disconnect the logical argumentative functions that cultural myths side-step to appeal as evaluative of the actions of others (273); cultural myths operate as a vessel for the sense-making ideologies that allow judgment without reflexive contemplation. Though Foust approaches myths as cultural discourse, this project draws on her note that mythic forms operate analogically (even when they are cultural myths), which the mythic form of the collapsed frontier benefits from through side-stepping the various processes of apocalyptic collapse to tell a compelling story.

²⁶ This debate played out during the Leff-McGee debates on text, context, and the role of the critic on rhetorical studies.

Alternatively, echoing some of the criticisms of Michael Osborn, Michaela Meyer argued in her reading of the Green Goblin in the 2002 film *Spider-Man* that mythic criticism blended with polysemic analysis and hermeneutic depth allowed for the critic to read mythic *contexts* within narratives and understand the polysemic readings and “truths” that texts contain. Osborn noted that Rowland’s critique held sincere confusion about the differences between narrative form of artistic works and the myths that may resonate from the text *as separate entities experienced and felt by viewers* (italics for emphasis, 124). Calling Rowland’s interpretation weighted with “narrow-mindedness,” Osborn stated that separating discourses into tidy categories²⁷ discouraged critics from finding “muted yet still important” mythic presences in texts that are open for critique (124). Meyer furthers this by arguing that polysemic readings of texts to address how the use of symbols shifts over time, context, and within culture and reveals a need to examine “*mythic patterns*” that shift and evolve rather than mythic forms of narrative that remain the same over time (526). Meyer critiqued Rowland for his obsession with the Western interpretation of myth, which disallows the study of mythic patterns across cultures. Using hermeneutic depth, she argues that critics cannot create “true” readings in their study of narratives, but can reveal patterns that repeat themselves across cultures or

²⁷ Osborn even further claims that Rowland found disquiet in Rushing’s love of science fiction films as part of her project in mythic criticism. In reading his critique, I sense Osborn implies that Rowland’s wish may have been to place science fiction outside of mythic speech and attempt to impede Rushing’s work. In many ways, this was a prelude to current debates within rhetorical studies, and the field of Communication Studies at large, about what *is* and *is not* within the bounds of communication.

discourses, such as the notion of the shadow as natural or “double” rather than “evil
“other (526-527).

Meyer’s approach merges well with the approach Foust takes in her critique of Judge Judy and “Tough Mother” mythologies as the rhetoric of tough motherhood operates through a form of sense-making that allows for identification with the allegory; though Foust argues that such an identification may operate analogically (273). Meyer’s argument about mythic patterns and Foust’s claims that myth creates a space for addressing analogical argument furthers Brummett’s call that critics form a “bricolage of signs inventively, creatively, even subversively” in order to propose different means of understanding and experiencing discourse (Brummett 133). Mythic forms of knowledge both queer the process of meaning making, as myth functions analogically, and the approach of mythic criticism serves as queer form of critique because it resists the conservative compulsion to constrain or restrict meaning—which was Rowland’s attack on mythic criticism. Brummett’s “bricolage” uses the ability form mythic critique to structure itself in opposition to conservative knowledge production, and this project makes use of such a bricolage by articulating Osborn’s notion that text and mythic feeling are separate and important. Further, this chapter draws in Meyer’s use of polysemy as avenue of exploring how myth, stigma, and virality intersect in *True Blood*’s final season toward a disappointingly conservative end.

Viral Apocalypse, Social Virality, and the Outbreak Narrative

Previously discussed in Chapter Three, viral apocalypse discourses evolved after the explosion of funding and communication about the US's viral susceptibility following September 11, 2001 and the suspicious sending of toxic agents to government facilities by lone wolf dissidents (Keränen, "Concocting Viral Apocalypse"). The political perception that the *bios*, or life sphere, of the American public was at risk by foreign or domestic terrorism using imperceptible or previously unknown chemical or previously contained pathogenic agents resulted in a heightened focus on biosecurity, which Keränen notes, comes with a drawback: as scientists attempt to study, isolate, manipulate, and recreate viral pathogens in labs across the US, they inadvertently raise the likelihood of human error causing catastrophe as well as create discourses of what this imagined catastrophe could look like. The "anxieties about emerging infectious disease" mixed within "the realm of national security" further leads to the imaginings of "viral apocalypse" that diverts and drains away funding and focus from causes (such as texting while driving, drunk driving, and cancer or heart disease) that actually have led to more deaths than bioterrorism or plague combined over the past 10 years (467). Keränen calls for the exploration of the rhetorical form of viral apocalypse across political, technical, and cultural domains because

naturally occurring germs and newly created biological agents are rising in prominence and symbolic power...The visual imaginary of viral apocalypse in particular deserves scholarly scrutiny, as does the technical and public framing of biological risks across multiple time periods and contexts. (467)

A study of *True Blood*'s HEP-V as viral apocalypse falls within the cultural domain of discourse, since the widely popular television show attracted audiences across seven seasons, and functions as fantastic imagery of an imagined, modern viral apocalypse. This representation of viral apocalypse draws on the historical and contextual and/or cultural psychic memory of the AIDS pandemic to function as emotionally evocative symbol use. This symbol usage is further strengthened by society's understanding (whether accurate or not) of the AIDS pandemic through interaction and communicative discourse, which I argue is a type of viral communication act. Often used to describe the sharing of media or texts in the internet age, the viral metaphor operates in media and communicative speech acts "[l]ike passing a viral infection by way of a handshake, people share viral audio and videos files in e-mail forwards, blog entries, and on community broadcasting Web sites, like YouTube and Google Video" and thus share the meaning of pandemics or texts across social spheres and spaces (Fox 418).

Ragan Fox employs the narrative methodology of critical virology in his study of how persona performance impacts the narrative interpretation of the *Yeast Radio* podcast and its audience. Viral critique "provides a methodological opportunity for performance scholars to better articulate how criticism infects (*or alters the significance of*) interpreted phenomena" (Fox 431, italics for emphasis). Though not a work of performance, this chapter borrows from Fox's critical virology to explore *outbreak narrative* as an altered state of a text by its coding as something "communicable," "viral," or "contagious." Fox draws from Fenske's exploration of the dialectic between the virtual and the lived or

embodied, and how meaning regarding identity contextually experiences “slippage” from the virtual and material. Fox’s artifact of study, a podcast and performance art piece, and Fenske’s exploration of body art and virtual identity in cyberspace are relevant to this project for their focus on the ability for virtual and digital technologies to operate as another way of disciplining and manipulating bodies. Such technologies are, not impossibly, applicable for the dissemination of information in an outbreak of a materially viral and communicable illness.

Defined by Ward as “an evolving story of disease emergence” that offers paradigmatic knowledge for understanding epidemics, *outbreak narratives* have consequences in the dissemination of information that affects survival rates, contagion routes, and “the stigmatizing of individuals, groups, populations, locals (regions and global), behaviors, lifestyles” while simultaneously changing economies (2-3).

Contagion, in its earliest usages, referred to the bringing or touching together of ideas and attitudes, the communicable possibility of transmitting ideas (2, 12). The etymological connection between defining viral microbes and bacteria that are *contagious* and *communicable* cannot be understated in their rhetorical significance. To put into the parlance of speech and public address, to communicate an idea is to potentially infect an audience with contagious implications, which leads to situating contagion in mythic structure.

In his book *Mythologies*, Barthes discusses myth as a type of speech that hides nothing; myth renders the object studied distorted and not disappeared (231). Further, as

a form of signification, mythological speech may “utter” a message that is conveyed as *value* (italics original, Barthes 217, 233). However, meaning and value are bound within a problematic dichotomy of intention/motivation and absence—that mythic speech holds the intention or motivation of and behind its use significantly close but intention or motivation is always made absent by the literal interpretation of the speech act (234). As part of the semiotic paradigm, Barthes’s focus on symbol use and interpretation would deserve its own project. I borrow Barthes’s elucidation of how mythic speech draws on incomplete imagery and thrives off vague—yet visually rich—imagery and allegory. If mythic speech thrives off the visual interpretations and readings motivated by value messages, deconstructing the mythic speech acts, motivations, and utterances of visual stimuli allows for intervention within stigma communication’s rhetorical application that challenges *why* and *how* contagious, communicable imagery perpetuates in popular culture. In other words, to have an outbreak narrative, must there be some sort of mythic function of contagious speech? I argue that the answer is yes, and the implications of this will be explicated in the conclusion of this chapter.

Outbreak narratives function within journalistic, scientific, and fictional incarnations, following a specific and formulaic plot, to convey the identification of an emerging infection, render visible the networks in which the infection travels, and chronicle the actions and rhetorical movements used for containment and/or termination of the epidemic (Ward 2). Emergent infections change meaning of networks, health, and connection through the “contagion”—the bringing together of separate things—of the

outbreak narrative. Since the outbreak narrative works in way that communicates a communicable, infectious agent—the narrative itself—that provides understanding for a contagious pathogen. Outbreak narratives are, therefore, communication acts that are “viral” in their ability to replicate meaning through the repetition of their constructed narrative.

Though Ward defines the outbreak narrative as a *story*, she also describes the outbreak narrative within a mythic paradigm for its ability to use “strong emotional appeal[s]” to be “derived from and affirm the fundamental values, hierarchies, and taxonomies” that a group expresses and authors to place the outbreak within terms of a collective identity (9). Such stories and their larger myths serve explanatory purposes and are a “significant expression of theologically or supernaturally inflicted collective identity [of a] contemporary moment” (9-10). Critical virology thus foregrounds how communicable, viral ideas within outbreak narratives *move* throughout populations, perpetuating mythic attitudes that have “imaginative hold and persistence” and touching upon the “influences of earlier accounts of plagues and theories of contagion, contemporary scientific explanation, and social concerns” (10).

Tracing this viral movement, the drawing together of people and ideas, reveals the networks of connection and contagious communication actions. Affirming the interpretation of Rowland’s critics, myth reveals the complex ways that power and structure emotionally appeal through analogical narrative. Rowland’s belief that myths must exist outside of time divorces them from power; myths and mythic critique is at its

strongest when it identifies recursive movements of power within moments of contextual significance. A mythic approach to critique is significant for exploring viral communication about disease and stigma, as evident by *True Blood*'s use of AIDS-as-allegory. While viruses may operate as their biology dictates, outbreak narratives operate with a different social "viral" agency that often seeks to identify, label (and by proxy, stigmatize), and contain risk through narrative approaches. When these narrative approaches make use of mythic form or patterns with powerful emotional appeals, such as the repetitive iterations of AIDS-as-allegory, a critique of the coming together of virology and mythic structure is necessary.

I justify this cross-paradigmatic borrowing through McGee's notion that texts are never complete, but are "fragments" of discourse texts which the critic arranges for study and interpretation (McGee). Further as Brummett noted in his reply to Rowland, critics are under no obligation when critiquing a text to respect the textual boundaries proposed by one who "authored the signs" for a discourse. In a special issue of *Text and Performance Quarterly*, Sloop and Hall each articulate that rhetoric and performance methodologies have much to offer each other; McKerrow's initial call for a critical rhetorical practice reminded critics that the act of critiquing toward a specific view and reading of a text and its implications was the performance of criticism but also the performance of scholar as advocate. Dwight Conquergood, in calling for a critical cultural politics, drew upon Rosaldo's the notion that boundaries—broadly defined—are not "barriers" but are instead "bridges and membranes" ("Rethinking Ethnography",

184). Further, and in support of the conceptualization of rhetoric as mosaic, Conquergood notes that there are “epistemological consequences” to “displacing the idea of solid centers and unified wholes with borderlands and zones of contest” in making culture and texts relational creations (184). Additionally, in bringing insight from performance studies to this rhetorical project, scholars and activists can see the ability to embrace both “written scholarship and creative works” such as a television show’s textual ability to provide analysis and articulation (“Performance Studies”, 151). Analysis, or the “interpretation of culture” and knowledge that comes from “concentrated attention and contextualization as a way of knowing”, and Articulation, or “activism, outreach, and connection to community” or “social commitments” and “intervention as a way of knowing”, serve as further insight into the way this outbreak narrative stitches together and clearly labels the moments of critical virology in this chapter. Critical virology, here, is showing the ways that *True Blood*’s narrative and mythic structure reinvigorated and disseminated problematic rhetorics of privilege and heteronormativity in its AIDS-as-allegory format.

