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AIDS and the Psycho-Social Disciplines: The Social Control of "Dangerous" Behavior

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AIDS provides society an opportunity to expand and rationalize control over a broad range of psychological phenomena. Social control today is panoptical, involving dispersed centers and agents of surveillance and discipline throughout the whole community (as exemplified by workplace drug testing). The control of persons perceived as "dangerous" is effected partly through public psycho-social discourse on AIDS. This reproduces earlier encounters with frightening diseases, most notably the nineteenth-century cholera epidemic, and reveals a morally-laden ideology behind modern efforts at public hygiene.

> The hospital psychiatrist, noticing Marcus' effeminate mannerisms, immediately decided to administer an HIV antibody test. And in fact, the boy tested positive. Instantly he became a pariah. When it became known that Marcus was currently sexually active, the professionals and officials began a steady campaign to get him out of town or locked up in a hospital or reformatory. (Epstein, 1988, p. 46)

AIDS today serves as an impetus and rationale for controlling marginal groups and their "dangerous" behavior. Marcus's story above illustrates that the interruption of the spread of the human immunodeficiency virus (HIV) occasions – like previous epidemics – measures for medical "policing" (Ergas, 1987). Social control today, however, is not only characterized by direct and punitive measures as suggested above. Instead, as Michel Foucault and others have argued, modern social control is "panoptical" in nature, involving widely dispersed centers and agents of surveillance and discipline throughout the whole community (Rodger, 1988). G. Marx (1985) put it this way: "the ethos of social control has expanded from focused and direct coercion [face-

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to-face] used after the fact and against a particular target to anticipatory actions entailing deception, manipulation, planning, and a diffuse panoptic vision [to observe and normalize]" (p. 26). Social control is thus no longer exclusively aimed at keeping "criminal" or "dangerous" classes at bay. Instead, modern surveillance penetrates – at "multiple levels" (Ericson and Shearing, 1986) – a broad range of social and health phenomena deemed or construed as "threats" to the body politic.

Foucault (1979, 1988) and Turner (1984) argue that imperatives of discipline and surveillance began to take shape in the late eighteenth and early nineteenth centuries with the rise of industrial capitalism. As early as 1779 in Germany, Johan Peter Frank proposed in his six-volume *System for a Complete Medical Policing* a scheme "to prevent evils through wise ordinances" (cited in Ericson and Shearing, 1986, p. 154). This was at a time when concerns about the social consequences of individual behavior, morality, and disease were first expressed, when the health and physical well-being of entire populations came to figure as explicit political objectives, when the "policing" of public hygiene could ensure economic regulations and social order (Foucault, 1980).

In the twentieth century, the social control of hygiene has undergone a scientific and technological transformation. Today, such control is characterized by the intersection of three general mechanisms of power which have virtually consolidated an "inclusivist gaze" (Smart, 1985): disciplinary technologies (e.g., psychoactive drugs), disciplinary institutions, and scientific discourse (Conrad, 1979). This work looks at the role that discourse has had in framing and managing sexuality during the AIDS crisis. I will examine the extent to which the psycho-social sciences – via scientific discourse – have extended and rationalized controls over sexual beliefs, desires, and behaviors. Under the term psycho-social, I include psychiatry and psychology, clinical medicine, the human sciences, and the various pedagogical and clinical practices aimed at controlling sexuality (see Lemert and Gillan, 1982).

My line of inquiry follows Mort's (1987) argument that "AIDS is the contemporary moment in a much longer history, the extraordinarily complex interweaving of medicine and morality with surveillance and regulation – even the definition – of sex" (p. 2). In focusing on discourse, I attempt to answer the following question: How do psycho-social disciplines fit into the much broader, historically-influenced agenda bent on normalizing and individualizing what has been designated in scientific publications as "promiscuous" behavior in the AIDS era? The label "promiscuous," as we will see, is meaningful only on a wider, nonepidemiological level (Murphy and Pilotta, 1987; Padgug, 1989). The notion of "promiscuity" has given the psycho-social disciplines an opportunity to penetrate and conduct surveillance of a broad range of psychological phenomena associated with the transmission of HIV. I do not mean to suggest that all HIV/AIDS-related behaviors labelled "pro-

miscuous" or "dangerous" are somehow epidemiologically spurious. Rather, these designations and the societal responses they evoke must be placed in some social-historical context in order to make sense of their ideologic components.

To help in this task, I first turn to two postulates from Turner's (1984) book, *The Body and Society*: (1) disease language is ideology and social practice, and (2) medicine is a political practice.

Disease Language as Ideology and Social Practice

The language of disease is not a value-neutral medium that communicates ideas and meanings independently formed. Instead language is a structure of sentiments and interests that frame and channel definitions, perceptions, and practices in certain directions (Connolly, 1983). In particular, the modern language of the psycho-social disciplines carries enormous institutional currency on what is to count as desirable or undesirable health-related behavior (Turner, 1984).

