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Taking Care of Themselves: How Long-Term Injection Drug Users Remain HIV and Hepatitis C Free

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Abstract

Though prevalence of HIV and especially Hepatitis C is high among injection drug users (IDUs) in New York, about a third of those who have injected for 8 – 15 years have avoided infection by either virus despite their long-term drug use. Based on life history interviews with 35 long-term IDUs in New York, this paper seeks to show how successful integration and performance of various drug using and non-drug using roles may have contributed to some of these IDUs' staying uninfected with either virus. We argue that analysis of non-risk related aspects of the lives of the risk-takers (IDUs) is very important in understanding their risk-taking behavior and its outcomes (infection statuses). Drawing on work-related, social, and institutional resources, our double-negative informants underwent both periods of stability and turmoil without getting infected.

Keywords

HIV and HCV prevention; role theory; injection drug users; New York City; qualitative study

Introduction

Although prevalence of HIV and especially Hepatitis C virus (HCV) are high among injection drug users in New York (Des Jarlais et al. 2009; Des Jarlais et al. 2011; NYC Health and Center for Drug Abuse and HIV Research 2009), about a third of those who have injected for 8 – 15 years remain antibody negative for both viruses despite their long-term drug use (Friedman et al. 2011). The Staying Safe project used a qualitative control-case design (Friedman et al. 2008) to study and analyze life histories of long-term injection drug users. It adapted grounded theory methods to develop hypotheses about how some injectors have avoided becoming infected with either HIV or HCV.

The people we studied in this project used and injected drugs—but they also fell in love, had families, provided for their families, had hobbies – in short, *they lived*. Although a substantial but varying part of their lives was related to drugs, they also played other important roles, had other (non-pharmacological) bonds, and pursued other goals besides using drugs. As we will try to show, these roles and the social practices through which they were performed affected people's drug use and their susceptibility to and handling of risk situations.

To understand safety—in this case not getting infected—we need to understand more than situations and behaviors that put people at risk. Epidemiologic theory that focuses on recent injection practices as infection risks cannot help much in explaining how these users “stayed safe” in the long run. In addition, by focusing all attention on drug users' risk behavior, it distracts researchers' attention from other important areas of drug users' lives *that are not in themselves risks but have important effects on various risks people who use drugs face*. As we shall show, non-drug related practices contribute to peoples' fates as drug users.

Even to understand who does not become infected, then, epidemiologic risk theory is inadequate. We need new theoretical perspectives on the social processes of avoiding infection in the long run. As we shall show, a person's adjustment to drug use, including his/her successful mutual integration of drug user roles with his/her other types of roles, are pivotal in defining his/her life chances (including his/her probability of getting infected by blood borne infections). Previously (Friedman et al. 2011), we showed that attainment by drug injectors of goals that are not focused directly on risk reduction (e.g. avoiding drug withdrawal, maintaining social support), which we called ‘symbiotic goals,’ may help injectors avoid infection with HIV and HCV. In this paper, we find that role theory provides additional perspectives on how aspects of drug users' lives that are seemingly not related to risk of infection contribute to their staying uninfected.

Theoretical background

In the course of coding our data (see Methods), it became apparent that role theory and structural symbolic interactionism could provide a framework to explain what we were finding (McCall and Simmons, 1978; Stryker, 1980; Stryker and Burke, 2000; Callero, 1994, 2008) While in ‘classical’ symbolic interactionism (e.g. Blumer 1969)) social interaction is a fluid process largely shaped by specific situations (Rock 1979) structural symbolic interactionism differs from this ‘classical’ version by emphasizing social structure as a significant influence on social interaction. Structural symbolic interactionism focuses, then, both on social process of interaction and social structure, addressing the dual nature of the agency-structure relationship (Stryker 1980)--which, as some sociologists contend, is a central problem of contemporary sociology (e.g. Archer 1995). In our case this problem can be posed as: how have some drug users managed to enact different strategies that helped them to stay safe in the structural conditions they were in?

While structural functionalism defines role as a *fixed set* of normative expectations, rights, or duties attached to positions in the social structure, structural symbolic interactionism underscores role's *duality*, which is expressed in its agentic and structural properties (see

below). Roles, according to Callero (Callero 2008: 1975) ‘represent patterns of social *actions* that are classified, identified and shared by members of a particular community’ (emphasis added). Roles have a central place in linking agency and structure (Callero 1994; Stephens 1991): thus, ‘...Social roles contribute to the production of social structure, while at the same time social structure contributes to the production of social roles’ (Callero 1994: 235). Callero (1994, 2008), following (Baker and Faulkner 1991), considers roles as resources, which can be *used* to attain different benefits, both material and non-material. Thus, ‘role-using’ serves as a social process through which the individual attains different goods. For instance, availability of the drug dealer role as a *resource* allows someone to *use* it to get money, drugs, or sexual favors.

