Chapter Eight

Methamphetamine Addiction, HIV Infection, and Gay Men

Stigma and Suffering

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Sam[1] smoked meth for the first time when he was 13, not long after being molested by a neighbor; he started turning tricks at 17, tested positive for HIV at 23, received an AIDS diagnosis at 30, and at 43 had been mostly homeless in San Diego for 25 years. Jorge left home in Guadalajara at 18 because of his parents' violent reaction to him coming out as gay; he tested positive and received an AIDS diagnosis in San Diego ten years later, started using meth at 42, and was in a halfway house at 47. Jonathan came out in his teens in Los Angeles and did meth for the first time at 25 and tested positive five years later; at 50 he was couch surfing in San Diego and living off checks from his aged father who did not know why Jonathan needed the money. Max's first long-term partner persuaded him to smoke meth during sex when Max was 33; Max left his partner when he discovered that his partner had graduated to injecting the drug. Max started living on streets, and when he tested positive for HIV and received an AIDS diagnosis, a case manager persuaded him to go into substance abuse treatment.

These stories were typical of the 14 men who participated in an ethnographic study of methamphetamine-using HIV-positive men who have sex with men in San Diego that I conducted from 2009 to 2012.[2] They each were subjects of person-centered ethnographies, sitting for five or more in-depth interviews regarding their life histories and illness trajectories, as seen in table 8.1.

They were all participants in what has been called a "double epidemic" for American gay men, the intertwining of infection with the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS), and the abuse of the powerful synthetic stimulant methamphetamine (Halkitis, Parsons, and Stirratt 2001). It is a syndemic, "the concentration

Table 8.1. Participants in the Study with Demographic Descriptors

Name (Pseudonym)	*Place of Birth*	*Race/Ethnicity*	*Age at First Interview*	*Age Tested HIV+*	*Age of First Meth Use*	*Ever Homeless*	*Ever Incarcerated*
Adam	Michigan	White	31	31	22	Yes	Yes
Brandon	California	White	22	20	12	No	Yes
Charles	California	Native American	41	17	15	Yes	Yes
Darrell	California	African-American	36	34	17	No	No
Eric*	Tennessee	White	46	22	25	No	No
Glenn	California	White	42	31	34	No	No
Jonathan	California	White	50	30	25	No	No
Jorge	Jalisco, Mexico	Hispanic	47	28	42	Yes	No
Matthew	California	White	32	26	12	No	Yes
Max	The Philippines	Pacific Islander	38	37	34	Yes	Yes
Richard	California	Hispanic	49	34	42	No	Yes
Sam	California	White	43	23	13	Yes	Yes
Walter	California	African-American	49	36	49	No	Yes
William	California	African-American	43	23	17	Yes	Yes

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

Source: Compiled by the author.

and deleterious interaction of two or more diseases or other health conditions in a population, especially as a consequence of social inequity and the unjust exercise of power" (Singer 2009). Not only is there strong evidence that methamphetamine augments the replication of HIV by enhancing HIV infection in microphages (Liang et al. 2008), but with an increased libido and decreased inhibitions methamphetamine users are much more likely to practice sexual behaviors that increase the risk of HIV infection (Volkow et al. 2007). The emotional reaction to an HIV diagnosis has been described as one reason some men seek out the drug (Reback 1997; Semple, Patterson, and Grant 2002). HIV infection and meth abuse are often only the dominant problems in the syndemic, with other sexually transmitted diseases, depression, poverty, and violence also linked and interacting with meth addiction and health complications from HIV.

Central to this syndemic are multiple, competing, and interrelated stigmas targeting HIV/AIDS, meth addiction, homosexuality, mental illness, poverty, and homelessness. Individually, these diseases and problems are difficult to manage on a quotidian basis, and the interaction of the stigmas compounds these difficulties. The stigmas create internal shame and mandate external management, both of which are made more problematic by the psychological and cognitive difficulties that HIV and meth create. That said, the men who took part in this study managed all of these problems—because they had to. Some were more or less successful than others, but all had to do it at a historical moment when the HIV-positive gay meth addict had become a folk devil of a moral panic, a pariah in the gay community. Their stigma was more than the sum its parts; it was worse because of its combination.

In this chapter, I describe how the men I worked with entered into this syndemic and how they responded to their illnesses, stigmas, and struggles, focusing on three exemplary cases. First, I describe the stigmas of AIDS and of methamphetamine addiction, and how the combination of the two, with meth leading the way, produced something worse. Then, I explain the epidemiological and sociostructural associations between HIV and meth among gay men. Finally, I illustrate these interactions and their health consequences through the stories of Charles, Andrew, and Glenn, three men who have different experiences but whose struggles create archetypes of social suffering. This ethnographic description of the syndemic of HIV disease and stigmatized meth addiction among gay men exemplifies the profoundly painful interactions between psychosocial behaviors, neurobiological experiences, and psychoculturally embedded stigmas. Disentangling the syndemic's causes and their combined effects may be able to help us ease the pain it brings.

HIV/AIDS STIGMA

"In its fullest sense," Philip Setel wrote, "the paradox of AIDS is that this *new* disease is enmeshed in *historically shaped* social environments" (2000, 4). When AIDS appeared in the early 1980s, those who initially suffered from it belonged to already oppressed or stigmatized groups (Shilts 1987; Treichler 1999; Farmer 1992): gay men, long considered dangerous sexual deviants; injection drug users, the worst of the victim-perpetrators of the then-new Drug War; and people from Haiti, the "basket case" of the Western Hemisphere. A fourth group, hemophiliacs, were considered by many to be innocent victims; it was not a coincidence that the 1990 Ryan White Comprehensive AIDS Resources Emergency Act, which provides medical care for under- and uninsured people with HIV, is named after a "compelling and nonthreatening" teenaged hemophiliac (Keeler 2007, 616). While White and other seemingly innocent people with AIDS helped turn scorn into pity, the remaining fears of people with AIDS, of their bodily fluids, their breath, and their simple proximity made treating AIDS, raising money for research, and preventing new infections extremely difficult.

