



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.

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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

Table 1
Sample characteristics.

Couple	Pseudonym	Age	Ethnicity	Hepatitis C status	Income source	Current relationship duration	Primary drug use
SITE 1							
1a	Demi	34	Filipino	Negative (post-TX)	Disability support	1 year	Ice (crystalline methamphetamine)
1b	Dean	34	German, Croatian, Serbian.	Negative (post-TX)	Disability support	1 year	Ice
2a	Patrick	52	Anglo-NZ	Positive	Disability support	20 years	Heroin
2b	Pam	50	Greek Cypriot	Negative	Newstart	20 years	Heroin
3a	Cameron	39	Aboriginal	Negative	Full time	9 years	Heroin
3b	Camila	39	Aboriginal	Negative (cleared)	Sole parent benefit	9 years	Heroin
4a	Natalie	43	Anglo-Australian	Negative	Disability support	3 years	Heroin
4b	Nigel	34	Anglo-Australian	Positive	Cut-off Newstart, currently car windscreen washing	3 years	Heroin
5a	Mindy	39	Anglo-Australian	Positive	Newstart	10 months	Ice
5b	Mac	35	Anglo-Australian	Negative (post-TX)	Disability support	10 months	Ice
6a	Samantha	39	Australian; Yugoslavian parents	Positive	Disability support	5 years	Ice
6b	Simon	42	Anglo-Australian	Positive	Disability support	5 years	Heroin
7a	Clare	46	Australian, Norwegian father	Positive	Disability support	20 years	Heroin
7b	Cliff	58	English	Positive	Disability support; part-time cash-in-hand	20 years	Heroin
8a	Les	55	NZ; Scandinavian & Italian parents	Positive	Disability support	1 year	Ice
8b	Libby	26	Aboriginal	Negative	Disability support	1 year	Ice
9a	Fran	31	Anglo-Australian	Negative	Disability support	1.5 years	Heroin/Cocaine
9b	Fred	34	Anglo-Australian	Positive	Disability support	1.5 years	Heroin/Cocain/Ice
10a	Andy	38	Anglo-Australian	Positive	Disability support	10 years ('on & off')	Opiates
10b	Angie	36	Anglo-Australian	Negative	Disability support	10 years ('on & off')	Cocaine
11a	Janine	48	Anglo-Australian	Negative (cleared)	Full time	15 years	Heroin
11b	Jim	61	Anglo-New Zealander	Positive	None, supported by partner	15 years	Heroin
12a	Rachel	30	Anglo-Australian	Positive	Newstart	8 years	Heroin
12b	Roger	33	Greek-Irish	Negative	Disability support	8 years	Heroin
13a	Christine	26	Australian (Indigenous heritage on father's side but does not identify)	Positive	Not disclosed	~2.5 years	Heroin
13b	Craig	29	Anglo-Australian	Positive	Newstart	~2.5 years	Heroin
14a	Charlie	34	Anglo-Australian	Negative	Full time work	10 years	Heroin
14b	Crissy	30	Anglo-NZ	Negative (seroconverted, then cleared)	Disability support	10 years	Heroin
15a	Tanya	23	Anglo-Australian	Positive	Disability support	8-9 years ('on & off')	Oxycodone
15b	Tim	39	Hungarian	Negative	Disability support	8-9 years (on & off)	Morphine
16a	Seth	34	Indian	Positive	Disability support	2 years	Heroin
16b	Suzie	47	Aboriginal	Positive	Disability support	2 years	Heroin
17a	Barbara	28	Anglo-Aust	Negative	Disability support	5 years	Heroin
17b	Brian	28	Anglo-Aust	Negative	Newstart	5 years	Heroin
18s	Christopher	29	Australian-Lebanese	Negative	Newstart	2 years	Heroin
19a	Matilda	20	UK-China	Negative (never tested)	Youth Allowance	2 months	Heroin
19b	Matt	23	Anglo-Australian	Negative	Youth Allowance	2 months	Heroin
20s	Josh	21	Aboriginal	Negative	Newstart	6 months	Oxycodone
21a	Elias	26	Filipino	Negative	Newstart	5 years	Heroin
21b	Elena	24	Anglo-Australian	Negative	Disability support	5 years	Heroin
SITE 2							
1a	Sean	41	Anglo-Australian	Positive	None	8 years	
1b	Sandra	40	Anglo-Australian	Positive	Disability support	8 years	
2a	Keith	40	Indigenous	Positive	Disability support	8 years	
2b	Karen	32	Indigenous	Negative (cleared)	Disability support	7/8 years	
3a	Jenn	31	Armenian Australian	Positive	Disability support	6/7 years	
3b	Jim	32	Greek/Italian	Positive	Unemployment benefit	6 years	
4a	Grace	43	British	Negative (cleared)	Disability support	6 months (known for 15years)	Marijuana (stopped injecting 2 years ago)
4b	Glenn	41	Anglo-Australian	Positive	New Start	3 months (known for 12 years)	Ice
5a	Janet	24	Anglo-Australian	Negative	Part time	8 months	Heroin
5b	Jack	23	Anglo-Australian	Negative	Unemployment benefit + Market research	7/8 months	Heroin
6a	Mandy	45	Anglo-Australian	Positive	Disability Support	3.5 years	Heroin
6b	Mike	37	Anglo-Australian	Positive	Disability support	3.5 years	Heroin, Ice and Amphetamine
7a	Shelly	34	Anglo-Australian	Positive	Part time work		Heroin
7b	Steve	33	Anglo-Australian	Negative (cleared post-TX)	Part time work	8 years	Heroin

