Once Upon A Virus

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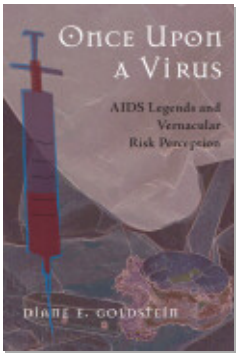

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Bad People and Body Fluids

Contemporary Legend and AIDS Discourse

In 1989, versions of a story circulating around St. John's asserted that a local teenager was covertly but deliberately causing damage to the condoms on display in local drug stores. One woman told the story as follows:

> My friend Marcia told me this story. She said her friend thinks she even knows who did it. Anyway, this guy finds out he's got AIDS and he's mad and he wants to get back at the whole world, so he goes into a drug store. And he borrowed his grandmother's hat pin. So, when nobody is looking he takes the pin and he pokes it all the way through a condom box on the shelf. He does that four or five times. Then he puts the box back and he leaves. The next night he does the same thing with a different box. Anyway, he kept it up—night after night, box after box, until, you know, he got them all. All the condoms in the whole city and not one fit to be used. So now, people are getting pregnant, getting AIDS, getting VD. They think they're protected and they're not.

The "Pinpricks in the Condom" story is a typical contemporary legend. It is told as true or, at least, as plausible. It contains a mentioned pedigree or source that is a few links removed from the teller but nevertheless appears to be close enough to be reasonably accurate (generally, this is constructed as a friend of a friend). It narrates a series of events of contemporary concern and opens up debate about those

issues. Like the well-known classic contemporary legends of dogs in microwaves, Kentucky-fried rats, and insects in hairdos, the condom story appeared on the local scene in a variety of versions, each supplying sufficient detail to concern, if not convince, the listener.

The term *contemporary legend* is used to describe "unsubstantiated narratives with traditional themes and modern motifs that circulate in multiple versions and are told as if they are true or at least plausible" (Turner 1993:5). Sometimes called "urban legends," "modern legends," or "modern myths,"[1] the contemporary legend has been described as a solidified rumor—a story that combines rumor with formal narrative devices (Kapferer 1989; Turner 1993:5). The legend form is dialogic: told to remark upon or debate issues related to contemporary concerns such as crime, technology, big business, government power, or sexuality. Health legends form a huge part of the genre, with hundreds circulating in most locales at any given time. These narratives cover a wide expanse of health issues—organ theft and transplantation black markets; medical consequences of sexual exploration; unusual animal, insect, and parasite infestations; medical experimentation and conspiracy; undisclosed forms of contagion; and numerous others. Of this massive and varied body of health legends, AIDS narratives currently comprise the largest corpus,[2] at least in North America. The vitality of legends

1. This group of terms reflects both popular nomenclature for the type of narratives discussed here and paradigm changes based on philosophical debates within the discipline of folklore. Popular usage appears to prefer the terms "modern myth" or "urban legend." The phrase "modern myth" is one that folklorists abhor. While popular usage understands myth to be simply a story that has no basis in fact, it is used within the disciplines of folklore and anthropology to refer to sacred narratives involving strongly held beliefs. References to myth as synonymous with untruth appear to be based on the ethnocentric belief stance of someone outside of the teller's tradition (it is a myth; I believe it to be untrue; therefore it is untrue; therefore all untrue stories are myths). "Urban legend" and "modern legend" were terms used by folklorists intent on contrasting these narratives with older notions of legend as a genre that found its primary vitality in the rural past. Today, most legend scholars agree that contemporary legends are neither urban nor modern, in the sense that they do not exist to the exclusion of rural communities, nor are they "new" stories. In fact, many narratives of this type (see the discussions of precursors to AIDS legends throughout this volume) have extremely long histories with variation appropriate for commentary on current concerns. For this reason, the term "contemporary" legend has gained in popularity over the last twenty years, suggesting that while the narratives may borrow older types and motifs, they focus on contemporary contexts and concerns and the narratives are presented as contemporary with those issues. For further discussion of debates about terminology, see the introduction to Bennett and Smith (1996) or Bennett (1985).
2. This assertion is based on my own survey of the genre.

about AIDS should not surprise us. Twenty-two million people have died from AIDS around the world over the past twenty years. Nearly twice that many, over thirty-six million worldwide, are now living with HIV. UNAIDS/WHO estimates indicate that in the year 2000, 5.3 million people were newly infected with HIV.[3] Legend follows worry and fear, not simply as a means of expressing anxiety, but also as a means to test information and sources, explore relevancies, and investigate the shape and nature of related issues. AIDS is a part of daily reality, but its magnitude is terrifying, information about it is inconsistent, and the epidemic continually takes on new bizarre twists and turns. In other words, AIDS is the very stuff of contemporary legend.

Contemporary legends have fallen prey in recent years to the ravages of popularization, becoming fodder for numerous horror movies, situation comedies, and novels. The popularity of the narrative form in film, television, and literature is largely due to its vitality as a natural discursive form (Danielson 1979). Nevertheless, popularization of the genre has shifted attention away from its ethnographic context to the sensationalistic content of many of the stories. Counter to the image of contemporary legends in popular culture, legend scholars cite *mundaneness* as a central characteristic of the genre (Smith 1998:493). Contemporary legends make the extraordinary ordinary and the ordinary extraordinary by combining common situations and events with unusual complications or results. The combination gives the narratives their powerful characteristic of plausibility. As Jean-Noel Kapferer (1996:246) notes, the narratives are characterized by "persistence, pervasiveness and persuasiveness." These characteristics create a powerful threesome—prompting a number of public panics related to the kidnapping of children (Best 1990; Campion-Vincent 1990; Victor 1993), mass poisonings (Best and Horiuchi 1985; Grider 1984; and Kapferer 1989), forced medical experimentation (Turner 1991), and numerous others.

Because contemporary legends exist primarily as a conversational form, they don't tend to feature single definitive texts or formulaic openings and closings (Smith 1998:493). They are often embedded in other types of discourse such as jokes or personal experience narratives and appear sometimes more as a reference to

3. Statistics used here have been taken from the "AIDS around the World" surveillance Web site http://www.avert.org/aroundworld.htm (accessed January 11, 2002).

a story than as a full narrative. Due in part to the fluid shape of these narratives, scholarly literature has focused intently on generic classification and definition, particularly in reference to the subtle distinctions between rumor and contemporary legend. While rumor tends to be defined as a "brief, oral, non-narrative statement based on hearsay" (Turner 1993:4), the legend is often seen as having a stronger narrative component, presented most often with fuller elaboration. Nevertheless, the tendency to shorten legend forms and embed them in other types of expression complicates the definitional problem. For the purposes of this study I will follow Patricia Turner's lead (1993), emphasizing the complementary nature of the two forms rather than continuing the debate about their exclusivity. Like Turner, I find that the material under discussion in this volume moves back and forth between rumor and legend but is nevertheless part of a clearly related narrative complex. For this reason, I have adopted Turner's usage—preferring "the term *rumor* to refer to short, non-narrative expressions of belief, *legend* to refer to the more traditionally grounded narratives of belief, and *contemporary legend* to refer to items containing particularly modern motifs" (Turner 1993:5).