Because of the severe stigma in the early years of the epidemic, people with HIV or AIDS quickly determined how they would communicate, or *not* communicate, their status to others, focusing on what Goffman called "information control" (Goffman 1963). Green and Sobo explain that, in general, "Chronic illness requires strategic management to minimize the impact of illness on social interaction. Social risk, which everyone must manage, is compounded in the chronically ill by the stigmas associated with various chronic illnesses and the indeterminacy of their definition of self and of events" (2000, 71). Because many people with HIV/AIDS internalize the stigma, many of them put great energy in hiding their status and, if necessary, their symptoms. Then and now, they try to preserve normalcy for as long as possible by simply not telling anyone and by hiding any symptom or developing cover stories, like a diabetes or cancer diagnosis, to explain doctor or hospital visit (Sandstrom 1990; Adam and Sears 1996; Cowles and Rodgers 1997; Green and Sobo 2000). Others will carefully decide who can and will be trusted with the information, weighing the possibility of rejection or discrimination with the ethical duty to tell, particularly, a family member or partner (Siegel and Krauss 1991).

HIV can become a "master status," dwarfing all other identities and markers. For some, embracing the stigma—through advocacy, activism, or art—is a way of disrupting the stigma's power (Gould 2009; Chambers 2004). It is often, however, a source of shame, and not just because of the stigmatized routes of infection, like homosexual sex or drug use. Loss of memory, conti-

nence, looks, and other "personal competences, taken for granted by almost any adult, challenges the sense of control over one's life and even personal worth (Adam and Sears 1996, 36). Managing and hiding such symptoms become a major concern, and it can lead to isolation and depression, denial of possible support, and delaying treatment (Alonzo and Reynolds 1995).

In the mid-1990s, after years of massive public health campaigns, unprecedented activism by people with AIDS and their communities, and enormous support from the entertainment industry, incredibly effective anti-retroviral treatments arrived, lessening symptoms, likelihood of death, and for many, fear. But the stigma persists, even if its power has waned. The stigma surrounding HIV/AIDS is still an "impediment to public health" (Valdiserri 2002). Fear of HIV and AIDS makes people less likely to be tested for the disease, and fear that others will find out about the infection makes many HIV-positive people avoid seeing doctors for treatment. The stigma of HIV/AIDS makes even discussing it difficult many people, leading to behaviors that put them at risk for infection.

METH STIGMA

In *Methland*, Nick Reding described the impetus for using meth in terms of American culture and political economy. Not only was meth not a surprising drug for people to take, it was also a sensible reaction to American labor conditions—as a reaction to the American dream.

> until the early 1980s, meth was a highly acceptable drug in America, one of the reasons being that it helped . . ."the salt of the earth"—soldiers, truck drivers, slaughterhouse employees, farmers, auto and construction works, and day laborers—work harder, longer, and more efficiently. It's one thing for a drug to be associated with sloth, like heroin. But it's wholly another when a formerly legal and accepted narcotic exists in a one-to-one ratio with defining ideal of American culture. . . . [The] ability to make something in your basement that promised work, success, wealth, thinness, and happiness was not necessarily too good to be true. (Reding 2009, 54)

But as Reding details, it *was* too good to be true. Addiction and the criminal, medical, and social results of the spreading addiction led to a social suffering in especially rural America that compounded the economic conditions that Reding claims encouraged its use.

Meth became an "epidemic" in the late 1990s and early 2000s as its use spread from Hawaii and California's coastal cities, across the entire West Coast, and then into eastern gay enclaves and particularly into the rural Plains

States and the Midwest, from the Dakotas to Tennessee. Once sleepy communities were amazed by the increased crime, the swelling population of addicts, and the misery that followed. To many observers, meth was doing to white, rural Middle America what crack had done to some black inner cities in the 1980s, and the construction of the meth addict resembled that of the crack addict. "Skinny, crazed urban blacks" were simply replaced by "prematurely aged, toothless, pockmarked rural whites" in media reports and shared fears. "[By] 2005," Reding writes, "thousands of stories across the country blaming meth for delusional violence, moral depravity, extreme sexual perversion, and an almost otherworldly, hallucinogenic dimension of evil" (2009, 43).

The media, not surprisingly, focused greatly on the worst case scenarios of meth use, from the horrible burns caused by meth lab accidents to abandoned children of meth addicts. Famous public health campaigns focused on the infamous "meth mouth," in which meth addicts lose their teeth because of incessant grinding. Others focused the potential for irrational violence, such as the ad from the Montana Meth Project that depicted a bloodied woman on the floor of a kitchen with the slogan, "My mom knows I'd never hurt her. Then she got in the way" ("Mother" 2011). Meanwhile, gay men were said to be in denial as they practiced "sexual roulette" (Cheshes 1999) and possibly starting a "rebound epidemic" of HIV (Torassa 2001). The *Village Voice* expressed its moral outrage about the hedonism of gay men: "Amid flashing lights and pounding music, untutored freelance pharmacologists conduct experiments on their own bodies to determine what happens when one consumes a bewildering array of pills and powders in the confined and humid setting of a nightclub. The results are not always pretty" (Owen 1999). The caricature of gay men as pathological narcissists who care only about pleasure, the men blamed for being the incubators of AIDS in the 1970s, was back.

Moral panic theory calls these enemies of society "folk devils" (Cohen 2011), not only a "them" that stands in opposition to an "us" but a repository of blame, fear, and immorality. Drug users are common folk devils, from the Mexican marijuana users in the 1930s to black crack addicts in the 1980s. Singer and Page argue that these drug users serve a social function, if a nefarious one, as they are Othered. "Despite the routine and redundant depiction of drug users as wasted and worthless, closer examination reveals that they regularly are put to good social use in multiple ways," they say. Drug users can "exist as negative role models who help define the boundaries of approved behavior [and] as evidence of the unassailability of dominant understandings and values, and as conveniently scapegoated objects of blame for an array of social ills" (Singer and Page 2013, 22). It must be stated, however, that not all moral panics, not all folk devils, and not all Others are conjured out of nothing simply to further the goals of the dominant group (Cohen 2011, xliii). For

every satanic cult that never existed, there are tangibly, empirically important problems, like AIDS and the meth epidemic. How extreme and imbalanced the response is the critical issue. But the general public, however defined, was not wrong to be alarmed the increase in the numbers of meth addicts and meth's role in HIV infection.

