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To Be Free and Normal: Addiction, Governance, and the Therapeutics of Buprenorphine

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Abstract

Methadone maintenance has dominated opiate addiction treatment in the United States for decades. Since 2002, opiate addiction has also been treated in general medical settings with a substance called buprenorphine. Based on interviews and participant observation conducted in northern California, this article analyzes how discourses of freedom and normalcy in patient and provider narratives reflect and affect experiences with this treatment modality. I discuss how buprenorphine treatment, in contrast to methadone maintenance, offers patients and providers a greater sense of autonomy and flexibility in how they receive and deliver treatment. It presents them with new obligations, responsibilities, and choices around care and conduct. It simultaneously perpetuates and shapes a desire to be "free" and "normal." I argue that the therapeutics of buprenorphine govern patients and providers through this desire for freedom and normalcy. Buprenorphine is thus a technology of governmentality that extends neoliberal discourses and values and produces self-governing subjects.

Keywords

buprenorphine; drug treatment; freedom; normalcy; governance

"Buprenorphine's a wonderful drug. You feel like you're free and you feel normal."

Introduction

Sam[1], a former heroin user, made this comment while at a community clinic. Through this remark, Sam expressed a sentiment that several patients and healthcare providers repeatedly imparted during fieldwork on the utilization of a substance called buprenorphine in office-based opiate treatment (OBOT)[2], a relatively new form of opiate addiction treatment in the United States. Sam, like many of my informants, explained that buprenorphine (colloquially referred to as "bupe") made him feel "free" and "normal." This seemingly simple yet common refrain raised several questions: What did my informants mean when they made this statement? To what kind of "freedom" and "normalcy" were they referring? In the

[1]All informant names are changed to ensure confidentiality.

[2]OBOT refers to opiate addiction treatment delivered outside of specialized methadone clinics. It is office-based because it is provided in general clinical settings, such as primary care clinics.

current climate of opiate addiction treatment in this country, what does it mean to feel “free” and “normal?”

This article engages these questions by examining how “freedom” and “normalcy” shape the experiences of patients and providers with buprenorphine and OBOT. Based on fieldwork on opiate addiction treatment in northern California, this article analyzes how discourses of freedom and normalcy in patient and treatment service provider narratives reflect and affect these experiences. I discuss how this treatment modality, in contrast to the rigors of methadone maintenance treatment (MMT), offers patients and providers a greater sense of autonomy and flexibility in how they receive and deliver treatment. It presents them with new obligations, responsibilities, and choices with regard to care and conduct. At the same time, it both perpetuates and shapes a desire to be “free” and “normal”. I argue that the therapeutics of buprenorphine govern patients and providers through this desire for freedom and normalcy. When coupled with OBOT, buprenorphine thus serves as a technology of governmentality that extends neoliberal discourses and values and produces self-governing subjects.

Methadone, buprenorphine, and opiate substitution therapy (OST) are the subjects of much social scientific analysis. One area of focus is the clinical spaces associated with these pharmacotherapies and their attendant treatment modalities. Bourgois (2000) and Friedman and Alicea (2001) critically examine MMT in the United States by describing it as a hostile system that monitors and disciplines bodies, pleasure, and productivity. They argue that the highly regulated space and interactions characteristic of the methadone clinic are repressive and detrimental to the patient. Furthermore, Meyers (2013) explores the novel therapeutic space offered by buprenorphine by showing the expansion of clinical decision-making and individual patient care made possible by OBOT. His work illustrates the importance of *where* treatment is located to studies of clinical practices and experiences with OST.

The substances that constitute OST are also scrutinized. Studies demonstrate that these substances, particularly methadone, change according to their use, location, and related discourse. valentine (2007) and Fraser and valentine (2008) explain that methadone does not have a priori qualities; its capacities are produced through particular interactions and do not exist apart from its situated use in MMT. Similarly, Gomart (2002) interrogates methadone's so-called inherent properties by comparing its uses in the United States and France. Her work illustrates how the “effects” of methadone emerge from the socio-political contexts of its use and not its pharmacology. Keane (2013) further argues that medical discourse produces different types of methadone credited with distinct effects depending on whether the problem being treated is addiction or pain. These analyses collectively question the idea of a singular, decontextualized methadone, a project that is also applicable to buprenorphine.

The topic of governance is also relevant in the analysis of pharmacotherapies and OST. A form often examined is what historian and philosopher Michel Foucault (1979) calls governmentality, a political rationality that allows for and encourages different forms of surveillance to regulate and govern individuals and populations “at a distance.” In displacing government from a central authority, governmentality relies on the formation of productive, obedient subjects through the self-regulation of individual behavior. Seddon (2010) draws

on this concept to discuss the "drug problem" in the United Kingdom through changing paradigms of governance. He traces how "addiction" emerged as a governmental concept that allowed particular practices and strategies to govern individual behavior in the liberal age. Some scholars, moreover, study governmentality in relation to MMT to illustrate how subjects are created and controlled within the treatment apparatus (Bourgois 2000, Friedman and Alicea 2001). As a regulatory technology, MMT creates docile subjects who become responsible for their behavioral choices. However, they argue that it actually limits choice and produces oppressive constraints on treatment.