(continued on next page)

Table 1 (continued)

Couple	Pseudonym	Age	Ethnicity	Hepatitis C status	Income source	Current relationship duration	Primary drug use
8a	Belinda	36	Anglo-Australian	Positive	Disability support	10 years	Heroin
8b	Bob	46	Greek-Australian	Positive	Disability support		Heroin
9a	Debbie	33	Aboriginal	Positive	Disability support	14 years	Heroin
9b	Dan	33	Aboriginal	Positive	Centrelink	14 years	Heroin
10a	Cath	31	Aboriginal	Negative	Newstart	8/9 years	Heroin
10b	Colin	29	Aboriginal	Negative	Newstart	8 years	Heroin
11a	Robert	42	Ango-Australian	Positive	Newstart	8/9 years	Heroin
11b	Rachel	41	Ango-Australian	Positive	Disability support		Heroin
12a	Ava	33	Anglo-Australian	Negative (cleared)	Not disclosed		Heroin
12b	Alan	48	Anglo-Australian	Positive	Centrelink	1 yr	Heroin
13a	Tegan	38	Aboriginal	Positive	None	6.5years	Heroin
13b	Terry	37	Aboriginal	Negative	Newstart	5/6 years	Heroin
14a	Erin	44	Anglo-Aust	Positive	Disability support	4 years	Heroin
14b	Ed	46	Anglo-Aust	Negative	Centrelink	4 years	Heroin
15s	Walter	23	Aboriginal	Positive	Youth allowance		Ice
16s	Emma	24	Australian	Negative	Centrelink, and sex work	10 months	Amphetamine
17s	Louise	29	British/Australian	Negative	Disability support		Ice and Amphetamine
18a	Fran	29	Australian-Armenian	Positive	Disability support	7/8 years	Heroin
18b	Fred	29	Greek-Australian	Positive	Disability support	8 years	Heroin
19s	Laura	25	Ango-Australian	Positive	Centrelink (now stopped)	4 years ('on and off')	Heroin
20s	Gareth	28	Aboriginal	Positive	Disability support	2 years	Heroin
21s	Natalie	19	Aboriginal	Negative (cleared)	Newstart	4 years	Ice
22s	Jane	29	Vietnamese/Cambodian	Positive	Not disclosed	9/10 months	Heroin
23s	Lisa	24	Aboriginal	Negative	Full time work	5.5 years	Heroin
24s	William	27	Ango-Australian	Positive	Centrelink	2 months	Heroin
25s	Ken	20	Aboriginal	Positive	Disability support		Ice

part or full-time employment, with nearly all receiving some form of social welfare ($n = 71$); one participant depended on their partner's income and two participants declined to answer. Over half the participants identified as Anglo-Australian and nearly a quarter as Aboriginal or Torres Strait Islander ($n = 17$). Hepatitis C antibody status was determined by self-report, and in some cases partners offered conflicting accounts, with 35 reporting themselves as HCV-negative and 45 HCV-positive. Of the 41 couples, 24 were HCV concordant (11 HCV-negative and 13 HCV-positive) and 17 HCV discordant (10 HCV-positive men and 7 HCV-positive women). Of these 41 couples, 29 or just over 70%, reported sharing injecting equipment within their partnership.