Public health researchers were alarmed, too. In one early and influential article, meth was described as a "substantial threat to HIV/AIDS prevention," because meth encourages risky sexual behavior. The authors point to the use of the drug in the creation of the "instant bottom" (implying the drug's influence on MSM's willingness to engage in sexual activities thought to carry greater risks for contracting HIV, such as receptive anal penetration) and in facilitating sexual marathons, group sex, fisting, and "a greater likelihood of having 50 or more sexual partners . . . as compared to their heterosexual counterparts" (Halkitis, Parsons, and Stirratt 2001, 25). The authors conclude that meth is at the center of behaviors that will exacerbate the AIDS epidemic, possibly by helping to create resistant versions of HIV:

> With the development of new treatment regimens for HIV infection, such as protease inhibitors, methamphetamine-related risky sexual behavior among HIV-positive gay and bisexual men presents the likelihood that newer seroconversions will occur with antiretroviral-treated and potentially mutated HIV virus (Halkitis 1998). The spread of drug-resistant strains of HIV will further complicate and prolong the HIV/AIDS epidemic. (Halkitis, Parsons, and Stirratt 2001, 28)

When a resistant strain seemed to arrive in the winter of 2005, the hysteria of the AIDS reportage from the 1980s was reproduced. The event easily fit into the narrative being created by the moralistic and angry anti-meth public health campaigns and the alarming academic research implicating meth use in new HIV infections. In turn, the media helped create a short, but intense moral panic that winter and spring. A man recently infected with HIV developed full-blown AIDS in few months, and he was resistant to three of the four classes of anti-retroviral drugs used to treat HIV. On February 11, 2005, health officials in New York City put out a press release announcing the case, with a quote from city's health commissioner: "This is a wakeup call to men who have sex with men" (New York City Health Commissioner). *The New York Daily News,* in a language typical of the press coverage around the country, railed, "Such reckless foolishness is the most extreme manifestation of a complacency toward AIDS" (*New York Daily News* 2005). While the panic that the super-strain garnered may have increased vigilance about HIV and meth and certainly was a factor in increased spending on anti-meth public health campaigns, interventions, and studies, it was not, in hindsight, something worth panicking over. The media response, however, was not

surprising: as in the original AIDS panic of the early 1980s (Patton 1985), the discourse focused on the irresponsibility of gay men, on out of control sexual behavior, on the danger that what gay men have wrought will lead to an second epidemic, and implicitly, this would be yet another epidemic that threatens the "general" and "innocent" population.

The meth-HIV panic was different from the original AIDS panic in that it was created and supported by gay men in positions of power in academia and the media. Gay men had made enormous progress in the 25 years since the beginning of the AIDS epidemic, not only structurally within institutions like large media conglomerates and research universities, but also in winning unprecedented healthcare for people with HIV and in the shockingly swift social acceptance of same-sex marriage. The disproportionately high numbers of meth users in the gay community, and the publicizing of this, threatened the hard-fought image of gay men as respected and responsible members of society. In turn, gay men crafted messaging that differentiated good gays from bad gays. For example, several gay AIDS activists were quoted in a front-page article in *The New York Times* advocating hunting HIV-positive gay meth users and incarcerating them (Jacobs 2005), and the noted gay sex advice columnist and political commentator/memoirist Dan Savage spoke out in favor of this (Conan 2005). Controversial posters created by New York City's Crystal Meth Working Group depicted a demented, bug-eyed man holding a giant meth pipe with the slogan "Crystal Meth Makes Me Sexy" and smiling, healthy looking man holding a sign saying "Crystal Free" (Halkitis 2009, 75). Memoirs like Patrick Moore's Tweaked (2006) depict meth addiction as a cautionary tale, with sobriety an idealized state, while Larry Kramer's the 2004 speech "The Tragedy of Today's Gays," lambasting gay men for not honoring those who fell before them by participating in a hedonistic culture of sex and drugs, was published as a book and reviewed in numerous publications, many quoting: "we are murdering each other" (Towle 2004; Kramer 2005). The stigmatization of meth use and condomless sex succeeded in making "No PNP" (No Party and Play) a fixture in online profiles for gay men seeking sexual and romantic partners, which in turn succeeded in shoving men who wanted to PNP and have condomless sex into both actual (underground sex clubs) and virtual (websites like BarebackRealTime) venues that would cater to them without stigma.

As the moral panic about meth and HIV in the gay community died down, the stigma set in. The general public and most gay men stopped paying attention; the anti-meth ads and messages became rote, omnipresent, like wall paper. The largest and most expensive anti-meth campaign in the country, 2008's California's $17.5 million "Me Not Meth" campaign, barely registered in the mainstream media and the gay media was only slightly concerned

(for example, *The Gay and Lesbian Times* 2008). Visitors on gay discussion sites like DataLounge typically mocked gay meth addicts without criticism from other site users, while a storyline on *Law & Order: Special Victims Unit* depicting meth-using gay men infected with the super strain as sociopaths (Makris 2005) was not challenged by the activists who had fought against AIDS stigma so valiantly. This particular panic dissipated, but the ideology that fed the panic remained, as did the scorned folk devil the panic created.

Meth Use and HIV-Positive MSM

HIV and meth abuse among MSM is one of several AIDS-related syndemics. Singer identified the Substance Abuse, Violence, and AIDS (SAVA) syndemic in studying the inner city Puerto Rican community of Hartford, CT (Singer 1994, 1996), and Stall described the syndemic of mental illness and HIV (Stall et al. 2003) in addition to joining Halkitis and others identifying HIV and meth abuse among MSM as a syndemic (Stall and Purcell 2000; Halkitis, Parsons, and Stirratt 2001). Halkitis has also described a broader syndemic of substance abuse, STIs, and mental health disorders among young MSM (Halkitis et al. 2015; Halkitis et al. 2013). In Africa, the syndemics of hookworm, malaria, and HIV (Hotez 2008) have been identified along with diabetes, depression, and HIV (Mendenhall et al. 2015) as well as HIV, tuberculosis, and poverty (Kwan and Ernst 2011) and HIV and food insecurity (Himmelgreen et al. 2009).