Also part of the legend complex are numerous non-oral and mass-mediated versions of the narratives. As with many contemporary folklore genres, the legend has adapted to modern forms of communications technology and is now disseminated, at least in part, through television, radio, literature, film, sound recordings, e-mail, fax, and photocopy. This inclusion of new forms of technology in circulation should not surprise us, for as Smith notes, "in the real world, not just a single *oral* medium of transmission is utilized to communicate folklore, *but any available and relevant media* is employed" (Smith 1992:41). Because of the popular appeal of contemporary legends combined with widespread concerns about AIDS, the narratives discussed in this volume have been frequent topics of news accounts, editorials, advice columns, and other journalistic endeavors. As can be seen in some of the case studies developed here, journalistic dissemination often becomes a significant part of the narrative-transmission process, acting as tradition bearer in much the same way as do individual storytellers but reaching much larger numbers with a single performance.

Similarly, AIDS legends have extremely wide international circulation on the Internet. They are commonly sent between friends

and acquaintances by e-mail, much as narratives are exchanged face to face between individuals. Legend telling has also become part of mass-posting traditions that have developed over the last decade. Part of a larger tradition of health warnings posted on e-mail, AIDS legends circulate often as a form of activism, in which narratives are sent out to warn the public of some new health menace. Such warnings often report on links between widely used products and health conspiracies (such as asbestos in tampons to make women bleed more or hidden links between breast cancer and antiperspirant). Many of these health warnings have their origins in fuller contemporary-legend texts. Several of the most widely circulated AIDS legends in the past two or three years (see, for example, chapter 6 on needle legends) have been forwarded as part of this larger movement of Internet health activism.

Enacting Legends, Ostension, and Health Behaviors

Whether circulated by mass Internet postings, reported in the newspaper, or discussed face to face in more traditional storytelling contexts, contemporary legends retain certain important features: as noted, they are told as true, factual, or plausible and therefore assume a level of authority; they provoke dialogue about the narrative events, their interpretation, and their plausibility; they both articulate and influence beliefs and attitudes toward the subject matter; and they have the capability of affecting the actions and behavior of the listening audience. These features, combined with the intense mass circulation made possible by popular culture, the media, and the Internet, provide contemporary legend with the potential of widespread cultural impact. As a genre that advises, warns, and informs with incredible speed and authority (Shibutani 1966), the contemporary legend can become a formative motivating factor in personal decision making, including decisions related to individual health-seeking and health-care provision.

This impact of the legends can have a wide reach. The narratives provoke response from "official" as well as "lay" members of the community—potentially affecting judicial and legislative action, public policy, the provision of social services, and health care. Many contemporary legends have made it into the pages of medical journals, either represented as assumed truths or deconstructed in

terms of their physiological or institutional probability.[4] An article by F. K. Taylor, for example, published in the *British Medical Journal* (1979), explores the medical implications of penis captivus symptoms described in contemporary legends concerning couples who lock during sexual intercourse. Fasting, Christensen, and Glending explore the potential realities of organ-theft legends in the *Journal of Nursing Ethics* (1998). Both of these articles, along with others that explore medical legends from the perspective of medical researchers and health-care providers, attest to the significance of health-legend complexes beyond trivializing functions of entertainment. Further, the attention these legends receive in the medical literature is characteristic of the legends' ability to create questions even in the minds of authorities on the various content areas discussed by the narrative.

Beyond medical exploration of questions such as "is there a real symptomatology connected to the narrative events?" or "does this narrative have a physiological basis?" or "can such failures of the medical system happen?" health legends continually affect the provision and use of medical services. Contemporary legends concerning AIDS have, in specific cases, had direct impacts on such crucial activities as blood-donation choices and blood-collection procedures (see chapter 6), contact tracing and partner reporting (see chapter 6), observance of universal precautions (see chapter 3), use of health facilities (see Farmer 1992), health related isolation of individuals and communities (Goldstein, Patton, and Worth forthcoming), and numerous other significant medical practices. The narrative informs the listener in ways that not only affect thinking but that also become enacted as the listener expresses belief or concern.

This relationship between narrative and action is referred to by contemporary-legend scholars as "ostension." In 1983 Linda Dégh and Andrew Vázsonyi introduced the notion of "ostension" to narrative research, borrowing the concept from semiotics (where it was defined as "a type of communication where the reality, the thing, the situation or event itself functions in the role of message") to account for actions that gain their primary meaning by being part

4. In addition to articles that explicitly deal with the legends, numerous others contain small assumptions or questions that betray narrative influence. Articles on AIDS origins in medical journals, for example, frequently betray exposure to the legend tradition (see Goldstein 2001).

of a recognized narrative (Dégh and Vázsonyi 1983). Ostensive action, in its narrowest sense, is similar to what is known popularly as a "copycat crime," in which an individual places him- or herself in the role of an antagonist in a crime narrative and performs an act previously known from narrative reports (Ellis 1989a). In 1993, for example, one individual, upon hearing narratives of intravenous needles found in food items, placed several needles and syringes in a soda can, which ultimately made its way to an unsuspecting consumer (de Vos 1996:154). Narrative ostension also affects behaviors in subtler ways that don't necessarily enact the entire narrative or suggest identification with the antagonist but that nevertheless indicate behavioral choices based on knowledge of the story. Contemporary legend and business rumor specialist, Fredrick Koenig, for example, was hired by Burger King Corporation in the late 1980s to help squelch the rumor that an HIV-positive employee had been ejaculating into the mayonnaise served to customers (Langlois 1991). Koenig's consultancy for Burger King was prompted by the company's recognition that rumors and narratives provoke choices by consumers, choices that took a significant toll on Wendy's and McDonald's when similar rumors suggested that the businesses incorporated ground earthworms into the hamburger meat (Koenig 1985). While consumers who act on narrative by withholding patronage are not *enacting* the narrative, they are making choices on the basis of narrative events and thereby transmitting the narrative through their actions. For this reason, the paradigmatic impact of ostension theory in contemporary legend studies includes a wider interest in the relationship between legend and action (Ellis 1989a; Fine 1991).

Legend and Vernacular Concerns about Health

The ostension focus in contemporary legend scholarship parallels similar theoretical interests in illness-narrativity research that have recently begun to explore the function of health narratives as culturally intelligible scripts or models for health and illness action (Good 1994; Mattingly 1998). As Mattingly suggests, "Since the stuff of narratives is the abnormal, the improper, and other departures from the norm, stories offer rich vehicles for passing along cultural knowledge about such matters as how to identify the appropriate social role as care giver for an ill family member . . . or how to adopt the

proper cultural identity associated with a particular diagnostic condition" (1998:13). On some level, contemporary legends, while not always tied in obvious ways to specific actions, become embroiled in the complex relationship between experience, health worldview, explanatory models (Kleinman 1975), choice, and behavior. While such stories may not directly lead us to action with the transparent ostensive relationship of modeling our activities on those of protagonist or antagonist or even of prompting directly related panic reactions, they nevertheless influence and express an understanding of health and illness patterns that motivate our choices and concerns. Health-related contemporary legends betray numerous cultural associations with disease and medicine: an association of "otherness" with contamination (Bird 1996; Goldstein 1991); a distrust of medical bureaucracy (Farmer 1992; Turner 1993); a resistance to both public-health constructions of risk and the increasing medicalization of daily life (Sobo 1995); a fear of bodily intrusion and violation (Bennett 1997; Schechter 1988); and others. The narratives simultaneously shape and are shaped by vernacular ideas of health and illness, ideas that form the basis of health decisions and actions.

