One muggy summer day in Massachusetts, an outreach worker and an investigator on a study of HIV transmission and syringe use were collecting discarded syringes in an urban park. They encountered a Latino couple who appeared to have just gotten high in the woods at the edge of the park. Although Antonio, the outreach worker, assured them that his colleague was a teacher engaged in research, not law enforcement, the latter’s photographs of discarded syringes nevertheless provoked enough discomfort that the woman blurted out, “We always use bleach!” Her assertion constituted her as an ethical actor who practices harm-reduction techniques because she understands the risks to which she is subject. It also could be heard as a move to shield her from further scrutiny and engagement with the ethnographer.

Assertions like “We always use bleach” center our analysis of the emergence of harm-reduction discourse and strategies in illicit drug-using worlds in the United States. Ethnographers play central, if ironic, roles in efforts to shift the practices of illicit drug users toward minimizing health risks associated with drug use. Such efforts run counter to entrenched and continually renewed constructs of illicit drug use that consider anything other than complete abstinence immoral. Despite official and popular opposition, harm reduction became sufficiently institutionalized within the public health community that its tenets were integrated into federally
funded research and propagated by ethnographers and Community Health Outreach Workers (CHOWs). Caught between “the state” and its subjects, ethnographers are situated where they can discern drug users both inventing and unevenly adopting harm-reduction practices. The story of harm reduction adds an interesting chapter to the history of critical ethnographic practice, showing how the state relies on ethnographic surveillance of drug users even while ethnographers seek to document the multiple ways in which their interlocutors resist such scrutiny. This essay traces a brief history of ethnographic drug research and then describes several scenes in which ethnographers and “subjects” incite one another to become coproducers of harm-reduction discourse. Concluding that ethnographic practice serves as both instrument and effect of governance, the essay hopes to provoke further analysis of the ethnographic state (Campbell 2007:200–202).

Origin stories about harm reduction construct it as a response to hepatitis and HIV/AIDS in Western Europe, perhaps Amsterdam, Rotterdam, or Liverpool, sometime in the late 1970s or early 1980s (Massing 1998:10–11; O’Hare et al. 1992; Reinarman and Levine 1997:345–361). Far more developed outside the United States, homegrown harm reduction has been officially repressed. However, risk reduction practices have long circulated informally in the United States among those dealing with needle-borne health conditions. As a public discourse, harm reduction did not find a platform in the United States until the HIV epidemic intensified in the 1980s and 1990s, when an influx of federal public health funding released in response to AIDS activists’ protests spurred a reorientation from a criminal justice to a public health approach toward drug use. By the mid-1990s, the media had begun to characterize the War on Drugs as a policy failure (Reinarman and Levine 1997:349–351), discrediting the widespread (although continued) incarceration of nonviolent drug offenders as ineffective in preventing drug use. In conjunction with this grassroots movement, community health outreach workers and ethnographers conducted “shoe-leather ethnographic research” (Reinarman and Levine 1997:351; see also Broadhead and Fox 1990).

Unofficially, harm reduction diffused into the discursive repertoires of drug users, outreach workers, and ethnographers. Its origins can be glimpsed in the pragmatic “harm minimization” approaches of the Nixon administration (Campbell interview with Jaffe 2007; Massing 1998; Musto and Korsmeyer 2002). Social scientists were attracted to the study of drug abuse during the 1970s expansion of federal and state resources for studying it (Campbell interviews with Jaffe 2007; Maxwell 2005; and Spence 2005). The national scaling up of a treatment infrastructure with some “harm minimization” features (i.e., methadone clinics),
provides a ready example of how structural and discursive conditions combine to produce ethnographic subjects. At the time, nearly all knowledge about drug users was produced by ethnographers stationed in methadone clinics or snowballing from their patient base. This practice convinced ethnographers that understanding how drug use worked meant studying those not enrolled in treatment. Few resources became available for doing so until the epidemiological discovery that intravenous drug use was a major mode of HIV transmission in the United States (Des Jarlais and Friedman 1988). This discovery enabled a major historical shift that promoted state-funded drug ethnography to the position of prominence we analyze in this essay.5

IMPORTANT DATES IN THE HISTORY OF HARM REDUCTION AND DRUG ETHNOGRAPHY

1937 Supervised by Herbert Blumer and Edwin Sutherland, respectively, Alfred Lindesmith and Bingham Dai finish dissertations at the University of Chicago. Both rely on qualitative interviews with heroin addicts.
1967 Blumer publishes the ADD Center Project Final Report on Youth Drug Use.
1973 The National Institute of Drug Abuse (NIDA) is established.
1976 NIDA forms the Community Epidemiology Work Group to provide community-level surveillance of emerging drug use patterns and hidden populations.
1976–79 NIDA holds meetings on ethnography with the Drug Enforcement Administration (DEA) in Key Biscayne, Florida, in 1976 and in Chicago in 1979.
1979 NIDA invests in ethnography after Feldman’s four-city study reveals PCP entering and diminishing these cities without ever showing up in national surveys.
1983 Retrovirus later named HIV isolated by Françoise Barre at the Pasteur Institute in Paris.
1986 The Lindesmith Center, now called the Drug Policy Alliance, is established.
1986 Injection drug use is identified as transmission route for HIV.
1987 Multisite NIDA ethnographic study on HIV and injection drug use.
1989 First International Harm Reduction Conference held.
1991 Former drug czar Bob Martinez and former Centers for Disease Control (CDC) director Bill Roper embark on objective review of syringe exchange programs.

1992 NIDA becomes one of the National Institutes of Health.

1993 Clinton administration obtains data showing efficacy of needle exchange programs for reducing HIV transmission but refuses to make it public and does not permit it to be disclosed under the Freedom of Information Act.

1996 First National Harm Reduction Coalition Conference held in Oakland, CA.

1999 NIDA funds the Syringe Access, Use and Discard Study.


2004 U.S. Rep. Mark E. Souder, Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, writes a letter to Dr. Elias Zerhouni, Director of the National Institutes of Health, arguing that syringe exchange programs encourage drug use. NIH-funded researchers decry the misuse of evidence and defend the research, theory, and practice of harm reduction.

