THESIS

INJECTING INEFFABLY: A QUALITATIVE STUDY OF HOMELESSNESS, COMMUNICATION, AND INJECTION DRUG USE IN DENVER, COLORADO

Submitted by

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ABSTRACT

INJECTING INEFFABLY: A QUALITATIVE STUDY OF HOMELESSNESS, COMMUNICATION, AND INJECTION DRUG USE IN DENVER, COLORADO

This study provides qualitative analysis of intra- and intergroup communication dynamics between injection drug users experiencing homelessness and people who do not inject. The analysis is grounded in Classical categories of *techne* and *phronesis* with expressive modes of *mimetic* and *diegetic* learning. Analysis also considers functional uses of public secrecy in discourses about injection drug use and secrecy's effects on social appropriations of phronesis, techne, and subjective identity with injection. This study presents five unique case studies of interviews with injection drug users experiencing homelessness in Denver, Colorado to discuss how themes of injection drug use are experienced, and/or communicated at the street level. Particular attention is directed to themes of initiation to injection drug use. This study is informed by a harm reduction curriculum set forth by the Break the Cycle program and the Harm Reduction Action Center in Denver, Colorado.

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CHAPTER ONE: INTRODUCTION

A vacant lot runs adjacent to Colfax Avenue, known as the world's longest commercial street, in Denver, Colorado right before it becomes an overpass organizing a cloverleaf of on and off ramps to Interstate 25. This piece of trivia is boasted in graffiti on the viaduct's concrete pillar directly below Colfax traffic: "Do you know where you're standing? Beneath the longest commercial road in the WORLD!!" The nearby vacant lot is posted as property of Denver's Regional Transportation District and is within view of low-income housing developments, a university campus, and a sushi restaurant. It is two blocks away from my kitchen, bathroom, and bedroom—my home. Looking around it can be a pleasant lacuna in the landscape. Walking in the lot I feel exhilaration for being somewhere I know I am not expected to be. When I see the first used syringe under the dry grass I am both abjectly disturbed and excited as though I have spotted something dangerous and elusive. I grow concerned when I find several more. Finally, when I return a week later with a friend, bringing biohazard containers, protective gloves, and garden trowels we remove 120 injection devices from the grass in order to have them incinerated at the hospital. The cache of used syringes becomes commonplace—set beside a bicycle, a scooter, a bag of gauze and antiseptic, a paperback of "Chicken Soup for the Soul," and many changes of worn out clothing that are also found in the lot. The needles are artifacts of something hidden and secret just below the humming idyll of the busiest intersection in Denver. They are artifacts of a social life in

hiding that is too easily reduced to the interface between chemical and mechanical technologies and the body. I am not excited about the syringe. I have seen enough of them to ebb any curiosity about the device. I am excited and concerned about the life that they were attached to. *Who was here? And what did they do?* My goal in this study is to bring light to complex communication challenges, and complex forms of caring, consideration, and love that are experienced among injection drug users who experience homelessness. This "light" does not necessarily call forth beauty or gratuitous sympathy. Indeed, to get to this point I look to a general and terrible problem within scenes of homeless injection drug use: turning new people on to the needle. I hope to develop better understandings of how injection drug users experiencing homelessness, do, do not, or cannot adequately engage responsibility for communicating about or demonstrating high-risk behaviors of injection drug use to people who do not inject. Initiation to injection drug use, as I discuss it in this study, reveals a particular communication-based problem. Initiation ensues after "talking about" and demonstrating injection practices. Not talking about injecting is a primary strategy offered to injectors who struggle with not introducing new people to injection drug use. I am interested in the utility of this silence, the discourses that emerge within it, its effects on those who keep it, and situational struggles in remaining silent within circumstances of homelessness. It is my goal to distinguish in qualitative detail how themes of intimacy, secrecy, and isolation influence discursive and performative communication about injecting and how communication and silence about injection characterize injectors' identification of intimacy and social relationships in contexts of homelessness.

This study relates to communication and cultural dynamics between states of homelessness and initiation to injection of heroin in Denver, Colorado during the second half of 2010. During this time, various (re)presentations of homelessness and drug addiction mingled throughout my hours and spaces in Denver. My study is informed by my professional, activist, and volunteer positions in relation to injection drug use and homelessness. While preparing the research protocols for this study I worked as a street outreach case manager to individuals experiencing homelessness, an activist as an outreach worker with a direct action syringe exchange program, as well as a volunteer with the Harm Reduction Action Center where this research took place. Understanding homelessness as a contextualizing factor of communication about injection drug use, I focus on communication among injecting heroin users experiencing homelessness and people they encounter who do not inject illicit drugs. I do not attempt to build or demonstrate causal relationships between injection drug use and homelessness or vice versa. This is to say that this thesis does not discuss whether homelessness leads people to injecting heroin, or whether injecting heroin ultimately leads to homelessness. However, literature that is consulted in this study discusses correlations between homelessness and injecting. Instead I am interested in how co-occurring environments of homelessness and injection drug use create elaborate communication challenges in instances when an individual is pressured to share knowledge about techniques and disclose benefits of injecting. Using five qualitative interviews with participants in the Break the Cycle (BTC) program at the Harm Reduction Action Center (HRAC), a Denver-based service provider to active injection drug users, this study qualitatively strives to answer the following research questions:

RQ1: How do BTC participants who experience homelessness describe intra-group and inter-group communication dynamics with people who do not inject drugs within contexts of homelessness?

RQ2: To what extent do BTC participants who experience homelessness find it possible to isolate communication about injection drug use?

RQ3: In what qualitative ways is experience as an injection drug user a culturally valued identity role within contexts of homelessness?

RQ4: What qualitative challenges does homelessness present to BTC's intervention into not discussing the benefits of injection with non-injection drug users?

These questions, crafted in dialogue with HRAC staff, provide the base inquiry of my exploration of communication dynamics between heroin injectors experiencing homelessness and other social agents that are relevant to scenes of initiation. Focus questions supplement RQ2 and RQ3 in the concluding chapter of this study where I return to address all research questions.

This introduction will provide specific detail of heroin's presence in Denver, discuss initiation to injection drug use as a signal event that introduces new categorical risks to drug use, discuss correlations between homelessness and injection drug use that poise environments of homelessness as particularly vulnerable contexts of initiation, describe the general philosophy of harm reduction as a response to challenges associated with injection drug use initiation and elaborate on its practical application in the Break the Cycle curriculum at the research site. A section discussing theoretical concepts that inform my analysis of the interviews follows the introduction section. Then I provide a description of the research protocols and methods used to observe groups, invite

volunteer subjects to individual interviews, and engage conversation on research topics. Finally, in this opening chapter I discuss my own professional, volunteer, and activist positionalities in harm reduction work to individuals experiencing homelessness and injection drug users and how these roles develop my research interest and guide my engagement in writing.

Heroin Trends in Denver, Colorado: Summary of the DEWG Report

The prevalence of heroin use in Denver is a difficult phenomenon to track. However, some methods of measurement help to conceptualize heroin's impact in the city. The Denver Office of Drug Strategy's Epidemiology Work Group provides estimates of heroin's saturation in Denver through data from treatment admissions, autopsy reports, and law enforcement seizure. All of the data presented in this section is referenced to the October 2010 proceedings of the Denver Epidemiology Work Group (Denver Office of Drug Strategy, October 2010). In the first half of 2010 16.1% of drug treatment admissions (excluding alcohol treatment) were heroin related. Of these, 85.8% of heroin treatment admissions were injectors (p. 25). Changes in methods of detecting heroin as a cause of death increased reports of heroin deaths in Denver. Newly implemented toxicology measurements allowed for the detection of 6-monoacetylmorphine, the signature compound that is revealed in the body as heroin metabolizes into morphine. Starting in 2008 the Denver Office of the Medical Examiner was able to better differentiate heroin deaths from morphine and codeine deaths by looking for the metabolizing compound. Consequently, heroin has displayed a very lethal presence among all drug-related deaths in Denver, finding heroin in a range of "4.0 to 23.7 percent of Denver drug related decedents from 2003 to 2009" (p. 26).

Tracking of heroin markets by law enforcement name Denver as "a prominent redistribution point for the Midwest and East Coast" (p. 26). Drug Enforcement Administration (DEA) analysis of trends in illicit drug markets suggest that Denver heroin is more pure and cheaper than heroin found elsewhere. DEA purity tests of heroin seized in the Denver region measure "heroin purity levels as follows: first quarter FY2010 purity at 44 percent for ounces and 71 percent for kilos; and second quarter FY2010 purity at 34 percent for ounces" (pp. 26-27). This supply of high-purity heroin is more consistent than other drugs due to their sourcing from "small, generally tight knit family based organizations [that are] largely independent of the well known poly-drug cartels [in Mexico]" (p. 26). Supply of other drugs in Denver is not as stable as heroin due to "cartel infighting" that brings dysfunction to production and distribution of other substances. In spite of the high presence of heroin in drug-related deaths, the stability of the heroin market in Denver, and the relative purity of the heroin supply, heroin does not prevail over cocaine, methamphetamine, or cannabis in frequency of hospital emergency visits or samples exhibited to law enforcement. The presence of heroin in drug-related deaths (most recently, 23.7%) alongside its scarcity in hospitalization and law enforcement outcomes is perhaps telling of the social insularity of heroin use as well as its stark lethality (p. 25). The pathological and degenerative effects of injection drug use such as HIV, Hepatitis C, or infection of abscesses extend this lethality.

Injection Drug Use and Initiation

Injecting illicit drugs signals a critical and decisive point in careers of drug use. The syringe is a technology of drug use that mediates new drug experiences, health risks (Roy, Haley, Leclerc, Cédras, & Boivin, 2002), and social stigmas (Rhodes, et al., 2007).

The point when a person chooses a particular route of drug transmission for the first time is known as "initiation." As its name connotes, initiation to injection drug use (hereafter, initiation) has largely shown itself as a social affair with identifiable socio-cultural relevance (Stephens, 1991). Injection, as a technical practice, requires keen attention to a number of details. The syringe, along with its associated technologies, known collectively as "works" (cottons, cookers, lighters, water, bleach, alcohol swabs, tourniquets, etc.), assemble many subtleties of cultural know-how that are orchestrated in a particular way to allow an individual to effectively administer a drug (shoot, or hit). Additional nuances in the practice of shooting illicit drugs are revealed with the type of drug being administered, geographic regions of drug markets and corresponding trends in unregulated drug quality (Andrade, Sifaneck, & Neaigus, 1999), physical condition of the injected tissue (Roose, Hayashi, & Cunningham, 2009), and improvisation of works based on need. Unlike clinical uses of the syringe, technical knowledge of illicit drug injection is cultural knowledge passed on through social networks at the street level. While a cultural ethic exists among many injection drug users to not initiate new people to injection drug use (Kerr, Small, Fast, Krusi, & Wood, 2009; Rhodes, et al., 2007), non-injection drug users (NIDUs) curious about injecting are often importunate in obtaining a first hit from an experienced injector (Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009; Hunt, Stillwell, Taylor, & Griffiths, 1998). Epidemiological and public health research has consistently probed social phenomena of initiation to injection drug use. Literature has sought to define social networks of initiation and evaluate their socioeconomic and sociocultural conditions. NIDUs curiousity about injecting is cultivated within communicating contexts of injection drug use where stigma of injecting

practices and social roles are demystified and NIDU become more amenable to positive associations with injection drug use (Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009; Sánchez, Chitwood, & Koo, 2006). Ecologies of social and intimate relationships (Bravo, Barrio, de la Fuente, Royuela, Domingo, & Silva, 2003), and environmental contexts have shown substantial influence on NIDUs' decisions to initiate, or not initiate, injecting. Seminal observations by Stillwell et al. found initiation to injection drug use was likely to culminate after NIDUs environmental exposure to "modelling" (sic) behavior by experienced IDUs. In particular, observation of injecting as well as communication about the benefits of injecting were factors that elicited recently initiated IDUs' inceptive curiosity about injection drug use (Stillwell, Hunt, Taylor, & Griffiths, 1999). Perceived intimacy between initiates and the modeling agent is also indicative of an NIDU's likelihood to choose injection as a primary route of heroin administration (Bravo, Barrio, de la Fuente, Royuela, Domingo, & Silva, 2003). Homelessness is revealed as one social landscape that is particularly vulnerable to incidents of initiation. The next subsection elaborates on correlations between street life and initiation in Denver and other urban areas.

Homelessness

Homelessness is broadly and locally correlated with injection drug use and initiation. In New York City, Neaigus et. al found that homelessness combined with "greater communication promoting drug injection" prevailed as primary predictors of NIDUs' likelihood to pursue initiation to injection drug use (2006). Specifically in Denver, Colorado, a 2002 needs assessment of local IDUs identified that most focus group participants were homeless or had experienced homelessness at some time

(Lineberger & Simons, 2002). Social contexts of homelessness have important influence on how communication and drug use occurs. The negotiation of public space in day-to-day activities of IDUs presents considerable intra and interpersonal challenges to the social life of IDUs. The arc of social experiences that maintain an individual's practice of injection drug use are navigated through stigma and isolation by mainstream social actors in Denver (Lewis, Koester, & Bush, 2002; Rhodes, et al., 2007) and further mitigated by everyday infractions of legal and social conventions (Sánchez, Chitwood, & Koo, 2006). NIDUs who experience homelessness may often experience exposure to injection drug use as part of their environment in the shared isolation of homelessness. This exposure may allude to communication and social influence about injection. As Neaigus et al observe, "homeless [NIDUs] may be receptive to direct social influence promoting injecting because they may have fewer social contacts with non-IDUs . . . and greater social contact with homeless drug users who may be more likely to inject drugs" (2006). These potential social influences, wrought through communication about injecting in scenes of homelessness, are the subject of this study. Harm reduction is a practical and philosophical perspective that considers social influences and communication as integral to social harms. The following section details harm reduction and its relationship to the topics at hand.

Harm Reduction Philosophy

One response to the rapid spread of disease among IDUs has been a reappraisal of cultural, interpersonal, and intrapersonal preoccupations of drug use and drug treatment. One important outcome of this reappraisal has been the cultivation of a set of practical strategies known collectively as "harm reduction" that guide the telos of drug control

away from more common methods of policing, prohibition, and court-mandated abstinence (Harm Reduction Coalition). In lieu of taking a prohibitionist perspective on drug use that creates antagonism between drug use, addiction, and good social order, harm reduction privileges individual relationships and choice-making as a strategic method of "reducing harm" of drug use. Within harm reduction, social control of drug use through the enforcement of policy is a remote experience to elaborating relationships, identifying harms within drug use, and creating multiple and poly-vocal options for preventing harm. In so doing, abstinence from drug use, or admission to drug treatment are merely two options among many in considering how to proceed through an addiction. Harm reduction principles have been applied to many issues of societal anxiety but its resonance with injection drug use is prominent. The strategy of harm reduction permits flexibility to discipline safer methods of drug use that prevent transmission of disease rather than "treating" use on an individual basis through clinical or policing initiatives. In spite of its effectiveness in decreasing and preventing the spread of disease by dialoguing with active users at the point of their participation in social problems such as injection drug use, harm reduction is often viewed as a pariah of public health strategy in the wake of the highly campaigned US-American led War on Drugs. As a result, harm reduction often presents itself as a progressively activist approach to human relationships and collective relationships to social anxieties such as HIV, crime, drug use, and homelessness. As a physical site, the Harm Reduction Action Center, originally inducted as the Harm Reduction Project, presents a unique environment of education, direct service, and civic engagement not found in other social service or health agencies.

The Harm Reduction Action Center

The Harm Reduction Project, located in Denver, Colorado, first opened its doors in 2002. Alternatively known as "the drop-in" or "the Little Red House," the Harm Reduction Project officially renamed itself as The Harm Reduction Action Center (HRAC) in May, 2009. The new name, elected by the client community, reflected a spirit of advocacy for harm reduction values and practice that had gestated throughout the history of the organization. HRAC is a small, inconspicuous, rented residential building that is recognized along with a number of other social-service oriented programs as forming a three block corridor of services that includes a free community bicycle shop, a food bank, and a day-time drop-in center for the homeless. Within the walls of the small two-bedroom house, HRAC provides a variety of basic need services such as showers and laundry facilities, a functioning kitchen, a coffee-maker, group programs, individual therapy, access to works (not including syringes), and pamphlet literature on basics of harm reduction and safer drug use. The backyard is encircled by a privacy fence and houses a community garden with several lawn chairs where individuals can feel at leisure. HRAC has been a convergence space for any number of other service providers in need of access to the drug using population. With a staff of three full-time employees and a volunteer base of 55 individuals, HRAC maintains 18 hours of open drop-in time per week as well as consistent street outreach efforts and public issue organizing. HRAC is positioned between a quickly gentrifying district of Denver, known as the Santa Fe Arts District, and an extended industrial hinterland of rail yards, public utility lots, scrap yards, and city lots storing raw goods for various construction projects. This landscape also includes a number of transportation arteries into the metro-area including a light-rail

line, Interstate 25, 6th Avenue, 8th Avenue, and Santa Fe Drive. Each of these arteries, with the exception of the light-rail and the commercial cosmopolis of Santa Fe Drive, exists as a viaduct moving over the neighborhood and providing shadowy seclusion and shelter for any number of homeless individuals who desire nocturnal proximity to the services they access during the day. A congestion of homeless camps endures near the I-25 bridge at 13th Street, less than a mile from HRAC. More camps make temporary homestead along the Platte River trail, which winds its way perpendicular to the opposite end of the 8th Avenue viaduct that meets HRAC. The heavily used bicycle trail is well maintained and provides deep banks of dense foliage in which homeless communities may excuse themselves from the invasive gazes of passerbys. By no means is this area the only district where homelessness is experienced in Denver. However, HRAC operates in a well-calibrated location for interacting with IDU who live on the streets and access services by neighboring organizations. One of HRAC's focal group programs, and the central program associated with this study, is Break the Cycle.

Break the Cycle

Break the Cycle is a practical intervention that attempts to provide strategies for active IDUs to avoid initiating new people to injection drug use (Alliance for Open Society International, 2007). HRAC has adapted the Break the Cycle protocol to a group intervention (hereafter, BTC). BTC engages active IDUs around three main strategies for preventing initiation among NIDUs: 1) not injecting in the company of non-injectors, 2) refusing requests for information about injection, and 3) not talking about the benefits of injection in the company of non-injectors (Harm Reduction Action Center, 2007). Within this triumviral approach to non-initiation, program evaluations of BTC report that not

talking about the benefits of injection around NIDUs has been the most difficult strategy for program participants to engage. Recent data from BTC evaluations at HRAC identified that 68% of annual participants in the program were homeless within 30 days of their participation in the program (Harm Reduction Action Center, 2010). BTC facilitators at HRAC seek a better understanding of barriers to practicing this strategy.

Consistent throughout current literature on initiation is a social environment inclusive of NIDU and IDU where injection drug use is revealed in a communicable way. Neaigus et al, and current Break the Cycle evaluation, has placed communication environments between NIDU and IDU within landscapes of homelessness. Furthermore, studies observe that communication about injection drug use is antecedent to NIDUs desire to try injection, their persistent requests for initiation to experienced users, and initiation itself in the eventual administration of a first hit (Neaigus, Gyarmathy, Miller, Frajzyngier, Friedman, & Des Jarlais, 2006; Hunt, Stillwell, Taylor, & Griffiths, 1998). While this literature observes that IDU modeling and communication about the benefits of injection are pursuant to NIDUs desire to transition to injecting, corresponding literature appears lacking in research that qualitatively examines how IDUs and NIDUs communicatively navigate topics of injection and drug use within situational communicative contexts such as homelessness. By understanding the ways cultural prerogatives of NIDU and IDU socially interact in shared social environs, qualitative research can improve practical interventions around communicating about injection drug use. This study qualitatively focuses on how communication about the benefits of injecting occurs between IDU and NIDU in social contexts of homelessness in light of BTC program curriculum.

Theory

Many theoretical ideas help to guide analysis and discussion of the research questions. This section details some of the fundamental terms and ideas used throughout this study. This section makes important distinctions in types of knowledge (*techne* and *phronesis*), modes of learning (*mimesis* and *diegesis*), errs of reasoned action (akrasia), and operations of secrecy in creation of subjectivities and discursive regimes. This section is organized in two main subsections: Classical Rhetorical Concepts, and Discourse and Secrecy.

Classical Rhetorical Concepts

This study understands its subject matter, initiation to injection drug use, as a type of practical learning set within particular social settings of homelessness. My theoretical departure for discussing knowledge associated with injecting is found in classical philosophies of reasoned action elaborated by Aristotle in the *Nicomachean Ethics* (trans. 1973). Furthermore, Aristotle's *Poetics* (trans. 1996) issues important distinctions in expressions of learning that inform analysis of initiation scenes. In particular, this study deploys Aristotle's concepts of techne and phronesis as forms of practical knowledge, concepts of mimesis and diegesis as expressive forms of social learning, and the concept of akrasia as a descriptive circumstance that results when the reasoned will does not compel a reasoned action. The remainder of this sub-section will operationalize these concepts in terms of their usefulness for organizing themes in this study.

