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Research paper

Retrospective accounts of injection initiation in intimate partnerships

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ABSTRACT

Background: The influence of family members, peers and sexual partners on initiation to injection drug use is well established. Furthermore, research on gender differences in injection initiation has recognized the increased vulnerability of women, in particular, to injection-related health risks, and the gendered nature of the injection initiation experience. Yet more research is needed on the interpersonal and structural dynamics that shape injection initiation within intimate partnerships.
Methods: This paper draws on narrative data from semi-structured ethnographic interviews with 25, relatively stable, drug-using couples from two New York City neighbourhoods. The study was conducted between 2007 and 2009. Our analyses focus on retrospective accounts of injection initiation from IDUs who were initiated to injection (or initiated their partners) in current or former intimate partnerships. In particular we analyse narratives of injection initiation events where both partners participated as initiates or initiators.
Results: Transition to injection within intimate partnerships was common, especially for women, and occurred in specific contexts. Structural and interpersonal dynamics, including the ubiquity of drugs in poor communities and the gendered nature of drug acquisition and use strategies, as well as the problem of increased drug tolerance, situational impediments to drug access, and the perceived cost–benefit of injecting, all influenced the process of initiation to injection drug use within couples. The data also suggest that, even when risks associated with injection initiation were understood, both pragmatic and emotional considerations within relationships tended to offset concerns about potential dangers.
Conclusion: The findings suggest the need for a broad range of interventions (including couples-focussed interventions) to minimize rates of injection initiation within intimate partnerships.

Background

Injection drug use, specifically of heroin and cocaine, is associated with long-term drug dependence and increased risk for acquiring HIV and HCV (Hagan & Des Jarlais, 2000). Despite a marked increase in non-injection use of heroin in the U.S. in recent years (Broz & Ouellet, 2008; Marel, Galea, & Smith, 2005), injection remains a predominate mode of administration for heroin and cocaine (Roberts et al., 2010; SAMHSA, 2007a, 2007b). Whilst prevention efforts have reduced infection rates, injection drug use continues to account for a sizeable proportion of new HIV and HCV infections; 8% of all new HIV infections amongst men and 15% of new HIV infections amongst women (CDC, 2011a). Moreover, injection-related risk for HIV is not equally distributed amongst racial and ethnic groups. Amongst injection drug users (IDUs) diagnosed with new HIV infections in 2009, 80% of all new infections amongst men occurred in African-American or Hispanic men and 72% of all infections amongst women were amongst African-American or Hispanic women (CDC, 2011a). The CDC also reports that IDUs account for the majority of new HCV infections. Nearly 33% of young IDUs (aged 18–30 years) are currently infected with HCV (CDC, 2011b). Injection drug use can also result in other serious health problems, including bacterial infections and overdose (Binswanger, Kral, Bluthenthal, Rybold, & Edlin, 2000; Darke & Hall, 2003; Galea, Ahern, Vlahov, Coffin, et al., 2003; Garfield & Drucker, 2001).

Given these health risks, much research has been devoted to understanding the factors that influence the transition from non-injection to injection drug use as well as the injection initiation process itself. Early research focussed largely on the potential health risks of practices associated with shared injection and drug preparation equipment (Des Jarlais et al., 1999). More recent work has focussed on the social and environmental factors that influence the initiation of new injectors, including the influence of

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family members, peers and sexual partners (Abelson et al., 2006; Goldsamt, Harocopos, Kobrak, Jost, & Clatts, 2010; Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009; Neaigus et al., 2006). One of the major findings to emerge from this work is the importance of gender differences and roles in drug injection initiation that reflect the dynamics of intimate relationships and that place women, in particular, at increased risk for viral transmission (Abelson et al., 2006; Barnard, 1993; Bryant & Treloar, 2007; Diaz, Vlahov, Edwards, Conover, & Monterroso, 2002; MacRae & Aalto, 2000; Martin, 2010; Ouellet, Rahimian, & Wiebel, 1998; Rhodes & Quirk, 1998; Sherman, Smith, Laney, & Strathdee, 2002).

Evidence indicates that women are more likely to be sexually involved with an injector than their male counterparts (Bryant, Brener, Hull, & Treloar, 2010; Connors, Brown & Escolano 1992; Crofts, Louie, Rosenthal, & Jolley, 1996; MacRae & Aalto, 2000; Powis, Griffith, Gossop, & Strang, 1996), and that male injectors are more likely to initiate their sexual partners than are female injectors (Barnard, 1993; Bryant & Treloar, 2007; Bryant et al., 2010; MacRae & Aalto, 2000). These gender imbalances often result in women's heightened risk for HIV and HCV because initiators (usually men) are often the first to inject and may use the same syringe to inject their female partner. Syringe sharing during initiation is common, even amongst non-intimates (Kral, Bluthenthal, Erringer, Lorvick, & Edlin, 1999; Spittal et al., 2002). These observations are consistent with reports that women have a shorter duration of non-injection illicit drug-use prior to injection initiation than men (Bryant & Treloar, 2007) and that women are more likely to seroconvert (HIV) earlier in their injection careers than men (Friedman, Curtis, Neaigus, Jose & DesJarlais, 1999), a finding which could also be influenced by sexual practices (Neaigus et al., 1995; Tortu, McMahon, Hamid, & Neagus, 2003).

