HHS Public Access

Author manuscript

J Gay Lesbian Soc Serv. Author manuscript; available in PMC 2017 July 15.

Published in final edited form as:

J Gay Lesbian Soc Serv. 2016 ; 28(3): 231–244. doi:10.1080/10538720.2016.1191407.

Fetishizing the health sciences: Queer theory as an intervention

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Abstract

Queer theory often falls impotent in its palatability across disciplinary lines. I offer a conceptual paper that interrogates the disease and divide when considering queer theory in and for the health sciences. In so doing, I look to foster a process of making queer theory more tenable to applied practice – and to make practice in social work, at least, more queer. The exemplar of HIV is deconstructed as a preeminent discourse and health disparity. In the end, it is argued that queer theory may be an essential intervention in the arsenal of the helping professions.

Keywords

Queer theory; identity; HIV/AIDS; social work

One of the most typical moments in my clinical work has been witnessing clients and practitioners alike fetishize the professional industry that has been developed around and because of HIV. Routinely, client-after-client presented unwittingly encumbered by risk. Amidst anxieties and seroconversion, clients have expected from healthcare providers prescriptions for how to comport their selves, reifying a belief in the natural order of events unfolding in- and out-side them. Seductive for me, however, has been the privileged witnessing of these same clients forced into liminal spaces when it becomes clear that their bodies, desires, and sex/ualities are not easily represented in the minds and technologies of the providers and the industry tasked to help them. It is too often in clinical practice that sex/uality and gender are indexed through social and health disparities such as HIV, through (psychiatric) diagnostic schema, or embodied via identitarian-based categories, such as "LGBTQ" (McPhail, 2004).

In the following pages, I enter the nexus of theory-and-practice – made messier by the objects of sex/uality, a queer standpoint, and professionalism. It is the site of abstraction (the stuff of ideas and intellectual commodities) that is the core problematic here, which is necessarily dense. It should be nakedly noted that queer theory is often experienced *de facto* by the social and health sciences as abstract, obtuse, and aggressive (Gamson, 2003). To that end, I first provide an argument about social work as an allied health profession. Second, I review the development of queer theory. Lastly, I deconstruct how HIV and risk can be understood within a queer epistemology. Throughout, it is my intention to foster a project of making queer theory more tenable to applied work, continuing the import of critical theories into social work, and queering our profession in ways commonly rejected.

Social work and the health sciences

The original social workers were a number of things. They were friendly visitors, charity volunteers, secular advocates, social reformers, settlement workers, and moral up lifters, among other roles and titles. This was in part promulgated by Judeo-Christian and bourgeois values, a concretizing humanistic philosophy on social issues, a developing social services infrastructure, and a political economy that allowed for schooling in the emerging science of charity. This also facilitated a normativizing belief system of the worthy client, professional ethics, and a need for (and anxiety due to) empiricism.

At the turn of the 20th century, our budding profession became further influenced by the evolving Western applied practices of medicine and psychiatry (*cf.* Flexner, 1915; Sperling, 2010), which privilege scientism, pathology, and expert opinion. Social work embraced this logic through, for example, developing "specializations" and promulgating medico-discursive technologies of *study*, *assessment*, *diagnose*, and *treat* (Dybicz, 2012). Buttressed by post/positivist epistemologies, the medical and health sciences posit the human body and -condition as some *things* discoverable in the natural world (Treichler, 1999). In late modernity, medicine gets to represent the truth of health and wellbeing, concordant with the micro and macro contexts in which they are personified. As such, *a priori* classifications and rational knowledge seductively constrain ideologies, forcing objects (e.g., viruses, populations) to conform to its way of meaning-making in order that they may be rendered knowable, intelligible, and legitimate.