Techne and phronesis are terms associated with practical knowledge. In this sense, when we discuss techne or phronesis we discuss *knowing how* a practical problem is overcome. Techne and phronesis are forms of knowledge that are poised to reveal

material outcomes and practical ends. In spite of this critical commonality, an important distinction between these concepts brings each term into a distinguished focus. Whereas techne concerns knowing how to engage knowledge as practice, phronesis applies practical knowledge alongside values-based analysis of what is "good or bad" in practical action. Phronesis is decisive on ethical implications within particular and variable examples, whereas techne is not critical of situational nuances that inform a good, valued action (Flyvbjerg, 2001). In this study I distinguish knowledge about injecting as a techne insofar as techne informs an initiate of how to put technologies and techniques associated with fixing and administering a shot to use. Techne describes the procedures of preparing drugs and works. Essentially injecting as techne is the form of knowledge required to prepare a drug and make the syringe register with a vein and function. I distinguish phronesis as knowledge about injecting that considers circumstance, ethic, consequence, and prudence within practical engagements of injecting. Phronesis is not a static technical knowledge but is knowledge in constant deliberation with value-placing factors of social life. Applied to the practical knowledge of injecting, techne yields knowledge about how "to," whereas phronesis may also consider other variable factors such as "how much," "how often," and "how come." While phronesis presumes techne, alternating distinctions of initiation as techne and/or phronesis have important effects on experiences of akrasia, and formulations of subjectivity in this study. Methods of learning, as well as the form of knowledge that is learned, inform formulations of IDU subjectivity in this study. Aristotle's concepts of mimesis and diegesis bring important distinctions to how techne and phronesis are learned.

Mimesis and diegesis describe learning through two distinct expressive characteristics. Mimesis distinguishes learning that is imitated in social action from diegesis, which is learning that is instructed through discussion. Diegesis requires symbolic action through speech or instruction whereas mimesis can be witnessed and imitated through everyday social learning. In scenes of injection drug use the difference is in learning how to inject by explicit instruction by an initiator (diegesis) or alternatively through seeing and imitating injection practices (mimesis). Both expressions of learning occur in scenes of initiation in this study and suggest consequences for how individuals perceive their subjectivity as IDUs and responsibility to techne and phronesis. The latter, a sense of responsibility toward practical knowledge of injecting, formulates states and experiences of guilt and/or regret that are akratic to the reasoned intentions of injectors.

The concept of akrasia describes incongruent states of rationality and action. Akrasia is associated with a "weakness of will" when presented with options of "good" phronetic action. The guilt, shame, and regret associated with descriptions of initiation in this study are symptomatic of akrasia. This study appreciates IDUs not as intrigants but as experienced social actors struggling with will, weakness, and phronetic hindsight. This study operationalizes the term akrasia to highlight diametrical tension between decisive reasoning and action in scenes of initiation. The concept of akrasia identifies irresolution between thought and action but does not interpret such irresolution. As John Callender states, "Akrasia . . . [is a term] that is descriptive rather than explanatory" (2010, p. 228). Akrasia occurs in key situations that obscure the phronetic judgment and will of participants in this study. This study discusses the detail of these situations as

well as tactics employed by IDU experiencing homelessness to strategically avoid situational factors that lead to akratic action (as opposed to improving upon an already fortified desire to not initiate new injectors).

The classical considerations of distinct forms of knowledge (techne and phronesis), distinct expressions of learning (mimesis and diegesis), and akratic tensions between reasoned will and action interpellate an economy of discourse about homelessness and injection drug use that is constitutive of secrecy. The next sub-section discusses theories of discourse and secrecy that inform analysis in this study.

Discourse and Secrecy

When we talk about "not talking" we are talking about contriving secrecy. In the case of Break the Cycle, where the objective of not talking about the benefits of injecting is to disparage the prospect of someone initiating injection drug use, secrecy is imbued with rhetorical significance. The injection high is ineffable—not in the sense that it cannot be spoken, but in the injunction that it ought not be spoken. In step with this secrecy is proscribed physical isolation of the practice of injection from NIDUs. Break the Cycle encourages secrecy in both mimetic (i.e., do not demonstrate injection) and diegetic (i.e., do not speak injection) arenas of knowledge. Break the Cycle counsels practical strategies of isolation and secrecy in order for IDUs to assume agency for preventing initiation of new people to injection drug use. This secrecy and isolation, providence to the uninitiated, has strong implications and revelations of knowledge's relationship to power in developing senses of agency and subjectivity for IDUs and NIDUs alike. Two intertwined approaches to secrecy inform this study's analysis and

discussion of the research questions in terms of identity formation, subjectivity, and the Break the Cycle program.

Foucault—Incitement to Discourse

Foucault's investigation into the relationship between secrecy and power on the matter of sexuality is instructive of how an ineffable injection moulds subjectivity and a societal drive to discuss injection. Foucault identifies a modern, proliferate emergence of multiple organized discourses about sexuality that at once appropriated discourses on sexuality while recasting them in a new discursive economy that implements secrecy (Foucault, 1978). In much the same way, BTC is shown to appropriate discourse about the benefits of injecting while interdicting secrecy and elaborating participants' subjectivity within scenes of social interaction with NIDUs. This is not to say, from the beginning, that the BTC curriculum is coercive, or robbing its participants of self-control or an ability they had before the class. Rather, BTC attempts to set participants' subjectivity to new ends, inviting a multiplistic view of their agency in scenes that lead to initiation. Indeed, in observation of the BTC groups much interplay exists between participants' being asked to remember their initiation, confess instances of initiating others, and assess scenarios when future initiations could occur. The transformative goal of the BTC curriculum is to invite injectors to practically assert responsibility toward their desire to not expose new people to injecting. BTC presumes participants' desire to not initiate new users, as evidenced by often-spoken regrets of initiators. Secrecy and silence are offered as practical strategies to prevent initiation. BTC's task and its utilization of secrecy is not far from the critical task undertaken by Foucault (1978) when he states:

> Silence itself—the things one declines to say, or is forbidden to name, the discretion that is required between different speakers—is less the absolute limit of discourse . . . than an element that functions alongside the things said, with them and in relation to them within over-all strategies. . . . [W]e must try to determine the different ways of not saying . . . things, how those who can and those who cannot speak of them are distributed, which type of discourse is authorized, or which form of discretion is required in either case (p. 27.)

The foundational contrivance of secrecy alongside harm reduction discourse about initiation is important to the analysis of intrapersonal identification with injection drug use, interpersonal intimacy among IDU (as well as with NIDU), and gratifications of communication and confession about injection drug use. However, within scenes of homelessness—where seclusion and privacy are not secure in spatial jurisdictions—secrecy, here secrecy about injection drug use, abides in a very publicly-known manner. Michael Taussig's work on defacement and public secrecy extends Foucault's working of silence and is instructive of how secrecy can codify information that is out in the open.

Taussig—Defacement and the Public Secret

Micheal Taussig operationalizes his concept of the "public secret" as "*that which is generally known, but cannot be articulated*" (Taussig, 1999, p. 5). This concept occupies Foucault's description of silence where silence is not a limit of discourse but a referenced mechanism of discursive productions that organize power. Much like Foucault's silence, Taussig's "public secret" operates along the fringes of discursive limitations, collocating subjectivities by retaining power of secrecy in spite of actualized

knowledge. Foucault, speaking in terms of sex, suggests that, "What is peculiar to modern societies . . . is not that they consigned sex to a shadow existence, but that they dedicated themselves to speaking of it *ad infinitum*, while exploiting it as *the* secret" (Foucault, 1978, p. 35). This discursive "exploitation" of secrecy—secrecy's utility to subjectivity and power—is perhaps Taussig's primary concern along with moments when this exploitation is defaced, or revealed in a negative action that re-mystifies the status of the public secret. This study understands initiation as defacement *par excellence* and discusses initiation as defacement in the conclusion. For now, Taussig's characterization of the public secret and defacement is helpful to guide discussion of communication dynamics when IDU are solicited to perform initiations, and emotional bonds that are created between initiators and those whom they initiate.

Methodology

Interview data, along with passive observation of two BTC group sessions informs this study. All methods of study were approved by the Institutional Review Board of Colorado State University.[1] Interviews were loosely structured around the interview guide provided in Appendix A. BTC group observations occurred in the first and third month of a six month data collection period (June 11 through December 11 of 2010). In order to not interfere with the environment of trust and integrity established in

[1] This study corresponds with Protocol ID number 09-1327H of the Institutional Review Board at Colorado State University. This protocol was initially approved on May 3, 2010 and slightly amended on June 3, 2010. The necessary amendment released the research site from responsibility for communicating participants' eligibility outcomes directly to potential participants.

BTC groups no notes were taken during the group sessions. However notes were immediately constructed following the session. Invitations to participate in one 40-60 minute interview with the researcher were communicated through a poster displayed at the research site. The poster displayed the following eligibility requirements to participate in the study: aged 18-45, homeless, participated within Break the Cycle within the previous year, primary heroin injector.

To correspond with HRAC's most recent program evaluation data on the BTC program, attempts were made to stratify the ideal cohort into male and female groups as well as three age groups. Snapshot evaluation data of BTC observed that 74% of homeless participants were male and 26% were female. This study attempted to stratify a 3 to 1 ratio of males to females for cohort subgroups yielding and ideal 12 person cohort of 9 men and 3 women. Additionally, upon recommendation by HRAC, the target cohort was stratified into three age-based subgroups: 18-24, 25-35, and 36-45.

Upon the initial conversation with potential participants a series of screening questions were asked regarding the age and gender demographic of the potential participant, their identification of homelessness, their preferred substance for injection (heroin), and the recency of their participation in the Break the Cycle curriculum. Additionally, potential participants provided answers to general questions that coded corresponding data in HRAC program evaluations. The regenerated data code was then provided to the Program Evaluator at HRAC for verification screening of eligibility requirements. At no time did the author of this study access individual data from HRAC. Upon verification screening of eligibility (age, gender, homeless status, primary heroin use, and BTC completion within the previous year) potential participants were re-

contacted by the researcher to schedule a time to review the potential risks and benefits of participation, acknowledge informed consent for participation (or not), and proceed to an interview (or not). Potential risk and benefits of this study were communicated to participants via a cover letter. However, documentation of informed consent was waived in review by the Institutional Review Board. All participants agreed to have their interviews recorded to audio for the purpose of transcribing interviews to written data. Upon transcription all recorded interviews were destroyed. Participants in the study were each given 20 dollar gift-cards to a local grocer. A flowchart of the recruitment process for this study can be found in Appendix B. Content analysis of the data collected by this method is presented in chapters two, three, and four of this study.

At the close of the six-month period of data collection, approximately 42% of the target cohort were interviewed. Additionally, the stratification of older men was fulfilled (N=3) along with the stratification of 18-24 year-old participants (N=1). Only one interview was completed for the largest numbered stratification of men between 25 and 35 (25% of the target number). No women between the ages of 25 and 35 or between the ages of 36 and 45 were interviewed. Four individuals contacted the research for more information about participating in the study but did not proceed to meeting in person.[2] In

[2] Many potential participants were reticent to discuss the potential interview and confused the study with simultaneous studies being conducted by an organization called "Project Safe" that is affiliated with the University of Colorado Denver's Department of Psychiatry. Project Safe is a familiar resource to the Denver IDU community, providing "prevention education, drug treatment facilitation, social service referrals, and street outreach" (Safe). Upon iteration of "Colorado State

total, this study engaged five English-speaking participants in individual hour-long interviews structured around the interview guide in Appendix A. The interview guide did not explicitly state the research questions of this thesis. However, the questions were crafted to guide insightful conversation research themes. Participants ranged in age from 19 to 44. All participants had participated in the BTC curriculum within the preceding year and had identified homelessness upon engaging in the program. Homelessness refers to having a primary residence on the streets or outside, in a shelter, temporarily with a friend or family member, in transitional housing, or in any other environment not suitable for human habitation. Of the five participants in this study, three reported camping as their main residence and the other two reported a mixture of camping and temporary stays with friends.

Researcher Positionality

Before moving forward with analysis and discussion of the research presented in this study, notes regarding my researcher positionality are befitting. My research interest in injection drug use and communication has been sown in professional, activist, and volunteer areas of my social life. These efforts have afforded me proximity to the research topics at hand while eliciting the research questions outlined in this thesis. During the course of this study and for three years preceding this study I have been employed as a full time Street Outreach Case Manager to homeless youth through Urban

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University" some potential participants immediately declined further conversation or hung up the phone. The invocation of "State" here perhaps signals associations with law enforcement (i.e. conceptualizations of "the State") that trigger anxiety and distrust with potential participation in the study.

Peak, a nonprofit organization providing social service to individuals under 25 years old who experience homelessness. In this capacity I walk the streets of Denver providing basic need services and case management to homeless youth whom I get to know. One service offered in the work of street outreach is the distribution of bleach kits to injection drug users on the streets. Bleach kits contain several works (sterile water, bleach, cottons, cookers, alcohol wipes, twist ties, instructions, condoms, and resource pamphlets) that allow injectors to clean needles before shooting. Distributing these technologies is a harm reduction effort. However, the distribution of sterile syringes remained outside the letter of the law in Denver during this time. Independent of professional efforts and time spent as a Street Outreach Case Manager I co-facilitated and organized direct action exchange of syringes to known injection drug users in Denver from 2008 until the beginning of this research with the Underground Syringe Exchange of Denver (Denver, 2009). This model of distributing clean syringes in exchange for the safe disposal of contaminated syringes is common best practice in many areas of the world and other states besides Colorado. Throughout this research I assumed an ancillary role to directly providing syringe exchange by organizing trainings and forums on direct action syringe exchange, facilitating clean-up of sites littered with contaminated syringes, fundraising for the underground program, and engaging political process for the legalization of syringe exchange in Colorado. Legalization was won in 2010, however continued work is needed to bring an above ground program to Denver. The research interests I elaborate here have been cultivated in partnership with the Harm Reduction Action Center, where I have been a volunteer and professional partner for several years. My familiarity with the site was not far removed when I began this research. As a

volunteer I occupied space when the drop-in center was open, and closed, assisted with community-based organizing, and discussed what research questions required elaboration in day-to-day programming with the organization's leadership. HRAC was instrumental in helping me conceptualize the methodology of this study but remained absolutely independent from contemplating the data and drafting this report. Finally, I have not personally experienced homelessness, injection drug use, or the use of illicit drugs.

Writing, Engagement, and Structure

Considering my positionality between advocacy, service provision, and the issues of homelessness and injection drug use, my hope in research and writing is not to defend a removed investment in the lives and stories presented in the following chapters. Chapters two, three, and four, present detailed accounts of actively engaged interviews that were complicated by numerous factors. For instance, the romantic relationship between Beth (chapter two) and David (chapter three) may call forth an extended drama in the reading—a complicated and terrifying circumstance of love in the midst of initiation to injecting. As it is, I have consciously attempted to present their contributions to the research independently while not discounting the complicated formulation of intimacy they experience together. In Chapter four I present testimony from three different participants whom all occupy the same stratified demographic of men between 36 and 45. It is important to keep in mind the diversity that exists within these three interviews while seeking to understand how they work together to inform the study. Although the interview guide in Appendix A helped to structure all the interviews, none of the open-ended interviews followed the same trajectory. For practical matters of reading I have opted to codify block quoted testimonies by the first initial of the

pseudonym of each participant (i.e., Beth's contributions to block text are preceded by [B]). My contributions in block texts are identified by the initial [R], for "Researcher." Chapters are organized sequentially by the age demographic of the participant(s). Chapter two is proprietary to the testimony of a 19-year-old woman, chapter three presents testimony of a 26-year-old man, and chapter four presents varying testimonies of men between the ages of 40 and 44. The final chapter returns to comment on the research questions, provide additional comments, and suggest limitations of this study and considerations for future research.

CHAPTER TWO: BETH AND THE PHENOMENOLOGY OF AN INITIATE

Beth consented to participate in this study shortly after being initiated to injection drug use by David, another participant whose interview is discussed in Chapter Three. Beth's recent initiation, combined with her exclusive gender and age demographic within the cohort of this study, presents unique thinking about intergroup communication dynamics between injection drug users and non-injecting drug users (RQ1), isolation of communication about injecting (RQ2), identity formation, and cultural roles of experienced injectors (RQ3). As a novice injection drug user, Beth occupied a great deal of her interview with reflections on her own changing identity and subjectivity as an IDU. At the close of the interview, in response to being asked "You're feeling alright with how [the interview] went?" Beth replied, "Yeah. Yeah definitely. That's the most I've ever talked about it. So it's kind of, it helps to actually hear yourself, what's going on." Beth's reply not only suggests that the interview had a self-reflexive effect for Beth, but also distinguishes her intrapersonal interest to discuss themes of self throughout the interview. This analysis, like the interview, is contextualized within predominant interests of self-identification and provides discussion of intrapersonal and social strategies that at once move toward and away from establishing subjectivity as "a junkie"—Beth's opted term for injection drug user. This analysis suggests that Beth creates a rhetoric of a "public secret" regarding technical knowledge (techne) of injecting that permits her to engage in injection drug use without fully subjectively identifying as

an injector. Indeed, although Beth can be regarded as an *injection drug user*, she is not appropriately distinguished as an *injector* since she does not perform injections on herself—she does not inject, she receives injections from her boyfriend. The public secret of (not) knowing how to inject stalls Beth's sense of agency in making choices about her growing dependence on heroin and sets her apart from other "junkies" who elicit and signify her deepest fears regarding addiction. Analysis of Beth's intrapersonal reflections on cultural identity as a "junkie," including the displacement of agency through public secrecy about injecting will guide discussion of communication dynamics between IDUs and NIDUs (RQ1), cultural roles of injectors (RQ2), and isolation of communication about injecting (RQ3) in Chapter Five.

Becoming an Injector

Beth is a 19 year old woman who grew up in an adoptive family in another state. While there she suffered an accident that broke both her legs. She was prescribed Percocet for pain-management and soon after grew dependent on the drug and started snorting crushed pills. Beth reported that she took "14 to 15 pills a day" at the height of a two-year addiction to Percocet and then independently stopped using them. However, Beth moved to Colorado Springs, took a job in the health care industry where the drug was widely available, and soon resumed her use of Percocet. In Colorado Springs Beth met David, another participant in this study, and they started a relationship. Throughout the interview Beth referred to David repeatedly as "my fiancé." David and Beth left Colorado Springs together and started camping and couch surfing in Denver. Beth states, "I just kind of dropped everything and followed my fiancé and, so, this is where I ended up and I don't regret it."

David is an experienced heroin injector and Beth started using heroin intra-nasally after observing him, "[Heroin] was my fiance's choice of drug. . . . being 19, young, naïve, and curious about things, I watched shit for a couple months and then I thought I'd have a drag and I got hooked." Beth snorted heroin on only three occasions, and within days she was initiated to injecting by David. When asked how long Beth had been using heroin by injection she replied, "I only snorted it three times before I injected . . . so pretty much four months minus, like, four days." Injecting immediately became the exclusive route of heroin transmission for Beth:

> [R] Since you've started injecting do you use heroin in any other way or are you injecting every time?
>
> [B] No, just injecting every time. . . . I just, for me it's just the ultimate high and I love how it makes me feel. So if you like something, you know, why try something different if you know what you like?

Beth's introduction to injecting quickly accelerated to an exclusive preference for injection drug use. Although Beth was able to assert this preference for using heroin, she remained unable to perform an injection. Beth was initiated without practical knowledge of the techniques of injecting. David administered injections to Beth and withheld information about how to inject from her. The next section discusses how techne of injecting was rhetorically contrived as a secret within Beth and David's relationship. The goal of this rhetorical secret was to curtail escalation of Beth's dependency on heroin injections by nullifying her ability to act as an autonomous, phronetic agent in administering injections.

Relinquishing Agency and Knowing What Not to Know

Beth intentionally maintained a passive role in her experimentation with heroin injecting by giving David control over administering her injections. Within the stated agreements of Beth and David's relationship David solely authorizes Beth's frequency of use, and dosage amounts by physically performing any and all injections of heroin.[3] David's role as a technician and authority was repeatedly invoked as a confidence-builder in Beth's decision to inject heroin. When asked "how did your mind change" about initiating injection, Beth suggests that her confidence is partially derived from trust in David's authority:

> . . . . the fact that he does it for me. The fact that he controls, you know, he maintains, he supplies doses. I'm not even personally allowed to, he, I've never even held it personally in my hand. I've never even held a balloon [of heroin] or anything personally. The only thing that I ever held that has to do with anything is a tourniquet, a cooker, um, alcohol swabs, and my rig in my shoe. You know, everything else, I'm not allowed to possess the actual dope itself. And usually I'm not even allowed to hold my rig . . . .

Beth considers technical knowledge of the techniques and technologies of injecting dangerous and actively attempts to distance herself from knowing how to administer

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[3] Chapter Three gives a detailed discussion of this arrangement between David and Beth. The practice of preparing and administering injections for novice heroin IDUs is often referred to as "doctoring."

injections by investing power, responsibility, and phronesis, in David. Beth recalled explaining to a peer who was critical of David's authority, "He's helping me as best he can by controlling what I do. By limiting me and denying me when he feels it's right . . ." Beth consciously impairs her sense of autonomy and choice-making in order to feel insulated from the possibility of addiction and overdose. She impairs her autonomy by exerting intention and effort into not knowing how to perform injections while establishing David as a separate agent responsible for maintaining her use. In this sense, Beth's concern is in "knowing what not to know"—in contriving a secret, and remaining inept at the techne of injection as a buffer against increasing her dependence on heroin (Taussig, 1999). Possessing technical knowledge of injecting would usher in a new sense of responsibility for restraining use that Beth feels unprepared to confront:

> [B] I don't know how to cook it up myself. I don't. That's something [David] won't let me know which I think is a good thing because it controls what I do. He controls my dosages, so, I don't know, to this day I've never been able to properly shoot up myself. Um, but, you know it's a good dependency, I think.
>
> [R] So, you prefer not knowing some parts of how to fix?
>
> [B] Yeah. Um, only because, obviously I want to know everything. I'm very curious and I love knowledge but I feel like if I know everything then I'll just go off and do it on my own. And not only that but I'll pick up a bigger habit and I don't want that.
>
> [R] So you think you can keep your habit in check by not knowing as much? Is that right?