Acording to Mercer (1983), the AIDS epidemic has produced a "rewriting of the codes and grammar of pleasure, within our culture" (p. 85). Treichler (1988) put it this way: AIDS language "enact[s] and reinforce[s] deeply entrenched, pervasive, and often conservative cultural 'narratives' about sexuality" (p. 192). As with earlier medico-moral crises, AIDS has brought the concerns over "promiscuous" behavior to center stage. Therefore, to understand the deeper social structures of the crisis we must understand the language or discourse of AIDS.

Smith-Rosenberg (1985) distinguishes between two types of languages: "public language" – which appears in printed, formal sources – and "private language" – the thoughts of individuals found in less formal sources. Theories of sexuality can be read as public-symbolic language in which the individual body stands as a representation of the social body; the structure of cultural forms and social relationships merge with visions of the body (Smith-Rosenberg, 1985, p. 48). Hierarchical societies concerned with rigid maintenance of social hygiene and moral order will act out this concern upon the physical body. Words, conceptual categories, rituals, and codes are used in these societies to label and demarcate the boundaries between health and disease, order and disorder. Consequently, those who are perceived as vectors of the disease will be treated as simultaneously dangerous and physically polluting, and stern efforts will be made to "police" them. The "public language" of AIDS on "dangerous" sexuality, while infused with epidemiological realities, is aimed at controlling a broad range of behaviors and, ultimately, at the inculcation of sexual/behavioral self-restraint. Thus a combination of moral and empirical factors have been responsible for placing "promiscuity" at the heart of the

concerns of the psycho-social disciplines (Mort, 1987). Borrowing from Gusfield's discussion in another context (1981, p. 9), on one side we have beliefs about the facts of the situation and events comprising the problem – for example, the probability of the transmission of HIV among heterosexuals. On the other side, we have beliefs about the morality which depicts the situation as abnormal, unnatural, and immoral. According to Gusfield (1981), the moral dimension is what makes eradication and social control desirable. With this formulation in mind, we can begin to see how medical constructs reproduce dominant socio-moral values, ranging from the older asceticism of Puritanism (purity = health = salvation) to the new sexual order (monogamy = health = salvation) [Foucault, 1979; Kyle, 1989].

Medicine Is a Political Practice

How does medicine, as a psycho-social discipline, fit into the administration of the body politic? We are not accustomed to thinking of medical discourse and practices as political, even when we recognize the inherently political nature of health care policy and research (Altman, 1986). In the twentieth century, the psycho-social disciplines have supplanted religion as the guardian of morality in the Western world (Turner, 1984). The management of the AIDS crisis provides the psycho-social disciplines with new surveillance opportunities and challenges. Writing in another context, Arney and Bergen (1984) could have been speaking of AIDS where they noted that "[s]een in this light, the care of the social body as a whole presents new and exciting challenges to the medical profession; it constitutes an enlargement of its calling" (p. 93).

Foucault more than any other author in recent times has brought to our attention the role psycho-social sciences play in the growth and maintenance of the disciplinary society. The utility of the Foucaultian framework is that it permits us to analyze the extensive disciplinary matrix which coordinates and subordinates individuals' bodies (Armstrong, 1983), their families (Donzelot, 1979), their work and leisure activities (Hecker and Kaplan, 1989), their sexual desires (Turner, 1984, p. 163), and even their "souls" (O'Neill, 1985, p. 25). In the case of medicine, a Foucaultian framework permits us to deconstruct the codes and the disciplinary matrix in which an individual who is ill resides (O'Neill, 1987, p. 33). A Foucaultian exposition requires that attention be given to broader socio-historical factors bound up with the development of this disciplinary matrix. For example, for Foucault, "[t]he hospital was born not of an inevitable or natural necessity but out of a set of practices resulting from the clinical gaze; namely, the internal demand for control, systematic observation, collections of cases and patient histories" (D'Amico, 1989, pp. 80–81). As for its potential social power, Foucault (1980) himself demonstrated that medicine

> assumes an increasingly important place in the administrative system and the machinery of power, a role which is constantly widened and strengthened throughout the eighteenth century. The doctor wins a footing within the different instances of social power. The administration acts as a point of support and sometimes a point of departure for the great medical enquiries into the health of populations, and conversely doctors devote an increasing amount of their activity to tasks, both general and administrative, assigned to them by power. A "medico-administrative" knowledge begins to develop concerning society, its health and sickness, its conditions of life, housing and habits, which serves as the basic core for the "social economy" and sociology of the nineteenth century. And there is likewise constituted a politico-medical hold on a population hedged in by a whole series of prescriptions relating not only to disease but to general forms of existence and behavior. . . . The doctor becomes the great advisor and expert, if not in the art of governing, at least in that of observing, correcting and improving the social "body" and maintaining it in a permanent state of health. (pp. 176–177)

Many of Foucault's ideas about social control revolve around the terms of knowledge and power. His conception of power constitutes a radical departure from Marxian and liberal interpretations. For Foucault, power is not a possession, won by one class that struggles to retain it against its acquisition by another. Rather, as suggested above, Foucault ". . . translates the problem of social control [i.e., surveillance and discipline] out of the terms of class conspiracy into the history of the scientization of power/knowledge produced in the double context of population policy and clinical medicine designed to administer the body politic. . ." (O'Neill, 1987, p. 24). The aim of power changed from the "visibility, excess and crudity" of punishment of earlier times to the "invisible, calculated refinement of discipline" which was transformed during the industrial revolution (Armstrong, 1980, p. 300). Modern power operates through inclusion of outcasts, rather than their exclusion (e.g., incarceration or quarantine). The modern practice of power is deployed by ". . . invent[ing] the individual [today's outcast] as an object to be measured and managed in a social space that no longer has a boundary since it incorporates *everything* in the name of 'scientific truth' " (Arney and Bergen, 1984, p. 126) [italics added]. Foucault, in *Discipline and Punish* (1979), dubs this modern control paradigm "panopticism."