Medicine also engenders a naturalizing logic and rhetoric as it is based on facts and nature. Thus, categories are rendered neutral and depoliticized, which achieves many ends (Waldby, 1996). This logic positions social matters against naturally fixed phenomena. It devises mutually exhaustive disciplines, concretizing its right to oversee health. It produces a rational mind-body split in which the mind is the purview of philosophy and the body is the subject of medicine. And, it defines the laws of the body via its clinical gaze. Effectively, medicine and its allied professions have successfully established their ontological and epistemological rights to represent the *real* or the truth of the human condition. This self-legitimizing power can set the terms of other discourses, making medicine an ideological system experienced as inescapably natural, as simply what *is*.

Despite possessive claims to objectivity, the fields under the umbrella of the health sciences cannot be separated from general ideas that operate in our culture. Health professions constantly engage and re-circulate *non*-scientific ideas into their technical discourses (e.g., sex/uality, ethnicity, gender). In fact, it is the *cultural* itself that becomes precisely what must be repeatedly evacuated in order to maintain a sense of what is real and universal: for example, in the HIV literature, *culture* is often cast as a reservoir of unhealthy practices to be eradicated (*cf.* Treichler, 1999), such the stigmatizing positioning of young people and gay men labeled as fatigued with prevention. This permeable relationship between health disciplines and social knowledge implies that medicine and its allied fields can be treated, in part, as *discourses* of culture. This understanding is often eclipsed in everyday life, however, due to medicine owning and deploying technologies that work upon and transform human

bodies. So, instead of some *things* scientifically discovered, health conditions like HIV can be seen as social constructions, or active cultural productions.

Getting to queer theory

Queer theory today is animated by linguistic and cultural genealogies. In large part, queer theory draws off post-structural perspectives on language. In the mid-20th century, poststructuralism extended our understandings of language by offering a means to "read" differently – appreciating the reciprocal relationships between language and society (Belsey, 2006). From a poststructuralist perspective, meanings of words, images, and texts are not found to be elsewhere, embedded in a looming structure, such as in a perceived fixed, immutable grammar that we must map onto and structure the messiness of everyday life. Rather, meanings are unfixed, discontinuous, and unstable. And meaning-making derives from our ability to differentiate. Moreover, poststructuralism brings to the fore that there is not a 'unifying voice' in language; instead, power displaces language as the central structure for ordering reality. A prime example of this is the power medicine holds in defining what is real (and not) about HIV. Accordingly, language is situated in and works *through* societal relations of power (Foucault, 1990).

Parallel to this linguistic reformation, in the later 20th century postmodernism ushered in re-/considerations of philosophy and culture (Crotty, 2004). Postmodernism can be seen as a response to the societal effects of modern industrialization. Alongside the material developments of an industrializing society, parallel logics have developed that privilege rationality, instrumental reason, progress, and capitalistic investments in truth and experimentation over realism. Being both a literary movement and a cultural theory, postmodernism works to deconstruct binaries and hierarchies that often result from modern industrialist logic. Such deconstruction often begins by decentering the human subject and rejecting the essentializing tendencies that lead to counting, categorizing, and homogenizing human experiences. Instead, postmodernism has an obsession with difference, the local (context), the particular, and positionalities (Hutcheon, 2006).

Underlying the intersection of linguistic and postmodern turns in the Western world has been the strong current of sex/uality and gender, often ricocheting between epistemologies of essentialism and constructionism (Jagose, 1996). From a biopsychological perspective, essentializing perspectives on sex/uality are concerned with its origins, evolutionary trajectory, and physiologic systems and differences. This concern frames non-heterosexuality as an inherited tendency that is catalyzed by intra- or interpersonal conditions, becoming a deviation from the 'normal' course of events in human development (Rahman & Wilson, 2003). Conversely, other discourses argue that homosexuality developed through the urbanization of spaces, since the 16th century, which allowed for homo-sociability, such as in New York's Bowery area (Chauncey, 1994). Infamously, Foucault (1990) asserted that sexuality became constructed, beginning in the 18th century, through emerging medico-scientific discourses as well as the privatization of sexuality itself. Under this perspective, sexuality was nothing more than an idea, with sex being nothing more than socio-political expressions of that idea. Through disciplinary technologies set forth by institutions and bourgeois social practices, such as psychiatric classifications, a dependency

