Pride, Shame, and the Trouble with Trying to Be Normal

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Abstract

I performed 14 person-centered ethnographies with methamphetamine-using HIV-positive men who have sex with men in San Diego, California, who were all subjects of the "anti-meth apparatus," a collection of government and nongovernment organizations focused on meth use and its sequelae. The apparatus attempts to coerce addicts to develop and perform certain identities and emotions, though addicts are capable of both passive acceptance and active disruption. In my research, those who failed to become the apparatus's ideal subject felt shame, while those who succeeded expressed pride. Those hovering in the middle experienced a perpetual struggle to become normal and rarely, if ever, succeeded. [addiction, HIV/AIDS, subjectivity]

One morning in March of 2011, my phone vibrated as I was getting into my car to go to the syringe exchange where I had volunteered every Friday morning for about a year. The "Hey, Ted" that I heard was instantaneously familiar; it was Sam, a funny, sweet, crafty, and homeless 43-year-old methamphetamine addict I had met at the exchange the previous summer. For three months last summer and fall, I had interviewed Sam, paying him $15 for each hour he talked to me. More so than any of the other 13 meth-using HIV-positive men who have sex with men (MSM) I worked with, Sam became my friend, and I became his friend.

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

"I fucked up," Sam said. "I really fucked up."

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

"I was clean for two months, and I walked out of Choices at 9:00 a.m. this morning," he said. "And I just drank a whole Four Loko, and I'm drunk." Choices is a free, nonprofit, heavily state-subsidized recovery program in northern San Diego County, and Four Loko is a malt liquor beverage that is intensely caffeinated. Because of the power for the price, Four Loko was popular among college students and the poor.

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

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

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

"Oh, we already scored some speed." Speed can refer to many different kinds of amphetamines, including methamphetamine, the most addictive form of the euphoria-inducing psychostimulant.

A week later, he called and asked for $20. When I went to meet him, he was thankful, but he was also, clearly, ashamed of his predicament. He was back sleeping in a tent in a leafy canyon below a bridge and a highway on-ramp known as Camelot. He kept saying that he's not strong enough, not patient enough, that this was all his fault. "This is all on me," he said.

Sam, clearly, was ashamed that he is unable to be clean and sober, to be able to work, to be able to avoid hustling, stealing, and asking people like me for $20. At one interview, Sam told me, "I always feel like shit after I talk to you." I immediately felt guilty and asked why. "Because you have your shit together and I'm such a fucking mess." I told him I did not want him to feel like shit, and it is not as if I've faced the same problems. He said that he knew that, but my existence made his predicament all the more clear. This was one of the moments in my fieldwork that most clearly showed me how emotional experience is an interactive cultural experience structured by power relations. Even in my concerted effort to be nonjudgmental, to just prod him to tell his story, my existence as an educated, housed, and seemingly happy academic researcher paying him $15 for his tales of woe reminded him of the pain of that woe.

Sam's shame arises from his inability to control his addiction, to become a recovering addict, to become a productive member of society, a "normal" American. In this article, I examine how, once they identified themselves as meth addicts, usually with the help of various governmental and nongovernmental forces, my informants formed subjectivities within a behavioral environment structured by attempts to encourage them to become a historically specific kind of normal. I argue that for some of my informants, normality becomes not the comfort of acceptance and conformity but rather a symbol of shame and frustration. After contextualizing the research and explaining the data collection, I describe how these men formed their subjectivities. First, I explain how they narrativize their identities as meth addicts and how these narratives culminate in imagined, often unobtainable normality. Second, I explain how they physically embody their risk to themselves and the community in their attempts to perform normality. Third, I explain how

their perceived successes or failures overcoming their addictions and social difficulties are inscribed in emotional discourses of shame and pride. Those who failed felt profound shame; those who succeeded expressed great pride in their abilities; and those who hovered in the middle were perpetually constructing, reconstructing, and struggling to become normal.

Normal, Abnormal, and Subjectivity

In 1934, Ruth Benedict published her influential essay, "Anthropology and the Abnormal," in which she took the then-daring position that the categories of normal and abnormal are culturally defined. Benedict points out that all cultures have normal and abnormal types, and only rarely do societies agree on what belongs in either category, and, in fact, in some societies, abnormal people are honored and are even key components in the social structure. In most cases, however, what is normal tends to be considered moral, and what is abnormal or not habitual tends to be seen as immoral. "A normal action," she writes, "is one which falls well within the limits of expected behavior for a particular society. Its variability among different peoples is essentially a function of the variability of the behavior patterns that different societies have creates for themselves" (1934:73). Throughout the essay, Benedict cites the example of homosexuality; while it is considered immoral, deviant behavior in the modern West, in certain indigenous American tribes, homosexuals were given honored places in society, and in ancient Greece, homosexual behavior was morally neutral.

More than 80 years later, while homosexuality is not yet considered a normal way of being in the United States, it is approaching that status in many segments of the culture. However, as homosexuality has become normalized, it is only certain kinds of homosexuality, only certain ways to be gay, that have become normal. This homonormative subjectivity represents, as Lisa Duggan writes, a "politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption" (2004:50). This has not been without both debate and conflict, with criticism of what is known as homonormativity coming particularly and powerfully from practitioners of Queer Theory in the academy. In *The Trouble with Normal* (1999), for example, Michael Warner attacks the notion that achieving normality, respectability, and assimilation is something that should be aspired to. To achieve normality, gay men must "redeem gay identity by repudiating sex" (1999:66) and in turn the queer ethos and counterpublics that formed during gay liberation in the 1960s and 1970s and celebrated sexual, social, and chemical experimentation. The problem with that argument is that only those who can thrive, or even survive—socially or economically or psychologically or physically, while resisting the normal—can actually benefit from abnormality. For my informants, men who exist outside the boundaries of acceptable behavior, trying to be normal is the only option for survival. And it is a fraught process.