In reading *True Blood*’s final season as outbreak narrative I adopt the role of a critic articulating for awareness and visualization of stigmatizing mythologies of viral apocalypse and their implications within the cultural domain coming from my analysis. Further, this chapter critiques the episteme of *True Blood*’s viral apocalypse rhetoric and the collapsed frontier myth it constructs as the end result of the narrative fails to address or heal the wounds of the AIDS crisis through the series’ rushed and fantastic conclusion.

It is important to think about the use of AIDS-as-allegory within *True Blood* as part of the larger discourse (or rhetorical mosaic) of HIV and AIDS. The viral apocalypse of *True Blood* cannot register within the minds of viewers without the “earlier accounts of plagues and theories of contagion” that defined the AIDS pandemic and previous epidemics that came before it (Ward 9). Further, to make sense of the outbreak, narratives are to be created in order to define who must be given attention and the focus of the pandemic, what actions are taken, and why the epidemic began. These narrations build upon myths from a larger, collective identity that targets specific groups, lifestyles, and ways of being (9).

To understand the outbreak narrative and *True Blood*'s rhetorical use of viral apocalypse; as well as how this cluster of tiles in the mosaic comes together; it is important to see how monsters and the study of them shape human interpretation of difference, identity, and the things that scare us.

Here there be Monsters: Vampires, Werewolves, and Stigma (Oh my)!

As objects of study, entertainment media within the genre of horror and monster texts are “paradoxical” in that these texts and artifacts often break traditional impulses of revulsion; audiences instead find pleasure in viewing things otherwise considered unwholesome or distasteful (Carrol). What we find distasteful about specific horror tropes or monsters reveals a curiosity or fascination with a taboo topic that audiences wish to learn more about or experience, but through the safety of a screen—leading to a form of cognitive mismatch that separates the *me* and the *not me* enough in order to allow

viewers to experience something that causes fear (Asma 184). The viewer's fascination builds from what Jeffrey Cohen describes as a form of desire that is built into the fear the monster radiates, as it is "linked to forbidden practices" which makes monsters attract in equal measure as they repel (16). Drawing from the formula of gothic novels articulated by Craft in his criticism of Anne Rice's *Vampire Chronicles*, Grady notes that the text first admits or allows a monster entrance, before entertaining it or allowing the audience to be entertained by the monster's behavior and the monstrous nature of its being, before exiling or expelling the monster and its disruption to the normal order (Craft, quoted in Grady, 234).

Further, monsters violate the "order of things" that allow society to continue in normative fashion; monsters are "disturbing hybrids" that reject categorization and "threatens to smash distinction" (6). The power of monsters to change and destabilize our beliefs and social structures positions them well within the realm of "shadow myths" that discuss the problems and fears a society has repressed. To borrow from the popular *Game of Thrones*, the night is dark and full of the terrors that society both made and then exiled into the shadowy margins. Brian Ott argues that the emotional and social psychic shock of the terrorist attacks of September 11, 2001 took form in aliens in shows like *Battlestar Galactica*. Focusing on televisual screens, or televised discourse (either fiction or non-fiction), serves as a form of Burkean "equipment for living" within contested times and provides "symbolic resources" that allows the "negotiating of social anxieties or ills" (Ott 15). The televisual screen also provides viewers the means by which to articulate

concerns, fears, hopes, or anxieties and motives to address these issues as they change and adjust (15-16). However, the dialectical tensions that are created between the lived world and the “strange, fantastic, and imaginary worlds” of science fiction and horror provide a moment for self-reflection (Ott 16).

Vampires serve as a remarkable monster for any discussion of HIV and AIDS because they can be jointly portrayed as suave and refined, while also being depraved and monstrous to meet the needs of a text. Though previous research has shown that Werewolves can serve a distinct means to talk about queerness (Bernhardt-House) or to explore HIV related discourses, as in J.K. Rowling’s *Harry Potter* (Hughes), this chapter focuses specifically upon the vampires of *True Blood* for their portrayal as alluringly sexual, market and financially savvy, and paradoxically sensitive to the pandemic caused by HEP-V that mimics the HIV and AIDS crisis. This is not new research, as Vampires have been connected with the monstrous nature of the AIDS crisis before (Calafell) because their need for blood is a type of sexual hunger—an allegory for blood and contagion and exposure (61). Further, as Calafell draws from Benshoff, the early comparison of vampires to “homosexual monsters” who spread HIV during the AIDS crisis cannot be ignored (62). As objects of (deadly) desire, vampires in an AIDS-as-allegory narrative force the audience to consider their own attachments to the characters as an investment within the discourse that is addressing stigma.

For these reasons, *True Blood* serves as a remarkable text for exploring how stigmatizing discourses are enveloped within the notion of vampires as monsters by an

audience presuming a post-AIDS²⁸ world. Much like the 9/11 attacks, the AIDS epidemic was a startling and psychically traumatizing event that shattered the gay and bisexual population of the United States and caused global suffering. Puritanical and shaming metaphoric language served as part and parcel the “epidemic of signification” regarding AIDS and HIV that Treichler discusses, and Poole notes that monster discourses and films regarding vampires were quick to draw upon the fear of AIDS specific to blood as a primary vector in the spread of the virus (Poole 206). Though Poole compares the usage of zombies with vampires, as both spread conditions through intimate contact (such as biting), he pays specific attention to how the “homosexual as vampire” and AIDS as “gay plague” served to fuel culture wars that raged against gay and bisexual men (207). As a monster’s body reflects the anxieties of a culture’s contemporary moment, sexual permissiveness became a central demon that was invoked in discussions of poison and disease as articulations and vocabularies of “threats” to a cultural body (Cohen, Poole). Specifically, the cultural body is at threat from a romantic, attractive, and presumed immortal/immoral blood sucker.

True Blood continued the trope of decadence and alluring sexuality that Grady notes smashed into American culture with the rise of Rice’s *Vampire Chronicles*. This

²⁸ I use the term “post-AIDS” as a means of conveying the hidden nature of HIV and AIDS in contemporary heterosexual society where HIV is not a daily consideration for most people who are not “high risk.” The term does not claim the crisis is over, but instead argues that HIV “awareness” discourses cannot succeed in rendering HIV and AIDS visible without conveying that “high risk” populations have intrinsic value that “low risk” populations should care (more) about. This notion needs more expansion in scholarly work.

allure had a recursive resurgence with the publication of Stephanie Meyer's *Twilight* series—though Meyer's vampires, specifically the Cullen clan, were much more conservative in comparison to Rice's debauched Lestat and his coven. The rhetorical and literary use of vampires as sex objects owes specific debt to Rice, who transformed vampires from disgusting and morbid husks into romantic gods (Dowdle). However, Rice's distinct homoeroticism has since become eclipsed by the avowed heterosexuality of contemporary vampire smut literature. The audiences that devoured the *Twilight Saga* and its films, who gushed at the actor's depictions on screen, were primarily middle-aged and older women escorting gaggles of younger girls to theatres (Dowdle 180). As an alternative example, Laurell K. Hamilton's *Anita Blake* supernatural romance series features a harem of male suitors for the protagonist, an early-30s Mary-Sue (or authorial fantasy fulfillment trope) preternatural investigator with nearly endless powers. The suitors, many of whom are centuries old vampires or various forms of shapeshifters, occupy a range of sexualities and identities. However, as later books in the series include more and longer graphic sex with greater inclusion of kink and bondage or masochism, the only sex acts described within the books are heterosexual—any same-sex acts occur off-stage.²⁹ Within smut literature, vampires seem to not only express society's discomfort regarding sexual permissiveness and disease, but also the internalized

²⁹ The author of this project would like to acknowledge that this pattern of non-representation of non-heterosexual sexuality in Hamilton's books was a grave disappointment for what was, initially, a great book series. The author doubts that he was the only reader disappointed by this and who also stopped reading the series as a result.

discomfort among heterosexual text creators regarding non-heterosexual sex and sexuality.

In exploring the homosocial continuum and the range of “homosexual panic” that exists within *I Am Legend*, Khader notes that the central figure, Robert Neville, expresses queer (erotic) desire for the undead Cortman. Using psychoanalytic framings, Khader shows the potential for reading queer sexuality and homoeroticism within texts and shows a form of ethics of queer monstrosity that builds upon Lacanian frameworks of both lack and excess that eludes signification and frames a posthuman perspective of relationships between self and other/human and vampire (550). Khader further notes that such anxieties and the need for ethics in queer monstrosity cannot be separated from neoliberal capitalism that is manifested within commodity fetishism, while queer communities are simultaneously blamed for the ills and instabilities within the capitalistic system (553). As such, it is clear to see that monsters serve as a powerful metaphor for the illusive and stigmatized homosexual within contemporary capitalist structures. The monster, as a stigmatized other, serves as a manifestation of communicable codes and means by which stigma is assigned and read onto others. However, even as stigma is assigned to the monstrous by these codes, the monster’s existence still teases the viewer; the monster represents freedom from the constraints of the system that creates and constitutes them.

As Cohen has described, the fear of a monster is actually a type of *desire*; Carroll notes that the fascination of the viewer manifests as revulsion or disgust, while serving

cathartic purposes. Disgust, specifically, is an important part of how Smith defines categorical “marks” that define how stigma is communicably created as a stigmatized other. These marks further allow for external, or mainstream group members, to create the stigmatized group as external or separate, assigning responsibility to the separated group (thus absolving the larger or mainstream culture), and finally to remind the external group of the danger the stigmatized other faces and for external group members to *eliminate the threat* (Smith 468, italics for emphasis). Again, Calafell’s reminder that monsters are created and not born becomes imperative: in creating the stigmatized population as external, the mainstream group absolves themselves of the responsibility of the creation of a stigma, a monster. Significantly, in her discussion of “peril,” Smith cites an STD pamphlet as a textual example of how context cues are created that mark the stigmatized group as a threat. Meisenbach notes that Smith’s explication of Stigma Communication, much like Goffman’s original text, lacks the ability for people to challenge the stigma’s existence. Her study explores the dual-axes of public and private interpretation of stigma, and she calls for critical or interpretive scholarship to explore how “power and control function in the various strategies for managing stigma” (287-288). Mythic forms of knowledge and criticism, however, allow critics to see how the stigmatizing discourses operate analogically and to address the underlying premises that create and perpetuate stigma communication acts. Smith’s approach is decisively uncritical, and Meisenbach takes that into consideration in her exploration, but this

project radically alters their approaches to rhetorically engage the mythic functions that stigma around HIV operates through.

For this chapter, the notion of mythic speech is deeply connected with the viral apocalypse narrative that the final season of *True Blood* weaves through its HEP-V outbreak narrative. As a form of narrative that relies upon mythic understanding (Ward), the outbreak narrative thus creates messages conveyed as “value” (Barthes) that draw upon the ability to label, isolate, and convey peril specific to stigma communication acts (Smith). However, in using the AIDS-as-allegory outbreak narrative, *True Blood* reinvigorates the possibility to critically examine how the highly stigmatized “homosexual monster” was treated during the HIV and AIDS crisis. To do so, it is imperative to explore the deployment of the collapsed frontier mythic form and then the specific iterations of stigma communication that occur within the show’s final season.

The remaining pages of this chapter use the above discourses in conversation with the four categorical functions of stigma communication Smith describes to tease out the creation of a monstrous other in *True Blood*’s final season. Doing so reveals how *True Blood*’s final season simultaneously invokes/invoked the rhetoric of viral apocalypse and inverts the frontier mythology that Rushing and Frenzt discussed within science fiction into a frontier of collapse. Critical virology and contagion discourses then become avenues for understanding specifically how mythological values of stigma become conveyed through the incomplete analogy of HEP-V toward specific affective, emotive motivations.