between normativity and bio-power was substantiated: the body and its comportment became a targeted site to maximize life, productivity, and capital. Thus, a shift occurred from focusing on sexual acts to focusing on a *type* of person, a sexual subject or 'the homosexual'. Moreover, within a Foucauldian analysis, power is not something simply dominating and top-down; rather, power is something productive, constantly circulating, and continually reformulated with situated purposes. For example, in the more recent era of capitalism, it has been asserted that the congealing of homosexuality has been coextensive with the proliferation of market-based economies (D'Emilio, 1993; Duggan, 2004). By this point in our post-industrial era, the domestic family has become less the site of economic production and more the foundation to cement heteronormative sociality and affectivity. Given its productive logic, free market economy has allowed for individuals to relocate and to develop capital. Therefore, individuals separate from nuclear family networks and construct their own visibility via communities and consumerism.

In this development, the focus on sex/uality has shifted from acts to identity, mired in contestations about essentiality or social construction. This analytic of identity has facilitated ever-growing political and social movements. Whether ones talks of the Chicago Society for Human Rights, the Daughters of Bilitis, or Stonewall (all of which clearly privilege Western histories), the aggrandizing social legs of a GLBTQ identity has brought about cultural struggle, violent resistance, self-determination, and a public challenging of the *status quo*. This 'gay liberation' narrative has portrayed homosexuality as an identity repressed by hetero-/sexist power structures, which demand gender-asymmetry, sexual reproduction, and patriarchy. There has also been an emphasis on a public 'coming out' and consciousness raising, underscored by the belief that a politicized identity can be socially transformative (D'Emilio, 1993). [Interestingly, in light of the AIDS pandemic and public health discourse (to be discussed further), a shift from identities *back* to sexual acts has been occurring in recent decades, exposing again the utter instability of 'the homosexual' and 'homosexuality'.]

The gay liberation movement, however, increasingly has focused on securing equality for a population defined in terms of same-sex object choice (Warner, 2002). As such, it has centered on community identity and cultural differences, which have promoted an increased focus on local struggle and securing *specific* rather than universal changes of social structures. Feminist frameworks have expanded this liberationist account through deeper analyses of the specificities of gender, staunch arguments for the institutional construction of sexuality, and an astute critique of compulsory heteronormativity (see, for example, Sedgwick, 1993; Butler, 1993, 1999). Resultantly, a coherent, alphabetized LGBTQ identity and community have stabilized today (at least for those in the mainstream), engendering intense focus on authenticity and inclusion; differences such as race, ethnicity, and multiplicity of genders have been neutralized. Moreover, sexual practices have become conflated with sexual orientation, contributing to stigmatization and reification of hetero/normative values (Jagose, 1996). The consequent political agenda of this perspective has focused on individual identities, community representation, needs/rights discourses, and state provisions (Warner, 2002). And, for scholars, a field of inquiry has cemented as Gay and Lesbian Studies.

Queer theory and queer identity

In the early 1990's, melding poststructural and postmodern frameworks, queer theory emerged in reaction to cultural, theoretical, and political discourses of lesbian and gay identities (Sullivan, 2002). Instead of being pseudo-scientific (i.e., homosexuality) or some deviation from a norm (i.e., gay), queer theory regards (queer) sexuality as an highly transhistorical, intertextual, and unstable sign that points to the principles and potentialities of Queer theory (Eng, Halberstam, & Muñoz, 2005). Initially, queer theory attempted to delegitimize liberal, liberationist, ethnic, and separatist notions of identity, and create a new discursive space for itself. It assumes that one primary aspect of modern life that structures the social world is sex/uality, and more specifically heterosexuality and heteronormativity. Yet, while it often targets sex/uality, queer theory interrogates multiple social particularities, all the while remaining faithful to the centrality of sex/uality to modern institutions, social systems, and discourses. In the most critical sense, the primary object of queer theory is the *normative*; it is a positionality *vis-à-vis* the normative, an effective challenge to the idea and everyday production of the privileged norm. It is a verb (Sullivan, 2002), an active strategy to apprehend difference as relational, rather than oppositional. In large part, queer theory investigates the mediated relationships with self-identification categories, showing the limitations of identity and unpacking naturalizing cultural categories (Eng, Halberstam, Muñoz, 2005).