2.3. Data generation

Interviews sought to capture participants' perspectives in relation to their day-to-day practices of drug use, health-related risk management, care, and relationships. Interviews took between 30 and 60 min, and were audio-recorded with informed consent for subsequent verbatim transcription. An overarching theme in accounts of partnership concerned how they enabled a sense of pragmatic, emotional and social protection. This was despite, as well as because of, drugs being a pervasive feature of relationship concern. Our approach to coding data and its interpretation was informed by a pilot study investigating couples undertaken by the research team (Seear et al., 2012), and by our previous work on the production of intimacy within partnerships (Rhodes and Cusick, 2000). Key themes emerging through the coding process, and which inform the analysis developed here on how partnerships enact care, included: best friend relationships; doing everything together; co-dependency; and normalcy. We also coded for varieties of care and protection, including that which was narrated as pragmatic, emotional and social, and that oriented to within and beyond partnership care. Data coding and management was assisted by computer software (NVivo 9) and the generation of initial theme files based around core coding nodes (most germane

here were those relating to relationships, dependence, and stigma).

2.4. Data analysis

While we acknowledge that our interview approach generated individual partner accounts of partnership, our analyses has sought to give primacy to the partnership as the unit of analytical interest. To this end, we organised all transcripts as emanating from couples ($n = 34$), including within NVivo, such that we were able to follow the thread of the story of the couple, always considering each partners' contribution to their narrative of partnership. To assist this process, each partner was given a code identifying them as part of their unique couple, which meant that every data extract was immediately indexed to also belonging to a couple.

In addition to our analytical sensitivity to the couple beyond the individual, our interpretations are also sensitive to narrative context. We treat our interview data as relational to its situation of production, wherein narratives perform and negotiate an identity and agency in a relational context of meaning (Riessman, 1993). This enables us to consider the accounting functions which narratives may serve and the relational nature of the story told. We investigate qualitative accounts for what they represent in relation to partnership affective care practices, and the network of effects indicated to shape these, as well as how such accounts seek to legitimise the forms of care they represent.

2.5. Presentation of analyses

A key feature of interview accounts is the emphasis they place on how intimacy within partnerships between people who inject drugs (primarily heroin) enacts social protection in relation to an inimical outside. The intimacy of partnerships is presented as offering insulation from emotional harm linked to surrounding social stigma. Awareness of the drug-using couple being represented as harmful and improper is a key element of this. We interpret these interview data below in relation to two linked domains: intimacy as

a resource of protection; and accounting as a resource of legitimation.

3. Intimacy and protection

The first narrative we analyse here is that of intimacy as protection. As we will argue, the accounts pose intimacy as a protective resource. The overlapping notions of 'best friend relationships' and 'doing everything together' are core to the narrative of how intimacy serves to accommodate as well as protect drug-using partnerships in relation to their surrounding social situation.

3.1. Best friend relationships

Many participants depicted their partnerships in romantic terms ("I adore him. I love him so much", Janine; "I love him. [...] He's just the most beautiful person I've ever met in my life", Crissy). In addition, however, partnerships were commonly constituted as best friendships: "We're best friends" (Fran, Belinda); "We're the best of friends" (Samantha); "He's my best friend" (Lisa); "She's my best friend" (Patrick); "She's my best mate, has been for twenty years" (Cliff). Those casting their relationships as romantic often also presented them as friendships ("She's my best friend, she's my lover, she's my partner and my companion", Seth). Yet, for some, best friendships and romance were distinct: "We've just been more friends than we have, you know, partners" (Nigel); "It's more just a friendship" (Clare); "More friends now, than anything... We get on better as friends" (Samantha).

In this depiction of best friend relationships, there is a sense of displacing (though time) or discounting (though drug use) romantic relationship potential, as a result of the day-to-day demands and routines of drug use. Fran explains that in her partnership with Fred drug use "takes over everything else" and is "just a constant". Fred sees this as limiting their relationship potential: "Look, we're on a good friends basis and, like, we're not going to get married, but we're together, and we've been together for about eight years". He goes on to say, "I do want to spend my life with her, but she's still in the immediate stage of her drug addiction... She likes the drug and that's something that we have to get over". While Fred is "just hoping she'll hurry up" and "come to her senses and realise enough is enough", and indicates that he is "running out of patience", his is an "unconditional love, no matter what happens".

It has been posited that relationships which are sustained through intimate and intense interaction with another based around the mutual satisfactions and pleasures that such relationships enable are more like 'friendships' (Giddens, 1992; Jamieson, 1998). Giddens (1992) offers the notion of the 'pure relationship' as one based primarily around the realisation of mutual pleasures and which protects itself from falling back to more traditional ways of partnership, including that defined by being a romantic couple. It is important to recognise that intimacy is enacted in multiple ways, including through pragmatic engagements linked to the everyday routines, shared activities and chores of partnership. Drug use can be a core momentum for best friendships, but these partnerships are no less intense or intimate. As Cliff says, "We'll be together until the day we die... She is my lifelong mate". Similarly, Tim emphasises that he'd "kill and die for that girl".