This link between attitudes toward health and illness and legend is beautifully illustrated in Laurie Stanley-Blackwell's analysis of the mysterious stranger and Acadian good-Samaritan legends, which became an inseparable part of the understanding and explanation of the leprosy epidemic in nineteenth-century New Brunswick. New Brunswick communities were hit hard by leprosy in the 1840s, particularly in the Acadian communities of Tracadie, Pokemouche, and Neguac. The disease quickly became linked, both in local belief and in official medical and government responses, to the Acadian way of life, emphasizing preexisting Anglophone attitudes toward Acadians as poverty stricken, backward, and morally depraved. Within Tracadie and its sister communities, the disease spawned a series of contemporary legends concerning the origin of leprosy in the area. These legends differed slightly in their plot but had some characteristic features; the disease was brought to the community by an outsider—a sailor or fugitive or a stranger from Europe—who accidentally left his host infected with the disease. This narrative made two issues clear: the disease was brought by an intruder, and the local community had no "sinful" part in the infection. A later version of the narrative underscored these issues. In this variant, the Acadian host invited the sickly visitor to her table, offered to launder his

clothes, and provided a bed for the night. According to the story, local infection with leprosy resulted from the contaminated bed linens. The narrative not only denied the imputation of sin and personal culpability for the disease but also asserted the neighborly goodness and irreproachable hospitality of the Acadian people; the disease was a result of simple local kindness. The good-Samaritan version of the narrative became so entrenched in nineteenth-century New Brunswick culture that special treatment of bed linens used with leprosy patients was legislated by government and medical officials (Stanley-Blackwell 1993). Stanley-Blackwell argued,

> Somehow, when a distinct pattern of sequence and events was imposed on the progress of the enigmatic disease, it seemed less cryptic and more real. Moreover, details about time and place gave the stories an air of authenticity and authority. They helped reduce the crisis to manageable proportions, fending off leprosy's stigma and validating the contemporary contention that the 'poisonous virus was not the growth of this spot, but was brought here by some traveler.' With these narratives the Acadian inhabitants in northeastern New Brunswick created a humanized and indigenous aetiology for leprosy. (1993:39)

While Stanley-Blackwell's study of the Acadian leprosy narratives traces the impact of legend on the construction of disease and illness in the community, its conclusions focus largely on the functional aspects of the narratives:

> They [the stories] became the medium by which the inhabitants could explain leprosy's foothold in their midst. Essentially the narratives served a therapeutic function. They demystified the disease, mitigated its harshness and combated the pervasive notion that the disease was an hereditary scourge among the Acadian population. In other words, the residents of Gloucester County took recourse to the format of 'once upon a time' in order to create some useable context in which to understand the enigmatic disease and to diminish its terrors. (1993:33)

Beyond such functional arguments, however, which try to interpret *why* the narratives came to exist, the narrative corpus reveals the role of legend as a forum for the expression of (and creation of)

deeply rooted attitudes and beliefs about disease and health. It is not simply the *need* for legend that is important or the legend's role in making individuals *feel* better but the nature and shape of the ideas themselves and the effect of those ideas on evolving lay understandings of physiology, contagion, and epidemiology.

Gillian Bennett, for example, in her article "Bosom Serpents and Alimentary Amphibians: A Language for Sickness" (1997), illustrates how legends serve as a language to describe symptoms and as an explanatory system allowing individuals to understand how they came to be ill and what they must do to restore health. Bennett traces geographically, historically, and thematically a corpus of legends concerning animals that invade the human body, arguing that such narratives constitute a form of medical discourse that emphasizes the prevalent lay notion that disease is an entity that takes up residence in the body and needs to be removed. The narratives are literal graphic renderings that reflect lay means of visualizing diseases, such as cancer, as "an animal creeping through the body and devouring flesh along the way" (226). Bennett argues,

> Stories of bosom serpents and alimentary amphibians are thus a complete language for talking about sickness. They are a metaphor-come-true which allows a rational aetiology to be deduced from the central image and a logical cure devised. But they are also a means whereby lay persons may talk informedly to each other and to their therapists about the nature and course of their sufferings. Best of all, they are a means through which the efficacy of the various medical alternatives may be debated. The doctor need never have the last word (though he often does even here). The stories are there to be told, to demonstrate that no matter how many times patients are told that their sufferings are imaginary, in the end the scoffers will be confounded and the patient will be dramatically vindicated. (1997:239)

Bennett's and Stanley-Blackwell's studies represent a portion of the still-small body of literature on medical contemporary legends that explores the connection between narratives and vernacular concerns about health or that focuses on applications of legend study to health care. In addition to Stanley-Blackwell's work on leprosy, Adrienne Mayor (1995) and Marcia Gaudet (1990) focus on legends concerning historical epidemics, demonstrating narrative associations

of disease with moral regulation. Farmer (1992) and Turner (1993) explore issues related to distrust of medical bureaucracy through their ethnographic analysis of conspiracy legends. Véronique Campion-Vincent (1990, 1997) and Nancy Scheper-Hughes (1996) have written on narratives concerning abductions of children and adults for body-part theft, providing application of legend analysis to organ donorship and transplantation concerns. Most recently, Marianne Whatley and Elissa Henken (2000) have demonstrated what a biologist and a folklorist can accomplish when engaged in the collaborative analysis of health and sexuality legends.

Because of the multitheme nature of contemporary legend, others have discussed health legends but not as a primary focus, highlighting crime or sexuality aspects of the narratives or other issues, instead of the implications of legendary material for insight into vernacular health systems. Numerous folklorists and anthropologists have written on AIDS legends, focusing on historical precursors and variants (Smith 1990; Brunvand 1989; Ellis 1989b), gender issues (Fine 1992), oral tradition and the media (Bird 1996), transmission (Langlois 1991), moral regulation (Goodwin 1989), and community narratives (Czubala 1991; Farmer 1992; Kane 1998; Krawczyk-Wasilewska 2000; Turner 1993; Sobo 1995). These studies (and others) provide a wealth of comparative information and significant insight into the multifaceted corpus of AIDS legends but with a somewhat wider net—either exploring the legend as a small part of studies of the larger health picture in a specific location or focusing on the narratives with minimal consideration of health implications. All of these works, and the narratives themselves, point to the potential for a somewhat narrower study of patterns of lay articulation of health and illness concerns expressed in the form of AIDS legends.

Situated Legends and Emergent Meaning

Understanding narratives requires insight into their context. This is particularly true of contemporary legends, which tend to be highly interactional due to their conversational form and highly situated to address local concerns and provide the details necessary for convincing others of their plausibility. Legends circulate around the world, sometimes seemingly at the speed of light—here one moment, there the next. Globalized technologies increase both the speed and the geographical reach of narrative transmission,

but ultimately the legends settle somewhere; they are told by individuals (or forwarded by individuals) situated in place and time. All folklore is context dependent, finding new words, new meanings, and performance styles in each telling. One of the first things folklorists learn as they begin to work with performed materials is that texts provide only a blueprint to what ultimately happens in a performance context. Meaning is situated and emergent. The setting, participants, goals, and numerous other factors affect what is said and how it is said, with each telling (or writing). Even the more inflexible forms of expression, such as Internet health warnings, which are generally forwarded relatively intact, have the addition of a whole new set of information added with each new forwarding address and perhaps an added comment or deleted bit of text—all small variations that might indeed make a big difference in how the narrative is interpreted and repeated.