Stigma is involved in all of these syndemics, though in different ways and at varying intensities. In the meth and HIV syndemic, the intertwining stigmas combine cultural prohibitions on promiscuity, fear of infection, and distrust of seemingly irrational behavior. They also help create situations that perpetuate the syndemic in parts and as a whole. The stigma around HIV/AIDS helps to promote HIV infections and complications, while stigma around meth use encourages meth users to hide (Halkitis, Parsons, and Stirratt 2001; Link et al. 1997; Ahern, Stuber, and Galea 2007; Katz et al. 2013; *The Lancet* 2014). The stigma around homosexuality has been repeatedly linked to depression and anxiety, which can lead to sexual behaviors that can cause both HIV infection and substance abuse (Herek 2009; Hatzenbuehler, Nolen-Hoeksema, and Erickson 2008; Cabaj 2000). The stigmas are markers of social attitudes that create social situations that in turn create biological events, and these in turn create behaviors, appearances, and more social situations which can double back to the beginning of the cycle.

The various parts of the syndemic—the diverse stigmas, the interacting biologies and psychologies of infection and addiction—are not equal players and do not function the same across the population. For example, meth was often the accelerant for problems the men I worked with had; HIV manage-

ment tended not to be difficult, while meth addiction was an exceptional struggle. The reasons for using meth are varied, but most MSM seem to use meth to self-medicate for emotional problems, to enhance sexual experiences, and to improve and facilitate socialization (Halkitis 2009, 85; Reback 1997; Reback, Larkins, and Shoptaw 2004; Semple, Patterson, and Grant 2002; Semple et al. 2006a; Shoptaw, Reback, and Freese 2001). These are not mutually exclusive, of course, as most men are likely to have multiple and overlapping reasons.

Depression, self-esteem problems, anxiety, and stress are all indicated as precursors to meth use, with robust findings of co-morbidity of meth use and depression (Ross 2004; Looby and Earleywine 2007; El-Bassel et al. 2001). As Halkitis writes, "Not only may methamphetamine directly impact depression by alleviating the mood disturbances engendered by this condition, but it may also mask feelings of fatigue as well as lack of concentration, both characteristic of a depressive state" (2009, 92). Since people with HIV are more likely to experience depression—for numerous reasons—meth is often used as a coping tool, particularly after seroconversion (Halkitis, Fischgrund, and Parsons 2005; Reback 1997). Unfortunately, meth exacerbates these symptoms; depression is both a cause and an effect of meth use (Rabkin 2006).

All of my informants all used meth to cope with depression. While not all of them described themselves as depressed prior to using meth, either using the term "depressed" or by describing emotional states that sounded to be depressive, during periods of abstinence from use or recovery from meth addiction, those who returned to meth did so to treat, alleviate, or mask their depression. Many seemed to have been prone to depression since childhood, indicating a possible genetic or biological basis. For others, their daily lives are extremely difficult, and like many who suffer under structural inequalities, they used drugs to temper the experience (Singer 2007). Some described the depression as a reaction of upsetting or traumatic events, like an HIV diagnosis or the death of a loved one. Adam, whose experience is described below, discovered as an adolescent that alcohol and drugs were the most effective tools for helping him survive his severe depression and anxiety, sometimes manifested in boredom. Meth was even better. "When I'm not high, actually," he said, "I feel really uncomfortable. I hate it because I'm bored, nothing to do. There's many people that don't do drugs that live everyday like that. . . . But I don't want to do that because it's boring. It's a messed up world. Too much hurt and too much sadness." Jonathan was enormously depressed and distressed by recovery and relapsed repeatedly. Sam was probably the most negative about his chances for recovery and the most depressive in his state-

ments, saying during one interview, "I often think I should kill myself. But whenever I have enough heroin to do it, I forget."

Suffering from attention-deficit/hyperactivity disorder (ADHD) is considered a major risk factor for meth dependence. Methamphetamine was once used as a treatment for ADHD, which may lead some people with untreated ADHD to be drawn to it (Khantzian 1985). In addition, ADHD is associated with defective or lower levels of dopamine receptors, reducing the capacity to feel pleasure. Taking meth floods the brain with dopamine and prevents its reuptake, boosting pleasure (Volkow et al. 2001). Several of my informants described being much clearer and focused on meth and recalled diagnoses, formal and informal, of ADD or ADHD. Sam was given Ritalin as a child for hyperactivity and Andrew was diagnosed with ADHD, while Glenn, Charles, and Eric were never given actual diagnoses as children, but in interviews, all claimed to have ADHD and to find that meth helped focus them. Both Charles and Andrew say that they only feel "normal" when they are on meth. Sam explains, "You know, I used to be down, and you put me on speed, I usually get calm. I mean, it depends on the deal, but . . . really, it's pharmaceutical."

Studies also indicate that some gay men use meth and other drugs as a means for coping with the stress of homophobia, loneliness, HIV disease, and social situations (Reback 1997; Semple, Patterson, and Grant 2002; Halkitis, Fischgrund, and Parsons 2005). Post-traumatic stress disorder is also associated with drug abuse and addiction; long-term sufferers of HIV who have many AIDS related losses show signs of trauma, PTSD, and existential crises (Nord 1998; Machado 2012). Cathy Reback argues, in her ethnography of meth use among gay and bisexual men in Los Angeles, that some tried to manage the physical, psychological, and social effects of having HIV/AIDS with meth. For men who had AIDS and lowered energy, meth gave them vigor. Meth helped others forget that they were grieving the loss of friends and lovers. In their study of HIV-positive men who used meth, Semple et al. found similar motivations. They quote one informant who used meth to escape HIV: "Everywhere you go, you're reminded of HIV. Can I have one day when I'm not reminded that I'm HIV-positive? Meth gives me that" (2002, 153).