Panopticism as the New Control Paradigm

The Panopticon is the "all-seeing eye" (Strub, 1989, p. 41). The *Oxford English Dictionary* defines "Panopticon" as "fully seen or visible" and adds that it was the name given in 1791 by Jeremy Bentham to a proposed form of prison of circular shape having cells built round and fully exposed toward a central "well," hence the prison officers could at all times observe the inmates. Bentham's original plan for the ideal prison serves as an eloquent symbol for the disciplinary sciences: "a system of knowledge whose radii penetrate into every corner of life, and thus make possible swift and effective control" (Ingelby, 1983, p. 164). Bentham's Panopticon represents the first stage in the

introduction of individual pleasures into the field of social regulation (Mercer, 1983, p. 91). Each person's conduct stands within the reach of a central, invisible inspection. Individuals, not knowing when they are observed, have to behave at all times as though they were being watched. The ultimate effect is that they are brought to internalize the locus of discipline, to exercise self-restraint, and thus to act in accordance with the conventions and expectations of the disciplinary system in which they are caught (Hecker and Kaplan, 1989). An important feature of this control paradigm is that it enables whole populations to be observed and classified. Zuboff (1988), in her excellent analysis of modern surveillance, notes:

> Panopticism is the general principle of a new "political anatomy" whose object and end are not the relations of sovereignty but the relation of discipline. . . . What are required are mechanisms that analyze distributions, gaps, series, combinations, and which use instruments that render visible, record, differentiate and compare. . . . It is polyvalent in its application. . . . Whenever one is dealing with a multiplicity of individuals on whom a task or a particular form of behavior must be imposed, the panoptic schema may be used. (p. 322)

We can trace the imperative of panoptical control back to the challenge of transforming a predominantly agrarian, pre-capitalist population into a workforce more amenable to factory production. According to Gronfors and Stalstrom (1987, p. 55), with the advent of industrialization, capitalism saw the control and disciplining of thoughts and feelings of workers as one tool for supporting economic expansion. By the late nineteenth century, according to Arney and Bergen (1984, p. 65), "[t]o [further] improve worker control, managers had to look deeper and deeper into the production processes . . . . Managers could control the relationships within the walls of the factory and make adjustments as necessary; events outside remained out of their control but they were crucial nonetheless and demanded consideration and monitoring." By the early twentieth century, with the advent of industrial psychology (Taylorism) and medicine along with a new focus on the "ecology of the factory" (Arney and Bergen, 1984), leisure-time activity would now be seen as an indispensable part of the factory's production process. For example, certain expressions of sexuality, defined as leisure-time activity, were seen to fit poorly into the early labor-intensive capitalistic efforts. According to Greenberg (1988), "medical writings of the eighteenth and nineteenth centuries viewed men as having a limited amount of bodily energy; excessive discharge of their energy through sexual release . . . would deplete the supply available for other purposes and would thus lead to enervation and lethargy, if not more dire consequences" (p. 362). Homosexuality, as Weeks (1985) documents, became a particular target of a panoptic network of moral agencies, political interventions, and diverse social practices. The net effect of panopticism was the production of docility, utility and governability of the

social body (O'Neill, 1987). According to Foucault (1979) and interpreters, the development of new techniques of industrial management – including Panopticism and Taylorism – laid the groundwork for a new kind of "disciplinary society," one in which the bodily discipline, regulation, and surveillance would soon be taken for granted (Zuboff, 1988, p. 319).

In the late twentieth century, we see the realization of panopticism throughout society in such forms as drug testing (i.e., urinalysis), pre-employment HIV testing ("60% of employers," 1989), pre-marital HIV testing (Mohr, 1988), and psychological evaluation of employees ("This is your life", 1989). In the workplace, drug testing as well as HIV testing give new and explanded means for probing and controlling the "inner environment" of individuals (Hecker and Kaplan, 1989). Bodily fluids tell tales not only about one's own "impairment," but about one's lifestyle, habits, and psyche. Drug, HIV, and other invasive probing constitute surveillance without interruption, induce "self-restraint" central to Panopticism, and transcend far beyond the legitimate concerns over threats to the public hygiene into the private and concealed domains of the individual body and mind. Put another way, testing of bodily fluids certainly appears to extend what Foucault identified as the exigencies of a developing industrial capitalist system: to ensure the mechanism and circulation of power through "progressively finer channels, gaining access to individuals themselves, to their bodies, their gestures, and all their daily action" (Foucault, 1979, cited in Hecker and Kaplan, 1989, pp. 26–27). In summary, the twentieth century has seen the deployment of a new and more penetrating surveillance and disciplining gaze, one that expands far beyond the confines of the body to its social sphere.