Besides the production of compliance through self-discipline and care, governmentality also generates normative assumptions. Normalization entails the formation of idealized norms of proper conduct that are internalized through diffusive disciplinary regimes (Foucault 1977). Through normalization, standards of normalcy are established and mediated, which influence how one works on the self. Foucault argues that the establishment of "the norm" is about processes of normativity and moralization. The disciplining of normalcy, therefore, exercises control by adhering the labels of "normal" and "abnormal" to bodies and behaviors. This is visible in biomedicine, for instance, whose rise is linked to statistical techniques that distinguish between "normal" and "pathological" bodies (Lock and Nguyen 2010:32); it understood "normality" through biological variations of individual bodies. As bodies are normalized, normal is further equated with what is morally right. Indeed, biomedicine as a social institution "reinforces and reshapes moral discourses about normalcy and makes judgments about what is normal and what is not" (Becker 1997:96). Practices and discourses of normalization, therefore, serve to regulate behaviors and bring them under the moral purview of "the normal."

OST is not immune to this normalizing influence (Ning 2008, Nettleton et al. 2013). In fact, the initial goal of MMT was the normalization of addicts' lives, "to enable addicts to reorganize their lives productively and healthfully" (Bourgois 2000:170). It was promoted because it allowed addicts to leave their street life and becoming law-abiding citizens (Dole et al. 1966). This process is also imbued with moralistic intention, as the methadone apparatus creates compliance and conformity and is, as Bourgois notes, "the state's attempt to inculcate moral discipline into the hearts, minds, and bodies of deviants who reject sobriety and economic productivity" (2000:167). Thus, while the ostensible purpose of OST is to "enable" users to become healthy and productive, it actually forces the choice to become healthy and productive in a way that is socially normative and acceptable according to those definitions.

Sociologist Nikolas Rose expands on these issues by showing how freedom is central to liberal modes of governance, whose objective and achievement now is "to govern through making people free" (1999:69). Governing is about acting through, not on, freedom. Such freedom is expressed in the ability of autonomous individuals to make choices about their own lives. It also instills certain obligations: "Modern individuals are not merely 'free to choose,' but *obliged to be free*, to understand and enact their lives in terms of choice" (Rose 1999:87). Freedom is also how the individual relates to and practices upon the self. Rose suggests that "normality" and the invention of "the norm" are the linchpins of self-care mechanisms (1999:75). Through different political projects, individuals are incited to

become and be normal. A “normal” state of being is desirable and achievable by working on the self, and the values of freedom, autonomy, and choice must be internalized to become a well-adjusted individual. The value of freedom, therefore, is not “as a state or a quality, but as a way of practicing upon oneself” (Rose 1999:95).

When it comes to addiction, however, freedom and normalcy are tricky to locate. Petersen observes “the tendency for individuals to be evaluated according to their abilities to effectively regulate themselves and others in line with prescribed norms of conduct for ‘healthy living’” in neoliberal contexts (1997:203). But, as Reith (2004) explains, addiction is often described discursively in terms oppositional to neoliberal values of freedom, autonomy, and choice. Incommensurable with these values, addiction is considered a problem of the freedom of the subject (Seddon 2010, Fraser and Moore 2011). In this sense, “addiction” serves as “a discursive device that transmits the notion of disordered consumption, and that articulates a sense of loss of control; a subordination of personal agency to some external or unwilled mechanism” (Reith 2004:286). Recovery from addiction is described in similar terms. To “recover” is to overcome “pathological” and social deviance by returning to a “normal” state (Nettleton et al. 2013:4). It, thus, involves an internalization of a desire to operate according to accepted norms regarding good health and proper behavior.

This desire for normalcy stems from institutional and non-institutional processes and discourses that contribute to prescriptive norms that determine what is and is not normal. Channeling Foucault, Mol explains, “Normality is not a law. Instead, those who do not manage to meet the standards of normality, the *abnormal*, are marginalized to the fringes of society...Thus ‘normality’ is something people come to positively desire, from the inside, instead of something that, like a rule, is imposed on them from the outside” (2002:58). Foucault himself also suggests that this desire produces compliance and conformity. With respect to buprenorphine, the disciplined patient observes the prescribed parameters of treatment, self-monitors their behavior, and knows “who he is; where he must be; how he is to be characterized; how he is to be recognized; how a constant surveillance is to be exercised over him in an individual way” (Foucault 1977:199).

