Skinny Bones #126-774-835-29: Thin Gay Bodies Signifying a Modern Plague

Ragan Fox

This autoethnographic report uses performative writing to explore significations of HIV as they relate to the study of thin, gay men. Specifically, I investigate how my own HIV-related fears speak to and against marginalizing discourses that frame cultural understandings of HIV, gay men, and body types. The essay concludes with a discussion that explains how performative interventions and narrative blueprints can be used to challenge misrepresentations of gay men in relation to HIV and AIDS.

Keywords: AIDS/HIV; Autoethnography; Body; HIV Testing; Narratization; Performative Writing; Performativity; Queer

September 18, 2003: It is a particularly warm fall in Phoenix. Triple-digit weather has turned the desert into a sizzling incinerator. One of my colleagues approaches me as I sit outside to read a book. Brushing the beading sweat from her brow, she proclaims, “Honey, you are way too skinny. Don’t you eat? It looks like you’ve lost twenty pounds!” Crackle. Burn. Insecurities flush my face, turning it a rich crimson. My body speaks; it reveals insecurities. Blood visits my brain and asks it to consider impurity in an age when bone dents in gay skin paint thin as chagrin. A seemingly innocent question transforms me into Frankenstein. The sun beats down on us. Am I a skeleton in the desert? Am I caught up in a mirage?

Ragan Fox is an Assistant Professor in the Department of Communication Studies at California State University, Long Beach. An earlier version of this essay was presented at the 2004 annual meeting of the National Communication Association. A later revision of the manuscript was awarded the 2006 Norman K. Denzin Qualitative Research Award by the Carl Couch Center and the National Communication Association’s Ethnography Division. The author would like to thank a number of people who encouraged the development of this essay, including Dan Brouwer, Bruce Henderson, Linda Park-Fuller, Karma Chavez, Sara McKinnon, Michael Bowman, and the two outstanding blind reviewers who provided thought-provoking and invaluable feedback. Correspondence to: Ragan Fox, California State University, Long Beach, 1250 Bellflower Blvd., Long Beach, CA 90840-2407, USA. Email: findragan@gmail.com.
In *The History of Sexuality, Vol. 1*, Foucault argues that in times of famine, epidemics, and violence, “blood constitute[s] one of the fundamental values” (147). “Blood,” he explains, is “a reality with a symbolic function” (147). In other words, blood is as much discursive as it is chemical or biological; blood signifies. Only a half a decade before the *New York Times* announced that a “rare cancer” had been found in several gay men (Altman A20), Foucault, a prolific scholar who would eventually die as a result of AIDS-related complications, foresaw the ways in which communities were prone to respond to blood-related epidemics. When he wrote that blood was a “fundament value,” he also meant that matters of blood determine *who* is valued in a culture, particularly when a community faces an epidemic. Dolan contextualizes this argument in terms of AIDS and “morality” in the United States when she suggests that:

> Morality and sexuality are closely linked and regulated through their representation, especially during moral panics like the one gripping this country, which variously scapegoats obscenity, pornography, homosexuals, and people with AIDS, along with other so-called sexual deviants. (181)

In *Presence and Desire*, Dolan explores the ways that gender, sexuality, and performance interact in the AIDS era. With respect to Foucault, how does blood *perform* and how do bodies perform texts *about* blood during the AIDS epidemic?

This autoethnographic essay explores the discursive fragments that communicate my HIV serostatus. I turn to autoethnography, because the method is grounded and invested in *self* (as the self relates to broader cultural scripts). Specifically, I consider how my thin gay body (as a material and discursive signifier) is performatively rendered meaningful in a homophobic society. I also investigate the social and personal implications of HIV testing.

I explore these issues because I want to articulate why the “Don’t you eat?” query leaves me feeling like a bag of skinny bones. When somebody asks about my thin frame, my gay ears hear, “You are abnormally thin. How long have you been HIV +?”

For the past two and a half decades, the physiques of gay men, small and large, have been ambiguously “read.” We currently live in a cultural moment where readings of gay male bodies are in flux. The chain of signification that once causally linked gay men to the HIV pandemic has lost much of its luster. Conversely, HIV contraction rates are substantially increasing among gay men (Dotinga; Krisberg; Sanchez). A narrative-based consideration of the aforementioned phenomena may provide a partial qualitative explanation as to why, in the United States, HIV seroconversion statistics are increasing at an alarming rate—particularly among members of my sexual brethren.

**HIV and Performativity**

**September 30, 2003:** The director for the one-person show I recently completed calls me into her office so that we can discuss her students’ written responses to the production. I am curious to see how the undergraduate students in her Gender class
dealt with the semiautobiographical account of child molestation. She grabs a paper
from her desk and tells me that I have to read “this one.” I glance down toward
the middle of the critique and read what my director has underlined in red ink, “Is he
gay? Is he gay because his brother molested him? Is he dying?”

It is the last question that sticks with me. Am I dying? What does this question
mean? Illness and death were never mentioned in the production. Does he think that
all gay men have AIDS?