AIDS Language as Social Control: The Regulation of Libidinal Impulses

> There are some theoretical grounds for believing that the nature of homosexual coitus can cause immunosuppression. (Lacey and Waugh, 1983, p. 464)

At the beginning of the AIDS epidemic there was an almost immediate emphasis in the scientific and popular discourse on "fast lane" behavior and "profound promiscuity" (Bayer, 1987). The first report of AIDS appeared in the *New York Times* on July 3, 1981, and included the comment that "according to Dr. Friedman-Kien the reporting doctors said that most cases had involved homosexual men who have had multiple and frequent sexual encounters with different partners" (cited in Altman, 1986, p. 34). If this claim had been clearly linked to the argument that "promiscuity" was significant because it increased the risk of exposure to pathogens, it would have been self-evident. Unfortunately, readers were left with the distinct impression that

"promiscuity" (as an adverse lifestyle behavior) *per se* was the cause of the disease, an idea seized upon by both scientific publications and mass media. For example Navarro and Hagstrom (1982) noted in the *New England Journal of Medicine* that "Promiscuous male homosexuals may therefore be repeatedly exposed to immosuppresive factors [in seminal fluid] as well as antigenic challenge during rectal intercourse" (p. 933). The reality constructed by this discourse is as follows: given the abnormally high "promiscuity" of gay men, some form of sexually transmitted virus (HIV) or exposure to a common lifestyle (i.e., the use of "poppers") played a critical role in establishing immunodeficiency. This interpretation directed attention to gay men as its victims and their sexuality as the problem. In the *Lancet* published in May 1982 a widely cited paper concluded that "amyl nitrate [poppers] exposure and sexual *promiscuity* were associated with development of Kaposi's sarcoma, as well as histories of mononucleosis and sexually transmitted diseases" (Marmor, Laubenstein, Williams, Friedman-Kien, Byrum, D'Onofrio, and Dubin, 1982, p. 1086) [italics added]. Pointing to salient links between the spread of the disease and promiscuity, the article drew attention to alarming differences between the sexual behavior of the infected homosexuals and a control group of non-infected heterosexuals. Fifty percent of the gay patients admitted to having sex with ten or more partners in an average month. The most promiscuous patient estimated he had intercourse with ninety different partners per month in the year before onset of the disease. Conclusions were tentative but an initial hypothesis was made clear – "promiscuous" behavior was an important factor in spreading this potentially killer disease (cited in Mort, 1987, p. 1).

A literature search through the National Library of Medicine MEDLINE Database reveals that a number of articles published as recently as 1988 and 1989 still implicate "promiscuity" in the transmission of HIV (see, for example, Couarvoisier, Tauber, and Luthy, 1989; Cruz, Dieguez, Fos, and Hierro, 1988; Duesberg, 1989; Fleming, 1988; Fouchard, Schmidt, and Krasnik, 1989; N'Galy and Ryder, 1988; Schroter, Nher, and Petzoldt, 1988; Seidlin, Krasinski, Bebenroth, Itri, Paolino, and Valentine, 1988; Soriano, Tor, Muga, Fernandez, Ribera, Balanzo, and Foz, 1989; Taylor, Taylor-Robinson, Jeffries, and Tyms, 1988; Titti, Rezza, Verani, Butto, Sernicola, Rapicetta, Sarrecchia, Oliva, and Rossi, 1988). All these articles specifically mention "promiscuity" as a HIV risk factor. For example, Fouchard et al. (1989) write that "HIV was introduced in Denmark toward the end of the nineteen eighties among *promiscuous* homosexual men in Copenhagen to a level in which ¼ – ⅓ were found to be infected in small selected materials" (p. 613) [italics added]. In the October 1988 issue of *Psychiatric Annals*, a psychiatrist could also write: "It is well known that promiscuity is a hallmark of homosexuality. It is also well-established that promiscuity promotes the spread of AIDS and has to be rejected on

statistical, if not *moral*, grounds (Tanay, 1988, p. 596) [italics added]. According to another psychiatrist, to "cease dangerous [read promiscuous] activity . . . public health authorities may be forced to resurrect sanitaria [read "policing"] for the quarantine of *relentlessly* contagious carriers" (Eth, 1988, p. 575) [italics added].

Again, the problem with such textual constructions of reality, according to Altman (1986), is that they inevitably lead to the conclusion that "promiscuity" is a risk factor and that everyone with AIDS (or infected with HIV) has necessarily been and remains dangerously "promiscuous." Moreover, professional vocabulary and imagery on the number of sexual partners tends to reinforce anti-homosexual sentiment that gay men are morally depraved (Meredith, 1984, p. 58). The image of the homosexual male as a dangerous/promiscuous individual has existed since the nineteenth century, when such an individual was viewed as a ". . . [walking] time bomb who at some moment [would] explode, destroying those who let themselves be seduced" (Gilman, 1985, p. 71). Contained in nineteenth century discourse on sexual "dangerousness" (see, for example, Foucault, 1988), as well as in the late twentieth century concept of AIDS-related "promiscuity," is invariably the notion of an immediate threat to the social order. The vocabulary and imagery of "promiscuity" constructed in the scientific literature serves as a foremost instrument of disciplinary power for normalizing non-normative sexual practices (Levine and Troiden, 1988; Smart, 1985).