Through an analysis of this process, we can see how culture and the self are co-constitutive. Hallowell writes, "the self is a social product—more accurately characterized as, also, a cultural product" (1955:81). He rejects the idea that we can ever have complete objectivity from which our initial understanding of reality—and ourselves—springs. "The

psychological field in which human behavior takes place is always culturally constituted," he says (1955:84). Hallowell contends that we do not live in a social or a cultural environment but rather a "culturally constituted behavioral environment" (1955:87). Hallowell considered his approach to be phenomenological in that the sense that it is through basic, socially constrained orientations that we construct and maintain self-awareness. The normative orientation is particularly important for the construction of the moral self. "Values, ideals, and standards are intrinsic compounds of all cultures," Hallowell writes. "Without normative orientation, self-awareness in man could not function in one of its most characteristic forms—self-appraisal of conduct … [The] individual must be motivated to consider whether his acts are right or wrong, good or bad. The outcome of this appraisal is related to attitudes of self-esteem or self-respect and to the appraisal of others" (1955:105–106). My informants have been the focus of the efforts to change their behaviors and subjectivities, and their orientation to what is normal in the behavioral environment is central to development of their subjectivities. For what is normal is not often what is actually experienced. As Lloyd and Moreau write, normal can be "an idealized 'other' state by which people know themselves to be irregular, disordered" (2011:593). The ideal of normality for my informants became, for some, not the comfort of acceptance and conformity but rather a symbol of shame and frustration.

Subjectivity is the expression and experience of the self, and like the self, it is the dynamic result of social, cultural, historical, and psychological processes. "Yet subjectivity is not just the outcome of social control or the unconscious," Biehl et al. write in their call for new analyses of subjectivities. Subjectivity "also provides the ground for subjects to think through their circumstances and to feel through their contradictions, and in doing so, to inwardly endure experiences that would be otherwise outwardly unbearable. Subjectivity is the means of shaping sensibility" (2007:14). The goal of the political and social institutions that are focused on the men discussed in this article is to create a certain kind of normal subject, a normal self, while the subjectivities of the men show how uneven and idiosyncratic the result of that process is, how difficult it is to make someone normal and to become normal. As an object of analysis, subjectivity can help us understand the effects of political economy on human experience and vice versa. But it is a rather amorphous thing, defined and analyzed in many different ways. For example, Biehl et al.'s edited volume includes 14 different approaches. In this study, I operationalized subjectivity by focusing on "the orchestration of self" (2007:15) within the culturally constituted behavioral environment, exploring how these men developed their identities, formed and articulated their emotional discourses, and experienced their bodies.

San Diego, Methamphetamine, and the Anti-Meth Apparatus

Methamphetamine use has been endemic in San Diego for four decades; a spokesman for the Drug Enforcement Administration declared San Diego "the meth capital of the world" in 1985 (Associated Press 1985; Warth 2007). The only reason it cannot still claim that title is that other locations have since developed similarly high rates of meth use, particularly in the rural Midwest. In the 1990s, meth migrated from poor white neighborhoods into gay enclaves, and by the first decade of the 21st century, meth had become the most popular drug among MSM in the Western United States (Mausbach et al. 2007:249). In 2008, 50%

of MSM in California had done meth in their lifetime, compared to 5% of the general population, with 15% of MSM between the ages of 18–50 reporting use in the last six months, according to a state report from 2008 (Engel 2008; Fisher and Quintanilla 2008). Along with numerous physical sequelae associated with meth use, including major neurological and cardiovascular problems, MSM who take meth are much more likely to engage in sexual behavior that puts them at high risk for contracting HIV (Boddiger 2005; Halkitis, Parsons, et al. 2001; Reback 1997; Semple et al. 2002; Shoptaw et al. 2001). Several researchers have referred to HIV and meth as an intertwined syndemic (Halkitis, Mukherjee, et al. 2008; Singer 1994; Solomon et al. 2012). This connection is partly what spurred the moral panic about HIV and meth among gay men in the middle of the last decade, an off-shoot of a larger moral panic about meth in general (Gideonse 2014; Patton 2014; Reding 2009; Valenzuela 2008).

Of the men in my study, half of them could partly blame meth for their HIV infection, while the other half knew they were HIV-positive before they ever tried meth. For all of them, however, HIV was much less of a day-to-day concern than meth. I had originally hypothesized that my informants would hypercognize HIV and their HIV status, but I found that they instead hypercognized meth and their struggle with the forces that tried to stop them from using it. HIV care is as well-funded as it is effective, with numerous agencies and their agents helping HIV-positive people with everything from medication to housing; it is simply not as troubling or worrisome to my informants as is meth. Treatment for meth addiction is neither well-funded nor effective (Colfax and Shoptaw 2005; Elkashef et al. 2008), while the efforts to control meth, meth users, and meth dealers are extensive. These range from increased and aggressive policing (Garriott 2011) to restrictions on precursor ingredients for the manufacture of meth (Reding 2009) to advertising campaigns devoted to demonizing the use and condemning the users of meth (Engel 2008; Erceg-Hurn 2008; Meth Doesn't Discriminate 2008).