I conducted my ethnographic research 13 years after Reback's ethnography was published, and none of them talked about HIV being the main stressor in their lives, at least not in 2010 and 2011.[3] I often found it hard to untangle stress from anxiety and depression in the informants' narratives, but several of them described the joys of using meth after a stressful week, as a way to take away their worries, or to disassociate from the "real world." Richard, who worked as an administrative assistant, constantly described his weekend

meth binges as antidotes to the stress of his job. When I interviewed him, he was in recovery, not working, and living in a sober living facility. He was calm and happy and was planning for the future. When he went back to work within a month, the stress of the job, he said, led him to relapse. Adam, who had begun using meth partly because of its successful masking of depression, also used meth to cope with the stress and anxiety of his life, which ranged from not knowing where he will sleep or how he will eat to dealing with an emotionally abusive boyfriend or his needy sex work clients.

These reasons people offer for their meth use are individualistic, and many of the researchers who have described them underplay the role that interpersonal influences, particularly within the family, have in encouraging meth use. Halkitis (2009, 102) argues that the composition and processes of the family can influence meth abuse, citing the work by Hawkins et al. (1992) that connects to meth use by children to meth use by family members, poor family management practices, heightened family conflict, and weak family bonds. These patterns, in their individualistic detail, certainly can be seen among the participants. Both Brandon and Matthew had family members who used meth. Dylan's mother was a dealer and his father had spent time in jail for possession. After his mother abandoned him, Glenn grew up in numerous foster homes, several of which were either or both physically and emotional abusive. Charles, Richard, William, Jonathan, and Jorge had missing parents, either dead, estranged, or far away. Max and Eric had enormous levels of conflict within their respective families. Max ran away from home as a child, and Eric was beaten. However, it bears mentioning that Sam and Adam, two of the most troubled of my informants, had intact nuclear families with parents who were not drug users not abusive, suggesting the importance of other factors.

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

Sexual experiences that seem impossible while not high are commonplace on meth. Since meth is such a powerful stimulant that intensifies the senses and dramatically increases dopamine levels, the physical experience of sex is enormously powerful. One of Reback's informants described the sex: "All your senses are ascending, suddenly awakened and not dormant. Like being

born; really cool, warm, everything is new and exciting, like the first time." Another echoes, "It's just every nerve in your body is standing at attention" (Reback 1997, 25). In addition, meth enables many men to have anal sex more easily, to experiment sexually, or to have sex for longer durations of time. Semple et al. quote one man for whom meth was "about pushing my limits. It's about seeing how far I can take it. The nastier sex, the better. Nastier being multiple partners, a lot of exchange of body fluids. I have to have multiple partners, one right after the other for hours and hours, and sexual marathons up to 20 hours of rough sex" (Semple, Patterson, and Grant 2002, 152). The informants echo these kinds of comments. Jonathan said, giggling, "I would do the craziest things on meth." Jorge said, "Oh, yes, all I wanted to do was bottom. And I would do it forever."

In the introduction to Reback's ethnography, the Los Angeles AIDS Coordinator Ferd Eggan, who commissioned the study, suggests that the "outlawry" inherent in the mythos of gay sex is partly to blame for this destructive behavior. He argues, "[My] readings of the narratives provided by the men in this study is that the lives they have constructed and had constructed for them involve internalization of stigma, a sexualized definition of self, and mechanisms to resist the internalized negative feelings" (Reback 1997, ii). Meth use may not simply increase risk-taking in otherwise risk-averse men. Rather, research suggests that "methamphetamine attracts a hypersexual risk-taking group of men who engage in unprotected sexual behaviors regardless of their methamphetamine use" (Halkitis, Shrem, and Martin 2005, 703). This possibility is supported by another study that shows a correlation between meth use and both impulsivity and sexual compulsion (Semple et al. 2006a; Semple et al. 2006b; Semple et al. 2008). It is not surprising that since self-control is so valued in American culture many gay meth users feel shame about their drug use and sexual behavior, and those who quit rarely have anything but extremely negative memories of their meth use (Reback 1997; Mimiaga et al. 2008; Menza et al. 2007). Several gay cultural critics (Halperin 2007; Warner 1999) have argued that this shame, which comes from pathologizing both gay sexual adventure and the use of illegal psychoactive drugs, is precisely what many men are resisting, probably more unconsciously than consciously, by using meth and having sex that is called "risky." Many of the men in this study described themselves as rebellious as children and cited their drug use as evidence of that rebelliousness, but it was unclear whether rebelliousness was an external description of their abnormal behavior by parents and teachers or a self-aware, agentive state of being in opposition to control or oppression.

The effects of meth abuse often perpetuate the social, psychological, and biological bases that encouraged the initial meth use, creating a cycle that is

difficult to escape. Prolonged use can change the dopamine system; it can take many months, even years, for the dopamine system to recover following cessation (De Vito and Wagner 1989). By reducing the dopamine transporters, more meth is needed to feel pleasure, furthering addiction to the drug. The decrease in dopamine transporters also can hurt motor functioning, memory, and verbal learning. Cognitive impairment is also common among meth abusers, from increasing distractibility to decreasing the ability to think abstractly (Simon et al. 2000). Dental problems, caused by decreased saliva and increased grinding (among other issues), are famously common among chronic meth users (Klasser and Epstein 2005), as are skin problems, often the result of obsessively picking the skin because of the common hallucination that bugs are crawling all of the body (Rusyniak 2013). Prolonged use can also impair social skills, making it difficult to "read" another's emotions and encourage awkward social interactions (though ADHD may also influence or intersect with/exacerbate these problems) (Homer et al. 2008). Withdrawal from meth leads to a depletion of catecholamines (Meredith et al. 2005), which can cause to a number of psychiatric problems—depression, anxiety, social impairment, psychosis, hallucinations, and both homicidal and suicidal ideation—that can lead directly to conflict with other people, especially the police. And the addiction to meth compounds problems associated with HIV. Studies have shown that meth users are much more likely to fail to adhere to treatment regimens, further compromising their immune systems (Carrico et al. 2007). Thus the increased likelihood of contracting STDs, because of sexual compulsivity associated with the drug, is much more problematic (Shoptaw and Reback 2007), as are the potential problems associated with toxic substances, like lead, found in impure meth (Halkitis 2009, 65). Meth is also associated directly with an increased replication of HIV and the replication of two of the 23 opportunistic infections that define AIDS: candida albicans, or thrush, and a fungus that causes meningitis, cryptococcus neoformans (Tallóczy et al. 2008). As health problems, illness, pain, and depression are drivers for meth use, these complications from HIV associated with long-term meth use can further encourage the use of meth or other drugs.