***True Blood*, Viral Apocalypse, and the Rhetoric of the Collapse(d) Frontier**

The television phenomenon *True Blood* used rhetorical tropes of technology and dystopia that qualify as a “Shadow myth” throughout its seven-season run. Within the universe of *True Blood*, the technological advent of artificial blood as a food source allowed for vampires to “come out of the coffin” and engage the world of the living as (longer-lived) equals rather than as mysterious predators. Of course, vampires were not the only metahuman denizens of this new world: werewolves and other lycanthropes or shapeshifters, faeries, witches, ghosts, and ancient religious fanatics and organizations also served as main characters, supporting cast, and as antagonists. Previous published work on *True Blood* in scholarly journals is rare, and one edited volume of vampire related essays exists specific to the television show. Maria Leavenworth explores the powerful contradictions between desire and disgust and difference that evolve in the textual world that Charlaine Harris’s novels and the television adaptation create. Frederik Dhaenens argues that the inclusion of gay characters within *True Blood* creates a queer resistance within the ambivalent heteronormativity of the 21st century’s fantasy discourses. Dale Hudson draws from Donna Haraway and asks what happens when two species meet and one is supernatural. Sabrina Boyer draws from Kristeva’s abjection thesis to argue that vampires are the ultimately abject object, the corpse. She complicates the narrative’s allegory of race and otherness by reminding the readers that vampires can “pass” for human while the people of color they stand opposite to in the Southern setting cannot. Brigid Cherry’s edited volume *True Blood: Investigating Vampires and Southern*

Gothic looks at the television show as form of vampire cult TV set in a southern gothic world. Further, the volume contains three essays that address myths specifically, but in the forms of religious ritual, fairy tales, and fables—completely different from the scope of mythic criticism this project engages.

Both the writing of *True Blood* and the scholarship around the show's characterization of its supernatural characters draw the viewer to question what, specifically, it means to *be* and to *feel* human. In the final two seasons, the drama switched from metaphysical horror to human-made disaster in the form of the genetically modified strain of Hepatitis D which became HEP-V. *True Blood's* use of HEP-V as a plague rhetorically combined the Frankenstein Myth and the Frontier Myth into a post-apocalyptic mythos that I call the collapse(d) frontier. This mythological setting is not unique in entertainment. Post-Apocalyptic television, literature, and film are not new concepts. However, the formation of a virus modified by human science to target a “dangerous” minority population (vampires), which causes not only the deaths of vampires but the collapse of societies and economies, creates new possibilities for myth.

While apocalyptic and end times mythologies are not uncommon in human culture and history, the collapsed frontier mythos is specific to the twentieth century's attempts to make sense of disease and human atrocity. Diseases such as HIV and AIDS, Spanish Flu, The Black Plague, Polio, and Sudden Acute Respiratory Syndrome (SARS) or human actions such as the German Holocaust, the U.S. American atomic bombings of Hiroshima and Nagasaki, China's Great Leap Forward, Apartheid in South Africa,

contemporary conditions (considered comparable to Apartheid) in Israel and the Occupied Palestinian Territories, or the genocide of Rwanda, may all provide historical material for which to construct fictional texts in the genres of science-fiction or fantasy. Unlike mythic forms that have been defined previously by Rushing and Frenzt, I draw on Meyer's notion of the mythic pattern to describe the collapsed frontier, since it is a recurring element in many forms of entertainment, media, and literature. Meyer describes a mythic pattern as patterns that repeat themselves across discourses. Meyer's argument that "true" readings of a text are impossible does not weaken the argument I make here, as apocalyptic form of myth do not require "monsters" specifically as we recognize them, but instead can be human or human made. Such patterns are polysemic and must be interpreted by the scholar/critic as means of creative or subversive readings of texts to tease out a "re-formed" text that operates in a way to draw together the "remnants of previous narratives present in the new narrative" she or he creates (526). Outbreak narratives, as described by Ward, "reference earlier accounts of plagues and theories of contagion, contemporary scientific explanations and social concerns;" these narratives "affect survival rates and contagion routes" (3, 10). Further, such narratives "promote or mitigate the stigmatizing of individuals, groups, populations, locales, behaviors and lifestyles, and they change economies" (3).

Examples of this pattern manifesting (in various intensities) can include, and are surely not limited to: *The Walking Dead*, *I Am Legend*, *The Maze Runner*, *Planet of the Apes*, *Dalghren*, *The Host*, *Bioshock*, *Dragon Age: Inquisition*, *Left 4 Dead*, and

Aftermath. Unlike the previous examples, the series *True Blood* does not begin in a state of apocalypse, but instead shows the viewers what happens when technology, human pride, and ideologies of individualism collide in epic and literally apocalyptic proportions. The final season serves as allegory for the need to understand the consequences of not only playing god with science but also the dangers of blind pride combined with a human propensity for destruction.

The collapsed frontier is notable by its three specific traits: the (re)turning of the urban into wilderness, failure of government or traditional aid structures to prevent and ameliorate the collapse, and the permanent diminishing of human life and its future—which often effects certain human lives more than others through old prejudices and stigmas. Much like the Frankenstein myth, in which humanity’s follies with science become its downfall, the collapse(d) frontier creates a scene in which humans must forage for survival, an environment that no longer allows humans to easily obtain sustenance or supplies in the now dangerous downtowns and suburbs that were once a middle-class paradise. Technology and development challenges humans’ ability to live off the land and survive. Further, humans are punished for their inability to even know how to live off the land—the consequences of urbanization.

As human beings are no longer familiar with their surroundings, the very structures that supported them have fled as well. The government—if it even still exists—is challenged to provide for its citizens to reduce, prevent or reverse the collapse. The only hope rests within a single hero or plucky group of survivors who must band together

against all odds to make things work where civilization has failed. Finally, in the culmination of a viral apocalypse, the future of humanity or life itself is dramatically shifted in scope. Humanity and the planet forge onward, after a fashion, ever reminded of the world-that-was through the environment around them. Evidence of the past in the form of abandoned cities, cars, roads, and hordes of zombies, monsters, or other creatures becomes the present-absence that feeds back into the other two pieces of the collapsed frontier to perpetuate the mythic and imaginary power it provides. When merged with the rhetoric of viral apocalypse, the collapsed frontier reveals the greatest weakness of humanity—itsself. Bioterror is not the threat, but the unchecked bio(in)security exploited in the creation of technological, modern utopia.

The realization of the collapsed frontier in *True Blood* becomes apparent in the final episode of the sixth season, “Radioactive.” The spread of HEP-V has caused a massive economic and humanitarian crisis. Six months after the escape from the vampire concentration camp, Joe Manganiello’s Alcide Herveaux has moved in with protagonist Sookie Stackhouse. As he leaves the shower and heads downstairs, the viewer hears MSNBC political commentator and journalist Lawrence O’Donnell talking on his show *The Last Word* to Stephen Moyer’s Bill Compton. Prior to introducing Bill, who wrote a book about temporarily being a living vampire god, O’Donnell mentions that the “CDC struggles to understand the strange mutation pattern” of HEP-V and that “new cases [emerge] every day.” In his conversation with Compton, O’Donnell mentions that the virus is estimated to have infected one-eighth of the vampire population worldwide.

Compton replies that the virus did not exist until Governor Burrell “dreamed it up” and that his book was a “confession” including the impact of his choices in the virus’s spread. He replies to O’Donnell, “although we ‘came out of the coffin,’ we have never been completely ‘out.’” Vampires remain secretive about who they are and what makes them strong or weak and they do, in fact, fear humans. This dialogue provides the opening description of a desperate world following the HEP-V outbreak. The pandemic has infected one-eighth of the vampire community and potentially millions of humans.

In the first episode of season seven, “Jesus Gonna Be Here,” we see Kristen Baur Van Straten’s Pam De Beaufort hunting through the slums of Marrakech, Morocco, for her sire. She is approached by a family offering her their daughter to feed upon claiming that pure, clean blood is a premium after the outbreak of HEP-V. This shows the level of decline that humanity has faced with the medical and economic crisis that HEP-V placed upon the world. The plotline of Pam and her sire Eric, played by Aleksander Skarsgard, follows the hunt for Anna Camp’s Sarah Newlin, the wife of Governor Burrell and muse for the creation of HEP-V. Sarah Newlin ingested the known “cure” for HEP-V and is being hunted by the pair in addition to the Yakuza arm of the Yakunomo corporation who manufactured “Tru Blood” that was used to infect millions of vampires.

During the season’s third and fourth episodes, “Fire in the Hole” and “Death is Not The End,” Eric and Pam hunt for Sarah Newlin’s parents at a Texas Republican event, where the political class attempts to hide its anxieties regarding vampires and the spread of HEP-V. The political class is obviously disturbed by the pandemic, but much

like the AIDS crisis of the 1980s they turn their heads and pretend that it is not happening while millions of people suffer. This runs in contrast with the narration and discussion shown by Compton and O'Donnell who openly talk about the virus and its spread across the planet. The scene in Morocco and the militancy of the Yakuza and Yakunomo Corporation show the economic impact that has arisen from the virus.

The previous world has been replaced by one of uncertainty, a hallmark of viral apocalypse. The technologies that allowed vampires to “come out” and survive alongside humans have backfired, manipulated by the spite of xenophobia, and turned against them with terrible consequences for vampire kind. Humans, too, feel this pain; many who have friends or family that are vampires now are infected carriers themselves along with their dying vampire companions. HEP-V has caused the familiar, liberal world that tolerated vampires (to an extent) and allowed them to flourish, to be replaced with a more imminent threat caused by the folly of human progress.

While these scenes show the challenges that a collapsed frontier pattern reveals across the globe, the focus of the season is on Bon Temps, where the collapsed frontier is a literal reality caused by the second mythic trait—the government’s failure to provide aid or contain an outbreak or crisis. Bon Temps has been under siege by roaming tribes of infected vampires that seek to capture and feed on humans to slow the progression of their disease. Later in the episode “Radioactive,” the town holds a community meeting at a church where they reveal a plan to keep the citizens safe from the vampire gangs. Sam Trammell’s Sam Merlotte acting mayor and states that since Baton Rouge and

Washington have “no idea what is going on in Bon Temps,” the community needs to band together to solve the problem. The residents of Bon Temps have been isolated in their town, unable to leave because traveling through the state requires travel by night when the gangs of vampires hunt. As such, the town has become a new “frontier community” where the law must be taken into the hands of the people who have survived. The collapse of civilization, the second hallmark of this mythic pattern, forces the survivors to abandon previously held beliefs and adopt new practices that would be considered unsavory by past logic.

Bon Temps mayor Merlotte and community leaders devised a monogamous feeding relationship between uninfected humans and uninfected vampires to address the protection of the community. As mayor Merlotte says: “every person needs a vampire, and every vampire needs a person.” Many people express shock and dismay, leaving the meeting immediately though most stay. This moment shows the pioneer mentality that follows the collapsed frontier pattern, as the forces of the United States and Louisiana government have all but abandoned the town of Bon Temps, and the global response to HEP-V has been less than effective (as shown by Pam’s trip to Morocco).

The plucky band of citizens must work together to overcome the challenges of this new frontier by doing something once unheard of or unimaginable—a monogamous feeding relationship with a vampire. Besides the direct correlation to Reagan-era Health and Human Services rhetoric about how to prevent HIV spread, this suggestion shows the shift in mentality that follows the viral apocalypse of HEP-V. To survive in a collapsed

frontier, the citizens must not only “get their blood tested” they must become the new food source that their protectors need since Tru Blood is no longer an option. Mayor Merlotte notes that it is a person’s choice to participate in the system, and that no one will be forced, but it is currently their best chance for survival. This sense of choice, ironically, is no choice at all.