Research designed to explain these practices has increasingly drawn on socio-structural conceptual frameworks such as the "risk environment" framework (Galea, Ahern, & Vlahov, 2003; Rhodes & Quirk, 1998; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; Rhodes, 2002, 2009) as an alternative to research highlighting individual risk behaviours. According to this approach, the risk environment encompasses the social and physical spaces in which a variety of factors interact to increase the chances of drug-related harm (Rhodes et al., 2005). These environmental factors operate at the micro-level of interpersonal relationships, the meso-level of institutional and community responses, and the macro-level of structural forces such as laws, policies, social inequalities, and gender norms (Bourgois, 1998; Parker, Easton, & Klein, 2000; Rhodes et al., 2005).

Injection initiation research has also benefited from examining the broader features of social context that go beyond the initiation event itself, such as the risk trajectories experienced by drug users as they escalate into more harmful drug use practices (Fast, Small, Krusi, Wood, & Kerr, 2010). Whilst drug users often view these transitions as autonomous choices, research has illuminated how these transitions are precipitated by a confluence of specific social, structural and material conditions. These include experiences of violence and trauma, persistent poverty, dislocation, homelessness, joblessness and other large-scale political and economic changes (Abelson et al., 2006; Bourgois, Prince, & Moss, 2004; El-Bassel et al., 2004; Fast et al., 2010; Maher, 1997; Rhodes et al., 2011).

One of the most vital components of the risk environment for understanding women's drug injection initiation by male partners and subsequent heightened vulnerability to HIV and other health threats, is that of gender dynamics—both at the interpersonal and structural levels. As discussed in previous work with drug-using couples (Simmons & Singer, 2006), gender dynamics are often fluid and change over time in response to altered circumstances (e.g. incarceration of male partner) and/or individual agency (e.g. leaving a partner). Long-standing historical, economic and socio-cultural forces, including persistent economic inequality, racism and other forms of structural violence endemic in inner-city neighbourhoods, also interact with and shape gender dynamics in intimate relationships (Bourgois & Schonberg, 2009; Bourgois et al., 2004; Farmer, Connors, & Simmons, 1996, 2011; Simmons & Singer, 2006; Zierler & Krieger, 1997).

Aspects of the risk environment that involve interpersonal and structural gender dynamics (i.e., socially and culturally sanctioned gender norms and roles that play out through the interactions and communication patterns of intimate couples) also falls within the spectrum of dyadic research concerned with the mutual actions, attributes and influence between two people. In dyadic research, the unit of analysis is the relationship itself (Thompson & Walker, 1982). This focus on the dyad has advantages because, as Rhodes (1997) has stated: "risk is rarely the consequence of any one individual's decisions or actions but is influenced by negotiated actions between individuals, as well as by wider social norms and values." Karney et al. (2010) have recently proposed a framework for dyadic research that builds on the risk environment approach. It posits varying levels of environmental factors influencing dyadic processes and relationships and the interplay amongst them. In this framework, interpersonal or relationship dynamics are categorized by six elements based on prior research: commitment, trust, satisfaction, power, communication and intimacy.

Although much research with street drug-users highlights extreme violence and exploitation of women (Bourgois et al., 2004; Maher, 1997), many drug-using couples aspire to ideals of love and intimacy, whether or not they are able to actualize these ideals in their relationships (Simmons & Singer, 2006). Numerous studies report that the transition to injection drug use amongst women stems largely from a desire to increase commitment and intimacy within a romantic partnership (Barnard, 1993; Bourgois & Schonberg, 2009; Bryant & Treloar, 2007; MacRae & Aalto, 2000; Martin, 2010; Sherman et al., 2002). As Sherman et al. (2002) state, regarding the women in their study (all of whom transitioned to injecting with their male partners): "Sharing the experience of injecting was a way to be a part of the single largest focus of their boyfriends' lives" (p. 116). In Bourgois and Schonberg's (2009) ethnography of a group of homeless heroin and crack users in San Francisco, a central figure, *Tina*, describes her rationale for transitioning to injection: "I wanted to reach Carter, to get closer to my man, to feel what he was feeling." Bourgois and Schonberg interpret *Tina's* dependence on *Carter* to inject her not only as an expression of intimacy, but also as a way of strengthening his commitment to the relationship and "reinforce [his] responsibility to generate income for her new heroin habit (p. 243)."

Women often learn how to inject themselves yet still desire to be injected by a male partner. This practise has been interpreted by MacRae and Aalto (2000) as "deference" to the expertise of the male partner. Whilst this appears to be the norm, more recent research (Bryant & Treloar, 2007; Martin, 2010) has found instances of women IDUs divesting themselves of these gendered practices and showing other women how to inject, sometimes in groups, or injecting themselves without assistance. Bryant and Treloar (2007) note that "young women are using new liberal ideas of equality and a 'same as men' sensibility to gain a sense of feminine identity. This new way of thinking uses masculine norms to define what it is to be a 'modern' young woman. In the case of injecting drug use, the masculine ideal of risk-taking may be positioned by young women as a desirable feminine characteristic (pp. 291–292)."