Apart from, but intertwined with, the performance context of telling is the larger cultural and ethnographic context that informs the legends, providing a basis of meaning for their themes and issues. As Bennett and Smith note, "the events related in contemporary legends resonate with the life circumstances of the people who hear or tell them" (1996:xxii). We tend not to repeat stories that are lacking in personal and cultural meaning. Further, as legends move from place to place, time to time, and individual to individual, variation occurs that continually elaborates the narrative in culturally viable ways. The told narratives are culturally salient, expressing concerns and ideas that are recognized as "tellable" (Labov and Waletsky 1967) or as significant within the cultural context. Elizabeth Bird (1996) has in fact suggested that the focus of AIDS legends has followed stages in the developing cultural awareness of the disease as outlined by Paula Treichler (1988). Treichler suggests that AIDS awareness had evolved in three stages, focusing initially on AIDS as a gay disease that would not threaten the "general public," then with the death of Rock Hudson suggesting the possibility that it might be hard to tell who was a "carrier," and during the third phase perceiving of AIDS as a pandemic to which heterosexuals are vulnerable. Bird suggests that narratives of the "contaminated other" follow the gradual awakening suggested in Treichler's phases, beginning with stories of gay individuals infecting each other, moving to narratives of "sexually active males and promiscuous females," and eventually by the late 1980s including all sexually active women (1996:51).

Of course, Treichler's observations and Bird's are not only time dependent but also location dependent. Information about AIDS and reactions to that information are not globally uniform. As Treichler would be the first to admit, the phases noted above are tied to Western responses to AIDS and are not those found throughout the world. It is not just the availability of information, however, that creates the cultural attitudes that shape narratives. AIDS did not arrive on a scene void of other experiences and concerns. Cultural attitudes are shaped by past experiences—with health, with disease, with politics and economics, with isolation or overcrowding, with bias and prejudice, with power and oppression, and with a host of other potentially relevant factors. It is not surprising, nor is it accidental, that AIDS legends in some countries and within some groups favor government-conspiracy issues. History has laid the groundwork for medical distrust. As Paul Farmer notes, "Those who would dismiss persistent rumors of medical experimentation on disempowered black people should read accounts of the Tuskegee Experiment in which treatment for syphilis was withheld from some 400 black sharecroppers in Alabama in order to chart the 'natural history of the disease'" (Farmer 1992:297). The reality and the historical narratives of the Tuskegee Experiment and other incidents of maltreatment and deception feed conspiratorial thought and become prototypical, a "symbol of . . . mistreatment by the medical establishment, a metaphor for deceit, conspiracy, malpractice and neglect, if not outright genocide" (Sobo 1995:44). Contemporary legends articulate attitudes that are already there, below the surface and sometimes inaccessible, in response to more formal means of assessing cultural concerns. The narratives have to be contextualized in ways that trace relevance structures: personal, social, cultural, and comparative.

Comparative analysis is one of the most fruitful ways of analyzing contemporary legends. As the narratives move from location to location, they take on new motifs, new elaborations, new concerns, and sometimes develop into entirely different narratives. Identifying recurrent patterns in the narratives and locating differences helps to establish cross-culturally tenacious narrative associations and other associations that are more locally significant. Even minor variations can reveal culture specific concerns. The "Welcome to the World of AIDS" narrative described below is reported in some Muslim countries featuring two women and two men. A woman

alone would represent a cultural transgression countering the innocence required to project the narrative's message. Stories of food contaminated with HIV-positive body fluids express considerably different sentiments when told about Burger King than when told about Mr. Hong's Chinese restaurant. The former narrative is likely to be commenting, at least in part, on concerns about the nature of fast-food establishments and big business. The latter variant turns the narrative into commentary on ethnicity and "otherness." Both variations express an association of a place or a people with HIV, an association that may have significant health-belief implications. Patterns of variation can reveal deep-seated health ideas shared within a group or culture. The caution, however, with this type of analysis is that it is easily misinterpreted within essentialist paradigms that generalize statements about thought processes. Essentialist constructions, such as "Newfoundlanders think . . ." or "Canadians agree . . . ," skew the philosophical basis of the effort, which wishes to use ethnography and narrative analysis to demonstrate patterns of shared concerns and cultural differences in conceptualization. The intent is to use a variety of articulations to explore cultural issues, opposing a priori stereotypical constructions.

While cultural variation in the narratives is instructive, so too is their constancy. Although contemporary-legend analysis demands that we recognize changes in the narratives over time and space, legend scholars have also been fascinated with historical consistencies in narrative plots and motifs, sometimes tracing them back hundreds of years. The repetition of narratives that have remained culturally viable and that resurface—albeit in new clothing—centuries later underscores the cyclical nature of cultural attitudes and the centrality of narrative articulations of pervasive concerns. Although AIDS is a new disease, its legends are often reformulations of narratives that circulated in response to smallpox, leprosy, bubonic plague, syphilis, and numerous other historical epidemics. The precursors of current popular health legends are bone chilling in their suggestion that hundreds of years of modern medical advancements make little difference in our gut reactions to illness and disease.

One of the most widely disseminated and frequently told AIDS legends involves a man who meets a woman in a bar, takes her to a hotel or back to his apartment, and sleeps with her. In the morning when he wakes up, the woman is gone. He gets out of the bed and

walks into the bathroom, where he finds a message written on the mirror in lipstick. The message reads, "Welcome to the World of AIDS." Paul Smith notes that Daniel Defoe's *Journal of the Plague Year* (1665) provides an early analogue to the "Welcome to the World of AIDS" narrative (Smith 1990). He quotes:

> A poor unhappy gentlewoman, a substantial citizen's wife, was (if the story be true) murdered by one of these creatures in Aldersgate Street, or that way. He was going along the street, raving mad, to be sure, and singing; the people only said he was drunk, but he himself said he had the plague upon him, which, it seems, was true; and meeting this gentlewoman, he would kiss her. She was terribly frightened, as he was only a rude fellow, and she ran from him, but the street being very thin of people, there was nobody near enough to help her. When she saw he would overtake her, she turned and gave him a thrust so forcibly, he being but weak, and pushed him backward. But very unhappily, she being so near, he caught hold of her, and pulled her down also, and getting up first, mastered her, and kissed her; and which was worst of all, when he had done, told her he had the plague, and why should not she have it as well as he?

Smith (1990) and others (Bird 1996; Brunvand 1989) note numerous antecedents to "Welcome to the World of AIDS," told about herpes, gonorrhea, and syphilis, as well as about incurable mystery diseases. The narratives share in common the notion of a deliberate infector who, upon finding out about his own condition, seeks revenge by transmitting his disease through sexual liaisons. The longevity of this narrative, continually resurfacing with new diseases and new health concerns, suggests the diachronic persistence of concepts such as the infected body as weapon, the personification of disease, and the evil, contaminated "other" seeking revenge. Over the last decade and a half, folklorists have come to refer to the "Welcome to the World of AIDS" story as "AIDS Mary" (or "AIDS Harry" when the antagonist is male). The reference came from writer Dan Sheridan of the *Chicago Times*, who recognized similarities between the narrative and the story of "Typhoid Mary," an Irish American cook (actually named Mary Mallon) who spread typhoid to some fifty people in the early 1900s (Brunvand 1989:197). Typhoid Mary

supposedly knew of her "carrier" status and yet continued to spread the disease for eight years after her discovery of the risk. Sheridan's name for the story demonstrates his immediate recognition of the antagonist in the AIDS story as recognizable from the typhoid narrative tradition.