Later in the episode, Adina Porter’s Lettie Mae Daniels addresses her daughter, the new vampire Tara Thornton played by Rutina Wesley, in order to bring the two back together. Lettie Mae and Tara’s relationship had been strained for years, but in a powerful moment she recants her abuse and poor parenting, saying “all this pain, it’s a blessing, a chance for us to heal.” Though this line is meant for Lettie Mae to begin reconnecting with her daughter, it also reflects the current situation in Bon Temps and the world at large, all of which are divided between accepting the metahumans amongst them. The arrival of HEP-V and the abandonment by the governments of the world created an opportunity for the community “to heal” itself from the perversion of technology that was Tru Blood, the divisiveness of human spite, and the invasion of vampire cultural mainstreaming. This rhetorical move echoes strongly the Reaganesque mandate of individual choice and action that followed the 1980 election and conservative political discourse of the decade toward family values and away from gay and lesbian liberation or identity politics in general. Through the focus on individual choice, the citizens must choose to work alongside vampires and feed them, so the survivors take agency while simultaneously placing blame on the government for failing to stop the spread of HEP-V

and protect them. Healing, then, becomes the role of communities and individuals rather than the faceless government organizations that should have the best interests of citizens at heart. The conservative rhetorical movement of this scene reflects the social rejection of the government as protector against bioterror or threats toward individuals and communities, instead forcing the community or individual to rely upon understandings of stigma to identify the threats to their community.

The third part of the collapsed frontier myth relies upon the present-absence of the past to make humanity always remember the diminished capacity of its life. The *True Blood* series finale (“Thank You”) shows the surviving members of the Bon Temps community happy and having a Thanksgiving dinner. A reminder of the viral apocalypse of HEP-V is made manifest through the shot of “Nu Blood” in Sookie’s fridge as the montage shows all the characters coming together. This is accompanied by a voice-over of Pam and Eric hawking Nu Blood on television to slow the spread of HEP-V and to feed vampires that are infected without spreading the virus. These moments are very clear analogies to the current crisis of the HIV and AIDS pandemic that has been semi-contained with the advent of antiretroviral therapies and treatments. While human civilization and vampire kind survived the apocalypse of HEP-V, the world has been permanently affected and countless vampires have died before the “treatment” of Nu Blood was released. Like HIV and AIDS, there are still carriers and infected vampires who must live with the condition for the rest of their lives. A powerful moment in the final season shows Carrie Preston’s character Arlene Fowler, a survivor of the vampire

gang's kidnapping, admit to her new vampire paramour that she is HEP-V+. Much like the above moment with Lettie Mae, Arlene's journey from xenophobic toward vampires in the first season to caring for one in the final episodes shows moments of healing made possible by the community efforts to band together. Further, this interpersonal moment reveals a strong present-absence of HIV because the conversation mirrors the process an HIV+ partner may undertake in disclosing their status to a new lover. On a larger scale, the deaths of many vampires reflect the millions of worldwide deaths that occurred (and continue) before antiretroviral therapies were introduced. The dead of the HEP-V virus stand in for the present-absent AIDS pandemic victims lost to the scourge.

This notion of present-absence is made even further blatant by the prevention materials in season seven, episode six ("Karma") where Sookie learns that she is a carrier for HEP-V and had been exposed by a spatter of blood to her eyes when a vampire was killed right in front of her a few days prior. Further, after this exposure, she fed Bill Compton, passing the virus on to him. During the episode, Sookie walks into the local clinic to get tested for HEP-V. While the nurse is drawing blood, the camera pans over the walls of the office to show HEP-V prevention materials not dissimilar to HIV prevention materials. The first poster behind Sookie shows a couple locking arms and says "everything you need to know about HEP-V." The second poster shows an opposite sex couple, with fangs superimposed on the man's mouth, and prompts with the question: "How can we choose to be healthy each day? You are the key to prevention. HEP-V." And the most powerful homage is the final, small sticker positioned next to the window

Sookie sees as she loos away while the nurse wraps up her blood specimen— hidden by a window sill and framed in sunlight, a black circle with a pink, befanged triangle bearing the words “Silence = True Death.” While the previous two posters left the connection toward HIV to the subtlety of interpretation, as either could be also drawing from other promotional materials for communicable diseases such as HPV or Hepatitis C, the invoking of ACT UP’s motto—“Silence = Death”—clearly and blatantly places the rhetorical allegory of the season into the realm of HIV and the AIDS pandemic.³⁰

While heavy handed for an entire ten episodes prior, the allegory is finally made visible in this scene—confirming HIV as the present-absent that becomes essential for the interpretation of HEP-V in this iteration of the collapsed frontier form. However, as Barthes notes, the present-absent as referent is always already lost in the interpretation of the literal (231). The collapsed frontier as a mythic pattern requires the present-absent referent—in this case, the HIV and AIDS pandemic—to function rhetorically. Meyer notes that critics “must account for these varied uses of symbols over time, context, and culture by shifting scholarly focus to mythic patterns rather than cohesive myths retold in a variety of narrative guises” (526). The allegory of HIV and AIDS to HEP-V in *True Blood*’s collapsed frontier reveal how symbols may shift or change over time, and not always for the better. As Barthes notes, the literal reading and limitations of mythic speech always create a failure of discourse to understand the allegorical power being used. Though the viewers may come to understand HEP-V as an allegory for AIDS,

³⁰ The author would like to acknowledge this moment in *True Blood* as the germinal seed for this chapter.

specifically in the moment of “Silence = True Death,” and the above explication of collapsed frontier myths show that HIV and AIDS mythically operate in *True Blood*, it is important to discuss how these rhetorical deployments fail in their interpretation on the screen.

In *True Blood*, this rhetorical device fails time and time again to appropriately and faithfully represent the HIV and AIDS pandemic, specifically because its deployment privileges heterosexual readings and understandings of the pandemic despite overwhelming potential for vampires and their feeders/lovers to be read as queer or homosexual. As allegory, HEP-V is an imperfect stand in for HIV as the show continues to perpetuate stigmatizing choices and communicative exchanges that become apparent when examined through the lens of stigma communication, critical virology, and monstrosity.

How to Have Theory in an Outbreak Narrative: *True Blood* and the Collapsed Frontier

The introduction of “Nu Blood” in the final episode (“Thank You”), concludes the rhetorical appeal of AIDS-as-allegory, with “New Blood” as a stand-in metaphor for contemporary anti-retroviral therapies. Taken together with the “Silence = True Death” sticker, these two moments cement the allegory of AIDS as an integral part of *True Blood*’s viral apocalypse in its final season. While the above analysis has yielded a rich discussion of *how* the final season of *True Blood* dually deployed the collapsed frontier myth while showing a rhetorical outbreak narrative play out, it is important to also

discuss *to what ends* both the collapsed frontier myth and the outbreak narrative were used rhetorically, and what is revealed by them. This, I argue, is the benefit of a final critique of the subtle, stigmatizing messages discussed above through a viral criticism lens. As Fox states, a critic maps the movements and replications, charting moments of departure and mutation of a communication-based infection (422). The contagious discourse of *True Blood* AIDS-as-allegory shows in bloody clarity the point Calafell makes when she says that, despite claims to the contrary, our society is becoming more conservative (again).

A viral criticism lens reveals three specific problems with the use of *True Blood*'s AIDS-as-allegory for HEP-V, specifically as a replication and mutation of previously occurring tropes about the AIDS crisis. Three deployments of highly conservative rhetoric serve as surrogates from the 1980's cultural approach to HIV and AIDS: *the scapegoating and monster-izing of Sarah Newlin as a replacement for Gaeten Dugas, the portrayal of Arlene and Keith's platonic-only relationship as stand-in for abstinence-only approaches to HIV prevention, and the use of Sookie and Bill's infection as a repletion of the trope of the tragic heterosexual victim of AIDS.*

First, throughout the final season, Anna Camp's Sarah Newlin is characterized as being a monster in her own right. She was personally responsible for convincing Governor Burrell to start the campaign of genocide against vampires, taking Burrell's scorned and broken heart and morphing his pain into a genocidal fervor. In a panicked moment to save herself, she downs the cure for HEP-V and later attempts to bargain for

her life with Pam in exchange for sexual favors (and is rejected). She is the subject of an international manhunt by the Yakonomo Corporation—whose figurehead in the United States eerily and appropriately for this analysis, dons a cowboy persona with boots, hat and twang to match. Finally, she is described by Eric, while pitching “Nu Blood” in the final episode, as being an “international mass murderer” for her part in the creation of the HEP-V virus. This, of course, leads the viewer to sympathize first with Sookie’s decision to leave Sarah in the basement of Fangtasia—which Sarah never left after—and to second feel justification for Sarah’s fate chained in the basement of the bar as Pam and Eric’s second source of income; the black-market complete cure still rests in Sarah’s veins. This is not an argument for Sarah Newlin’s redemption as a woman scorned who sought power by any means necessary; such women are often made into monsters.³¹ However, it is an argument to show that Sarah Newlin stands in rhetorically for the “typhoid Mary” of the AIDS pandemic—Gaeten Dugas. The infamous Quebecois flight attendant was dubbed “patient zero” and in Randy Shilts’s *The Band Played On* he was metamorphosed into an inhumane virus/human hybrid that frequented bathhouses and sought to infect as many people as possible (Ward).

³¹A strange parallel here can be made between Sarah Newlin and Erzsébet Báthory, a Medieval Hungarian noble and accused serial killer known colloquially as “the Blood Countess” for her supposedly gory tortures and propensity for bathing in the blood of virgins. While historical proof of her involvement in many murders is difficult to verify historically, her only known (real) crime was being both one of—if not the—richest people in Europe and a woman. Both Newlin and Báthory were rich women who desired power and were made into monsters by the people who opposed them; Further, both met their ends sequestered in dark, closed-off dungeons.

As Ward notes, when viruses and the humans that carry them merge, and humans begin to give voice to their infections and conditions, they elicit and evoke the outbreak narrative. For the purposes of *True Blood*, the patient zero or initial infection was Nora Gainsborough. However, Sarah Newlin's rhetorical portrayal as the "international mass murder" who helped create the virus, and her status as *the living cure*, create her as the inverse of patient zero, the eternal and impossible penitent. In "Thank You," we see that Pam keeps Sarah locked in the basement of Fangtasia and charges large sums of money for a "taste" of her blood, thus providing an inoculation against HEP-V. Further, as Shilts and the press demonized Dugas, the characters of *True Blood* demonize Sarah Newlin. Sarah Newlin's construction as inhumane antagonist, monster, and criminal cannot be separated from the rhetorical narrative that was constructed around Gaeten Dugas, as Dugas's vilification as "patient zero" in the AIDS crisis and his deviant sexual behavior became key components of outbreak narratives afterwards.

Second, the relationship between HEP-V-positive Arlene and Keith, the vampire who rescued Arlene from death by the HEP-V vampire gang, reiterates the conservative abstinence only approach to preventing HIV infection that the Reagan administration pushed in the early days of the AIDS crisis. Paula Treichler notes that prior to the advent of treatment and the identification of the virus, prevention models were specific to include abstaining from sex as the only 100% effective way to prevent contraction. While such information may be factually true, it is a high order to ask human beings to avoid sexual intercourse of any variety—resisting biology is a superhuman challenge. However,

the metaphysical human (Keith) is expected to display a level of restraint beyond human in his relationship with Arlene, who is a carrier of HEP-V following the events in the cellar of Fangtasia.

The difference between the early days of the AIDS crisis and the HEP-V allegory is that the inhabitants of *True Blood* are completely aware of the viral nature of HEP-V as science has already identified the virus and scientists are stumped at how to address in in “Radioactive;” this is a significant difference between the world of *True Blood* and the early days of the crisis Shilts describes. *Of importance is the notion that the inhabitants of True Blood’s world cannot conceptualize HEP-V as a problem without first understanding HIV as a problem.* In an earlier episode in the first season, Lafayette confronts three redneck patrons of Merlotte’s who claim they didn’t order an “AIDS burger” (“Sparks Fly Out”). After a speech which includes the line “faggots been breeding your cows, raising your chickens, even brewing your beer long before I walked my sexy ass up in this motherfucker. Everything on your god damn table got AIDS!” the very existence of HIV and AIDS *vanishes* from the television show until season six where it is (re)introduced as allegory (“Sparks Fly Out”).