[B] Yes. I think that if I'm not fully knowledgeable on the situation then it won't, you know, extend to what it could.

Beth's confidence in managing her progressing habit is devised by contextualizing a lack of techne about how to perform an injection. Beth's dependency on David as a phronetic agent assumes David's mastery over her dependency on heroin. Beth *chooses* ignorance over knowing how to inject. This makes her ignorance not a matter of naivety, but a matter of maintaining the integrity of a secret in order to remain more distant from the possibility of autonomous action and addiction. However, in the next section we find that as Beth experiences the symptoms of withdrawal she assumes confidence over the secret techne of fixing and shooting. As Beth's heroin use asserts withdrawal the secret techne reveals itself as a mimetic (i.e., demonstrated) knowledge and Beth speaks more confidently about knowing how to inject. This confidence presumes a growing responsibility, and agency, for making choices about injecting. As Beth becomes more autonomous in her mastery of injecting she must consider limits of her phronetic sense.

Withdrawal, Learning Injection, and Establishing Agency

By presuming that David controls the techniques and instances of drug use, Beth also presumes that David controls the trajectory of her use. However, Beth's cooperation with David is not always unassertive. Beth identifies a growing obstinacy with David as her use of heroin progresses:

[B] For me, every 45 minutes to an hour I will ask for another dose. Um, but it's good knowing that I'm not capable of dosing myself . . . I need him. . . . But I do push it a lot. Every 45 minutes to an hour. And when I started it was only every two to three hours.

[R] How do you push it . . . ?

[B] I don't even ask. I just say I need another dose. Um, sometimes I will get to a point where I will walk to a bathroom I know is safe and I'll tell him, 'Go in there and make up my dose.' And then I'll say, 'Let's go to the park. Let's go underneath this bridge. . . . I need it. I need it. I need it.'

[R] Does he turn you down sometimes?

[B] He does [laughs]. He does and it pisses me off.

Beth's need for a dose demands that she strongly assert herself to David. Beth does not "ask" but "tells" David that she requires a fix. If David fails to execute an injection for Beth, Beth resists and is "pissed off." As Beth's dependency on heroin and exposure to contexts of injection drug use increases she loses confidence in the governing structure of her relationship with David and assumes more agency in determining the course of her habit through exposing herself to techne associated with injecting:

[R] . . . do you feel like if you wanted, if it came down to it and you felt you wanted to know [how to fix], that you'd know how to find out?

[B] Oh, yeah. I'd know how to find out in a heartbeat. And I've seen it done enough times that I kind of know in my head. So, it's all a matter of getting proper dosages, you know, melting it down to the proper amount, or mixing it to the proper amount. So, I mean, probably if someone set me up right now I could probably do it myself. But the fact that I don't know everything makes me happier because then it's less of a temptation I guess.

In this instance Beth differentiates mimetic knowledge (demonstrated) from diegetic knowledge (symbolic). Beth acknowledges that the secret of knowing how to inject is a public secret; it is a secret whose integrity as a secret is rhetorically invoked since the knowledge that it has purported to conceal has always already been revealed as a display. Beth suggests a degree of confidence in knowing how to inject but retains support in feeling incompetent to describe how to inject. Later in the interview Beth discusses her fear of heroin withdrawal as a motivator to breech her agreement with David. She exhibits strong ideation for making the breech due to a growing dependency on heroin and is fraught with worry for her relationship with David:

> [B] it is difficult sometimes. It was even more difficult at first when I never thought of using the park . . . .I started doing it more frequently and then it started reversing the roles. And he's, he denies it to me enough to protect me but I'm just hoping he doesn't deny it too much to the point where I have to learn myself. . . .
>
> [R] How realistic do you think it is that you'll learn how to fix yourself?
>
> [B] Um, I will probably unfortunately know within the next week or two myself, I have a feeling. . . . I mean he's going to go away for a couple days to get an ID and paperwork and I will get sick if I don't have someone to take care of me for it. So I obviously need to learn for myself. Um, but at the same time, young, naïve, inquisitive, you know I'm curious. If, I just hope I can control myself once I know how to do it myself. . . . my biggest thing is I don't want to push away my fiancé for dope. . . . I love him too much to push him away. But at the same time,

you know, I haven't been sober, you know, so I don't know what's going to happen.

[R] Do you have your plan already? Do you know who will teach you?

[B] He will probably end up teaching me just out of pressure of me asking him to.

Withdrawal is a circumstance that requires Beth to assume autonomy from David's role as her injector and presume practical knowledge toward lifting mystification about the techne of injecting. Beth's worry for David extends to other social choices. In particular, when asked "do you ever try to keep your injecting a secret" Beth responds in the first person plural pronoun "we." By enfranchising David in her response, Beth provides a reasoned response that aligns itself primarily with consequences for David's face and reputation:

[B] there's a few people who we do congregate around sometimes that we don't like knowing. . . . we don't keep it a secret because they're judgmental, we keep it a secret because they're around here and we don't need . . . word getting out about things we're doing personally.

[R] What would happen if word got out?

[B] Actually it did recently. . . . and it was just really hard because a lot of blame was being put where blame shouldn't have been there at all. You know everyone was accusing my fiancé of introducing me to the drugs and getting me a habit and, you know, it's not like that at all. I mean, yes there was influence, but in the end I'm the one who made the decision.

In spite of Beth's investment of power and control in David, she retains responsibility and agency in accounting for the decision to initiate injecting. Beth acknowledges a tension between "influence" and responsibility for consenting to being initiated, but opts "in the end" to assume responsibility for her initiation. Her discussion of David's influence is sympathetic, presenting David as initially making overtures to deter initiation. Beth describes David's efforts to deter her interest:

> Other than getting high faster and quicker, I was introduced to all the disadvantages first. I think [David] made a point of that. You know, he walked me around and he showed me people with abscesses. He showed me people who were strung out. He showed me people with horrible track marks that looked like someone literally took a razor blade along every vein. I mean, he showed me all the negatives that he could first, before letting me learn of the positives . . . .he threw pamphlets in my face about endocarditis, and [Hepatitis] C, and everything that he could . . . .

Beth's absolutist descriptions of being shown "all the negatives" by David, who was doing "everything that he could" to reveal abject horrors of injecting fortified an objective base from which Beth could dissociate risks by inciting more discourse about proper ways of performing injection. The alterity of corporeal displays of symptoms of injection drug use combined with digests of associated infections and diseases in the form of pamphlets established one end of a dichotomy between good and bad hygienic practices of injecting. The next section details how the fears that resonated with seeing negative aspects of injecting were subdued by discourse and displays that detailed "proper" methods of injection.

Dialectics of Hygienic Street Injecting: Teaching/Learning "Both Sides"

Beth recalled her experiences of seeing negative aspects of injecting as having a deterring effect for a short period of time. Beth stated, "it scared the crap out of me. . . . And it was a major turn-off. And I was, like, 'I don't like this. . . . I don't want to do this if this is what's going to happen to me.' . . . so I didn't, I didn't like it at all." However, as Beth became more certain about street hygienic practices of injecting she became more comfortable with the idea of initiating injection. Beth established certainty communicatively. David provided a "rhetoric of display" (Prelli, 2006) that created a dialectical construct of "proper" ways of injecting and assuaged Beth's initial fears about injecting:

> [R] And so, how did your mind change [about initiating]?
>
> [B] Um, he showed me what cut dope looks like, as opposed to regular. You know, if it's straight. . . . And watching him do it. And, um, he made me knowledgeable of both sides and I didn't like it at first. I didn't want to do it at all. . . . Um, and you know I wanted to inject but all these things, they were sketchy . . . .But he showed me the clean ways. He showed me everything that it looks like. Proper ways to do this, proper ways to do that. And I felt sort of an assurance that it was going to be ok.

Beth's experience with initiation suggests that representations of injection drug use on the street can be multiple. Dialectics of "clean and dirty," or "proper and improper" ways of injecting prefigured Beth's decision to initiate injection. These dialectics were largely revealed to Beth as either corporeal manifestations of "improper" injecting or displays of substances, technologies, and techniques of "proper" injecting. In this sense Beth was

able to reduce the complexity of injection drug use to becoming "knowledgeable of both sides." Beth could proceed with a decision to inject by rendering negative aspects of injecting null in light of David's display of more hygienic injection practices. David's experience as an injector, and closeness to Beth, made him a valued rhetorical agent in Beth's decision to initiate injecting. By transposing responsibility for techniques of proper injecting to David, Beth was able to feel comfortable as an injector, or injected, heroin user. David's role as an expert and model figured largely in Beth's decision-making. Beth elaborates on David's role in populist terms as a paternal figure and a disciplinarian:

> I'm blessed to have my fiancé, you know, he's 26. So he has the maturity and wisdom that I don't have so it makes me seem a little bit mature. So I'm not like being a child. But at the same time you can see, you know, I have the eyes of a child on a Christmas morning. You know, he has the eyes of a man that gets up every morning nine to five and does his work and has a cup of coffee.

Beth's allusions to age, experience, work, holidays, and weariness speak to American motifs and folklore of patriarchal family responsibilities. Beth characterizes herself as infantilized, insatiable, naïve, and in need of David's guidance to make her "seem a little bit mature." In a very clear sense, she feels a need to surrender responsibility as she cultivates her curiosity around injecting. However, in a short time, the machinations of withdrawal and addiction pressure Beth to assume responsibility and self-reliance for her habit, including technical knowledge of injecting.

Borderlands of a Novice Injector: The Vocative Junkie, Fear, and Friendship

Like most people in their late teenage years, Beth's life is one of exploration. Beth arrived in Denver with no social network besides David. She acknowledges feeling isolated when she says, "it's really just, you know, [David] and I. You know, he knows everybody and I'm just kind of, there. I don't really have a good friend here." Although Beth's social network is built around her partnership with David, it would be wrong to presume that she has no social mobility at all. In spite of Beth's isolation from "good friend" relationships, Beth has optimism in her approachability and out-going personality. Still, Beth identifies many changes in her ability to navigate social relationships while experiencing homelessness as an injection drug user. Beth feels her sense of subjectivity is in flux as she acquaints herself with using and street life. She states:

> This didn't even used to be me. I used to be, you know, long hair, earrings, make up, you know the whole preppie thing. Then, you know, I started becoming me and started doing drugs . . . I acquainted myself and I surrounded myself with a lot of people I never would have before. . . . You know, [people] who are just nodding out when they're walking. So yeah, I definitely acquired a new taste in friends but I've also kept my old taste.

As a recently initiated injector Beth struggles to understand the protocols of stigma experienced as an injection drug user. The "junkie" is a scopic and vocative object for Beth. As Beth becomes objectified within scenes and economies of drug trafficking she grows anxious over the waning dissimilarities between her and the junkie. Because the junkie calls her out, with his abscesses, track marks, and bandages, she is pulled into a

gaze where she imagines her own individuality. This sociality, not of the junkie revealed as an object, but as the junkie interacting with Beth in the everyday, eclipses the security Beth once felt about being dissociated from the corporeality of the junkie:

> [B] it's already been happening, people coming up like, 'Do you know where it's at?' You know. 'Can we get any off of you?' And it's difficult because it's kind of, it's a big reminder that I'm a drug addict, you know? I'm a junkie and all these other junkies are coming up to me and I don't like that. I'm not comfortable with it at all. Um, it just, it puts thoughts in my head that I don't want there.
>
> [R] What are those thoughts?
>
> [B] Um, just, just kind of like, 'Is this what I'm going to be in the next three to five years?' Um, there's some people downtown whom we're acquainted with that they're incapable of standing straight because . . . they're dope fiends. And I, you know there's just, I don't want to be that. And I know that I have enough control not to but it's difficult when they're coming up to you looking for the dope, when they're coming up to you looking for the suppliers, they're coming up to you because you have a cell phone and they can call their pager or their plug. . . .
>
> [R] So you get afraid that these other people are modeling what you'll be in . . .
>
> [B] Yes, my biggest fear with it is, 'This is what I'll become.' . . . .the predominant thing is, well, they come back from the hospital with bandaged arms because they have horrible abscesses . . . .Or they're

> completely strung out and they can't focus on anything. . . . And it's hard because I like it so much and . . . probably I'm going to do the frequency that they do but I want to do whatever I can to be sure that I have the control so that I'm not, um, well we call it a 'bust.' Someone who's right there, obvious, 'Hey, I'm a junkie. You know, I'm completely strung out. Check out my pockets, you'll find a tourniquet and a rig.' You know? So I don't want to be that.

Beth is reluctant to identify with other users on the street but understands them as extensions of herself. Her view of the "bust" is the archetype of her fears, articulated as a walking manifestation of bodily sores and easy profiling to police intervention. Her fledgling emergence in communities and economies of use places her in a borderland of identities where she is "reminded" of her identification with drug addiction but finds the possibility of its fulfillment loathsome. Later in the interview, Beth identifies her substance use as a growing problem insofar as it is signified corporeally. Beth describes changes to her own body and a detached "hope" for control:

> This is such a girl thing but I got my first facial acne in my entire life when I started, from stress and everything like that. And I was like, "I don't want this! I love my face! . . .'. my back has all these sores and stuff on it now. I have it on my legs, you know, everything like that. And, um, for me, you know, it brings it back to the whole religious 'your body is a temple.' . . .if it starts, um, what's the word, decomposing from the outside? That's going to make you stop and think. And I'm hoping that it

will either never come to that point or I'll catch myself before it gets too bad.

Again, the physical symptomatic manifestations of drug use lead Beth to consider the severity of her use. For Beth, acne foreshadows a narrative that ends with the body decomposing itself. Beth's acne is also vocative, luring her from grounded states of femininity ("this is a girl thing") and religiousness, to a separate state of illness.

Socially, Beth's reads her body as communicating for her. On many occasions Beth discusses a process of learning about people's judgments of injection drug users. Beyond Beth's concerns about assimilating to a junkie identification through the gaze of other injection drug users, Beth also describes her body being read by non-injectors. Beth senses that people see her as an injection drug user by reading symptoms on her body. Beth recounts being asked about drugs by a non-injector and immediately managing the real or imagined corporeal signals of injecting that her body presented, "I didn't know what to say. Um, I got really embarrassed. I started tucking my arms in. Um, and they're not even that noticeable but, you know, to me, every shot that, you know I can see that hole sticking out. Like it's right there." Beth understands that there is a qualitative difference between how she sees her arms and how other people likely see her arms. Beth's nervousness about how she is seen becomes a strong mitigating factor in how she navigates social interaction. She questions whether her arms are noticeable but learns, not from the outside, but from her own eye to tuck, hide, and conceal her habit.

Judgment and "To Each Their Own."

In spite of Beth's preoccupation with her body's presentation, she reports being considerably *less* socially anxious speaking with people who don't know that she injects:

[B] It makes me feel more comfortable to talk to somebody who doesn't know that I'm a junkie because I don't see the judging eye, I guess.

[R] So you don't see the judging eye with someone who doesn't know as opposed to someone who does?

[B] Right. Because I mean, when you talk to somebody who knows, whether they do it themselves or they don't, I mean you're always going to notice their eyes averting to your track marks. You're always going to notice, you know, they're looking around. . . . I'm very observant and it's kind of hard seeing them look at that and look for things to judge you on.

Beth senses herself as an object of others' scopophilia insofar as they are aware that she is an injector. Beth understands that her status as an injector ushers new protocols of social interaction where she will literally be seen in a different way. Gradually Beth finds herself in a process of questioning whether or not she is being judged in her social interactions. Beth's identification with the streets as a homeless young person offers a sense of relativity to other individuals she meets. When asked how non-injectors on the street get along with people who inject drugs, Beth claims, "here on the streets it's a bit different because we all have something in common, we're on the streets. And no one's fully ever judging anybody." However, immediately she moves to acknowledge the new scopophilic mandates of her interactions. "I mean, obviously they're going to look at your arms. They're going to see your track marks. I mean, they're going to look at your face . . . . but no one . . . is quick to judge or make a comment rudely toward you because you are an injector." Although Beth is not victim to rude comments, as a recent injector Beth begins to understand isolation as a modality of social stigma associated with

injecting. "Um, although there are people who are 'Oh, you do that? I don't want to be near that.' And who will walk away." Beth struggles to adapt to her social role as a stigmatized individual on the street, and to determine the terrain of social judgments she experiences. When asked "How does that feel?" regarding people "walking away" when they sense she is an injector, Beth talks about her experience historically, alleging that her values of respect and fairness allow her to adapt in her role:

> At first I was offended by it just because I don't like to judge anyone on anything, you know . . . ? But at the same time I have to respect them . . . .and say, 'well ok, I will leave or you may leave' because it's not fair to them and I know . . . .And it's understandable, it is, and, um, so I'm not as offended by it anymore. But it seems how I look at it, and, you know, I wasn't like this five, six months ago, so it's different. I'm not used to it; I'm a very good people person. So I want to be your friend but I do something bad that you don't like.

Beth adapts to the circumstances of stigma by understanding that the actions of both injectors and those who stigmatize them occur within a normative ethical relativism. Aphoristically speaking Beth continues, "So it's a little different, um, but I mean every time we get . . . 'mean-mugged' as we call it, we just say, 'to each their own' because it really is." Beth's underlying philosophy of moral action, tautological as it may be, allows her to retain her values of respect and fairness in social action even when those values are not presumed to be mutual to people with whom she interacts. Beth describes her values and how they interact with stigmas of isolation and her own sense of self:

> [R] So tell me about 'to each their own' . . .

> [B] Um, I think it's just everyone's personal perspective. Like, when I say 'to each their own' I mean everyone is entitled to their own views and their own opinions. Um, and if you're a true friend, obviously you'll stick around. Um, but I don't have the right to take away your opinion on a situation or to take away your views or your beliefs. So if you don't want to be near me because I stick a needle in my arm, you know, personally I don't think that's the greatest reason. I don't think my character has changed. I don't think my personality has changed. . . . Um, I think I'm still the same person, I just have a different activity that I do every day. But, you know, if you want to look at me different that's how you're going to look at me.

Beth invokes the sense of sight as a conduit for other's opinions and beliefs. She states that qualitative changes in her relationships determined by her injection drug use are seen; she is looked upon differently. Beth's response of "to each their own" is a relativist response to this looking. However, it is not an impotent ethic. The next subsection details Beth's thoughts on interaction with people who do not inject from her developing subjectivity as an injector.

Hopes and Ethics for the Future

In spite of Beth's avowed relativism in social interaction, she still identifies emotions within social contexts that figure largely in her self-awareness and self-identification as an injection drug user. In particular, Beth highlights how changes in her social life affect feelings of embarrassment regarding her use. When discussing feeling

isolated and embarrassed while talking about injecting with a non-injector, Beth describes how embarrassment functions as an emotional register of her identity as an injector:

> [R] Are you still embarrassed?
>
> [B] Um, sometimes, yeah I am. But at the same time I think it's just when I personally do it and people know. Um, this one place that we stayed yesterday, we just do it in her home right in front of her because she does it as well. . . . So it's not as embarrassing or whatever. . . . You know, and I don't like the fact that I've gotten used to it. You know, I'm not really embarrassed by it anymore.

Embarrassment, a socially derived emotional state, belies Beth's understanding of an identity that is not static. Beth understands that as her environment changes so do her social relationships. As she becomes more familiar with scenes of injecting she becomes less embarrassed and more uncertain about how she feels about the change. Beth, within the borderland between identifying as an injector and a non-injector, begins to take inventory of her surroundings. Beth states, "I started becoming me and started doing drugs, and yeah, I acquainted myself and I surrounded myself with a lot of people I never would have before. . . . So yeah, I definitely acquired a new taste in friends but I've also kept my old taste." As Beth grows more familiar with an identity as an injector, she also considers a strong responsibility toward not initiating new users. Her primary strategy for not initiating new injectors is isolation. Beth is enthusiastic about the idea of sharing a social life with people who do not inject drugs. However, at the same time she acknowledges an inability to communicate about injecting in a manner that doesn't encourage other people's interest in injecting:

[R] What would it look like to be friends with a non-injector without introducing them to injection drugs?

[B] Um, I think, honestly I think it could be really easy. I don't think it has to be as difficult as people think. . . . I think if you do it properly you can maintain a great relationship without pressuring or maybe even making the other person aware that you are a junkie.

[R] Do you think you'd be able to talk about injecting without introducing somebody to, or sparking somebody's curiosity about injecting?

[B] I don't think I could. Um, just because I know my eyes light up every time I talk about it, you know? I know for me it is Christmas morning. . . . That wouldn't be fair to them. I personally don't think I'm capable of having a conversation about dope or smack or any drug without sparking an interest.

Beth understands that social interactions with non-injectors are wrought with responsibility if she does not want the burden of having turned on a non-injector's curiosity about injecting. Beth's fears of identifying with injectors (becoming a "bust") combined with her fear of initiating non-injectors leads her to isolate communication about her drug use. The influences of physical addiction, intimate relationships, cultural fears, and responsibility to non-initiation coalesce into competing anxieties and optimisms regarding identity, use, and social relationships. At 19, Beth retains an idealistic view of community with her peers until she considers her use.

[R] What would you say you have in common with non-injectors on the street?