The motifs in these narratives persist because the vernacular health concerns they describe remain problematic. Stigmatizing the diseased individual, feeling vulnerable in the face of illness, distrusting particular societal subgroups, blaming the victim—all bridge the time span between the plague and AIDS because they still reflect our attitudes toward illness and disease. The case studies explored in the chapters that follow look at these concerns as they emerge in new forms adjusted to a new disease, in a specific social and cultural context. In what remains of this chapter, however, I will more generally explore the AIDS-legend complex as it relates to persistent, recurrent health themes.

Tainted Food and Contaminated Spaces

Contamination narratives are one of the most common forms of contemporary legend, circulating widely and creating panics about commercial products, general household items, or common food items that contain harmful ingredients, insects, parasites, deadly bacteria and viruses, poisons, or substances that consumers would find repulsive. Numerous contemporary legends about HIV/AIDS focus on the contamination of food, objects, or spaces, most often with HIV-positive body fluids, but not infrequently concerning a more amorphous general contamination achieved through close contact or through a kind of "contagious magic." Like all contemporary legends, the AIDS contamination stories combine themes, providing commentary on the disease but also on discomfort with fast food, specific ethnic groups and cultural differences, concerns about government conspiracies, and so forth. While the narratives might suggest, on the surface, a lack of knowledge about the "facts" of HIV transmission, surveys conducted in North America and internationally suggest that knowledge levels are much higher than the continued spread of the disease and reports of practice would lead us to believe (see chapter 3 on risk perception). Nevertheless, contamination narratives suggest difficulties with such issues as casual

contact, low-risk body fluids,[5] and shelf life[6] of the live virus. These apparent incongruities between beliefs expressed in the narratives and reported knowledge concerning the disease could easily be interpreted as the result of lay misunderstanding or ignorance. Such an interpretation, however, treats narrative as a simple conveyor of information and neglects its role as a *social force*. The persistence of narratives that counter belief and knowledge surveys could alternatively be understood as an articulation of distrust of information authorities, resistance, logical reconsideration of issues through independent thinking, or suppression of "facts" in favor of other kinds of cultural truths. The narratives may actually be more about moral discourse than about mechanisms of contracting the virus, but as such they nevertheless reinterpret the disease and have the potential to create a master narrative that can fill interstitial gaps.

Contamination involves contact with something that is too distant from the self, either biologically or socially (Nemeroff and Rozin 1994). It focuses on things that are *outside* getting *inside*. "Dirt," as Mary Douglas argues, is a metaphor concerning things that are out of place. She notes:

> Shoes are not dirty in themselves, but it is dirty to place them on the dining table; food is not dirty in itself, but it is dirty to leave cooking utensils in the bedroom, or food bespattered on clothing; similarly, bedroom equipment in the drawing room, clothing lying on chairs; outdoor things indoors, upstairs things downstairs, under-clothing appearing where over-clothing should be, and so on. (1966:36)

Many contemporary legends involve private acts that are engaged in in public places (the "Castrated Boy," the "Hook," the "Surpriser Surprised"—all acts that are "out of place"). AIDS contamination legends, because of their focus on body fluids, depict both *activities* and *matter* out of place. Tim Cresswell, following on Douglas, notes that bodily secretions have a heightened "out of place" metaphoric connotation. He argues, "The orifices of the body connect the

5. Low-risk body fluids include saliva, sweat, tears, and urine. There is also no evidence that HIV can be transmitted through feces.

6. The shelf life of the virus is how long it lives outside the human body. The viability of the virus will be variable according to the kind of container or surface on which it is found. In general, the virus is extremely fragile outside the body, lasting only minutes to a few hours.

inside to the outside and the stuff that goes into them or comes out of them is subject to the strictest taboos as such substances transgress the inside/outside ordering of the world" (1997:341).

Food contamination legends concerning AIDS are generally not depicted as accidental but rather as occasions of premeditated substitution. In contrast, other food-contamination legends tend to be accidental; the mouse happens to get into the Coke bottle, the severed fingertip falls into the ice cream vat. In the AIDS legends, the contamination is most often constructed as random revenge for infection with the virus. Typically, a male employee of a large fast-food franchise (most often Burger King or Domino Pizza) learns that he is HIV positive. Out of anger and "unwilling to die alone," he ejaculates into the mayonnaise used on the hamburgers and then serves the burgers to unwitting customers. Janet Langlois, who has explored this legend in depth, has dubbed the story "Hold the Mayo."[7] In the coda to the story, the unsuspecting customer gets sick and must have his or her stomach pumped, or the manager acts on complaints of a foul taste by sending the food items to a laboratory, which ultimately discovers the semen after microscopic examination. While the legend is often constructed as a revenge narrative in which the person with AIDS intends to infect others, the story seems to stop short of actually asserting that the consumer contracted the virus from the food item. The report sometimes suggests the belief that you can get AIDS from eating the contaminated food but does not generally go so far as to offer narrative evidence of resulting infection. The following account is typical in this respect:

> You know why Burger King is putting out all those free Whopper coupons? The company is going bankrupt. There is a big lawsuit filed against the company in New England. Some employee had AIDS and decided to get back at people by jacking off in the mayonnaise. You can get AIDS by eating Whoppers. That's why they're giving them away. (Langlois 1991:155)

Like other contamination narratives, the "Hold the Mayo" story focuses on the contaminant itself, more than on the harmful effects.

7. Langlois notes that she borrowed the title from a student's field journal entry, "Hold the Pickle, Hold the Lettuce, Hold the Mayonnaise." She says, however, that this was also the title informally given the rumor by staff at Burger King (1991:168).

Gary Alan Fine notes in his study of the "Kentucky Fried Rat"[8] legend that only 13 percent of the collected narratives discuss resulting illness (Fine 1992:130). Interestingly, while other body fluids are used in the HIV food contamination narratives, blood, despite its association with AIDS, is rarely the fluid of choice. Langlois notes,

> Although blood is one of the most potent ritual symbols . . . and is recognized as a major transmitter of the AIDS virus, rumor and legend literature has noted few instances of blood contaminated commercial food. One exception is Paul Smith's reference to my Palestinian student Dalal Aswad's account of her ten-year-old sister's story of an AIDS-infected McDonald's employee in their Dearborn, Michigan neighborhood cutting his finger and sprinkling blood on the grill. (Langlois 1991:168)

In a similar story, the *Phoenix Gazette* reported that guards in local county jails had requested that they be supplied with alternatives to meals cooked by inmates. One of the training officers interviewed on the issue indicated that inmates sometimes urinate or spit on the food (Sanchez 1995:A1).