Obviously, many social interactions, especially between family members or close friends, cannot be reduced to the utilitarian plane of resource using; the richness of meanings that these interactions have for their participants should be a focus of another paper¹. Thus, we employ the term “role-using” with caution to avoid any utilitarian overtones: use of a role as a resource need be neither intentional, nor the main motive for social interaction. (Of course, in some instances intentionally manipulative relationships do take place). That is why we also employ such terms as role-playing or role performance. Among drug injectors, as among other people, there is no unitary script for role-playing – they are what Bourdieu calls ‘virtuoso social actors’ (Bourdieu 1977), whose agency and behavior are always to some extent intuitive and improvisational. Although there are some shared understandings of roles in particular social situations to make the social interactions possible there is sufficient degree of variability in how people interpret roles they are supposed to play. Cultural definitions of roles are very general frameworks within which people construct particular lines of action. As Turner (1956) argued, actors creatively ‘make’ a given role and do not just follow some unitary cultural script of its performance. Thus, role clearly has an *agentic quality*.

Roles are not only agentic, however. They also have a *structural quality*. According to structural symbolic interactionism ‘...social structure is made up of interconnecting positions and associated roles...’ (Stryker and Burke 2000: 289). In this paper we define the individual’s position in social structure as different sets of roles available to her, each of which is related with the individual’s distinct social relationships. We suggest that there are three types of social relationships and corresponding sets of roles linked to each type, which are particularly relevant for this article.

In this paper, we use the term ‘resources’ to mean a distinct type of social relationships and a set of roles associated with it. We employ a typology of three types of resources – work-related, social, and institutional. By *work-related resources*, we understand a set of roles that his working social environment (in legal or illegal economy) makes available to him that lets him attain various benefits like money or drugs by performing working roles (e.g. ‘worker,’

¹Since the question of how people remain uninfected over a number of years of drug injecting requires a long-term perspective that also recognizes that momentary lapses can lead to infection, we had to examine the life trajectories of many informants during many years. This meant that we had to concentrate on the ‘big picture’ and only selected short-term situations. We did not have space to present other different aspects of human interaction related to specific definitions of the situations, multiple meanings and diversity of human acts—except in cases where this was clearly necessary to explain particular lapses from safety

‘drug dealer’). *Social resources* refer to an individual’s immediate social environment (such as relatives, sex-partners, friends, neighbors) through which he can get certain benefits by performing role of a ‘son,’ ‘friend’ etc. *Institutional resources* are sets of roles available when someone interacts with various governmental and non-governmental agencies (syringe exchange programs, methadone programs, welfare, public housing, shelters etc.) that let someone get various services and benefits by using the role of a ‘client,’ ‘welfare recipient’ and the like. Use of a particular role may not only bring direct benefits such as money or drugs, but may also provide access to another set of roles that can bring additional benefits. For example, using a ‘friend’ role can lead to getting a job if an individual’s friend tells him about some job opportunity. Although distinctions between these kinds of resources are sometimes blurred in real life situations, they are useful analytically.

Social interaction involves social processes between at least two persons engaged in role making, and thus cannot simply be an outcome of one person’s activity, however skillfully she performs her role. Thus, resources are not reified ‘things.’ Consequently, our informants’ successes or failures in meeting their goals depend not only on their own role performances but on their social environments.

Understanding role as resource helps us think about how the concept of role is a link in a dialectical relationship between agency and structure: on the one hand, successful performance of a role in a role set available to a drug injector may maintain or increase her set of available roles, while failure to perform a role successfully may decrease her set of available roles. In this way, role-performance influences the individual’s structural position. On the other hand, the set of roles available to the individual both enables the individual’s agency (if a particular role is available to him) and constrains her agency (when she lacks access to a role). Therefore, structure both enables and constrains agency (Giddens 1984).

As was mentioned above, we intend to show how use of various drug using and non-drug using roles by drug users contributed to their staying uninfected despite many years in which they injected drugs. By *drug-using roles* we mean roles directly related to drug consumption – roles involved in finding and buying drugs, injection skills, managing dosage, interacting with other users in the process of joint drug intake, procuring access to needles, etc. *Non-drug using roles* are all other roles in the life of a person who uses drugs: social roles – son, partner, friend; working roles – both in legal and illegal economies; and institutional roles – client of rehab, detox, methadone program.