[B] Non-injectors on the street? Um, I think personally just for me, because I'm still young, um, I have the whole, all the hopes and the dreams. And the unrealistic things, as well as the realistic things, um, it's just the thoughts I have. The running around, the jumping in the river, the just kind of taking your day, day by day, relaxing and doing what you want. . . . we all have that little picture in the back of our head, that little kaleidoscope that keeps turning and you see this city that you want to go to and you see this thing that you want to be in life and, you know, I'm not going to give up on those little dreams and those little hopes.

[R] Where do you see your [drug] use being in three years?

[B] Um, unfortunately I don't think it will be gone. I wish it would but I think that if we get out of Denver and if we stay away from a bunch of cities . . . it could be limited so that instead of it being habitual it will just be, you know, every once and a while . . . .

Beth's response highlights tensions between what is realistic and unrealistic. Although she is resolute in her optimism she accedes that this optimism is based in her youthfulness. Because she is young, she can retain unrealistic hopes even when her vision for the future involves an ongoing struggle with drug use.

Chapter Summary

The objectification of the injector's body, creates dynamics of mimesis and alterity for Beth that allow her to understand injecting within binary terms of proper and improper—or "both sides." Beth negotiates technical knowledge (techne) of injecting as a public secret: knowledge that is generally shown and known by demonstration but

inarticulated in a diegetic manner. This inarticulation invokes injection as a secret in spite of its technical mimetic display and permits Beth distance from identifying subjectively as an injector. However, when the objectified body of the injector speaks, when it engages as an interlocutor within the drug economy Beth participates in, Beth is drawn toward identification as an injection drug user. By Beth's avowal, she is "reminded [that she is] a junkie." Furthermore, withdrawal creates an exigent circumstance for Beth to consider transforming technical knowledge from mimesis (demonstration) to diegesis (symbolic action). This movement compels a stronger intrapersonal identification with injection drug use by betraying the rhetoric of (public) secrecy that was constructed around knowing how to inject. Beth's interview informs discussions of dynamics of communication and cultural roles between injectors, people who use drugs by injection but do not inject themselves, and people who do not use injection drugs (RQ1 and RQ3). Furthermore, themes of isolation and alterity inform a discussion of isolating communication about injecting (RQ2) in the conclusion. The next chapter analyzes interview data from Beth's partner David.

CHAPTER THREE: DAVID AND THE PHENOMENOLOGY OF AN INITIATOR

David is a 26-year-old male who reports an ongoing five-year injection habit. Throughout the course of his habit, different cultural roles emerged where injection drug use was a central factor. Analysis of David's interview will display salient cultural values between pre-initiate, initiate, and initiator statuses as an injector. Throughout David's history of use he distinguishes perceived intimacy as a strong motivator for initiating injection drug use. This chapter will discuss how practical knowledge about injecting facilitates David's exploration of intimacy in social relationships. David emerges from the interview identifying a desire not to initiate new users. This desire culminates alongside David's wisdom about negative outcomes of initiating new users. Chapter Five will return to this analysis to discuss social and emotional needs that are gratified in communication about injection drug use within scenes of homelessness. Analysis of David's interview will also guide discussion of qualitative ways experience as an injection drug user is a culturally valued role (RQ3).

Becoming an Injector

David was initiated to injecting cocaine after experimenting with cocaine, methamphetamine, and heroin through other routes of transmission. David's initial community of drug injecting, including his access to the drug economy, was based off a

trusting friendship with another user. This user also held a formal position of power over David's precarious living situation:

> [R] This fella, you said he's a good friend, and he was a good friend of yours before?
>
> [D] Yeah.
>
> [R] You trusted him quite a bit?
>
> [D] Oh yeah.
>
> [R] What was the nature of your relationship with him? How did you meet him?
>
> [D] Um. When I first moved to Salt Lake, you know, I had limited funds so I stayed in a hostel. And he was the manager of that hostel. . . I was like, 'I use drugs' and he told me he could score dope so . . . .we just became really good friends. Still are to this day.

David reports that he was initiated by his friend after they obtained drugs and he was unable to assert his preference to not inject. After scoring a load of cocaine David felt coerced into injecting after his share of the substance was prepared as a liquid to inject instead of powder when he wasn't looking. David states:

> One day [we] had bought a balloon of coke, . . . and he put it in a spoon . . . and I think I was watching TV or something and he was like, 'hey your cut's here.' And I looked down and there was no powder. . . . I said, 'Where's my cut?' He says, 'Aw, here.' And he hands me a syringe. . . . He said, 'Look, every dog has their day.' I'm like, 'Well, fuck it.'

David recalled that it was during the experience of the ensuing high that he subdued his reluctance to inject and committed to exploring injection with other substances, particularly heroin. "I sat down and he's like, 'You like it.' And I'm like, 'yeah. How is it with heroin?' And he says, 'Better.' . . . So I went and got a load and it was on from there." David's experience of injecting was foreshadowed by protracted communication with his friend and hostel manager about the benefits of injecting as a route of drug transmission. David did not solicit this communication, however the topic was exigent in an environment of diverse styles of drug use. David clearly asserted his preference to abstain from injecting before his friend prepared his first rig. After being questioned by his friend over not injecting David asserted his choice to not inject, "I was just, 'Naw. You know. Naw, I'm not doing the whole needle thing, c'mon.'" Regardless, David's friend continued to persist in his criticism of David's choice not to inject:

> [R] What kind of things would he say about injecting before he worked up that rig for you?
>
> [D] 'You're wasting it. You're not even getting high. You're not feeling the whole potential of it. . . .' And then, you know, not make fun of me but he'd razz me. He'd be like, 'C'mon, dude, you might as well cut the foreplay. Fucking get right down to it. Might as well get high.' And I did it. And now I go out the same way. You know, if you rabble around with heroin and shit, might as well get high.

The euphemisms David recalls in the scenario of his initiation allude to economic and psycho-sexual benefits of injecting. Communicating about styles of drug use that are independent of injecting as "foreplay" envisages injecting as a crucial and erotic pleasure

before which any other method is paltry by comparison. The homologue of drug injecting *as* climax also suggests that drug use by any other nuance is not an authentic fulfillment of "the whole potential" of use. This homologue figures largely in David's social relationships surrounding injection initiation.

Injection drug use, and its initiation to new users, becomes a conduit for David to experience intimacy. In both roles of "initiated" and "initiator," David experiences various forms of intimate bonds between himself and other individuals implicated in initiation.

Intimacy Before Initiation: Ungratified Social Needs

The theme of intimacy as a motivator for initiating injection drug use precedes David's role as an initiator or initiate. David described his foundational curiosity about injection as mitigated by social isolation and a desire for belonging before he started using needles. David named "intimacy" when asked to describe benefits of initiating new users. Intimacy became a focal concern of David's when discussing his relationship with initiates as well as injectors he knew prior to his own initiation. Much of the interview consisted of probing David's talk about intimacy. David's concern for intimacy gestated prior to his emergence as an injection drug user alongside scenes of social exclusion by injectors:

> [R] Are there people who you've felt intimacy with who, um, don't inject and didn't wind up injecting while they knew you?
>
> [D] Not like that. . . . Like I grew up around it, like I said, you know, I didn't grow up but I was around heavy drug users, needleheads and shit like that. And they'd always be the ones going to the bathroom . . . .And

> nobody saw and it was always 'hush-hush.' And you know what I mean? It was just to spark my curiosity, of course. . . . definitely it was 'what's going on in there?'
>
> [R] Yeah. How did it feel when your curiosity was sparked?
>
> [D] It was, it was just there. It was. I don't know. You kind of feel part of something. Like part of a clique and shit. . . . It's kind of leaving everybody behind.

David identifies a social exclusion that forebears his interest in injection drug use. David was not originally curious about the high, or economic benefits of injecting; David was curious and felt excluded from a social group whose aloof behaviors were the "spark" of his curiosity about injecting. The site of this exclusion, the bathroom, was consistently reified as a place of built and experienced intimacy throughout David's description of his drug career. The bathroom is a place with many layers of meaning. Perhaps most importantly, public bathrooms are the only socially sanctioned sites of momentary privacy for people who experience street-level homelessness. The walls of public bathrooms frame the only doors that homeless individuals have power and prerogative to shut. The opacity of the bathroom wall presented David an early rendering of socially created, and embodied, mysteries of drug use. These mysteries concerned a drug's relationship to a new, secret, and unfamiliar society that was created inside the bathroom but experienced with the body. Even before David's initiation to injection drug use, he proscribed uses of the bathroom as a site to overcome naiveté by intimating himself with injecting, and social customs of injectors. Later, as David is initiated and emerges as a

bona fide injection drug user, the needle, and its introduction to new users, continued to be a conduit of intimate social relationships in the bathroom.

Intimacy Upon Initiation: Models of Guilt, Economy, and Culture

David describes his friendship with his initiator in intimate terms, especially after his initiation:

> [R] Do you remember what kind of questions you'd ask about injecting before [you were initiated] or did you ask many questions about it?
>
> [D] Um. Not before that. . . . But afterwards, yeah. Because I couldn't do it myself for a long time, you know what I mean? I just could not stick that needle in my vein. . . . So he did it a lot for me. So I'd be like, 'What's up with abscesses?' You know what I mean . . . ? I'd be on the phone with him, 'Yeah, what should I do? Y'know, I got a balloon, I've got a rig.'

David's inexperience as an injector bonded him in intimate dependency to his initiator. Eventually this dependency became a burden to David's initiator and David learned how to inject himself. "He got tired of shooting me up. Because we'd have to find a bathroom and all this stuff. . . . But I got it done. Um. You know, he taught me a lot." As a teacher and initiator, David's friend established a strong attachment that lasted well beyond his drug career. When David's friend quit using drugs he passed his source connection on to David to ease the economic burden of maintaining a habit. David describes:

> He, uh, he actually, after I started you know injecting myself and all that, and couldn't stop, he, uh, he stopped. He could. He killed a 13 year habit.

> And he gave me the number to the guy, you know? The dude, so I could go through him and not have to go through my friend to chase.

David's access to sourcing drugs established him as a lucrative drug contact in the community. This however, did not equate to a balanced economy in David's personal life and David's initiator continued to nurture David through economic tribulations of his quickly progressing habit:

> [D] So I got the number [for sourcing heroin]. . . . I used to go out and I got really strung out and lost everything and I could tell that he felt bad. You know? Because he knew what he was doing that first shot. You know? That's just what we do. . . . I mean it's beneficial towards us, towards our high. . . .
>
> [R] So when he kicked that 13 year habit how did your relationship with him change?
>
> [D] He took care of me. If I was really sick, you know, he'd give me money to get high. Because, you know, partially he blamed himself.

Initiation of injecting created a bond between David and his initiator that included sharing economic opportunity as well as economic responsibility to maintain David's habit. This intimacy was cultivated by the initiator's conscious regret for introducing David to injection drug use. For David, this regret was an early model of akrasia—or acting against one's better judgment. This akrasia is associated with initiating someone to injection drug use. The relationship between the initiator's care and the act of initiation was steeped in regret, "feeling bad," "blame," and most of all an acute self-awareness of knowing "what he was doing that first shot." David speaks about this

dynamic with an awareness of emotional impulses established when an individual is initiated. David is also aware of roles and responsibilities assumed by an initiator as well as ways initiators may benefit from introducing new people to injecting. David's choice of a first-person plural pronoun ("That's just what we do") when describing his own initiator's remorse suggests that David sees initiating new users as a cultural progression of injection drug use. David absolves his initiator by enfranchising himself into the scenario in a way that presents initiation to injection drug use as a culturally determined exchange. David does not file resentment toward his initiator. Instead he describes a cultural quandary, or economic predicament that over-shadows any individual's personal responsibility for initiating new users. When David discusses the benefits of initiating new users, he is speaking toward economic benefits of bringing novice users to the market. David describes individual benefits of compelling a community of dependency where he controls the sourcing of drugs. "That's just what we do. You know? I mean it's beneficial towards us, towards our high. I mean if you go up to me to get you some smack you better break off a piece. You know what I mean? So I can get my fix." David's move between first-person plural and first-person singular pronouns suggests that while he understands his own subjectivity he also understands a heritage of initiation that objectifies the circumstances of initiation as cultural. An initiator can easily assert himself as the initiate's connection to drug markets and thereby benefit in drug supply. David suggests that this economy, in part, determines a cultural effect of initiation. David's cultural appraisal of initiation even absolves his own initiator's coercion; it also allows David to channel himself toward a cultural role as an initiator.

Intimacy as Initiator: Rhetorical Action and Akrasia

As David's drug career proceeded he found himself assuming the role of an initiator. David speaks very candidly about his self-confidence as an effective initiator:

> [D] I mean, I, uh, I wouldn't say that I'm really persuasive or manipulative but I'm good at getting people to try it, you know what I mean, for the first time. Yeah, I've turned on a lot of people in my life. . . . it's easy for me to say, 'Hey, you want to try it dude?'
>
> [R] What kind of situations are you in when you're turning people on to heroin?
>
> [D] They're usually . . . because it's been on the streets, they're right around me while I'm dosing. And I can see the curiosity in their eyes. So I bring it up, you know what I mean. . . ? They're curious about the needle high, man, they really are. . . .
>
> [R] About how many people do you think you've turned on to the needle?
>
> [D] From Salt Lake City to here, man? A lot. A lot. A lot in the Springs. A lot here. You know? I couldn't even tell you a number.

As David assumed the role of initiator to an untold number of neophyte injectors, he transposed many of the forms of intimacy modeled in his relationship to his initiator and drew clearer connections to psycho-sexual intimacies established in the initiator/initiate relationship. Throughout David's descriptions of his power in the initiator role there is a strong tendency to remain self-critical of his prowess for introducing people to injection drug use. In spite of his self-confidence as an effective initiator, David does not consider his initiating to be beyond moral reproach. This

dynamic is symptomatic of David's experience with akrasia. David describes his method of cultivating interest of potential initiates by talking about the benefits of injecting. He also appraises his methods with moral resolution:

> [D] I talk [injecting] up I guess, you know?
>
> [R] So what would that look like? What kind of things would you say to talk it up to somebody? What would a conversation look like?
>
> [D] I kind of rag on them a little bit. I'm, 'What are you doing? You want to get loaded, dude? Let's do this.' 'What do you mean?' 'Let's fucking put that shit in a needle.' 'Really? Oh, what's that?' Like, like, it's cold, dude. It's fucking cold. I get a lot of 'just this once.' But it never happens.

David repeats the modeling of his initiator by "ragging" individuals who use by other means. David notes individuals' curiosities about his injection and pursues them "coldly" to entice them to inject. David's akratic dramatization is not merely descriptive; it is morally evaluative. After providing a pantomime of "ragging" David is set beside his self and assesses "ragging" as "cold." Nevertheless, David persists in this strategy of persuasion and does not subjectively identify as a "cold" person. Rather, David goes on to discuss edifying outcomes of neglecting moral concern in the rhetorical action of initiation. In the next section we will see how perceived intimacy emerges as a strong gratification that allows David to reconcile his akratic state when he performs initiation.

Doses of Intimacy: "It's our little thing . . . .Whether they know it or not"

As an injector, David possesses practical knowledge of injecting. David is self-confident as an initiator who does not only cultivate interest in injecting, but is also able

to perform the practical work of providing someone a dose of drugs via an injection. David experiences an akratic tension between performing this technique (techne) and appraising its moral implications (phronesis—prudent wisdom that leads to a good end). Regret is symptomatic of David's akratic state as he commences initiating new users. David applies a historicity to his regret when asked to identify people he would not wish not to initiate:

> [R] Um. Has there ever been somebody that didn't inject that you knew you didn't want to turn on to the needle? Like, because, like 'This person, I don't want to see them turned on.'
>
> [D] Oh yeah, dude. All of the people that I've turned on.
>
> [R] All of the people?
>
> [D] Yeah, I mean I look back . . . . I'm like, 'What the fuck was I thinking,' dude. And, um, that just, but my whole thing at the time was to get high to, I don't know, like I said, to strengthen the relationship between us . . . .

Strengthening social relationships and building intimacy provides David a rationale to neglect negative concerns when initiating users. Throughout the interview two homological themes of intimacy emerged when David discussed performing initiations: possibilities of intimacy by sex and death (Brummett 2004). Within both homologues, phronetic knowledge of the initiator creates dynamics of mastery and control over the initiate.

Mastery over Sex

David resources his expertise as an injector and others' curiosities about injecting to establish intimacy in his relationships, particularly with women. When discussing how he understands curiosity of non-injectors, David appraises potential initiates along gendered lines. "It's mainly chicks. You know. They like to play with the needle anyway." This delineation becomes a point of departure for David to explicitly eroticize initiation through the frame of heterosexual, patriarchal desire.

> [R] So what's the, how does it feel to be in [the role of initiator]?
>
> [D] Well, it's, it's you're in control. You know what I mean? And you're in control for a while until they get their dosages right and shit like that. . . . Um. I personally, I mean I don't look at it like I'm in control. Uh. I definitely though, like if you're, almost with girls, it's you're like taking their virginity. You know what I mean? And they're just, they're stuck on it. So it's uh, you know.

David speaks awkwardly and cautiously as he draws the analogue between initiating a girl into injection drug use and seducing a virgin. His response to "how does it feel" is a clear metaphor to a psycho-sexual drive for power and control over women, specifically. David continues to explore the roots of this drive in his response, highlighting a melancholic longing for heterosexual intimacy that is resolved only by perpetrating initiation:

> Um. It's uh. It's, uh you get a relationship with somebody that you don't, you can't have with somebody else. It's a very intimate relationship. You know what I mean? Like it's, 'It's our little thing.' You know? I mean, a

> lot of my girlfriends up in Salt Lake I've gotten high. And it was like our little thing. I mean, like we'd go to the bathroom. You know, it's a very intimate exchange. You know, like, because I'd be there getting complete trust, you know what I mean? Whether they know it or not they have to trust me. Not to fuck it up, you know what I mean? And I, that says a lot. Especially with a female. . . . Essentially you have a closer bond with somebody.

Intimacy with women is only consummated for David by resourcing sexual subtexts of injecting that he cultivated throughout his own career as an injection drug user. One subtext that prevails within David's pursuit of intimacy is the use of the bathroom as a site for intimate exchange. David returns to the site of the "spark" of his own curiosity about injecting, the bathroom, as a rhetorical setting for establishing intimacy by initiating new users. The bathroom, along with its meanings of group identification, becomes a territorial jurisdiction for David's mastery of injection drug use. When shared by David and a girlfriend, it also becomes a site of heterosexual intimacy and secrecy insofar as it breeches social conventions of gender-identification and place. David's use of the bathroom, as an injection site and site of privacy for heterosexual exchange, is perverse to hegemonic uses of the same space. Sharing in this perversion establishes a context of intimacy for David. In a sense, David had not gone far from where his curiosity was sparked. David merely presumes the role of the "spark" himself; the role of an original interest and coveted social knowledge about injection drug use that presides over his vision of the bathroom. Initiating a woman in the bathroom becomes a homologue for mastery over larger mysteries, such as sexuality and sexual difference

(Brummett 2004). David also identifies bathroom intimacy through mysteries and possibilities of death that are at once vicariously and directly related to the needle.

Mastery over Death

Beyond sexual intimacy, David also procures intimacy by presiding over the risk of overdose and death. David is able to experience bliss in his role as a consummate injector, understanding that overdose is a very real danger and he possesses power with an ultimate, if not mutually acknowledged, trust "not to fuck it up." David's endowment of talent for injection drug use permits him to secure a sense of trust from initiates even when initiates are naïve to overdose risks associated with injection drug use. David allows scenes of initiation to demonstrate this sense of mastery to himself. David declares:

> I pretty much have a reputation . . . .I've never OD'ed anybody, you know? Well. To the point where their lips were turning blue, you know what I mean? The ones that are after me like, 'oh I want to get high, I want to get high, high, can I try just a little bit?' I'm like, 'Alright, we'll get you high, man.' He'll fall out for a second and I'll sit there watching him. You know, it's, for some reason I've always been good with dosages. Um, so, there's always that trust thing, you know? You don't got to worry. . . . I pretty much established that I can handle it . . . and I can handle yours as well.

When David facilitates an initiation, he frames a very deep dependency around the event. The initiate's dependency on David is a gratifying outcome of the initiation. Even in situations where an initiate's consent is misinformed or unfulfilled, David views himself

as a mediator of risks of death or overdose. Indeed, in the scenes of initiation that David discusses, the initiate is never fully able to endorse their own consent. To David, the *dependency* created through initiation is *trust* by proxy. As an initiator, David participates with a sense of great responsibility but does not invoke a difference between trust and dependency. David presumes himself as a caretaking agent, but only by subsuming an initiate's agency in administering a first injection. David's avowal of "You don't got to worry. . . . I can handle yours as well" takes agency from the initiate by positioning David's expertise as an injector as a surrogate for an initiate's fears or reasoning.

Intimacy Within a "new perspective": Knowing the Road for Beth

David's self-awareness of his power to entice new people to injecting and steward their move toward addiction is astute as he considers a "new perspective" on initiating. David acknowledges culpability for being a clever rhetorical agent convincing people to inject. David recalls a former girlfriend whom he initiated and then left. The former girlfriend "started to push dope because I wasn't around and now . . . she's all strung out." David assumes blame and then grows self-revelatory as he invokes themes of persuasion and choice:

> It sucks, but I did what I did at that time, you know? They say everybody has that, has that, uh, 'It's their decision' but, dude, if you're persuasive, dude, and you know what you're doing, and you're, and I'd like to admit, not in a conceited way whatsoever, but I'm a little bit brighter . . . than most people. . . . if you're in that position and you know exactly what you're doing then they really don't have a say-so, you know? If you know

> how to go about it . . . .So yeah, ultimately it's their decision, but, you know, you're like the serpent in the garden . . . . you see that little twinkle in their eye, you know, that curiosity, and you run with it, and you know how to go about doing it, then . . . it's out of their hands really. You know, then finally you give them their dose and they're fucked . . . .

