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Keeping it in the family:

The moral economy of Suboxone in southwest Virginia

ABSTRACT
Opioid agonist medications, such as the buprenorphine-based Suboxone, are becoming increasingly important tools for caring for people with opioid use disorders. Yet, whether at the level of the family, the clinic, or pharmaceutical companies, the circulation of Suboxone can involve forms of concealment, secrecy, and deceit, even as it is used to provide a vital form of care. In exploring the moral economies that shape the licit and illicit circulation of Suboxone in southwest Virginia, we aim to unpack the logics of obligation, care, and secrecy that emerge within a family network caught in a set of sociopolitical, economic, and therapeutic conditions. In exploring how Suboxone circulates at these different scales—in families, in clinics, and in the global pharmaceutical economy—this article shows how secrets lubricate the social, economic, and moral mechanisms through which relationships are sustained and substances circulate. [*moral economy*, *secrecy*, *substance use*, *care*, *rural United States*]

Tripp steps back into the car. She and Josh are parked up by the side of the road, at the foot of her mother's driveway in a small town in southwest Virginia.[1] A thin rain spits down from the clouds hanging flat over the Appalachian Mountains. Before they pulled over, they had to make sure that Steve—Tripp's stepfather—wasn't expected back anytime soon. Tripp's mother, Sally-Anne, has been keeping her Suboxone usage hidden from her husband, a secret Tripp takes care not to disclose.

They are at the house so Tripp can pay her weekly rent. Instead of money, though, Tripp pays in Suboxone. For Tripp, paying rent means diverting two of the nine Suboxone pills she receives from her weekly prescription into her mother's pocket. Sally-Anne will supplement Tripp's contribution with Suboxone sourced from other connections. This week, Sally-Anne has struggled to get hold of what she needs and has already been in withdrawal for about 12 hours. If she had any left, Tripp would readily give her some from her own prescription. Unfortunately for Sally-Anne, though, clinic day is tomorrow, and Tripp has nothing left to give. All she has are the leftover cottons, or "trash shots," from the previous week's injecting, something she won't dare tell her mother—who abhors needle use.

That's why they're parked in the puddle-strewn shoulder and not by the garage at the top of the driveway. Tripp wants to fix before she drops off the Suboxone she's just bought from a high school friend who now sells it on the other side of the mountain, using cash given to her by her mother. Injecting is Tripp's favored delivery technique. "It's just easier this way," she says, as she lights a cigarette and squats by the side of the car, using the open door to conceal herself. Using the passenger seat as makeshift table, she gets out her works and dissolves the Suboxone quarter that she convinced the dealer to throw in for free, along with the pills she bought for her mother. After tying her arm off with a rainbow string cut off from an old bikini,

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she draws the solution into the needle and finds a forearm vein after a few misses. For a moment, her eyes close in relief. Afterward, she takes a long, serious drag on the cigarette that had otherwise been idling between her lips, her previously subordinated desire for nicotine now commingling with the analgesic intensity of the buprenorphine, wiping her face with a tranquil pleasure.

Concealment and circulation

Suboxone is used to treat opioid use disorder (OUD). It comprises two medications: buprenorphine and naloxone. Buprenorphine is a partial opioid agonist that is used in medication-assisted treatment (MAT) programs to reduce cravings and withdrawal symptoms. It has been shown to reduce the risk of overdose, relapse, the use of other substances, and all-cause mortality (Greiner et al. 2021; Mattick et al. 2014; Santo et al. 2021). Through its activity as a partial agonist, buprenorphine produces effects similar to that of other opioids, reduces cravings, and staves off the physical and psychological symptoms of withdrawal while producing a "ceiling effect" that limits euphoric sensations and minimizes the risk of overdose. Buprenorphine became the first medication for OUD that could be prescribed by office-based practitioners in the United States after the passage of the Drug Addiction Treatment Act (DATA) in 2000 (Campbell and Lovell 2012). This expanded access to treatment and offered patients new possibilities for autonomy and flexibility in OUD management and treatment (Harris 2015). The presence of naloxone in combined buprenorphine-naloxone formulations is intended to further reduce the medication's abuse potential by producing symptoms of withdrawal when injected instead of taken sublingually, a point we examine below.