2004 Under the editorship of Ernest Drucker, the journal *Harm Reduction* is launched.

2005 Congressional hearings on harm reduction as a form of “harm” held by Rep. Mark Souder.

**ENTWINED HISTORIES**

Drug ethnography demonstrates how a critical discourse—and a set of critical ethnographic practices—can be absorbed by the state and reshaped into a regulatory surveillance regime. What we are calling “drug ethnography” grew out of sociological struggles to define inductive, qualitative social research traditions. Drugs and drug users provided conceptual and material resources to the so-called Chicago school of sociology, starting with dissertations by Bingham Dai (1970[1937]) and Alfred Lindesmith (1937, 1947). An ardent critic of U.S. drug policy, Lindesmith advocated a public health approach and became the object of concerted harassment by the Federal Bureau of Narcotics (Becker 2005; Keys and Galiher 2000). Lindesmith was interested in how opiate users redefined themselves as “addicts” through an interpretive learning process. Downplaying incidence rates and statistical representations that we would now define as “epidemiological,” Lindesmith (1947:5) resisted conventional typologies through which addicts were categorized and wrote about opiate addiction as a social learning process rather than a “natural” physiological process (Becker 1998:197). Howard S. Becker’s 1953 study, “On Becoming a Marijuana User,” which formed the core of *Outsiders: Studies in the Sociology of Deviance* (1963), was based on first- and secondhand knowledge of the experience of smoking marijuana without getting high the first time. Working as a jazz musician shaped Becker’s view of drug use as an activity that amounted to a “career,” a
fruitful research trajectory for generations of drug ethnographers (Rosenbaum 1981). Becker bent sociological understandings of the legitimate professions toward the “deviant careers” of nonprofessionals.

Although Becker and Lindesmith wrote about people categorized as marijuana users or opiate addicts, they did not mistake membership in a social category for an ontological state. For them becoming a drug user was a social process governed by a set of activities, norms, and epistemological moves. For Becker, the habitual sociological distinction between deviant and nondeviant was not an ontological claim about “social types”:

Both Lindesmith and I talked (as everyone else does) of kinds of people. . . . But we used those expressions as a kind of shorthand, a way of noting that some people engaged in these activities in a more or less routine or regular way. We meant readers to understand (though they often didn’t) that these usages were shorthand, and that the subjects of our research were just ordinary people who happened to do these particular things a lot. [1998:46]

Sociologists who specified the characteristics of drug users thought that charting parameters of “deviance” would destabilize rather than reinforce the division between the “normal” and the “pathological.”

Ethnographic methodologies denaturalized working assumptions about what counted as “deviant.” Drug worlds provided a resource for the critical sociology of deviance, which expanded along with widening popular drug use in the 1960s. By contrast relatively few anthropologists studied drug use. Heir to Chicago sociology, a West Coast cluster anchored by Patrick Biernacki, Harvey Feldman, Alan Sutter, and Dan Waldorf was associated with the Bay-area Institute for Scientific Analysis (ISA). An East Coast cluster owed more to the intellectual history of cultural anthropology. Edward Preble, who with John Casey wrote the classic text of drug ethnography, Taking Care of Business (1969), redefined perceptions of drug users as “escapist” by displaying the sheer amount of work it takes to maintain an active heroin habit. Building on Preble’s work, a cadre of drug ethnographers worked the streets of New York as the city and state sought data on rising heroin use. The New York State Narcotic Addiction Control Commission (NACC) brought in Michael Agar, an anthropologist who had worked at the U.S. Public Health Service Narcotic Hospital in Lexington, Kentucky (Agar 1973, 2002; Campbell 2007); James Inciardi, a parole officer who became a leading drug ethnographer based in Miami; and Columbia sociologist Bruce D. Johnson, now at the National
Development and Research Institutes (NDRI), a large “ethnography shop” that grew out of NACC and the New York State Division of Substance Abuse Services (DSAS). Each now claims to have known little about ethnographic practice when they began and to have learned about fieldwork from Preble.

Epidemiology, however, was imported into drug abuse research in the late 1960s with the framing of addiction as an infectious or “epidemic” disease that “followed the course of contagious diseases, fluctuating from periods of epidemic spread on the one hand to relatively quiescent periods on the other” (Hughes et al. 1972:1000). Advocating “epidemiologic field teams” to displace the problematic emphasis on the psychological and sociological characteristics of “diseased individuals,” Hughes and colleagues display the tension between knowledge production systems that rely on individual behavior and those that rely on statistical aggregates (1972:999). An epidemiological discourse of risk was nascent in the mid-1970s, yet neither ethnography nor epidemiology received much attention within the drug research activities funded by the National Institute of Drug Abuse (NIDA) on its inception in 1973. Ethnography was viewed as critical of law enforcement; ethnographers feared that any association between the ethnographic enterprise and law enforcement would compromise access. At meetings held with the Drug Enforcement Administration (DEA) in Key Biscayne, Florida, in 1976 and in Chicago in 1979, ethnographers “opposed common research undertakings; and the idea of ethnographic field stations was shelved” because of the law enforcement presence (Feldman and Aldrich 1990:22–23; Campbell and Spillane interview with Inciardi, June 2006). Drug ethnographers avoided seeking National Institute of Justice (NIJ) funding, instead using ethnographic practices to respond to states’ and municipalities’ desire to understand the dimensions of their drug problems.

As conceptual practices epidemiology and ethnography remain distinct. However, epidemiology sometimes reveals “unexpected dynamics requiring [ethnographic] clarification” (Bourgois 2002:259). Not only was NIDA aware of this, according to Inciardi, but “the biggest push ethnographers ever got was from NIDA” (Campbell interview with Inciardi 2006:30). Ethnographers gain access to so-called hidden populations who might otherwise elude the normalizing gaze of public health. The term “hidden populations” was taken to euphemistically refer to those who are disadvantaged and disenfranchised: the homeless and transient, chronically mentally ill, high school dropouts, criminal offenders, prostitutes, juvenile delinquents, gang members, runaways, and
other “street people”—those we are all aware of to one degree or another, yet know so little about. . . . The very individuals who might benefit the most from drug abuse treatment and prevention efforts are the least studied, the least understood, and the most elusive to epidemiologists, clinicians, researchers, and others concerned with understanding and improving the public health of these populations. [Lambert and Weibel 1990:1]

Thus, confined to the terrain of that which eluded epidemiological explanation, ethnographers worked within NIDA’s Community Epidemiology Work Group from its inception in 1976 to identify emergent drugs and drug-use practices.8

NIDA support for ethnography did not expand until Charles R. (Bob) Schuster, the behavioral psychologist who pioneered the concept that drugs work as powerful “reinforcers” of learned social behaviors, became director in the late 1980s. His administration used ethnography to understand how users not in treatment responded to public health interventions (Campbell interview with Bob Schuster, June 2004). Research, service, and surveillance converged to justify maintaining governmental support for ethnographic research with drug users, beginning in the context of the Reagan administration. Each of these governing relationships contributed ethical, scientific, and political justifications in an administration that Schuster saw as “very, very viciously dedicated to getting rid of drug abuse primarily by getting rid of drug abusers,” and that forbade the discourse and practice of harm reduction. The enduring classificatory scheme that consigns nonmedical drug users to the category “criminals,” while designating medical users as “patients” suffering from a “disease” (Becker 1963; Lindesmith 1947) positions harm reduction as an always alternative and immoral commitment. Thus, the project to reposition harm reduction as an ethic of care—and drug users as ethical subjects—provided a counterweight to the abstinence-only messages of the Just Say No campaign.