As with Fred and Fran, Tim's partnership with Tanya is organised to a significant degree around drug use. The habits, pragmatics and pleasures of drug use are core elements of the mutual satisfaction their relationship brings. Yet his account also comments directly on the fragility of such best friend relationships. Of the eight years they have been together, Tim says, five "were absolutely beautiful" but the last three have seen his partner show "more love for [drugs] than for me". Tanya says in turn that "he's always either trying to

get the next fix or trying to sort it out". He is, she says, "very greedy and it's only for him".

We can interpret these narratives of best friendship as accounts of *accommodation*, for they accept the shared immediacy, even primacy, of drug use. For some (like Fred) this is *until such time* as drugs take less precedence. Equally, the narrative of best friendship circumvents the trope of partnership as primarily a performance of romance in presenting intimacy as rooted in the mutual satisfactions of everyday activities such as drug use. The 'pure relationship', as imagined by Giddens (1992), is a 'post-traditional' relationship, somewhat detached from its material and social relations. It is an equal partnership enacted purely through the intimacy derived from the realisation of mutual pleasure. Here, we see a counter-narrative of the couple produced through the notion of best friend relationships organised in relation to drug use. The narrative of best friend relationship seeks to balance the pragmatics and emotions, as well as fragilities, of partnerships affected through, and affected by, drug use. As we will go on to see, these relationships are far from pure in the sense of being detached or protected from their social relations.

3.2. The 'everything together' of care and protection

A striking characteristic of how partnerships were presented in the interviews is their totalising effect on everyday social interactions. Almost without exception, accounts emphasised constant unity: "We do everything together" (Les); "Absolutely everything" (Samantha); "Every second of every day" (Mike). Unsurprisingly, these strongly united partnerships give rise to a pronounced logic of sharing: "If you're in a relationship, then it's 50-50 on everything" (Cliff); "Once you're a couple, that's it, you have to share everything" (Jim). For Jim, this "everything together" dynamic de-emphasises individuality in favour of shared experience: "We're two partners become one. We're in it together" (Jim). One consequence of this intensity of contact and logic of sharing is intimacy and trust: "We know everything about each other" (Dan); "We don't have any secrets" (Lisa); "By sharing in the relationship, it's a way of just showing absolute trust" (Belinda). The everything-together approach to partnership is an all-encompassing relation of care and protection:

We've been together, well, half way through August will be 10 years. We met, and ran into each other the next day, and we've spent every night, every day, together since... He's my rock, he's always been there. (Charlie).

We've been injecting together since, almost since we started seeing each other. We're very much obsessed with each other, and so spend 90% of our time together. We look after each other, you know, financially, emotionally. (Jack)

We met at rehab, and we've been together 10, about 10 years... It's just the two of us, and we're best friends. We only have each other, and we're very lucky to have someone to bounce things off, and yeah, without him, I don't think I'd be here. (Belinda)

The above accounts suggest partnerships established in a context of drug use quickly become consuming, and function thereafter as indispensable mutual care and support. Such partnerships provide affective capital in an uncaring world ("We only have each other"). This care potential is highly valued: "He's so gentle, and caring, and loving, and understanding. [...] He's a beautiful human being. He's got a beautiful heart. He's very caring and I've never met anyone like him in my life" (Suzie). Crucially, the care that is enacted through this everything together of

partnerships is not detached from its 'outside' but shaped in relation to it. Interview accounts emphasise the coming together of partners into a care relation as an effect of the particularities – and difficulties – of drug use and its wider social and material relations. Drug-related and other material troubles can be the making of care relationships. For example, Jenn describes how her partnership emerged in relation to homelessness:

It started off as a friendship, 'cause we were on the street, and he really helped me. We were both kind of street, and we got to know each other, and so it was kind of really based on the friendship, and then kind of helping each other, and we both had a (drug) habit... It was kind of like, that kind of thing, looking after each other, because it's hard, I think it's hard, I think it's harder on your own. (Jenn)

Jenn's account emphasises shared troubles as a defining feature of the care that partnerships provide: "When you're on the street with someone and you go through such a full-on experience together, you know what I mean, you kind of really bond... because we've been through so much". Similarly, Belinda says of her partner Bob: "The only friend, the only person who understands who I really am". And as Roger says: "I've got family and all that, but when it comes to this... she's everything" (Roger). This care dynamic of everything-together emerges relationally; an effect of felt 'difference' from the 'normal', of exclusion, of detachment, and of otherwise being alone:

When you're normal it's different. But when you're using, I think, because you need somebody, it's better than being on your own, it helps you help each other. You know what I mean, kind of thing, with money, and this, and the emotional support. (Fran)

It is here also that we can appreciate how intimate and affective practices are enacted through the pragmatics of partnership. The day-to-day shared care of generating income for drugs, sourcing and sharing drugs, moderating drug withdrawal, managing overdose, avoiding police, negotiating social harms, and injecting safety are at once pragmatic and emotive, both enacting the difference and everything-together of drug-using partnerships. As Belinda says: "If one is sick (in withdrawal), the other is sick. If one goes out to make money, the other goes out to make money as well. It's always 100% together. That's the commitment we made from the beginning, and I'll stick to that until I die". Fred too explains: "We make sure one another is all right. We try to, we pool in together, to make it easier. If she is sick, I'm there for her. If I'm sick, she's there for me".

The everything-together of care is also an enactment of *social protection*; it serves to accommodate and negotiate a hostile outside which excludes, stigmatises, and undermines. Fran says her relationship operates as a "kind of bubble". Libby describes her partner as a "soul mate" to "help get through every day". Jenn's account merges together her material concern about managing drug-related risk (in this case, overdose) with a more general sense of her partnership as a buffer against social isolation (which the everything-together of partnership may serve to reproduce):

I haven't used on my own in a long time and just having him there I know at least if I overdose I'll be OK. I trust him completely, and just kind of, I think safety. Like I feel you know, just having somebody there, because we have been using a lot, we've kind of been very isolated, like don't really see many people, lost kind of friendships, so it's kind of like, that's why we kind of relied on each other for everything. (Jenn)

Jim, Jenn's partner, similarly envisages their partnership as a "break up from the pack". Borne out of their social relations of difference, these partnerships may have weaker economic and material ties to the outside. The everything-together of care may constitute resistance to conventional devaluing of drug-using partnerships, or cushion against social exclusion, but it would seem to reproduce the social isolation it seeks to address:

It's safer, but then again, you're cut off from the world. It's like couples think, 'Oh, we're better, we've got each other'. Like you're in a safer environment, but you're not... Actually you're not getting the help you need, and you're just forgetting about everyone, and just sticking to you two. You can just run away with each other, and the world just goes by. (Jim)

We interpret the doing of everything together as an effect of, and response to, the stigmatisation of drug users and the devaluing of their partnerships. Yet the narrowing of attention to the partnership may entrench a sense of distance from the world going by. The doing of everything together may be seen as a form of *resistance* in defence of living an alternative life (one in which drugs are a core feature of the relation), as well as *momentary retreat* from the symbolic violence and material hostilities linked to a life with drugs. The shared-care of everyday drug use activity – raising income, purchasing, sharing, using, managing risk – is thus at once pragmatic *and* emotional. This is the "common cause" of an intimate partnership based in difference (Beck and Beck-Gernsheim, 1995). Its intimacy is a practice of care because navigating drug-related troubles and material hardships necessitates partnership rather than sole survival (for instance, through the pooling of material and emotional resources), but also because it lends these partnerships specific affective meaning.

4. Accounting for care in partnerships

A key issue identified in our analysis is the marked attention participants pay to challenging or deflecting the negative connotations of their partnerships and to accentuating their normalcy. Envisaging qualitative accounts as acts of performance is helpful here. In doing so, we can recognise how interview narratives work to negotiate the legitimacy and relative normalcy of otherwise marginalised partnerships.

4.1. Accounting for co-dependency

While participants emphasise the care that defines their relationships, they also reflect on these performing perverse forms of care. These accounts resonate with the language of co-dependency, once not uncommon to psycho-behavioural therapeutic explanations of dependency-related harm (Haaken, 1990). For instance, Seth and Jenn both temper their accounts of their partnerships as caring with a normative therapeutic concern about co-dependency as bad. In doing so they deflect a possible charge that the everything-together of their relationships is harmful:

I share everything with her. It might be a bit co-dependent in other people's eyes. I don't mind saying we help each other. I think that's *always a positive thing*. We're not lonely because we have each other to turn to, so I think that again is a *healthy thing*. It's a beautiful relationship. (Seth)

When people say like, if they see me by myself, they're like 'Where's, where's Jim?' You know what I mean. Or they think something's wrong... I don't like that about it you know,

because I kind of feel really co-dependent. I feel like I lose my identity a bit, but I mean, what can you do? Take the good with the bad. As much as that's bad, *there's so many good things about being in a relationship.* (Jenn)