In this article, I draw on Foucault and Rose's insights to underscore how buprenorphine enables patients and treatment providers to be governed and to govern themselves. As Rose points out, technologies help “understand the human being in terms of identity, autonomy, and the desire for self-actualization through choice” (Rose 1999:85). Technologies like the pharmacotherapies used in OST operate on the same neoliberal values of self-regulation and individual responsibility. Such “technological fixes” (Campbell 2011) engage patients as responsible choice-makers in their addiction treatment and recovery. In the case of buprenorphine, it appeared as a maintenance therapy “at a time when addicts — like other citizens — were expected to take responsibility for health and healthcare, and where such decisions were seen as individual matters of choice and political entitlement” (Campbell and Lovell 2012:137). Buprenorphine is, therefore, a “civilizing technology” which produces healthier, more responsible individuals capable of adhering to social duties and obligations (Vrecko 2010a).

As with methadone, buprenorphine also produces new subjects and modes of existence (Fraser and valentine 2008, Campbell 2011). Buprenorphine patients and providers come to imagine themselves through their experience and desire for freedom and normalcy. This is the precise result and goal of this type of governmentality and quite possibly the true mark of liberal governance. Consequently, this article concerns the ways in which the therapeutics of buprenorphine in the United States mediate experiences of opiate addiction treatment and shapes the subject positions of those undergoing treatment as well as those providing it.

Opiate Addiction Treatment in the United States

The provision of opiates for drug treatment in the United States dates back over a century.[3] It was first federally regulated with the Harrison Act of 1914, which allowed doctors to provide them within a "legitimate" medical context, but placed restrictions on their use for addiction maintenance. Several municipalities responded by establishing morphine maintenance clinics (Courtwright 1982, Musto 1973), but were closed in the 1920s. Pressure from the federal government and the medical community as well as fear of prosecution further deterred doctors from providing such treatment.

The development of non-addicting analgesics in subsequent decades led to the rise of addiction therapeutics, including methadone (Campbell and Lovell 2012). Between the 1940s and 1960s, methadone was used for medically-assisted detoxification (Campbell 2011). In 1964, research on the use of orally administered methadone to treat heroin addiction showed that maintenance doses reduced heroin use and criminal activity and improved general health and employability (Dole and Nyswander 1965). Methadone helped "block the abnormal reactions of addicts to heroin and permit them to live as normal citizens in the community" (Dole et al. 1966:304). Through this "narcotic blockade," methadone was a medical means to treat the newly recognized disease of "addiction."[4] Yet methadone maintenance was criticized by sectors of the federal government, law enforcement, patient advocacy groups, and the medical community for being misguided, unsafe, and ineffective (Jaffe and O'Keeffe 2003). Nevertheless, the Nixon administration promoted it as a useful treatment and called for expanded access.

Methadone maintenance soon became widespread. It marked the end of the "classic era" of narcotics control, when punitive laws restricted drug treatment to prisons and detoxification programs (Courtwright et al. 1989). Still, strict regulations controlled methadone's distribution by setting limits on initial doses and treatment type.[5] Distribution was also confined to specialized clinics or "medication units." Patients and providers consistently critiqued the restrictions to care posed by such regulations (Courtwright 1982, Campbell and Lovell 2012). An inquiry by the National Institutes of Health led to a consensus statement in 1997 calling for increased and less controlled access to treatment, which led to the development of the Drug Addiction Treatment Act (DATA) of 2000. This legislation

[3]For more on the provision of opiates in drug treatment in the United States, see Courtwright 1982 and Campbell 2011.
[4]The Supreme Court declared "addiction" a disease and not a crime in 1962 (Musto 1973:237).
[5]There are three types of methadone treatment: short-term detoxification (under 30 days), long-term detoxification (30-180 days), and maintenance.

permits doctors to prescribe opiates in a general medical setting rather than in the highly controlled space of the methadone clinic.

OBOT, however, is not exempt from regulation. Doctors must meet training and licensing requirements and prescribing specifications, and federal restrictions determine which opiates can be used. Due to its purported safety profile and low overdose risk, buprenorphine is the only pharmacotherapy that can legally be used in OBOT. Buprenorphine was first studied in 1977 as a potential addiction treatment drug (Campbell 2011).[6] Despite its therapeutic potential, buprenorphine faced hurdles, including drug scheduling issues, the fear of abuse of its analgesic form, and the unwillingness of pharmaceutical companies to handle addiction medications (Campbell and Lovell 2012). It took nearly three decades to approve buprenorphine for addiction treatment.

In the United States, buprenorphine is offered in two formulations in OBOT: Suboxone® and Subutex®.[7] These sublingual tablets differ slightly; Subutex® contains buprenorphine while Suboxone® contains both buprenorphine and naloxone. If Suboxone® is injected or used with another opiate, the naloxone will precipitate withdrawal. This serves as a pharmacological safeguard to discourage injection and diversion to street markets. As such, Subutex® is used only during the first few days of treatment while Suboxone® is prescribed for maintenance.

The main objective of incorporating buprenorphine into office-based settings is improved access to treatment.[8] No longer confined to specialized clinics, treatment is now available in medical practices. OBOT may also attract those who might not seek care at methadone clinics, mainly youth and middle and upper socioeconomic opiate users (Fiellin et al. 2001, Ling et al. 2004). Thus, buprenorphine treatment might also improve treatment adherence (Jaffe and O'Keeffe 2003). This treatment modality, however, was never intended to replace methadone, which is effective for maintenance and appropriate for treating specific populations (Ball and Ross 1991, Amato et al. 2005). Rather, the coupling of buprenorphine and OBOT broadens the range of treatment options. Therefore, those dissatisfied with other modalities celebrate it as a useful method for addressing opiate addiction in the 21st century (Stancliff 2004).