For an immortal being who is dependent upon blood to survive, how is Keith supposed to resist feeding or being truly intimate with Arlene? As Calafell reminds us, blood and sex are intimately tied to vampire literature as blood is linked with desire and power (61). If HEP-V is an AIDS allegory, should the highly conservative and practically impossible rhetoric of abstinence be deployed if the show’s creators are attempting to

humanize the victims of the AIDS crisis through the inhabitants of Bon Temps? Such a rhetorical move is not only strange in today's world of antiretroviral treatment that renders people with HIV undetectable and non-contagious, or paradoxical when positioned alongside the metaphor of antiretroviral therapy introduced in the final episode, but it is highly irresponsible for promoting abstinence when abstinence only sex education has been proven time and again to be a complete failure. Arlene states that they are being "careful" in the episode "Love is to Die." Viewers are left with the impression that sex and intimacy are off the table *permanently*. Does such a rhetorical move imply that serodiscordant relationships in the real world also engage in non-sex intimacy despite the abandonment of serosorting as a prevention tactic? If the AIDS-as-allegory carries over, the implications for this conservative and moralistic rhetorical deployment are serious.

Third, the narrative of Sookie's exposure and Bill's infection recreates the rhetorical trope of the tragic heterosexual victim of AIDS that was used to discursively obfuscate the suffering of homosexual and bisexual men who were dying during the crisis. Outside of Bill, Nora, and Eric, none of the other vampires of Bon Temps to which viewers are introduced contract HEP-V. Though Nora is the first casualty and Eric survives, the reality of Bill's (and to a lesser extent, Eric's) infection is significant. Sookie is exposed to HEP-V in "Fire in the Hole" when she is used as bait to attract the HEP-V vampires—infected blood from an exploding vampire gets into her eye. In the next episode, "Death is Not the End," Bill unknowingly becomes infected by feeding

from highly-contagious Sookie on their way to free the captives from Fangtasia. As vampires are intimately tied with conceptualizations of sex and power, and if the AIDS-as-allegory rhetorical deployment is to be believed, then the act of feeding from a human—a vampire’s “natural” or “normal” food source—is equivalent to heterosexual intercourse while drinking Tru Blood would be homosexual intercourse. It is important to signify that vampires, in the world of *True Blood*, *naturally* feed on human blood and *unnaturally* can *choose* to feed on Tru Blood. The significant parallel here is that even in a television show that positively portrayed homosexual and queer characters, the structure of the fantasy continued to construct heterosexuality as natural and the homosexual as unnatural.

The narrative of *True Blood*’s final season rhetorically focuses on the drama of Bill and Eric’s impending deaths from HEP-V. Both were infected by drinking from contagious humans. The show entirely sidesteps any protagonist characters that could have become infected from drinking the tainted Tru Blood, the way that millions of vampires were infected by Governor Burrell. *This deployment reiterates heteronormativity by focusing on characters who were infected the “natural” way vampires are “supposed” to feed.* By rendering such characters as props for the vilification of the virus (the HEP-V vamps) or showing them as tragic and broken (Sarah’s sister Amber), viewers empathize with the human-feeding/heterosexual vampires rather than the peaceful, queer, Tru Blood feeding/homosexual vampires. It is important to note, again, that the discovery of Tru Blood as a feeding source allowed

vampires to “come out of the coffin” and interact with mainstream society much like LGBTQ people must “come out” to be their “authentic” selves in public. By segregating the victims of HEP-V who were infected and died by means of Tru Blood, the series creates a parallel erasure on par with the denial and favoritism perpetuated by the media of the 1980’s. Specifically, this rhetorical deployment mirrors conservative rhetoric that focused on tragic victims of AIDS who were infected by tainted blood transfusions while drawing attention away from homosexual and bisexual victims who were dying in massive numbers by performing their desires via a stigmatized sexuality. The present-absence of the queer/homosexual stand-ins in the finale moments of the series is disquieting when compared to the ways that heterosexuality is privileged in the survival of the series protagonist characters. As Conquergood noted, “communication becomes even more urgent and necessary in situations of displacement, exile, and erasure” (Rethinking Ethnography”, 185). The performative and rhetorical displacement of gay and bisexual HEP-V surrogates and their erasure from the happy ending that *True Blood* provides is severely disquieting. To name these implications and to point out the problematic elements that they use as “glue” in the joints of this mosaic is critical to piecing this chapter into the larger textual mosaic of the project.

These conservative deployments are bone-chilling in their implication for *True Blood*’s AIDS-as-allegory attempt; if the show was attempting to provide closure and discursive potential to address HIV and AIDS in a new way, the level of rhetorical violence done by refocusing the pandemic to the plight of straight/heterosexual people

who are infected completely misses the mark. Further, by killing off Bill and placing Sookie happily married and pregnant at the end of “Thank You” following the introduction of Nu Blood, the audience is lead to believe that the HEP-V crisis, and the HIV endemic by proxy, is over. As this project has already shown, nothing could be further from the truth. This chapter cannot be disconnected from the discourses of the federal government in preventing the spread of HIV throughout the United States (and the world) as in Chapter 2, or that such attempts to deploy the AIDS-as-allegory rhetorical format in *True Blood* is indebted to the work of organizations like The Stigma Project in Chapter 3—though The Stigma Project may be more adept at managing their messaging than the complicated, if imperfect, attempt done by *True Blood*. In drawing these three chapters of analysis together, the theorization of a rhetorical mosaic, a discursive and recursive construction that reveals the various discursive entanglements of HIV and its stigmas becomes apparent. The following project conclusion will reveal these connections.

5. How to Have Radical Hope in a Rhetorical Epidemic of Stigma

In Vice Media's thought-provoking documentary, "The End of HIV? The Truvada Revolution," PrEP advocate Damon Jacobs states a prescient implication shared by many gay and bisexual men:

We thought this was going to be over in the '90s, at least I did. I thought "this can't keep going like this." And when 2000 came and went and we were no closer to a cure, and we were no closer to a vaccine, that's when this hopelessness started coming in. That I—I don't think I'm ever going to live without this being a presence in my life. And I don't think I'm ever going to be able to have sexual freedom without the fear of HIV. That came to be something I accepted. (*The End of HIV? The Truvada Revolution*)

Damon's words about the fear of HIV—and by extension dying from AIDS—are embedded within the fabric of the LGBTQ community. His words convey a memory of pain and death so powerful that it shapes the very perceptions of what life as an openly gay or bisexual man meant (and still mean) for many: that true sexual freedom was impossible.

This sentiment is alternatively echoed in Tim Dean's volume, *Unlimited Intimacy: Reflections on the Subculture of Barebacking*, where he states that "[t]he principled abandonment of condoms has led to scenarios of purposeful HIV transmission and, on that basis, to the creation of new sexual identities and communities" (Dean ix). Where Damon admits the fear of HIV as pervasive to the everyday life of many men who have sex with men, Dean's exploration of bareback subculture reveals an

alternative response to this fear: the acceptance of HIV as inevitable and/or the intentional acquiring of the virus as a means of alleviating the fear. This approach can be easily summed up through the phrase, “if you can’t beat ‘em, join ‘em.” Simply, the easiest way to end the fear of seroconversion is to let it happen. Dean notes that many self-identified barebackers are “happy to consider themselves outlaws, claiming only the right to fuck whom and how they wish” (9). These two approaches to the realities of life as a gay or bisexual man, or any man who has sex with men, crystalize the centrality that fear of HIV plays in their sexual lives and this fear’s negotiation through either an acceptance of inevitability or constant vigilance.

Or at least, it did. The FDA’s acknowledgment and approval of Truvada as Pre-Exposure Prophylaxis changed *everything* in the playbook about sex, HIV, and prevention. *Unlimited Intimacy* was written in 2009, three years before the FDA approved Truvada as PreP; Dean’s book is now strangely outdated by the very concept of people who are HIV negative having the ability to participate in the bareback subculture *and intentionally remain negative*. That this reality is backed by medical science only further confounds the previous fears of HIV’s inevitability with the pursuit of condomless sex acts. Dean’s volume and the Vice documentary intersect when the documentary shows Damon going in for a check-up with his specialist. He says, “I feel like I spent enough of my life losing sleep over consequences of sexual behavior” (*The End of HIV? The Truvada Revolution*).

I begin this concluding chapter with a discussion about Travuda because this discussion invites reflection on the central implication of this entire dissertation project: the shift to a universal sexual health paradigm for men who have sex with men. This new paradigm combining physical and chemical prophylaxis (condoms and anti-retroviral medications, respectively) both for those who *are* and *are not* HIV positive—along with a move away from physical prophylaxis for all and chemical prophylaxis for some—is a dramatic shift in the medical and cultural war on HIV and AIDS. Specifically, this tile of our mosaic is the most significant advancement in the fight against the spread of HIV since the advent of antiretroviral medication in the 1990s and the identification of the virus before that. Further, physical and chemical prophylaxis challenges the stigma that fear of HIV enables (and, by extension, the communication actions fueling an endemic). Chemical prophylaxis serves as a realization of sexual “thin walled” societies where the only barriers are “invisible condoms” and stigmas are absent. The communicative implications—broadly defined—of this shift will be the focus of this conclusion chapter, as well as the implications of this shift in concert with the governmental, social mediated, and popular culture discourses in which HIV and its associated stigmas can be found.

As shown in Chapter 2, official actors, like the CDC, state/community public health campaigns, and the federal government, focus intensely on gay sexuality and the possibility that HIV may spread and infect others. The problem with such an approach is that it renders the sexuality of men who have sex with men as a *problem* and not a *sexuality* (Dean 11). This becomes more problematic as the inability to see HIV without

scientific equipment has lead “gay men [to] develop a range of ideas, beliefs, and fantasies about it, only some of which coincide with current scientific knowledge about the virus” (Dean 12)—chief among which, for Treichler and others, is an epidemic of signification, or discourse of stigma. Stigma is only exacerbated by a range of myths and beliefs that people who are not at high risk for HIV develop through an absence of scientifically accurate information about HIV or even a lack of discourse about HIV altogether. The problem of popular culture’s depictions of HIV is that they often lack nuance and information or are blatant in their depiction, such as the case of *True Blood* (which was discussed in chapter 4). As such, it is important to carefully reflect upon the implications that the previous chapters have left for this investigation of a rhetorical mosaic of stigma.

Seeing the Mosaic in Parts: A Review of What Constitutes a Mosaic

As described in the opening parts of this project, a rhetorical mosaic is *a drawing together of textual tiles/fragments and arrangement of them in such a way that their contradictions and complementary meanings allow for the viewer/critic to step backward and rhetorically see a larger, complex social text and the relationships of power and rhetorical force that travel along the gatherings of textual tiles*. Such textual tiles show the connections and specifically “joints” where rhetorical meaning overlaps/overflows from one piece of the mosaic into another. The construction of such mosaics, especially the reading of the connections, renders a performative space where critics must contest discourses that use such rhetorical articulations. Such recursive assemblages, as Jasbir

Puar reminds us, remain dominating or constraining to oppressed populations because the grids or textual bodies that we critique are not placed in critical conversation with each other.

This project used three methods of analysis, governmental critique, viral/biocriticism, and mythic criticism, to explore the possibilities offered by viewing rhetorical criticism through the lens of a mosaic. As collections of (con)textual tiles that must be read and reviewed through their arrangement, analyzing the connections/joints between separate textual tiles, allow for criticism of complex rhetorical discourses to tease out communicative meaning that may have been missed before. Such meaning renders mosaics a complex rhetorical form that contradicts a modernist, colonial ordering of the world. Drawing from Wanzer's decolonial project of textual fragmentation, this project has shown that despite a surfeit of official and popular discourse about HIV, very little of this discourse is coming from the mouths of people living with or at risk for HIV. Despite advancements in social acceptance of homosexuality, opportunities for inclusion in discussions and policy, and central participation within advocacy against the spread of HIV, gay and bisexual folk remain a population that is paternally *spoken to* or *spoken about* within official channels, such as the CDC in its campaigns and on its websites, and even in popular culture, such as *True Blood's* use of the AIDS-as-allegory deployment in its final season.