The Rise of Medico-Moral Discourse

The reactions evoked by AIDS are determined not only by its biological nature but by historically produced meanings attached to sex, health, and disease (Mort, 1987, p. 215). That is, social and moral ideologies along with biomedical realities define the meaning and management of epidemics both for its victims and the entire society. Therefore, the impact of AIDS, the fear of HIV, and the development of public and personal hygiene must all be seen within the larger context aimed at disciplining and civilizing (Goudsblom, 1986).

Nineteenth Century Cholera Epidemics

The framework guiding the societal interpretation and response (images and vocabulary) to AIDS has its roots in the nineteenth century cholera triangular relationship of morality, sexuality, and pathology. According to Rosenberg (1986), nineteenth century cholera is the closest modern analogy to AIDS. No other disease had a more terrifying impact in the nineteenth century than cholera, which reached Europe from Asia around 1830, and

immediately unleashed panic as well as determined efforts to contain it. It was widely believed that cholera was a disease which would find its victims almost without exception among the poor – then referred to as "dangerous classes" (Goudsblom, 1986). The words of a popular German writer and physician, C. Reclam, captured the general fear of these marginal groups as the source of the disease in the following lines:

> Don't think that the foul air of the street, propelled by the wind, turns around and humbly recedes when it meets windows adorned with marble and sculpture. Be assured that the germs of disease from the dwellings of the proletarians can be easily transmitted through the air to the parlour and the bedroom of the first servant of the state. (cited in Goudsblom, 1986, p. 178)

The cholera epidemic in Europe and the United States fell disproportionately on marginal groups. During the nineteenth century, poverty and disease were viewed as a consequence of idleness and intemperance – the latter believed to make the individual more susceptible to cholera. In the United States, not only were the poor blamed but the new immigrants were accused of bringing the disease into the country. Prostitutes were accused of being reservoirs of disease and rounded up under social hygiene provisions even though cholera was not thought to be a venereal disease. Many felt that immigrants' and prostitutes' "moral corruption" caused them to develop cholera.

> Representations of sexual immorality were constructed through institutional programmes which linked the habits and environment of the urban poor with medical-moral pathology. Professional experts and groups targeted their therapeutic gaze at the specific domain of sexuality, attributing the spread of cholera to "excessive bouts of unnatural sex." (Mort, 1987, p. 215)

In Great Britain, the newly founded medical journal, *Lancet*, along with other leading periodicals, carried many articles on the causes of cholera and the steps to be taken for prevention (Mort, 1987). Evidence was conflicting and contradictory, reflecting current medical divisions on the origins and transmission of disease. But though there was little consensus about causation, physicans, clerics, bourgeois reformers and other local officials all agreed that the urban poor and their lifestyles, including their sexual behavior and morality, were responsibility for spreading contagion. According to Mort (1987),

> The logic which twinned poverty and immorality with contagion was made through a specific language – the discourse of early social medicine – and was circulated at key institutional sites within the central and local state. The intentions were clear: greater surveillance and regulation of the poor. . . . The proposed solution was twofold: to isolate the human sources of infection, subjecting them to a regime of compulsory inspection and detention, combined with propaganda to educate the poor into a regime of cleanliness and morality. (p. 16)

In the pamphlet, *The Moral and Physical Condition of the Working Classes Employed in the Cotton Manufacture in Manchester, 1832*, the British sanitarian Dr. James Phillips Kay set out his own early contribution to the debate on the immorality of the urban poor. As Kay put it, the development of a strategy for the "mitigation of suffering" had to take in fundamental questions of economic, political and moral causation (cited in Mort, 1987, p. 19). Reform of sexual conduct was an important part of Kay's schema. Sexuality – always referred to by Kay as sexual immorality – was constructed in relation to the themes and the perceived threat of an oppositional culture (p. 21). The strategic aim then was much broader, namely, the panoptic surveillance and regulation of the urban working-class culture (p. 25). In the following section I discuss how nineteenth century morality has infiltrated modern notions of disease causation.

Modern "Lifestyle" Disease

Nineteenth century discourse on sin, disease, and morality is still frequently translated into the etiological formulations of AIDS, while the reaction to the AIDS epidemic has implicated lifestyles, desires and sexual practices. With AIDS such schemes of disease etiology constitute a framework within which a blend of moral and social assumptions can be legitimated (Rosenberg, 1988). Since the late 1970s, the emphasis on disease-producing lifestyle decisions has been at the center of Americans' debate over health and government policy (Bayer, 1989). As far as lifestyle explanations of AIDS are concerned, both popular and some of the scientific literature emphasize that persons with AIDS are afflicted as a direct result of their lifestyle excesses – their sexual practices or their use of illegal drugs. These recent depictions of promiscuity serve to individualize responsibility for the disease. The individualization carries moral overtone and fits well into the goal of the panoptic vision – a shift from the punitive external control of behavior to the inculcation of disciplined self-restraint.