Despite proscriptions, NIDA invested in ethnographic studies of drug use and deliberately used ethnographers to get harm-reduction messages out. “We wanted to set up needle exchanges but we were forbidden to do that [by the administration in which I worked]. We were allowed to pass out bottles of bleach and teach people to clean their needles so they would disinfect them,” said Schuster. Grantees were instructed not to budget for bleach but to request funds for “miscellaneous supplies” (Campbell interview with Roy Pickens, January 2007). Ultimately found less effective depending on how it was used,9 bleach was based on underlying principles of harm reduction and was seen as the next best thing to needle exchange. “The reason
why we could not use needle exchange was because in the Drug Abuse Act of 1988 [Congress] specifically stated that no federal funds will be used for support of needle exchange until the Surgeon General certifies two things: (1) that it decreases the spread of HIV infection and (2) that it decreases drug abuse” (Campbell interview with Bob Schuster, June 2004). Congress was concerned that “if we made it safer for people to use drugs, more people would use drugs. If you used the term ‘harm minimization’ in the federal government at that time and now to some extent, you would have to wash your mouth out with soap” (Campbell interview with Schuster, June 2004).10

Officially, harm reduction remained unspeakable in federal policy. Continuing in the same vein, the Clinton administration suppressed a 1992 Centers for Disease Control (CDC) review showing needle exchange reduced HIV transmission, which recommended lifting the ban.11 Harm-reduction principles were put into practice beneath official notice; the extent to which drug ethnographers were aware of their role as “officially unofficial” conduits for harm-reduction practices remains unclear (see, e.g., Broadhead and Fox 1990; Kane and Mason 1992). Ethnographers were expected to convey harm-reduction practices—not unlike public health educators and outreach workers—while collecting data on the degree to which users adopted harm-reduction norms. Stephanie Kane and Theresa Mason, who worked on a multisite NIDA-funded ethnographic study beginning in 1987, noted that ethnographers were not only supposed to determine what factors influenced drug use and sexual practice but also to “act as catalysts for the cultural changes necessary
to reduce the prevalence of high-risk behaviors” (Kane and Mason 1992:200). “Intervention,” “risk reduction,” and “harm reduction” became primary goals of ethnographers, while epidemiological notions of “risk groups” categorized populations based on behavior and helped individualize harm and personalize prevention (Lupton 1999; Petersen and Lupton 1996). By isolating behavioral factors that increase HIV risk, ethnographic researchers helped construct the “injection drug user,” or IDU, as the subject of such studies.

Ethnographic encounters stage performative relationships between representative knowers, who are taken to embody norms supposed to reduce risk, and representative users, who are represented as risk-bearing subjects. Subject formation takes place within encounters in which ethnographers deliver information on harm and risk reduction while collecting data (e.g., Broadhead and Fox 1990; Mosack et al. 2005). Understood to play an important role in documenting emergent drug use practices, ethnographers circulate stories about risk that inform public health interventions, document adoption or rejection of them, and provide evidence of their effectiveness. Viewed as arising from drug users themselves, harm reduction, like drug ethnography, achieved a degree of legitimacy based on its perceived efficacy at reaching “hidden populations.” As it did so, it became an alternative governing mentality and a set of normative practices that drug users knew they should adopt (Singer 1992). After decades of harm-reduction education delivered in health care settings, drug treatment centers, and by street outreach workers, IDUs know the appropriate things to say when asked, “Do you [how often do you, why do you] share your works?” The very practice of social science research on drug use and HIV prevention sends the message that researchers are concerned about syringe sharing and obsessively focused on drug paraphernalia. During ethnographic research on HIV risk among people who inject drugs, participants would repeat these mantras—“I always use bleach” and “I never share needles”—even while failing to use bleach or using their partner’s needle before an ethnographer’s eyes. Repeated invocations have multiple aims, including the dismissal of moralistic claims issuing from the public health domain, shielding users from further “intervention,” and establishing ethical harmony between participant and researcher.

Harm reduction was simultaneously constructed in and through grassroots mobilization and public health research, outreach, and education (Erickson et al. 1997; Feldman 2001). Social movements and public health bureaucracies alike transformed epidemiological constructs into behavioral guidelines that were promulgated through an institutionalized and even standardized set of beliefs and
practices issuing from high reaches of the federal public health apparatus. Alternately repressed and promoted, harm reduction became a normative set of practices that expanded far beyond drug use and the attempt to contain HIV transmission (Nichter 2003). How did drug users learn what they should say in response to ethnographic interviews? How have harm-reduction norms been created, enacted, and enforced by the harm-reduction movement and public health educators? Finally, what role did researchers and outreach workers play in this process of cultural diffusion? Campbell’s historical work on the constitution of drug users as objects and subjects of knowledge (1995, 2000, 2007) suggested that addicts have long been represented as unreliable subjects, incapable of self-government, and by extension undeserving of public trust. Getting drugs users to adopt “protective” features of self-government departed from both paternalist and prohibitionist discourse. By vesting some degree of trust in drug users, harm reduction presumes that drug users can and do change out of concern for their own health and that of others (Feldman 2001). Harm-reduction discourse assumes that drug users are ethical subjects who can use the results of ethnographic and epidemiological research to reduce the harms and risks to which they are exposed.