Methods

Fieldwork was conducted from May to December 2005 at eight clinical sites in northern California where treatment was offered through the dispensing of methadone at specialized clinics or the prescription of buprenorphine in office-based settings. Compared to other regions of the country, northern California is a “treatment rich” area with a range of drug treatment services, yielding a number of fieldwork sites. Several were private clinics providing care for specific physical or psychological disorders in addition to drug treatment.

[6]For more on the development of buprenorphine as a pharmacotherapy, see Jaffe and O'Keeffe 2003 and Campbell and Lovell 2012.
[7]During fieldwork, buprenorphine was only offered in tablet form. In 2009, Suboxone® was formulated as a sublingual film to improve treatment compliance and decrease prescription drug misuse.
[8]Hansen and Roberts (2012), however, suggests that prescription and marketing practices create a two-tiered system in which buprenorphine is targeted to white, middle class prescription opioid users while methadone is relegated to the Black and Latino urban poor.

The majority were part of the public health system that served indigent, uninsured, or underinsured populations seeking drug treatment or general healthcare.

Participant observation was a key fieldwork component. First, I observed patients at a methadone clinic to learn how methadone is administered. With their consent, I followed patients through the intake process to receive counseling, a medical exam, and their first dose. Second, I observed a weekly group meeting for buprenorphine patients at a community clinic. This group functioned as an open discussion forum for treatment-related concerns. Third, I attended a monthly seminar on buprenorphine and OBOT at a large public hospital. These seminars presented research on opiate addiction treatment to healthcare professionals, often stimulating discussions about the provision of care. Lastly, I participated in a federally mandated training for doctors interested in prescribing buprenorphine, which provided insight into their education around this substance and OBOT.

I also conducted 30 semi-structured interviews at private and public facilities offering methadone or buprenorphine. Interviewees included 13 patients, five doctors, three nurses, two medical directors, two psychologists, two program directors, one counselor, one therapist, and one pharmacist. The wide sample of interviewees reflects the patient and provider composition of the fieldwork sites. Interviewees also played varying but critical roles in the treatment process. Interviews with providers focused on experiences with patients receiving methadone or buprenorphine as well as views on these substances and OBOT. Interviews with patients, most of whom were male,[9] focused on experiences with these treatments and local treatment programs. This research received Institutional Review Board approval.

Fieldnotes and transcripts from participant observation and interviews were analyzed for key themes. A coding system was developed to refine the data through the classification of sub-themes to establish a structural framework for organizing the narrative analysis. This analysis provided invaluable insight into my informants' individual and collective experiences with drug treatment and provision.

Domains of Normalcy

The long shadow cast by methadone over opiate addiction treatment provided my informants with extensive experience with this treatment modality. This is manifest in their narratives. Yet the advent of buprenorphine contributed another dimension to these narratives: buprenorphine is positioned in relation to methadone and comparison is the predominant narrative form. As this comparative work is performed, three interrelated domains emerge to reveal experiences and discourses of freedom and normalcy with buprenorphine and OBOT. These domains — which I call physical normalcy, treatment normalcy, and medical normalcy — are ethnographic windows into how freedom, normalcy, and governance are discursively and experientially linked in the therapeutics of buprenorphine.

[9]It is unclear why there were more male than female patients at my field sites. However, research claims that women are underrepresented in treatment and that the use of maintenance pharmacotherapies is gendered (Unger et al. 2010).

Physical Normalcy—Methadone and buprenorphine maintenance is meant reduce the physical symptoms and cravings associated with opiate dependence by stabilizing patients on a steady dose of medication. As with methadone, medical sources claim that the physical sensations attributable to buprenorphine are related to its pharmacology (Fiellin et al. 2001, Ling and Smith 2002). Specifically, they maintain that buprenorphine's properties address opiate withdrawal in the same manner as methadone, but cause less several physical changes. In their narratives, patients and providers embrace this biomedical truth claim through their descriptions of how these milder changes are more favorable than those induced by methadone.

A patient who articulates differences between the two substances is Louie. A heroin user since the 1970s, Louie was on methadone for 13 years until he transitioned to buprenorphine in 2004. His description of buprenorphine's physical benefits echoes those of other former methadone patients:

> I appreciate the clarity of thought. I can sit down and not fall asleep. Like, on methadone, I'd sit there, as soon as I sit down, I'd start feeling sleepy. I sometimes drove with one eye open. I didn't like that. I reduced my driving a lot, which I didn't like to do. And with buprenorphine I don't have that problem...Every once in a while I get a craving, but usually when it's at night, when I'm in bed. I get an urge to use drugs or I'll have a drug dream, but those are getting less frequent. With methadone, the sleep you get, you're like a stone. With buprenorphine, you can dream and, like I said, clarity of thought. You don't have that methadone haze about you.