Methods

This project recruited 35 participants. To be eligible, they had to have injected drugs for 8 to 15 years, including in the recent past, and to have recent test results confirming their HIV and HCV serostatuses. Participants were referred to the project from other research projects and from a detoxification clinic. The study design is described in more detail in Friedman et al. (2008). Twenty-one participants were negative for both HIV and HCV (double-negatives -NN), 11 were negative for HIV but positive for HCV (single-positives -NP), and 3 were positive for both viruses (double-positives - PP). Seven were women, 28 men. Almost half (16) were Hispanics, 17 were White, and 2 were Black, which may indicate a relatively low

prevalence of Black injectors who started injecting since the early 1990s in New York City. Participants were reimbursed \$40 for their time and effort for the first interview and \$30 for the second interview.

In-depth life history interviews covered both drug-related and non-drug related aspects of their lives, including jobs and other sources of income; educational experiences; relationships with family, relatives, partners, friends and neighbors; sexual practices; drug history, including their experience with drug treatment and harm reduction services; and institutionalization experiences such as imprisonment and hospitalization. We got ‘thick description’ (Geertz 1973) of injection practices and management of drug use. We inquired about their drug-using practices against the background of other events to framing drug use in overall life context. Informants sometimes raised important topics that were not part of our interview guide; so informants’ life experiences significantly shaped the interviews.

Interviews were recorded, transcribed and coded for themes significant for our project using Atlas.ti software. In several cases, we conducted second interviews to clarify themes that were unclear in the first one.

During analysis, it became apparent that double-negative informants differed from positive participants in many ways other than risk practices. Most double-negatives had different relationships with their social environment, were more concerned about their health and personal outlook, were able to sustain income strategies for prolonged periods, and had goals apart from using drugs. Notions of ‘roles’ and ‘resources’ emerged organically during data analysis as ways to conceptualize aspects of double-negatives’ lives and to formulate grounded hypotheses about why they remained uninfected (Glazer and Strauss 1967).

The NDRI Institutional Review Board approved our methods and informed consents. We use pseudonyms for informants based on specific aspects of their lives. Unless otherwise indicated, the serostatus of informants whom we quote or describe is double-negative.

Results

Taking care of oneself: unraveling the meanings of what we learned about double-negatives

One emergent concept about how most double-negatives remained uninfected is that ‘they took care of themselves.’ Indeed, they often used this emic category when describing their lives. It is important to understand what the phrase means: *how* they managed to take care of themselves, in what sense, what resources they marshaled and, under what circumstances. We try to unravel this expression taking into account complex dialectical relationships between agency and structure: how informants’ use of various roles let them both inject drugs safely and maintain relative stability in their lives². Importantly, our informants often experienced more or less regular periods of turmoil, coming from their stigma, drug

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²A sizable literature describes how drug users control their drug intake and remain ‘functional’ (e.g. George 1993; Grund 1993; Zinberg 1986). This literature, however, cannot explain how our double-negatives stayed uninfected over the long haul because it does not consider HIV and HCV serostatuses; because it deals primarily with ‘recreational’ drug users, not injectors who exercised a good deal of self-regulatory behavior despite severe dependency; and because our informants periodically lost control over their addiction.

dependency and various features of their social and risk environments, which were reflected in partial loss of control over situations, disruption in role performance, and break-downs of stability of their everyday lives. These have been described as periods of (see Friedman et al. 2008b) of devolution, which may be more or less severe.

What does taking care of themselves mean for our informants? Consider the following quote:

'...try to get high successfully... Getting high without getting broke, without getting sick, without people telling you what the fuck to do...Be successful at getting high... Getting high and still maintaining... your appearance...taking care of your bills, and you stay with money in your pocket... and you still have all the heroin...'
(Pedro, male)

Thus, 'taking care' when using drugs means successfully performing both non-drug-using roles and drug-using roles—financial well-being, 'taking care of the bills,' good health (*which also includes avoiding blood-borne infections, as is discussed below*), good appearance, and getting high. This also implies a strong and independent self—'without people telling you what the fuck to do.' Thus, taking care of oneself includes taking care of one's self—in terms of external appearance, good physique, and mental well-being. All our informants also emphasized that they took care of themselves by actively trying to avoid needle sharing. For instance, Frank always made sure that he had either sterile needles or needles only he had used because he 'didn't want to get into the desperation mode' without them. Being *desperate*, with the implication that someone stops caring about sharing needles, was perceived by double-negatives as a dangerous state of self to be actively avoided.

Successful adaptation to drug use, realization that drug use per se does not equal either physical or social death, expression of this adaptation through performance of various non-drug using roles, and pursuing non-drug related goals is evident in these ruminations by James, a person who has injected drugs without getting infected despite numerous ups and downs in his life:

...I don't want to get sick. I'm sick enough as it is... the drug use is a sick thing... I can still do normal things...So just because I'm using drugs I don't consider myself to be dead. ...I don't risk myself to get close to death...

Interviewer: What are your reasons for living...if that matters to you?