Finally, the division of labour around procuring and preparing drug(s) and injecting equipment has also been discussed as an example of gendered power dynamics which play an important role in injection initiation. Initiators, usually men, tend to control the initiation event by buying and preparing the drug(s) and injecting equipment (Bourgois et al., 2004; Bryant & Treloar, 2007;

Bryant et al., 2010; Simmons, 2006). This practise has been viewed as increasing women's vulnerability during initiation (and subsequent drug sharing practices) due to the relatively more passive role initiates assume in procuring sterile needles and drug preparation equipment (Bryant et al., 2010). This gendered pattern may also be changing as more women acquire and prepare their own drugs and injection equipment, but the majority of initiates (both women and men) are still likely to be initiated by men as partners or peers (Bryant & Treloar, 2007).

Despite the growing body of research focussing on the social and structural dynamics that shape injection initiation amongst intimate partners, gaps remain. Because intimate partnerships comprise such a significant proportion of injection drug users, and women are more likely than men to be paired with an injector, further analysis of the interactions that shape injection initiation in these relationships is crucial. In addition, whilst the small body of research has illuminated some of the motivations of initiates, especially women (Barnard, 1993; Bourgois & Schonberg, 2009; Bryant & Treloar, 2007; Bryant et al., 2010; MacRae & Aalto, 2000; Martin, 2010), little research has focussed on the motivations and rationales of the initiators, usually men, in initiating their partners (Rhodes et al., 2011).

This qualitative study builds on the extant literature and utilizes a dyadic risk environment framework to explore the interpersonal dynamics and structural factors that shape injection initiation within heterosexual couples. Our analysis highlights the commonalities, contrasts, and social context within and across injection initiation scenarios for study participants who were initiated (or served as initiators) in current or past intimate partnerships. By eliciting the views of both male and female partners whenever possible, and highlighting their respective roles as initiates and initiators, we aim to provide a more dynamic account of the social context shaping injection initiation.

Methods

This study is part of a qualitative, longitudinal study of relationship dynamics and treatment barriers experienced by (primarily) African American and Puerto Rican drug-using couples. Twenty-five relatively stable drug-using couples (20 IDU/IDU partnerships where both partners inject; 5 IDU/NIDU partnerships where only one partner injects) were recruited from two of New York City's poorest neighbourhoods: Harlem and the South Bronx. NYC ranks amongst the nation's highest for HIV/AIDS prevalence and incidence. Rates of new HIV diagnoses and rates of people living (and dying) with HIV/AIDS in these neighbourhoods are more than twice the rates in NYC overall (NYCDOHMH, 2011). In the parent study, a series of interviews and field visits were conducted with the 45 partnered IDUs and 5 partnered NIDUs (heroin or cocaine users who never transitioned to injection). For this paper, we identified those IDUs who had participated in injection initiation as initiates or initiators in current or former intimate relationships ($N = 15$). We then analysed retrospective accounts of injection initiation from these partnered IDUs. Particular emphasis was placed on analysing narratives of injection initiation events where both partners participated as initiates and initiators.

Screening and recruitment

Couples were street-recruited by an experienced recruiter who screened potential participants according to the following eligibility criteria: (1) they both identified as a couple; (2) they had been together for at least 2 years; (3) they both used heroin or cocaine; (4) at least one partner had injected heroin and/or cocaine in the last 30 days or had a history of injection prior to entering drug treatment (for those currently in drug treatment); (5) both resided together in Harlem or the South Bronx; (6) both were between the ages of 18 and 65 years; and, (7) both consented to participate in the study. Consent was always obtained from the woman first in case she was uncomfortable about participating with her partner. No women or men eligible for inclusion in the study declined participation.

A sample of HIV-positive concordant, HIV-negative concordant and HIV discordant couples was purposively recruited. HIV and HCV status were provided via self-report during screening and during initial (separate) interviews with both partners. Participants reported their own status as well as their partner's status and no inconsistencies in reported status of HIV or HCV were found. There were no reported seroconversions during the study period. Eligibility screening also included a couple's verification screening instrument (McMahon, Tortu, Torres, Pouget, & Hamid, 2003). This verified the couple's relationship through the administration of parallel questionnaires. Recruitment and data collection took place between 2007 and 2009. To further ensure the anonymity of our participants, the federal government granted a certificate of confidentiality. The National Development and Research Institute's Institutional Review Board approved the study.

Data collection

Participants received $25 for initial $1 - \frac{1}{2}$ to $1 - \frac{3}{4}$ h, semi-structured ethnographic interviews. The interviews were conducted separately with each partner in a field site in Harlem. Interviews were conducted privately; first with the woman and then with her partner. This order was chosen to alert the interviewer to potential conflict (e.g. potential for domestic violence) as a result of the interview. An interview guide facilitated the elicitation of study participants' accounts. Injection initiation stories were elicited at the beginning of the interviews in response to a question about how and when the participant began using drugs. All interviews were conducted in English or Spanish by Dr. Simmons (PI/Ethnographer). Interviews were transcribed verbatim and cross validated against the audio files to ensure accuracy.