The association between HIV transmission and needle sharing drove the expansion of both the epidemiological and ethnographic enterprises within drug abuse research in the mid-to-late 1980s. Viewed as more than a supplemental nicety, the ethnographic enterprise expanded within many biomedical institutions during this period. Anthropologist Michael Agar claims that ethnography becomes interesting to biomedical institutions “when paradigms crash” (Agar 2002). Such institutions evolve routines in accord with their prevailing conceptual frameworks; when these “no longer work, the problems become too varied or too different from what used to walk in the door, then institutions have no idea how to proceed. At this point, the question surfaces, ‘what in the hell is going on out there?’ Exactly this question, phrased in more elegant ways, motivates those who fund ethnographic research” (Agar 2002:251). This point is illustrated by a four-city study that piqued NIDA’s interest in ethnography because it showed PCP entering and diminishing within these cities without showing up in national surveys (Feldman et al. 1979). Yet NIDA only became enthusiastic about building ethnographic capacity after discovering that needle sharing was associated with HIV transmission in the United States (Feldman and Biernacki 1988; Wiebel 1988). It is just then, in the late 1980s, as drug ethnography is recognized by state agencies as valuable research methodology, that its outreach and service delivery role also becomes more apparent. As two key drug ethnographers articulated it at the time:
Ethnography and the experience of street-based interventions have accumulated evidence that the notion that IV drug users are hard to reach and resistant to change may be in serious error. The experience of street-based efforts in San Francisco, Chicago, and now several other cities has demonstrated that addicts are receptive and responsive to educational campaigns and will change certain behaviors as long as the necessary changes do not require alterations of customs, values, and lifestyles that are essential to their identities and cultural associations. . . . The strategy of employing ethnography as the forerunner to aggressive outreach to IV drug users at risk for HIV infection has now been expanded to 27 major American cities. As these ethnographically based projects develop, one result may be the creation of a structure for the delivery of health care, early intervention, and social services to inner-city communities that is new and more closely tailored to the needs of urban populations. [Feldman and Aldrich 1990:22–23]

The new service model cast ethnographers as public health advocates who embodied and transmitted new social norms. This model represented practical and epistemological shifts that complicated the relationship between ethnographers and drug users. Seasoned ethnographer Sheigla Murphy noted that harm-reduction policy is construed as “sending certain messages” that diverge from abstinence norms (Campbell interview with Sheigla Murphy, 2003). Not only is public policy a symbolic system that expresses and conveys messages about governance, so too does the ethnographic research process work on symbolic as well as instrumental dimensions. Knowledge production practices have symbolic aspects that help to govern subjects constructed by others as unruly and unreliable. In response to such constructions, users define themselves as ethical beings concerned about the effects of their drug use on themselves and others, and who act responsibly to reduce negative consequences: “We always use bleach!”

ETHNOGRAPHY AND/AS GOVERNANCE

Substance abuse has been recognized as a key site where “governmentality” hits the ground (Dean 1999; Mugford 1993; O’Malley 1999; Valverde 1998). As a mode of governance, harm reduction has been propelled by antagonism between top-down state actors and bottom-up activists, reformers, ethnographers, and outreach workers. Regardless of its social movement origins or governmental pedigree, harm reduction deserves attention as a technique that has mobilized drug users to become more self-governing. It is integral to the process by which “governing gets
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‘biomedicalized’” (Epstein 2007:18). State-funded ethnographers elucidate links between behavior, social and economic circumstance, and disease transmission, but “seeing like a state” tends to reduce complex and variable communities to abstract simplifications “disciplined by a small number of objectives” (Scott 1998:23). These include containment of infectious disease, the “responsibilization” of individuals (Fischer and Poland 1998), minimization of social and health consequences of drug use, all within the context of avoiding sweeping changes to existing legal regimes.

Regulatory regimes constitute highly differentiated populations, managing risk while “empowering” individuals to become responsible and productive citizens (Erickson et al. 1997; Fischer et al. 2004:358; Miller 2001). Because harm reduction remakes drug users’ self-definitions, conduct, and control over things like drugs, blood, and syringes (Bluthenthal et al. 1998; Inciardi and Harrison 2000; Wodak 1999; Wodak and Lurie 1997), it is well suited for navigating neoliberal political rationalities that relocate responsibility for health to individuals without addressing structural constraints, cultural geography, or the social economy of drug markets.14 Many point out that the War on Drugs has intensified the criminalization of the minority poor and the transcarceration of the mentally ill (Clear 2002; Kane and Mason 2001; Reinarman 1994) just as public resources were withdrawn from drug treatment or methadone maintenance programs. While macrostructural forces impinge on micro-interactions between ethnographers and participants, risk is disembedded from the social–structural conditions that produce it. Ethnographers provide an important relay between drug users and a public health apparatus that assigns individuals responsibility for “behavioral health.” Having been placed in the position of embodying or enacting harm-reduction norms, the very presence of ethnographers in drug-using social worlds incites drug users to locate and voice ethical practices. Encountering researchers in sites associated with harm reduction such as syringe exchange programs or drop-in centers, participants identify them with the norms and goals of those programs.

Constituting Risk

Public health and ethnographic drug research have narrowed to identifying and describing parameters of risk associated with drug use. Elaborations of risk ground calls for ever-expanding regimes of vigilance, surveillance, and control (Castel 1991). Behavioral epidemiologists aggregate groups or populations that can be sorted by “risk categories” to facilitate intervention (Clatts 1994). “By focusing not on individuals but on factors of risk, on statistical correlations of heterogeneous
elements, the experts have multiplied the possibilities for preventive intervention” (Petersen 1997:193). NIH funding is aimed at identifying and reducing risk; thus do ethnographers participate in the process of documenting and constructing risk. As in earlier days of drug research, ethnography is mobilized by public health researchers because it uncovers hidden or unknown populations such as “homeless drug-injecting youth.” Following such “discoveries,” public health researchers then acculturate their epidemiological surveillance methods to ethnographic findings in efforts to standardize ever more detailed populations at risk.

Throughout this iterative process, researchers learn to see and represent degrees of risk, often with the aid of a structured epidemiological interview between researcher and participant that is used to quantify risk. Ethnographers who administer such instruments also become acculturated to epidemiological models of risk. Training outreach workers and ethnographers to do research on HIV transmission among injection drug users entails helping them learn to see the risk they quantify in self-report surveys. “Follow the blood,” investigators on the Syringe Access project used to say, as it moved from syringe to water to cooker to syringe to vein. This would allow the researcher to visualize the paths of HIV infection (Davis and Rhodes 2004:380). HIV prevention educators and harm-reduction workers take part in the proliferation of risk every time they “educate” users that water touched by a syringe that is not brand new is potentially contaminated, and, therefore, must be treated as if it were contaminated.