The focus in these narratives on semen, urine, and spit, rather than blood, combined with the concentration on the contaminant in the narrative but not the consequences, suggests that the story is more about the repulsive imagery of the body fluids involved than it is about beliefs about the efficient transmission of HIV. This is not to say, however, that the story is not about AIDS. Like the "blood libel" narratives about Jews in the fourteenth century contaminating local wells, the story depicts the HIV-positive person as a danger and a threat to society, a contaminating force by virtue of his or her implied lack of control. That lack of control is depicted in the story not just through the revenge motif but also through the imagery of the potent, diseased, ejaculating male. One version of the narrative collected in Newfoundland indicated, "This guy liked to ejaculate, always, everywhere—he'd cum here or there and in the food and everything." The person with AIDS in the narratives is often depicted as hypersexed, and that hypersexualization

8. This story chronicles a customer who is served a breaded and fried rat in a Kentucky Fried Chicken restaurant.

spills (pun intended) over into the lives of ordinary fast-food-eating individuals.

Most contemporary legend scholars would argue that "Hold the Mayo" is mainly a corporate or mercantile legend, providing commentary on our distrust of fast-food establishments or, alternately, small ethnic businesses. Certainly, the narrative fits into a large category of similar stories about fast-food companies. The choice of contaminator and contaminant, however, is not insignificant. As Langlois notes, "misplaced semen becomes a particularly potent symbol configuring the gendered body, the body politic and social crisis" (1991:160).

Non-food contamination narratives appear to work in a different way. Objects and spaces contaminated by AIDS in legend appear to be impacted *by contact or association*. Contamination by association is clearly illustrated in AIDS versions of the popular contemporary legend known as the "Death Car." In its non-AIDS version, "Death Car" details the story of a very fancy, normally expensive car selling at an incredibly low price. The reason for the low price is that the previous owner had died in the car and had remained undiscovered for a long time, leaving a lingering smell of death in the vehicle. In some versions the car retained a blood stain that was ineradicable, rather than the smell (Sanderson 1969). In the "AIDS car" version, both the smell and the stain are gone; what remains is the disease association. One story in Newfoundland reported,

> In the summer of 1988 an advertisement in a newspaper read '1987 Firebird for sale $1000.' My brother, who was looking for a car at the time, told me about it. Apparently, the owner of this car had AIDS and he had died. The owner's wife was having a great deal of trouble trying to sell the car and thought that reducing the price of the car would make it easier to sell. The story was told to me by my brother and it was told as truth, but I found it very hard to believe considering the facts about how AIDS is spread. (Goldstein 1991:128)

While this telling of the narrative leaves it unclear as to whether or not the car is seen as contagious through some kind of airborne misunderstanding of HIV, other versions suggest that the car had simply taken on negative connotations. In one story, a Newfoundland teacher had died of AIDS, and his family could not sell his

expensive car at all, eventually being forced to dispose of the car by pushing it over a cliff.[9]

The "AIDS Death Car" motifs suggest a kind of contagious magic in reasoning, the belief that physical and moral properties are transferred through contact. Frazer's (1890) magical law of contagion, introduced over a hundred years ago as one of the principles of sympathetic magic (Frazer 1959), detailed thought processes that held that people and objects influence each other through the transfer of essential properties and that that influence continues after the physical contact has ended. From time to time social scientists have suggested that the principle of magical contagion is universally operative in the everyday thinking of adults and can be seen in numerous contemporary daily rituals. Despite the extension of such notions of contagion to quotidian reality, the principle still carries with it an unfortunate connotation of "primitive thought." Further, the notion of "magical" may suggest a conscious metaphysical understanding that is clearly not present in the material referred to here. Nevertheless, associative contamination does appear to address the "AIDS Car" motifs. The car is unsellable because it somehow retains something of the prior owner.

Similar notions are evident in numerous public and even legislative actions taken since the discovery of the virus. Pakistan initiated a ban on importing used clothing after the first HIV-positive case appeared within their borders (Rozin, Markwith, and Nemeroff 1992). Several states in the United States have debated adding AIDS to real-estate disclosure laws, which require that homeowners intending to sell must disclose to prospective buyers any issues that "psychologically impact" a property[10] (Hines 1991). Psychologists Carol Nemeroff and Paul Rozin have explored concerns about HIV contamination beyond microbial risk through a series of experiments involving attitudes toward objects previously owned or held by HIV-positive individuals. Nemeroff and Rozin found that contagion concerns operated both materially and symbolically, often in the same person; prior AIDS contact was seen as both a physical and a moral threat.

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9. It should be noted that disposing of a "perfectly good" car in this manner in a culture that has experienced such poverty is quite a significant statement.
10. Disclosure laws are already pretty interesting. In several states, sellers are required to disclose anything that might have an effect on home purchase, including the reputed presence of a ghost.

The association contagion demonstrated in the "Death Car" narrative and in the activities and experiments discussed above dovetail with a body of legends associated with smallpox and other epidemics that Adrienne Mayor refers to as the "Nessus Shirt" legend. Mayor takes the name for the corpus from Shakespeare's Mark Antony, who cried out, "The shirt of Nessus is upon me!" (1995:54). Death by poisoned apparel, Mayor argues, has been a compelling image in folklore and literature since classical antiquity, but the motif enjoyed incredible revival in variations of "Smallpox Blanket" narratives that depicted infected blankets given by white men to native peoples to wipe the population out (1995:54). The narratives link disease to gifts of personal attire. While smallpox is highly contagious and transmittable through cloth and AIDS is not, the theme of the fatal gift nevertheless pervades AIDS folklore and concerns about contamination. Interestingly, Jan Brunvand suggests that the non-AIDS versions of the "Death Car" legend carry with them the message that you can't get something for nothing (1981:21). The "AIDS Death Car," in that context, like the blanket, suggests a contaminated fatal "gift" from a stranger (in other words, you "get more than you bargained for").[11]

The Deliberate Infecting "Other"

The construction of the infected individual as morally deficient, discussed above in terms of the original legends about New Brunswick Acadians and leprosy, occurs with regularity in relation to epidemic diseases. The more virulent diseases become, the more likely it is that certain groups and individuals will be seen as responsible for the threat on community welfare. In the case of HIV/AIDS, epidemiology's early concerns about homosexuals, Haitians, and drug users provided a series of already marginalized communities ripe for scapegoating. The later educational effort emphasizing risk activities instead of risk groups came too late; the scene had already been set for the association of specific communities with the evils of disease and devastation. Public policy and legal efforts continue to underscore connections between cultural "otherness" and HIV. Immigration laws that exclude HIV-positive individuals from entering

11. This would fall under what George Foster has called "the image of limited good" (1965:309).

countries such as the United States; discussions worldwide about the internment of infected individuals; loss of jobs, homes, and insurance for those who test seropositive or for those who refuse to take an antibody test; and the creation of new HIV-related criminal legislation in numerous countries and jurisdictions—all add to the growing sentiment that the world is divided into "them" and "us," the "positives" and the "negatives." In this context (which is already poised by human nature to scapegoat), the *infected* other becomes the *infecting* other. As Elizabeth Bird notes, "The AIDS sufferer is a victim-turned villain[12] in the popular mind, recalling the lepers, and maimed, crippled evil-doers of popular culture" (1996:50).