I spend days reflecting on my performance. Other instructors told me that a small
but significant faction of their students felt uncomfortable with my onstage costume
changes. I never got nude, but the audience saw me donned in nothing but boxer
briefs. Did my skinny body provoke distress? I cannot help but wonder whether the
students would have commented on my partial nudity had I been straight or better
built.

I keep going back to the ominous question, “Is he dying?” Reading these words is
like pulling the card of death from the tarot. It has been nearly a decade since my last
HIV test. Does my body signify decay?

When the student asks if I am dying, I feel utterly abject. My body and my personal
narrative are cited in his response to the show, but I cannot shake the feeling that he
skimmed the texts and unfairly co-opted pieces of me to fit his argument. Bits of my
being have been taken out of context. Have I been misread? What other texts inform
his query? My performance does not stand alone in his comprehension of thin, gay
physiques. There is a chain of signification at work here. His reading of my body is
unapologetically performative. The seemingly innocent questions he posed pull from
larger discourses. His performative reading of my flesh swims in a deep sea of
citations. The performative situation seems unfair in the way simple questions
implicate my blood, my body, and my sexuality.

Who do I blame for my hurt feelings? The student? What about the texts that
influence him? Or am I mad at myself? Infuriated that I refuse to go to a free clinic for
an HIV test? I also wonder how I might employ theoretical understandings of the
body to work through my own neuroses. Can theory help combat the hurt, shame,
and fear I feel when I hear people talk about my weight? Do the comments and
questions about my size incite me to perform the imagined constitution of my blood?
When I resist an HIV test, for example, are my actions an exemplar of HIV serostatus
performativity?

“HIV serostatus performativity” refers to the ways in which people perform their
subjectivities in relation to presumed HIV-positivity and HIV-negativity. The
construct modifies and builds upon Butler’s notion of gender performativity. In
her discussion of gender performativity, Butler claims that performativity “must be
understood not as a singular or deliberate ‘act,’ but, rather, as the reiterative and
citational practice by which discourse produces the effects that it names” (Bodies 2). SIMILARLY, HIV serostatus performativity connotes multiple, layered, and, oftentimes,
unintended actions, behaviors, and attitudes that are prompted by discourse. In this
essay, I am guided by the performative in a number of ways.
Performative Writing as a Mode of Cultural Intervention and Narratization

First, I use performative writing as a compositional strategy because the reporting style can act as an “intervention” (Román) that both talks to and back to discourses that filter understandings of my body. In his discussion of HIV and performance, Román defines an “intervention” as a “tactical position assumed in relation to dominant ideology in order to question and abolish its effects” (43). When making such a move, Johnson believes that we should highlight how performance paradigms complement notions of performativity by noting the ways that these performances activate a “politics of subjectivity” (11). “It is a performance of the self for the self in a moment of self-reflexivity that has the potential to transform one’s view of self in relation to the world,” he writes. Johnson suggests that, “People have a need to exercise control over the production of their images so that they feel empowered” (11). Performative writing is one way in which scholars, particularly marginalized academicians, may display creative control of their respective subjectivities.

While some theorists who practice performative writing are hesitant to provide a concrete definition of the genre, fearing the implications in setting definitional boundaries, Pollock declares that effective performative writing exemplars tend to be *metonymic*, meaning they are “self-consciously partial”;

> I remember a cold that took me two weeks to shake.  
> Was that cold a sign of things to come?

performative writing is *evocative*, or asks the audience to actively participate in meaning construction;

> On day eight of the illness, I had to perform at a poetry event.  
> I coughed myself blue.  
> I remember a woman asking her friend if I was “sick.”

performative writing is *nervous* (i.e., nonlinear) and *subjective*, meaning that it focuses on the personal but remains self-reflexive;

> Of course, “sick” could have meant a number of things.  
> Cold? Flu? HIV? Full-blown AIDS?

performative writing is also *citational*;

> When I hear a straight woman say “sick,” I can see through the smokescreen.  
> I’ve seen the HIV-related movies and read the AIDS articles; I know the code.
finally, performative writing is consequential; it promote new modes of thought (82–95). The writing style is especially appropriate for this project because it asks readers to consider very specific significations of HIV as they relate to a particular thin, gay man.

Several communication scholars (Dillard; Pineau, Gingrich-Philbrook, and Mohtar; Pollock et al.) have utilized what I consider to be interventions to describe their experiences with HIV. These studies have proven to be especially fruitful (so to speak) for gay men, because, as Román suggests, “HIV-negativity is considered a tentative status or a temporary condition located on a trajectory leading to eventual seroconversion” (229). Emphases on the personal challenge abstract conceptualizations of HIV-negativity and HIV-positivity.

