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The intimate relationship as a site of social protection: Partnerships between people who inject drugs

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ABSTRACT

Public health research treats intimate partnerships as sites of risk management, including in the management of HIV and hepatitis C transmission. This risk-infused biomedical approach tends to undermine appreciation of the emotional and socially situated meanings of care in intimate partnerships. In this article we explore qualitative interview accounts of the care enacted in partnerships between people who inject drugs, drawing on a 2014 study of 34 couples and 12 individuals living in two locations of Australia. A thematic analysis highlights 'best friend relationships', 'doing everything together', 'co-dependency', and 'doing normalcy' as core to narratives of care. As we will argue, the accounts position the care undertaken by couples as at once shaped by day-to-day practices of drug use and by social situation, with the partnership enacting care as a form of *social protection*, including protection from stigma and other environmental hostilities. The intimacy of doing everything together offers insulation against stigma, yet also reproduces its isolating effects. While the care produced in drug-using partnerships is presented as double-edged, we note how interview accounts are used to deflect the charge that these relationships represent harmful co-dependency. Taken together, the interview accounts negotiate a 'counter-care' in relation to normalcy, presenting the intimate partnership between people who use drugs as a legitimate embodiment of care.

1. Introduction

A growing body of public health research positions the intimate partnership as a tool of risk management. The fields of HIV prevention and drug addiction are prime examples of this. Here, couple-focused interventions are endorsed as a way of improving engagement in care interventions such as testing, counselling and treatment, and of fostering couple-based changes in risk and drug use practices (El-Bassel et al., 2014a,b; Jiwatram-Negron and El-Bassel, 2014; Simmons and McMahon, 2012). Among people who inject drugs, there is growing interest in couple-oriented interventions as a means of hepatitis C prevention (Dwyer et al., 2011; Fraser, 2013). A key feature of such couple-oriented interventions is an attempt to move beyond narrowly-defined psychological conceptions of individual behaviour change and self-care towards more broadly conceived social strategies of change. This includes rethinking the intimate relationship as a unit of social change and as a resource of shared-care in the face of risk or uncertainty (Montgomery et al., 2012; Lewis et al., 2006; Rusbult and Van Lange, 2003).

In this article we investigate these issues by focusing on the affective care practices enacted within partnerships between people who inject drugs who live day-to-day with heroin and other opiate use. Rather than framing our analyses in relation to public health infection control, and hepatitis C prevention specifically (Rance et al., 2016; Fraser et al., 2015), we pick up on alternative framings of care in couples' accounts of their partnerships. These enact the partnership as a resource of protection, both in negotiating a certain way of living as a couple in relation to drug use and addiction, and in offering social protection in relation to an inimical world. We thus consider how the care practices enacted by partnerships are inextricably linked to their social contexts.

Using accounts generated through in-depth qualitative interviews, we explore the care practices enacted by drug-using couples as unavoidably interconnected, and in conversation with,

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their network of social relations. Following Mol (2008), we envisage 'good care' as that which is practised as an effect of how care is attuned to everyday social relations, interactions and situations. This stands in contrast to a logic of care which draws primarily on assumptions of individual autonomy and choice through which citizenship and duty of care is enacted in relation to surrounding public discourses of care expectation and risk rationality. The emphasis thus becomes describing the care practices undertaken within socially situated partnerships, in which individuals and their technologies of self-care are but one force. In considering how the affective care practices of marginalised intimate partnerships enact social protections in relation to an inimical outside, we also emphasise how the accounts of partnerships enact resistance through their narrativisation.

1.1. Intimacy and care relations

In our earlier work on couples affected by viral dangers such as HIV and hepatitis C, we highlighted how risks and dangers selected for public attention are socially situated. This includes how partnerships are negotiated as intimate, meaningful and secure (Rhodes and Cusick, 2000; Seear et al., 2012; Fraser et al., 2015). Distinct from a primary emphasis on viral risk, these qualitative studies describe alternative frames of rationality in relation to risk, care and safety arising from the embodied emotions and everyday pragmatics of partnership. Significantly, they emphasise how intimate partnerships can enact a sense of psychic protection from risk or uncertainty, including that linked with chronic illness. For example, in the case of living with HIV prior to the advent of combination antiretroviral treatments, couples' accounts presented a sense of shared relationship security and destiny realised through intimacy, including through unprotected sex (Rhodes and Cusick, 2000). Here, enacting a sense of relationship security is balanced against viral safety in a situation characterised by an uncertain future. This work envisages the intimate partnership as a local solution to pervasive risk and, in its broader relation to the management of contingency in late modernity (Giddens, 1992), casts intimacy as an alternative to doubt when navigating an inimical world (Beck and Beck-Gernsheim, 1995).