I refer to the collection of governmental and nongovernmental organizations that focus either partly or exclusively on meth use and its sequelae (e.g., homelessness, addiction, crime, and HIV) as the "anti-meth apparatus." I use the term "apparatus" as Foucault did, referring to "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic proposition" (1980:194). In San Diego, the various institutional branches of the apparatus include the city's police department and the county's sheriff department, the district attorney's office and court-supervised drug courts, the county's jail and mental hospital, two research universities and a medical school, three community health providers that also ran meth abuse and HIV prevention campaigns and programs, multiple outpatient and residential recovery programs, and dozens of meetings of 12-step programs. While the various branches are united in their opposition to meth use, this anti-meth apparatus is not only heterogeneous, but also in many cases inefficient, confused, and at odds with itself, sometimes philosophically and other times simply because of mismanagement. The people working in the apparatus's disparate branches all want meth to be gone from their community, but few can agree how or why. Either they see meth use as morally wrong, or they see the suffering caused by meth addicts as morally wrong, or they

see the desire for healthy living as a moral imperative; this dissonance is representative of the ethical and moral confusion that American culture has about addiction.

A telling example involves the city's only syringe exchange, where I volunteered for three years. While the city allows it to operate, the county refuses to allow the public health department to fund it, since, as San Diego County Supervisor Dianne Jacobs said, "It sends a message to our kids that as county government, if we gave out clean needles for illegal drug use, that we condone illegal drug use" (Goldberg 2009). The conflict between harm reductionists and prohibitionists is sometimes described as policy disagreement based on different interpretations of evidence and research. Considering the copious amount of research showing that zero-tolerance prohibition policies are considerably less effective than harm-reduction methods in lessening drug abuse and addiction (Bluthenthal et al. 1999; Kerr et al. 2005; Wood et al. 2003), this description has become a canard. The difference is moral; on one side, the use of an illegal drug is moral error; on the other, the moral error is in treating illegal drug use as a moral error. The cultures of the organizations operating on the different ends of the spectrum are similarly distinct, as the glaring difference between a uniformed police officer and an outreach worker for a syringe exchange would indicate. However, this conflict belies the goal that both sides share: the creation of a healthy, drug-free, law-abiding subject.

Methods

The fieldwork that produced the data for this article lasted three years, from 2009 to 2012. I did participant observation in various organizations in the anti-meth apparatus: I worked at a syringe exchange where injection drug users were encouraged to join treatment programs when they came to pick up clean drug paraphernalia; I was a HIV testing counselor at a clinic that specialized in gay men's sexual health; I attended meetings of organizations like the Meth Strike Force and the HIV Planning Council; I interviewed more than four dozen people who worked in drug treatment, HIV medicine, and law enforcement.

In addition, I conducted person-centered ethnographies of 14 meth-using MSM who have been diagnosed with HIV.[1] Hollan describes person-centered ethnography as the anthropological attempt "to develop experience-near ways of describing and analyzing human behavior, subjective experience, and psychological processes. A primary focus … is on the individual and on how the individual's psychology and subjective experience both shape, and are shaped by, social and cultural processes" (1997:219). I used person-centered ethnography in order to produce descriptions of subjectivity through descriptions of identity formation, emotional discourses, and embodied experience. I conducted multiple in-depth interviews— six or more hours over several months—with each of the men in my sample in addition to observing them in various domestic and social settings (Levy 1973; Levy and Hollan 1998). I attempted to understand how and why their subjectivities came to be, looking for causes in the phenomenological dialectic between political economy and personal psychological experience. Subjectivity, after all, is co-constructed, formed in an

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[1]Eleven of the 14 called themselves gay, and the other three bisexual; Darrel and William, both named in this article, are two of the three. Five of the gay men had previously had relationships with women.

interaction between the self and the behavioral environment; in this case, it is the addict and an environment largely structured and controlled by the anti-meth apparatus. In analyzing the subjectivities like those of the men in this study, we can develop a more detailed and much more dynamic description of how those who are stigmatized manage their "spoiled identities" (Goffman 1963). While the anti-meth apparatus has great power to coerce addicts to form certain identities, to feel and express certain emotions, and embody and perform these identities and emotions, the addict is agentive, capable of both passive acceptance and active disruption and refusal.

Practicing and Narrating a Normal Identity

Within the anti-meth apparatus, addiction treatment programs, from intensive residential centers to more informal 12-step meetings, are the most focused on transforming actively using addicts into recovering addicts. This change involves more than behavior modification, more than just stopping drug use, but also a change in identity from the immoral, abnormal addict to the moral recovering addict who aspires to normality. This new identity, as with all identities, must be practiced (Holland et al. 1998), and one of the central methods used in recovery programs is repeating statements like "I am an alcoholic" and telling stories of addiction as folly and recovery as redemption. This narration helps the addict transition into another state, "to shift the perceptual, cognitive, affective, and practical frame of activity" (Holland et al. 1998:63). In this context, narration is a means of self-control because it helps to frame emotions and experiences and to narrate history-in-person. Treatment counselors and veteran addicts work with their new charges to encourage the stories and the statements, to correct when the story is told wrong or the wrong affect is produced. As Carr writes in her ethnography of a recovery program, the constant communications between treatment counselors and recovering addicts are

> semiotic entanglements: clients worked to effectively represent themselves and their problems, and therapists worked to script, or set the terms of these representations. Because of the institutionalized ties between … therapists and other social service professionals, a variety of resources … hung in the balance of these intensive verbal transactions. (2010:2)

Addicts must accept the authority of addiction treatment programs, counselors, and recovering addicts to identify them as addicts in order to access needed services. Particularly in the case of my informants, whose treatment was funded by government agencies acting under Drug War ideologies and, often, funding, this process is a profound example of governmentality, in which the development of my informants' stories describing the origins of their addiction is tied to the means of their survival. These narratives also serve to distance my informants from considering structural issues—like mass incarceration, the neoliberalization of social services, and endemic poverty—and to focus solely on the self as the root cause of suffering. Similar to the self-esteem programs for poor women that Barbara Cruikshank studied, the addiction treatment programs my informants experienced were meant "to deliver a technology of subjectivity that will solve social problems from crime and poverty to gender inequality by waging a social revolution, not against capitalism, racism,

and inequality, but against the order of the self and the way we govern our selves" (Cruikshank 1996:231).