Dillard, for example, employs personal narrative to advance a mythological vernacular for gay men in the time of AIDS. After reflecting on the dearth of sanctioned roles presently available for gay men, he presents a dramatic monologue, “Breathing Darrell,” in which he considers the possibility of gay male spirituality. For Dillard, performance pieces provided by Tim Miller and Larry Kramer are well suited for discussions about the body because the texts inspire readers to move from “intellectual to visceral” responses to the pandemic (80). Specifically, theatrical representations of gay male subjectivity present a gay mythology that, in more conventional forums, has been denied to gay men. Personal tales about gay life contribute to the “useful mythology” (79) of which Dillard speaks by revealing multiple trajectories that stem from gay subjectivity.

Reading the narrative monument Dillard built for a partner who died as a result of AIDS-related complications, I notice that his language is grounded in the past and present. He reflects upon the last moments he spent “breathing in” Darrell. Inspired by the NAMES Project AIDS Memorial Quilt, Dillard also speaks of keeping his partner’s “spirit alive” in the present. In this essay, I build upon the conversation Dillard started by exploring how narrative-based interventions can influence future behaviors. In other words, I re-perform my tale to narratize.

“Narratization” describes an “agent’s on-going mediation of his/her own physical and verbal actions within a temporarily configured field in order to achieve an envisioned but, as yet, unrealized end” (Allison 109). When an obstacle threatens an idealized end, agents project an alternate outcome and revise their behaviors to help actualize new goals (114). HIV testing is an emotionally charged context where narratization rules the day.

In 1994, for example, I took my first HIV test. The fourteen days I waited to receive the result of my first HIV exam were a prolonged and painful exercise in narratization. On those fourteen days, I literally and figuratively “sweated” potential HIV-related futures. I learned how connected my narrative, real and imagined, was to HIV. Goaded by performative discourses, I imagined how the “obstacle” of an HIV + diagnosis would affect my future. I worried that no man would want to be with a skinny boy who contracted HIV in his teens. I thought about all the beefy studs I wanted to look like (and with whom I longed to have sex). I envied the ease with which they appeared to carry their physiques. Twelve years later, I realize that gay
muscles are often seen as a clever way to combat the traditional AIDS physique: a performative exercise in its own right. But that is a subject for another essay. I mention narratization to demonstrate how HIV discourses and technologies help shape one's narrative model or "blueprint" for living. In the next section, I discuss narrative models in more detail.

While the act of narratization keeps an eye to the future, the performative process is grounded in past citations. Much the same way test numbers performatively call upon a person's history of sex, my test number is a synecdochical reference to my past. Similarly, Gingrich-Philbrook's personal narrative reflects upon an HIV test he underwent. The performance script humorously calls upon his memories to highlight several problems in HIV testing, including the impersonal setting of the testing center and categorizations of risk based on activities. Coincidentally, Gingrich-Philbrook also plays with the signification of his HIV testing number. I say "coincidentally," because I read his narrative a year after I completed the first draft of this essay. Not surprisingly, I strongly identify with Gingrich-Philbrook's frustrations regarding the HIV testing experience, because I have had similar encounters. As a researcher, I am "triggered" by his tale. I hope to contribute to the discussion he started by investigating how daily interactions and scientific discourses, alike, communicatively project HIV onto my thin, gay body.

I, therefore, aim to dialogically demystify a "painful dis-ease" (Park-Fuller, "Performing" 24) by constituting my-self "against and within oppressive and objectifying discourses" (26). Ultimately, I ask, "In what ways have readings of my thin, gay body been influenced by HIV discourses?" Moreover, what specific forms of communication about HIV contribute to these readings?

Performative Metaphysics and the (Ir)reducibility of Blood and Bones

I also employ performativity as a theoretical construct to conceptualize the materiality of bodies. In an effort to better link performativity to materiality, Barad considers a "performative metaphysics" that takes into account the most basic unit of scientific presupposition—a atom (813). Reflecting on Bohr's quantum model of the atom, Barad suggests that atoms are "things" that cannot be reduced to the "transparency of language" or clearly explicated through the "transparency of measurement" (813). In other words, discourse "constrains and enables what can be said" (819). Scientific apparatuses (i.e., HIV test) and (my) body are, then, part of the same "world-body space in its dynamic structuration" (829).

Because the body performs as materiality and signification, personal narratives about my embodiment demonstrate both the reducible (i.e., skinny bones = HIV+) and irreducible (i.e., blood and status). The personal experiences I chronicle in this essay weave in, around, and against performative readings of my flesh. Influenced by Bohr's understanding of atomic models, the tales I present function as narrative blueprints for living. A narrative "blueprint" is a personal tale made public with the intent of inspiring identification among audience members seeking a narrative model to help guide future attitudes and behaviors. Park-Fuller
speaks to the importance of what I call narrative “blueprints” when she argues that “without human behavioral models, people encountering [a real or imagined] disease do not know how to behave” (Narration 62). Narrative models serve a pedagogical function for people who lack effective HIV-related coping strategies (Fox 60). In the ten years I waited to undergo an HIV test, for example, I sought out a number of narratives about HIV. The narratives I discovered tended to highlight HIV topics that did not speak to the specificity of my fears and frustrations. While I read a number of stories about people losing loved ones to AIDS-opportunistic infections and performance pieces by and about people living with HIV, I had a difficult time finding narratives about men and women like me, people who were too afraid to test. I was a gay man in search of a narrative model. Given that one-third of HIV+ gay men in the United States do not know they are infected (“One in Three”), I may not have been the only soul seeking out a narrative blueprint that articulates, evokes, and embodies tensions between performing and not knowing HIV serostatus.