While contemporary legends about AIDS are numerous and varied, by far the most popular and consistent theme is deliberate infection. Such stories range from "Lipstick on the Mirror," "Pins Used to Deliberately Destroy Condoms," and "Hold the Mayo," all noted above, to narratives concerning AIDS-infected stick-on tattoos (containing millions of small infected needles) sold to children, prisoners who slit their wrists and attempt to infect their guards, HIV-positive hotel robbers who are caught on security cameras contaminating toothbrushes of hotel guests before leaving with their valuables, and dozens of others. While different in structure,

12. Moral-panic theorists refer to the creation of "folk devils"—individuals or groups seen as perpetrators of a major threat to the social order (Cohen 1973). Moral-panic theory shares many issues of interest with contemporary-legend scholarship. Stanley Cohen, who is credited with systematically introducing the concept, defined it by writing the following:

> Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more visible. Sometimes the subject of the panic is quite novel and at other times it is something which has been in existence long enough, but suddenly appears in the limelight. Sometimes the panic passes over and is forgotten, except in folklore and collective memory; at other times it has serious and long lasting repercussions and might produce such changes as those in legal and social policy or even in the way society conceives itself. (Cohen 1973:9)

One of the major criticisms of moral-panic theory concerns its insistence on disproportionality as a primary characteristic, focusing on the irrationality of the societal response to the issue (Thompson 1998:10). While this characteristic fits well with trends in contemporary-legend research focused on debunking narratives, it moves us away from the "hermeneutic of generosity" discussed later in this chapter.

the stories share two striking motifs, often nearly identical in their articulation: the infected individuals find out about their HIV status and reason, "If I am going to die, I am taking other people with me"; and, despite variation in plot, the tagline ("Welcome to the World of AIDS" or "Welcome to the AIDS club") is incredibly consistent. As is seen with the Defoe excerpt, the motive and even the tagline have historical precursors. The infector in these narratives has murderous intent, portrayed as a desire for random revenge. Generally, the attack is not directed at specific individuals, which makes the revenge motif even more frightening as it suggests that everyone is equally at risk (Best 1991:113). The "Welcome" tagline makes the interaction all that much more sinister in its seeming self-satisfaction with communicating the virus.

Parallel to the "Welcome to the World of AIDS" narratives is a series of localized panics related to specific, sometimes even named, individuals constructed as AIDS villains. In 1991 a letter published in *Ebony* magazine by a writer signed C. J. AIDS, Dallas, Texas, began a huge local and even national scare. The letter said,

> I have AIDS. No one knows it. I go to clubs more now so I can meet new men. I feel that I am a beautiful person and I couldn't believe I got it. I sleep with four different men a week, sometimes more. I've slept with 48 men so far, some of them married. I feel if I have to die a horrible death I won't go alone. I know I'm not right in what I'm doing. Can you tell me what's wrong with me? Why don't I feel guilty? (*Ebony* 1991:90)

C.J.'s letter was eventually exposed as a hoax but not before creating terror in the Dallas community (Bird 1996).

The C.J. story is similar to a panic created in Dungarvan, Ireland, in 1995, when Father Michael Kennedy, a parish priest, told his congregation that a twenty-five-year-old woman with AIDS had confessed to sleeping with between sixty and eighty men in the area. According to *The Guardian*,

> Father Kennedy said the woman had emigrated to London 10 years ago. She returned last November, picking up her victims in pubs and nightclubs across four counties. "Out of her anger and desperation she wanted to get her own back on as many as she possibly could," said the priest, who is a cousin of Senator Edward

> Kennedy and officiated at the wedding of a daughter to the American ambassador to Dublin, Jean Kennedy Smith. (1995:2)

The Dungarvan "Angel of Death," as she was called, was never arrested; and area health officials found no evidence of truth to the story, nor was there any resulting increase in local HIV statistics.

Rumors of localized "Angels of Death" and "Black Widows"[13] are supported by the many legal cases of nondisclosure of HIV status that have been prosecuted in the last decade and a half. These cases help to construct an image of uncontrollable hypersexed AIDS criminals or outlaws intent on infecting their innocent victims. While legal cases of "deliberate" infection generally involve one or two counts of the crime, narrative tradition often wraps itself around the local and media accounts inflating the numbers of individuals infected by the defendant (see chapter 6) and portraying sensational murderous intent. Unfortunately, both the narrative tradition and its effect on the media and public opinion do significant damage to the notion of safe sex as the equal responsibility of all partners.

In many of the deliberate-infection narratives, the aggressor is portrayed as a member of a threatening ethnicity or social group—a group already thought to have eroded morals. The infecting other is often a person who was already thought to be a predator: a prostitute, a foreigner, a homosexual, a criminal, or some other *known* individual. Gilmore and Somerville refer to this as "double scapegoating"—people who are scapegoated on the basis that they are HIV positive are people who were already scapegoated on some other basis (1994:1346). Beyond associations with crime, Islanders blame Mainlanders, Anglophones blame Francophones, one community blames another—but often with a certain closeness between the blaming and blamed groups, reflecting localized rivalries. Gilmore and Somerville suggest further dualities that are intrinsic to the localized assignment of blame:

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13. Early deliberate-infection narratives featured women as antagonists, inspiring Gary Alan Fine to explore the narratives as functioning more as discussions about relationships between women and men—articulating revenge fantasies toward men for rape and expressing male collective paranoia toward women (Fine 1987). In the 1990s deliberate-infection narratives featured male antagonists as often as female, but localized rumors such as C.J. or the Dungarvan "Angel of Death" still seemed to focus on women. Interestingly, legal cases attempting to prosecute AIDS crimes focus nearly always on males.

> Duality is . . . intrinsic to scapegoating, namely that the the scapegoated person is at once seen as innocent and guilty; human and dehumanized; identified with the persons undertaking the scapegoating and disidentified from them. People who are scapegoated must be sufficiently similar to the people who scapegoat them to allow the scapegoater's problem which triggered the scapegoating to apply to them. At the same time, however, they must be sufficiently different that it is possible to blame them or find them guilty, without finding oneself likewise blameworthy or guilty and, consequently, to justify expelling them as a scapegoat. (1994:1346)

The Number and Names Game

The fear of randomness expressed in the deliberate infection narratives is ironically accompanied in tradition by a fear of specificity, expressed through a series of narratives that place the virus in hugely inflated proportion in one's own backyard. One of the narratives that has circulated extensively or that may indicate polygenesis (multiple origins) indicates that a high-school blood drive rejected a high percentage of locally collected blood due to HIV found in testing. The venue of this narrative varies, but the result is HIV found locally in epidemic numbers. Mike Royko, a Chicago newspaper columnist, reported a phone conversation that he had received from an elderly man. The man said:

> "I'm calling to give you a story about a very shocking and dangerous situation that is being covered up by school officials in Hoffman Estates. A volunteer blood drive was held at the Conant High School," the man continued. "It was for senior students only. Blood was given by 317 seniors. The blood has since been tested, and 61 tested positive for the HIV virus." (Royko 1992:C3)

Royko interviewed the principal of the school, who reported that 125 students and 37 teachers donated blood and none of the donations had tested positive for HIV. The blood-drive rumor, however, continues to appear periodically in new locations. Barbara and David Mikkelson have reported the following:

> The rumor has raced through Chicago (1992, 20% of the students in one particular high school), Los Angeles (1992, 12%),

> Dubuque (1996, "dozens of students"), Kansas City (1996, 15%), Orlando (1992, "dozens"), Seattle (1992, 15%), St. Petersburg (1991, 20%), Orange County, CA (1987, 14%), Sonoma County, CA (2001, 82%). (2001)

While most versions of the story show a fascination with numbers, similar narratives simply characterize the suggestion that the local community is the "AIDS capital of the World" or suggest that the "bloodmobile" was immediately removed from the neighborhood following testing (see chapter 6). Whatley and Henken reported that the numbers story circulated in Athens, Georgia, in 1996, claiming that 35 percent of donors at the student blood drive tested positive for HIV (2000:76).