The Stigma Project, conversely, works as a counter-discourse, rendering silenced voices which have been challenging stigma audible. Its social media campaign imagery

contests the normative stigmas that have been within HIV discourses since the Reagan era. Further, the Stigma Project's possibility for HIV neutrality opens a wide door for new ways of constructing identity and self-advocacy, especially in the era of PrEP. However, these examples must be placed in conversation with each other to see how their joints and connections form a *text* that can be interpreted.

First, I revisit Chapter Two and The Act Against AIDS campaign, specifically the Start Talking. Stop HIV campaign. As rhetorical deployments of the CDC's regime of health, both simultaneously exemplify progress and regression in their depiction of who is and is not at risk. In its representation of diverse bodies and peoples, the campaign does an amazing job of bringing its message to many men who have sex with men across the spectrum of race and age—something that is not always done well in HIV prevention campaign media. However, when coupled with the rhetoric of the federal agencies responsible for the fight against HIV, specifically the CDC and the ONAP, the Act Against AIDS campaign does not address stigma as a means by which to fight HIV. Additionally, the ONAP's placement of stigma as a confounding variable that is really addressed only once in their national HIV and AIDS policy document, complicates the situation. If the (former) President of the United States cannot say the word "stigma" in his speeches about HIV, why should anyone invested in combatting stigma take seriously the federal agencies that he oversees as agents of contesting said pervasive stigmas about HIV? This becomes most damning when the regime of health rhetoric focuses on "awareness" of HIV, because what constitutes "awareness" and what does not is never

fully defined. The subject position created is thus rendered hollow and unsatisfying as a tile in this mosaic.

Second, *True Blood*'s deployment of AIDS-as-allegory within a collapsed frontier mythic form revived highly problematic portrayals of whose story matters most, and who is to blame, in HIV discussions. The series finale shows heterosexual characters impacted by HEP-V through sex and feeding on humans, the "normal" and natural way vampires feed, rather than the "queer" vampires who were infected by drinking tainted Tru Blood. The series focused specifically on tragic heterosexual love stories (Sookie and Bill) and normative family structures (Eric and Pam), and re-stigmatized those who are different or marked by queerness (the off-screen death of bisexual vampire and series regular Tara) and the HEP-V virus (the abstinence only relationship between Arleen and Keith). Additionally, the way in which Sarah Newlin was rhetorically created as a monster parallel to Gaeten Dugas is chilling from any perspective, as this shows how easily scapegoats are still created and justified within outbreak narratives. Even if Newlin was directly responsible for the creation of the virus, Sookie's abandonment of her in the Fangtasia basement bespeaks an inhumane punishment that should give any critic pause.

However, it is important to acknowledge that *True Blood*'s allegory was—intentionally or not—a rhetorical attempt to provide closure to an epidemic that was never given the opportunity to *be closed*. The epidemic of HIV rages on across the world, despite the advancements of medical technologies; the global community is no closer to slowing the epidemic than we were almost 40 years ago. Since *True Blood* potentially

reached an audience larger than both the CDC's campaign and the Stigma Project's social media presence combined, this desire to provide closure is significant and should be questioned since such a move implies that like the *True Blood* series, the national endemic and world-wide epidemic of HIV has concluded. Nothing could be further from the truth. With 39 million people living with HIV across the world, and roughly fifty-thousand new infections in the United States every year, such a rhetorical move is appalling as it attempts to force an uncomfortable happy ending while people are still suffering. When combined with the implication of *True Blood's* privileging of tragic heterosexual and normative family structures, this can be read as a crass way of saying that majority of low-information and HIV-uninformed straight folks and the heteronormative world-at-large may really just want to "move on" from AIDS and leave queer folks and those living with HIV to pick up the slack.

Finally, and perhaps most significantly for this project, the possibility of HIV neutrality proposed by the Stigma Project combined with Renato Barruco's reimagined hierarchy of animatic risk is a dramatic turning point in discourse about HIV. In examining the animatic potential of HIV to move between bodies, the viral agency of HIV becomes central to discussions of who is at risk and which sexual partners are risky, rather than a system of risk based on outdated serosorting practices and personal (bio)insecurities that operated on fear and stigma. Barruco's positioning of people on PrEP and undetectable people at the top of the hierarchy radically shifts how prevention workers and sexually active people can talk about risk. PrEP and TasP offer a major

intervention in slowing the tide of HIV infection, but the larger question of how these chemical prophylaxis technologies—which Dean calls “invisible condoms”—will reach those who need them has yet to be sufficiently answered. While language and science are catching up to each other through discussion of the benefits of an undetectable viral load and being “PrEP-ared,” recursive stigmas are still prevalent in other discourses. While the Affordable Care Act placed anti-retroviral therapy as a medically necessary part of medical coverage, thus bringing PrEP and TasP options to all people with insurance coverage, this intervention is challenged by a new presidential administration and conservative Congress that wants to roll-back health insurance access to millions. HIV neutrality will do very little good as a subject position when the medical technologies that the position requires are not available to a large cross-section of people who are at risk.³² Further, if language used by the CDC to position the responsibility of preventing HIV infections falls solely on those who know their status, as well as the rhetorical deployment of *True Blood*'s homophobic privileging of heterosexual love is not critiqued, our societal discourse runs the risk of re-fighting the same Reagan-era stigmas every time a new advent of technology renders HIV and AIDS less scary and more normal.

³² This is not to claim that the current system is perfect, but improving the current system is much preferable to gutting everything and starting from scratch with fewer protections.

Brining the Tiles Together

It is important to further address, having discussed the textual tiles of this project, that these are not the only tiles of the mosaic of HIV stigma. Many salient movements and rhetorical acts have occurred since this project began and many of utterances and actions outside the scope of this project's analysis chapters implicate and connect at the joints of the textual tiles discussed above. The largest and most salient tile to examine is political in nature. Most specifically, any possibility of an AIDS-free generation has been put on an indefinite hold following the 2016 election cycle and the inauguration of Republican Donald Trump.³³ Trump's campaign for the White House—which was itself a rhetorical gold-mine for critiques of his and his campaign's tapping of deep rooted rivers of conservative American racism, misogyny, classism, nepotism, homophobia, nationalism, and xenophobia—was predicated primarily with the repeal of Obamacare/The Affordable Care Act and attacking “political correctness” anywhere and everywhere to “make America great again.” If a sympathetic Obama administration did not focus on stigma in its attempts to combat the spread of HIV, any movement to address the epidemic will be dramatically challenged by an administration that is silent at best about HIV, and hostile at worst towards any subject LGBTQ and poverty related.

³³ The author, as a person living with HIV at direct risk from Trump's policy decisions, refuses to call Donald Trump “President.” The author holds that Donald Trump's occupation of the office is an insult to the United States' democratic traditions, as flawed and imperfect as they may be, and constitute a blatant corporate power grab obfuscated by the Trump superbrand. For further information see Naomi Klein's 2017 book *No Is Not Enough: Resisting Trump's Shock Politics and Winning the World We Need*.

In the nearly six months since his inauguration, Trump has done literally nothing in regard to HIV and AIDS policy. Immediately following Trump's inauguration to/occupation of the Office of President on January 20, 2017, the website for the Office of National AIDS Policy went dark and remains a blank page as of the final revisions of this chapter on July 11, 2017—172 days later. Recently, six members of the President's Advisory council on HIV/AIDS resigned after the Trump administration appeared to be seeking no advice from them on HIV and AIDS policy. Scott Schoettes, the HIV Project director for Lambda Legal, an LGBTQ focused legal organization, said that a major part of the reason he and his colleagues departed from the advisory council was Trump's handing of health care. Schoettes expounds:

[p]eople living with HIV know how broken the pre-ACA system was. Those without employer-based insurance were priced out of the market because of pre-existing condition exclusions. And “high risk pools” simply segregated people living with HIV and other health conditions into expensive plans with inferior coverage and underfunded subsidies—subsidies advocates had to fight for tooth-and-nail in every budgetary session. (Schoettes)

Further, the reality of who is advising Donald Trump on medical and social policy cannot be ignored. Vice-President Mike Pence, former Indiana governor, somehow managed to survive an entire election cycle as the second name on the Trump ticket without the public acknowledging the fact that he was directly responsible for a massive HIV and Hepatitis C outbreak in southern Indiana, through the closing of many Planned Parenthood clinics and shift away from needle exchanges to prayer-based activity (Twohey, Schumaker). The use of needle exchanges and testing services provided by Planned Parenthood would have slowed the diseases' spread during the current opioid

epidemic, which hits former industrial areas (such as southern Indiana) the hardest. Eventually, Pence signed a bill allowing formerly illegal needle exchanges to open, but many counties still have not opened them because the state refuses to provide funding to do so (Harper). Tom Price, the current Secretary of Health and Human Services, is hypocrite to the Hippocratic Oath a remarkable monster in his own right. A Republican physician, Price advocates the creation of high-risk pools in the replacement of the Affordable Care Act. Such pools would penalize people with pre-existing conditions before pricing them out of the market and into penury and possibly homelessness; such high-risk pools would do very little for the vulnerable people who need care the most (Jones).

Of course, it would be remiss to not address the ways that the alternative candidate failed, too, in addressing HIV related topics. At the funeral for Nancy Reagan on March 11, 2016, Former First Lady and Secretary of State Hillary Clinton baldly misspoke (i.e., lied) when she claimed that as First Lady Nancy Reagan was involved with “low-key advocacy” regarding the epidemic of HIV and AIDS (Taylor and Kurtzleben). Low-key advocacy apparently translates to leaving family friend Rock Hudson to die in Paris from AIDS when a call from then President Reagan to the French foreign minister could have resulted in his survival through experimental treatment (Topping). Though she later apologized and claimed she misspoke, many HIV and AIDS activists were deservedly furious with her campaign for weeks after. To be fair, both Clinton and her primary opponent, Senator Bernie Sanders, sought council from HIV and

AIDS activists; but only Clinton—potentially because of her mistake at Nancy Reagan’s funeral—specifically mentioned HIV in her approach to medical policy and improving the Affordable Care Act. These realities are compounded by the further push for repeals of LGBTQ rights occurring in both conservative and swing states across the country. This resurgence of homophobic and anti-trans legislation is popularly felt as a reprisal for the Supreme Court’s decision for marriage equality in *United States v. Windsor*. The impact and extent of this resurgence has only just begun, and the duration of this new assault on the rights of LGBTQ people, sadly, cannot be estimated now; however, it is not hyperbole to state that the Trump administration could potentially set the fight against HIV and AIDS in the United States back to the days of the George H. W. Bush administration, or roughly thirty years. It is not just ironic to consider the days of President George H.W. Bush (years before the advent of antiretroviral therapies to treat people living with HIV and AIDS) as preferable for being the last time a sitting Republican President paid attention to the HIV and AIDS crisis domestically in the United States, it is simultaneously horrifying, shameful, and painful to imagine.

While the political realm of textual tiles may leave critics with anxiety, the tile collection from areas of popular culture and medical technology offer some insight into how the hopeful direction of vernacular discourse. In May 2017, scientists at Temple University published a paper about the possibilities of editing out a live HIV infection in mice using the powerful gene-editing technique of CRISPR/Cas9 (“Gene Editing Strategy”). While the technique is still being perfected, this study expanded upon a

previous proof-of-concept, and the next stage would be to move to primate models from lab mice. However, the potential translation of this method of viral eradication would be impractical for mass treatment—the procedure would require intense precision as the HIV virus replicates and mutates in minute different ways in each person. And yet, this advancement shows that complete eradication of the HIV virus in a living body after infection *is possible*. Though this may be a decade or two from practicality, the same was once said about anti-retroviral medications.