Barad’s use of quantum physics as a metaphor is also a provocative fit for this project because her comparison is analogous to gay male sexuality being condensed down to a virus. The metaphor suggests that language stands in for the thing it represents. In both cases, matter and scientific instruments are coconstituted. For Barad, the bridge between description and reality is not a question of reflection; rather, the practice is framed in terms of refraction (803). In Bodies that Matter, Butler considers the conundrum of representation when she argues that, “Signification requires the loss of the referent, and only works as signification to the extent that the referent remains irrecoverable” (209).

I, therefore, search for my-self in a sea of signification. Because I, the referent, am displaced, I am forced to navigate my way through the “multiplication of signifiers at the site of the lost referent” (Butler, Bodies 209). Butler’s reference to a “multiplication of signifiers” implies the presence of discursive markers that stand in for the body’s materiality. Narrative models map out these signifiers. Like an atomic model, my HIV tale charts a dimension of embodiment that is, as previously stated, both reducible and irreducible. Like the atom, HIV cannot be seen; it can only be presumed. While symptoms of the virus are undeniably “real,” so, too, are the performative responses incited by medical discourses that equate gay and any individual symptom of HIV with positivity.

“Is he dying?”
Am I too shy to share a tale
of possible infection?

I am not too modest to share a crippling narrative of disease and fear to illustrate how powerfully bodies signify. Read me. #126-774-835-29 is a drop of my blood and a piece of my flesh that was stuffed in a box, stuck with a stamp, and sent out to sea—a
letter of distress in a sanitized container. Read me. #126-774-835-29 is my attempt to put flesh on words. Read me.

Taking the Test

October 18, 2003: I couldn’t sleep last night. I kept thinking about AIDS. It has been ten years since my last HIV test. I procrastinate because I am deathly afraid of the result. “If the test comes back ‘positive,’ I’ll have to re-imagine my future,” I tell myself. “I’ll put the test off and wait for a less hectic time to deal with an HIV+ diagnosis.”

Two hours later, I look at my reflection in a bathroom mirror and evaluate my flesh text. The topography of my body betrays conventional notions of “health.” Have I unwittingly allowed myself to confuse metabolism for symptom? And what exactly are the symptoms of HIV? It has been years since I last heard a public service announcement about recognizing HIV symptoms. I feel as if I am positive. For the past five years, I have felt an inexplicable and internal ache—an intuition, perhaps.

I am up late tonight because, lately, insomnia beats dreaming. Two nights ago, I dreamt that I was Sigourney Weaver in Aliens. (The dream followed typical dream logic, so I was Sigourney Weaver but I could also fly and randomly transport to different settings, like gay dance clubs and the zoo.) In the dream, an alien beast grew inside of me. The invader, akin to a parasite, fed on my life force to advance its own. I suppose I have AIDS on the brain. The question is: Do I have HIV in the bloodstream? These are the current complexities of my flesh text. One more question: Does the text have a coauthor?

AIDS, after all, is a writer who wants to produce under my skin. He will write until he runs out of ink. When he does, he will be forced to express himself with my blood. He tugs and pulls on veins and slowly writes a book for the world to see. Make no mistake, people read a swollen lymph node; the site of a bloody lesion communicates. Skinny gay bodies signify a modern plague.

I am a thin gay man who touches his lymph nodes daily hoping that they will not turn to Braille under my trembling fingertips. Standing in front of my bathroom mirror, I decide to purchase an FDA-approved, at-home HIV testing kit. This finger-pricking examination will account for years of promiscuity.

Step 1. Save Your Home Access Code Number. Within five seconds, I knew it was love. We waited four months to have sex for the first time. After two years, he was home to me. Fifteen years of AIDS education went swirling down a vacuous drain in the Bates Motel because “It doesn’t feel the same with it on.” Funny, when his teeth clamped down on my ear, he never thought to call me #126-774-835-29.

Step 2. Wash and Dry Hands. His touch became cold.

Step 3. Choose Finger and Clean Puncture Site with Alcohol Prep Pad. Our love grew sterile.

Step 4. Stimulate Blood Flow to Fingers. I learned to ignore the nights he never came home. He liked to take long walks on San Francisco city streets at two in the morning. I told myself to “Go with the proverbial flow.”

Step 5. Position Your Hand and Safety Lancet. Did it “not feel the same with it
on” with the others?

**Step 6. Draw Blood Drops.** All infection takes is one drop. One part cut, one part semen, one part blood, and one part trust is a recipe you cannot even find in the *Anarchist Cook Book*.