In order to achieve this, within queer theory a number of critical perspectives are harnessed to challenge essentializing narratives of identity. Ideologically, identity can be seen as an interpellated subject, which is to argue that (social) context always precedes the individual or that we embody the discourses promoted and sustained by institutions (*cf.* Althusser, 1976, *cf.* Marx, 1867/1992). Psychoanalytically, it can be a learned subjectivity, or an active (interior) process of meaning-making through development and socialization (*cf.* Freud, 1905/2000, *cf.* Lacan, 1977/2002). Given a mythological construction, identity can be seen as a unified Self, resultant of representational codes grounded in language as well as other sign systems like multi-media (*cf.* Barthes, 1957/1972). Poststructurally, identity and authenticity are seen as the effects of language systems versus some-/thing *a priori* (*cf.* de Saussure 1916/1998, *cf.* Butler, 1990/1999). In a postmodern frame, the domain of sex/uality and its multiple identities are not essential personal and private attributes, instead discursive productions arising from available cultural categories and the effects of power networks (Foucault, 1990).

Within this queer epistemology, identity is most typically understood as performative (Butler, 1993), or the repeated stylization and congealing over time that provides the appearance of substantive identity. Performativity is not some-*thing* that a subject theatrically does (i.e., a performance), rather it is a process through which the subject is consolidated. For example, gender is not an expression of what one is, rather it is *various things that one does*. Similarly, categorized sexualities are not fixed, rather they are conditions of *doing* straightness or doing queerness. All identities, then, are acts that have been rehearsed, much like a script, and we (the actors) make the script a reality through *repetition* (not just in a one-time performance, that is, "drag show"). Moreover, identities are not social impositions on neutral body, rather they are modes of *self-making* through which

subjects (individuals and communities) become socially intelligible, visible, knowable. And, our performative acts sit within a matrix of power and oppression; thus, it is the repetition over time, space/place, and context that brings our identities into being.

One might question, then, what is queer identity, if there exists one? Queer is identity without an essence; it is always ambiguous and relational (Jagose, 1996). In other words, it is a subject-less critique, necessarily indeterminate and referring more to self-identification rather than to empirical observation of factual social characteristics. It is the denaturalization of identity as something fixed, natural, and coherent. This ontology, however challenged, does not seek an annihilation of lived experiences. On the contrary, queer theory asserts that identity is imperative and serves strategic social functions, rejecting politics that replicate race, class, and other oppressions (Sullivan, 2002). Moreover, queer theory denaturalizes identities, exposing the essentializing residue of positivism that typically is at the heart of identity and its politics (Eng, Halberstam, Muñoz, 2005). It seeks to further understanding of identities as intersectional and diasporic, reconceptualizing relations and (social) locations in terms of queerness, affiliation, and social contingency, rather than ethnic dispersion, filiation and biological traceability (Manalansan, 2005).