Complex webs of social, economic, and moral relations underpin the networks through which substances like Suboxone circulate, both licitly and illicitly. Whether at the level of families, clinics, or pharmaceutical companies, these networks involve forms of concealment, secrecy, and deceit even as they provide vital forms of care. Social scientists who study substance use might recognize the opening scene above as evidence of a moral economy of sharing (Bourgois and Schonberg 2009), in which webs of reciprocity and mutual obligation determine the circulation of psychoactive substances under conditions of socioeconomic scarcity.[2] Such webs create enduring ties of reciprocity to guard against the threat of withdrawal and are inextricably tied to deeper systemic forces of deindustrialization, socioeconomic abandonment, racialized segregation, and coercive policing.

At first, pharmaceutical opioids like Suboxone might be taken as archetypal examples of a *pharmakon*, or a substance that acts as both remedy and poison. Such drugs oscillate between the licit and the illicit (Bourgois 2000; Garriott 2011; Lovell 2006; Lyons 2014), between promise and deceit. They are at once "good" medicines and bad "drugs," miracle cures and deadly poisons (Biehl 2005; Derrida 1981; Meyers 2014; Persson 2004). Yet the boundary traced around the therapeutic use of Suboxone is not easily drawn. As others have shown, a large proportion of diverted Suboxone is used for therapeutic purposes, given an ongoing shortage of providers willing and able to prescribe it (Carroll, Rich, and Green 2018). By taking Suboxone diversion in rural Appalachia as an example of a moral economy, rather than moral pathology (Duff 2011; Raikhel 2015; Singer 2012), this article problematizes and contextualizes current public health debates surrounding Suboxone diversion (Lofwall and Walsh 2014) and, in so doing, provides a more nuanced framework for analysis. More broadly, we aim to unpack the logics of obligation, care, and secrecy that emerge in a family network caught in a web of sociopolitical, economic, and therapeutic conditions in southwest Virginia. In exploring how Suboxone circulates at different scales, this article also contributes to an emerging conversation about how secrets figure in moral economies. While those studying moral economies have often focused on their most visible components, in this article, we aim to show how the visible circulation of Suboxone runs on a slippery substrate of secrets and lies. In so doing, we follow scholars like Archambault (2016) and Haram (2005) in arguing that secrets lubricate the social, economic, and moral mechanisms through which relationships are sustained and substances circulate; we also draw on Meyers's (2014) observation that lies and secrets give order to the often-contradictory processes of addiction recovery, bringing this into conversation with the literature on moral economies.

Finally, this article brings questions of rurality and substance use into sharper and more sustained ethnographic focus. Social scientific explorations of drug sharing have overwhelmingly focused on urban environments,[3] while rural areas receive disproportionately low levels of attention. This is especially important in the United States, where rural communities have been at the heart of the prescription opioid epidemic (Van Zee 2009). While local cultural forms have certainly shaped the epidemic and efforts aimed at its amelioration, we must understand this situation not as produced by an essentialized and naturalized culture (Briggs and Mantini-Briggs 2003) but as shaped by the actions of mining companies, industrial producers, and in particular the pharmaceutical industry. The latter successfully pushed an extraordinary volume of opioids onto the market using aggressive marketing tactics (Dasgupta, Beletsky, and Ciccarone 2018; Macy 2018; Van Zee 2009), racialized ideas of its patients' whiteness, and the purported safety of its "smart drugs" (Netherland and Hansen 2017).

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Family's family

Before she married Steve, Sally-Anne had been part of a methadone maintenance program for over nine years and had eventually weaned herself off opioids. She began using Suboxone when she was driving her sister to the clinic to pick up her Suboxone prescription.

> I said to her, "When you get in, don't offer me anything—I don't want it." And she always would, every time. I kept telling her, "I don't want it." And then one day, I guess I was just in the right mood, and I took one of her pills. And here I am, right back to where I started. That's why it's so humiliating. I was out of it, and now here I am all over again.

Having internalized a stigmatizing view of both substance use and MAT, Sally-Anne sees herself as stuck in the old familiar cycle—reinitiated back into a pattern she had managed to break by, of all people, her sister. Here, we can already see how Suboxone works as a kind of intrafamilial currency, a way for her sister to repay Sally-Anne for driving her to the clinic. As Garcia (2010, 2014) has shown, opiates and other drugs can circulate among family members, figuring as a form of care and identification, and this can make it all but impossible for people to break patterns of substance use without severing their most important social ties. Indeed, as Sally-Anne's return to Suboxone demonstrates, relations of care, support, and kinship in this region are intimately tangled up in the daily rhythms and existential struggles of substance use.