**Step 7. Add Blood Drops to Circle on Blood Specimen Collection Card.** Is he dying? Am I? #126-774-835-29 is much more than the sum of his numbers.

**Step 8. Apply Bandage.** If Humpty Dumpty has a great fall, who will take care of his parts?

When somebody asks me if I am “sick,” he or she may give little forethought to the impact that question will have on my broken and busted psyche. My body, unfortunately, reacts to what is projected onto it. Anzaldúa proclaims that the body “does not discern between external stimuli and stimuli from the imagination. It reacts equally viscerally to events from the imagination as it does to ‘real’ events” (60).

My performative reflexes, for example, encourage me to inch away from people who get close to me on a bus because I am convinced that they think that my body is contaminated. When I move away from men and women on the vehicle, I narrate, or, in the midst of experience, act with a projected (and perhaps unreal) HIV end (i.e., serostatus) in mind. A faulty narrative blueprint guides me. I reference traditional narrative models about HIV, sexuality, and physiques in the ways in which I think about and perform my HIV serostatus in relation to the world. If I am ever going to discover a new blueprint, I need to know and respond to the discourses that comprise the narrative model I find so reductive and incomplete.

I was born in 1976. Growing up in the 1980s, my early AIDS education was decidedly homophobic. Early labels for HIV and AIDS that focused solely on the homosexual community, such as “The Gay Plague,” “Gay-Related Immune Deficiency” (GRID), “Gay Men’s Health Crisis” (GMHC), and “Gay Cancer,” convinced me, among others, that gay men were primarily responsible for the spread of the disease (Stiff et al. 745). My history speaks to the performative implications of early HIV labels and prejudices.

When I was ten, skating rink bullies taunted me with gay jokes. They made fun of my high-pitched voice, skinny body, and eccentric style of dress. Throughout this history of verbal abuse, one memory, above all others, stands out in my mind. Marcy, a girl with whom I shared a few “slow skates,” began hanging out with Brandon, a boy who thought I was a “sissy” and “faggot.” I remember approaching Marcy and asking her, “Why aren’t we friends anymore? I miss you.” “Because,” she explained, “you are a fairy and Brandon told me you have AIDS.” Marcy laughed, rolled her eyes, and skated away.

In the small Texas town where I grew up, gay equaled AIDS. While the federal government all but ignored people dying as a result of AIDS complications, people in my town joked about the deaths. Today, AIDS jokes that focus exclusively on gay men continue to advance stigmatizing behaviors. People in some circles have transformed *GAY* into an acronym for “Got Aids Yet?” and make jokes like, “What is the
first symptom of AIDS? A pounding sensation in your ass.” While heterosexuals
and do have anal intercourse, we know that they are rarely, if ever, the brunt of
this joke.

Challenging the Sexual “Caste System”

October 23, 2003: After mailing a drop of my blood to a laboratory, I sit at my desk
and re-member my body. AIDS prevention websites and their list of symptoms for
the disease transform every abnormality that I have noticed in the past ten years into
a soothsayer’s whisper. When I wake up in the morning, there is a white film on the
back of my tongue. Could this be oral thrush? After I spent the millennium New Year
in Provincetown and had sex with a man I hardly knew, I came down with awful flu-
like symptoms. I remember not being able to open my eyes or move a limb. Is he
crippled by fear?

In 2001, President Bush’s administration established a color-coded system to alert
the American public of terrorist threat levels. Bush’s rainbow of terror is a compelling
analogue for the HIV testing experience because both warnings needlessly galvanize
fear by way of their rhetoric. The fear-inducing discourse greases up the performative
machine. The medical community, for example, is careful to distinguish between
what they consider to be “high” and “low” risk behaviors. Not surprisingly, high-risk
activities are more often than not associated with culturally unapproved conduct,
such as gay sex and intravenous drug use. Many lists include a “medium risk”
category that demotes anal sex with a condom to a “mid-level” risk, but claims
vaginal sex with a condom is “low risk” behavior (Engender Health). Botnick likens
the separation of risk behaviors to a sexual “caste system” (52). As he puts it, “The
essential point is not one of risk taking, but of the psychological and social
implications of definitions of risk” (52). Put differently, many of us allow a
performative metaphysics, or risk-related narrative blueprint, to influence who we
value and what to expect from our sexual encounters. HIV serostatus performativity
is, however, based more on assumptions of risk than actual risk taking.

HIV testing is a highly charged context that foregrounds the cultural scripts that
have come to dominate the ways in which many articulate their fears regarding
homosexual bodies. Specifically, the HIV “caste system” provides faulty narrative
blueprints that may lead to HIV testing aversion. Increasingly, homosexuals are
contracting HIV and not getting tested regularly enough to help contain the spread of
the virus. Moreover, HIV infections for gay men have, in fact, risen seventeen percent
in the last three years with forty percent of newly reported diagnoses coming from
gay men (Dottinga 1). Am I one of these men? I always play safe but I know the sound
a man’s condom makes when it breaks in me. The muffled “pop” paralyzes me,
reminds me that I am at the lowest rung of the caste system of which Botnick speaks.