In its development, however, queer theory has taken a materialist turn, being faced with a queer liberalism of sorts. Current queer theory problematizes its long-standing subject-less critique *vis-à-vis* contemporary liberal demands for a nationalist gay/lesbian U.S. citizen-subject who “cannot not want” to petition for rights and recognition before the law (Spivak, in *ibid*.). Yet, political economies cannot be abstracted from the racial, gendered, and sexual hierarchies of the nation-state; rather, they operate *through* them. Extending modern capitalism and consumption, homonormativity has emerged in queer theory, entrenching a transparent White, neoliberal subject, one who replicates heteronormativity (Duggan, 2004). In this variation, homonormativity anesthetizes queer communities into passively accepting alternative forms of inequality in return for domestic privacy and the freedom to consume (Manalansan, 2005). A preeminent example of this is the fight for “marriage equality,” which privileges a specific form of intimacy and relationship-making (i.e., legal marriage) while silencing and eclipsing other aggrandizing notions of intimacy, domesticity, sexuality, and sociality, among other discourses.

Overall, queer theory has strengths that make its import into the health disciplines and its export beyond the object of sex/uality highly productive. Queer theory apprehends the deployment of naturalizing tendencies and terminologies, offering increased nuance, a decreased security (in the Self), and increased competence to the various negotiations that are compulsory to any mobilization of identity (Jagose, 1996). More importantly, Queer (and its theories) deconstruct the inner workings of identity, destabilizing and interrogating the limits of its own production (Butler, 1993).

HIV/AIDS

I now want to shift to the exemplar of HIV. As the allied health sciences and their technical narratives are discourses *of* culture, we cannot solely focus attention on medical pre- and proscriptions of HIV. Instead, we must investigate where these determinations occur, that is,

in discourse. HIV is both a biologic reality and a discursive syndrome of historically contingent meanings, situated politics, and marginalized identities.

Physiologically, HIV is a practical threat as treatments are not curative, as well as an ontological threat because the pandemic challenges the metaphysical status of humans. The infection by HIV involves a colonization of human genetic identity with viral genetic identity (Haver, 1996; Waldby, 1996). It is expected, then, that medicine has been at the forefront of our war against HIV, taking the primary role of protecting bodies and the body politic from viral invasion.

As we have come to understand, however, we are not just at war with a microscopic virus. We are also in an "epidemic of signification": we are in a battle over meaning, power, discourse, culture, and bodies (Treichler, 1999). The virus attaches not only to genetic processes, it harnesses social discourses and capitalizes on operating dynamics of marginalization. This is to say, the issue is *not* whether HIV exists, rather the issue is what the *stakes* and *consequences* are in various contexts as it is positioned HIV as reality and embedded within networks and bodies. Medical discourses dominate the pandemic today; among other things, they:

- reference universally agreed upon signs;
- make representations conventional in journals and media;
- verify reality via ongoing laboratory and clinical opportunities;
- shorthand reality in discussions and strategies across institutions and people;
- are weapons to defend and attack science;
- metaphorize and explain other phenomena (e.g., sexual "deviance"); and,
- are sites in which to develop future research.

Moreover, medicalized HIV discourse exists across culture at large, and has become both a fabrication and fact. In a word, "HIV has become…a reality that is too costly to give up" (Treichler, 1999, p. 173).

With this degree of power in discourse and in bodies, queer theory becomes a needed intervention in this pandemic (Patton, 2002a). In fact, queer theory better parallels the *personality* of the virus, more so than the often-punitive tactics of medicine. Under a queer epistemology, focus turns away from HIV's movement and is redirected to the *processes* for *knowing* and *making sense* of the virus and its social formations in the first place. In a way, queer theory can also be seen as a response to the simultaneously emerging AIDS crisis in the 1908's and the fomenting homophobia in the public sphere. The psychic presence of AIDS alone signifies a collapse of identity, as it literally destabilizes ontologies and epistemologies: it signals a difference that refuses to be excluded from the system of self-knowledge. In a word, both AIDS and queer theory reformulate the subject, wherein identity becomes a highly ambivalent site. This viral and psychic crisis allows for a refashioning of subjectivities. In a queer frame, HIV challenges the fictional notion of stable identity, as it

works against those constituents it claims to represent; categorical LGBTQ identities, deteriorate as exclusive sites for investigation to find definite and predictive solutions, as so hoped by dominant sciences. For example, HIV calls attention to the differences across sexuality, desire, pleasure, self-identification, and sexual behaviors. It unhinges the assumed prediction between identity and behavior.