These affective, behavioral, and physical changes signal to many observers, especially in communities with large meth problems, who is a meth addict. While some react to the stigma with empathy, others become afraid and work to distance themselves. Shunning and incarcerating meth addicts out of fear or disgust is both a result of and driver for stigma, and the consequence is isolating the meth addicts from their larger communities, making them less likely to seek help or treatment and more likely to socialize with other meth users, which will only further the addiction.

Three Pathways of Interaction

In the three narratives that follow, I demonstrate how Charles, Andrew, and Glenn deal with social, psychological, and biological interactions between methamphetamine addiction, HIV, depression, and stigma, to illustrate the syndemic proposed in this chapter. Their stories depict the individualized and idiosyncratic nature of this syndemic, but these individuals also have a good deal in common: stigma, shame, and an uneasy, sometimes hostile, relationship with the potential for recovery from addiction. These commonalities need to be understood not only through their different iterations but also through the ways they are structured by cultural, political and economic forces that drive the syndemic.

Charles

Of the informants discussed in this chapter, Charles had the most extensive psychotherapy, and through it he developed a great deal of insight. During the study, Charles was the only informant who saw a psychiatrist every week. The others saw drug counselors, had medical doctors prescribing anti-depressants, or were members of at least one support group. Charles did all of these, as well as psychotherapy. Charles seemed to have the most self-awareness of anyone in my study, but at no point did he stop using meth for longer than a few months. Still, he was rather high-functioning; had his own apartment, picked up monthly federal disability checks, and always kept his appointments. But despite having analyzed his past and his emotions so thoroughly, and despite being on numerous psychotropic medications, Charles had an almost exclusively negative, if not depressive, analysis of his psychodynamic narrative.

Charles grew up in the northern part of California's Central Valley. When asked about his earliest memories, he discussed 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 explained to me that is why he was always early for interviews. "Now I have to be early, or they won't wait." "They" referred to anyone he might rely on. Charles links this fear of being left behind with his fear of his family discovering that he was gay; they suspected it early on because of his effeminate mannerisms: "To my dad's parents, who were dumb rednecks, I was devil spawn." Instead of disappearing into himself and hiding, he became an extrovert. "I was afraid of being found out and afraid of being forgotten, so I would be as obnoxious as I possibly could." In his self-analysis, he sees this extroversion, much of which was a clown-like performance, as a defense mechanism. "They could

never know how depressed I was," he said. "It takes so much effort to put on that happy face. I have a hard time attaching myself to people. That's why I had to be outlandish." But that didn't always work. Charles was always acting out as a child, and was not treated well because of it. "When I was 12, I went on a crazy rant—ADHD stuff—and one of the teachers slapped me." On meth, his mind is quieted. "Meth calms me down; I can focus."

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

As he explained his behavior, he repeated the various analyses offered him by his therapists and counselors. His current therapist told him, "You're not crazy, you just do crazy things." In one support group, which used an intervention curriculum designed at UCLA, he said, "We were trying to figure out why a lot of us have underlying reasons for using. You're supposed to be responsible to yourself." This responsibility meant that, as Charles came to believe, "I made my life this way." In analyzing himself, both through years of psychotherapy and in various interventions, from groups to one-on-one sessions of motivation interviews, he has learned to narrate his life. But he is not the good guy in his own story. He feels shame for letting these events and situations make him—and others—suffer. He said: "I have to stop using my past as an excuse for being bad."

But an argument can be made for Charles' past experiences being partly to blame for some of his problems, a past (and present) with stigmas, depression, and HIV biologically and socially interacting and influencing each other. Untreated childhood ADHD coupled with depression resulting from his family and community's homophobia may have led not just to meth use but also to risky sexual behavior and HIV infection. The stigma around HIV encouraged Charles not to tell anyone about his status, and that internalized shame, fear, and sadness only made it more likely that he would seek solace in meth. Charles completely internalized the stigmas of the syndemic he suffered. He hated himself for being depressed, for being addicted to drugs, for

having HIV, for lying, for failing. Considering how well-managed his HIV and his meth addiction was, it was actually the depression and the multiple stigmas that brought Charles the most suffering. It made sense why he periodically went back to the drug. When I asked Charles to describe the feeling of meth, he focused on its ability to take away his worries. "Oh, it's like every care in the world is just gone," Charles said. "You're not worried about anything. For that moment, it's just perfect."

Adam

The author met Adam at the syringe exchange where I volunteered. He was a tall, lanky man in his late 20s, wearing a tank top and shorts and eyeing me suspiciously while smoking a cigarette. Adam told me during their first meeting that he was living with friends, was working for a landscaper, and was looking into going back to school. These were not exactly false statements. In a way, the men he lived with were his friends, but they were friendships forged in drug use and had numerous strings attached. Adam was thinking about working: one of his other friends had said he could help him get a job assisting a landscaper. As for school, this was a goal, or rather an idea of a goal, that he had been told over and over again to have, by drug counselors, case workers, and probation officers. Because of who I resembled—a researcher, a therapist, a drug counselor—he seemed like the kind of person who wanted to hear that Adam was thinking about going back to school. Otherwise, Adam did not contemplate the future very much. He was more concerned with where his meth would come from, where he was going to sleep the next time he decided to sleep, where he was going to be able to find money, who was going to give it to him, and what he would have to exchange for it. Adam had been doing meth for more than a decade.

As a child, Adam had felt disconnected from his family. "I'm not their blood, you know?" he said. "I'm not their biological son. I'm adopted. So, that kind of threw me off. It made me feel like, you know, I don't have parents. Ever since I was little, I've felt that way. So, that kind of made me feel like I was less than. . . . It screwed me up." He thinks it led him to look outside for social kinship. He grew up upper middle class, the son of a lawyer and a doctor in suburban Michigan. His parents, he said, were obsessed with being good at being parents. But when he was 12, he became fascinated with the other side of the tracks—literally. The kids from that side of town smoked cigarettes before school, they drank a lot, and they did whatever they wanted to. By 14, Adam was getting arrested, and he was using all kinds of drugs and copious amounts of alcohol to self-medicate for severe depression, anxiety, and ADHD. His parents paid for psychiatry, rehabilitation, and lawyers, and they pulled strings to keep him out of jail multiple times. But no treatment,

no prescription psychopharmacological substance worked to soothe him the way that the drugs and alcohol did. Finally, his parents put their feet down: If he would not cooperate, they would not take care of him anymore. He left Michigan when a warrant was issued for his arrest for writing bad checks.