David's confession demonstrates that David sees himself not merely as an influence, but as a rhetorical agent who has a perpetual advantage over a perpetually vulnerable audience. David begins describing his advantage by acknowledging "decision" in scenes of initiation as a *doxa*, or a commonly held but incomplete truth. David elaborates that his persuasive skill is able to command choice within a rhetorical situation while retaining choice's value as doxa. David begins rhetorical activity non-verbally by seeing cues that belie a potential initiate's curiosity about injecting. Upon seeing this "twinkle in the eye" David arranges organized rhetorical activity toward creating the opportunity for initiation. Although David does not detail particulars about this protocol, he acknowledges his guile as specific and "knowing exactly what you're doing". David cites "the serpent in the garden", co-opting a myth that is ripe with themes of persuasion, doxa, drug initiation, and truth, to approximate his role and skill as a rhetorician. This myth also distinguishes a higher rhetoric in the drug itself. As the serpent's tongue leads to the apple of knowledge, so does David's rhetoric lead to a drug that has its own protocols of rhetorical high. David, after performing as a rhetorical agent, "then finally [gives] them their dose and they're fucked . . . ." David, like the serpent, presumed that his rhetoric would evanesce back into the terrain of the garden, or in David's case the doxa of free will, rendering rhetorical innocence in the shadow of "will" and "drug."

However, David eventually experiences pangs of conscience. His retrospection on the results of his rhetorical work is remorseful. David experiences guilt and speaks with a confessional bearing. Still, in spite of his remorse, David continues to navigate an akrasia between his confidence as an initiator, opportunities for initiation, and a lack of perceived intimacy. David continues to initiate new users with whom he grows close.

David's legacy of initiating new users is brought current through his relationship with Beth, another participant in this study. David and Beth have a stated plan to leave Denver and settle in a smaller town to escape the lures of their addictions. Although David feels as though his relationship with Beth has changed his values and perspective on initiation, he still relies on initiation to instill trust and intimacy within his relationship with Beth.

> [R] What makes you, um, what do you feel motivates you to [initiate] anyway?
>
> [D] My thing is her [Beth] . . . I want, I want her to experience what, you know, how it feels. . . . I want her to be on the same level. You know? And I want that intimate relationship. . . . Um, I just wanted her to be in there, in the bathroom with me. 'This is what it's like, this is how I take it.' Like I said, the intimacy.

Once again, David returns to the bathroom. When David returns to the bathroom with Beth he does so to build a narcissistic intimacy. David desires Beth to be "on the same level" as he is. David does not work rhetoric around Beth's display of curiosity but initiates so that Beth can occupy the intimate meanings David has inscribed in the bathroom. The bathroom becomes a "returning place" where David is able to mirror the

history of his relationship with injecting to Beth. In a sense, it may be a place where David is infantilized, a place where he can display where his habit originated and then matured to mastery. When David states, "I just wanted her to be in there, in the bathroom with me" he is *placing* an intimate trajectory of use that starts from Beth's position as a pre-initiate through his entire drug career. In the bathroom David turns pages to bring Beth to his current chapter, "to be on the same level" via performing her initiation.

David feels considerable anxiety as he comes to terms with a "new perspective" on initiating people to injecting. He invokes a nearly fatalistic worry about Beth's ability to avoid death or prison without him after he has initiated her to injecting.

> [R] You say recently you've been changing your mind [about initiating]?
>
> [D] Yeah. Shooing people away from it, yeah man.
>
> [R] Yeah? But your motivation for that has been something you've learned about yourself or something that has to do with other people?
>
> [D] . . . I'd rather than just feeling bad for turning people on, I'd rather not. . . . And especially my girl right now. . . . We had a talk yesterday, last night about it. I don't want her doing it period, you know, but it's, it's, I've turned it on and she likes it. . . . But it saddens me. Because I know, like if we were to split up and she were to still have a habit or whatever, like, then there's another one, you know? That's just the thought, period. . . . And I know the road that it leads to. You know. So that's my perspective. I know exactly what's going to happen. I've seen it time and time again. You're either going to die, you're definitely going to go to jail at some point . . . .You're going to fuck up.

David's new perspective is a move from repository of responsibility for initiator and initiate, to acting as a soothsayer for what ensues after someone is injected. David's accountability to the knowledge he has about negative effects of injection drug use is the basis of his new perspective. In rhetorical terms, David identifies and embraces *sophia* (wisdom) regarding the phronetic knowledge of initiating people to injection drug use. David has experienced "feeling bad" as an outcome of akratic action and "would rather not" repeat his akrasia to produce the same result. David sees a perpetual pattern of death and prison emerge over his years as an initiator and asserts himself as an oracle of negative outcomes. David's new perspective is self-referential and subjective. The root of David's perspective is in accounting for knowledge he possesses about "the road," and about "knowing exactly what's going to happen." David, presuming knowledge of the ends of initiation, claims a sophia, or wisdom that renders a new responsibility to his talents for initiation. Understanding that he possesses this knowledge in the face of the most recent incarnation of initiation—his girlfriend Beth—creates a mixture of sadness and responsibility that challenges David's confidence. It also creates a motivating fear.

> [D] She's brand new to all this, so. She's, I mean she, I'll just kind of, I'll take her with me to go get some, you know, and seeing her eyes like looking at someone, like strung-out junkies, and she's like, 'Holy shit.' And sometimes she'll pull me aside and be like, 'I don't want you to turn me out looking like that.' And I'm like, 'Don't worry about it'.
>
> [R] Do you think her habit is more serious than yours right now?
>
> [D] Yeah. Because she doesn't know. Yeah, she's very, I can see she's very susceptible. Oh yeah.

The closeness that David established when he initiated Beth does not include an intimacy that allows Beth to "know" the sophia of negative effects of addiction. David acknowledges Beth's naivety and its relationship to the severity of a developing habit. After "turning it on" David fears that he will be emotionally responsible to Beth's addiction if they were to break up. As David witnesses Beth's growing dependency on heroin he sets his phronetic knowledge to new ends to prevent her addiction from worsening:

> [R] So what kind of responsibility do you feel, um, to make sure she knows [the road of heroin injecting]?
>
> [D] Well. She's not allowed to do it if I'm not around and she's very respectful about that. She doesn't mix up her dosages; I take care of that. She doesn't stick herself; I've taken care of that. You know what I mean? Just so there's some level of she doesn't run amuck with it.

As Beth's initiator, David does not allow her to possess practical knowledge of how to inject. Instead, David constructs jurisprudence to secure his own perceived mastery and talent for injecting. Through a series of prohibitions, David presides over the practical knowledge of injecting that enables or disables Beth's ability to progress in her habit:

> [R] So, you keep some knowledge withdrawn from [Beth]. Like she doesn't know how to shoot herself up or prepare her own rigs. Is that intentional to make sure that when it comes to the point of kicking she won't be able to . . . .
>
> [D] Yeah. It's like, everything, I've made sure . . . .

Because David does not have mastery over the suasion of heroin he resolves to command the technologies of its administration. David orients prohibitions over every aspect of techne regarding performing an injection so that Beth cannot act as a technical agent of her escalating habit. David's motivation is his newfound wisdom regarding death, jail, and overdose and the acknowledgement of remorse after a history of akratic action. The prohibitions David has written are enforced by perceived trust from Beth. David is able to control Beth's habit to the degree that Beth is "very respectful" of David's authority. However, the differences between trust and dependency may prove more salient in time. Perhaps David fears a return to the role modeled by his own initiator's guilt: feeling responsible "because he knew what he was doing that first shot."

Chapter Summary

David's interview displays many social needs and gratifications that accompany different roles in injection drug use initiation. Need for intimacy was a consistent motivator for David as he cultivated various roles as a pre-initiate, initiate, and eventual initiator. David returned to the bathroom as a place where intimacy through injection drug use was explored, established, and remembered. As a pre-initiate, David imagined injection drug use as a function of a social group that was mystified in the bathroom. After David was initiated, and as he progressed in his own habit, David utilized injection drug use to explore homologies of intimacy in his relationships with non-injection drug users. These homologies presented themselves as perceived trust and mastery over sex and death. Initiating women to injection drug use gratified David's longing for intimacy. David was able to assume power over life and choice by seducing initiates toward a relationship that was mediated by his technical skill (techne) for administering injections.

David acknowledges a legacy of initiating new users who suffered negative outcomes associated with addiction and embraces a sense of sophia, or wisdom, of the end results of initiation. David's most recent initiation, of Beth, cultivates a more austere appreciation for the dynamic between the practical knowledge and wisdom of injecting; David emerges as a phronetic agent. David accounts for initiating new users as an akratic action and navigates his akrasia by asserting judicial authority over knowledge about how to perform injections. Although David still initiates Beth to the experience of injection drug use he asserts control over her ability to act as an autonomous phronetic agent of her own habit. In Chapter Five, David's various reflections on intimacy, power, and agency within roles as pre-initiate, initiate, and initiator will inform a discussion of social and emotional needs that are gratified when talking about injection drug use in scenes of homelessness (RQ2). David's testimony will also inform a discussion of how the identity of an initiator is experienced as a culturally valued role (RQ3). The next chapter will consider themes of initiation and communication about injection drug use among three older men.

CHAPTER FOUR: LUKE, COLE, WARREN, AND PHENOMENOLOGIES OF OLDER INJECTORS

Luke, Cole, and Warren were the first to interview for this study and occupied the common group stratification of men between the ages of 36 and 45. All three reported sleeping outside in Denver, Colorado and provided histories of their own initiation to injection drug use as well as specific histories of initiations they had performed or declined. Interviews with this group provided focused conversations about dynamics of communication in homeless camps in Denver. Luke, Cole, and Warren were the only respondents that reported outdoor environments as their primary place for sleeping (unlike Beth and David of the previous chapters who reported occasional camping but primarily couch-surfing). Throughout the interviews Luke, Cole, and Warren describe relationships with non-injection drug users (RQ1), intimacy established through initiation (RQ2), perceived cultural roles as street injectors (RQ3), and emotional identifications as street injectors. Although this chapter groups Luke, Cole, and Warren by their common age and gender demographic in the cohort, each participant provided unique character to their interview. This chapter structures sections proprietary to each individual with sub-sections that identify thematic interests of each interview. The concluding section identifies commonalities and differences within this demographic while summarizing emerging themes of the analysis.

Luke

Luke is a 43 year old man who reports periodic states of homelessness since he was 27. Luke states that he has "been in the drug game all my life" however reports that he "waited a long time" before injecting. Luke states, "I stayed away from needles for a long time but probably about, like I say, I'm 43, about four years ago, five years maybe, I first injected." Luke reports that he frequented daily injections only within the previous year and a half. The progression of Luke's habit was notably more gradual than other participants', however the onset of symptoms of addiction was not. Luke states he quickly became addicted to heroin on the street after finding himself in an environment of street drug use after not being able to obtain a prescription for a pre-existing health condition:

> . . . not to push the blame or anything but I have pancreas problems and I don't drink but, um, in California they were giving me my scripts, you know, and then when I got here in Colorado they wouldn't give me a script for it and, well, I was camping with, you know junkies and man I started doing the heroin to take away the pain and made the mistake of doing it for like, it only took a week and a half and I was hooked.

At the time of Luke's interview he was exploring the use of methadone to curtail his use of heroin on the streets. Luke reported very healthy communication with his doctor focused on creating a collaborative effort to find a proper dose of methadone:

> I actually just started methadone too about a month ago. But I'm still, I'm still not at, I just went up on my dosage today. To 10 milligrams. I'm still not at a stable dose, so. . . . And I'm upfront with my doctor. It's what's

> really cool. Because we're trying to fix it. And I told him last night, 'Yeah, I had to shoot up last night.' You know, because I'm not stable yet.

Luke identified the Harm Reduction Action Center (HRAC) as a resource that helped him identify his options for treatment through a process of self-identification as a drug user. Luke's identification signaled a deep engagement that gestated within the Harm Reduction Action Center's specific environment. Luke describes the community at the Harm Reduction Action Center as "a bunch of misfits all together. That fit together" highlighting a separation from other communities where he spends his hours. A self-assurance prevailed through Luke's community at HRAC that enabled him to reflect on his addiction. Luke describes HRAC as a place where "[I] feel comfortable with myself. . . . I think, you know, for me you have to first feel, I've got to feel, accept that I'm a drug user. Inside with me, myself, and I. You know, and then I can work on the problem." This blend of solace, intrapersonal reflection, and community differs from Luke's descriptions of the street, where his individuality is truncated by social taxonomies of drug use.

Street Taxonomies of Drug Use

Luke describes his social life on the streets as ordained by modalities and preferences of drug use. Despite stating that he has friends who do not inject, Luke presents stark demarcations of social mobility that are pre-determined by taxonomies of drug uses and styles. The following is part of a question and response exchange between me as researcher [R] and Luke [L]:

[R] . . . how do relationships with other injection drug users look different than relationships with people who don't inject? In camps, or shelters, or on the street or wherever you're experiencing homelessness?

[L] Hmmmm. Well, on the streets here it's like I got friends that don't inject but it's really, it's like we don't actually hang out or anything because it's a main thing out here on the streets. I mean, you've got your drinkers, you know, you've got your drug users, and then it breaks down even more than that. You know, even with your drinkers for instance, you'll have your, like your, um, vodka drinkers. They're in their own groups. Seriously, with the beer drinkers in their own groups. They all think they're better. . . . it breaks down to that. To actually like that, you know. And then even with the drug users. Um you've got your heroin, like even with needles, you know, it even breaks down, hey I know like people who shoot meth, eh kind of like they're acquaintances but I don't hang out with them . . . .Heroin people just stay to themselves. Cause there's differences.

Luke describes the social order of the street as primarily organized around drug uses and styles. Associations within this social ordering preclude individual identifications of drug use or other aspects of sociality. Group ordering effaces any requisite of secrecy regarding Luke's identity as an injector on the street. The group is the secret in the form of a public secret that is "generally known" in the sense that its reputation precedes itself:

[R] . . . .Are you pretty comfortable sharing [that you inject] or are you ever, like, reticent or try to keep that a secret on the street?

[L] Oh yeah, I don't announce it. . . . But pretty much the people on the streets, they all know. Because they know your groups. You know what I mean? You know I can see somebody and I can say, 'Aw yeah, he's a potato head, he drinks vodka' because of the groups, you know what I mean? By who's hanging around.

[R] So by association with other groups?

[L] Yeah. 'Guilt by association.'

The group models a public secret of injection drug use. Luke does not need to speak his habit of injecting, or hide it for that matter. The information of injection drug use is socially available within orders of street homelessness in Denver. Luke describes rigid and resolute groups of sociality based on drug using that deduct street relationships down to a point of intimacy. When I asked a research question that probed for information about communication across social groups of drug use styles, Luke described the groups as impermeable and corrects my interview question:

[R] So, talking about people . . . who are in your circle who don't inject but know that you inject. Do they ever talk about injection, or what do they say about injecting?

[L] You mean, people who are in my circle who don't inject? I don't have any people in my circle.

[R] No?

[L] Nooooo!

[R] So even the people you mentioned before who are on the streets, maybe in different groups or something.

> [L] They're not in my circle though. No. My circle is very, very tight knit. I mean, my circle is, what I would say, is four people. Four of us, who we camp together and we all use.

The metaphorical abstraction of a "social circle" coalesces to very particular relationships for Luke. Luke responds to the idea of a social circle by nominating its members, whom are all injection drug users. The hold of injection drug use on Luke's configuration of his social circle is underscored when he considers methadone and its disruption of his social grouping with injection drug users. This disruption of street taxonomies of drug use makes Luke reconsider his sense of belonging in the group. Luke continues, "We all use together pretty much too. I'm kind of like. But I'm starting to veer off by myself because of the methadone." Luke's methadone program disturbs the cohesion of the street taxonomy of heroin injecting and this disturbance brings forth intimate conflict within the social group.

Isolation, Lonesomeness, and the Professional Bad Influence

As Luke deepens his investment in methadone in order to remedy his dependence on street heroin it affects his relationship with the campmates who comprise his identified social circle. Luke describes a conflict with another older injector when attempting to introduce methadone treatment to the youngest, and presumably most impressionable, member of the camp:

> Well, I can see they're like. Well, there's the one youngest guy. I'm really trying to. I laid off but I want him to get on methadone. You know he's only 26 but, um, he's got this one bad influence, and I will say it out loud, he's a bad influence. He doesn't want him to get on methadone. I

know he doesn't. Because this guy doesn't want to be by himself. . . . his girlfriend left him, he's got this guy right here. I mean they're not gay or anything but it's still a replacement. . . .

Luke's description of the "bad influence" is characterized by lonesomeness and fear of isolation. Luke goes on to describe the lonesome injector, "He just can't be by himself. . . . He's always going to find somebody. . . . He's going to have somebody with him. And he's going to use them." The lonesome injector's influence, according to Luke, is calculated when discussing methadone with the young injector. Luke describes a strategy of arranging communication that presents methadone as an option but always maintains a fear-based criticism of methadone treatment as the apotheosis of an argument:

[R] So what kind of things, um, when you say 'he's a bad influence' or influential. Like what kind of things are talked about or communicated that are influential that would, uh, keep somebody's habit active?

[L] Ok, this is for instance, it's just like this guy's a trickster. He's a professional, man. . . . And this guy, he'll be like, he's suave about it and the fact that he'll be like, 'Yeah I want to get on methadone too.' And then, within five minutes, 'Yeah, but I'm kind of afraid to get on methadone because my brother, he was on it, for like, he was on it for about 7 or 8 years and he still, he ain't right in the head anymore . . . .'

But he'll slip that in and [the young injector] . . . is eating all that up. . . .

But he's slick about putting shit in like that.

Luke and the lonesome injector's competing investments in the future of the younger campmate's drug career highlight manipulations of care and paternalism in the social

circle. This paternalism is structured around an economy of intimacy that is determined by the stringent drug-based rules of social groupings in street-level homelessness. The fear of loneliness that drives the lonesome injector's manipulative pining is set within the social group and precluded by heroin injection. If we understand Luke's descriptions of the "bad influence," there is no room in the social group for both methadone treatment and heroin use. Luke must "veer off" by himself, perhaps packing his good intentions for the young injector with him as the older injector finds his social circle becoming more bereft of intimacy and brings rhetorical craft to discussions about methadone. Luke understands the "bad influence" to be rhetorically strategic as a "professional" and "suave" individual fearing isolation in an already immobile social landscape of street drug use. Luke becomes further removed from the social group as methadone begins to improve the symptoms of his heroin addiction and the conflict regarding methadone takes the form of "resentment":

> [L] They even say, 'God you look better' and blah, blah, blah and the one guy has no intentions of getting on methadone. [The young injector] is curious. But I can tell, I haven't been talking to him because . . . I'm busy all the time now . . . but I can see there's resentment.
>
> [R] Yeah?
>
> [L] Yeah.
>
> [R] What kind of things—
>
> [L] There's jealousy because I can actually sleep in until maybe eight o'clock or something, you know what I mean? And they're up [snaps

> fingers] they're up at 5:30 because they have to be up . . . .You got to start flying that sign, start making dope.

The maintenance of heroin addiction through methadone forecloses Luke's participation in the group's need to "make dope." Luke is displaced from the daily struggles of the social group to remain isolated in the luxury of sleep. Luke's priorities shift and he grows "busy" with other matters as feelings of resentment loom over his social circle. Luke's abstinence from injecting heroin, and his commencement of methadone treatment threaten to isolate remaining members of his circle of heroin injectors. Remaining members respond to the threat of lonesomeness with strategic communication and "bad influence" to prevent anyone from following Luke's example. In the next subsection Luke discusses a different form of isolation that he implements to prevent initiating new people to injection drug use.

Talking About the Benefits of Injecting

Regardless of Luke's descriptions of his social circle, he occasioned conversations with people who do not inject heroin. Luke struggles to find topics of conversation with non-injectors. When asked to identify commonalities with non-injection drug users on the streets Luke presents very base, phatic exchanges, "Being homeless. This is going to sound silly, but I'll tell you. Like, ok a big topic would be like, flying a sign. You know, areas that are good. . . . Or maybe other conversation would be like there's a lot of, like, new people." However, after probing for specific exchanges with non-injectors where injection drug use was discussed Luke gave a lengthy account of the following scenario:

[R] Can you tell me about a specific time when a conversation with a non-injector turned to injection drug use? . . .

[L] Hmmm. [Pause] Let's see. Oh. This happened about probably, fuck, it was about February or something. This one girl, uh, and she's uh, I'm guessing she's like fucking she might be like 19, 18, 19. But she's a street girl, you know, she's living on the streets and shit but she doesn't inject and um, we were all talking and uh, she was getting real fucking curious. I mean, and, uh, because she was with a friend who does inject and I'm friends with her and um, but she was asking, I don't know if she. She was kind of flirty, flirting. She kind of like, I could just tell, had a little crush on me or something . . . . And she was, at first I thought well it was partly just to talk to me but then she was like really like, 'Yeah, I want to try it' and I was like, 'No. No fucking way.'

Luke's telling of his encounter with the young woman is at first apprehensive, hesitant, and punctuated with nervous expletives. As Luke goes on with the story he talks about isolation as an action he took to prevent being pressured to initiate the young woman:

[L] she kind of looked, she was kind of pissed you know what I mean? And it kind of just, like I actually ended up leaving about 30 seconds after that, I took off.