Individualization blames the individual and limits the responsibility of the larger society (Nelkin and Gilman, 1988). Rosenberg (1986) put the individualization of the disease this way:

> [T]he desire to explain sickness and death in terms of volition – of acts done or left undone – is ancient and powerful. The threat of disease provides a compelling occasion to find prospective reassurance in aspects of behavior subject to individual control. . . . In the nineteenth century epidemics of cholera . . . there was much talk of predisposition. The victims' behavior or place of residence explained why they, in particular, succumbed to a general epidemic influence. With decreasing fear of acute infectious disease in the mid-twentieth century, Americans have turned increasingly to a positive concern with regimen – to diet and exercise – as they seek to reduce their real or sensed risk, to redefine the mortal odds that face them. (p. 50)

"Dangerous" Sexuality

In an important essay, "About the Concept of the Dangerous Individual in 19th Century Legal Psychiatry," Foucault (1988) argues that the notion of "dangerousness" gave psychiatric medicine an opportunity to infiltrate the law: ". . . while for a long time, the criminal was no more than the person to whom a crime could be attributed and who could therefore be punished, today, the crime tends to be no more than the event which signals the existence of a dangerous element . . . in the social body. . . . The doctor must therefore be the technician of this social body, and medicine a public hygiene" (p. 134). This image of the doctor is akin to the "straightener" in Samuel Butler's *Erewhon* who was called upon at the first sign of immoral behavior (cited in Siegler and Osmond, 1974).

Foucault suggests that sexuality deemed "dangerous" has been repressed in the West, at least since the beginning of industrial capitalism. In his *History of Sexuality*, Foucault (1978) argues that this repression led to progressively more complex means of "policing" the person. As the deployment of surveillance expands today, so has the scope of what encompasses sexuality (see, for example, Lotringer, 1988). "It is no longer a question of simply saying what was done – the sexual act – and how it was done, but of reconstructing, in and around the act, the thoughts that recapitulated it, the obsessions that accompanied it, the images, desires, modulations, and quality of the pleasure that animated it" (Foucault, 1978, p. 63). As the contemporary moment in the history of sexuality and its repression, AIDS presents an opportunity for the imposition of what Goldstein (1988) calls "sexual retrenchment and libido shrinking" (p. 42). Seen from a critical perspective, the scientific formulations regarding the spread of the HIV – while promoting rigid sexual norms of monogamy on utilitarian grounds – are unwittingly upholding authoritarian and unegalitarian values.

Conclusion

While the official history of AIDS as a medical entity in the United States began in 1981, the beliefs and values responsible for the social reaction to the epidemic have deeper historical roots. In my analysis I identified the heavily moralized structure of AIDS discourse as well as the individualization, pathologification, and social regulation of lifestyle choices.

AIDS, like past epidemics, must be viewed not only as a medical crisis but as an opportunity for expanding panoptic surveillance and repressive modes of social control. The current political anatomy of AIDS, namely, the decision to analyze and intervene at the level of the individual body, has some additional undesirable consequences. This reductionist and fragmented

analysis means that a number of critical issues are not being addressed. For example, we know that the epidemic is attaining particular virulence in the urban underclass (Ergas, 1988). Yet, very few psycho-social investigators have penetrated deeply enough to understand an array of overarching adverse socio-structural factors contributing to, and associated with, the transmission of HIV. Whether analyzing intravenous drug use behavior or sexuality, the time is ripe to focus on the potentially lethal effects that repressive cultures and economies have on the psyche. Most people's choices and behaviors are influenced by the conditions of the social relations in which they are caught. Our attention therefore must be aimed at identifying and changing the adverse social relations which often make "dangerous" choices appear optimal. Sexual minorities have been particular targets of this oppression. This brings to mind Berube's recent observation (1988, p. 16): "How do you rationally weigh risks when your shelters seem to threaten your life?"

References

Altman, D. (1986). *AIDS in the mind of America.* New York: Anchor Press.

Armstrong, D. (1980). Madness and coping. *Sociology of Health and Illness, 2,* 293–316.

Armstrong, D. (1983). *Political anatomy of the body.* Cambridge: Cambridge University Press.

Arney, W.R., and Bergen, B.J. (1984). *Medicine and the management of living.* Chicago: University of Chicago Press.

Bayer, R. (1987). *Homosexuality and American psychiatry.* Princeton: Princeton University Press.

Bayer, R. (1989). *Private acts, social consequences.* New York: Free Press.

Bersani, L. (1988). Is the rectum a grave? In D. Crimp (Ed.), *AIDS: Cultural analysis/cultural activism* (pp. 197–222). Cambridge: MIT Press.

Berube, A. (1988). Caught in the storm – AIDS and the meaning of natural disaster. *Out / Look, 3,* 8–9.

Connolly, W. (1983). *The terms of political discourse.* Oxford: Martin Robertson.

Conrad, P. (1979). Types of medical social control. *Sociology of Health and Illness, 1,* 1–11.

Couarvoisier, S., Tauber, M.G., and Luthy, R. (1986). Bisexuality and AIDS. *Schweizerische Rundschau fur Medizin Praxis, 78,* 486–493.