Of course, these pathways of circulation encompass not only her sister but also her daughter, Tripp, whose history of opioid use opens up other spaces of interpersonal demand, deception, and care. The flow of Suboxone is underwritten by a familial intimacy that operates through a set of moral, social, and economic coordinates that simultaneously converge with and diverge from what has been observed within urban drug-sharing economies in the US. On one hand, Tripp's family situation resonates with other anthropological studies that have debunked the myth that substance use invariably catalyzes a breakdown or rupture in kinship relations—a misconception that has all too often perpetuated highly racialized discourses and policies that target Black and brown populations in US cities, often through punitive regimes of policing, surveillance, and welfare retraction.[4] As these studies have shown, addiction in families often creates a kind of parallel universe where, alongside its destructive potentialities (i.e., death, morbidity, imprisonment, social alienation, etc.), there simultaneously emerge complex projects of social and moral rebirth (Mattingly 2014), intergenerational care (Burraway 2020; Garcia 2010), and mutual support across symbolic hierarchies (Bourgois 1998).

Although the circumstances described in these studies resemble Tripp's, the particular coexistence of the destructive and the restorative in her family unit must be situated within local understandings of what family means in Appalachia. Without making a unitary claim about the nature of kinship in this complex and heterogeneous region, we may note that social scientists have consistently described extraordinarily resilient kinship networks that are bound together by a keen sense of intergenerational belonging and cultural identity (Keefe 2014), often refracted through a deep understanding of and embodied connection to land (Anglin 2002, 2016; Batteau 1990). Family can figure as a site of work, of ancestral potency, of survival, of solidarity, of entrepreneurial grit, and, increasingly, a site of loss, pain, and nostalgia. For those who call these mountain ranges home, it is often all these things at once (Stewart 1996).

The flow and circulation of Suboxone can also be articulated in these terms. Invoking the idea of drug economies as a form of "outlaw capitalism" (Black 2009; Contreras 2013), Tripp and her partner Bruce often connect the production and movement of substances through contemporary Appalachia to the original outlaw tradition of moonshining. The cabin where Bruce lives was, in fact, used to store illegal home-distilled liquor for Bruce's grandfather's bootlegging operation during the Prohibition era. So when Bruce says that "nothing's new" in reference to the trade and distribution of prescription opioids, he is tracing a direct ancestral line between the criminal ingenuity of his forebears to their current way of life. "It's about getting by and making do with what you've got," he says. Expressed as a kind of entrepreneurial bricolage in the face of endemic scarcity, Bruce sees himself, at least to some extent, as carrying on the family tradition. Just as his grandfather and like-minded bootleggers turned the mountainous terrain and their extended kinship networks to their advantage, Tripp and Bruce have turned their therapeutic topography into a site of economic opportunity in the face of entrenched precarity.

Tripp and her family's precarious economic position has also been shaped by the operations of extractive industries (Billings and Blee 2000; Catte 2018; Thorne, Ticakmyer, and Thorne 2004) and by changes in southwest Virginia's labor market over the past 40 years. Jobs in mining, manufacturing, and agriculture have largely been replaced by jobs in health care and social assistance, retail, and food service. The Appalachian Regional Commission classifies Tripp and her family's county as "distressed," its lowest classification, noting that 20 percent of the county's population lives below the poverty line (Appalachian Regional Commission 2021; Pollard and Jacobsen 2021). While some areas of southwest Virginia have seen a recent rise in jobs connected to tourism and technology companies, these jobs haven't yet reached the areas where Tripp and Bruce

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live. Instead, their county has embraced a form of carceral entrepreneurialism by investing in two supermax prisons. Both prisons were built in the late 1990s, one on land donated to the Virginia Department of Corrections by a mining company and the other on land where a coal company once employed 750 people. Many of the miners who had been laid off applied for jobs as prison guards (Greene 2002; Schept 2021). Aside from the burgeoning prison population, their town was in a state of contraction. High schools were closing and consolidating. The bar that Bruce's mother had owned, where he had worked for years, went out of business years ago as her customers lost their mining jobs and shifted from alcohol to OxyContin. Bruce claimed that "death by franchise" had been the fate of many other small businesses. But in the end even the Walmart shut down.