[R] Yeah, you just found another place to be?

[L] Yeah, I just took off. Yeah. Cause I was actually going to stay with the one girl at a motel with somebody else who had a room and that young girl but I just, I'm sure she didn't use. You know what I mean? But I just

didn't want, I just had to leave. Cause I'm not going to fucking get somebody in on it. I don't do that.

Luke resigned the opportunity to sleep in a motel with friends to avoid extending the possibility of introducing the young woman to injection drug use. His isolation from the young woman's expressed interest in injecting heroin allowed him security to express certainty that she did not initiate. When asked to identify what cues identified her curiosity, Luke figured his own role in speaking about the benefits of an injection high:

[R] How could you tell she was getting curious sort of?

[L] Cause she said she wanted to do it, you know? And I made the mistake, I'll always, sometimes will make a, but I'm pretty careful about it. It's just once you start using a needle you'll never go back to snorting it or whatever because the high is just so pure. You know. I mean if you snort cocaine and then you shoot it you might still snort a line but you're going to want to shoot it. Because the high is intensified like 10 times, you know? And it's the same high but it's just better and it's more intense.

While speaking about his culpability in talking about the benefits of injecting, Luke also names benefits of the injection high. Luke truncates many statements that attempt to articulate his mistake but then makes a clear shift to describing drug injection (in this case cocaine) as having rhetorical effect unto itself. The effects of the first injection (benefits) call forth desire for shooting. After further probing into his exchange with the young woman, Luke speaks with more clarity about talking about the benefits of injection:

[R] Did she give you any reasons why she wanted to try it or was she just—

[L] She was just like 'I want to do it.' You know, yeah. Because I fucking put my foot in my mouth. Cause she asked me. She's like, 'Why do you shoot up?' . . . I go, 'Because the high is just so pure.' I pretty much said, I said, 'It's way better.' And not knowing I'm talking to a fucking 18 year, you know? It's a wrong move. Wrong thing to say. You know?

Luke introduced an ethic about discussing the benefits of injecting independently of the research questions. In spite of questioning about behaviors and rationales of the young woman, Luke opts to settle his own accountability for revealing the benefits of injecting. Luke describes his sense of failure in the situation as an accident. He goes on to describe the situation in terms of making a practical error, "But that was a total slip though anyways. It was, just was what it was. You know you get caught up and it just caught me off guard, man." Luke's language of being "caught off guard" leads into a deeper description of the sense of defending his conscience against discussing curiosities about the injecting:

[R] . . . how confident are you that um, you would or would not be caught off guard again in this situation or what factors would go into whether you were caught off guard or not?

[L] Oh I don't think I'd be caught off guard. It'd have to be someone real tricky. Yeah. No just street stuff it, no I wouldn't be caught off guard.

> No! No I'd be on guard anytime I'm like that and I just won't, to be honest with you too, I don't try to associate myself with young people.

Luke emphasizes an adversarial resolve to remain guarded against scenarios where he might be asked about injection drug use by young people in particular. A defiant "no" is repeated several times in his response while he describes a wariness of young people in general who might "trick" him into exciting their curiosity. Luke associates protracted isolation with his guarded defense against initiating new users. However, in the next section Luke describes yet another strategy for deterring curiosity about injecting—revealing negative impacts of addiction.

Discussing Injection's Negative Side

After discussing the previous scenario, when Luke was asked to initiate by a young woman, Luke invoked another narrative to discuss a scenario where he felt success in deterring an interest about injection. As the researcher attempted to move the interview toward a focused conversation about the Break the Cycle curriculum, Luke interjected by stating, "Oh, wait, wait, wait. I'll back up though. I've got to pat myself on the shoulder for this one." Luke then recollected the following narrative regarding a 21-year-old, non-injecting male who was invited to camp among a group of injection drug users:

> [L] There's this kid that's 21 years old. And this is about, what, two weeks ago. And he's up at this other camp I might move to and, um, but he's really, you know, he's street thug, 21 though. . . . he's like, 'Yeah, what is it?' You know, cause I had to get well that morning . . . .but he doesn't inject, thank God, but he's like, 'Yeah man, what is it? What's it

> all about, that stuff?' And instead of saying 'Aw man it makes.' . . .I told him straight, I said, 'This fucking shit's the devil, man.' I said. And he's like, 'What?' And I said, 'I'm going to tell you, dude.' I said, 'You just saw me do that shot and stuff like that?. . . That right there is fifteen bucks. . . . Do I look high?' And he goes, 'No, man. . . . I saw you do all that.' I go, 'I'm just well. . . . I'm not puking. . . . That's the fucked up thing about this drug, dude. . . . I'm not even getting high. I'm just being well how you are right now for free. I got to go out and hustle fucking fifteen bucks. And in another 12 hours I'm going to have to have another fifteen bucks.'

Luke divulges information about the negative effects of prolonged heroin use as though it were secret betraying a commonly held belief. Luke presents a meta-communicational prelude to the information he communicates, "I am going to tell you, dude." Luke then discounts the doxa of injection's relationship to a drug high by demonstrating to the young man that he is not experiencing a high at all. Luke is heretical to the common belief about injection as the ultimate route of drug transmission. Luke's demonstration of his lack of high is then supplemented by a demonstration of an economic detriment of heroin addiction. For Luke, the selection of truths that represent negative economic and chemical effects of heroin use allow him to effectively deter interests in heroin injection. However, Luke does not deny that opposite truths are just as valid. When asked to identify what turns people's curiosity on to injecting, Luke frankly answers, "What gets them curious is because of the high, you know, how much better it is. You know, the talk

about it." Luke then elaborates on the truthfulness of common knowledge about injecting:

> And that's for real. You know people aren't stupid anymore. You know they're educated at a young age that they know if I'm looking for that high, they know that, yeah, I can snort it but shooting it is the ultimate high. But on the flipside, on the flipside, ok, that is all true what I said. It is. There is no comparison. You know, if you're looking for the high you're going to get the best high by shooting it up. No if's, and's, or but's. You know. It's the best.

Luke does not deny truthfulness to the benefits of injecting as they relate to getting high. However, as Luke continues discussing the "flipside" of injection he calls forth multiple and *opposite* truths about injection:

> But, what they need to do to educate people is what they don't fucking say and don't preach about is, they need to do real fast before heroin rips this country apart is, yeah, it's the best high but it is by far the worst motherfucking come down you're ever going to experience in life. . . . You're going to be fucked for the rest of your life and you're going to be so fucking sick you can't stand it. You would wish you were fucking dead. . . . If anyone knew how fucking sick you get you'd have to be insane to fucking shoot up.

Injection drug use is, by Luke's account, both more and less expensive, and a better high or no high at all. Luke either isolates himself from communication or actively chooses which truths to communicate about injecting when confronted by curiosities of non-

injectors. By giving credence to the negative aspects of injection Luke is confident that he deters interest in injection drug use.

The next section accounts for a different interview with Cole and considers initiating injection drug use as a perceived intimacy builder. The section contends that the relationship between initiator and initiated is deepened in part because of a dynamic where performative (mimetic) and discursive (diegetic) repressions are absolved in an initiation rite.

Cole

Cole is a 40 year old man who reports staying with his wife "under a bridge in a park." He reports a ten year drug career that started because he was unable to get a prescription to manage chronic pain. Cole laments an inability to find medical care appropriate for his condition while naming pain prescriptions as the root of his addiction to heroin:

> When can I find a doctor that's going to be compassionate enough to understand the fact that I have pain management issues? I've got bad knees. I've got a bad back. I got a hernia that I've had operated on twice . . . .I'm not using this to get high but the medical community thinks that once you're a shooter you need a methadone program. [The medical community are] the ones that got me hooked on this in the first place 10 years ago. Started out with Vicodin. Vicodin, then I went to Percocet, you know, Darvon, whatever, then it went to OxyContin and then they just cut me off . . . .

Cole states that he does not have interest in using heroin recreationally but moderates his use on the street as a replacement for clinical pain management. Cole is defensive against the idea that he pursues heroin for a high. Nevertheless, stigmas of heroin use and addiction require Cole to keep his use a secret and "hide" his use from non-injectors. Cole puts significant attention into isolating himself from people who don't inject on the street:

> [R] . . . how do your relationships with other injection drug users look different or similar to relationships with people who don't inject on the street?
>
> [C] Well, it's a lot different, really. Because I'm basically hiding it from them. Because I don't want them to know that, you know, I have this issue. And if there is anything I can do to just kind of separate myself from that to where they're not seeing me use and they say, 'oh, well, let me try that.' You know. 'Naw, you don't want to try this.' This is not something you just try once.

Stigma of use, as well as the potential of initiating new users, deters Cole from discussing his use. The inability to openly discuss heroin use results in feelings of "shame" for Cole. Cole describes injection drug use in environments of non-injectors as "just kind of like a shameful feeling. Because, you know, . . . you're hiding something from somebody. You're not being completely honest with them, you know? And I don't particularly like that." Cole maintains a level of use that secures his ability to "function," Cole's term for presenting performance that does not demonstrate symptoms of a high. Although Cole understands his addiction and discussed experiences of withdrawal

throughout the interview, he asserts his ability use at a level that allows him to "function":

> Prolonged use of the drug, you don't get high anymore. You just stay well. That's all it is. Just staying well. You can still function. You can still work. . . . I feel like I have some kind of responsibility to tell people that, look, yeah, at first the drug does get you high but after so long it doesn't get you high anymore. You're just doing it to stay well so you don't get sick, so you're not going through withdrawals. . . . I've stayed the same the whole time I've been using. It's usually about 20 dollars a day.

The modest maintenance of Cole's heroin dependence is at times frustrated by his wife's escalating frequency of using. Cole administers her injections since he possesses stronger technical skill for injecting. Cole identifies reluctance to perform injections for his wife as a consistent conflict in their relationship:

> She don't even know how to fix the stuff herself. And that's a big issue right there . . . .I've showed her and showed her and showed her how to do all this stuff and she just, there's something not clicking in her brain. She's like, 'Why don't you do it?' . . . .And I'm like, . . . 'it's not that hard. Just throw it in there, put some water in there, cook it up, put a cotton in there and you're done.' You know?

Cole's wife had quit using injection drugs after an overdose experience but resumed using needles after witnessing Cole inject. Cole says that he left his wife "a couple

times" because of conflicts over her injection drug use and at one point attempted to reveal her use to her son as he left:

> When I left her son was with us at the time and we had an apartment and I just packed up what I needed, put it in the car, and took off. But I left her stuff there. All her paraphernalia, I left it out so her son could see it when he walked in the door, all of a sudden, Boom! There's needles, cookers, cottons, drugs, everything. That way maybe he could confront her and say, 'Why are you doing this?' But apparently that didn't happen. Apparently she got in there before he did and cleaned it all up.

This exhibition of paraphernalia, the son as an audience, and the goal of requiring him to intervene in Cole's wife's drug use, is a rhetorical display. The rhetorical action lies in spoiling the status of a secret and destroying any idyll of returning to the apartment. It might be assumed that the secret was generally known by the son already, that he wasn't quite naïve to his mother's use. It maybe matters little either way. Cole's objective is to summon discourse through a demonstration (i.e., defacement of the secret) that reconfigures the status of the secret. "Boom!" the display forces non-complacency; it "cuts" and reveals secrets in the environment in which it is situated, summoning forth an intervening discourse, 'Why are you doing this?' Fortune, however, did not allow this display to present before its intended audience. For better or worse, the son was not wiser for the defacing action. The intimate passion in this scene of secrecy and defacement, wrought though it may be in fear and anger, is thematic of injection drug use's capacity in Cole's social relationships.

Using Cole's testimony regarding his closest friendship, the section to follow details how secrecy is featured in roles of initiator and initiated, how initiation defaced secrecy between the initiator and initiated, and how perceived intimacy resulted from initiation as a 'rite.' Initiation to injection drug use is a ceremonious mechanism that establishes intimacy between Cole and the initiated by defacing secrecy around injecting.

Honesty, Secrecy, and Understanding

When Cole mentions his feelings of shame in environments where he hides his injection drug use from non-injectors he roots his feelings in an inability to be "honest." Honesty, and its counterpart, secrecy, impede Cole's imagination of social relationships with non-injectors; he states:

> I like to feel like I'm an honest person. I like to do things above the table, you know, and say, 'Hey look . . . this is what I'm doing. This is why I'm doing it.' . . . But a lot of people hear me say that and it's like, 'I'm gone. I'm gone right now; I don't want to hear no more.' You know? 'You're just a fucking junkie, see ya later, bye.' You know. 'That's all you want, is your drug.' And it's like, 'No, that's not all I want!' I'd like to have friends that can understand what I'm going through. And the only other people that understand what I'm going through is other junkies, or ex-junkies. You know? And those are the only people that right now I have any kind of friends with.'

Cole anticipates abandonment by non-injectors when honestly discussing his use of heroin. This perception resigns Cole's prospects for friendship and intimacy to individuals who have also injected—and thereby harbor Cole's secrecy, rendering

repression of an honest conversation about injection unnecessary. "Junkies, or ex junkies" exist for Cole as embodied epistemes demarcating potential social relationships and classifying them along lines of honesty/friendship and secrecy/abandonment. The hold of honesty and secrecy is intensified and complicated when Cole is invited to initiate a non-injector to injection drug use. The next sub-section describes how themes of secrecy are resolved through an initiation and how initiation becomes a rite of intimacy between Cole and an importunate non-injector.

Intimacy via Initiation

Regardless of Cole's attempts to hide his drug use, Cole identifies times when "there's just not enough space. [There is] no place else to go" to perform an injection and stave off withdrawal. During these times Cole requests that other individuals leave. Cole states, "a lot of them leave, like, 'Ahh. I don't want to be around this guy.' And I ain't seen them since. But some other people are like, 'Do what you got to do, dude. . . .'. My research probe into dynamics around these scenarios lead Cole to recall a friendship that was fortified in disclosing his drug use and eventually performing an initiation to a non-injector:

> [R] Are there people who leave in those times [when you need to fix but have nowhere to go] but remain friends with you?
>
> [C] I've only had one. Yeah. And he's shooting now. Which I kind of regret. Because he's homeless and I invited him over to the place that I had at the time and I told him just flat out, I said, 'Look dude, I'm getting sick. I have no place else to go. If you want to go in the other room for a minute I got to take care of some business.' He said, 'Dude, whatever you

> got to take care of we're friends, just take care of it right here. I'm not leaving.' He said, 'I don't care if you're fucking shooting heroin or whatever.' I was like, 'Really? Because that's exactly what I'm going to do.' And his jaw just hit the floor.

Cole's friend's invocation—his naming of the secret: "shooting heroin"—bridged the cleft of Cole's secrecy around non-injectors. Cole, though unable to articulate his secret, was able to validate the telling of his intention to shoot up by his friend. Following this revelation Cole went on to confess hidden symptoms of using that his friend had been blind to:

> He's like, 'What? I've known you this long and I didn't know you shot heroin?' And I was like, 'Well why do you think I always go to the bathroom all the time? Whenever I have a runny nose, or am feeling sick, or I've got a headache, and I come back and I'm fine.' He says, 'Yeah, I've been wondering about that. I was going to ask.' I said, 'Yeah, that's just where I go. I go out to the porta-potty or I go off to the bus stop outside and I shoot up and I come back and I'll be fine.' And he's like, 'Whoa, I didn't know.'

Cole's summation of heroin injection's hidden presence throughout his relationship with his friend casts new curiosities and expectations over the relationship. These curiosities gestate within a new affinity with the idea of injecting. Cole's very next words in the story are, "And then he had me initiate him."

Cole's initiation of his friend was not immediate upon revealing heroin use to his friend. Rather, when Cole states "and then he had me initiate him" he identifies a set of

protracted strategies and circumstances that obliged his role as an initiator. Cole reported a "six or eight month" time lapse between revealing heroin use to his friend and his friend expressing desire to initiate use. Voyeurism was the first way Cole's friend's interest reified itself. Cole states:

> Every time I went to go fix he's like, 'Hey, can I watch? Can I check it out and see how you're doing it?' It's like, 'Look, dude, I'm not real comfortable having people watch me.' 'Yeah but we're friends, dude, you know? We should, you know? We're like that, we're close like that.' It's like, 'Alright dude, that's fine. If you want to learn that's fine but I don't suggest you do it.' But he just kept pressuring me to hit him.

The blending of sensory experience with affectionate speech is the beginning of an eros, or a sensual and shared intimacy. It is also an instructive intimacy. Cole permits his friend to "learn" by his demonstration. The presentation of the technologies of injecting, the syringe and the works, creates a foundation for sensual experience. Cole's friend quickly absorbs this knowledge and independently acquires technologies to commence injecting and expedite his willingness to initiate. Cole asserts:

> he just kept pressuring me, pressuring me, pressuring me. He went out and bought all the dope, all the rigs, the cottons, everything. He's like, 'Here. Make it up and do me.' I said, 'Dude, I can't do that.' He's like, 'Well, either you're going to do it or I'm going to do it.' I was like, 'Oh crap.' What do you do?

This scenario, motivated by Cole's friend, contrived an exigency for initiation. When Cole acquires needles and works he demonstrates a fledgling understanding of injecting.

He then presents alternatives to Cole, "either you're going to do it or I'm going to do it." Cole's friend also contrives a *kairos,* or appropriate timing for his rhetorical act, by providing his contrived circumstance when Cole suffers from symptoms of withdrawal. As Cole recounts:

> He went out and bought the needles, the whole nine yards and he just kept on me, kept on me. He's like, 'I know you're sick. Just hit me and you can have whatever's left.' I'm like, 'Dude, I can't. You don't know how bad I don't want to do this. I'd rather be sick and have you not be in the situation I'm in.' But, you know, when you're dopesick you do crazy shit. . . . I was getting pretty loopy and he knew that I was pretty dopesick and that's when he got me. When I was at my weakest point. It's like, 'Alright, dude, fuck it. Here. . . . This is how you make it up. Go ahead and do it because I'm too shaky,' you know. And I explained it to him, how to do it. 'Throw the cotton in there.' I told him, 'Don't boil it. If it starts to boil take the flame off of it.'

Cole's move from silently demonstrating technologies and methods of injecting to the diegesis of *explaining* how to perform an injection occurred in the midst of many seducing factors by his friend. Cole's consent was pursued by his friend and Cole felt manipulated, "got" at his "weakest point," when the pangs of illness crippled his ability to decline initiation. Cole did not feel he possessed all his faculties for remaining lucid about not initiating: "when you're dopesick you do crazy shit." Within this manipulation that destroyed Cole's will (so clearly, cleverly, and seductively orchestrated by his curious friend), the phronetic secrets of heroin injection were discursively and

demonstratively exposed. The "weakest point," a bare base of vulnerability augmented by physical crippling sickness, was resolved by a rite—a ceremony of grounding mimetic action within discourse: initiation. Also resolved was the insatiable curiosity of Cole's friend. Within the sophisticated micro-biopolitics of this scenario there are two points of defacement: Cole commits his secret to speech in order to resume "life" from sickness, and Cole's friend prepares a fix to instructions and, quite literally, injects a revelatory sensual experience into his body. Both Cole and his friend emerge defeated, defaced. However, in the wake of these betrayals and injuries their relationship is re-enchanted. There is an element of rhetorical mysticism that prevails after the initiation in the sense that intimacy and knowledge is obtained within the mutual surrender to discourse and the needle. The next section explains the initiation rite's mystical effect on Cole's relationship with his clever friend.

"Now we can talk about anything."

Cole's account of initiating his friend provides a ripe visualization of conflicting passion, calculated persuasion, and manipulation of another's vulnerabilities in order to triumph over reticence to consummate an eros. Cole describes an enduring amount of pleading with his friend that is suddenly ruptured with a nearly violent and terse, "Alright, dude, fuck it. Here." Cole's interests in not initiating his friend are not overpowered by strength of argument, but by his own self-described "weakness," a compulsion toward "crazy shit" when in withdrawal. As a result, Cole understands that rhetorical advantage belonged to his friend from the beginning. "[T]hat's when he got me," as Cole states, "[w]hen I was at my weakest point." The initiation is a scene that is ambient of terror. There is a reluctant collusion against biopower that occurs in this

initiation. It is a bio-*political* struggle that churns the blend of knowledge/power, producing and destroying and ultimately re-enchanting Cole and his friend's relationship, as well as their mutual relationship to injection drug use. But what shakes out of the other end of the violent defacement? Cole is clear to identify newfound intimacy wrought through an ability to speak:

> [R] And then what happened? Did your relationship with him change at all?
>
> [C] Actually I think it made it a little better. Because now we're closer and now we can talk about anything. And I do mean anything. I mean, if we're having problems with our girlfriends or wives or anything we can talk about that with each other. Because it kind of made us closer.
>
> [R] And you couldn't do that before?
>
> [C] No, I couldn't do that before. And I know he couldn't do that before. But now it's, you know, 'Hey, I'm having problems with this chick. Yada-yada. How do you deal with it with your wife?' . . .And I can say, 'You know, this is how I dealt with it.'