More critically, often overlooked in the current quest to brand HIV nowadays as a chronic condition and stabilizing discourse is the enormous generational gaps because of longstanding certain death (Haver, 1996). Queer theory repositions relationships among identity, contagion, and death. Even today with antiretroviral regimes, those who express seropositivity are seen commonly as the Walking Dead. For the sake of stable identities and the solidity of the HIV industry, the thought of death and its anxieties are undesirable and necessary to prevent. Yet, the incessant investment in life distracts active engagement with the trauma of the incalculable deaths and resultant generational gaps for LGBTQ and many other populations. Instead of eliding death, a queer perspective works to accommodate death within a positive ideal of life (Waldby, 1996), and has more potential to bring into focus the intergenerational traumatic effects due to HIV and its epidemic of signification.

Queer theory also recasts the meanings of viral and hybrid identities, or those identities that operate within Western scientific rationales for AIDS surveillance and evidenced-based practice (*ibid.*; Crimp, 1988; Watney, 2000; Manalansan, 2003). The health sciences privilege essentialized notions of human beings and populations, encumbering them with objectivity and empirically determined values, beliefs, attitudes, risks, and social trajectories. HIV calls into question the centrality of this certainty through contesting binaries and continually exposing social inequities. Whereas medicine pathologizes hybridity as the subjectivity of contagion, one that creates instability around human identity, queer subjectivity tries to interfere in the reciprocal constitutions between the naturalized body and the normative social order enabled by medico-discourse. Queer theory looks to dislodge this concordance through insistent adoption of viral processes of rapid transformation, mutation, and momentary identity, processes against which the normative subject wishes to defend itself. On one level, the endgame of queer theory would be to use these viral processes as a way to infect and hence transform the body politic (Waldby, 1996).

Another major domain within the field of HIV work that Queer theory can disturb and transform is that of one of the fundamental tenets of modern medicine and the allied health sciences: risk. In recent times, Western culture has become a society obsessed with risk: a “risk society” (Beck, 1998). In the age of industrialization, the most imminent edges to life were literal dangers and hazards due to the general conditions of labor. With the freeing of society from mechanized labor, a shift towards a next phase of modernity was made: a shift towards a *risk society* (*ibid.*). In this era, nature and culture begin to blur, and an investment develops to manage these hybrid manifestations of human dominance in the world (e.g., emerging diseases). As a result, society becomes more attuned to the reflexivity of human presence in the world, alongside a focus on individualization. Beyond just managing risk, contemporary society is concerned primarily with aspiring to *control* risk, or unwanted outcomes (Giddens, 1998). Industries (like insurance) and technologies (like science) have been established to minimize risk and maximize control. Ultimately, risk society is most

concerned with more than just colonizing people and land: it seeks to colonize the future, seizing what is yet to come.

One of the industries founded on a central concern with risk and core to HIV prevention and care is public health. Since European colonial times through the early 20th century, public health has been largely defined by an ideology of disease as symptomatic of uncivilized societies; that is, it was imperative to immunize against "infestation" from indigenous people and far away regions of the world (*ibid.*). With the advent of scientific technologies, public health has become predominantly invested in epidemiology, wherein the concern is predicting, identifying, and containing disease. Central to this enterprise is the practice of defining and categorizing risk groups in order to place boundaries around disease and to protect the health of the body politic. It goes without saying, the body politic has been measured against the middle class or the "imaginary anatomy" of clean, deserving, immuno-competent bodies that are in need of protection (Waldby, 1996). In this way, epidemiology has privileged nominalizations of risk (e.g., identity), and has served political ends in order to imagine a social unity (e.g., the public in *public health*). The effect of which has naturalized the power medicine has over our social unity, imbued with the ostensible charitable goal of eradicating disease and its vectors of risk.