Further, the entertainment world has a new celebrity who has become open about his struggle with HIV. In an exclusive with the *Today Show* on November 17, 2015, actor Charlie Sheen revealed that he was diagnosed with HIV in 2011 (Kim). Sheen’s public disclosure came as the actor was facing blackmail by people who were attempting to use his HIV status as a means of extorting money from him. Sheen claims that he does not know how he contracted the virus and was adamant about the fact that he could not have infected any else. Despite Sheen’s courage in revealing his status, the news coverage by the *Today Show*—specifically the web reporting—contained phrasing that undermined his disclosure. The article by *Today Show* writer Eun Kyun Kim concludes with calling an HIV diagnosis a “manageable illness” rather than a “chronic manageable condition,” and states that “antiretroviral medication must be taken for a lifetime” (Kim). Such language suggests that people on successful medication regimens are always “sick,” rather than having to monitor their health like those with other chronic conditions such as diabetes and hypertension. Additionally, Kim’s language suggests that HIV is not a death

sentence, but a life sentence. Though these distinctions are ones of language, they also demonstrate the linguistic building-blocks of stigma. Despite being medically accurate, the reporting on Charlie Sheen further reveals the need for discussion about how to talk about HIV and AIDS in a humanizing, non-stigmatizing manner.

Conversely, there is one positive political example that can be provided for the fight against HIV and AIDS. In 2014, New York Governor Andrew Cuomo launched a radical program to halt the progress of HIV in New York by 2020. Called “Bending the Curve” the program seeks to identify people living with HIV who are undiagnosed, linking and retaining people with HIV in specialty care and suppressing their viral loads, and connecting and providing access to PrEP for high-risk persons (“Governor Cuomo announces Plan”). Remarkably, the plan includes a mandatory cap on HIV+ person’s rent to 30% of their income, thus establishing stable housing and improving their chances at being retained in care. Despite advancements in medical technology, the retention level for those who have been linked to care for HIV remains at 40% (“HIV/AIDS Care Continuum”). Though there are many explanations for why only 40% of the estimated 1.2 million people living with HIV in the United States,³⁴ or roughly 480,000 Americans, are engaged in care—and of this number, only 360,000 are virally suppressed or undetectable—one reason that is rarely discussed is housing security. By improving the

³⁴ The data from HIV/AIDS Care Continuum study by the HIV Care Continuum Federal Working Group was gathered from 2013, when the rounded estimate for people living with HIV in the United States was 1.2 million. Current estimates accounting for those who are newly infected raise this number to 1.3 million; roughly 137 people are newly diagnosed every day in the United States of America.

chances for someone with HIV to have a safe and reliable place to live, the chances of an individual to fall out of care and potentially off their medications is much lower.

Governor Cuomo's plan is not perfect, however. Many of the people in desperate need for PrEP do not have access to it due to structural racism and poverty, specifically for communities of color and trans identified individuals—both of whom share a disproportionate burden of HIV and AIDS cases (VICE Media). Interventions must be made structurally at many different levels to address and reach communities underrepresented within political and medical discourse.

Final Thoughts and Interventions: How to See Radical Hope in a Rhetorical Mosaic

But what can we scholars of rhetorical studies and educators do, specifically, to address the stigmas of HIV and AIDS? The simple answer is *to talk about these stigmas*, because every time we—educators, Americans, world citizens, friends, lovers, and family members, alike—talk about HIV, the virus becomes a little less scary. ACT UP said it best years ago: silence equals death. The death of conversations about HIV and AIDS equals an enabling silence for people who believe themselves to not be at risk—that HIV and AIDS are only problems for *other* people. And further, this silence allows such people to believe that AIDS is no longer a serious problem at all. If this argument is a bitter pill to swallow, I should reiterate that Donald Trump, despite campaigning as a friend to LGBTQ folks and having an ardent “gays for Trump” following, still has not nominated a department head for the Office of National AIDS Policy. Donald Trump's silence about HIV and AIDS is reflective of a larger silence by privileged folk—of many

creeds and identities—for whom HIV and AIDS is not a daily thought or complication.

The answer then is to not stop talking about *why* these conversations matter, to have them when opportunities arise, and if necessary, to force these conversations when official discourse mandates silence.

Such conversations are built upon a foundation, a radical one, that positions the future as one of hopeful possibility. This reality is clearly framed through the Stigma Project's use of HIV Neutrality and its utopic vision of a world where serostatus carries no stigmatizing or affective baggage. In writing about the role of hope, José Esteban Muñoz reminds us that “bad sentiments” such as depression, bitchiness, and cynicism are ways of finding an exit out of despondence and hopelessness: “these sentiments associated with despondence contain the potentiality for new modes of collectivity, belonging in difference and dissent” (Duggan and Muñoz, 277). Further, Muñoz argues that such forms of “educated” hope must be revolutionary in their aims:

Feeling revolutionary opens up the space to imagine a collective escape, an exodus, a “going-off script” together. Practicing educated hope, participating in a mode of revolutionary consciousness, is not simply conforming to one group's doxa at the expense of another's. Practicing educated hope is the enactment of a critique function. It is not about announcing the way things ought to be, but, instead, imagining what things could be. It is thinking beyond the narrative of what stands for the world today by seeing it as not enough. (Duggan and Muñoz, 278)

In order to arrive at the world proposed by the Stigma Project, we—scholars and activists—must work to both imagine and act toward the way things *could be* were society to abandon HIV related stigmas. What I term a radical hope, which Muñoz calls

“educated” hope, sits within the ability of communicators to speak, write, and act-into-being different worlds that make possible the different ways things could be.

Though such conversations may be complex and imperfect, they are immensely necessary because stigma, at its core, is a *myth with material consequences*. Goffman reminds us that stigmas are not about the stigmatizing attributes themselves, but the attitude toward an attribute that is read negatively and the association between the attribute and the attitude is communicated as stigma. If Barthes is correct and myths render objects and texts distorted by embedding them with specific values toward specific ends, intentions, and motivations, the clarity of such a connection between stigma and its mythic function becomes obvious. If stigmatizing speech is contested for its mythic functions—the perpetuation of specific ends and the replication of power relations—the connection between negative associations and attributions becomes clear.

Above, I provided an example of this by critiquing the misspeaking of *Today Show* writer Eun Kyung Kim who called HIV an “illness” and not a “condition,” as if to suggest that people with HIV are always already (permanently) sick. This placement hierarchically positions people living with HIV closer to being “touched by death” biopolitically and also having less animacy or liveliness. As Chen would remind us, this renders people with HIV less (perfect) human(s). While I doubt that Kim did this intentionally, that is a consequence of mythic speech; the utterance of values beyond oneself, about which one may be ignorant or uninformed. Further, this mythic speech act creates a linguistic slippage that then sets up the material consequence: a “lifetime” of

punishment/dependence upon antiretroviral mediations. This is the nuance of HIV stigmas and their mythic deployment, and to not speak about them or reveal them only empowers them further. Having such conversations and pointing to such moments of stigmatizing rhetoric—big or small—is part of the solution. It is important to talk about the fears that undergird our stigmas toward gay and bisexual men, anal sex, disease and queer sexuality in general as a means of ending stigma's mythological deployment. Such fears appear in the CDC's "Start Talking. Stop HIV" campaign when an individual is suggested to "whisper" something, to disclose meekly, keep their partner safe. Additionally, by not uttering the word "stigma" in his address, President Obama missed a direct opportunity to actively combat stigma while holding the office of President.

These examples crystalize the personal (bio)insecurities that are critical to deconstructing the mosaic of stigma. This project has shown larger examples of this method of intervention in its critique of the federal discourses about HIV and the implications of *True Blood's* AIDS-as-allegory deployment. These are larger discourses, texts, and speech acts and the nuances of their stigmatizing language may have slid under the radar for many audience members, but by revealing these nuances scholars of rhetoric are become better equipped to see *more* tiles of the mosaic of stigma and how they connect and join with other discourses.

An additional intervention this project proposes has been visible since page 1, and it may have become so normal to readers of this project by now that it is an afterthought, but it is a subtly powerful linguistic form of intervention in how HIV and AIDS is written

and talked about. Perhaps for ease of writing and speaking, the colloquial way of talking and typing about HIV and AIDS has been to combine them with a slash (“/”) as HIV/AIDS. The end result has been the connection of the two in speech as one word (which often sounds like a letter soup as HIVAIDS) and the powerful and rhetorical marrying of the two together in the cultural psyche. If only one thing from this project should be remembered, it is that we are not in 1984 anymore, Toto. Advancements in medical technology have allowed people on antiretroviral medications the ability to lead normal, healthy lives. Confounding variables such as smoking, diet, economic status, race, sex, and access to health care or insurance can complicate this, but such is also the case for people who are HIV negative as well.

In other words, it is time linguistically and communicatively to acknowledge that HIV—the virus—and the end-stage condition—AIDS—are not the same thing by speaking about them as separate words: HIV *and* AIDS. *It is the responsibility of activists, governmental officials, journalists, and health workers to make this shift—specifically in published writing about HIV and AIDS—and end the practice of linguistically and psychically merging the two together.* If we wish to truly create a world without AIDS, should we not first separate the two from this powerful mental joining? It is entirely possible that someone diagnosed today will *never* have their infection progress to AIDS—so long as they remain in medical care and have access to their antiretroviral treatments. Unpacked further, this distinction frames the management of an HIV infection is a personal commitment to one’s health and the safety of others; the

management of AIDS is a social responsibility as an AIDS diagnosis reflects a cultural and systemic failure to diagnose early and link someone to care. Stigmatizing rhetorics may make claims about someone based on their HIV status, but an AIDS diagnosis says more about the community, municipality, and state a person resides in and the failures of that system to address the needs of their constituents. It is time to name the responsibility of preventing AIDS as a cultural responsibility of our health system and legal frameworks rather than a personal responsibility of prevention alone. This shift is already in progress in the calls for AIDS free generations and specifically in Governor Cuomo's plan to lower the number of new HIV infections in New York per year to lower than the number of people dying with AIDS.³⁵

These solutions may seem like common sense and appear underwhelming, but are they not what this project has been about? To show *and talk about* how federal discourses and popular culture create problematic elements for undoing stigmatizing rhetoric? To show *and talk about* how the Stigma Project creates a new subject position in HIV neutrality that radically transforms our cultural approach to HIV prevention and discourse? To show *and talk about* how Renato Barruco's animatic hierarchy of HIV risk rejects and replaces the problematic poz/neg binary that came before it? To show *and talk about* a perspective approach to rhetorical criticism as a mosaic that enables textual

³⁵ An important distinction: someone who dies *with* AIDS may not always die *from* AIDS. Further, persons who are living with HIV and die from unrelated complications, illnesses, or accidents sometimes are mistakenly added into tallies for people who die *with* AIDS. Distinctions from the CDC and various municipal and state health departments do not clarify the distinction linguistically and are quite vague in how this is established.

criticism by examining the joints and connections between discursive fragments and textual tiles of discourse with the example being the assemblage of stigmatizing rhetorics about HIV and AIDS? To show *and talk about* how these stigmas are built upon beliefs and myths about gay and bisexual men that reflect colonial attitudes about sex and normalcy? If Burke is to be believed and criticism is what critics do, then *in talking about* such criticism, are we not also participants in the very speech acts we critique? I would believe so, and I further believe that my arguments in this project would concur with these statements.