In some cases, participants explicitly engaged with questions about the potential for co-dependency in partnerships between people who use drugs:

I love him to death and I love being with him, but the, we're, we're very um, aware of um, let's see, you know, being co-dependent and all that stuff. Um, we've both like, done a lot of you know, therapy... We're pretty tuned in like with what's going on. (Grace)

Grace's account has a confessional quality. It presents her as in tune with therapeutic concerns that her loving partnership is instead potentially harmful. In this way, narratives of caring partnership must somehow bridge a tension between good and bad dependency. Andy admits that he has "a very co-dependent relationship, which is bad in some ways, but is good in other ways", and Jenn likewise says "I think it's good that we're together, and other times I think it's not good", but "actually, as much as we've hindered each other, we've helped each other".

The participants also addressed directly the potential 'bads' of drug using partnerships. Fran and Mandy, for instance, both depict their partnerships as having become consumed by, or dependent on, drug use:

It's kind of become because of the drug use. It's become bad in a way, because it's kind of become, we've become co-dependent on each other, and kind of we use together so it's kind of at least, if something happens you know, it's kind of a bit unhealthy in that way, because we depend so much on each other. It's the using [that] plays a big part of it. (Fran)

It's all based around drugs. [...] From the very start, it's all about drugs. We haven't really had a chance to get straight and see each other in a different clear mind... There's nothing that we really do except going to buy drugs and use drugs together. (Mandy)

In a similar fashion, Sandra laments her partnership as a "drug relationship". The object of the drug is a key partner here. Fred, Fran's partner, sees drugs as a pivotal actor and pervasive presence in their partnership, always positioned between them, so much so that Fred questions whether they have any intimacy together beyond the drugs:

It's like déjà vu, every day. It's like just the same in and out, day in day out. And it's an ugly routine. And you start to fall behind in life and bills, and just your friends are moving forward and I'm staying back. And it's the worst scary place to be, because it's quite lonely at the end of the day. Even now with my partner, we can't connect because of it. It's *always in the middle of us*, daily. We can be so much in love but at the end of the day if we've been together eight years on drugs as soon as we stop and stay on scratch, so you're really not together, you are, but *the drug is in the middle.* [Fred]

Jenn also presents the drug as a central element of her partnership's interdependency, extending beyond the humans involved. She says that "when you are using... you tend to be needy, and maybe a bit more kind of co-dependent". She emphasises that

"you don't want to be [or] have to be like that, of course, but it *just kind of happens*". Here, the drug shapes partners' agency to some extent; enacting effects beyond reasoned action ('don't want to') but not entirely ('don't have to'). This interdependency of drug-human partnership is cast as common to such relationships: "It's just the same [with] all the relationships I've seen where people use". For some then, alongside its human co-dependents, the drug is an architect of relationships, shaping their everyday momentum. This generates reflection on the 'substance' of these relationships. In Mandy's account presented above, she speaks of losing sight of the meaning of her relationship, while Fred says his relationship is somehow less real or its true potential is being postponed. As Jenn ponders:

It keeps you together in a way... Am I here for the right reasons, or am I just kind of, because it's easier? I do think that sometimes. Because it's easy. We just kind of keep going... But I do really love him. (Jenn)

The incorporation of the drug as a substantive actor in the partnership invites us to think of the drug as acting alongside multiple other human and non-human actors (Duff, 2013, 2014). The partnership is constituted from multiple actants, which in addition to the humans involved incorporates drugs, discourses of stigma, love and care, discourses of dependency and addiction, and so on. For all their caring potential, participant accounts tend to frame their everyday relationship troubles in relation to the object of drugs. Here, drugs are presented as having destructive potential in that they can entrench risks and heavy drug use:

We've tried many times together to quit, and we have dragged each other down. There were times when she wanted to quit I wasn't ready, and times when I was ready but she wasn't. But all in all, I think being together has been safer, and we've been able to cope, I think, being together. (Bob)

If one person wants to stop and the other doesn't, how do you fucking deal with that? Or work around it? Because it's almost impossible without causing some initial trouble in the relationship. (Janine)

This is an acknowledgement of the "double-trouble" of living relationships of interdependence:

Once you're a couple, that's it, you have to share everything. You go halvies and everything you share. But, you know, unfortunately heroin couples, they rely on each other too much, so they become married straight away. It's like when you become an addict and a couple it's like double-trouble... It sort of gives you the green light, because you'll both agree we're gonna use together, we're gonna go and start making money together, and the ball rolls. (Jim)

Despite these reservations most remark that they are "lucky" to have met their partners and to *have* such partnerships, and they accentuate the *work* they invest to protect them. This communicates a sense of need – pragmatic and emotional – which is catered for by relationships borne out of accommodation to their situation. Protecting the 'good' of the care relations of partnerships seems paramount: "We give each other heaps of shit, every now and again, but you know, she's always there for me, and I'm always there for her" (Cliff); "I think we both worked really, really hard to be where we are today" (Barbara).