Cover-ups

Looking after your family in this context isn't just about what you share; it's about what you cover up. This is why Tripp covers her arms before she goes inside to give her mother the Suboxone. Secrets and lies constitute family life as those truths that are held out in the open (Smart 2011), making and unmaking the bounds of our most intimate selves (Lovell 2007). Genetic "facts" are not neutral pieces of trivia; they are, rather, potentially dangerous pieces of knowledge that can radically alter how people relate to one another (Strathern 1999). In other words, secrets in families are high-stakes stuff, holding within them the power to disrupt and impair even the most enduring family ties.

Desperate not to bring this kind of damage on her relationship with her mother, Tripp goes to great lengths to keep her injecting secret. As she walks up the driveway, she pulls her sleeves down and pushes her thumbs through the holes she's purposefully cut in the cuffs, the homemade design serving as a built-in defense to prevent her from accidentally exposing her forearms. In covering up the veins running along the surface of her body, she is also covering up a vein of truth—that she is an "injector," as her mother would put it, the ultimate transgression, in her mother's eyes.

In one sense, Tripp's concealment of her forearms echoes what has been observed in other drug-sharing moral economies, namely that cover-ups, misdirection, and subterfuge are fundamental aspects of the moral lifeworlds inhabited by vulnerable people—interlaced as they are in deep relations of interdependence. This dynamic tension between deception and dependence is especially acute in communities of unhoused people (Bourgois and Schonberg 2009; Burraway 2021). In these communities, care and betrayal are linked, since the need to help others continually conflicts with oftentimes brutal cost-benefit analyses that can never leave everyone satisfied. That said, the notion of hiding track marks from other drug users would have been laughable to most people in a London homeless community (Burraway 2021). There are many things that these people hide from each other on the streets—drugs, money, the truth—but their skin isn't one of them.

Tripp's concealment thus discloses a different moral order, one that has its own set of existential and ethical stakes, and is uniquely attuned not only to the everyday dynamics of the people in a kinship unit—their shared histories, their anxieties, their expectations of one another—but also their cover-ups and failures.

Sally-Anne, recall, has her own secrets to keep. Her husband, despite having struggled with alcohol abuse, takes a dim view of drug use and has told Sally-Anne on several occasions that he could never marry a person who used drugs, and he includes Suboxone in that category. On several occasions he has almost caught her in possession of Suboxone; the only thing that saved her was either her quick thinking or Steve's obliviousness. "He ain't the sharpest knife in the drawer but still, if he finds out I've been lying to him about me being on the box [i.e., using Suboxone], he could finish it. He's always said that he doesn't wanna be married to an addict." As Sally-Anne's strategies for avoiding such an exposure reveal, the line between secrets and lies is often hard to discern (White 2000).

Circulatory systems

Back at Sally-Anne's house, Tripp delivers the Suboxone pill she's illegally scored and tucked away at the bottom of a pack of cigarettes, hidden like a piece of contraband stored in the false bottom of a smuggler's suitcase. Had this been the following day and Tripp had been returning from the clinic with a renewed prescription, she would have had no need to take such precautions. In the eyes of the law, she would be viewed as a dutiful patient returning home from her doctor's appointment, in full legal and clinical compliance.

The nature and value of commodities is defined by constant negotiation and transformation (Appadurai 1986). Seemingly simple things, like matsutake mushrooms, circulate through their various supply chains, drifting in and out of commodity status, oscillating between capitalist and noncapitalist value systems (Tsing 2015). The circulation of Suboxone, straddling the licit (as therapy) and the illicit (as tradable commodity), can be thought of in similar terms, drawing our focus to the complex and often-contradictory relations that exist between carceral and therapeutic governance, social control, and interpersonal caregiving.

The moral economy of Suboxone hinges on such oscillations and their enmeshment in the deceits, the disclosures, and the debts that constitute the social world of the family. Take, for example, the $30 that Sally-Anne gave Tripp to score a single 8 mg/2 mg Suboxone pill (i.e., a pill that consists of 8 mg of buprenorphine and 2 mg of naloxone).[5] At first glance, this seems like a standard consumer-seller

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transaction: dollars for drugs. But if you trace the biography of the cash itself, another layer of deception emerges. To afford black market Suboxone, beyond the "rent" that Tripp gives her, Sally-Anne has had to come up with some creative solutions, since her irregular employment as a cleaner cannot furnish the $200 she sometimes spends each week staving off withdrawal. Consequently, when she goes to the supermarket to buy groceries using her husband Steve's bank card, she "doubles up" on certain items, before then "doubling back" later on in the day to return them for cash. She then uses this money to buy Suboxone without Steve's knowledge.