Data analysis

Field notes and transcripts were downloaded into *Atlas.ti* for coding and analysis (Muhr, 1991). An initial set of codes was developed *a priori* to reflect the broader study's aims. For the purposes of this paper, all narrative data initially coded for "drug use initiation" and "initiation to injection" was subsequently grouped into categories of initiators. The relevant categories were: peers of a similar age, family members, other adults, or intimate partners. Of the 45 IDUs participating in the parent study, 10 were initiated within their current or former intimate partnerships. Another 5 assumed the role of initiator in their current partnership. Initiation scenarios collected from these 15 participants were analysed for this paper. (One additional scenario of an extremely violent initiation, not included in this count, is also presented.)

We were especially interested in analysing interpersonal and/or structural dynamics in narratives describing injection scenarios. Interviewing each partner separately provided a unique analytical opportunity because five initiates were still with the partner who initiated them. These injection initiation scenarios were especially context-rich and enabled comparison of the same initiation event from the perspective of both partners. The scenarios were compared and contrasted to each other and also to scenarios described by the five partners who were initiated to drug use and/or injection prior to meeting their current partner. The presentation of our results is a product of this analytical process. By prioritizing the narrative presentation of these initiation scenarios over a thematic presentation, we sought to make connections between

particular initiation events that occurred together in time and place. In this sense, categorization is based on contiguity rather than similarity or difference (Maxwell & Miller, 2008). All names used are pseudonyms.

Results

Of the 45 IDUs enrolled in our study, 14 were initiated to injection by their peers, 12 by a family member, 9 by an adult (at least 5 years older than the initiate) and 10 transitioned to injection within an intimate partnership. This last group comprised five IDUs (four women and one man) who were still with the partners who initiated them. Eight of the 10 initiates were women — two men were initiated by female partners.

Two initiations of women were violent; one within an intimate partnership and one with 'peers'. (We have included the initiation with 'peers' because it was accomplished in the context of sexual exploitation.) Similar to other studies (e.g. Abelson et al., 2006) most initiations took place at a young age: approximately 17 years old (mean = 17.3 years; SD = 4.3). Our primary focus here is on the 10 IDUs who were initiated to injection within a current or former intimate partnership, as well as the 5 IDUs who initiated their current partners to injection. Characteristics of these 16 participants (including the woman who was violently initiated by 'peers') are presented in Tables 1 and 2. The majority of participants had already used heroin and/or cocaine with others (peers, older adults, family members, former partners) prior to their involvement with the partners who helped them transition to injection. Whilst the eligibility criteria for the study required that couples be together for at least 2 years, most were in much longer relationships, ranging from 2 to 39 years.

We found that injection initiations were shaped by both structural and interpersonal dynamics. These dynamics included the ubiquity of drugs in poor communities, the gendered nature of drug acquisition and use strategies, situational impediments to drug access (especially amongst drug-discordant partners), the problem of increased drug tolerance, and the perceived cost–benefit of injecting (in comparison to less effective delivery methods). We also found that, even when risks associated with injection initiation were understood, both pragmatic and emotional considerations within these relationships tended to offset concerns about potential dangers. The 'push and pull' of the demand to be initiated and the resistance of the initiator resulted in 'in the moment' decision-making to initiate based on situational factors in which a powerful confluence of pragmatic, interpersonal and structural factors converge in the decision to initiate an injector.

Evidence of this confluence follows. We will present three 'voluntary' injection initiation scenarios from the perspective of the initiates and the initiators. In the first two, the women were initiated by their male partners. In the third scenario, a woman initiated her male partner. We will then present two injection initiation scenarios that were violently coerced.

Initiation scenarios: narratives and social context

(3F/3M) Maggie and Manolo: "If you can do it, why can't I?"

For women like Maggie, who had never used heroin or cocaine, finding out about her husband's dependence on heroin was a shock. Manolo had done jail time for dealing heroin and had been a daily heroin user since his early teens. After he was arrested and incarcerated for selling drugs, he entered a long-term treatment program and then left New York City to avoid using again. At that point, he met Maggie. She had on occasion used alcohol and cannabis with peers and family members but had never used heroin or other illicit drugs. He never told her about his heroin dependence. In separate interviews both Maggie and Manolo described their relationship as "very close." For the first two years of their relationship Manolo was drug-free. He helped Maggie take care of her young son and they both worked. Then Manolo returned to New York to visit a friend and relapsed. When he returned to Maggie, she witnessed the change in her husband and demanded to know what he was using. After he disclosed, she tried to get him to stop. She pleaded, she threatened, and then ultimately, she joined him. She explained: "My husband started me on it. I didn't even really know he ever touched it before. I didn't know until when he was in New York to do something for a friend and then he came back with dope, and I was like, 'What is this?' And I just kept getting frustrated. 'What do you like about it?' I kept saying to him, 'Why do you like it so much?' I would see him nodding off and I would get so mad at him. 'Wake up!'" Manolo told her that because he had used for so long, he would go through withdrawal. "What kind of withdrawals do you go through?" Maggie would ask. "Again, he tried to explain, 'Well, my bones hurt.'" Maggie would respond, "Well, deal with it, be a man! And Manolo would say, 'Well, I am being a man.' He would go two days without it, knowing that his body would hurt, but then he would be like, 'I can't take it no more.' And I would say, 'You only have one more day of the physical pain.' And he would say, 'It's not just the physical; it's the mental too. You don't understand.' And then he would go and use." When she couldn't get him to stop using, Maggie demanded to try it. "I would be like, that's it. I wanna use." Manolo refused to initiate her until, she explained, "He just came over with a needle. He used to stick himself with the needle at the time. And he said, 'You wanna try it so bad? Here.' And then he stuck it in my arm up here and that was it."