Cruz, M., Dieguez, A., Fos, E., and Hierro, F. (1988). Epidemiologic survey on hepatitis B in gypsy women. *European Journal of Epidemiology, 4,* 314–317.

D'Amico, R. (1989). *Historicism and knowledge.* London: Routledge and Kegan Paul.

Donzelot, J. (1979). *The policing of families.* London: Hutchinson.

Douglas, M. (1966). *Purity and danger.* London: Routledge and Kegan Paul.

Duesberg, P.H. (1989). Human immunodeficiency virus and Acquired Immunodeficiency Syndrome: Correlation, but not causation. *Proceedings of the National Academy of Sciences, 86,* 755–764.

Epstein, S. (1988). Nature vs. nurture and politics of AIDS organizing. *Out / Look, 1,* 46–53.

Ergas, Y. (1987). The social consequences of the AIDS epidemic. *Social Sciences Research Council Items, 41,* 33–39.

Ericson, R.V., and Shearing, C.D. (1986). The scientification of police work. In G. Bohme (Ed.), *The knowledge society* (pp. 129–159). Boston: D. Reidel Publishing Company.

Eth, S. (1988). AIDS, ethics, and psychiatry. *Psychiatric Annals, 18,* 577–581.

Fleming, A.F. (1988). Seroepidemiology of human immunodeficiency viruses in Africa. *Biomedicine and Pharmacotherapy, 42,* 309–320.

Foucault, M. (1978). *The history of sexuality Vol. 1* New York: Pantheon.

Foucault, M. (1979). *Discipline and punish: The birth of the prison.* New York: Pantheon.
Foucault, M. (1980). *Power / knowledge.* C. Gordon (Ed.). New York: Pantheon.
Foucault, M. (1988). The dangerous individual. In L.D. Kritzman (Ed.), *Michel Foucault: Politics, philosophy, culture* (pp. 125–151). New York: Routledge.
Fouchard, J.R., Schmidt, K.W., and Krasnik, A. (1989). HIV infection among homosexual and bisexual men in Denmark. *Ugeskrift for Laeger, 151,* 613–616.
Gilman, S.L. (1985). *Difference and pathology: Stereotypes of sexuality, race, and madness.* Ithaca: Cornell University Press.
Goldstein, R. (1988, April 5). Fatal contraction. *Village Voice,* p. 42.
Goudsblom, J. (1986). Public health and the civilizing process. *The Milbank Quarterly, 64,* 161–168.
Green, B.S. (1983). *Knowing the poor: A case-study in textual reality construction.* London: Routledge and Kegan Paul.
Greenberg, D.F. (1988). *The construction of homosexuality.* Chicago: University of Chicago Press.
Gronfors, M., and Stalstrom, O. (1987). Power, prestige, and profit: AIDS and the oppression of homosexual people. *Acta Sociologica, 30,* 53–66.
Gusfield, J.R. (1981). *The culture of public problems.* Chicago: University of Chicago Press.
Hecker, S., and Kaplan, M.S. (1989). Workplace drug testing as social control. *International Journal of Health Services, 19,* 693–707.
Ingleby, D. (1983). Mental health and social order. In S. Cohen and A. Scull (Eds.), *Social control and the state* (pp. 141–188). Oxford: Martin Robertson.
Kyle, G.R. (1989). AIDS and the new sexual order. *The Journal of Sex Research, 26,* 276–278.
Lacey, C.J.N., and Waugh, M.A. (1983). Cellular immunity in male homosexuals. *The Lancet, 2,* 264.
Lemert, C.C., and Gillan, G. (1982). *Michel Foucault: Social theory and transgression.* New York: Columbia University Press.
Levine, M.P., and Troiden, R.R. (1988). The myth of sexual compulsivity. *The Journal of Sex Research, 25,* 347–363.
Lotringer, S. (1988). *Overexposed: Treating sexual perversions in America.* New York: Pantheon.
Marmor, M., Laubenstein, L., Williams, D.C., Friedman-Kien, A.E., Byrum, R.D., D'Onofrio, S., and Dubin, N. (1982). Risk factors for Kaposi's sarcoma in homosexual men. *Lancet, 1,* 1083–1087.
Marx, G.T. (1985). I'll be watching you: Reflections on the new surveillance. *Dissent,* Winter, 26–34.
Mercer, C. (1983). A poverty of desire: Pleasures and popular politics. In *Formations of pleasure* (pp. 84–100). London: Routledge and Kegan Paul.
Meredith, N. (1984, January). The gay dilemma: The AIDS threat has brought it up: Why are some homosexual men so promiscuous? *Psychology Today,* pp. 56–62.
Merquior, J.G. (1985). *Foucault.* London: Fontana Press.
Mohr, R.D. (1988). Mandatory AIDS testing. *Report from the Institute for Philosophy and Public Policy, 8,* 8–11.
Mort, F. (1987). *Dangerous sexualities.* London: Routledge and Kegan Paul.
Murphy, J.W., and Pilotta, J.J. (1987). Research note: Identifying "at risk" persons in community research. *Sociology of Health and Illness, 9,* 62–75.
Navarro, C., and Hagstrom, J.W.C. (1982). Opportunistic infections and Kaposi's sarcoma in homosexual men. *The New England Journal of Medicine, 306,* 933.
N'Galy, B., and Ryder, R.W. (1988). Epidemiology of HIV infection in Africa. *Journal of Acquired Immune Deficiency Syndrome, 1,* 551–558.
Nelkin, D., and Gilman, S.L. (1988). Placing blame for devasting disease. *Social Research, 55,* 361–378.
O'Neill, J. (1985). *Five bodies: The human shape of modern society.* Ithaca: Cornell University Press.
O'Neill, J. (1987). Sociological nemesis: Parson and Foucault on therapeutic disciplines. In M.L. Wardell and S.P. Turner (Eds.), *Sociological theories in transition* (pp. 84–100). London: George Allen and Unwin.
Oxford English Dictionary. (1984). Oxford: Oxford University Press.
Padgug, R.A. (1989). Gay villain, gay hero: Homosexuality and the social construction of AIDS. In K. Peiss and C. Simmons (Eds.), *Passion and power: Sexuality in history* (pp. 293–313). Philadelphia: Temple University Press.