As noted above, Suboxone itself transforms as it moves from the clinical into the criminal sphere, ontologically enacted, through events and practices (Mol 2003), as a legal beneficial medicine in one and an illegal, dangerous drug in another. After all, if sourced outside clinical regimens, Suboxone is a Schedule III controlled substance—possession of which can lead to a $2,500 fine and up to a year in jail. Tripp thus hides the pill she's bought from her friend underneath the cigarettes. It carries the stain of the black market, confirming her movement outside the patient circle and into the criminal one. She knows that if the police searched her and found it, she would be subject to potentially life-changing forms of disciplinary intervention.

These are risks that Tripp understands all too well. At the time of this particular expedition, she was already on probation after the police had pulled her over a few months back and found a quarter of a Suboxone pill on her person. This happened when she was between clinical programs that could account for the pill, so not only was she charged, but the investigation also brought with it the attention of Child Protective Services (CPS), causing her to lose custody of her two young children.

Like the many women who are targeted by CPS because of their substance use (Buer 2020; Knight 2015), Tripp has to jump through a number of disciplinary-cum-therapeutic hoops in order to regain custody of her kids. The final hoop is gainful employment. To her great frustration, though, her history of substance use combined with an endemic scarcity of viable employment prospects in the region has meant that securing a steady job in the formal economy has been extremely difficult. Denied realistic access to the formal labor market, she and Bruce have been forced to sell a portion of their prescription in the informal economy, a reality that invariably puts them at increased risk of falling back into the same carceral patterns that saw her children taken from her in the first place. In this sense, it is the ambivalent circulation of Suboxone between clinical and criminal domains that ultimately entraps Tripp in a vicious circle, in which tactics for negotiating scarcity amplify the interrelated risks of carceral governance and familial separation.

In Tripp's case, these interrelated risks have also created new moral coordinates of care, debt, and support within her wider kinship network. After the intervention of CPS, Tripp's children were moved into the care of her sister, Tammy. While Tammy's willingness to look after the children, along with her own three young kids, is testament to the enduring strength of Tripp's broader kinship ties, there are also several complexities and contradictions. For one, Tripp is subject to a court order that requires her to pay child support directly to her sister, even though Tripp doesn't have a job. Not only are these mounting unpaid costs a financial burden, but they also take a psychological toll, not least because repeatedly failing to come up with these payments can lead to a misdemeanor or felony charge. This anxiety compounds Tripp's economic precarity, pushing her further into the Suboxone black market. Here we see how the risky practice of selling off parts of her prescription to pay her sister child support emerges in direct response to a judicial order that resulted from previous engagements with nonprescription use of Suboxone.

Further, Tammy's husband, Wayne, has also been enrolled in a Suboxone program for several years. Like Tripp, he has been forced to divert a portion of his prescription into the illicit sphere to make ends meet and help put food on the table. Having sold part of his prescribed allotment, he too often finds himself running low, forced to make demands on the family's sharing economy. When she can, Tripp will "look after" Wayne when he is out of Suboxone; facing withdrawal, he will—depending on his liquidity—also *buy* Suboxone from her. This money then finds its way back to Tammy in the form of court-ordered child support.

While Tripp was happy that her children remained in the care of their aunt, rather than another family within the foster system, this arrangement was not without its tensions. Tammy, for one, was holding down a full-time job as a veterinary assistant while caring for the children. Watching Tammy organize the five children at her home was like watching a general marshaling their troops in the heat of battle as the children ran in and out of the house; demands for food, play, and help with homework collided in a wall of noise that made it hard to hold a conversation. Though there was no doubt that Tammy loved her niece and nephew, what had been meant as a temporary arrangement had slowly become something that felt far more permanent. This new sense of permanence, Tammy thought, was about more than her sister's inability to find employment. Rather, Tammy thought Tripp was caught up in a deeper kind of existential malaise—underpinned and amplified by her ongoing substance use—and that this malaise was preventing her from taking the steps, structural and personal, to get her children back. Certainly, the somewhat chaotic nature of Tripp's relationship with Bruce, along with her transient housing situation, complicated matters further.