Manolo offered his point of view: "I look back at it as a way I could get high. She was fighting me. She was upset. Maggie is not an aggressive person. We always would communicate, but she could hurt with her words more than if you gave her a baseball bat... There was my stinking thinking: 'That wasn't Manolo, the man who I know I am.' I was somebody else: Mr. High. I wanted to say, 'No,' but I was selfish. There was a part of me that wanted to reprimand her and tell her, 'What are you doing?' But then there was another part that said, 'So what if she's getting high? You control it.' I told her, 'You can't get addicted the way I am. You can get high today and then we'll skip a few days.' But it didn't turn out that way. It turned out, 'If you can do it, why can't I?'"

In Maggie's estimation, the blame game followed: "At first, it was my fault because I egged him on so much, but afterwards, I was blaming him. 'It's your fault. You did it to me.' That's how I felt." Now 7 years into their marriage, Manolo still regretted bringing heroin into his home and initiating his wife. "Maggie started using after our third child. I brought it around, I brought it around the family, I brought it into my home."

In this example, Manolo's relapse changed the partnership in ways that frustrated Maggie. Unable to comprehend why he couldn't just stop using; Maggie felt left out and demanded to experience the drug herself. He gave in, partly to make his own use easier, but also because he thought he could control her use to prevent addiction.

(8F/8M) Carmen and Carlos: "I had to have money for my heroin habit and her heroin habit."

Both Carmen and Carlos started using substances in their early teens. Carmen was initiated to cocaine sniffing at 14 by a 30-year-old woman whom she described as a friend. She experimented infrequently with sniffing heroin at 27, but didn't "cop a habit" until she had lived with Carlos for four years. Carlos was initiated to crack by his peers at 16, but switched to heroin at 18. After they got together, he consumed heroin, she consumed cocaine, and

Table 1
Characteristics of participants. Initiated to injection with *current partner*.

Participant	Race/ethnicity (Puerto Rican; African American; White)	Age (years)	HIV status	HCV status	Heroin and/or cocaine use	Initiate or initiator	Duration of partnership (years)
01F	PR	52	HIV−	HCV+	H,C	Initiate	39
01M	PR	55	HIV−	HCV+	H,C	Initiator	39
03F	WH	26	HIV−	HCV+	H	Initiate	6
03M	PR	32	HIV−	HCV−	H	Initiator	6
05F	WH	51	HIV−	HCV−	H,C	Initiator	16
05M	PR	56	HIV−	HCV−	H,C	Initiate	16
06F	WH	27	HIV−	HCV+	H	Initiator	7
06M	PR	36	HIV−	HCV+	H	Initiate	7
08F	PR	40	HIV−	Unknown	H,C	Initiate	17
08M	PR	38	HIV−	Unknown	H,C	Initiator	17

both avoided injecting. Like most couples (Simmons & Singer, 2006; Simmons, 2006) Carlos also assumed all the risks obtaining both her cocaine and his heroin, except when he was incarcerated. He recalled how she began using heroin with him after years of sniffing cocaine: "When I met her, she wasn't doing heroin, she was just smoking pot, sniffing coke, and maybe drinking. And one day her cocaine ran out. She saw me, I was sniffing my bag and she noticed that I was all mellowed out in a corner and she was in this "jonesing" stage. She had no more coke. And at that moment she would've done anything. But I played a huge part, because I said, 'Listen, you're kind of wired up. You got no more coke.' She wanted me to run down and do a run and cop her some more coke. I told her, 'No.' I says, 'You're running through money too quick. Listen, I'm going to give you a little pinch of this stuff right here, just enough so you could come down.' And I gave it to her. Like two minutes later, she wasn't fiending. Her head came down. She was real mellowed, and she took a liking to it. So then it became a ritual where every time her cocaine finished, she would come running to me. 'Please let me get a pinch of this.' And I told her, 'Listen, I can't do it today because I did it to you yesterday and the day before, and if I do it to you today, you're gonna catch a habit.' She was like, 'Oh, I promise it's going to be the last time.' All these promises . . . and she kind of like, persuaded me into it. So I was like, 'Ok, here.' Sure enough, before you know it, she had a habit."

In Carlos' description, a combination of factors — interpersonal, structural and situational — led to offering Carmen heroin at a particular juncture in their relationship. Whilst he assumed responsibility for his role in initiating her, he actually re-introduced the drug to her. She had tried heroin with the same woman who had introduced her to cocaine years earlier, but Carmen had never divulged this information to Carlos. Cocaine was not Carlos' "drug of choice," yet, as the man, he assumed responsibility for supplying both his own drug as well as hers. Her desire for more cocaine, just as he was savoring his heroin high, explained his reluctance to go out again to acquire cocaine (and risk arrest) at this inopportune time. Carlos, like Manolo, also recounted his belief that he could control Carmen's use by "feeding her" limited amounts of heroin so she wouldn't become dependent—a common misconception of men in this study.