While Whatley and Henken discuss the negative impact of the narrative and the resulting drop in blood donations, they also note that the narrative indicates positive recognition of the possibility of HIV in one's own group (2000:76). As Sobo and others have argued, the emphasis in early public-health messages on knowing your partner has helped to create the perception that it is safe to have sex with people you know because they are less likely to be infected (1995:30). Whatley and Henken suggest that the blood-drive narrative indicates a move away from the "stranger danger" notion that exposure is more likely outside the safety of your own community (2000:75–76).

In Newfoundland, the epidemic numbers story circulated with the added motif that initial samples from the school blood drive suggested so many positive donors that public-health officials were going to conduct house-to-house mandatory testing. The blood-drive and mandatory-testing narrative suggests links to another story found extensively in Newfoundland, either as a relatively undeveloped rumor or attached to other AIDS legends. Current AIDS narratives frequently feature mention of a list, either developed as a "hit list" in deliberate infection narratives or as a long list of sexual contacts given to public health by someone who tests positive. One of my colleagues wrote to me in 1989, for example,

> [A]nother student had heard that there are "four girls down at the Sundance [a local popular bar] who have AIDS and that the police

> have compiled a list of contacts. . . . [She] made a gesture as if to say "long as your arm," as if she were rolling out a scroll.

The "List" narratives comment on excessive numbers of infected local individuals (similar to the blood drive) but also suggest fear that contact tracing might lead authorities to individuals too close to home for comfort. One narrator from a community near St. John's indicated,

> I know there was a girl from my community who was going to the doctor for an entire year and he was treating her for flu when finally he sent her for a blood test. The test showed that she had full blown AIDS. She was admitted to the hospital and two weeks later she died. It was going around that she gave fifty-four names of the men she slept with. There are also a few from my home town who people believe have the virus and are maybe even passing it on to their wives.

The "List" narratives carry with them not just the implication of large local numbers of infected individuals but also the added theme of those individuals being specifically named. The identification motif posits the frightening possibility that, correctly or not, one could find one's own name present on the list of infected individuals. Fear of identification on such a list mirrors larger anxieties about methods of medical epidemiological contact tracing, providing a vernacular critique of a practice that is seen to have the potential to "implicate" individuals on the basis of hearsay. Debates about epidemiological contact tracing have focused on this very concern—exploring how one should learn of one's serostatus and who has the right to discover someone else's. It is possible that list and naming anxieties, popular also in contemporary legends of crime "hit lists,"[14] suggest concerns parallel to classical notions of the possession of someone's name as having power over the individual. Being named on the list is life changing even if the identification is incorrect; one "becomes" HIV positive by implication whether or not one's serostatus or contact with the original individual

14. These hit-list narratives are currently popular in the context of stories about school shootings. Following the Columbine shooting, numerous hit-list stories appeared in North American papers.

is confirmed. In this sense, in a small community, being named is nearly as frightening as being infected.

Conspiracy Theory

Conspiracy beliefs are widespread in medical folklore and are rife throughout the subgenre of AIDS legends. The traditions articulate the distrust of government and medical officials that underlie lay responses to the AIDS crisis. The narratives implicate the government, the CIA, scientists, and medical researchers in a variety of AIDS cover-ups largely linked to targeted genocide. Conspiracy narratives suggest that government created or nurtured the AIDS virus to control "undesirable" populations: the poor, people of color, homosexuals, drug users, prisoners, and other marginalized communities. Conspiracy theories suggest that government was responsible for the origin of AIDS (that it was man-made in laboratories, accidently created through government mishandling of vaccines, or created in a government experiment in biological warfare), that transmission vectors are hidden in the daily life of targeted populations (contaminating particular ethnic foods or certain neighborhood food establishments or sprinkled contaminants on the floor of gay bathhouses), and that there are known cures that government refuses to release (because the virus is so efficiently wiping out minority and undesirable populations).

Patricia Turner quotes a typical articulation of AIDS conspiracy belief from an African American/Seminole woman, who reported,

> The story was told to me by an aunt. Apparently the CIA was testing to find a disease which would resist any cures known to man. They did this testing somewhere in [South] Africa. The purpose of finding this incurable disease was to bring America back to the old days of the moral majority. Therefore this disease was to be transmitted sexually among the outcasts of society, namely people of color and gay men. (Turner 1993:159)

The conspiracy theory of AIDS origins is particularly popular in Africa and Haiti, forming a cultural critique of the industrialized West and, as Paul Farmer (1992) argues, a counterprotest of those who themselves have been accused of introducing AIDS to the United States. As Paula Treichler notes,

> The notion that AIDS is an American invention is a recurrent element in the international AIDS story, yet one not easily incorporated within a Western positivist frame, in part, perhaps, because it is political, with discursive roots in the resistance to colonialism; the Western response, accordingly, attributes it to ignorance, state propaganda, or psychological denial. (Treichler 1989:43)

Treichler's comments reflect the Western political discursive tradition but not the extent of conspiracy belief in North American *vernacular* tradition. In North America, like in Africa and Haiti, conspiracy theory appears to also be most often reported among those communities regularly "blamed" for the disease. Ethnographies, particularly of African American AIDS traditions, suggest that notions of government and medical origins or cover-ups have a significant hold in popular belief. Less work has been done exploring the extent to which AIDS conspiracy beliefs are held within the general North American population. Recent surveys, discussed in the next chapter, suggest a more widespread sense of distrust along with the perception that AIDS conspiracies are at least possible in the current medical and political climate.

Because blame is ever present in epidemic and health crisis situations, it is not surprising that conspiracy beliefs arise as a counterattack from those who feel disempowered in general, but even more significantly in the face of such blame. It is important, however, that counterattack theory not lead analysts to be dismissive of conspiratorial thinking as simply a mechanism of defense. Conspiracy theories point to areas of vernacular concern and highlight basic notions of distrust, the identification of inequalities in the system, and areas of clash in medical worldviews. Paul Farmer suggests reading conspiracy theories with what he calls "a hermeneutic of generosity":

> What might happen if we were to insist that such commentary is worthy of investigation? What might happen if we were to proceed as if our informants were themselves experts in a moral reading of the ills that afflict them? What follows is an attempt to extend a "hermeneutic of generosity" to the very notions dismissed as paranoid rubbish by the experts. Such an exercise leads us once again to an interpretive analysis accountable to history and political economy, the force field from which the conspiracy theories initially rose. (Farmer 1992:235)

Farmer's hermeneutic of generosity captures the spirit in which the following chapters were written. Each case study attempts to address the concerns and ideology behind the narrative, focusing on the AIDS legend as an articulation of vernacular perceptions of risk. First, however, it is important to explore risk and notions of vernacular perception as they are understood by health educators, public health researchers, and social scientists. It is to that task that we turn next.