A nurse named Thomas makes a similar comment about the substances' physical effects as conferred by his patients:

> The things we hear most often are that the patients don't feel medicated. And another thing which has surprised me because I *don't* hear it in methadone clinics where I've worked for so many years, patients say, once they're on buprenorphine, "Methadone was always a little tricky for me." There was this really fine line for so many patients where they'll feel a little bit in withdrawal and if they take just a couple milligrams more, five milligrams more or ten milligrams more, those typical "bumps" up or down, then they say, "Then I started feeling a little bit high and then I feel guilty about it. And I wouldn't want to go back down on my dose." So I am learning about such a smaller window for patients' comfort in their own methadone dose whereas they don't talk about that with the buprenorphine. What they *really* talk about, that everyone's really clear or most people are really clear on buprenorphine, is they say, "I don't have heroin cravings." Which is very different from methadone.

Some patients are adamant about this last point: buprenorphine is better than methadone at controlling cravings. During group meetings, patients often discussed how buprenorphine reduced cravings to "stick themselves" with a needle or to "chase" a bag of heroin, feelings that methadone was unsuccessful in quelling.

Out of these and similar descriptions emerges a discourse on physical normalcy: buprenorphine makes patients feel more physically normal than methadone. Joseph, a psychologist, illustrates this by reflecting on his patients' experiences:

> From speaking with certain patients on methadone, they have that nodding maybe 45 minutes after their dose. For certain patients, they feel a little light buzz, a slight euphoric effect from the methadone. For other patients, they have side effects from the methadone...And some reports of patients on buprenorphine who've been on methadone, they say all that stuff goes away and they feel more normal. They're not feeling a little buzzed like from taking the methadone. They're not feeling that "opiate feel." So from that standpoint, I think certain patients are gonna respond much better to the buprenorphine and they'll feel more normal, they won't have the same side effects.

As a patient, Louie describes methadone as maintaining the physical sensations of addiction while simultaneously preserving the guise of addiction. Buprenorphine, conversely, releases him from both that physical state and the physical semblance of an "addict":

> I'd seen the people coming in and get clean and get clean *quick*. Within a matter of weeks they started looking like humans. You know, humans get that glow about them. Dope fiends, they just look dull and faulty. You'd see people with a little spring in their step and with their heads held high. And that's a plus as far as I'm concerned. With methadone, a lot of people get cleaned up, but they still feel like a drug addict. And there's a big difference between that and bupe because bupe breaks the chains as far as I'm concerned.

His comment highlights buprenorphine's presumed ability to convey the outward appearance of normalcy. This, plus the physical benefits conferred by buprenorphine, including clarity of thought, alertness, and reduced cravings, contributes to physical normalcy.

Gomart (2002) cautions against claims that presume a substance's properties or effects are pharmacologically inherent. Nevertheless, those who consume and dispense these substances *do* often makes such claims. For my informants, the normalizing effects of buprenorphine are, in part, pharmacologically produced. The articulation of such a belief in their narratives is the result of governmental power that prescriptively deems buprenorphine's corporeal effects normal and, therefore, desirable.

Treatment Normalcy—Both patient and providers, nonetheless, explain that the physical benefits of buprenorphine are enhanced by its utilization in OBOT. Patients can receive treatment from their doctor and obtain their medication at a local pharmacy. OBOT also provides distance from the regulations and clientele at the methadone clinic. A doctor named Karen discusses the options afforded by this alternative treatment modality:

> The beauty of buprenorphine is it allows the patient to *completely* get away from all the rigors and ritual of the methadone treatment programs...There's oversight at many, many levels of how much the patient's on and if they're getting take-homes short-term and if their urines are dirty for other drugs. And I think that the cynical side of me says methadone programs are about controlling drug addicts. But I had

> some patients who were around in the early years of the first methadone programs in New York and they talked about the number of friends of theirs that overdosed on methadone. So it *is* a drug that you have to be careful of, and, with addicts, you worry that they'll push the envelope...So there's the safety concerns that have led to this *incredible* industrial complex of methadone treatment, and you have none of that with buprenorphine.

For patients and providers, the movement of treatment outside of the methadone clinic is a powerful force in normalizing treatment in ways not possible with MMT.

A heroin user for 35 years, Jim transitioned to buprenorphine in 2004 after several years on methadone. He said buprenorphine makes him feel “like a regular person” because he can take it like other medications, and he can get it at a pharmacy “like antibiotics or Viagra.” But what was most significant to Jim was the release from the methadone clinic with OBOT. The frustration of going to the clinic everyday was no longer a routinized part of his life. Louie also emphasized the significance of this freedom: “You don't feel like you have chains on. I look at methadone as liquid handcuffs.[10] You can't travel unless you have take-homes. There a lot of changes you gotta go through to get on methadone. With bupe, you don't have that.” A doctor named Julia also mentions how separation from the methadone clinic contributes to patients’ feelings of normalcy:

> There's the physical effects of not feeling sedated, not feeling like you're nodding out or slowing down, but there's also the feeling normal part about “Well, I don't have to go to the methadone clinic everyday. And I can retain some anonymity about my substance use or my opiate dependence.” I don't have to stand in line at the methadone clinic where people walking by can say, “Oh, that's where the junkies go and get treated.”