While HIV+ diagnoses may also be increasing in the heterosexual population,
I believe that testing aversion justifications differ between the two groups (homo- and
heterosexuals). For heterosexuals, HIV is narratively constructed as much less of a
looming threat. Many heterosexual men and women may put off getting tested because they do not believe that they engage in “high risk” behaviors (Stein and Nyamath 353). Conversely, homosexuals may put off testing because they dread the presumed inevitability of an HIV+ diagnosis (Chesney and Smith 1159).

Chesney and Smith explain that gay men are particularly discouraged from HIV testing because they fear governmental agencies will share their results with others and they assume HIV-related discrimination will complicate an already potentially perilous situation (1160). Several of the HIV+ people I know, for example, refuse to seek treatment because they fear medical confessions of HIV positivity will limit their access to insurance companies. One HIV+ friend, in particular, refuses to see a doctor. One month before he tested positive, he quit his job and, as a result, lost his medical insurance. “With a pre-existing condition,” he once explained, “no insurance agency will take me as a client.” One night, as we gulped down Coronas at a dive bar in Austin, TX, he told me about his last HIV test. He said, “I knew, Ragan. While the doctor asked me questions about my sex life, I was overcome by an intense feeling of anticipation. Something told me I was HIV+. When the doctor asked me if I had sex with men, I lied.”

“Why did you lie?”

“I don’t know,” he replied. “It may sound strange but I lapsed into a daydream. I convinced myself that, if the doctor thought I was straight, he’d tell me I was negative. So much for that theory.”

For me, my friend’s words “ring” eerily true. Stigma-oriented questions that ask people to reveal a history of homosexual behavior or drug use encourage many to lie about their pasts in order to avoid being seen as part of an “at risk” population and then judged by their physicians or other health care workers (Maugen and Armistead 169–70). After enduring the average one-hour counseling session that is required by the US Centers for Disease Control, over 700,000 people have not returned the following week to receive their results (“Faster HIV Test” 12). Clearly, there are both methodological and ideological problems at work within the HIV testing process that impact a much broader circle than the gay population.

I chose a take-home HIV test. Home testing circumvents many of the problems I have with on-site HIV exams. Currently, only one at-home HIV testing kit is approved by the FDA, the Home Access HIV-1 Test System2. For those men and women who would rather not discuss their sexual adventures or history of drug use with a complete stranger, home collection tests provide an anonymous method of screening that requires little or no dialogue with HIV counselors or physicians. While customers are required to listen to a pre- and post-testing recording that highlights the common topoi of HIV prevention (i.e., the “window” of time it takes for a test to identify the presence of HIV antibodies, safe sex practices, etc.), they are not subjected to the verbal and nonverbal value judgments that sometimes pervade on-site testing practices.

The FDA approval of the Confide testing system in 1996 marks a kairotic intervention in the world of HIV testing (Scott 202). These tests signal a countermovement against the medicalization of the body during HIV testing, requiring the tested
individual to penetrate his or her own skin and collect a blood specimen that is sent off to a screening facility. The Home Access test is completely anonymous. Anonymous testing combats opportunities for the government to regulate the infected body, allowing the seropositive individual to do research on the virus, weigh medical and financial options and opportunities, come out of the HIV “closet” on his or her own terms, and, in effect, narratize with increased agency. Increased agency when trying to negotiate the self-presentation of HIV is crucial in an era that is already quick to assume which bodies are and are not infected based on superficial markings and prejudices, such as perceptions of body weight and homophobia.

**October 24, 2003:** A rerun of *Beverly Hills 90210* litters my television screen. Donna Martin grabs Kelly’s hand and tells two mocha-slurping hunks, “We’re best friends. We do everything together!”

**Today, on a very special episode of my life:** I convinced my best friend to get tested. Like me, he has unearthed poor excuse after poor excuse to keep away from white-washed clinics and know-it-all doctors who look down their noses as they ask, “Have you had any same-sex sexual partners?” Is that supposed to be a riddle, Mr. Sphinx? Previous screenings have taught me that many physicians think they know the answer to this question before they ask it.

My friend, #126-865-485-37 (a pseudonym), submitted his blood yesterday but will receive his results in a matter of days because he was smart enough to purchase the Express Home Access HIV test kit. I am so glad that I am not doing this alone. I take solace in knowing that we’re best friends. We do everything together.

**October 28, 2003:** It is my best friend’s birthday and his results are due. Before the first family member or friend is given an opportunity to sing birthday songs in his ear, he decides to call and retrieve his results. An automated voice on the other end of the phone explains to him:

Do not be alarmed if you are immediately transferred to an operator. As a leader in telemedicine, Home Access has a responsibility to continue providing excellent service. Therefore, you may be transferred to an operator and asked about your testing experience. Please enter your Home Access code number after the tone.