James: Life itself...A beautiful day outside, there's beautiful women outside ... my daughter...and as long as I keep myself controlling my disease I can continue to live this life....I won't let the disease...bring me to a point where I don't care... it's the frame of mind.'

Many informants try to appear 'normal,' perform 'normal' roles, and pursue 'normal' goals. For some, but not all, the decisive test of 'normalcy' is their ability to pass as 'normal' in the eyes of others, that is, the inability of the latter to identify (and therefore, stigmatize) them as

drug users. (See Mateu-Gelabert et al., 2005). Consequently, successfully avoiding stigmatization let them perform non-drug using roles. Chris expresses this with pride:

‘I’m a good carpenter. And we’re talking about ten thousand square foot home and up...They are like ten million dollar homes and up and you got a fucking heroin addict fucking running the whole show and nobody knew because they couldn’t tell I was an addict...’

Even such a drastic characteristic of many drug users’ risk environment as homelessness was not an impenetrable obstacle to stay safe. Majority of our informants have been homeless at some point and several informants took care of themselves despite being homeless over long periods.

Dialectics of stability

Even though many informants ‘took care of themselves’ and maintained long periods of relative stability, these ‘rational,’ ‘keeping-it-together’ drug users nonetheless sometimes undergo periods of devolution³ - in which they partially lose control over their lives and intentions, becoming vulnerable to health-related and social harms. However, even in periods of partial loss of control, some participants maintained safer behaviors and considerable rationality. Thus, in order to understand how double-negatives stayed uninfected, we must account both for their periods of relative stability and their periods of devolution and turmoil. We also need to understand transitions between these periods, interrelationships between them, and how periods of abstinence from heroin and other drugs can help them maintain staying safe behavior. As stressed earlier, we need to analyze peoples’ life trajectories in their complexity and integrity. This section describes processes through which stability is maintained in terms of the dialectical relationship between agency and structure.

One primary mechanism in maintaining their stability is a stable source of income (see DeBeck et al. 2007; Johnson et al. 1985; Sherman and Latkin 2002) for discussion of drug users’ income generating activities). Just as work and the income it brings shape different aspects of other peoples’ lives, our informants’ ability to perform both drug-using and non-drug-using roles depend on income strategies and their capacity to draw on different types of resources. A successful income strategy or other income source (such as disability payments) lets them perform these roles and enact their other strategies more successfully. It helps them maintain access to drugs and to syringes; lets them borrow money based on their ability to return it (which includes receiving credit from drug dealers if the informant temporarily lacks cash); and lets them avoid pooling money with other users to buy drugs—which facilitates safer injecting (Mateu-Gelabert et al. 2010). A stable income strategy thus reduces frequency of being in risky situations like withdrawal (Connors 1994; Rhodes and Treloar 2004; Mateu-Gelabert et al. 2010), lack of sterile syringes (Medhi et al. 2011; Neagus et al. 2008; Normand et al., 1995); and needing to inject with other users (Connors 1994; Bourgois et al., 1997; Koester, Booth, and Zhang 1996; Mateu-Gelabert et al. 2010).

³Thus, the picture of taking-care-of themselves users who ‘have everything under control’ in the previous section was accurate, but incomplete. That picture described what ‘taking care of oneself’ means. Though such periods of control are of paramount importance for our informants for staying safe, they by no means exhaust their life trajectories.

For instance, Richie, who maintained a stable job as a barber during five years, could rely on his dealers for credit. Having a stable income source also allows drug users to perform non-drug-using roles like spouse, parent, son, daughter, other relative, or friend, and to maintain a proper appearance and avoid homelessness. Richie's job let him both get high and take care of his family:

'To me, if I was working, then it was okay, cause I was still putting money in my pocket and I was still taking care of my family...That was the important things for me. You know? Maintaining a proper image and taking care of them.'

Robert tells how his role as husband and worker restrained his drug use for years.

'I wanted to be home for her when she got home from work too. So I wasn't always out ... getting high and chasing drugs you know, and stuff like that. So I'd spend time with her, and that kept me from being out on the street using a lot... because...the other things that I had going on in my life, work and ...the wife and stuff... I just couldn't spend everything on-I mean I came too close to spending everything I had on...drugs, but... the time didn't allow for it.'

Thus, stability is an accomplishment that is achieved through complex dialectical relationship between agency and structure. Injection safety is reinforced and facilitated by performing non-drug using roles. For example, the role of worker or drug seller not only provides means to perform various drug-using and non-drug-using roles—it provides means to support the worker or seller roles themselves. Most aspects of 'taking care of oneself' as described above are made possible through realization of some income strategy, and, in turn, this 'cared-for-self' makes these strategies realizable. Clean appearance is necessary to maintain a job of successful drug dealer but without this income (or any other) it is impossible to project this image. Similarly, even while homeless, James and Michele could take care of themselves because they had stable income strategies – drug selling for James, prostitution for Michele.