Carlos then described how supplying drugs for the two of them became too much of an economic burden. The weight of that burden led to his own initiation to injecting: "It got to a point where I couldn't afford my heroin habit and her heroin habit because sniffing it was too expensive for me to keep up with. And I also noticed that, going into the streets, I had to have money for my heroin habit and her heroin habit. So there was a day where I didn't have it, and I knew that one bag wasn't going to do the trick." He described his first injection: "I kind of already knew what to do 'cause watching people. So I did it, and once again, that feeling came in like the first time I did heroin."

Despite the quality of this new high, Carlos didn't want Carmen to start injecting. He hid his syringes and injected at times and in places where he could hide his behaviour. This caused conflict between them, because, as he described it, "a lot of red flags went up." He had to keep making excuses to explain why he wasn't using with her. "I already did mines; here's yours," or "I'm in a rush." But then she found one of his syringes. Like Manolo, Carlos described how he initiated Carmen to injecting only after she demanded it. "One day she discovered it. She found the needle, and she started crying, but like an hour later, she was like, 'I wanna try it.' I said, 'No, it's bad enough you're doing it like this. I don't need you to pick up this needle.' And she kept on and kept on, and I knew that she was going to continue. She wasn't going to stop until I gave in."

Carmen confirmed how she persisted until Carlos gave in and how she continued to beg him to inject her, because, like many women injectors, she never learned to inject herself. "When he's around, he injects me. He tells me, 'I don't like doing this to you. I'm hurting you. I'm marking you. You shouldn't be doing this, Carmen.' I gotta fight him, beg him. 'Please get me, get me.' He doesn't like to do it. He'll do it just to shut me up." If Carlos was not around and Carmen wanted to use, she skin-popped.

Carlos recounted the difficulty of gaining access to both heroin and cocaine, as well as the increasing cost of their drug dependence. The "burden of care" experienced by men who are attempting to fulfil their social role as providers by obtaining and supplying illicit drugs in a normative gendered division of labour is common (Simmons & Singer, 2006). This burden ultimately drove Carlos to start injecting, albeit discreetly. The enhanced experience of the new high, combined with the cost benefits of injecting versus sniffing (a less efficient form of administration), compelled him to

Table 2
Characteristics of participants. Initiated to injection with a *former partner (plus 10F)*.

Participant (M/F)	Race/ethnicity (Puerto Rican African American White)	Age (years)	HIV status	HCV status	Heroin and/or cocaine use	Duration of current partnership (years)
02F	PR	47	HIV−	HCV−	H,C	6
10F	PR	49	HIV+	Unknown	H,C	11
18F	PR	33	HIV+	Unknown	H,C	2
20F	PR	40	HIV−	Unknown	H,C	7
22F	PR	30	HIV+	Unknown	H,C	2
25F	PR	34	HIV−	HCV+	Unknown	2

continue. Carmen, like Maggie, recognized a change in behaviour and then found his syringes. Already appreciative of a heroin high, Carmen quickly overcame her initial resistance to injecting and wore down Carlos' resistance to initiating her.

Like Carlos and Carmen, many partners used different drugs when they first got together. Switching over to the drug used by one's partner is an initiation context described by many couples. Both men and women recounted introducing their partners to their "drug of choice." As in the scenario described above, injection initiation often followed when increases in tolerance of heroin elevated the burden of supplying the drug for both partners.

(06F/06M) Rachel and Raúl: "I kind of manipulated her to do that."

Rachel and Raúl met in a detox facility. As he put it, she was "from the suburbs" and he was "from the belly of the beast." But it was Rachel who initiated Raúl to injecting. Rachel started using heroin when she was 17. When she was first introduced to heroin by a friend she had just met, she had no idea what it was or that she could become physically dependent on the drug. Within a year she was injecting, as were many of her friends. Raúl and a younger brother were raised by his aunt and uncle. His uncle was a dealer. Witnessing his brother's descent into heroin addiction delayed Raúl's interest in trying either heroin or cocaine. But at 18, after his uncle and several of his cousins were arrested and imprisoned in a federal drug bust, Raúl took over the family business. He found that cocaine kept him alert and better able to deal with the myriad challenges he encountered selling his products. Then he started to binge on cocaine. An arrest and a total of 7 years in jail broke up his first marriage, and he finally found his way to a detox facility where he met Rachel. Though both wanted to get clean, their lives still revolved around drugs. After they both relapsed and returned to their respective modes of heroin consumption — injecting for Rachel and sniffing for Raúl — Raúl explained why he wanted to inject and how he persuaded her to initiate him: "[Before] when I used drugs, I never was involved with people who used needles. The people I had been around sniffed. I never used needles. I didn't even know how to inject myself. So, being with her, I remember we didn't have too much money. I figure we got four bags, I do two, she does two. Sniffing — most of it falls out. You waste it. So if I inject it, it lasts longer and I'll feel it more. I heard a lot of stories. People tell me when they shoot; they feel the heat and all that. Damn, I would like to feel that. That started me thinking and I figured, she's a white girl, she's clean, she's young. I took a risk, the worse risk I ever took. I liked it. I enjoyed the feeling. And I felt badly because, you know, I kind of manipulated her to do that. She didn't want to. She was like fighting with me, and I was like, come on. I believe I even lied, told her I'd done it before. But I really didn't, because I didn't know how to do it. She kept saying, 'Do it on your own, because I'm not doing it.' I was like, 'Damn, I don't know how. 'Just help me out with this one, then I'm not going to do it no more. But I ended up doing it. It's the worst thing I did. I believe that's how I caught Hep C, from her."