Epidemiological research eventually frames people’s perceptions of their own HIV risk through popular understandings of what constitutes “risky” behavior (kissing? oral sex? sharing a cooker? sharing water?). Drug users incorporate these understandings in idiosyncratic ways as they profess, adopt, and resist harm-reduction practices. Observations of people injecting drugs often yield illustrations of particular norms that they seem to associate with harm reduction.15 Two African American friends shared a bag of heroin in a single cooker, each using his own syringe, while performing and commenting on aspects of the process they considered significant to reducing risk. Because Frank was too self-conscious to inject himself in front of an observer,16 Harold did it for him. Here the harm-reduction norm Harold seized on as important was using clean water. When Frank picked up a plastic cup off his dresser and handed it to Harold to mix up the dope, Harold looked at it skeptically and asked if it was “new.”

Frank: “Coulda swore I just put this water in this cup.”
Harold: “Well I didn’t see you.”
Frank: “Watch me.”
Harold: “I’m watching you now.”

Frank went into the kitchen, elaborately tossed the water down the sink, and refilled it from the tap. They both laughed as Susan asked if they always bickered like that. Harold said,

I have to be very careful. Ain’t going to pass nothing on to nobody. You know what I mean? . . . I make sure I bleach, today I didn’t have no bleach, but normally I do that. And when I get through with my tools I put ’em in a bag and go up to [a needle exchange ten miles away] and exchange it for brand-new ones.

Yet at the end of this injection session, Frank drew used water up into his syringe to clean it without using bleach, while Harold simply recapped his syringe without rinsing it. The statement “ain’t gonna pass nothing on to nobody” constructs Harold as an ethical subject despite his uneven and idiosyncratic uptake of harm-reduction practices. Acting on his knowledge that water touched by a syringe carrying HIV-infected blood can transmit the virus, Frank was focused on the water during the injection scene in ways that obscured the risk associated with using the same water to rinse his syringe. Harm-reduction norms arguably drive Frank’s behavior and declarations while imperfectly protecting him and his partner from actual harm.

In another ethnographic encounter, Juan, a middle-aged Puerto Rican heroin user, squatted in the woods outside an apartment building to prepare his dose with the help of a younger running buddy, Teddy. Juan used a piece of paper as a makeshift table because he didn’t want to place his supplies right on the ground. He pulled his syringe out of his pocket and Teddy gave him a bleach kit containing water, cooker, and bleach. He opened the water bottle, poured a little in the cap, and put it on the paper. Juan asked Teddy for a piece of cotton—somehow they misplaced the cotton that came in the bleach kit in the course of mixing up the drugs. Teddy pulled a thread off his shirt, washed his hands using another water bottle, and made a little ball with the thread. He handed the ball to Juan to use as a filter for drawing up the heroin–water mixture, but Juan said, “I want to do it with my own fingers.” Juan then repeated the whole procedure, washing his hands and then the thread-ball with water before dropping it into the cooker. In this case, Juan seized on a particular aspect of the injection process—injecting with a clean cotton filter—as his concern, perhaps because of fears of hepatitis
or “cotton fever,” a folk illness attributed to dirty or shared cotton. Juan was concerned enough about the status of the cotton to argue with his friend and running buddy over it, yet in response to a question whether his syringe was new he reported that his syringe was “second used. . . . I didn’t use it. A friend of mine did.”

While these participants clearly espouse some harm-reduction norms, their verbal presentations were at odds with practices they actually performed (“I make sure I bleach, today I didn’t have no bleach, but normally I do that”). Perhaps their responses were constrained by the researcher’s presence. Despite frequent voicing of a commitment to cleaning syringes, field observations show that bleaching is not the norm among drug injectors, as evidenced by the empty water bottles and unopened bleach bottles that littered outdoor injection sites surveyed in the Syringe Access study. Uptake of bleach has been reluctant and the scientific evidence that it works equivocal (Bourgois 2002; Buchanan et al. 2002b). Changing recommendations regarding bleach use have reinforced distrust of government institutions (Shaw 2006). While drug users endorse and even practice harm-reduction norms, pragmatic considerations shape resistance and adherence to them. Aware they are under scrutiny, users realize that data gathered about their experiences will be used in calculations of health and risk that correspond to calculations of the moral worth of those who occupy the IDU category. In addition to providing empirical evidence of “risk,” ethnographic encounters reveal the work participants do to (re)position themselves as ethical subjects—and the degree of success of the incitement to discourse that results from the interaction of drug research practices with harm-reduction norms.

People who use drugs do not passively receive risk information but, rather, take up and act on information regarding risk in unanticipated ways. Epidemiological information builds on ethnographic insights to construct meanings of “risk” that are then formed into new harm-reduction norms. For example, one of the ethnographic activities in the Syringe Access study was the Syringe Acquisition Interview (SAI) to be conducted as ethnographers accompany participants as they procure syringes from their usual sources. This was done to learn where and how injection drug users acquire syringes and to collect syringes being sold on the street for laboratory testing (Singer et al. 2000). Participants used a variety of terms to rate the degree of risk represented by a given syringe (Eiserman et al. 2003). A diabetic might sell a syringe after using it to inject insulin; heroin users regarded this as “skin popping” and considered it fairly safe in terms of HIV risk; they rated diabetics preferable to other syringe providers (Stopka et al. 2003). Eiserman and colleagues identified
“emic” categories of risk used to describe syringes purchased on the street. The harm-reduction norm of “always use a (new or clean) syringe when you inject” was invoked by drug users even when they purchased used syringes. Depending on who used it in what manner, a participant might rate a given syringe “new” and calculate the degree of risk as less rather than more. In the above vignette, when Juan was asked if his syringe was new, he responded, “Yes. It is second used.” Susan asked, “Where did you get it?” and Juan answered, “I bought it on [a nearby street],” then volunteered, “I didn’t use it. A friend of mine did.”

Harm-reduction discourse is used to designate new syringes as “safer” than old ones. Users sometimes insist that a clearly used syringe is actually new to occupy an ethical position. A syringe cleaned with bleach, considered as safe as a new syringe, is now called “new.” Even when confronted with direct evidence of use, participants might continue to insist that it was new. In another interview, the participant admitted to buying used syringes “only once,” despite the fact that he had earlier described his response to moments of crisis when his regular syringe sources were unavailable:

I don’t have any choice. I go to the park and look around to see if I can find any of my syringes there. . . . (Q: How long will you wait for her?) I’ll wait a little while. The most I will wait for a person is an hour. After that hour, forget it. Either that, or I try to buy it off of somebody else.