Adam and his then-girlfriend decided to come to San Diego. They spent days on buses and arrived at her father's door expecting a bed to sleep on. But her father did not want to see her or help her, and they spent the next couple of weeks sleeping on sidewalks downtown before cobbling together enough money to rent a unit at an SRO. It was in the lobby that he met his first boyfriend, who introduced him to meth.

> We start smoking meth and then we had sex. So on that night I had sex, anal sex for the first time. And smoked meth. He was a drug dealer and he liked me, and shortly after that I moved in. And I had a really bizarre fun time for . . . a couple years. So that was my introduction. Selling meth, unprotected sex. I got warned of like HIV or something like that. I don't even know if that was true or not. I just didn't care, that is really sick. That is how I was thinking. (*Adam*)

After that relationship ended, Adam discovered that his good looks and mostly mellow demeanor gave him an advantage; he could easily trade sex for drugs, for a bed, for cash. Some of the men were nice, many were not. Some would get him involved in the drug trade. He found himself carrying drugs for dealers, selling some on the side, and one day, at a Wal-Mart, he was arrested with a duffle bag full of meth, ecstasy, marijuana, and cash. He had been high when he went into the store, and paranoid and agitated, and he easily piqued the suspicions of the security staff. This was not the first time he ended up in jail, but it did lead to his longest stay.

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

During the months that Adam met with me, he would discuss his depression frequently. This was the depression that even the meth couldn't mask. He often said he didn't see any point in trying, that he expected failure, that he didn't see anyone interested or willing or able to help. One day Adam came to the my office covered in bruises and dried blood; he was incredibly agitated and terrified. His boyfriend, who he called Psycho, had crossed a gang in a check-kiting scheme, and the gang had held them and Psycho's brother hostage for two days. They were beaten and tortured before, for no seeming reason, and then they were released. Adam seemed to have a concussion; he needed medical attention. But he was terrified to go to the hospital because the last time he went—for bronchitis—he ended up with $50,000 in bills. He repeatedly stopped himself from crying, which was most difficult for him when I said I wanted to help him.

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

During this period, as I contemplated why Adam would refuse help I was reminded not only of Reback's conclusion, that meth made sense in the lives of meth users, but also of the stack of studies (referenced above) about meth users using the drug to self-medicate their clinical depression, other mental health disorders, and their existential dread, as well as to cope with the knowledge that meth was not actually helping relieve the depression (Looby and Earleywine 2007). Adam was addicted to meth, and that physical need was the most powerful drive for his continued use of the drug, but when he was sober, he didn't utilize the resources, however weak and ineffective, that might have helped him. Those resources came from institutions that told him he was a failure, a criminal, that his struggle was deserved and necessary; the people that were charged with helping Adam recover were also the ones that most powerfully reinforced the stigma of being a meth-addicted, HIV-positive gay man. Being sober did not make sense to Adam. Sobriety meant feeling all of the stigmas, hating himself, having panic attacks, and having to make Herculean efforts to do things as mundane as grocery shopping. Even

though staying on meth would have other, negative consequences, from self-loathing to physical pain, it made sense to Adam to continue to use.

Glenn

Glenn grew up in and around San Diego, bouncing from foster parents to an uncle who touched him inappropriately, then to more foster parents. His father was gone and his mother had been incapable of taking care of him; his temporary families were only slightly better. Some were violent. Many he cannot remember. One family stuck the longest, and he refers to the other boy his age who lived there as his brother, still, more than 30 years after he left the system. When he was younger, he was always getting into trouble, either because of his anger or sometimes, because he made passes at father figures. "I thought that that's how you loved a father figure," he explained. "I was a kid. I just wanted to be loved." Glenn experienced a great deal of chaos and emotional violence as a child. He said that when he is high on meth he is most sexually turned on by degradation and humiliation (as explained below). When asked if there was a connection, he said, "I don't see that as a reflection on my childhood."

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

When his kids graduated from high school, he saw his responsibility to them lessened, and he and his brother decided to get a fresh start back in San Diego. They packed everything up, and without jobs or a plan, just an imagined belief that San Diego really was American's Finest City, they drove west. But like the wannabe starlet who arrives on a bus in Hollywood and is promptly introduced to sex, drugs, and rock and roll, Glenn's return to San Diego was also his arrival to meth. The night they arrived, Glenn went to Montage, a gay club not far from San Diego's airport, and he drank and

danced, thrilling by his new old home. He met two men on the dance floor, roommates who invited him back to their apartment for an after party of more booze and sex. When they got to the men's home, the roommates disappeared into one of their bedrooms, where unbeknownst to him they injected meth, while Glenn waited in the living room. Then, they opened the door, revealing themselves to Glenn both naked and in ecstasy. Glenn looked at them and saw freedom from care and constraint, from sadness and anxiety, and he thought, "I want to feel like that."

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

Glenn had sex with men who he'd never have looked twice at while sober, he crashed on couches, he spent his savings, and he started finding and reselling junk to make ends meet. After four years of this, after a couple fits and starts attempting recovery, he says he hit bottom in an SRO, crying all night long because he knew he was killing himself, destroying his children, ruining his life. When he came to our first interview, Glenn was crashing on a friend's couch and applying to sober living housing, for social security, and making plans for the future. He went to meetings every day, volunteered at a community health center, and said he wanted to become an addiction counselor. He was positive, focused, full of goals. He was also dishonest, both with me and with himself and with the sober living programs. He outlined one life story over three interviews, and then during the fourth, he read the addiction narrative he had written for San Diego's Crystal Meth Anonymous Book, and the tale was different. In the addiction narrative, he had been a crack addict in Kansas and to me, he'd said that he'd tried cocaine once. I asked about the discrepancy and he mentioned, off-handedly, that he probably had wanted me to like him.