Carr's ethnography describes a Midwestern treatment program in which the interaction between addicts and therapists was localized in one clinic, and she specifically focuses on psychotherapeutic language. My informants, on the other hand, were being scripted and were scripting themselves in a much more diffuse behavioral environment, interacting with a heterogeneous anti-meth apparatus comprised not only of addiction counselors but also doctors, case managers, outreach workers, police officers, and district attorneys, all of whom operate in a discursive milieu constructed by the Drug War and self-help ideologies. Carr writes that "there is a distinct clinical logic to the theorization of addiction as a disease of insight" (2010:123), and my informants focused on the psychological power of key moments in the narratives constructed when explaining their addictions. These narratives were especially well-structured, even well-plotted, among the older addicts more experienced with recovery programs and addiction ideologies. The men who I worked with who had more interactions with arms of the apparatus—court orders for treatment, sober living complexes, therapy paid by the federal HIV/AIDS assistance programs—were more likely to recite life stories that they scripted in conjunction with (or at least in the context of) the anti-meth apparatus.

In their narratives, my informants focused on traumatic life events, often from childhood, that created the needs that meth helped them fulfill: the death of a parent during childhood, chronic depression, rape. With this moment identified, the informant described looking for situations that might make him feel physically or emotionally better, content, or safe. This quest often led the informant away from family and friends, replacing both with the gay community, usually a segment more focused on sex, drug use, and physical experiences of pleasure. It is in this context that he first took drugs; sometimes meth, sometimes drugs that led to meth. They describe honeymoon periods full of meth, sex, and exciting new friends. This period lasted months, sometimes years, but for each of my informants, it ended with some sort of personal disaster: an HIV and/or AIDS diagnosis, jail or prison, homelessness, estrangement from friends and family. After a period of recovery, a few stayed sober (at least during the period of my study), while the others started the cycle again, most blaming their own personal failings for their situations. If addiction is, as many in San Diego anti-meth apparatus believe, a disease of insight that affects the sufferer's ability to understand the reasons for their behaviors and emotions (Carr 2010:90–95), then developing an understanding of this process is supposed to be part of the treatment. These insights can also lead to self-loathing, and without further treatment, a return to active addiction. However, many clinical psychologists and addiction researchers no longer believe that insight is the key to addiction, espousing cognitive, psycho-chemical, and psychoanalytic reasons instead. That so much addiction treatment is recalcitrantly embedded in the insight paradigm highlights how much the apparatus is focused on moral behavior rather than scientific medicine.

It is possible, as Carr explains, to "flip the script" and use the language of treatment and recovery strategically to gain approval from agents of the apparatus who control resources: not just drug counselors, but also doctors, social workers, and probation officers. However,

William (45, African American) was the only one of my informants who discussed doing this knowingly. But William had internalized the psychopathologized cause-and-effect narrative, just as had the rest of my informants. These narratives, as discussed above, help them practice and perform their identities, which are centered on their addiction, their HIV status, and the burdens they place on their community, friends, and families. William, for instance, saw his adolescent exposure to Oakland, California's red light district, and the sexual and moral corruption he experienced there, as a prime cause for why he became "fucked up." Adam (31, Caucasian) did not blame an actual event but rather the mental illness for which he had self-medicated since high school, first with alcohol and eventually with meth. Three other men recounted being molested and connected their molestation to later feelings of shame and depression that their drug use helped mask. For Richard (41, Latino), "HIV just derailed me," and it took him ten years of what he called "denial" to admit his addiction and see himself as an addict. "I wanted to use it to have some fun on the weekends," he told me. "And the therapist said, 'You're an addict.'" After he was told this enough times, Richard came to believe it. He accepted the description of himself as an addict and used that term to shift into the identity.

For Max (38, Filipino-American), the narrativizing process worked as designed. His HIV diagnosis at 37 was when he, in 12-step parlance, "hit bottom." When he sought help from San Diego's largest HIV service provider, the counselor told him that if he did not find housing, get into medical treatment, and beat his addiction, he would die. "I fucked my life," he said. This realization sprang him into action. I saw that by embracing recovery, both practically and ideologically, he was able to survive; his acquiescence to the hail (Althusser 2010) of "addict" allowed him to receive services and social acceptance. But it also transformed his identity.

> I'm all about being a new person. Getting a new job, a new place. I know I'm healthier. Before I didn't check on my health. I need vitamins, nutrition, food, psychiatry—everything. [At the recovery program] you talk about your past. You're going to find [the answer to your problems] there. I learned a lot about myself, about learning to say no, about taking more responsibility. In 12-step, your mind is getting more cleared up.

In the process of clearing his mind, of learning why he needed the approval of men and of his new nonusing friends, he transformed himself from an addict into what many in the anti-apparatus would call a "recovering addict." The procedures of recovery programs constantly reinforced this new identity. He practiced this identity not just as Holland et al. (1998) describe the process of identification, but also in its more literal meaning, that practice makes perfect. As Max said, reciting a version of the script provided by his drug counselors, "I just follow the tools [the program provides] … and work my steps."