The cheerful man-chine calmly says, “Please hold, you are being transferred.”

My best friend loses his breath. With no wind, who will blow out his birthday candles? Who will breathe his wish into existence? He thinks to himself, “Stay calm. The man on the machine told you that they do service surveys.” There is a click on the phone; another recording tells him “All of our counselors are currently helping other callers. Your estimated wait time is five minutes. Please wait.”

Do not open until your twenty-eighth birthday.

*Happy birthday to you!*  
A stranger tells my best friend that he is HIV+.

*Happy birthday to you!*  
He tells him something about Magic Johnson; he tells him that there is hope.

*Happy birthday, dear . . .*  
When he tells me the news, it takes forty-five minutes for me to believe him. He tells me that he no longer has health insurance. Snot fills my nose when he dryly
proclams, “I guess it’s just a matter of time.”

*Happy birthday to you!*

Two days until I call to get the result of my own test.

“I don’t know what to say to you,” I cry. “I love you so much.” I want to tell him that HIV is no longer a death sentence. I want to tell him that there are drugs he can take that will allow him to live a normal, healthy life. I want to say these things, but with my own test results coming in just two short days I know how utterly meaningless these words would sound.

You cannot write fiction like this. No reader would believe your words; nobody would buy your book. There is so much resolve invested in belief. Did my friend believe that he was invincible? He tells me, “I didn’t always use condoms.” Obviously, he is not alone.

According to a 2003 federal study, for every 200 people diagnosed with HIV antibodies, three are over the age of sixty-five, five percent are attributed to men and women between the ages of fifty-five to sixty-four, and thirty-five percent come from the heterosexual population (Dotinga 8). The chains of signification and narrative blueprints that once, and in many circles still do, implicate(d) gay males in the spread of HIV/AIDS is beginning to lose its seductive and convenient luster. With more and more “low risk” populations (i.e., elderly Americans) testing positive for HIV, bodies are read with less confidence in the new millennium. The HIV-stricken body is no longer just the man with sloughing flesh who is a friend of a friend; in 2006, the HIV positive individual can be your grandmother.

Given the changing face of the virus, one could assume that the gay male body defies the moral backhand that has repeatedly swept queer men into a spiral of personal and cultural shame. The new HIV demographics convincingly refute the notion that AIDS is a “gay-eradicating” plague (Sedgwick 79). Yet, no matter how many different groups have come out of the HIV “closet,” gay men continue to represent an illness that they alone do not own.

My skinny, gay body speaks louder than the fleeting primetime news report updating HIV statistics that clear gay men of terrorist status. My thin build is more pronounced than words that are *bold, italicized, and underlined*. If my test result comes back “negative,” I will be an exemplar of the postmodern moment—an appearance that shows the instability of a projected and performative reality. Can there be multiple readings of my text? Can skinny + gay = HIV— and HIV +? Should my result be “negative,” will the arcane finding allow many people to treat my body as “clean,” “healthy,” and “HIV—”? Will a secret test result make one less person ask if I am “sick” or “dying” when they spot me in a bathing suit? Is the “reality” of an HIV— diagnosis any more *real* than the projected signification of the disease?

**October 30, 2003; Judgment Day:** I was fourteen years old the first time I had anal sex. The shame I felt after the experience sent me spiraling down a tube of irrationality. Sitting outside of my best friend’s home the next morning, I thought each dog bark was God sending me a message of disapproval.

Thirteen years later, I walk up two flights of stairs to get to my third floor apartment. I hear a kid throwing a tantrum on the third floor. The open windows
carry his screams through the breezeways of the adobe building. At the top of his little lungs, he screeches, “Fucking faggot! You stupid faggot bitch! Fuck you! I hate you!” Just as I assure myself that his expletives are directed at somebody in his apartment, I hear another small voice coyly greet me as I trek up the last set of stairs, “Hey, gay man.” I stop walking. It feels like I have been sucker-punched. Blood rushes to my face as I contemplate my next move. Should I talk to the kids’ parents? Should I ignore their calls and remain complicit in my own marginalization? Unlike random dogs barking ambiguous calls of upset, the mouths of babes are direct, clear, and much more upsetting.

I opt for complicity. There are larger things to take care of today. I quickly make my way into the apartment, pick up the phone, and call the 800 number that will potentially forecast the rest of my life on this planet. In my mind, it is as simple as an automated connection. If I am told that I am being transferred, I will spend the rest of my life taking pills, crapping blood, and uncomfortably explaining my serostatus to each potential love interest that graces me with a date. On the other hand, staying on the phone with the recording will disconfirm ten years of fear; no transfer will allow me to start grieving for my best friend as I celebrate my own negativity.

Number by number, I punch in my access code. My identity has been reduced to a drop of blood. Will it continue to be? 1–2–6–7–7–4–8–3–5–2–9.

Finally, a recording proclaims, “You have tested . . .”