In these narratives of co-dependency we see the everything-together approach to relationships acknowledged as a potential

bad, but only in relation to the goods of care. Critically, we find that while some speak of co-dependency, they primarily challenge it, emphasising that the care and protection produced in relationships outweigh the bads as others might present them. While the accounts do not ignore the tendency for everything-together partnerships to have their “up and downs” or drug-related harms, they nonetheless insist that these relationships are to be protected and defended. In this respect, they form a counter-narrative in the negotiation of what partnerships *should* be.

4.2. Doing normalcy

Lastly, the accounts generated by this study also emphasise the relative normalcy of their partnerships. Participants describe their relationships in prosaic terms: “We read a lot, we talk, we plan, we just stick together” (Craig); “We walk, we go to the beach sometimes, just walk around the city” (Mac); “We watch a lot of movies together, listen to music” (Simon); “We watch a lot of films, we cook dinners together, we share a lot of the same friends” (Janet)“. Indeed, some accounts exhibit a reflexivity in relation to the doing of normal things: “We like to go for walks to the beach, parks, stuff like that, trying to do as much barbecues, normal stuff, what people call normal” (Rachel). These enactments of the normal are, of course, situated alongside habits linked to drug use. While Seth says “We love watching movies together, reading, and getting involved with our church”, he also remarks “Well, funnily enough, our life is quite involved with clinics and picking up our medicine” (Seth). Les comments that he and his partner Libby “watch TV”, “eat”, and “talk”, while Libby says that “I think the only thing we really like doing together is using drugs” (Libby). Some participants may make extraordinary efforts to do ordinary things. As Natalie explains:

To make us feel that little bit normal, we go down to [city restaurant] to have dinner and lunch and stuff, or have breakfast. And it's the littlest thing, but it makes us feel normal... It started like basically depressing me because it was like the one thing [drug use] that we'd always do. I said 'There is not anything normal that we ever do, like we don't do anything normal like couples do. They go on dates or take you out for dinner'... It was good, like just making me feel that bit better... So, at least we got that normal thing together. (Natalie)

Maintaining a sense of normality in partnerships where drugs are a key element can take work, and this work features as part of the up and down of relationship negotiations. Tanya, who describes living in her partnership as a “rollercoaster” because “drugs have gotten in the way”, likes “going on ferry rides... to the movies... [to] the park and reading on a nice day... and [...] to the beach with [Tim]”. But Tim “just won't do that, that's too much for him, I got him to do it [go to the beach] twice in nine years”. As she explains, “Our lifestyle has been a lot more of just chasing, surviving, in terms of not being sick, because that is survival for most of us... Our lives are so consumed by the lifestyle”. Tim reflects that the consuming nature of drug use in their partnership, and their distance from normalcy, risks diluting its fundamental substance, making it less real: “I try to have a proper, real, relationship with her, but in our lifestyle it's just difficult at the moment” (Tim). Rachel and Belinda also lament how the drug in their relationships renders normalcy more remote:

Drugs, that's the sad part. As I said to him a couple of weeks ago, we don't do nothing normal together, like go to the pictures, go for tea, go to you now see a film. Normal things like normal people do. It doesn't happen with us. (Rachel)

It's just we are unable to function without the drugs... I wish it could be like that every day. (Belinda)

In these accounts we can see many efforts to overcome the challenges of enacting care in partnerships dominated by drug use. Appeals to normalcy reflect the experience of difference and detachment that characterises drug using partnerships. These are narrated as partnerships at once the same as any other (in descriptions of doing, and wanting to do, normal things) but also different from them (in their distance from, or incapacity to do, normal things). It is the *legitimacy* of relationships that are the same but different which is in negotiation when accounts seek to deflect the charge of double-edged care.