When directly queried, users maintained the position that they adhered to harm-reduction norms by “never” sharing syringes or purchasing used syringes. However, when describing his daily routine, it became clear that Sam sometimes relied on syringes used by others first, or even those he stashed in a public location.

Ethnographers record on-the-ground interpretations of epidemiologically constructed concepts of risk. In the Syringe Access study, traditional ethnographic methods of participant-observation were adapted and transformed to meet the expectations of public health researchers. Instruments such as the Injection Observation Guide or the SAI were employed to prompt ethnographers through participant-observation (see Figure 2). These tools made ethnographic data legible to public health researchers accustomed to “objective” survey instruments and helped standardize findings in a multisited study with high staff turnover. Contemporary drug ethnography spans both the empirical standards of public health and cultural anthropological models of hidden populations, drug subcultures, and solidarity. Ethnographic methods are of undeniable utility in fostering long-term relationships that ultimately lead to greater trust and therefore more empirically
“valid” information. Yet ethnographers must make their data legible to epidemiologically oriented reviewers and funders who require standardized measures not typically seen in ethnographic research. As a result, drug ethnography both contributes to and adopts behavior-based risk categories proposed in response to stigmatizing “risk groups” for HIV such as homosexuals and addicts (Singer et al. 1999).
Constituting Research

Carrying out state-funded drug ethnographies places ethnographers and outreach workers in the position of representing to IDUs the goals of HIV risk reduction: don’t share syringes, clean your works. Because outreach workers, who are integral to participant recruitment and retention (Broadhead and Fox 1990), are often themselves people in recovery from addiction, they embody norms of abstinence and harm reduction in a much more literal and personal way than ethnographers, who are perhaps more likely to approach the topic of addiction from academic or activist interests. Given how rooted public health and substance abuse regimes are in imbuing certain forms of behavior with moral value (Lupton 1995), there is a gap between those who deliver prescriptive messages, and those who are “targets” of intervention. The moral value associated with abstinence under the War on Drugs is fast being replaced by a neoliberal emphasis on individual responsibility for health and HIV prevention. Ethnographers represent the public health discourse on AIDS/HIV, thus embodying a moral discourse even as they document what people are actually doing. People who use drugs are compelled to speak certain truths and perform in ways that validate their behavior as consonant with harm-reduction norms. Given unequal power relationships between participants and researchers, the perception that all the ethnographer looks for is an assurance that the subject is enacting harm-reduction principles has become a barrier to discerning actual practices and the broader structural constraints that shape them.

George, a middle-aged African American man whose heroin and cocaine use spanned three decades, illustrated the strength of harm-reduction norms in shaping addicts’ narratives about their drug use habits. While reminiscing about the partying he did “back in the day,” he interrupted himself to declare that he never shared syringes. This, he said, was because he always knew “that blood is a microscopic thing. . . . Even though you don’t see no blood in there, that’s what’s got a lot of people fucked up, so to speak. They don’t see no blood up in there [in the tube of the syringe], they washed it out with water, they thinkin’ it was clean. No sirree Bob.” He articulates the kind of commonsense public health prevention educators dream about, a common sense that endorses no syringe sharing:

all you have to do is, just get your own set of works, and keep ’em. Don’t share with nobody. If somebody want to use your works, don’t let ’em use ’em, even if they do say, ‘well I got bleach.’ No. You don’t do that. Get your
own damn works, man. That’s how I been doing it for years. I never shared with nobody, even back in the day.

Does such a common sense really exist among injection drug users, or was George compelled to say this because he was participating in an HIV prevention study? Leshawna, a former heroin user and syringe exchange activist, felt that this common sense was in fact already an internalized norm among injection drug users:

I’m just saying as a recovering addict, as someone who used to shoot dope, and it wasn’t too long ago, that the education is out there so common sense will tell you, [if] you gonna use a used syringe then you would bleach it out. Because common sense is out there. So [if] you can’t get access to a clean syringe, you definitely can get free access to bleach kits and you can go find bleach in a cabinet. And I have yet to find a used syringe or buy a used syringe and not bleach it out.

This participant offered her own drug-using behavior as a sterling example of the common sense out there among drug users in general.

By setting her own behavior as representative, Leshawna constitutes herself as an ethical subject who adheres to what she assumed researchers value and seek to document: responsible adherence to harm-reduction behavior. As another 50-something heroin user insisted when he assumed that needle sharing was the ethnographer’s focus, “I don’t play that”—indicating a principled refusal to share syringes, which he assumed was all the ethnographer wanted to know. These statements signal participants’ efforts to establish ethical positions that adhere to normative harm-reduction standards. The omnipresence of harm-reduction discourse among drug users, coupled with lack of evidence that harm-reduction practices are equally widespread, indicates users’ ambivalent willingness to occupy the categories of risk created by public health discourse and promulgated through research.

**Constituting Identities**

Anthropological research on drug use and HIV risk has contributed to the construction of a range of new identity categories constituted in the course of carrying out governmental mandates to protect the public health and manage unruly populations. As Ian Hacking writes, “Counting [populations] is no mere report of developments. It elaborately, often philanthropically, creates new ways for people to be. People spontaneously come to fit their categories” (1986:223).
Ethnographic drug research has been a central discourse through which the construction of identity categories has metamorphosed into the IDU subject position. Early in the AIDS epidemic, ethnographers “philanthropically” contributed to the production of new behavioral categories to combat the stigma initially associated with the popularly and epidemiologically constituted notion of “risk groups” for HIV (injection drug users and gay men; see Clatts 1994, 1995; Patton 1990).

Behavioral risk categories were advanced as benign alternatives to pejorative terms such as *junky* or *addict* (Glick Schiller et al. 1994). In the late 1980s and early 1990s, AIDS educators drilled into our heads, “It’s not who you are, it’s what you do” (Clatts 1995). *Injection drug user* defined a population based on activities understood to create risk for HIV infection. Millions of state and federal dollars have been spent researching, serving and governing the population—IDU—thus defined. While “IDU” has emerged and functioned as a behavior-based identity category for researchers and service providers alike, ethnographic interviews with drug users emphasize that in fact IDUs identify along a variety of dimensions—as women, as Puerto Rican, as mothers, as truck drivers. Their self-conception may or may not revolve around their externally identified “risk category.” Some clearly do inhabit the category to which they are assigned, like the woman who said, “Why should I be afraid to use the [syringe exchange] van? This is who I am.” Others prioritize their families, jobs, or marriages above their drug habit in their self-conceptions (Agar 2002).