Glenn had seemed so excited about his future and his recovery, had thrown himself so fully into the recovery community, repeating their mantras in our interviews, volunteering at meetings, and declaring his desire to make a career as a former addict. He acted like a veteran of 12-step programs, but he was barely two months into his sobriety when he started sitting for interviews with me. He would also beat himself up after every set back, blaming him-

self for his failure to recover more quickly. After six interviews, Glenn and I took a break from interviews; I had planned on doing two or three follow-up interviews after six months. But a couple of weeks after the sixth interview, another interview subject, who was living in the same recovery housing for people with HIV, told me that Glenn had left the complex. He had relapsed; he left one night, shot up meth, and returned a few days later to pick up his stuff. Within a week, he was back in Kansas, out of contact with his friends at the complex. Brandon, a 22-year-old who Glenn had suggested for this study and who was in love with him, was livid: "He just gave up. He couldn't handle it. He couldn't be sober."

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

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

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

Glenn's path to recovery was a long one. He mentioned during one interview that he'd introduced himself as a new member of Alcoholics Anonymous eight times; he'd relapsed seven times so far. This time, it seems, the program, both as a series of meetings and exercises and a series of cognitive scripts and behavior modifications, has worked. He has stopped using. For now. Perhaps for good.

CONCLUSION

Like Charles and Andrew, and the other men in this study, Glenn's addiction has been powerfully individualistic experience. As they describe it, the desire for the drugs is theirs alone, the triggers are theirs to avoid, the use of drugs is theirs to end; they deserve their stigmas. The discourse of addiction promoted by the 12-step programs, popular culture, and anti-drug campaigns expresses drug use as an individual choice; you choose to follow the path of recovery or you choose to follow the path of addiction. The informants who were not able to follow the path of substance use recovery often described experiencing disastrous consequences for which they blamed themselves despite larger structural circumstances, from Adam's assault and torture to Charles' constant sadness and anxiety, from Glenn's internalized stigma manifested as self-loathing to others' incarceration, homelessness, or even death. With few exceptions, the informants describe walking their paths to addiction under their own moral power.

Neither biological nor structural reasons were addressed, likely because the informants were never told about them or because they were told to minimize them. I never heard that untreated childhood ADHD was a major risk fact for methamphetamine abuse; that it was methamphetamine that increased libido and decreased inhibitions, not one's moral failing or lack of self-control; that methamphetamine itself made HIV more likely to replicate, that the harm to cognition made it harder to remember to take medications. Rarely did anyone discuss the structural poverty that contributed to many of their difficult childhoods, and rarely did they talk about the structural violence of the governmentalities of the Drug War. Glenn did not see the state's failure to provide him with a safe foster family or to treat his mental health problems as a child as having anything to do with the trauma he is still dealing with. He did not see how state-sponsored recovery programs push 12-step ideologies on him not because they are the most effective, but because they are the cheapest.[4] He does not see how the shame, guilt, sadness and despair that he felt during his recovery is partially determined by these programs, not because one needs to feel these things in order to overcome an addiction but rather because the

Drug War, and the cultural, political, and economic processes that started and perpetuate it, need the shame, guilt, sadness and despair in order to justify itself (Singer 2007; Singer and Page 2013). As Glenn said, in describing his rapes at the hands of men who drugged him, "I didn't deserve it. But it happened because I put myself in that situation."

Glenn, like other participants, was indoctrinated structurally and culturally to individualize his life experience rather than to consider genetic predispositions, structural factors, and hierarchical social influences; he was taught to blame himself for "poor choices" and life failures, for creating his own life situation. What this individuation of causation cannot explain, however, are the structural patterns across the lives of the men in this study. It is the study of these patterns that leads us to a useful assessment of the role of structural factors in interactions between meth use, HIV, their individual and compounded stiamas, and other biological and behavioral aspects of illness, addiction, and suffering.

The stigmas against HIV, meth addiction, and homosexuality stem from and are embedded in entrenched cultural ideologies, which in turn influence state and non-government structures and systems that further reproduce the stigmas. These stigmas serve a function, as Singer and Page argue: "Othering is purposeful; it has practical benefits. Specifically, it serves interests and rewards its perpetrators. Othering, in short, has its advocates, its operators, its benefactors" (2013, 208) The institutionalized legal and cultural heterosexism of Western culture (despite recent marriage equality) *needs* homophobia, either overt or covert, to define itself (Foucault 1976). The hostility to substance users, whether of marijuana or meth, helps to define what is normal, rational, and acceptable. And HIV—which seemed to come from already racially, sexually, and behaviorally problematic peoples—worked as the danger that defined the purity of the ideal American family (Patton 1985). The forces that promote these ideologies and produce the stigmas have interacted with the biological, psychological, and social manifestations of meth addiction and HIV to create a syndemic that behaves almost like a perpetual motion machine. Stigma toward HIV, however lessened since the mid-1990s, continues to make prevention, care, and treatment difficult. The stigma of methamphetamine addiction, based not only on the imagined monster of the meth addict but also on the embarrassment that addiction brings to the gay community, is fresher but also currently more resistant to critique. It drives meth addicts underground; they are less likely to talk about it, harder to reach because of it, and more likely to get sicker, progress faster, and die from it. Perhaps only by reducing these stigmas, fighting the cultural logic that structures them, and reforming structures that support them, we might be able to address the syndemic they help to fuel.

NOTES

1. The names of the study participants have been changed to protect their anonymity.
2. This chapter includes sections that appear in different forms in other publications (Gideonse 2015a, 2015b, 2016).
3. Eric and Jorge, both of whom contracted HIV in the 1980s and identified greatly with being gay and with the gay community, would have been the most likely to provide me with data that would match Reback's, but they did not describe their meth use as having such meaning. William was old enough and has had HIV long enough, but he did not identify himself as part of a gay community.
4. As Carr explains, "by prescribing talk that can only reference the inner states of speakers, addiction counselors effectively, if not intentionally, enervate clients' institutional critiques and discourage social commentary" (2010, 5).

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