In conclusion, I echo the words that Mary Fisher spoke to the Republican National Convention in 1992:

In the context of an election year, I ask you, here in this great hall, or listening in the quiet of your home, to recognize that [the] AIDS virus is not a political creature. It does not care whether you are Democrat or Republican; it does not ask whether you are black or white, male or female, gay or straight, young or old. ... We may take refuge in our stereotypes, but we cannot hide there long, because HIV asks only one thing of those it attacks. Are you human? And this is the right question. Are you human? Because people with HIV have not entered some alien state of being. They are human. (Fisher)

This project has explored the various nuances of HIV stigma as a communicative force within human discourse that has multiple intertwining and complex nuances. The answer, I feel, lies somewhere within the joints of the textual mosaic that scholars of rhetoric can translate and deploy toward better ends in articulating who suffers at the hands of a continuing epidemic of signification, and by whom such rehetorical deployments are normalized. The easy answer here is that queer folks, gay and bisexual men, people of color, injection drug users, and trans folks alike lose in this continual epidemic of

signification. Further, it is those who wish to obfuscate the material realities that are created by this epidemic of signification—specifically people invested in cultural racisms and homo/queerphobias—toward specific ends who wish to simply let a horrible chapter in human history end; but that chapter is not yet over. The fight against this epidemic of signification and the stigma it enables is not just the realm of scholars and those who are living with HIV, it is all our fight because we human beings are all together, each of us, beautifully imperfect. And as beautifully imperfect human beings, we are each far more than the viruses we carry, and we are all culturally more than our outdated mythologies that cry out for critique.

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Appendix A: Images



Image 1



Image 2

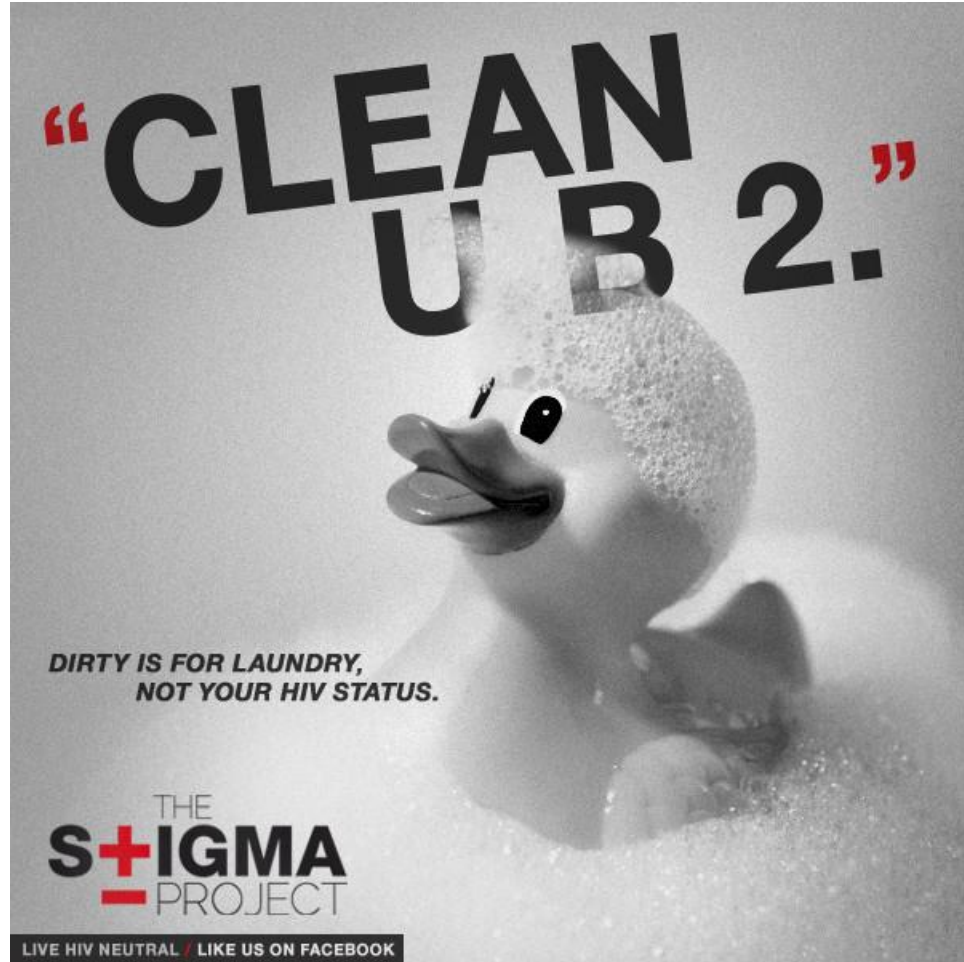


Image 3

**A QUARTER OF THE U.S. POPULATION
THINKS HIV CAN BE TRANSMITTED BY
SIMPLY SHARING A DRINKING GLASS.**

THE
S+IGMA
PROJECT

THEY'RE WRONG.

EVOLVE.



SOURCE: KAISER FAMILY FOUNDATION

LIVE HIV NEUTRAL / LIKE US ON FACEBOOK!

Image 4



Image 5

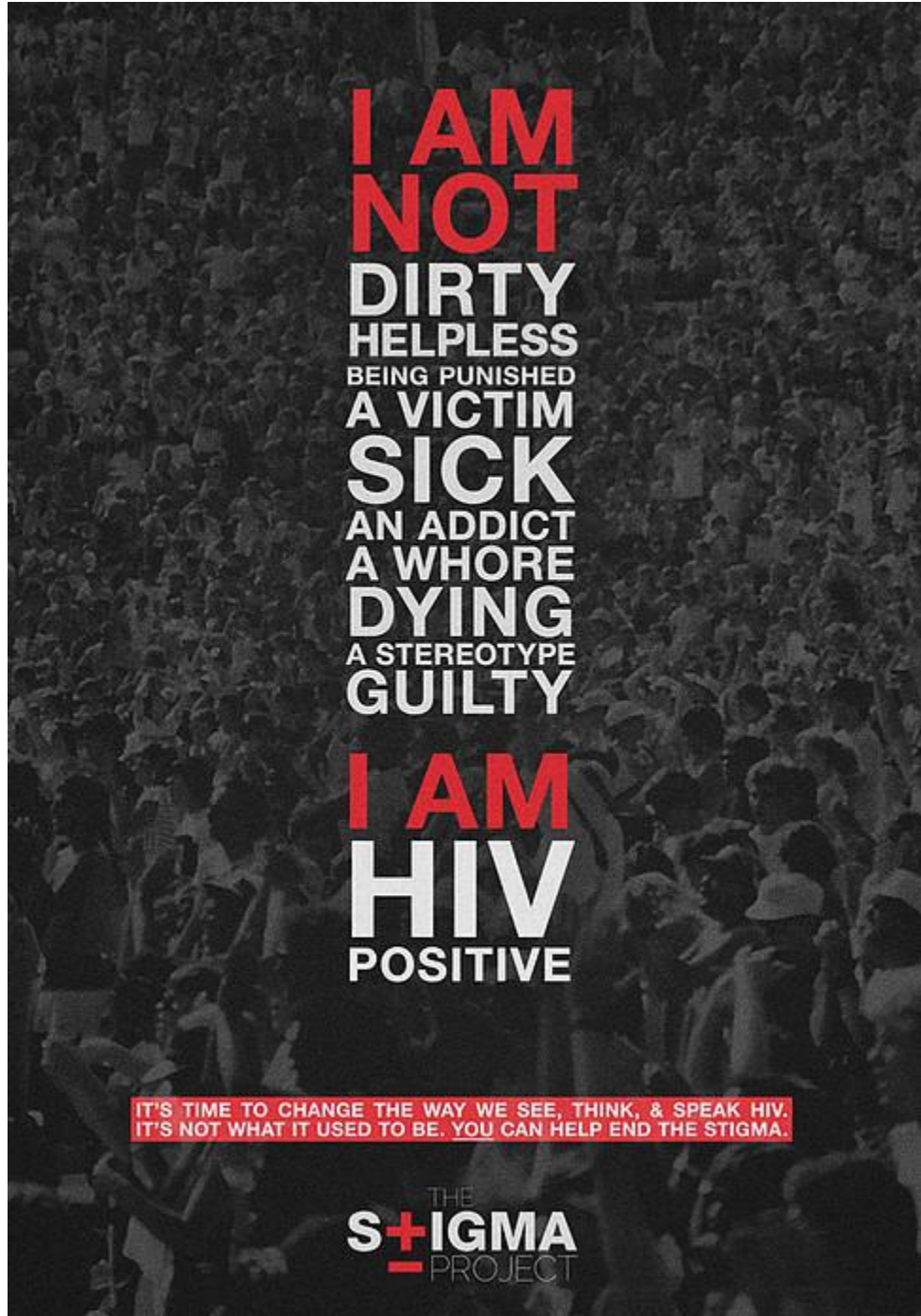


Image 6

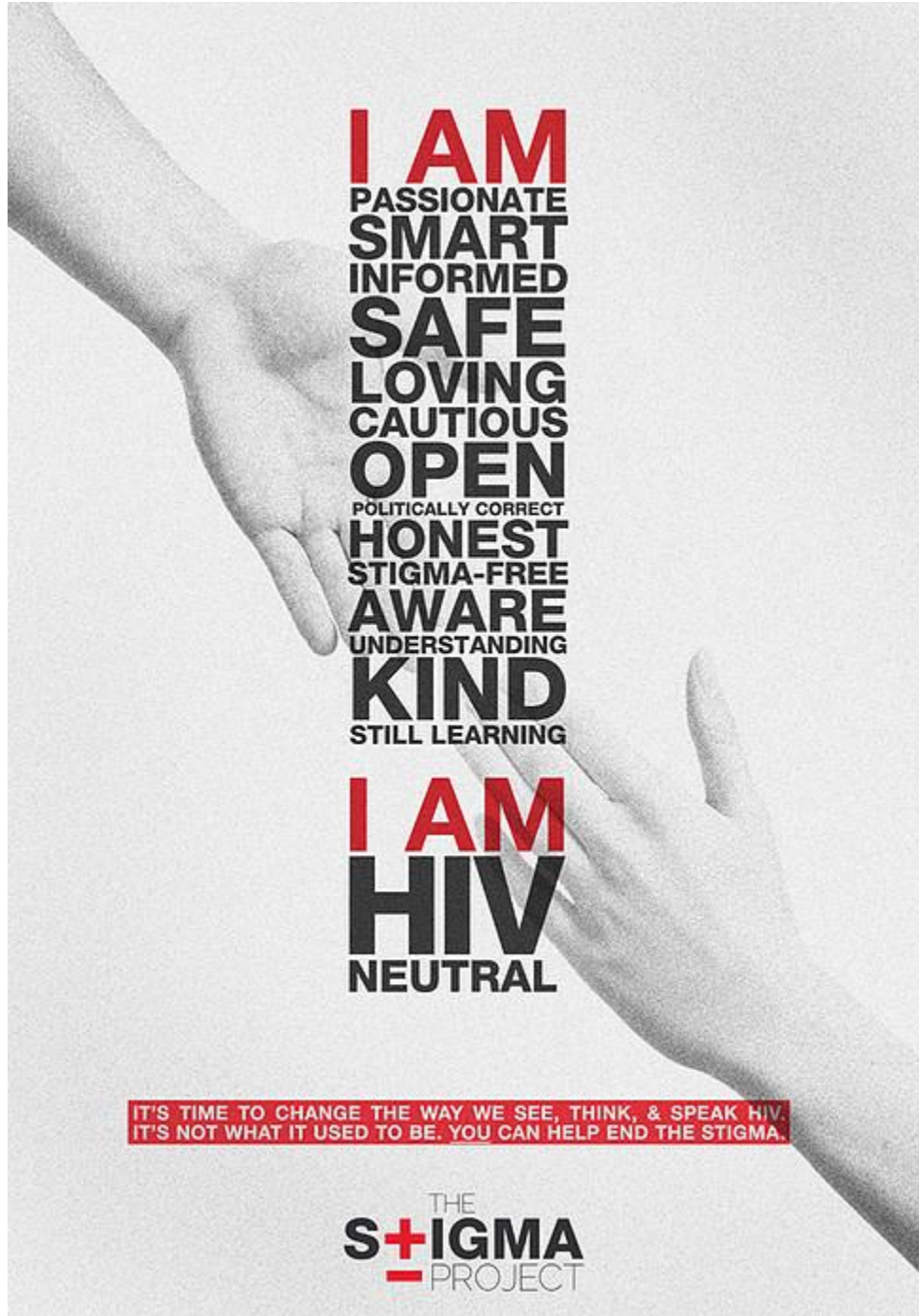


Image 7