Rachel described the initiation and subsequent syringe and injecting equipment sharing from her point of view. "He was sniffing until he met me. In the beginning I did him [injected him]. For a long while I did him. He just didn't want to be bothered. He just wanted it done for him. He was always telling me, 'No, you gotta do mine. You gotta put it together. You gotta do it for me. You gotta put it in my arm.' All the time, all the time! I'd say, 'You have to do this yourself.' But then he practiced so he could do it." . . . "We don't cook it. We just put it in the cap and mix it with the cotton. Sometimes I'll use the cap and then he'll use it. I put my stuff in, and I take it out, there's just the cotton left, and then I give it to him and he puts his in."

The discordance in mode of use, sniffing for Raúl and injecting for Rachel was, in some ways, similar to the partner drug discordance Carlos and Carmen experienced. In both cases, changes in drug tolerance, the perceived cost–benefit of injecting, and a desire to feel the *rush* of injection resulted in injection initiation despite resistance on the part of the initiator. These dynamics unfold on both structural and interpersonal dimensions in the context of addiction. They also take place at a certain point in time, as a result of situational or pragmatic factors such as Raúl's recognition that injecting would be more efficient than sniffing and he could also experience a new heroin high. Also of particular interest in this scenario, is the reversal of conventional gender roles. Rachel is an experienced injector and because both use drugs together, it is only "natural" that Raúl would pursue her to initiate him in the context of their relationship. However, she also describes some frustration at his reluctance to assume a 'male' role and inject himself. At her insistence, he eventually does learn, but both continue to share the cooker ("cap") even when they use their own syringes to inject themselves. It is also worth noting that whilst Raúl decries his choice of initiator; his exclusive partnership with Rachel did not protect him from acquiring HCV, but did protect him from HIV. Rachel injected with several men as peers and lovers prior to her union with Raúl, but they occurred in an area of the city with low HIV seroprevalence and she was spared co-infection with HIV despite her high-risk injection practices. In this sense, their exclusive relationship has been protective in regards to HIV.

Violently Coerced Initiations: (22F) Clara and (10F) Susana

Whilst the majority of initiations amongst our participants were not coerced, structural and interpersonal violence directly associated with injection initiation were evidenced in two cases. One of our participants (Clara) had been forcibly "initiated" by her husband who tied her to their bed and injected her with heroin, reportedly to prevent her from leaving him. After his arrest and incarceration, she began using heroin again to help her deal with the ensuing psychological distress. Another of our participants, at the age of 13, (Susana) was abducted, raped and prostituted as "fresh meat." After trying heroin a year later, she realized she had been injected with heroin by her abductors to subdue her. Susana describes her ordeal:

"I got raped. That's how I got the heroin. My friend invited me to go to the movies, and the girl had set me up to get raped. She was a hooker and the guy that raped me was a pimp. And they needed a girl, you know, new meat, fresh meat, so they could make more money. So I guess I was the new meat. So they came and they gave me a Mickey, what they used to call a Mickey, back in the days. That's how I got raped. [And] they had me hostage. I was there like for three weeks. They were selling me. Oh my God, this is difficult . . . the men used me, they used to inject me with the heroin. I would fight them. I didn't want them to touch me or anything. Finally, a lady went in the room to clean the room and she found me. She called the police. That's how they got me. Then I stopped the heroin. When I was like fourteen, I got back into the heroin on my own because, the rape and all — it really did a lot of damage."

We have included this case of injection initiation because it is an example of sexual exploitation at the extreme end of a continuum of interpersonal and structural violence experienced as profound social suffering by our participants. Other participants recalled extreme violence, including two rapes, as well as other traumatic events as precipitating factors in their initiation to drug use 'proper' and ultimately injection within a year to several years after initial use. These events included the premature deaths of parents, siblings and children as a result of sickness, overdose, AIDS or gang-related violence, usually against a backdrop of unrelenting poverty, dislocation (e.g. migration from Puerto Rico or the south-eastern Unites States) and the ubiquity of drugs and drug selling

in Harlem, the South Bronx, and other neighbourhoods where our participants were raised. Many of the men as well as the women experienced multiple traumas in their lives.

Conclusion and implications

These injection scenarios are consistent with the dyadic risk environment framework and findings that have emerged from research on injection initiation within intimate partnerships. Except in two cases (one involving the role reversal in the third scenario), men initiated women after injecting themselves. The ways in which the costs and benefits of injection initiation were negotiated between the two partners demonstrates the centrality of the relationship for both women and men, but also reveals how broader gender norms, drug use trajectories, and specific social, structural and material conditions influenced initiation behaviour. Dyadic analysis indicates that the set of factors that influence the decision to initiate are not the same for both partners. Although some women in our sample were invited to experience an injection-induced high by their partners, most initiates (usually women) were the ones to insist that they be initiated after witnessing their partners inject. These demands were almost always met with resistance from their injecting partners, but this resistance was ultimately overcome.