**Conclusion**

It has been almost two years since I completed the initial version of this essay, but the research is not done with me. After I learned that I was HIV-negative, I spent one and a half years in sexual fear. I went eighteen months without engaging in any form of sexual activity—peculiar behavior for a man in his late twenties. Or, is it? There are, in fact, several men and women who “abstain from sex once they become aware of their HIV serostatus in order to preserve it” (Román 243). Different scholars use various forms of nomenclature to describe periods of sexual abstinence after an HIV test has been performed. Johnston, for example, refers to this phenomenon as “revirginization” (121). Román frames the practice as a type of “sexual apartheid” (264). Morrison believes that these actions signal the “end of pleasure.” For me, the phenomenon was unexpected—a behavior I failed to anticipate in my preliminary acts of narrativization and a communicative response never mentioned by the medical practitioners who have tested me in an office since my 2003 HIV exam.

By documenting my experiences in this essay, I performatively intervene on reductive understandings of my body. Specifically, I share my story to humanize both the pre- and post-testing experiences, as they relate to a specific gay man embedded in a state of generational HIV limbo—too young to have been sexual in the 1980s and too old to forget the importance of HIV prevention. While increasing HIV seroconversion rates are an intergenerational problem, narratives contextualized by generation may provide insight as to why some men and women avoid HIV testing. In campaigns that target specific generational consciousnesses, HIV prevention
organizations may want to address testing aversion. Moreover, applications of “narrative models” or “blueprints for living” may help some AIDS prevention organizations and medical practitioners in their HIV-related outreach. If, for example, HIV tests were reintroduced to mainstream US citizens as a standard procedure, detached from moral judgment, the future or “projected horizons” (Allison) of HIV tests in the greater context of individual narratives may appear less daunting.

The ways in which I build upon Barad’s theory of performative metaphysics may also prove useful for people invested in how narrative aids in the comprehension and prevention of disease. Barad’s theory demonstrates how tools of measurement (i.e., prescreening questions and HIV tests) shape attitudes regarding and performances of HIV serostatus. When narrative theory and practice are added to Barad’s “metaphysical” mix, two key understandings related to the performative process are gained.

First, a deployment of performative metaphysics in terms of narrative models situates Barad’s theory in a language that better connects performance and performativity. Unlike atoms, Barad’s primary metaphor, narratives are performances with identifiable beginnings, middles, and ends. A narrative “model” better articulates the partialities, performative implications, and subjectivities of lived experiences. The current discussion also builds upon other conversations started by Diamond, Langellier, and Johnson that investigate how “performance itself as a contested space” (Diamond 4) “constitutes identities and experience, producing and reproducing that to which it refers. Here, personal narrative is a site where the social is articulated, structured, and struggled over” (Langellier 128). I, for example, employed a narrated rendition of my lived experiences to help “map out” the discourses that influence my thoughts about HIV, AIDS, and HIV testing. As I navigated my way through a “sea of signification,” I became better able to explicate my own prejudices and fears. Narrative exercises similar to the one I engaged in may be an effective way for sex educators to get people in the United States to talk about HIV and AIDS in a meaningful manner.

Second, narrative “blueprints” text-urize Barad’s theory by extending her performative model into the realm of the future. The application of narratization in this essay suggests that performative conceptualizations of the world do not necessarily lead to a loss of individual agency. While community members may be dependent on previous chains of signification to articulate the “here and now,” they are not entirely “chained down” by the past. The experiences I chronicle in this essay showcase one way in which I pulled from my past to alter my present and future. Narratization brings with it possibility and potential. After completing this essay, for example, I now see “Is he dying?” and “Are you sick?” as conversation starters—invitations to talk about HIV and possibly share my tale and/or listen to somebody else’s. Narrative interventions make our understandings of HIV more complex by asking cultural members to use personal stories to challenge misconstructions of HIV and AIDS. The performative aspect of the intervention calls upon the performer to
locate and interrogate specific iterations of HIV that may be resisted through the use of narrative.

The form of performative metaphysics I advocate in this essay places special emphasis on the crafting of self as the personal relates to broader cultural constructs and the future. As a compositional strategy, narrative interventions respond; personal stories text-urize; they situate and deconstruct the past and present, and reconstruct the future; interventions in the form of narrative inspire the telling of other tales; the stories implicate; they replicate the past but whisper hope for the future.

Notes

[1] In “Skinnybones,” I use “performative” in a broader sense than Butler initially defines the concept. In Gender Trouble, for example, Butler’s deployment of the term is articulated in terms of gender performativity, an argument that she clarifies in Bodies that Matter. In her second book, Excitable Speech, Butler links her rendition of performativity to J. L. Austin’s Speech Act Theory, demonstrating how reiteration opens up possibilities for change and subversion. For the purposes of this essay, I am more interested in how other scholars have reconfigured performativity to better fit within performance paradigms.

[2] Confide was the first FDA-approved home collection HIV testing kit. Johnson and Johnson pulled the test off the market due to poor sales (Scott 207).

References