This statement highlights additional reasons why patients seek distance from the methadone clinic: loss of privacy and stigma associated with being treated there. Jim emphasizes these points:

> Nothing is secret at the methadone clinic. Everybody knows your business and they know that you're an opiate addict. Everyone in the neighborhood around the methadone clinic doesn't like you because they're afraid of crime and drug sales coming into their community. People think that the methadone clinic is the place where people with the plague go.

Louie also appreciates these aspects of OBOT, but specifically notes dissociation between himself and the people hindering his recovery:

> I appreciate the freedom I get from the methadone clinic. You stand in line with all them knuckleheads that are still using. And with buprenorphine, you don't have the craving to do any of those things. So, to me, that's one of the biggest benefits. And I used to stand in the methadone line and you'd hear a lot of people talking about

[10]According to Fraser, this image of liquid handcuffs has “international currency among drug users, referring in part to the perceived role of methadone treatment as a form of incarceration; a convenient method of controlling the behavior and limiting the freedom of those who would otherwise use heroin” (2006:683).

> their crimes, about their addictions...And that gets old if you're trying to move on. With methadone you still feel like a junkie. You're around junkies. With bupe, you can choose not to be around ‘em and not to talk with them about dope. You can concentrate on other things and you just feel like a normal person.

These narratives illustrate the importance of treatment location in perceptions and experiences of normalcy.

OBOT also presents providers with new clinical freedoms around patient care. Susan, a doctor with considerable experience treating patients with methadone, speaks highly of these freedoms:

> You can make more clinical decisions compared to the very highly structured, regulated environment of the methadone clinic where, in the federal regulations, it tells you who can get onto detox and who can get on maintenance. And they have set up how often you have to write your treatment plan and what it has to consist of and how a person can earn their take-homes. And you can't write a prescription. It has to be dispensed at the window and how many milligrams of methadone you can give on the first dose...All of that stuff is *extremely* regimented. And it's true for the physician and it translates for the patient as well. And even though it's part of good treatment and responsible care, it's also a major barrier to treatment because a lot of physicians and a lot of patients don't want to engage in that kind of limited ability to make choices. And you end up pretty much relating everyday to some aspect of the regulations...So if you're working in methadone maintenance and you suddenly start to use buprenorphine in an office-based model, it's a huge relief. You can just make clinical decisions about what the patient needs. You can individualize treatment.

A desire to make more clinical decisions and individualize treatment is pervasive throughout Susan's narrative. Joseph, a psychologist, makes a similar point:

> I think a lot of the regulations that we have in methadone programs are foolish. I think a lot of it is based on safeguarding the methadone. It's more geared toward avoiding diversion than in the best practices treatment. It's so heavily regulated and, as such, buprenorphine is exciting because it offers clinicians an opportunity to provide *real* treatment.

Another doctor named Christopher explains that while MMT is heavily controlled, buprenorphine treatment is also regulated. He believes this might dissuade many doctors from utilizing buprenorphine. Susan agrees that this may prevent a sense of normalcy for some:

> If you're just in plain family practice in your neighborhood and you want to use buprenorphine to treat opiate dependence, it means you have to go to a class, you have to notify the Secretary of Health and Human Services. There's a standard of care that involves using a special DEA number to write the prescription, the DEA says you have to keep a record of all those prescriptions for a couple of years at least, and if you store any medication on-site, you have to keep track of every tablet and you have to keep your receipts for two years. So there are all these restrictions

> on regular docs that maybe doesn't make them feel as normal as it would make me feel because I work in a methadone clinic.

While providers without methadone experience may be reluctant to adopt buprenorphine because of these strictures, Susan, nonetheless, believes it is rewarding to have the clinical options associated with buprenorphine because it makes her feel like a normal doctor.

These narratives illustrate an important performative dimension of treatment normalcy. The opportunities provided with this therapeutic regarding the receipt, delivery, and management of treatment allow patients and providers to behave normally. For patients, this means no longer receiving treatment in the stigmatized, structured environment of the methadone clinic. Instead, they are treated in a space without the same regulations and "junkie" population. Likewise, they can pick up their prescribed medication from a pharmacy at their leisure rather than during a designated timeslot at a bulletproof window at a methadone clinic. They believe that buprenorphine breaks, in Jim's words, the "liquid handcuffs" of methadone, allowing them to hold down jobs, spend time with family, and live normal lives.

For providers, the distancing of treatment from the methadone apparatus is similarly important to feeling free and normal. As Joseph and other providers note, prescribing buprenorphine in an office-based setting allows them to feel and act like normal healthcare professionals whose medical decisions are less controlled. As Meyers (2013) corroborates, OBOT grants greater flexibility and autonomy with regards to patient-provider interaction, medication dosage, and general care.