Paternek, M.A. (1987). Norms and normalization: Michel Foucault's overextended panoptic machine. *Human Studies, 10,* 97–121.
Rodger, J.J. (1988). Social work as social control re-examined: Beyond the dispersal of discipline thesis. *Sociology, 22,* 563–581.
Rosenberg, C.E. (1986). Disease and social order in America: Perceptions and expectations. *The Milbank Quarterly, 64* (Supplement 1), 34–55.
Rosenberg, C.E. (1988). The definition and control of disease: An introduction. *Social Research, 22,* 563–581.
Ross, J. W. (1989). The militarization of disease. *Soundings, 72,* 39–55.
Ruse, M. (1988). *Homosexuality: A philosophical inquiry.* Oxford: Basil Blackwell.
Schroter, R. Nher, H., and Petzoldt, D. (1988). Skin manifestations of syphilis maligna in HIV infection. *Hautarzt, 39,* 463–466.
Seidlin, M., Krasinski, K., Bebenroth, D., Itri, V., Paolino, A.M., and Valentine, F. (1988). Prevalence of HIV infection in New York call girls. *Journal of Acquired Immune Deficiency Syndrome, 1,* 150–154.
Sheridan, A. (1980). *Michel Foucault: The will to truth.* London: Tavistock Publications.
Siegler, M., and Osmond, H. (1974). *Models of madness, models of medicine.* New York: Harper Tourchbooks.
60% of Employers Report AIDS Cases. (1989, June 14). *Los Angeles Times,* p. 2.
Smart, B. (1983). *Foucault, marxism and critique.* London: Routledge and Kegan Paul.
Smart, B. (1985). *Michel Foucault.* London: Tavistock Publications.
Smith-Rosenberg, C. (1985). *Disorderly conduct.* Oxford: Oxford University Press.
Soriano, V., Tor, J., Muga, R., Fernandez, J.L., Ribera, A. Balanzo, X., and Foz, M. (1989). Human immunodeficiency virus type 2 infection in Western Africans living in Catalonia. *Medicina Clinica, 92,* 161–163.
Strub, H. (1989). The theory of panoptical control: Bentham's panopticon and Orwell's nineteen eighty-four. *Journal of the History of the Behavioral Sciences, 25,* 40–59.
Tanay, E. (1988). Psychiatric reflections on AIDS education. *Psychiatric Annals, 18,* 594–597.
Taylor, D.L., Taylor-Robinson, D., Jeffries, D.J., and Tyms, A.S. (1988). Characterization of cytomegalovirus isolates from patients with AIDS by DNA restriction analysis. *Epidemiology and Infection, 101,* 483–494.
This is your life. (1989, December). *Harper's Magazine,* p. 19.
Titti, F., Rezza, G., Verani, P., Butto, S., Sernicola, L., Rapicetta, M., Sarrecchia, B., Oliva, C., and Rossi, G.B. (1988). HIV, HTLV-1, and HBV infections in a cohort of Italian intravenous drug abusers: Analysis of risk factors. *Journal of Acquired Immune Deficiency Syndrome, 1,* 405–411.
Treichler, P.A. (1988). AIDS, gender, and biomedical discourse: Current contests for meaning. In E. Fee and D.M. Fox (Eds.), *AIDS: The burden of history* (pp. 190–266). Berkeley: University of California Press.
Turner, B.S. (1984). *The body and society.* Oxford: Basil Blackwell.
Weeks, J. (1985). *Sexuality and its discontents.* London: Routledge and Kegan Paul.
Weeks, J. (1988). Love in a cold climate. In P. Aggleton and H. Homans (Eds.), *Social aspects of AIDS* (pp. 10–19). London: The Falmer Press.
Wright, P., and Treacher, A. (1982). *The problems of medical knowledge: Examining the social construction of medicine.* Edinburgh: Edinburgh University Press.
Zuboff, S. (1988). *In the age of the smart machine.* New York: Basic Books.