Usually, all types of resources are utilized for maintaining stability. A person may work at a legal job (drawing on work-related resources to perform 'worker' role), stay at his relative's house (using social resources through performance of 'son's' role), and get syringes through a syringe exchange program (employing institutional resources through 'client' role). The combination of resources and relative significance of a given type of resource varied throughout a person's life trajectory and between different people.

Frequently-employed stable income strategies of double-negatives included both legal and illegal strategies: legal jobs, drug selling, stick-ups (robberies) of drug dealers, boosting (stealing from stores and other places), and sex work. The central income strategy that drew on social resources was a relationship with a partner who could provide money or drugs. For example, Ernesto, who used to do stick-ups – thus employing work-related resources to get needed drugs—told us about such long-term relationship with a non-drug using woman who supported his drug use.

To summarize, stability maintenance for double-negative informants involves a very skillful mastery of both drug-using and non-drug-using roles, finding a dynamic set of compromises

between them in changing role conflict situations, and virtuoso use of various types of resources.

Dialectics of Devolution

Instability is also a product of the dialectic relationship between agency and structure: it is a downward spiral in which losing control over drug use and failure to successfully perform either or both drug using and non-drug using roles lead to diminished resources that in turn reduce opportunities (available role sets) to regain stability. As a consequence, people may lose such stabilizers as social support, income sources, and housing. As we point out later, however, drug users who take care of themselves often resist these downwards tendencies.

Sometimes, it seems like addiction itself derailed our participants' lives. Participants told us stories, familiar from both medical and popular discourses, about how their tolerance to heroin grew, how they started to use more to feel the 'high', how their income strategies became insufficient for providing for their habit, and how they failed to successfully perform both types of roles. Pedro, who, as we have seen, managed to 'get high and still maintain,' describes one period of devolution:

'I'm using heroin and now all my money is gone. I'm stealing from my mother's purse. I'm stealing from the family. I'm sticking up drug dealers. I'm selling dummies in the street. I'm selling crack. It turned...into a really big monster.'

He then describes his stopping caring about himself and failure to perform non-drug using roles:

I'm starting to have like a non-caring attitude about myself. Like I stopped caring about the rest of the world and just concentrated on dope.'

This is the point where my mother doesn't want anything to do with me. I robbed my mother for \$1,000. I stuck up my cousin. I robbed my other cousin's house.

Nobody wants me around. People are looking for me to kill me.'

Our informants also told us about other triggers of devolution such as, traumatic events, (divorce, loss of loved ones or starting use of new substances (e.g. crack)).

After his wife's death James underwent a serious devolution when, among other things, he stopped taking care of his appearance:

'So when she died of that, it really broke everything, my spirits, my mind. I really went berserk. So loading up was the only way I could deal with it. Like I said, I did that for about four or five months, where I actually don't remember intervals, couple hours, I'd be nodding out, then I'll wake up, look for the next shot, "Hey Sophie, do it up," then fall out again. It was like that for a while. I was dirty, grungy, no shower, beard was out to here, 'fro was out to here. I was really, really fucked up.

The consequences of devolution are various, and so are its degrees. As a result, some informants found themselves homeless, some in prison, some totally without social support and isolated. Some, however, even though they strained their relationships almost to the

limit, avoided the most severe consequence of these kinds. In either case though our double-negative subjects retained considerable agency and rationality for not to sharing needles.

Breaking the vicious circle of devolution

One crucial question about the life trajectories of double-negatives is how they managed to break the vicious cycle of devolution at its various stages and regain stability in their lives.

In maintaining stability, double-negatives drew primarily on work-related and social resources, and used institutional resources mostly as secondary stabilizers. To end devolution periods, however they relied on institutional resources. This is not surprising. In periods of heavy and uncontrolled or poorly-controlled drug consumption, they used up almost all their work-related resources (perhaps due to an inability to work) and social resources (relationship benefits), so their only way to regain stability was to use institutional resources like drug detoxification or rehabilitation, harm reduction, or methadone programs. In other cases, where less-severe devolution threatened to spiral out of control and destroy social and work-related resources (even when these resources were not spent completely), double-negatives also used institutional resources to disrupt the spiral and re-establish control.

In some cases, the remaining social resources took the form of a relative who took the informant to a program. But without institutional resources, it is very hard to imagine how our informants could get back on track. Thus, program staff friends in a syringe exchange program helped James overcome his devolution following his wife's death.