The ability of patients and providers to enact normalcy greatly impacts their feelings and experiences, as the use of buprenorphine in OBOT permits certain kinds of conduct that help them become normal patients and providers. Like methadone (Gomart 2002, valentine 2007, Fraser and valentine 2008), the effects of buprenorphine stem from their contextual use. As my informants explain, part of buprenorphine's normalizing effect is due to its deployment in office-based settings.

Medical Normalcy—For many buprenorphine providers, the shift to office-based care is an important step toward incorporating addiction medicine into mainstream medicine. Moving treatment outside of the methadone clinic enables more of the medical community to address addiction in their practices. Several providers, however, mentioned the reluctance or aversion of some to treat addicted patients. Joseph, for example, admits that addicts are often viewed as "difficult" patients:

> From speaking with physicians who have private practices, people don't want to touch it [addiction]. From what I've heard, they're saying, "These are difficult patients to treat because they require a lot of time." They require a lot of time and they refer them to methadone programs. 'Cause often times, patients who come in with opiate dependence, it's hard to treat in an outpatient setting like that. Often times they come with lots of other clinical disorders. So my take from physicians I've worked with here, the general consensus is that they don't want to do it.

Thomas also draws a connection between some doctors' hesitations and what they consider the potential consequences of treating addiction in their practices:

> Some doctors voice concerns, “Boy, if we start prescribing buprenorphine, is this going to open up our practice and make our waiting room look like a methadone clinic waiting room?” That's understandable, I think. They've considered that, “Does that mean that our lobby will be one where people are dealing drugs?” I don't know if it's necessarily reluctance, but certainly people want to be prudent when signing up for treating substance-abusing patients on a regular basis.

The stigma surrounding addiction also influences experiences of freedom and normalcy. This is evident by the unwillingness of some providers to offer drug treatment. Carol, a psychologist, believes that addicted patients frequently feel stigmatized during the course of their treatment. She relayed a story about a patient who recently tried to refill prescriptions for buprenorphine and a benzodiazepine at a pharmacy. When he picked up the benzodiazepine, he asked if he could also get the buprenorphine to avoid a second trip. The pharmacist refused and explained that he still had one more day before his buprenorphine ran out. The patient interpreted this as not as observing protocol, but as discrimination; he believed that the pharmacist did not like having a “junkie” as a client.

Susan was quick to note that the stigma attached to the addicted patient is often transferred to the provider, what Goffman (1963) calls “courtesy stigma”. Susan ruminates on how her colleagues often perceive her:

> The patient is kind of stigmatized and physicians who work in methadone maintenance are sort of stigmatized. It was very common, when I would say that I work in a methadone clinic, to be called a “juice pusher” by colleagues. It's just a stigmatized kind of treatment. I think that, sometimes even in the field of addiction medicine, the patient who's doing well but they're on methadone maintenance is not seen as somebody who's in recovery or as somebody who's abstinent...It maintains physical dependence and because there's a medication involved, it's seen as somehow less, you know, lower standard than a patient who's going to residential treatment or group therapy or going to 12-step programs and maintaining their sobriety. And really what they're looking at is, in my opinion, the range of severity. And we have the more severely ill people who need their medicine. They're seeing the people who don't need medicine and they're saying, “Why would this person ever need medicine? Don't push juice on them!”

She admits, however, that the HIV/AIDS epidemic relieved some stigma within the biomedical establishment, as research showed the effectiveness of MMT in preventing and reducing HIV incidence. Yet she maintains that doctors providing pharmacotherapy for addiction treatment are still stigmatized: “That's a brick wall you run into all the time.”

Many providers, nevertheless, hope that normalizing addiction treatment will open the door for the further medicalization of addiction and the destigmatization of addiction treatment. This entails adopting a disease model of addiction that regards it as a chronic, physical condition requiring medical attention.[11] This model gradually gained credence, and is recognized by official diagnostic systems and major national and international health

[11]For more on the disease model of addiction, see Acker 1993 and Vrecko 2010b.

organizations. But, many acknowledge that addiction also has strong psychosocial and behavioral components. In this respect, many still struggle when dealing with addiction and addicted patients. Susan addresses this by reflecting on her own experiences:

> I think the field is struggling with the medical model. And I think the world is struggling with the medical model for addiction. And we end up saying, “Think about insulin. Think about anti-hypertensives.” Trying to make people reshape their thinking about addiction and see it as a chronic illness with a wide range of severity, relapse rates, and so on. There is a lot of “all or nothing,” a “black or white” kind of approach to addiction. You're either a hopeless addict or you're wonderful, sober, and in recovery. And, in reality, most patients are in between there. And there is such resistance to using a plain, chronic disease model for addiction. Anything that has a very strong behavioral side to it is very stigmatized.