Whilst initiator partners (usually men) tried to warn against injection, experiencing the same kind of high as their partner and sharing in that experience was a major incentive for the women. This finding is consistent with the dyadic risk environment framework in that injection initiation was motivated by a desire to increase intimacy, satisfaction and commitment in the relationship. This desire to experience the drug and/or share the experience with their partner overruled their partners' warnings. In addition, within drug-discordant couples, cocaine users tended to be less cognizant of the dynamics of addiction to heroin and were not persuaded by their partners' explanations of heroin addiction and withdrawal. For these initiates, heroin also had the added benefit of counterbalancing the effects of cocaine consumption or taking the edge off their desire for cocaine. Finally, for heroin sniffers experiencing increased drug tolerance, the perceived cost–benefit ratio of enhancing their high through injecting greatly influenced the decision to initiate injection.

Also consistent with other studies was the initial reluctance of initiators (usually male) to participate in the initiation process (Rhodes et al., 2011). As for IDU couples in Hartford, Connecticut (Simmons & Singer, 2006; Simmons, 2006), with a demographic very similar to that of Harlem and the South Bronx, many of the couples in this study were in and remained in relatively satisfying relationships. Both partners came together in the hope that they could overcome their dependencies, or find someone they could trust and confide in whilst living life on the margins as they struggled with their addictions amidst persistent poverty and loss. As the "gatekeepers" of drug injection practices, men in these relationships, sanctioned by gender and cultural norms, felt an initial obligation to protect their partners from harm. It is likely that the men's eventual concession to initiate their partners had less to do with women's power in the relationship and more with other gendered norms such as the men's belief that they could control their partners' use. Other features of the situation such as the (male) initiator's own need for heroin and the way this need affected his judgment — what Carlos called his "stinking thinking" — also played a role. Men also consented to initiating partners to reduce relationship conflict (e.g. when the women were insistent), to make their own use easier (they no longer had to hide their syringes or drug use), and/or for other pragmatic reasons such as the cost–benefit of injecting versus sniffing.

Finally, the confluence of a gendered division of labour with structural violence and the risk of drug-related incarceration also played a central role in the decision-making process. In their role as providers and protectors, men typically obtain the drug(s) for both partners. The "burden of care" that men feel as the primary suppliers of the drug(s) (Simmons & Singer, 2006; Simmons, 2006) lessened men's resistance to initiating their partners. This was especially true of drug-discordant partners. Men who had to procure multiple drugs (for themselves and their partners) increased their risk of encountering violence in drug-exchanges as well as risk of arrest. These structural factors shaped injection initiation when the "burden of care" made the perceived efficiency of injection less burdensome. These interpersonal and structural factors led initiators to override their sense of moral responsibility to spare their partners the added health risks of injecting or heroin dependency.

In sum, even when risks associated with injection were understood, and initiators resisted injecting their partners, micro-level (e.g., interpersonal dynamics such as the desire for increased intimacy, satisfaction and commitment; gender role enactment; drug dependence and tolerance), meso-level (e.g., impediments to drug access; cost–benefit ratio of injecting versus inhalation), and macro-level factors (e.g., gender and cultural norms; gendered division of labour; structural poverty and violence; risk of arrest/incarceration) tended to offset the perception of potential dangers.

Our findings have implications for intervention efforts for IDUs with intimate partners, though this is not without challenge. Ideally, interventions should account for intimate partner dynamics in particular contexts and incorporate a preventive component to minimize rates of injection initiation within couples. To date, no couples-based interventions to reduce injection initiation have been developed. Peer-based interventions have had some success at least in the short-term (Des Jarlais, Casriel, Friedman, & Rosenblum, 1992; Rhodes et al., 2011). The challenge for interventions with couples, as compared to peer-based interventions, is that such approaches will require a focus on the relationship itself, particularly positive elements of the relationship (trust, intimacy, satisfaction, communication, etc.) — the same elements that motivate many women initiates, in particular, to pursue initiation in intimate relationships. Research has begun to call for couples-based HCV and HIV prevention interventions (Dwyer, Fraser, & Treloar, 2011; Simmons & Singer, 2006; Simmons, 2006) and some couples-based interventions have had success in reducing sexual risk (El-Bassel et al., 2003, 2005; Gilbert, El-Bassel, Terlikbayeva, & Rozental, in press). However, there are challenges posed by targeting reduction of injection initiation — such as the possibility that the initiated will find someone else to initiate her (or him) if a partner refuses. A more promising approach may be to provide comprehensive, integrated, harm-reduction and recovery-oriented drug treatment services to couples. For this to happen, however, paradigmatic shifts in the way in which intervention services are provided may be required. Harm reduction services will need to provide both individual and couples-based services. Likewise, drug treatment services will need to overcome the assumption that all couples must separate in order to get and stay clean (Simmons & McMahon, in press). Currently, drug treatment services in the U.S., especially for the poor, are almost entirely individually based and even hostile to partners (see Simmons & Singer, 2006; Simmons, 2006). In addition, prevention of structural antecedents to drug use and injection such as persistent poverty, and its relationship to structural violence, including gendered violence, is critically important to reduce the lure of drugs and the transmission of HIV and HCV during initiation or in subsequent sharing of injection equipment in intimate partnerships.

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