Populations designated on a behavioral basis can have the same negative effects as populations stigmatized on the basis of identity. Detailed ethnographic studies have elaborated categories based on both behaviors and identities—we now have categories for, and perhaps even mental images of, “inner city drug-using Puerto Ricans,” “substance-abusing victims of domestic violence,” “homeless drug-injecting youth,” and so on. While the proliferation of finely differentiated subpopulations can further more appropriate, culturally sensitive, and effective interventions, behavioral categories must also be recognized as new categories for governing that did not preexist research. Insofar as the provision of specialized services (e.g., shelters for drug-using women involved in violent relationships; drug prevention programs for inner-city youth) makes people newly subject to state scrutiny and other forms of authority, these programs can be seen, to use Nikolas Rose’s (1999) apt term, as *techniques of governing* applied to the populations delineated by research.
THE ENABLING CONSTRAINTS OF ETHNOGRAPHIC ENACTMENT

“We always use bleach.” “We never share needles.” What compels assertions like these by injection drug users? What do they signify for ethnographers? Far from considering such assertions meaningless repetitions of the dominant discourse, we consider them strategic assertions of ethical personhood. Mapping contexts in which harm-reduction efforts in illicit drug worlds have emerged, we have shown how ethnographers were assimilated to the purposes of surveillance for the sake of governance while at the same time diffusing harm-reduction norms and practices. Despite often being personally critical of dominant modes by which illicit drug use is governed, ethnographers have also come to serve as instruments of governance. The structural dualities imposed on ethnographic practice present ethical dilemmas that must be navigated in order for ethnographic observation to take place at all—for ethnographers, too, are ethical subjects subject to the enabling constraints of the discourse that speaks through them. The incitement to discourse intrinsic to contemporary drug ethnography dictates that all research participants voice their commitment to harm reduction. Researchers and participants alike are inescapably implicated in the subject positions of harm-reduction discourse, which are complex and ambivalent positions to occupy: individualizing risk while simultaneously seeking systemic changes that may take many forms, such as legalizing drugs or expanding access to treatment.

Having created the terms through which risk is understood (e.g., designating using a syringe that someone else has used first as a “risky” practice), research instruments such as epidemiological surveys then enforce particular understandings of what counts as risky behavior. Those terms are behaviorally but also morally defined (Fischer et al. 2004): If you shoot drugs, do you share syringes? How many people do you share with? If you have sex, do you wear a condom? How often? The moral status of injection drug users is always undermined by the assumed violation of social norms implicit in their answers to these questions (Berger 2004). Such statements can be regarded as strategically useful ethical constructions that assert users’ personhood in the face of their reduction to mere membership in an epidemiological category. They must be read as produced within constraints that enable critical ethnographic work, rather than as the simple use of ethnographers as eyes and ears of the state. Recalling Brian Wynne’s (2001) argument that those who aver trust in situations of institutional authority often do so to mask their alienation from those very institutions, we read such statements as both strategic attempts by which drug users construct themselves as ethical subjects and signals of the suspicion and skepticism that harm-reduction practices work as public health authorities say
INCITEMENTS TO DISCOURSE

they will. Power differentials pervade all ethnographic encounters, not always in "obvious" directions. Given the uneven terrain within which ethnographers meet members of hidden populations, ethnographers must get beyond the masks if they are to contribute nonreductive accounts of the multiple ways in which people exceed the categories to which they are assigned by techniques of governance. (For an example of an ethnographic essay that hauntingly enacts just such an excess, please see “The Elegiac Addict,” which appears in this issue.)

Through earnest efforts to reduce the risk of HIV transmission among drug users—and to avoid stigmatizing particular ethnic and social groups—ethnographers who are not alert to such statements ironically end up foreclosing the very spaces of possibility for personhood (Hacking 1986:229) most crucial to successful HIV prevention efforts. Consider the Brazilian case discussed by Richard Parker (2003), who found narrowly technocratic prevention programs focused on risk behavior alone ineffective compared to those tied to broader movements for social justice. The consolidation of behavior-based population categories may ultimately exclude the very holistic details that we, as anthropologists, consider crucial to public health. By focusing solely on behavioral risk instead of thinking about how people navigate everyday cultural contexts, we risk eviscerating the liberatory possibilities of education and prevention movements linked to larger movements for social justice. A relentless emphasis on personal responsibility can do little to overcome the structural patterns and cultural geographies in which drug markets flourish. Only a political agenda that involves structural change by growing meaningful work, educational opportunities, and a greater voice in governance can bring the commitment to harm reduction fully into the light of day. The radical potential of drug users’ self-defined concepts of harm reduction, identity, and social responsibility risks being obscured by the technocratic enactment of harm reduction for the ethnographic eyes of the state.

ABSTRACT

This essay traces a brief genealogy of state-funded drug ethnography and its relationship to public health projects such as HIV prevention. Ethnographic research on drug use was a critical part of making invisible practices visible in ways that rendered them amenable to intervention. The essay goes on to describe how harm-reduction norms were promulgated through the bottom-up tactics of health-oriented social movements, and simultaneously administered through an institutionalized and even standardized set of beliefs issuing from the highest reaches of the public health apparatus. Harm reduction is a pragmatic movement to change the personal practices of drug users through “modest interventions” aimed at reducing the risk of HIV transmission though
contaminated injection equipment. The essay draws on ethnographic research with injection drug users to discuss how drug researchers represent the social norms associated with harm reduction. We demonstrate how injection drug users take on the language and ethical stances of those who study them, in an effort to construct themselves as ethical subjects. The construction and elaboration of a harm-reduction model in and through grassroots mobilization and public health research is an example of the governance of populations through epidemiological constructions of risk transformed into ethical—behavioral injunctions. Their work has changed the nature of ethnographic encounters between drug researchers and injection drug users (IDUs), who are subject to the incitement to discourse constructed by harm-reduction norms and practices as they participate in ethnographic research.