Agents of the anti-meth apparatus attempt to transform troublesome addicts into productive members of society, but they rarely produce the subject desired, because of their flawed methods, because the addicts are more agentive than expected, and because meth addiction is so difficult to beat. Charles (41, Native American) had extensive psychotherapy, but this therapy did not succeed in creating a narrative that Charles could use to transform himself as Max had. During my fieldwork, Charles was the only one of my informants who saw a

psychiatrist every week.[2] Despite having the self-awareness and insight demanded by many drug counselors and other agents of the apparatus, at no point did he stop using meth for longer than a few months. He and William were the highest-functioning active addicts I interviewed; they had their own apartments, picked up their monthly federal disability checks, and never missed their appointments. But, despite being the focus of the apparatus for so long—doctors, social workers, parole officers, corrections institutions—despite having analyzed his past and his emotions so thoroughly, and despite being on numerous psychotropic medications, Charles had an almost exclusively negative assessment of his psychological narrative; insight did not help his addiction, but rather helped him to hate himself for being an addict.

Charles cites his "pathological fear of abandonment" as his explanation for two key moments in the narrative of his illness. When I asked about his earliest memories, he told me about being left at his grandparents' house often. "I would sit and stare out the window," he said, "waiting for my parents to come pick me up. They would never show up." He told me that is why he was always waiting for me when I arrived for our interviews. "Now I have to be early, or they won't wait." He has always been afraid of being forgotten, left behind, and rejected. When he found out he was HIV-positive at 17, he told no one. "I never talked about it until I was 35," he said, not even with his partner of many years, Greg. "I never told him. I knew for sure he would leave me." When Greg died, Charles's fear was realized: "He told me he would never leave. And then he died." In response, Charles says, he focused on a combination of denial and self-destruction: He spent all of the money Greg left him on drugs, eventually becoming homeless and incarcerated.

As he explained his behavior, he repeated the various analyses offered him by his therapists and counselors. His current therapist told him, "You're not crazy. You just do crazy things." Of one support group, which used an intervention curriculum designed at a nearby university, he said, "We were trying to figure out why a lot of us have underlying reasons for using. You're supposed to be responsible to yourself." This responsibility means that, as Charles believes, "I made my life this way." In analyzing himself, both through years of psychotherapy and in various interventions, from groups to one-on-one sessions of Motivational Interviewing (Miller, Rollnick, and Moyers 1998), he learned to narrate his life and to blame himself. These stories are not the only ways that Charles is reminded of his identity as bad, as a meth addict, as HIV-positive, as mentally ill, problematic, as the object of public-health-risk discourses. There are also the syringes he uses, the anti-retroviral combination therapy he takes, the cocktail of psychopharmaceuticals: trazodone, Seroquel, Abilify. But the narratives he developed in concert with the agents of the anti-meth apparatus are what give all of these aspects of his daily life meaning, making his subjectivity cohere.

Charles's subjectivity is not what was intended by the anti-meth apparatus, and, of my informants, only Glenn and Max resemble the ideal subjects of any of the institutions that comprise the anti-meth apparatus. Partly this is because not all addicts agree with the interpretation of their psychology provided by treatment counselors or the more moralistic agents of law enforcement. It's difficult to practice something that you believe to be false.

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[2]The others saw drug counselors or had medical doctors prescribing antidepressants.

More importantly, even if the addicts agree with and feel comfortable with the narrative they have constructed along with the agents of the anti-meth apparatus, completing the process of becoming a recovering addict is made profoundly difficult by the addiction itself. In addition to being more addictive than any other drugs of abuse, besides heroin and nicotine (van Amsterdam et al. 2010), chronic meth use causes significant cognitive impairment, leading to confusion, forgetfulness, and difficulty focusing (Simon et al. 2000). The narrative cannot climax with the hoped-for identity transformation if the protagonist cannot stop using the drug. This leaves the process stunted, with addicts stuck at the desire to change but blocked by their own brain and their desire for meth. The ideal future then remains tantalizingly out of reach.

The Normal Ideal

In the life narratives my informants recited, their future plans—the unwritten, imagined sections—were remarkably similar. They reflected not just the broad American hopes and goals of individualism, but also the neoliberal desire to become a self-managed, economically competitive subject (Harvey 2005; Ong 2006). The narratives also expressed a longing to become homonormative, to become part of "privatized, depoliticized gay culture anchored in domesticity and consumption" that is closely linked to neoliberalism (Duggan 2004:50). This is not surprising since a focus on self-management and individual responsibility is central to the 12-step process, and the central topic of the cultural discourses surrounding gay culture during my fieldwork was the pinnacle of homonormativity, same-sex marriage, both the political fights over its legality and the decisions of many gay couples to wed. Duggan, Warner (1999), and others (Halperin 2007; Wharton and Philips 2004) have pointed out that the close connection between neoliberalism and homonormativity is distinctly conservative; they criticize the political prioritizing by gay rights organizations of marriage rights over economic justice issues and the radical sexual politics of the early gay rights movement. Race (2009) connects these politics to the worldwide Drug War, arguing that drug use has come to be seen as the antithesis of the family, economic viability, and homonormativity. The presence of these conservative discourses in the hopes and dreams of active meth addicts is testament to their pervasiveness and power.