Care and coping practices enacted in intimate partnerships can thus be interpreted through their specific social relations, including patterns of social and material inequality, uneven power dynamics and historical location (Wetherell, 2012; Nielson and Rudberg, 2000; Skeggs, 2004). In this article, we envisage affective care practices as shaped by their entanglement in a network of connections, which pattern together "feelings, thoughts, interaction patterns and relationships, narrative and interpretative repertoires, social relations, personal histories, and ways of life" (Wetherell, 2012: 14). Affective care practices are at once felt and embodied and produced through the habits and representations of everyday social interactions. In this respect, we can extend our earlier work on HIV health and illness futures (Rhodes and Cusick, 2000), to consider the drug-using couple as a relation of affective practice, with its particular social relations and emotional regimes, emotional capital and care expectations (Reddy, 2001; Ahmed, 2004).

1.2. Care and the drug-using couple

Research focused on the public health aspects and harms of drug use primarily interpret partnerships between people who inject drugs as pragmatically oriented to accessing drugs and managing risk, especially HIV and HCV transmission risk and the escalation of drug use (Bourgois et al., 2004; Simmons and Singer, 2006; MacRae and Aalto, 2000). Cast as risk producing, the drug-using couple can be presented as a perverse style of care in that the cooperative work in managing drug use is seen to diminish rather than enhance health and welfare (Simmons and Singer, 2006; Glick-Schiller, 1992; Rotunda and Doman, 2001). While this depiction of such partnerships is often resisted (Simmons and Singer, 2006; Rance et al., 2016, 2017), it remains influential (Cavacuiti, 2004), with implications for how partnerships are understood and valued. Critically, people who use drugs often express awareness that their partnerships are cast as falling short of proper intimate and caring relationships.

While it is important to question the reduction of these relationships to pragmatic alliances established only to manage day-to-day demands, this is not to deny that such demands do help shape those relationships (see for instance, Bourgois, 2009). The urgency that can arise in managing withdrawal, the challenges of generating resources and acquiring drugs, the navigation of risks (overdose, infections, violence, criminal convictions), exposure to hostile community attitudes and social stigma, and the regulation of drug use in relation to other social and partnership roles (such as parenting, employment) all shape partnerships (Fraser et al., 2014). Envisaging the drug-using couple and the care it enacts as both affected by, and affecting, its network of social relations shifts analysis from naturalising discourses that decline to interpret partnerships through their social relations to approaches that actively situate them in the social.

2. Methods

The analysis conducted here is based on 80 qualitative interviews conducted with people who inject drugs (see also, Rance et al., 2016; Fraser et al., 2015). Participants included 34 couples, each of whom were interviewed, and 12 additional individuals, of whom seven were in current relationships and five had previous relationships with partners who also injected drugs. Participants were recruited from low-threshold drug services in four inner-city locations in two Australian states during 2012/13. Partners in a couple were interviewed separately by the same researcher, with assurances of confidentiality emphasised. We elected to interview partners in a couple separately to facilitate a conversational context enabling of talk in relation to partnership dynamics, including of partnership negotiations in relation to risk management and care (Eisikovits and Koren, 2010; Rhodes and Cusick, 2000). This has generated a thematic triangulated analysis of individual partner accounts of their shared partnership rather than an analysis of a single negotiated account co-produced with the researcher in situ. Participant selection proceeded purposively initially and thereafter theoretically as data emerged, including in relation to: relationship experience; age (although our data set under-represents younger drug injectors); gender (equally distributed between men and women); and reported hepatitis C antibody status (representing a mix of concordant and discordant couples).

2.1. Ethics

The study was approved by the Human Research Ethics Committee of The University of New South Wales and from the relevant human research ethics committees at each site. Written, informed consent was obtained from all participants. All names reported here are pseudonyms. Each participant was reimbursed $30 (Aus) for their time and travel expenses.

2.2. Dataset

Table 1 summarises the study participants. The duration of partnerships varied from two to 20 years. Nine participants were in