5. Conclusions

In public health research, intimate partnerships between people who use drugs have been addressed primarily as sites of risk surveillance and care intervention (El-Bassel et al., 2014a,b; Montgomery et al., 2012; Dwyer et al., 2011; Fraser, 2013) and risk management of drug dependency (Rhodes and Quirk, 1998; Simmons and Singer, 2006; Bourgois et al., 2004). Here, the couple is envisioned as a technology of public risk management, often linked to infection control. In this article, we have departed from this approach to focus more directly on the partnership itself and what it means for those engaged in it. To do so, we have taken partnerships between people who inject drugs (primarily heroin) as a case study for exploring qualitatively how care is enacted. Overall, our analysis identifies the intimate partnership as a practice of care in its social relations (Wetherell, 2012; Burkitt, 2014). These intimate partnerships produce alternative affective value linked specifically to the pragmatics and emotions of life with drug use. They enact care through enabling a resource of protection to a form of partnership conduct questioned from an inimical outside. Intimacy enacts social protection, upholding alternative values of affective care practice while cushioning isolated and stigmatised individuals from emotional harm.

We can draw some additional linked conclusions. First, people who use heroin regularly must navigate extremely hostile social environments, characterised by multiple forms of risk, violence, stigma and insecurity (Bourgois, 2009; Singer, 2004). This involves living against the trope of the ‘junkie’ and normative constructions of ‘addicts’ as less than full citizens who are positioned as incapable of conducting proper relationships given their perverse preoccupation with drugs (Keane, 2004; Seear et al., 2012). Critically, such social stigma is incorporated as structural violence through material and welfare inequalities – for instance, linked to access to income, employment, housing, and treatment – which can create a pervasive state of fragility demanding a focus on coping and survival (Bourgois, 2009). Intimate relationships have been theorised as forms of psychic defence offering ontological security in hostile and uncertain environments (Beck and Beck-Gernsheim, 1995; Giddens, 1992; Rhodes and Cusick, 2000). The intimacy of partnerships between people who use drugs constitutes a relatively safe haven, buffering the internalisation of everyday violence, or at least cushioning its effects.

Second, while the drug-using partnership is generally cast as a perverse form of care, this care produces an alternative emotional capital. According to Reay (2004), emotional capital is the capacity to navigate the emotional suffering produced by differentiation or a falling short of expectation. The care enacted through intimate drug-using partnerships generates emotional capital for negotiating the harms attendant upon difficult and stigmatising social conditions. This then, is an enactment of care negotiated in relation

to what is afforded by social conditions (Mol, 2008). Here, care extends beyond the pragmatics of enabling a partnership in which drug use features to an ethics or politics regarding how drug users, their relationships, and their care practices should be viewed and valued.

Third, whilst drug-using couples' accounts of their partnership care can be viewed as acts of defence or resistance against a norm unaccepting of drug-using partnerships, the care they enact appears in large part a coping response to managing emotional and material harms. The everything-together dimension of these affective care practices seeks to combat social stigma, but paradoxically may entrench it by reproducing the social isolation it seeks to manage. Importantly, although such partnerships may function to manage the felt effects of pervasive stigma or lack of access to employment and housing, they do not transform these relations through social change. Here, intimacy insulates from harm; it does not fundamentally alter structural relations.

Lastly, a core feature of the narration of care in partnerships in our data is its double edge. The everything-together approach of mutual reliance which makes up the care relation was also presented as potentially entrenching undesirable drug use patterns and dangers. These tensions – for instance, in pooling resources to purchase and use drugs and prevent withdrawal, and in entrapping both partners in continued drug use – were also voiced via the language of co-dependency. Accounts of drug-using partnership thus seek to negotiate, even possibly transform, their social representations. Through their critical engagement with normative representations of care in relation to the drug user and the drug-using couple, the accounts enact alternative care meanings and affect relations. It means that the care enacted is an effect of how discursive relations are played out in everyday life (Wetherell, 2012; Goodwin, 2000).

Taken together, these findings suggest a need for wider appreciation of how partnerships between people who use drugs enact affective care capital in response to social conditions and not merely in response to individual circumstances (linked to health or otherwise). This extends the scope of couple-based interventions beyond that currently envisaged by public health research. For instance, interventions of social protection may be envisaged that enable the development of emotional capital through strategies of stigma management. There is a concomitant need, of course, for structural interventions to shift both the discursive and material dynamics of the social relations which make up, as well as limit, such potential.

In this article we have envisaged the relational effects of partnership care as the coming together of people, substances, discourses, and situations (Wetherell, 2012). Perhaps unsurprisingly, participant accounts tend to reify the object of the drug as a critical actor in drug relationships and everyday relationship troubles. We can, however, see partnership care enactments as made up of a network of situated connections, including the patterning together of substances, feelings, interactions, narratives, and ways of life. In future research efforts, there is a need to move from “singling out one actor” in the relationship – usually the consuming subject – to “acknowledging the agency of the myriad additional actors involved” (Duff, 2012: 155). This implies a shift in intervention mentality from rational to relational actors (Law, 2004); that is, from individuals to couples to relationship networks.

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