‘I went to the needle exchange, they actually did—I think they call it an intervention, where a few of the counselors who really care about me, I guess, they locked me up in a room, “Hey, look, we see you going downhill. Before you kill yourself, this is what we’re going to do.” They showered me right there...they shaved me. ...They cared, that’s why today I still go there, I’m still cool with everyone in there. ...If it wasn’t for them I’d be dead right now....’⁴

We can see from that quote that in the peak of his devolution James had several counselors that ‘really cared’ about him. This was so because previously James had performed the client role actively and creatively (‘role-making’ in Turner’s terms): in contrast to many clients who use their ‘client’ roles rather passively – exchanging syringes, receiving the program’s materials and leaving, James hanged around at the program venue and made friends with some of the program’s personal, which helped him later.

During times of devolution, many informants interpreted their poor performance of both drug-using and non-drug-using roles as a signal that something was seriously wrong and urgent measures had to be taken to prevent further decline. Pedro went to a methadone maintenance program. Richie relates how, in the period of devolution set in motion by doing speedballs, he began to fail to perform various non-drug-using roles and had to enter a methadone program to stabilize the situation. His account, which stands in a striking contrast

⁴This quote also appeared in (Friedman et al. 2008b)

to James's one, shows how different devolutions can be from one another in terms of severity:

'Yeah, certain things that I would normally pay attention to, I wouldn't. You know like I would be late with the rent. I would...fall off on my responsibilities at home... I broke some of my own rules...it would take me longer to take a hair cut, people would notice when I needed to shave, you know, I started slipping a little bit, not slipping to the point that I was like out in the street, but it wasn't normal... people, everybody knew that there was something wrong... I was always making excuses for them, ...for my girl, making excuses for my family...I started missing days at work... Then after all that, that's when the methadone program came...into play.'

Thus, performing non-drug-using roles and/or taking care of oneself even somewhat substandardly can be indicators of trouble and signals to act to restore the balance. Comparing the cases of devolution of James and Richie we can also see that apart from *objective* variability in devolution's degree, there is also variability in devolution's *meaning* for different participants. Whereas for James devolution in terms of appearance means being '*dirty, grungy, no shower, beard was out to here, 'fro was out to here*' for Richie to be in a state of devolution means that '*people would notice when I needed to shave*.'

In the overwhelming majority of cases, devolution ended with the aid of institutional resources, and our participants regained stability either in an institutional setting of a detox or long-term rehabilitation program, or in a methadone program, or even in prison

'Client' and 'prisoner' roles that our informants performed helped them rebuild work-related and social skills and resources that were later mobilized for stability-maintaining drug-using periods. For example, Chris – a talented carpenter, whom we have encountered earlier, maintained his stability when using drugs by carpentry – a trade he had learned in a rehab program. As Thomas (who learned the trade of tattoo-making in jail) puts it: '*People learn a lot of trades in jail – both legal and illegal*.' These institutional roles also help to repair relationships with relatives and partners that were disrupted in devolution periods. Pedro describes how participating in a methadone program helped him repair relationships with his family:

'And I started going there, and I stayed on the methadone maintenance program. You know I'm doing pretty good, you know. I'm starting to look good. My family is starting to look for me again. I'm not getting high.'

By enrolling in detox and methadone programs, Richie not only restored family relationships but found a social support network of individuals similar to him (in terms of drug use and injection safety and also in terms of their performance of non-drug-using roles), who looked out for each other.

As with devolution when a diminished agency led to a diminished structural position, agentic use of institutional client roles helped these double negatives to improve their structural position – to build or restore other types of resources that then helped them maintain their stability during later drug using periods.

Failing to Stay Safe

Though we have concentrated on life-histories of those who succeeded to stay safe, it is important to discuss why our single- or double-positive informants failed to do so. The vast majority of the infected participants could be named 'indiscriminate sharers' as they frequently shared syringes in situations where they didn't have their own ones.

Several people in our sample, however, had practiced staying safe behavior for a long time but then ceased to do so. It is somewhat unclear why this happened, and this question needs further research. When asked why they started sharing syringes after years of having avoided sharing, the usual answers were: 'I stopped caring,' 'I didn't give a fuck,' and the like. There was also a small subgroup of informants who were identical to double-negatives in terms of staying safe behavior but nevertheless got infected with Hepatitis C (see more on that in Conclusion).

The 'indiscriminate sharers,' however, differed from double-negatives in many ways. One important difference was in terms of caring about one's health. Systematic comparison between the two groups showed that the double-negatives took care of their health significantly more than the positives. They were more concerned about contracting HIV and/or 'catching disease,' 'catching something' via injecting than the positives. They also expressed more concern about getting 'infection' (of any kind) via non-injecting routes. In addition, they were more worried about the condition of their veins (both as physical routes of drug intake, as potential stigmata, and as collapsed veins or abscesses; they were more careful about overdose; and they sought medical help in non-emergency cases ('as normal people' – and they took pride in it). Differences in approach towards one's health appeared most clearly in situations of drug withdrawal when informants did not have their own injection equipment. Most double-negatives, even in periods of devolution, managed not to share needles, or did so very rarely (using bleach, with its uncertain ability to reduce infection risks). They narrated numerous other strategies of coping with withdrawal (Mateu-Gelabert et al. 2010). They told us: *'I'd rather sniff,' 'I'd be sick as a dog but still not share.'*

By contrast, positives accentuated the importance of immediate relief from withdrawal despite possible infection by blood-borne viruses.