In their imagined futures, my informants described wanting to be not just free from meth addiction, to be working, and self-sufficient, but also settled down with a husband, owning a house, and focusing on family. While these futures varied in the specifics, they were primarily economic and secondarily affective. For example, Darrell (36, African American) said he wanted to "go with the flow. Hopefully get married, settle down, working stress-free. Living." That these goals are achieved by "going with the flow" seemed to say that he was following the path of least resistance, not that it would be easy to achieve, but that it would be the most expected, the taken-for-granted place the "flow" would send him. Max was following the rules of Crystal Meth Anonymous (CMA) and was waiting a year before looking for a boyfriend, though he was thrilled when men at his meetings asked him out. While he worked the steps, he said, he would only look for friends, not lovers: "I need to focus on my career." After his career and sobriety had been established, he would find a partner. Brandon (22, white) told me he wanted to go to school to become a lawyer, while Glenn (42, white) focused during his sobriety on earning his degree and being a present

father and grandfather. William (introduced above), despite refusing to become sober as an act of political resistance (and articulated as such), realized that to be a member of his nuclear family, he had to be sober and at least act the part of a self-sufficient heterosexual man. Sam (introduced above), in his letters to me from jail, told me that working would give him worth. Extremely wistful for the year that he was sober, working as a tow-truck driver, and living with his boyfriend Howard, his ideal future is a re-creation of that time. When Sam was at the recovery program where Howard worked, Howard refused to be part of that future; this is one of the reasons Sam said he relapsed.

Matthew (32, white), who had been dishonorably discharged from the Marines and incarcerated several times for meth use and sales, saw work, family, and his relationship as keys to his success; success would lead him to these things, and these things would ensure his success. During our interviews he was newly clean and living at one of San Diego's sober living complexes. His daughter from a high school relationship lived in Northern California, and his boyfriend was living in Florida, trying to get sober. "I never wanted to stop [until now]," he told me. To achieve his dream of success, he was working at a convenience store and going to school, both at a community college and at a vocational school. In his vision for the future, he would work and then come home to his boyfriend and to his daughter, connecting his economic and affective hopes.

Richard (49, Hispanic) also expressed an idealized middle-class gay future. Perhaps more than any of my informants, Richard was focused on work, both as the cause of his addiction and as the goal of his sobriety. He repeatedly said that it was the stress of work that he was escaping on his weekend meth binges, that it was dreading his stressful job that made him not want to return after a weekend of drugs and sex. But during our interviews, when he was living at one of the recovery programs, he was focused, almost obsessed, with going back to work. His addiction was not technically what was keeping him from work; rather an injury had allowed him to go on disability from his administrative job at one of the local universities. Richard, who had been sober longer than most of the other residents in his program, was bored, anxious because he was not being productive. "Obviously, I want to do things to be productive," he said. But he had to be patient. "I just try to work one day at a time." In the last interview before we took a four-month break, I asked him about the far future: 15 years from then. He told me, "Fifteen years is so far in the future … " but within 15 seconds, he pictured what he wanted: "having a house in West Hollywood, where I can go walk to have coffee. That would be nice." This image could have been plucked from a gay fashion magazine or from the "No on Prop 8" advertisements that famously depicted the homonormativity critiqued by Duggan and Warner and aspired to by so many urban gays and lesbians. To get there, Richard said, "I need to be trying to work towards my goals and working on my action steps."

Both neoliberalism and homonormativity have become taken-for-granted ideologies, and their power has come, at least partly, from their ability to resist critique. Those who do not or cannot accept or achieve the neoliberal homonormativity fail, according to those who subscribe to the ideology, because they do not work hard enough or are not moral enough. The blame rests solely on the individual. Addicts who fail to stop using are encouraged to believe that they are solely at fault for their failure, while structural and institutional failures

are rarely addressed except as an afterthought. Loud and powerful critiques on the Drug War and the failure of the health care system to address addiction are increasing, but those who fail to overcome their addictions are still condemned. To survive, the condemned will do what they can to perform, physically and emotionally, as if they haven't failed.

Embodying Risk and Performing Normality

As with identity, both physical experience and bodily performance are structured and developed within a behavioral environment. The men in my sample have both meth addiction and the anti-meth apparatus written on and into their bodies, but they were never passive. Many critiques of policing and some of public health utilize Foucault's concept of "docile bodies," or bodies that "may be subjected, used, transformed, and improved" (1975:136). Foucault is describing a body inscribed with meaning; in his work, bodies are submissive. Crossley contends that by synthesizing Foucault and the French psychologist Merleau-Ponty, it is easier to see how the body can be both "active and acted upon: a locus of action and a target of power" (1996:104). For Merleau-Ponty "meaning is not produced by a transcendental or constituting consciousness but by an engaged body-subject" (1996:101). While Crossley points out that for Foucault, order and control are accomplished through "direct and active attempts to control, direct, and delimit, and co-opt the actions of the body," these attempts are only possible through agency: "It requires a person who acts and person who acts upon those actions" (1996:105). The expected physical behaviors of my informants were defined by cultural norms and most often monitored by the law enforcement arm of anti-meth apparatus, and my informants had various levels of agency to meet or mimic those norms, having learned over the years that defying normality leads to punishment.

My informants were in constant fear of being discovered, by the police, members of their community, and strangers on the street. To survive, they had to perform normality, which they did to different levels of success. Though an active meth user, William presented himself in our interviews as sober, offering the same measured affect that my sober research subjects did. He was always wearing clean clothes, his beard was trimmed, and he was always exactly on time. When I noted that he seemed sober despite telling me that he was used meth regularly, he told me that he made sure to be sober or near-sober for the hours that he had to interact with doctors, case workers, nurses, court officials, and academic researchers such as me, all agents of the anti-meth apparatus. I suggested that if he did not need meth to make his appointments maybe he was probably not as addicted as other members of my sample, some of whom injected the drug. He replied, "Oh, don't let that fool you. I'm a meth addict. I just maintain very well."

William learned how to "maintain," to present himself as sober, respectable, harmless, and not worthy of suspicion through a lifetime of being profiled as the opposite. He grew up in Oakland, California, during the 1970s, which William called "a powder keg." The war between the gangs and the police was brutal, with "the middle," as William called the rest of the city, caught in the literal crossfire. The police, according to William, were particularly ruthless. "They [were] over the top. They were sanctioned Klansmen. They got room in jail for every fucking thing, a crack pipe, open container, drunk in public."