The providers I spoke with promote the medicalization of addiction in conjunction with psychosocial and behavioral factors. They stressed the need to address perceptions and practices that historically contribute to the stigmatization of addicts and providers and that are still prevalent within certain sectors of the medical community. For them, the normalization of treatment through buprenorphine and OBOT plays an important role in the medicalization and treatment of addiction along side other chronic diseases. It also significantly contributes to their own sense of normalcy, of feeling like a normal doctor who treats patients with a legitimate disease in a less segregated, stigmatized way.

Freedom, Normalcy, and Subjectivity

The sense of freedom from all aspects of methadone treatment presented by buprenorphine and OBOT is central to liberal modes of governance, which rely on the promotion of freedom and the ability to make individual choices (Rose 1999). With the freedom to make decisions about their treatment, such as choice of doctor and dosing schedule, buprenorphine patients are responsible for monitoring their behaviors and obligated to adhere to the prescribed medical regime. They govern themselves through their everyday choices and self-care around their health and treatment. With increased autonomy and flexibility to make medical decisions, buprenorphine providers are also afforded more responsibility over choices regarding medical practice and patient care. In a sense, the coupling of buprenorphine and OBOT is no different from MMT in that both treatment modalities are about governance. The distinction, however, is that, while MMT is often characterized as more overtly controlling, buprenorphine treatment governs through the very freedom and normalcy it confers to patients and providers.

The granting of freedom and normalcy with buprenorphine and OBOT is further implicated in the production of potentially new subject positions for addicted patients and treatment providers. Campbell (2011) notes that each opiate addiction treatment technology constitutes different formations of addict subjects. One of the initial benefits of methadone, for instance, was the transformation of the street addict from a “junkie” to a “patient” (Agar and Stephens 1975). These “patients” actively seek treatment in methadone programs and are incorporated into the biomedical sphere as addiction is medicalized. Yet the patients that MMT produces

are of a specific kind, a variety that many of my informants believe is altered through OBOT.

The patient subjectivity offered through MMT is shaped by an extremely regimented treatment regime within the controlled space of the specialized clinic; it is contingent on that restrictive structure. Methadone regulations are meant to generate productive and obedient subjects (Bourgois 2000, Friedman and Alicea 2001). The coupling of buprenorphine and OBOT, alternatively, allows one to be a more "normal" patient through the administration of a more "normal" medication in a more "normal" treatment environment. Under current regulatory conditions, his subjectivity cannot be achieved with MMT in the United States. However, buprenorphine, according to my informants, opens that door. Whereas methadone constrains freedom on various registers, buprenorphine functions as a normalizing technology that bestows patients with more freedoms, choices, and responsibility for making healthy decisions. These shifts also have important implications for the subjectivity of buprenorphine providers. As patients normalize through OBOT, providers come to feel and behave normal due to their increased responsibility and freedom over treatment delivery. Buprenorphine and OBOT, subsequently, also incite a shift in their subject position as medical professionals.

The opportunity to become a normal patient or provider is a consequence of discourses of freedom and normalcy that permeate the therapeutics of buprenorphine. The positions of patients and providers in relation to biomedicine, however, are vastly different. The effects of these discourses are not necessarily the same given differences in background and power relations. Nevertheless, freedom and normalcy are pivotal to how subject formations and experiences of both patients and providers are mediated and governed by this treatment. These discourses of and the desire for freedom and normalcy reflect and affect how patients understand their bodies and recovery as well as how providers recognize their relationship with their patients and biomedicine. The therapeutics of buprenorphine, though framed by alternative logics of freedom and normalcy, remains unabashedly about the governance of bodies, behaviors, and desires.

Conclusion

This article examined the roles of freedom and normalcy in the experiences of patients and providers with buprenorphine and OBOT. I argued that this treatment modality encourages self-governance and produce subject positions that reflect and align with neoliberal discourses and values. Particular analytic attention was paid to the ways these discourses move through informant narratives to reveal how the desire to be free and normal impacts experiences with this treatment in the broader context of opiate addiction treatment in the United States.

The production of new subject positions of both buprenorphine patients and providers further reflects important institutional and relational changes within and around the field of biomedicine. This article illustrated how this development — while discussing the normalization of patients and providers and their behaviors and desires — also points to interesting shifts in the doctor-patient relationship, the clinical encounter, and the medical

treatment of opiate addiction. Yet given the fact that the coupling of buprenorphine and OBOT is still relatively recent to the United States, it remains to be seen how experiences with this treatment modality as well as these subject positions hold up with time.

When the fieldwork for this article was conducted, drug treatment with buprenorphine in this country was in its honeymoon phase. My informants could be classified as “early adopters,” and their enthusiasm for buprenorphine might be partially a result of bottled up frustrations with methadone and the long wait for new treatment options. With that said, the purpose of this article is to relay the experiences and convictions of my informants, many of whom viewed the utilization of buprenorphine in OBOT in a favorable light. It is not my intention to paint it as either “good” or “bad.” Rather, my point is to illustrate the messy space where both the benefits and limitations of this treatment modality are lived and experienced in profound ways.

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