'But as a heroin addict and you more... scared of being sick at the time than worrying about if you going to catch disease, because, you know what, you not going to die instantly. You know, I worry about the late consequences later, like right now I just want to get off E [drug withdrawal], I just want to get all right, you know. Never in my mind it cross about like, "Oh, should I needle from this guy? No, no, no, no, I'm sick right now, I just, can I use your syringe?"' (Emilio, m, NP).

Thus, positives failed to perform the drug-using role successfully, which is an indispensable condition for avoiding HIV and HCV infection. In contrast to the double-negatives, who underscored that drug use was not and end in itself (*'I can still do normal things...So just because I'm using drugs I don't consider myself to be dead'* - James) and tried to 'get high and still maintain,' some of the positives expressed fatalism with regards to their health or

even life, as illustrated by the following quote: *'I'm a junkie, if I die it's ok'* (Sandra, female, PP). Consequently, while double-negatives have resistant, *agentic* selves, the positives tend to have *fatalistic* selves. This fatalism maybe one reason why 'indiscriminate sharers' failed or did not want to perform staying safe practices.

We have stressed the importance of successful combination of both non-drug-using roles and drug-using roles in staying safe behavior. The example of Juan, Hepatitis C positive, who may be considered a typical 'indiscriminate sharer,' demonstrates how failure to successfully perform both types of roles leads to frequently being in risky situations (withdrawal, lacking one's own syringes, needing to inject with other users), which, in turn, may lead to high-risk behaviors.

We asserted above that having a regular income is pivotal to maintaining stability in the lives of double-negative informants. Juan rarely had a stable income strategy, most of the time he had small 'hustles,' like selling syringes, which he obtained from a SEP (as a result, often finding himself without a syringe himself), selling 'loosies' (single cigarettes from a cigarette pack) and the like. He did not have non-drug related life goals like maintaining a stable relationship, raising a child or keeping a job. Even in his 'best time' when he was selling drugs, he was getting paid with drugs, so he didn't have spare money to spend on other goals beside drug use. We can say that Juan was heavily engulfed in drug-using roles (Stephens, 1991). Early in his drug injecting career he failed to successfully perform a 'cousin' role, and consequently, remained without relative support, which proved to be so vital in lives of the double-negatives.

'And he [cousin] went to take a bath, I took his pants and I took his wallet. And I have it. He had like 200 and change. So I took his wallet, took the money and threw the wallet on the bed and I left the house. I never seen him again'⁵.

As a result, Juan has lived in the street ever since. While the double-negatives underwent both periods of stability and devolution, Juan's life has been characterized by systematic instability, which manifested itself in frequent difficulties in finding money for drugs (*'I don't got no job. It's hard for me to accumulate \$10 dollars for a bag'*), drugs themselves, lack of syringes at hand, large and often anonymous injection network. These are risky situations of the kinds we described above. As in the case of many other positives, when being in drug withdrawal the need to get an immediate relief from pain associated with withdrawal prevailed over safety reasons.

'I'd use anybody's syringe... Most of the time, yeah...Like I say, I'd wake up sick... And, and I don't have the energy to go, go get a syringe and then go to the spot and you know, it's really bad. The sickness and all that stuff.'

Summarizing the brief description of Juan's case it is apparent that he did not take care of himself in the many aspects the double-negatives did.

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⁵Though this quote looks very much similar to where Pedro described how by sticking up his cousin he severed his social relationships, there is a crucial difference: Pedro later managed to restore his relationships, while Juan did not.

Conclusion

We have tried to demonstrate how non-risk related activities in the life-trajectories of long-term drug injectors helped some of them avoid HIV and HCV infection. Staying uninfected for a long time seems to require actively ‘taking care of oneself,’ which includes skillful performance and integration of both drug using and non-drug-using roles, and being able to resort to institutional roles in periods of devolution. Successfully playing roles of ‘worker,’ ‘relative,’ ‘client’ etc. are as important for staying uninfected as playing the role of a careful drug user. Only simultaneous consideration of these two types of roles can clarify how these individuals maintained stability in their lives and fought and overcame periods of devolution. Efforts to stay safe and avoid needle sharing are a part of more general efforts to take care of oneself and maintain ‘normalcy’ by enacting a variety of roles in one’s life.