While San Diego in the 2000s is not policed with the same sort of excessive verve as Oakland in the 1970s and 1980s, William still felt the pressure of police harassment. He could not avoid the policing, so he learned how to manage it, either through modulating his interpersonal interactions or utilizing his knowledge of the law: "I can't really beat the system. I can blend in with the system. If there's a cop who's harassing you, call him 'Sir.' The ends justify the means. The end is to walk away from his punk ass." It was best to avoid any contact at all: "If you dress right … if you're going to use dope tonight, you dress like you're going to party [at the downtown bars]. You can blend in. Because they're acting like a fool, too. But if you dress a certain way, you don't got a shot in hell. That's why I dress a [different] way." Similarly, when his neighborhood was besieged by police trying to rid his apartment building of criminals, he moved. His new apartment, a studio a few blocks from San Diego State University, is near a major thoroughfare where he can buy meth and find sex, but his complex is small, calm, and gated.

While William was able to control his body skillfully enough to avoid arrest for many years, many of my informants were not so lucky, or so skilled. All of them knew that they needed to maintain, to communicate a normal affect, a regular gait, to dress and groom like a "normal" person. The few of my informants who had never been arrested explained they never went outside when they were high; they knew the limitations of their performances while high. An-drew, who was homeless off and on when I interviewed him, was not able to hide, and he also was unable to consistently maintain. While he was usually well groomed and dressed in clean clothes, his paranoia and jittery walk tipped off police officers who were profiling drug users. Similarly, Sam had little control over his behavior, and straightforward but burdensome tasks, like pretending to be sober, seemed Sisyphean. He is aware that the police are watching him and he says he needs to walk a certain way so that they will not suspect that he is high. It rarely works, however; in his tentative, nervous fidgeting, he is immediately suspicious to police, and so he gets stopped, frisked, and arrested on a regular basis. He does not see any of his difficulty as the result of political economic forces, as William does. Sam blames all of his hardships on himself, his lack of strength, his failure to be disciplined, his poor performance of normal.

None of the men I interviewed had docile bodies. The goal of many efforts of the anti-meth apparatus was docility, however. In response, my informants were active participants in the embodiment and the performance of either their normality or their abnormality. When they were high, they tried to avoid the gaze of the anti-meth apparatus, particularly those in law enforcement, and other supposedly normal members of the community. If they had to be in public, they tried to conform to expectations, to varying degrees of success. If they were successful in their performances, the active addicts were rewarded with continuing pleasure or freedom from their troubles, while those trying to kick meth were granted housing, sustenance, medication, and other services. When their performances failed, they were physically aware of it, because they could be cuffed and arrested, denied medication and food, abandoned and left to sleep outside. Clearly, these different situations have substantial emotional ramifications.

Emotional Discourses of Pride and Shame

Sam's emotions on the day that I describe in this article's introduction were not atypical among my informants. Emotions were often intense: drug use is precipitated by the desire to feel particular emotions, the physiological response to getting high and coming down elicits intense emotions, being poor and homeless is emotionally fraught, and my informants are constantly told what emotions they should be feeling by various segments of the anti-meth apparatus. Emotional experience is central to subjectivity, and it is, importantly, intersubjective and culturally constructed. As Catherine Lutz writes, "Emotion can be viewed as a cultural and interpersonal process of naming, justifying, and persuading by people in relationship to each other. Emotional meaning is then a social rather than an individual achievement—an emergent product of social life" (1988:5). Emotions are created through interpersonal negotiations and the subjective experience of social structures and power relations. Thus, the conceptualizations, descriptions, and discussions of emotions are laden with ideology, history, and "ethnotheoretical ideas about the nature of self and social interaction" (1988:10). This interactionist model of emotion helps to explain some of the power of morality: "The force of emotion is to a great extent the sense of moral or pragmatic compulsion, the sense one must do what the emotion 'says' one will do" (1988:213).

Because of how closely tied emotions and emotional discourse are to morality, they are inherently political, and the state has a vested interest in controlling, if not reconstructing, them. The debate over whether someone is actually ill has profound moral and political consequences, as Jenkins writes: "Someone who is distressed might still deserve that distress, but … someone who is sick is relieved of culpability" (1991:155). This tension, between what is a disease (like addiction) and what is a moral failing (like criminality), leads to the confusing and erratic emotional discourses expressed by both my study participants and the anti-meth apparatus. In this cacophony of emotional discourses, two emotions still became particularly salient. Overcoming a disease like addiction is cause for pride; not overcoming the disease is cause for shame. Both pride and shame are considered self-conscious emotions that arise from self-reflection and self-evaluation, with shame being the "negative evaluation of the global self" (Tangney 1999:545) and pride being "generated by appraisals that one is responsible for a socially valued outcome or for being a socially valued person" (Mascolo and Fischer, qtd. in Tangney 1999:558).