Keywords: harm reduction, HIV, ethnography, drug research, governmental-

NOTES

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1. The Syringe Access study included epidemiological surveys with 989 injection drug users in three New England cities (Springfield, MA, Hartford, CT, and New Haven, CT), plus a variety of ethnographic research methods. See Singer et al. 2000, 2005; Stopka et al. 2003; Buchanan et al. 2002a, 2002b, 2004, 2006. All ethnographic vignettes in this essay were drawn from Susan Shaw’s ethnographic fieldwork in conjunction with this project.

2. Our subject matter in this article illustrates the disunity of “the state,” the multiplicity of its projects, and the continued need to avoid analyses that reify “the state” or its subjects.

3. Research scientists, advocates, and policymakers from Europe and Australia openly use the term, whereas those from the United States do not even if their beliefs and practices are similar (for an example, see Edwards 2002).

4. All oral history interviews quoted in this essay were conducted by Nancy D. Camp-
bell and/or Joseph F. Spillane with funding from the National Science Foundation grant SES-0620320. Many interviews can be accessed at http://sitemaker.umich.edu/substance.abuse.history/home.

5. Public health literature on drug use and HIV transmission focuses on syringes as routes of transmission, and sexual practices of drug users and their partners. Harm reduction shares this utilitarian focus on syringes but includes a broader effort to contextualize both drug use practices within socioeconomic and political constraints, including poverty and discrimination.

6. See “The Role of Ethnography in Substance Abuse Research and Public Policy” (Feldman and Aldrich 1990:12–30), which located historical origins with the early Chicago school and acknowledged Herbert Blumer’s 1967 report, “ADD Center Project Final Report: The World of Youthful Drug Use,” much of which was written by Alan G. Sutter (Feldman and Aldrich 1990:21). Blumer was interested in how the images that sociologists carry into their work shape their analyses, writing, “These images are constituted by [the social scientists’] theories,
by the beliefs current in his own professional circles, and by his ideas of how the empirical world must be set up to follow his research procedure” (Blumer 1969:36).

7. Ethnographers’ access to so-called hidden populations has proved essential to law enforcement. For instance, “Pulse Check,” an intelligence report that tracks drug-use trends and is put out by the White House Office of National Drug Control Policy (ONDCP), defines ethnography as a “mode of research that analyzes the behavior of groups in the natural settings in which these behaviors occur. Ethnographers use field observations and interviews to gather data. Ethnography is not undercover work. Rather, the ethnographer, who is fully revealed as a social science researcher, enters the drug user’s world to record and describe it “on its own terms,” that is, without predetermined ideas” (accessed at http://www.whitehousedrugpolicy.gov/publications/drugfact/pulsechk/summer97/pcapph.html#ethnog). ONDCP relies on seasoned drug ethnographers who enter the field without the motivation of drug control.


9. For a detailed analysis of the literature pertaining to the non-uptake of bleach, and the unintended consequences of its limited uptake, see Bourgois 2002.

10. Echoes of this attitude among high government officials can be found in current discussions of overdose rescue kits containing naloxone, an opioid antidote demonstrated to save lives that would be otherwise lost to heroin overdose. Bertha Madras, deputy director of ONDCP, argues that overdose rescue programs remove drug users’ motivation to get into detoxification and drug treatment. “Sometimes having an overdose, being in an emergency room, having that contact with a health care professional is enough to make a person snap into the reality of the situation and snap into having someone give them services,” she said on January 2, 2008 at http://www.npr.org/templates/story/story.php?storyId=17578955, accessed January 9, 2008.


12. The enormous literature on risk, the “risk society,” and risk assessment in the sociology of science and technology (Beck 1992) recapitulates modernist efforts to quantify risk. Brian Wynne (2001) and Lash et al. (1996) offer a trenchant critique of Beck’s “realist” definition of risk as a “systematic way of dealing with hazards and insecurities induced and introduced by modernization itself” (Beck 1992:21). Beck characterized the risk society as an outcome of elite decisions made about actual risks and dangers. By contrast, Wynne delves into how institutions operate at a distance from those they seek to govern and, thus, often promulgate inadequate models of social relations on which perceptions of risk are based. His work on how risk perception shapes public trust or distrust toward institutions is germane because Wynne argues that those who aver trust in situations of institutional authority often mask their distrust of and alienation from those very institutions. Neither Beck nor Wynne consider the kinds of biobehavioral risk cultures we deal with in this essay.

13. See Bourgois 2002 on the relative safety of sharing in tightly organized social networks and the relative ineffectiveness of “failed magic bullets” such as bleach or condoms.

14. In “Addiction Markets: The Case of High-Dose Buprenorphine in France,” Anne M. Lovell argues French harm reduction has “evolved into a highly individualized set of bodily practices and discourses that are resonant with the individually focused ‘new public health’ (Petersen and Lupton 1996), which locates responsibility in the lifestyle of the individual as purely an individual decision” (2006:161). The drug user so constituted is not simply a “target” of intervention but, rather, an individual “decision maker who rank-orders his or her own practices in terms of the level of risk he or she ‘chooses’ (to inject ‘safely’ rather than to stop injecting, to sniff rather than inject, to use ‘soft’ drugs rather than ‘hard,’ and so on)” (Lovell 2006:161).

16. Frank is a pseudonym, as are all names presented as part of the ethnographic data.
17. For a cogent discussion of anthropologists’ views of epidemiology and how it differs from medical anthropology, see Inhorn 1995.

Editor’s Note: Cultural Anthropology has published many essays that critically engage Foucault’s conception of governmentality. See, for example, Paul Hanson’s “Governmentality, Language Ideology, and the Production of Needs in Malagasy Conservation and Development” (2007); Kaushik Ghosh’s “Between Global Flows and Local Dams: Indigenousness, Locality, and the Transnational Sphere in Jharkhand, India” (2006); Olga Demetriou’s “Streets Not Named: Discursive Dead Ends and the Politics of Orientation in Intercommunal Spatial Relations in Northern Greece” (2006); and Aradhana Sharma’s “Crossbreeding Institutions, Breeding Struggle: Women’s Empowerment, Neoliberal Governmentality, and State (Re)Formation in India” (2006).

Cultural Anthropology has also published other essays that analyze the practices and politics of ethnography. See, for example, Charles R. Hale’s “Activist Research v. Cultural Critique: Indigenous Land Rights and the Contradictions of Politically Engaged Anthropology” (2006); Quetzil E. Castañeda’s “Ethnography in the Forest: An Analysis of Ethics in the Morals of Anthropology” (2006); and Alexandra Bakalaki’s “Students, Natives, Colleagues: Encounters in Academia and in the Field” (1997).

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