Initiation to heroin injection also "initiated" Cole's ability to speak to his friend about heroin injection and other topics. As Cole's friend injected, he also repositioned himself within Cole's episteme of friendship. Even though Cole's telling of the initiation may lead us to think that his secret had somehow been stolen by his friend's clever arrangement of a rhetorical situation, Cole and his friend emerged with a deep intimacy vitalized by a newfound honesty in communication. This honesty was only wrought by bringing Cole's covenant of non-initiation to ruin. Whatever the consequences of

initiating Cole's friend were to be, and whatever seduction was required to initiate, a lack of secrecy emerged between Cole and his friend. This lack of secrecy entreated honesty, and communication to emerge. This establishes Cole's requisite for intimacy. As Cole establishes honesty with his friend they are able to associate together as users. Cole elaborates on his closer relationship with his friend:

> [C] even to this day, if he calls me and he's sick and I have something he's got it. And vice versa. . . .
>
> [R] Do you camp together or does he stay—
>
> [C] No, he stays [at a different location]. I stay clear on the west side. . . .
>
> [R] But you see each other pretty often?
>
> [C] Yeah. At least twice a week.
>
> [R] And where do you, do you both come here or do you meet on—
>
> [C] Sometimes we come here. . . . And then sometimes I go down to his camp and sometimes he'll call me up and say, 'Hey, where's your camp today?' You know? And he'll come over to where I'm at. And we'll just meet at some random place like [a fast food restaurant] or something and I'll go in the bathroom there and I'll fix it up and I'll bring him out a clean one.

All anxieties about hiding heroin use disappear in Cole's newfound relationship with his friend. Furthermore, the relationship finds a new utility. Cole and his friend mutually support each other in avoiding withdrawal and find casual opportunities to use together. These social and economic intimacies are valuable to Cole and were born from Cole initiating his friend to injection drug use, by both demonstration and discourse. However,

Cole remains intrapersonally scarred by the occasion of initiating his friend and recalls the particular initiation, in spite of the intimacy it ushers, as a main motivation for not initiating new users. The next section discusses the latent regret Cole experiences after building intimacy by initiating his friend and how this regret manifests as a reason to decline new initiations.

The Modeled Initiation, Overdose, and Akrasia

After the initiation of Cole's friend Cole continued to encounter situations where he would be requested to initiate. Cole reported that the friend he initiated suffered two separate instances of overdose but survived them both. Cole projects these overdoses as strong reasons to isolate himself from the possibility of initiating yet more users. Cole discusses a particular example of a community that solicits his expertise about injection drug use:

> [C] I don't speak to those people anymore even if they come by. It's like, no. I've already done initiated one person and I feel really crappy because of it, because he's ODed twice now and I just feel really bad about even showing him and I don't want it to happen to anybody else.
>
> [R] So you don't talk to them at all about anything?
>
> [C] No. Not anymore. I don't even say hi to them anymore.

Cole commits to isolation from this group because he is wary of their interest in injecting. Overt appeals to Cole for help in injecting draw strong responses from Cole:

> It's just those particular people that I just don't want anything to do with them anymore because they're, every time I see them they're constantly trying to get me to, you know, 'Hey, man. Give me a needle, hook me up.

> . . . Like you did so-and-so.' Nope. 'It's not going to happen. Just stay the fuck away from me, leave me alone. Don't talk to me and I won't talk to you.' 'Oh, you helped a dude out.' And it's like, 'Yeah. And I fucking regret it because now I got you, and you, and you, and you, and this guy over here asking me to do the same thing.'

Cole is very clear to assert his absolute isolation from the group. He then goes on to confess regret for initiating his friend, acknowledging a tangled bind that he feels between his friendship and his sense of responsibility for his friend's overdose. Cole explains:

> I said, 'look, the guy has already overdosed twice. He's been to the hospital twice because of me. I feel responsible for that because I showed him how to inject. I helped him and he did too much and he ended up in the hospital. And it hurts because, you know, that's a really close friend of mine.' We'd been out on the streets together for close to a year. In October it will be a year that we've been out on the streets together and our friendship has gone from one that was back and forth to one that's become really close. We can talk about anything.

Cole does not impart the circumstances through which his friendship grew in intimacy. However, he does re-assert that he and his friend are limitlessly able to talk with each other. Cole assumes heavy responsibility for his friend's use in spite of his friend's rhetorical maneuvers to compel the initiation, and the ensuing depth of relationship. Cole does not conceptualize a resolution to his sense of responsibility and is stifled between the interests of intimacy and non-initiation. Cole shrouds the details of mutual injection

drug use with an opaque description of the longevity of their street life. His description of his relationship with his friend is reclusive and withholding. Cole does not easily articulate that his friendship deepened through initiation alongside his regret of the initiation. It is the overdose that returns to the scene of the initiation as a secret potential that loomed over the mystic intimacy that resulted from Cole speaking injection to his friend. Overdose revises the rule of silence about injecting and isolation around curious non-injectors. Cole describes the passion of his intimacy upon hearing about his friend's overdose:

> He told me one night that he ODed [and] I was just like, 'What? No way.' And I went over and I hugged him and I said, 'Dude, you got to get alright. You got to quit doing this shit. Either that or cut down or something.' And he's like, 'I'm kicking it. I'm kicking it.' And he kicked it for about a week but there again is the stronghold of the drug. And he got so sick he couldn't handle it anymore and went back to using. And then he ODed again. That day. He shot up and he fucking passed out right in the park . . . .

The overdose reconciles Cole's isolation from non-injectors. However, nearing the close of the interview Cole acknowledges a struggle to keep the topic of injecting isolated among *friends who don't inject*—a character he had previously sworn off:

> [R] So for the people who want to talk to you about injecting and its benefits and how-to-do-it and such, is it pretty easy not to discuss that with them and to shut them out or is it a hard thing to do?

> [C] Sometimes it's hard but then again it depends on the person. And where I'm at with that person, as far as friendship goes. If I'm not friends with them, it's like, 'dude, you don't want to do it.' But if I'm friends with them it's like, 'Ok, yeah there is benefits but the benefits are way too much. You don't want to do this. You do not want to try it. You don't want to even think about it anymore . . . . You're a friend of mine and I don't even want to see you in the same boat that I'm in. Or that this other person's in that ODed twice.'

Cole, perhaps, finds a different level of friendship with non-injectors that is charged with deterring curiosity about injection. Overdose, modeled by Cole's friend in terrifying repugnance, instills a tremendous responsibility in Cole that he has wavering confidence in fulfilling. Cole's anxiety for his future relationships is evident, "I try to be helpful as much as I can and sometimes it seems so fucking hopeless because you have so many people asking you . . . .I don't want to inject somebody and have them OD on me. I, that would, God, that would just kill me."

The next section analyzes the final interview in the stratified grouping of older men. Warren, unlike other respondents, represents himself at ease in his friendships with non-injectors.

Warren

Warren is 44 years old and says he is highly motivated to get off the streets after being continuously homeless for "six or seven years." Warren stays in a camp but identifies as a "loner." Although still homeless at the time of the interview, Warren reported that he was "working with a girl from the Coalition [for the Homeless]" to

obtain housing and food stamps. Warren's estimation of the span of time he has experienced homelessness was generous. When asked if his experience with homelessness was continuous or intermittent Warren replied, "Yeah, about six, seven years. Maybe longer. You know, I'm not sure. When you're out there doing all that crap, chasing dope, you're not really keeping track of time. I lost my house probably, it's been at least ten years. Or more." Warren's dissociation with the calendar years of his homelessness, and its association with "chasing dope," suggests long term homelessness and addiction became a normalized experience for him. Indeed, Warren identifies himself as a "drug addict" who has "been doing heroin since, uh, 1985, '86" with occasional "periods of clean times [that lasted] a couple of years." Health problems, in particular an "abscess [that] turned into a huge, like, they call it a tumor, or something" have encouraged Warren to find assistance in obtaining housing. Warren states, "I'm tired of being on the streets so, um, I'm trying to get my life back together." Despite Warren's long career as an injector he offers stark recollection of his initiation to injecting and the process he engaged to reconcile his initial experimentation with injecting. The next section discusses Warren's first experiences with injecting.

Initiation to Injecting: Transgressing Prohibition

Although Warren reports a long period of heroin use, his introduction to heroin and initiation to injecting are recalled in stark detail. Warren strongly identifies his introduction to heroin with his immersion in a historically placed scene of popular culture: Seattle underground punk music. When asked how Warren learned about heroin before experimenting with it Warren interrupted,

> It was always there. I mean, it was there. You know, I was hanging out with guys in bands out there, you know? You ever heard of [mainstream Seattle punk band]?
>
> [R] Yeah.
>
> [W] You know, I was sitting right there. I was hanging out with [the band leader], you know, and he was a junkie. I mean they were doing it, you know. I knew about heroin.

Warren's invocation of celebrity alongside an omnipresence of heroin also invokes a publicity of heroin in Warren's social scene. The band leader, notoriously associated with heroin use, died of an overdose. In a sense, when Warren invokes the famous band leader, he summons him from the dead as a cadaver of public heroin use and Warren's abject identification. Although Warren never reached punk-celebrity status in the Seattle music scene, he extends his participation in the sub-culture as a precursor to his experimentation with heroin. Warren details:

> I've been in bands. You know. Successful underground level punk rock bands. I lived in Seattle for 12 years. That's where I started shooting dope. I was in Washington. And I had always told myself I would never do it. You know, I'd messed around. . . . But I said I'll never inject and I'll never do heroin. And I started to.

As Warren goes on to tell the story of starting heroin injection he presents a narrative that clearly relates his initiation to his own strongly held, strongly stated, and strongly enforced prohibitions against heroin use and injection drug use; he states:

> I started dating this girl out there and we'd be hanging out drinking beer and the Mexican guys would come over and they'd go into the bathroom and they'd come out, and we'd be drinking the same amount but these guys would be all fucked up. I was pretty naïve about it and then I found out. And I was in the skinhead thing and we used to, I wasn't like a Nazi or anything, per se, but, uh, we would hang out with those guys and you'd see junkies in the bathroom and we'd fucking break in and dump their dope down the toilet and all that shit, 'Get the fuck out of here you dirty junkie.' And one day I just said, you know, 'If I'm going to be so adamant about this then maybe I should try it.' And there it went. I tried heroin. First time I did it I felt it. It was a weird feeling but I liked it.

In a very clear sense, Warren's own prohibition against injecting heroin reconfigured itself as a challenge to initiate heroin injection. Warren's structure of an If/Then logic around his *apprehension* (offered here as a double-meaning of both "fear" and "policing") of heroin injection is a call for defacement. Warren anticipates the revelation of a secret by defiling his own dictum: 'Get the fuck out of here you dirty junkie.' By defacing his own body (the exemplary "sacred object" by the more or less eugenic perspective of "the skinhead thing"), the (public) secret of heroin injection is not tested but intensified. Or rather the test is not whether or not heroin injecting is reprehensible; the test is of Warren's own subjectivity to the rule of prohibition. In order to remain "adamant" to the rule, Warren must transgress the rule, uncover its secrets, and return to the fold to speak the prohibition. The test is in the testimony, so to speak, the telling of the sensual conversion experience. However, heroin injection emerged as likable after

all, molding new secrets and re-mystifying the relationship between self, body, and the heroin rig. Warren's initiation also revealed new (public) secrets of heroin use in the forms of things he was never told but came to experience. Not least was his acceleration toward addiction. Warren describes:

> The first time I shot heroin it was, you know, it was kind of scary because like I'd heard of people, like, ODing the first time and shit. And, uh, I did it, for a while I did it. I had no idea about getting sick. You know, I just didn't know. I was totally fucking naïve about it. So I wake up one day and I'm like, 'I think I got the flu, man.' . . . My girlfriend's like 'Well, we'll get some dope.' And I say, 'No I've got the flu. I got to get rid of this.' And she's like, 'Ah, it's not the flu.' . . .And she went to cop and sure enough I took a shot and got better just like that. And I'm like, "Fuck, you got to be kidding me, I'm strung out."

The flu, a cloak for Warren's identification of withdrawal, was the discursive and ontological replacement for being strung out until Warren took another shot. Warren's defacement of the secrets of heroin use issued new physiological knowledge that he would embody in discourse and presentation for many years. He would never again presume the flu over withdrawal.

The next section discusses Warren's contemporary relationships with non-injectors. Unlike many of the interviews, Warren discusses an easy ability to navigate friendships with non-injectors who know of his heroin habit with little anxiety or cause of concern. Warren constructs many interests beyond his dependence on heroin to facilitate his communication with non-injectors. First, however, Warren must reveal his use from

the stigma of injection drug use and surmises that his use is not unbeknown to his friendly relationships with non-injectors.

Public Secrecy and Deliverance From Stigma

Warren names two specific friendships he has cultivated with non-injectors while he holds a sign for change on the street-corner:

> I have relationships with people who don't inject, who are sober. And I prefer that much better. And I have a couple guys who I met, actually, on the street. I was flying a sign to help me try to buy. And one man . . . he's a Christian man, he's married, he's got his own business . . . .And there's another guy that is the same way. He's a land developer . . . .His wife's an ex-heroin addict so he understands what my situation is, so he's very understanding about it.

Warren describes these relationships as casually intimate and benevolent, "[He] sends me birthday cards . . . gives me birthday presents, bought me a Christmas present." When asked what topics of conversation emerge in his friendship with non-injectors, Warren is quick to state that his relationships are not focused on his heroin use but are cultivated in other interests in the arts, "Well, I've gone to movies with my friend. We'll go to movies and talk literature and music and, you know, it's not just about the drugs . . . Because . . . that shit's boring." When Warren's sense of ease was affirmed by interview probing, Warren anticipated questions of secrecy and hiding and disavowed anxieties of keeping his use a secret:

> [R] But you feel pretty comfortable. Do you ever feel like you have to keep—

[W] Hidden?

[R] Yeah, exactly.

[W] No. No.

[R] You're pretty upfront then?

[W] Yeah.

Warren did not come upon his sense of ease automatically, but described a process of confession that re-framed Warren's concern about revealing his use.

[W] Well, I wasn't [upfront] at first . . . But he eventually found out because there's another lady out there who was flying [a sign] and she told him everything after I moved away . . . .

[R] So how did that feel when you, um—

[W] I just told him, ". . . I'm sorry. I wasn't trying to fool you." And he was like, "You think I didn't think or knew something was going on?" You know?

Warren's friend set Warren at ease by stating that he knew the secret of Warren's use before Warren felt a need to confess. Warren's secret was not revealed by the other woman who was asking for change at the corner. The secret was merely latent, a public secret that was a generally known but not discussed topic. Warren understands heroin use and its relationship to homelessness as not unknown so much as it is unspoken. Warren describes how substance use is displayed vis-à-vis the practice of making money by flying a sign, "People know, man. People know. You know, I'm in a lot better health right now. . . . But people know. They know you're either a drunk or something. Everyone out there that flies. . . . People aren't stupid." According to Warren, his

conversations with his non-injecting friends do not excite interests in injection. Rather, Warren's states his friends are interested in his ability to stay well, "And they know I'm shooting drugs. And they're not going to [ask], 'how many times a day?' . . . or, 'What's it feel like?' You know . . . basically they know I maintain to stay well, you know. I do talk to them about that." Warren's was able to frame his use of heroin outside of its stigma by understanding his use as a "generally known" secret and discussing his moderation of use to prevent withdrawal. However, Warren demonstrates some difficulty in not describing the benefits of injection throughout the interview. When asked if anyone ever broaches the topic of injection's benefits to Warren, Warren repeatedly responds with descriptions of what the benefits of injecting are rather than initially disclosing if anyone has ever asked him about them:

> [R] Would anybody ever ask you about what the benefits of injecting were?
>
> [W] Instantly high. Within about 10 seconds. Whereas if you smoke it, it takes a while. And if you muscle it, it takes about 15, 20 minutes. The IV is the way to go. I mean, if you want to get high and you have a clean needle it's the way to go. . . .
>
> [R] Would people ever ask you though? Would they ever be like, 'Well, why do you do that? What's the point of injecting? Or what do you get out of it?'
>
> [W] Because it makes me not get sick. And because I like the way it feels. I like that warm rush that goes to your body. . . . The warmth in your body and you start to feel better and it's fucking intense, man.

[R] But nobody ever asked you about that? Like out in your social life?

[W] To hook them up, you mean?

[R] Or just because they're curious for any reason. . . .

[W] Well, sure.

There are many potential reasons why Warren did not lucidly interpret the meta-communicational focus of questions about whether or not other people have asked him about the benefits of injecting. However, Warren's earnest description of the benefits suggests little guile in discussing benefits of injection as they arise in conversation. Although Warren expresses no interest in bringing up the topic (he states that it is "boring") he also does not censor information about injecting in casual conversation. Warren's description could be perceived as an endorsement in spite of Warren's self-perception as deterring use. Warren frankly states, "The IV is the way to go" alongside sensuous description of heroin injection's ensuing high. While it is certainly possible that Warren's earnestness was cultivated by the interview environment, it is also possible that Warren's ability to withhold information about the benefits of injecting lapses when the topic is brought to him in conversation. Later in the interview, this complicated ambivalence is presented again in conflicting evaluative statements about injecting. Warren states:

> Honestly there aren't really any benefits to it at all because drugs are fucking evil, man. But I guess if you're going to do them, like I said, if you have clean needles that's the best way to do it, that's the safest way to do it, . . . if you're going to try it . . . ask somebody about it. You know, say, can you stick around, you know watch me. . . . Sure. But I mean, I

would never say do it. I mean, I understand the curiosity but you should get over it. If you're going to do it you should use a clean needle . . . .

Warren does not perceive himself as an antecedent to other's initiation to injection drug use in social life. Although he does not explicitly encourage initiation he espouses proper ways of moving forward with a decision to initiate. In this sense, initiation is not so much an austere prohibition to Warren but a social eventuality, or a circumstantial situation re-evaluated in a social contexts. Warren's deliberative approach to the topic of injection drug use falls outside the protocols of Break the Cycle. While Warren does not excite conversation about injecting he does not feel anxieties similar to other study participants about keeping injection secret. This may be due to the complexity of conversation topics Warren enjoys in his relationships with non-injectors. Injecting, as a conversation topic, is not belabored as a facilitator of intimacy in the same way as other participants' experiences.

Chapter Summary

Luke, Cole, and Warren's differing accounts of their experience with injection drug use on the streets of Denver suggest that the face of street level injection drug use for this demographic is multiple. Luke presented a society of street level homelessness where sociality was strongly demarcated by taxonomies of drug use. Luke's pursuit of methadone treatment complicated his relationships with other injection drug users due to scarce economies of sociality on the terrain of "social circles" determined by substance and styles of drug use. Cole, operating in a similar terrain, described difficultly finding friendship beyond the social boundary of other injectors. The circumstances that resulted in Cole's role as an initiator were rhetorically invoked by a non-injector over an extended

period of time. Cole's eventual initiation of his friend to injection drug use at once wrought unprecedented intimacy through an ability to "talk about anything" and feelings of guilt that motivated Cole toward deterring injection. Overdose of the initiated was the origin of Cole's guilt and a re-configured secret trauma of initiation. Cole's experience with initiating instilled fear of the burden of leading a neophyte injector to overdose, an eventuality modeled by his experience of initiating a friend. Warren was unlike the other two participants in this chapter insofar as he found navigating relationships with non-injectors eased by the revelation of his use. Warren's interview suggests that the acknowledgment of injection drug use's status as a public secret re-configures injecting as a banal issue that is easy to manage within Warren's relationships with non-injectors. This banality, however, may reflect underestimation of Warren's role in unwittingly communicating benefits of injection drug use to non-injectors.

All three men suggest strong cultural parameters around injecting (RQ3) and unique communication dynamics and levels of intimacy with non-injectors (RQ1, RQ2). Luke, Cole, and Warren's narratives provide a longer arc of experience with communities of injection drug use and homelessness. The final chapter returns to the research questions proposed by this study to discuss diverse themes of secrecy, agency, and communication that resulted from all the interviews. Concluding remarks will discuss limitations of the study and prospects for further research.

CHAPTER FIVE: CONCLUSION

Each of the five interviews I completed for this study provided unique perspective and dramatic detail to social life within scenes of homelessness and communication about injection drug use. Each interlocutor compelled nuanced considerations of research questions. Still, descriptions of communication about the benefits and encumbrances of injection drug use were elemental to all interviews and operated alongside invocations of secrecy and forms of isolation constitutive of contexts of homelessness and injection drug use. All interviews focused on challenges and adaptations of social life in regard to thematic initiation scenarios. However, subtleties of experience, demographic, and subjectivity within the category of "injection heroin user experiencing homelessness" textured each interview differently. For instance, Beth put her interview to use to deliberate on her changing subjectivity as a recent injection drug user whereas Luke sensed changes in his social life as a result of foregoing injection drug use and starting a methadone program. While idiosyncrasies abounded throughout each personality involved in this study, I draw strength from the diversity of considerations brought to the research topic. My goal in bringing conclusion to my research questions is not to provide definitive general answers that applied resolutely to all interviews, but to highlight how the questions engaged particular exchanges within each interview and the theoretical ideas that conceptualized my study. The exception to this prerogative is RQ4, which

solicits proscriptive suggestions offered in interviews for deepening Break the Cycle's appreciation of factors associated between its curriculum and homelessness. Direct discussion of the BTC curriculum was scarce in all interviews so my response to RQ4 is conjectural, but written in close association with topics offered in interview. Explicit invocation of BTC curriculum occurred at the end of the interview guide and was only briefly considered in the one-hour time limit on interviews. Below I review the four research questions before structuring this chapter into sections proprietary to individual research questions. Following my discussion of each individual question I also offer a section highlighting limitations of this study and a section suggesting advances in research that includes a theoretical discussion of the relationship between injection, defacement, and secrecy.