In the case of HIV, medicine has been invested not just in the refinement of health statuses through micro technologies (e.g., HIV positive, −negative), but also in the growth of identity categories to nominalize and make intelligible behaviors and types of people who are risky and "at-risk" (Erni, 1994). For example, interventions against HIV were initially driven by The Four H's (i.e., homosexuals, Haitians, hemophiliacs, and heroin addicts), and more recently by MSM (i.e., men who have sex with men), a category developed by public health to label and locate non-gay-identifying men (Young & Meyer, 2005). Through these efforts to pinpoint the virus and its bodies, a complex matrix has been developed that hierarchizes identities against health statuses. This provides for an anxiety-provoking worldview in the age of HIV that constantly references the imaginary (social) anatomy, categorizing ab-/normal, us/them, visible symptoms/invisible illness, and risk/non-risk (Erni, 1994). Furthermore, embedded in this epidemiologic matrix is an obsession with the individual citizen, one who is rational, thoughtful, obedient, and who seeks to preserve life and avoids death (Davis, 2002). Quite sensibly, this universalized subject is also expected to act responsibly and in the body politic's best interest, given information about how to do so. Thus, prevention technologies are based on a risk administration focused on this imaginary risk-avoidant subject (*ibid.*). However, this risk calculus does not account for interpersonal factors or social inequities; it is based on a teleology that knowledge will lead to certain responsible behaviors, disallowing for contradictions of choice (Davis, 2002; Davis *et al.*, 2002). The failure to protect one's Self is deemed as not legitimate, irrational, and deviant. Ironically, a sexual subject citizen can "choose" to be deviant (e.g., be a homosexual), but they cannot choose what types of action, if that action does not protect the investments of the body politic. Anyone who deviates, moralistically or ethically, becomes the deserving target of charitable public/health interventions (Davis, 2002; Waldby, 1996). Consequently, this logic paints predictive conclusions amongst identities, behaviors, and health statuses: you know who you don't want to be least you get HIV.

However, if risk calculus were simply linear, a reduction or even cessation of HIV transmission would have occurred by this point in time. Frustratingly, incidence persists to be stable annually in the U.S. (CDC, 2008, 2011, 2012). Given this, Queer theory can be a productive, additive analytic to comprehend risk and radicalize this longstanding war. First, queer theory brings to the fore that risk is anything but clear, definable, and manageable. Uncertainty is at the heart of risk; and, risk is at the heart of the health sciences. Risk is a precondition for the existence of these fields, as well as the outcome of modern social life. Risk is, therefore, necessarily and intimately intertwined with the health sciences. Queer theory increases risk's transparency, denaturalizing the altruistic rhetoric of medico-discourse to expose the proscriptive authority of our practices. By virtue of their singular ability to intervene with the microscopic and the psychological (as the public or the pedestrian cannot), medicine and the health sciences wield great power.

Next, queer theory takes to task the panoptic gaze of the health sciences (*cf.* Foucault, 1995), which is promulgated by our surveillance technologies, hierarchies of identities, and categories of risk, among others. Queer theory works to excavate the directions and maneuvers of power provided by these macro technologies and terminologies. On one hand, this matrix of infectious persons ("at-risk"), behaviors ("MSM"), and global and local places ("developing countries") in the pandemic can be seen as information and education. On another, more critical hand, this expert matrix shows the ways in which racism, hetero-/sexism, and classism have been concretized in medical and allied practices (Waldby, 1996; Patton, 2002a). That fact often eclipses the practices communities employ to adapt to risk and the dialectical relationship between identities and institutions, between discourses and lived experiences, and wellbeing and (marginalizing) places. For example, barebacking (or condom-less anal sex) among (queer) men has been a long-standing target of public authorities (Halikitis, Parsons, & Wilson, 2003; Crossley, 2004; Mansergh *et al.*, 2002; Davis, 2002; Yep, Lovaas, & Pagonis, 2002). Ironically and in fact, queer intimacies co-occurring with the HIV pandemic facilitated the invention of "safer sex", which resultantly discharged gay male sex/uality as mere compulsion (Crimp, 1988). Often barebacking is met with social and public health policing. Instead of indictment, a queer epistemology would be interested to regard this phenomenon as one of strategic behavior and dialectical. This is to suggest that attention would be paid to barebacking, or other strategic positioning, as an expression of actively negotiating risk, sex, and desire – *in relation to* the larger age of HIV, the oppressive silencing, and to hegemonic prevention technologies and ideologies. Instead of reckless and pathological, the barebacking sexual subject sits within an intersectional matrix of sex/uality, gender performatives, empowered agency, and normative (public health) policing. It is relational and responsive, not simply uncontrolled "bug chasing", that is, purposefully seeking HIV-infection.