Stability and instability are products of dialectical relationships between agency and structure, where having a stable income strategy plays a pivotal role. A stable income strategy allows successful performance of various drug-using and non-drug using roles including the one that generates this particular income strategy. Our informants used three types of resources both in periods of stability and turmoil: work-related, social, and institutional. Throughout their lives they drew on these resources simultaneously, although the relative importance of a given type of resource varied, both during the life of a given individual and among different individuals. Our informants’ narratives showed constant process of using various resources by performing corresponding roles – for example, use of social resources (talk with a friend) leads to use of work-related resources (taking a job), which can maintain and strengthen extant social resources (relationship with relatives). The same talk may also lead to using institutional resources (going to a syringe exchange program), where again new social resources (new friends) can be accumulated⁶. Work-related and social resources played a central role in stable periods of our informants’ lives, but institutional resources were necessary to interrupt the vicious cycle of devolution.

Comparing double-negatives with the infected showed that most positives were unable to consistently perform these types of roles. This led to their being more often in various risky situations, which increased their chances of getting infected with HIV and/or HCV.

This study has several policy implications. First, it suggests that various stakeholders should re-evaluate the roles of methadone, rehabilitation and detoxification programs. Discussions of these programs usually focus on their effectiveness in ending clients’ use of illegal drugs. For instance, there is research on transformation of selves from “drug-user self” to “former drug user self,” and adoption of new roles that are useful for ‘staying clean’ while in these programs (e.g. Hughes 2007). Our study shows that these programs also help drug injectors to stay “safe.” People who inject drugs (and, probably, others who use drugs—but we did not study this) use these institutions to restore and accumulate various resources that they

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⁶We should underscore the provisional, interactional and context dependent nature of roleusing as it involves at least two persons, interacting in particular situations. In the above example, ‘friend’ cannot be construed as something akin to a material, ‘guaranteed’ resource such as money; it is *both* successful role-playing on the part of our informant and her friend’s ability and willingness to help (e.g. to engage in the conversation and provide information) that result in a practical outcome. In other interactional situation, a talk with a friend can be completely useless in terms of increasing an individual’s resources. Thus, roles-as-resources are not things but opportunities.

lost in periods of devolution. Thus, these institutions can be major vehicles to return stability (and, therefore, more chances to keep themselves and others safe) to vulnerable people, even if they continue drug use. Our data suggest that widening programs' scope and making them more easily accessible could reduce infection rates among drug injectors. There are also indications (for example, the case of Richie) that safe injection and support networks can be formed at these centers, so they also can be vehicles to help propagate safety norms.

The study also showed that having a stable income strategy is paramount for people's viral safety. Many of our informants prefer to work in the legal economy, and some succeed in doing this. However, due to stigma, past criminal histories, unstable housing, low education level, a lack of employable job skills, or just lack of employment opportunities for anyone in a locality, opportunities for legal employment for many people who use drugs are scarce (Bretteville-Jensen and Sutton 1996; Rothbard et al. 1999; Sherman et al. 2006). Special programs for employing drug users should be implemented and/or widened.

Finally, on the basis of this and other work that we have done, we are convinced that new types of intervention programs among drug injectors should be developed and implemented. This paper indicates that such programs might use what we have learned from double negatives' lives to help people who inject drugs to successfully combine drug using and non-drug using roles, to prevent and/or cope with devolution, in short, how they can 'take care of themselves' and maintain 'normalcy' in their lives despite their drug use.

Taking into account the probabilistic nature of viral infections—i.e., that with HIV and Hepatitis C, any given behavioral interaction such as an instance of syringe sharing or unsafe sex between discordant partners is unlikely to result in successful viral transmission—we see that our accounts of why some people stayed safe despite their long-term drug use are by necessity incomplete. The probabilistic nature of infection has implications: on the one hand, it means that even one instance of injecting with an infected syringe can lead to infection; on the other, it means that a person might take risks hundreds of times and remain uninfected. In short, avoiding infection involves 'luck.' Remaining double-negative does not require 100% avoidance of syringe sharing and other risk behaviors, and, indeed, many of the double-negatives had rare instances of syringe or other drug paraphernalia sharing. On the other hand, we had a small group of informants who were indistinguishable from the double-negatives in terms of their risk practices but nevertheless got infected with Hepatitis C. That the number of such informants was small – there were only three of those – provides support to the role-theory approach to understanding of blood-borne infection avoidance undertaken in this paper.

There are many research issues that were left unaddressed in this paper. One of them, mentioned above, concerns the subgroup of positive informants who had practiced staying safe behavior for a long time but eventually ceased to do so. More research is needed on why this happened, what conditions preceded these events, and what might keep it from happening. Last but not least, more research (both qualitative and quantitative) is needed to deepen, confirm or refute our results.

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