Review of Research Questions

My appreciation for studying themes of communication, injection drug use, social occasions of initiation, and homelessness was practically crafted in conversation with the Harm Reduction Action Center. After much refinement, four focus research questions were developed for the purpose of this study:

RQ1: How do BTC participants who experience homelessness describe intra-group and inter-group communication dynamics with people who do not inject drugs within contexts of homelessness?

RQ2: To what extent do BTC participants who experience homelessness find it possible to isolate communication about injection drug use?

RQ3: In what qualitative ways is experience as an injection drug user a culturally valued identity role within contexts of homelessness?

RQ4: What qualitative challenges does homelessness present to BTC's intervention into not discussing the benefits of injection with non-injection drug users?

Research question one seeks a general description of communication dynamics of the target population while research question two sharpens inquiry to themes of silence and secrecy proscribed by the Break the Cycle strategy of not discussing benefits of injecting with non-injectors. Research question two was further focused in interview when discussing intimacy and emotional gratifications that were fulfilled when participants discussed injecting with non-injectors. Research question three engages the communicative *ethos*, or credibility, of established injectors in scenes of homelessness. Research question four applies information and analysis directly to the Break the Cycle curriculum at the research site.

The following discussion section will conclude each research question with insights gained from analysis of the interviews. Discussion will engage the theoretical themes of phronesis, techne, mimesis, diegesis, akrasia, incitement of discourse, and public secrecy as they are befitting to the conclusions. Operational denotations of these terms can be found in the introduction.

Discussion

This section is divided into proprietary discussions of each of the focal research questions discussed above. Discussion at times references particular participants' testimonial engagements found in chapters two through four that analyze the data obtained in interviews.

RQ1: Intra- and Intergroup Communication Dynamics Between Injectors and Non-injectors Experiencing Homelessness

Analysis of interview data among older men suggests that street settings proscribe stark taxonomies of group identification that hinge on type of drugs consumed and preferred styles of drug transmission. Interviews with Luke and Cole demonstrate that solitary groups of injecting heroin users exist within a broader ecology of groups of people experiencing homelessness and addiction. This terrain of group identification is often presumptive to individual campsites and participants suggested that an individual's preferred drug and style of use can be determined by their association with a particular camp. Both Luke and Cole expressed that such social groups fortified critical senses of intimacy for their members. Luke invoked a narrative about lonesomeness on the part of a former campmate and emotional distension in the group upon his commencement of methadone treatment. Cole elaborated that he only trusted other individuals who were injectors. Both testimonies suggest that communication dynamics with people who do not inject heroin are relatively uncertain and distrustful compared to dynamics with other injectors.

Alternatively, younger participants who did not exclusively reside in camp environments did not report allegiance to isolated communities based on style or type of drug used. Beth and David presented communication dynamics that were much more mobile than Luke's or Cole's. Interviews with Beth and David highlighted particular dyadic relationships based on drug use but did not highlight exclusive group associations based on heroin injection. However, relationships grounded in the drug-trafficking economy caused Beth specific anxieties related to group identification as "a junkie."

Beth described how commencing her use of injection drugs introduced a new "taste in friendships" and continued to struggle with perceiving new forms of communication dynamics with injectors and non-injectors while retaining her appreciation for "old" friendships. Beth described many occasions of embarrassment or fear that were socially placed in communication exchanges with non-injectors and injectors, respectively. Beth's intrapersonal process of identification with injection drug use was intensive and powerful, at times over-determining what she reasoned were actual *social* dynamics. For instance, Beth began to view her body as symptomatic of a "junkie" despite acknowledging that this was not an identification made in social interactions. Beth was more comfortable engaging communication with people who did not know that she injected opposed to those who did.

David expressed few barriers to communicating with injectors or non-injectors. David presumed an easy ability to discuss heroin and injecting in many social environments. David espoused a talent for presenting benefits of injection to non-injectors and performing multiple initiations. David struggled to establish new communication dynamics with non-injectors upon feeling akratic conflict in his recent initiation of Beth. Discussion of research question two develops this theme.

Finally Warren presented relatively little conflict or anxiety in his relationships with non-injectors. Warren preferred company of non-injectors and found more dynamic foundations in relationships with them. Warren described communication about drugs and injecting as "boring" and expressed more interest in other dynamics of his communication with non-injectors, such as poetry and film.

RQ2: Isolation of Communication About Injecting

Many research participants discussed several strategies to limit discussing injection with non-injectors. However, in spite of these efforts participants also discussed social environments that compelled discussion of injection. These social environments incited discourse about injecting from non-injectors' mimetic curiosities about injection drug use. In other words, situational secrecy about injecting created foundational curiosities among non-injectors that delivered intensive questioning and discourse about benefits and processes of injection drug use. Luke, Cole, Warren, and David characterized non-injectors as importunate and sophisticated in their attempts to extend conversation about injecting. Luke was able to disassociate himself from a situation where he was asked to initiate a user. However, Cole was not and ultimately provided an initiation during withdrawal.

Mimesis and diegesis are distinct expressive forms of communication and learning. Mimesis refers to learning through imitation while diegetic learning requires instruction and symbolic action. Respondents suggested more difficulty isolating mimetic communication than "not talking" about the benefits of injecting. However, observing injection (Beth, Luke), or secluded societies of injection (David, Warren) established essential curiosities about injecting that summoned forth sustained discourse. Beth grew curious about injecting after *seeing* David inject. David grew curious about injecting after being excluded from secret activity in a bathroom. Likewise, Warren's curiosity about injecting was cultivated after a desire to imitate injection practices he had witnessed. Interviews suggest that situational mimetic communication preoccupies discourse about injecting.

Categorically isolating diegetic communication about injection drug use was perhaps not useful to participants' efforts to not initiate new users. Indeed, Luke describes success at deterring an initation after responding to a non-injector's mimetic curiosity with revelatory talk about economic and physiological detriments of heroin injection. Luke was witnessed injecting by a non-injector and proceeded to "reveal" the negatives about injecting discursively. David's judicial relationship with Beth is also instructive. David limits Beth's exposure of both mimetic and diegetic elements of injecting by not discussing how to inject but also limiting Beth's ability to manipulate or hold works. David also attempted to influence Beth's mimetic curiosity about injecting by presenting her with negative embodied representations of injection drug use, "junkies." However, David also presented Beth the option of hygienic injection practices through diegetic and mimetic displays of cut dope, and discursive knowledge. In a sense, David precedes Beth's exposure to technical knowledge with value-based phronetic insight into "good" and "bad" injecting. David then assumes trust and dependency for phronesis associated with Beth's habit. This perceived trust is a critical gratification of communicating and sharing information about injecting for David.

David disclosed very direct associations between initiation and intimacy. David's social and emotional need for intimacy was only gratified through initiating social partners to injection drug use. David reported that initiating Beth allowed him to feel as though she was "on the same level" as he was. David invoked a feeling of trust in his performances of initiation that was gratifying to a patriarchal desire for control. David drew explicit analogies to gratifications of power over sex and death that he was not able to presume without communicating and performing initiations. In David's pursuit of

intimacy he suggested that he was unable to isolate communication about injecting. In a similar way, Cole discussed not being able to "trust" anyone who was not an injector because he did not sense that they understood stresses that he experienced as an injection drug user. When Cole reluctantly initiated his friend he felt intimate emotional gratification that enabled communication; as Cole states, he and his friend could "talk about anything." In these cases, communication about injecting and initiation gratifies intimacy needs through sexual subtexts, and trust. However the appetite for these gratifications are akratic to reasoned desires to not initiate new users. Both Cole and David express feeling regret for initiating in spite of the levels of intimacy wrought in their relationships with initiates. When Beth describes forging friendships with non-injectors she considers isolation of communication about drugs a pre-requisite to the relationship. Beth acknowledges that she feels limited in her ability to discuss drug use without encouraging use at the same time. Beth understands that isolation of communication about injecting is necessary and is optimistic that it is also possible to not let people know that she uses heroin.

Luke physically left a social situation after cultivating curiosity about injecting to a young woman. In so doing, Luke also left an economically scarce opportunity to stay in a motel. Although Luke acknowledged a mistake, he avoided akrasia by leaving the environment and going to a different camp. Warren felt little anxiety about the prospect of being asked to initiate non-injectors whom he befriended since he did not perceive their interest in injecting.

RQ3: Culturally-valued Identity Roles of Experienced Injectors

Interview analysis suggests that techne associated with injecting is a sought after and commodified knowledge at the street level. At times the role of initiator was described as having economic advantages insofar as the initiator could then source drugs to their initate. Interviews suggest that important distinctions are made between phronetic injecting and techne associated with injecting at the street level. David boasts his phronesis for avoiding infection, abscesses, and overdose compared to other injectors whose infections and sores embody a lack of prudence. This distinction resonates deeply in Beth's decision to initiate. Beth supplants her own autonomy (i.e., self-mastery) to David's phronetic talent (as well as the techne he possesses for injecting) in order to assuage her fears about initiation. There is an identity role that is explicated in David's relationship with Beth. This identity role, based within David's experience and phronetic talent as an injector, is an extension of David's own appraisal of his social value to initiates and other users. When David espouses his talent for preventing overdose he suggests that he has acquired a "reputation." This suggests that David is a cultural figure among individuals whom he doctors. His assertion that "I can handle yours as well" when discussing overcoming reticence about injecting places him within a cultural and paternal economy of responsibility. David speaks both proudly and despondently of this talent and reputation and its expansion of a drug using community and struggles to adapt out of his cultural value as an experienced injector by adopting a "new perspective" that acknowledges initiation as akratic to his desires.

All participants with the exception of Beth reported prolific requests by non-injectors to receive a first injection. Beth did report concern over being identified within

the drug market as a culturally-valued resource for facilitating drug connections. This association "reminded" Beth of her association with a community and culture of "junkies." No participant emerged from their interview identifying a current willful complicity with discussing injection's benefits or initiating new people to injection drug use (although David affirmed his talent for persuasion and initiation he did not suggest it was his current desire). The value of conversations about injecting was formed in particular situations elicited by non-injectors. However, participants discussed communicating injection drug use visually before conversation about injecting began. Modeling injection drug use provides foundational exigence for communicating about injecting and becoming known as a culturally-valued potential initiator.

RQ4: Challenges to the BTC Curriculum

Interview participants offered little criticism to the Break the Cycle curriculum. However, some perspective on improving Break the Cycle interactions could be drawn from interview analysis in this study. In particular, focus on intimacy exchanges, non-verbal aspects of communication about injecting, and facilitation of discussion about negative aspects of injecting was developed through interviews.

Observations of Break the Cycle groups presented conversation about intimacy and initiation in the sessions. However, Break the Cycle may benefit by asking participants to identify different forms and strategies for experiencing intimate relationships that acknowledge a need for mutual power and dependability rather than dependency on injection drug use as a conduit of power. Highlighting sources of trust, power, skill, and confidence that are independent of injection drug use may assist participants in avoiding akratic pursuits of intimacy through initiating new injectors.

Non-verbal cues of injection drug use summon forth curious discussion by non-injectors. One component of Break the Cycle advises participants not to model injection drug use to non-injectors by not injecting in front of them. Expanding a consideration of social taxonomies of drug users could help curb the potential of non-injectors growing curious or feeling excluded from injecting. Many participants reflected that their curiosity was cultivated by a social exclusion from injectors. Considering the reflections offered in interview, advising participants to not inject together at once as a group could help participants elude non-injectors curiosity.

Finally, participants nominated talking about the negative aspects of injecting as a successful strategy for making injection less interesting to non-injectors. Break the Cycle could consider the potential benefits and liabilities of such conversations with program participants and create practical strategies for spinning questions about the benefits of injection to conversations about the economic, emotional, and physiological detriments of addiction.

The next section reviews limitations of this study and suggests points of interest for future research. This section also discusses theoretical relationships between injection and defacement of public secrecy.

Limitations, Future Research, and Injection as Defacement

Relationships between homelessness, injection drug use, and communication are subject to change with any number of factors. Inconsistencies in underground markets of drug production, changes to the terrain of street-level homelessness by law enforcement, and changes in service-capacities of organizations such as the Harm Reduction Action Center effect individual relationships and communication practices on the streets. This

study offers a qualitative glimpse of communication, homelessness, and injection drug use over a period of six months. This study is limited by the relatively small number of interviews that were completed by the end of the data-collection period. This study did not fulfill its target cohort; only 5 of 12 potential interviews were completed. Age demographics of the emerging participants were skewed to younger (19 and 26) and older (40,43,44) participants. Older participants reflected a different lifestyle experience of homelessness (i.e., camping) than younger experiences (camping and couch surfing). Interestingly, the broadest strata for participation in the target cohort was men aged 25-35 (potential N=4), followed by women aged 25-35 (potential N=3), and men aged 36-45 (potential N=3). In my study the latter category was filled with the first three interviews engaged for this study. The remaining interviews, with Beth and David, were completed in the same day as they were together at HRAC. No women besides Beth contacted me to ask about participating in this study. Four men contacted me but did not proceed to interview. This study is significantly limited by its lack of gender and age representation in its unfulfilled cohort, as well as the lack of cultural categories such as ethnicity and sexuality that may have provided further insight into particular cultural factors associated with my topic. Cumbersome recruitment protocols may have prevented some respondents from participating in interview. The recruitment process required pre-screening upon the initial call, as well as relinquishing information that comprised a code for secondary screening with the research site. In order to facilitate this secondary screening measure I needed to place return calls to potential participants. This process was not expeditious to potential participants and perhaps privileged those who were more patient or more easily contacted. In spite of the small number of emergent participants in

this study, the resulting interviews were rich in value and insight into my research. Structuring entire chapters to the individual interviews with Beth and David permitted a more thorough understanding of their particular challenges. Equally gracious was amount of analysis I was permitted to afford Luke, Cole, and Warren's hour-long interviews.

Although my research ought not be considered representative of experiences of homelessness and injection drug use, the qualitative detail of the particular experiences in this study offers valuable nuance to complex processes of self-identification, intimacy, and communication in communities of homelessness and injection drug use. Qualitative research offers a forum to narrate particularly complex forms of emotion and sociality that are difficult to capture in more generalized studies. When considering stigmas of homelessness and illicit drug use, the target population of this study has good reason to be reticent to participate in research. By engaging qualitative methodology I was able to offer participants ample time and attention to detail their contribution to my research in dialogue.

My research could inform additional inquiry into communication, injection drug use, and akrasia associated with practical knowledge and initiation of high-risk behaviors. Additional research on formulations of secrecy among injection drug users and discourses that emerge at the fringes of secrecy about drug use is suggested. Qualitative investigation into the establishment of "curiosity" about drug use in the midst of mimetic presentations of injecting could assist harm reduction efforts to curtail initiation to injecting. Also, inquiry on relational dynamics of intimacy between injectors and non-

injectors that do not result in initiation could help harm reduction create practical strategies for positive relational modeling.

Critical communication studies can contribute to the study of embodied representations of drug use discussed in this study. Recent anti-drug campaigns such as The Meth Project (The Meth Project, 2005) approach themes of initiation, overdose, infection, and disease associated with methamphetamine use with graphic media depictions of embodied disease. Considering the complex dynamics associated with initiation, how does the spectacle of embodied drug use function in initiating or deterring drug use in general, or injection drug use specifically? What elements of (public) secrecy are mystified, demystified, or re-enchanted by contrived presentations of embodied drug use? Within communities of drug use what differentiates these representations from lived experience; what differentiates the "junkie," as an embodied stigma, from other drug users who struggle, care, love, and speak? Critical communication studies could also extend research into discussing the material and technological rhetoric of the syringe among initiates. The syringe, in a sense, facilitates knowledge in relationship to (public) secrecy around bodily experiences of drug use. Initiation, as a signal event, establishes learning and "deface" the naivety of a pre-initiate. This study has distinguished injection as a categorical method of drug experience that determines various forms of social inclusion and exclusion. From David's struggles with interpersonal intimacy, to social taxonomies of drug use that structure domiciles of homelessness, injection structures social experience. What elaboration of knowledge constitutes these communities and what ritualistic or mystical function does initiation bring to social relationships? Michael Taussig's consideration of defacement is apt to assist this

conversation. Taussig (1999) employs descriptions of defacement as an act that "spoliates and tears at tegument . . . [to] also animate the thing defaced"; acts of defacement break through forms of knowledge that are removed from diegesis (p. 3). This may precisely be a rhetorical, technological, and embodied function of the syringe.

In conclusion, the five participants who shared their experiences with me discussed unique, and often complex, forms of caring, communication, and contradiction. This research presents ways injection drug use is discussed or not discussed, and how, at times it is openly communicated without being "communicated." My research suggests that the (public) secrecy of injection drug use in scenes of homelessness—the sense that it is known outside of articulation—is a useful secrecy, not only to the BTC curriculum and the prevention of initiation, but also to injection drug users' processes of self-identification and navigation of akratic circumstances. Forms of practical knowledge as techne and/or phronesis, as well as the communicative modes of mimetic and diegetic learning combine to help approximate complicity with the secret by (re)forming agency and structuring experiences of intimacy.

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APPENDIX A: INTERVIEW GUIDE

The following outline was submitted and approved as part of the research protocol to loosely structure interviews with all participants.

I. How do NIDU on the street get along with IDU? How do relationships with other IDU look different than relationships with NIDU in camps, shelters, or the street?

   a. Do you have friends who don't know that you inject?

      i. Can you tell me about them? What do you talk about?

      ii. Do you try to keep your injection drug use a secret?

         1. Is that hard to do on the street?

   b. What about the people you hang out with who don't inject but know that you inject?

      i. Do they talk about injection?

   c. What kinds of things do you have in common with NIDU on the street? What do you talk about?

      i. Can you tell me about a time when a conversation with a NIDU turned to injection drug use? How did the topic come up? How did it go?

II. In Break the Cycle they say that hearing about the benefits of injecting drugs makes people more interested in injecting. What has been your experience? There's no right answer.

a. What do people say is good about injecting? [Defining benefits]

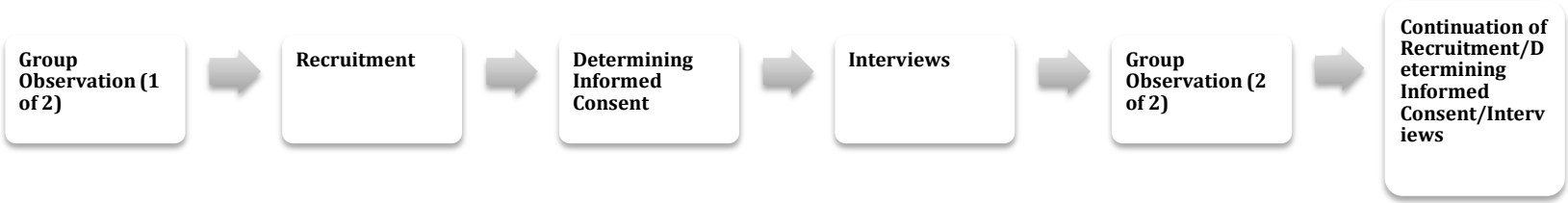
b. In your opinion how do non-injectors on the street wind up discussing or hearing about the benefits of injecting? [Defining communication contexts]

    i. Can you tell me about a specific time when you were homeless when a non-injector may have heard about benefits of injecting?

    ii. Can you tell me about a specific time when you were homeless that a non-injector openly discussed the benefits of injecting with you or told you reasons why they wanted to pick up a needle?

c. In your opinion when is it difficult to be on the streets around non-injectors without discussing injection drug use and its benefits?

APPENDIX B: FLOWCHART OF STUDY RECRUITMENT PROCEDURE



- Passive observation of BTC group will occur to create a researcher understanding of curriculum content and context.

- BTC Facilitator will refer recent program participants to poster advertisement
- Co-Primary Investigator will screen initial respondents for age, recent BTC participation, drug of choice (heroin), and homelessness.
- Co-Primary Investigator will obtain data codes for program evaluation data held by HRAC. Codes will be given to Stephanie Wood, Program Evaluator at HRAC, for final eligibility screening. Co-Primary Investigator will also obtain phone contact information and an alias to contact respondents concerning their eligibility.
- Co-Primary Investigator will contact respondents via telephone to inform them of their ineligibility for the study, or to schedule an appointment to determine consent and proceed with an interview (if eligible). Respondents will be informed of their option to have individual contact information erased at any time at their discretion. No contact information will be preserved beyond the six-month duration of this protocol.

- Respondents will meet with Co-primary investigator and review the risks and benefits of study participation as described on the study cover letter.
- Respondents who are determined competent to participate in the decision-making process will be invited to verbally acknowledge their informed consent to participate in the study. If a respondent is not determined competent to participate in the decision-making process s/he will be advised to reschedule a meeting for another time.
- A cover letter detailing the potential risks and benefits of participation will be offered to participants.
- Potential volunteers will be informed of their option to have their individual contact information erased at any time at their discretion. No contact information will be preserved beyond the six-month duration of this protocol.
- Respondents who acknowledge informed consent will immediately proceed to interview.

- Volunteers will interview with the Co-Primary Investigator for no more than 60 minutes or until a volunteer determines the interview complete. No interviews will proceed longer than one hour.
- Interviews will be based off of an interview guide. Interviews may be digitally recorded for transcription puposes. Recordings will be erased upon transcription to print text. Volunteers may opt to interview without being recorded.
- Upon determination of completion of interview by a volunteer or the Co-primary Investigator the volunteer will be given a $20 gift card to a local grocery store.

- In the third month of the six month data collection period the Co-primary investigator will passively observe a second BTC session.

- Recruitment, Determining Informed Consent, and Interviews will proceed until the target cohort of 12 volunteers (9 men and 3 women in combination with age-group limitations) has been fulfilled or the 6 month duration of data collection has expired.