Sam's shame discussed above was echoed by several of my informants. Six months after our interviews ended, Richard called me several times in one afternoon. He had relapsed and told me he needed to talk to me. We met for coffee; he was driven to the cafe by one of the men with whom he had spent the weekend. He was sweaty, jittery, and he had lost his belt, which was making it hard for him to keep his shorts around his waist. Because he had spent our previous interviews discussing how much progress he had made in his sobriety, progress that I lauded him for, presenting himself to me as so far from that made him ashamed. In my position, I had become aligned with his therapist and drug counselors, and the disappointment he assumed I would feel mortified him. Richard told me that he had first relapsed a few weeks before, and then this past week the stress at work had been too much for him. The pressure to do everything right and do it all on time activated panic and anxiety that Richard thought a weekend of meth and sex would be able to quell. He was wrong, as it

turned out. Worse, in leaving his sober living apartment for the weekend without providing notice, he had been kicked out. He was homeless, had none of his belongings, and had no clean clothes. I spent the afternoon with him; I took him to Target, then to a motel, and I put in a good word for him with a new case manager. Throughout, he was terrified of admitting what he did, not just to his boss (to whom he called in sick), but also to the case manager, the director of the sober-living complex, and to me. Without us, he may not have felt shame at all.

Sam's shame could be totalizing; it is both about using meth and the life he felt forced to live as an addict. With Richard and others, shame was less about meth itself and more about the consequences of addiction: economic, physical, and interpersonal. Before he relapsed, Richard was almost defensive about not feeling shame, or even guilt. "Everybody is doing meth," he said. "Why should I feel guilty about it? I didn't do horrible things to people." But the year he spent in recovery programs, interacting with veteran 12-steppers and drug counselors, taught him how to feel if he were to relapse: That day, I could see the guilt and shame embodied in his palpable anxiety and tears. William, on the other hand, protected himself from shame by carefully presenting himself as sober not just to the people, like the police and social workers, who could take away his freedom or his service, but also to his family, who knew about neither his drug use nor his sex with men. If they could not tell that he was using, then they could not encourage him to feel ashamed, guilty, or afraid.

One of the goals of recovery programs is instilling positive emotions that create happiness and protect recovering addicts from relapse. Pride does both, and it was a powerful replacement for the shame my informants felt after they admitted their addiction or saw their addicted, suffering selves through others' eyes. Max, the proudest recovering addict among my informants, told me initially, "I didn't want to go [to the CMA meeting], because I was ashamed. But I'm not anymore. All of my friends are so proud. You know how it feels when someone says you look good. It makes me proud of myself. It makes me happy like that." The interaction with others at the meetings and with friends approving of his change encouraged his recovery and granted him permission to feel and mimic the pride he saw expressed by the veteran members of the groups. At the beginning of our sessions, Glenn was enormously proud of his progress, an emotion encouraged by his drug counselors and friends at CMA. Part of why Sam longed for his time sober was that he longed for the pride he had felt in being sober, happy, and productive; his ability to work steadily as a tow-truck driver impressed his family, who he was able to see and impress. Jonathan, the last time we talked, was thrilled by his progress. "I've accomplished a lot. I've been really diligent," he told me, and I agreed with him, praising his progress. "I've networked, marketed myself, and now I have a job that I like. I'm very adamant on starting school. I'm not overwhelmed by it. I have confidence." William felt proud about preventing himself from feeling shame, and even though he was not sober or in recovery, he was proud of being able to manage his addiction and disease, to be able to "maintain."

Pride and shame are powerful vectors for the reproduction of the discourses promoted by the anti-meth apparatus. The emotions become signposts. To feel pride, the addict must behave in certain ways. To avoid shame, the addict must do the things to feel pride. Various agents of the anti-meth apparatus, particularly those involved in public health communications, are

aware that these emotions are excellent tools for social control and social stability. While the messages in public health campaigns that focus on preventing meth use often use fear, those that focus on stopping meth use promote shame. The "Me, Not Meth" public health campaign in 2009, which California's Department of Alcohol and Drug Programs spent $17 million to promote, featured dark images of gaunt, sad men next to the words "I lost me to meth." In the television advertisements, which ran for several months in the spring of 2009, the men told stories in agonized tones about how their meth use destroyed their families, careers, and identities. This campaign and those like it succeeded in shaming meth users, which did encourage many to stop. But because of the many structural, biological, and cognitive difficulties meth addicts face in their efforts to stop using, the shame became less a motivator and more a punishment. The struggle between pride and shame, between survival and punishment, is central to the subjectivities of the men in my study.

Perpetual Struggle

Charles was not happy about his day-to-day life, but he was proud when he was not using. "I made my life this way," he said. "I do a lot of nothing. I'm just not using. Things are working. I'm proud. But if things go too well, I start having panic attacks." Charles's emotional life was perilous. He hovered between pride, depression, panic, and the promise that meth could take it away; he told me how it felt: "It's like every care in the world is just gone. You're not worried about anything. For that moment, it's just perfect." In the eyes of the anti-meth apparatus, Charles is a risk to the community, and that is why its various branches want to regulate his legal and illegal drug use, the amount of HIV in his blood, and how much money he can receive from the federal government. He, like all of my informants, is also a risk to himself, both because his behavior puts his body in harm's way and because his inability to be normal makes him likely to be punished by agents of the anti-meth apparatus and by his shaming superego. He has learned this because the agents of the apparatus have told him so, and they have made sure that he suffers for not following their rules. But the rules are difficult to follow, and even those who eventually become the person the apparatus wants them to become suffer along the way.

Charles's subjectivity is defined by his perpetual struggle. It is produced during the interaction between, in this case, a meth-using HIV-positive man who has sex with men and an amorphous concatenation of organizations and agencies focused on changing his behavior and transforming him into a productive member of society. With pressure from doctors, drug counselors, and various law enforcement agents, he developed a narrative and then an identity as a socially problematic addict, as a person who must learn how to change his behaviors so that he can become an idealized normal person. This process involves not only telling a new story about his life, but also embodying normality; he must perform normality to signal his success as a recovering addict and perform normality simply to survive if he cannot recover. Achieving normality is cause for pride, but shame is felt constantly, for shame is the motivator for the work to become proud and is the result of failure.

Acknowledgments

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