Similarly, use of social media to sexually network amongst Queer men has equally come under scrutiny. From a normative risk standpoint, this media channel is deemed a post-electronic vector of transmission, or a veritable e-barebacking, inducing no less than a continued shaming of Queer men. In the early days of AIDS, locales such as bathhouses came under socio-political scrutiny across the U.S., questioning the civil liberties of particular bodies as well as policing these stigmatized bodies behaviors in the public sphere (Bérubé, 2003; Cochrane, 2004; Disman, 2003). Epidemiologic findings fostered more

attention to movements of queer (male) bodies as HIV mirrored venues of association such "public cruising areas" (e.g., bar backrooms, adult bookstores; Binson *et al.*, 2001). More recent research correlates increased HIV risk with Queer habitation in U.S. "gay ghettos" (Mills *et al.*, 2001) as well as in the virtual spaces (Keith *et al.*, 2008). From a queer standpoint, use of media to (socially and sexually) network might be better considered as acts of resistance and democratic, as well as radical attempts of queer world-making. This *e-longing* does not signal diseased belonging; rather, it is a channel to becoming, a real-time co-construction of identity, fostering *en vivo* (physical) encounters. More critically, e-networks continue the quest to bring sex into the public sphere, ideologically and materially, versus unwittingly buttressing hetero-/normativity, or the privileging of privacy, domesticity, and monogamy (Berlant & Warner, 1998; Warner, 2002).

Effectively, queer theory approaches risk and its negotiation as something relational and reflexive, taking the focus away from rationality and the obedient, normative subject. Queer looks at risk in *lived* contexts, which are confluences of knowledge, meaning, and ir-/rationality. In a more resilient frame, risk can be understood as the utterly unstoppable "alterity" that flies against the annihilating screen of medico-health sciences (Patton, 2002b). Risk is evidence of all that professionals and public citizens cannot see or understand. Risk is life. It is evidence of the differential social locations that exist for various citizens that engender infections and instability, but in our hyper-individualized world become indictments. Queer theory, therefore, destabilizes any distance from risk, inverting the clinical gaze back to the health sciences and its professionals, exposing their discursivity and the thin security we sell to citizens. Queer theory, then, resituates health professionals and their disciplines at the center of risk – as *part of* the engine of infection – rather than the treatment or cure. Fundamentally, this stance questions how we engage in practice, who we serve, to what ends, and what are the stakes? Importantly, a queer analytic works to decolonize the underlying, seducing narrative that intoxicates the health sciences into believing they are saving, in the pandemic, all the "risky" and "filthy" subjects from their own kind (Grewal & Kaplan, 2001). In this context, queer theory proves to be a critical intention as well as an essential intervention.

Acknowledgments

Much gratitude goes to my primary mentors and supervisory committee: Prof. Emeritus Tony Ishisaka, Prof. Karina Walters, and Prof. Crispin Thurlow. This work was supported, in part, by a NIMH Pre-Doctoral Prevention Research Trainee grant (2-T32MH20010-09).

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