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In her lower moments, Tripp would express a sense of shame that she could not "be there" for her kids in the way she wanted. Often these feelings of inadequacy would lead to escalations in her injecting, creating another feedback loop that propelled her deeper into the moral brackets that contain women who both mother and use substances (Baker and Carson 1999; Buer 2020; Kilty and Dej 2012; Knight 2015; Radcliffe 2011). Though she remained grateful to Tammy for taking care of her children, Tripp also expressed suspicion that Tammy was going behind her back to CPS to find a way to keep the children in her care, thus ensuring the continuance of the maintenance payments provided by the state of Virginia to foster parents. Neither sister had ever directly confronted the other about their suspicions. Instead, these suspicions took on the ineffable form of family rumor, cropping up in conversations with other family members and friends, bound up in a process of continual retelling, moving in fragments before vanishing just as quickly (Perice 1997). Like secrets and lies, rumors respond to the social contexts in which they circulate.

In its circulation between clinical, carceral, juridical, and kinship domains, Suboxone is defined by the ambiguous multiplicity of the *pharmakon* (Biehl 2005; Derrida 1981; Meyers 2014; Persson 2004). In rural Appalachia, this ambiguity has real-life consequences as families organize their daily lives around the circulation of these Janus-faced substances. The ethical imperative to "look after" one's kin in times of dopesick is intimately tied to diffuse forms of economic marginalization and disciplinary governance.

"The largest addiction pipeline in the world"

Of course, the generation of value from the circulation of pharmaceuticals is not limited to parking lots, living rooms, and clinics; the logics of extractive capitalism in southwest Virginia did not end when the mines closed. Purdue Pharma transformed pain, both physical and psychological, into a site for value creation through the marketing of OxyContin. As has now been well documented, discussed, and litigated, this process of circulation was enabled by many secrets. There was the concealment of OxyContin's abuse potential, the concealment of Purdue's role in establishing new discourses about pain in medicine, the concealment of the company's highly aggressive marketing tactics, and the careful crafting of a segmented market focused on white consumers who were portrayed as less likely to become addicted to opioids in America's racialized politics of pain (Dasgupta, Beletsky, and Ciccarone 2018; Macy 2018; Netherland and Hansen 2017; Van Zee 2009; Wailoo 2015).

The development and distribution of Suboxone was supported by the discursive construction of a population of white sufferers, as well as claims that new "smart drugs" were safe (Netherland and Hansen 2017). The DATA 2000, which allowed for the office-based treatment of opioid dependence, was engineered by Charles O'Keefe, then the president of Reckitt Benckiser Pharmaceuticals, the UK-based manufacturer of Suboxone, in collaboration with the National Institute on Drug Abuse (Campbell and Lovell 2012). DATA 2000's passage turned on racialized rhetoric that allowed those testifying at the hearing to claim that this new form of treatment was more appropriate for "suburban" populations, for "citizens who would not normally be associated with the term addiction" (Netherland and Hansen 2017, 230). Further, the circulation of Suboxone in office-based settings also depended on the idea that it is uniquely safe.[6] This claim hinges both on buprenorphine's being a partial opioid agonist, which makes it significantly safer than other opioids in terms of the risk of overdose, and on the idea that the addition of naloxone deters injection.

Because of this latter point, Tripp's experience of pleasure and relief from injected Suboxone may have come as a surprise to readers familiar with this discourse. Yet, while the possible deterrent effects of the added naloxone have made buprenorphine-naloxone the standard of care, these effects may be produced only under a narrow range of conditions (Blazes and Morrow 2020; Duke et al. 2010). Moreover, given that, as studies suggest, the chronic use of opioid antagonists may predispose people to overdose after ceasing treatment, some have even argued that the addition of naloxone is both misleading and potentially harmful to patients and that clinicians should be prescribing buprenorphine alone (Blazes and Morrow 2020).

The continued profitability of Suboxone also depends on its protection from generic competitors. This protection was initially achieved by claiming orphan drug status for Subutex and Suboxone, using the rarely used cost recovery principle.[7] As the sublingual tablet formulation of Suboxone neared the end of this protected period in 2009, Reckitt Benckiser's spinoff company Indivior pulled the sublingual tablets from the market, citing safety concerns related to the higher likelihood that children could inadvertently swallow the tablets. Indivior sought to put patients on a new formulation, drawing from its large portfolio of addiction therapy candidates, an array of potential drugs that CEO Sean Thaxter described as "the largest addiction pipeline in the world" (Banks 2014). The company suggested that patients instead be prescribed its sublingual film formulation, which it claimed was safer, all the while continuing to sell the tablets in Europe, where they were still on patent, and aggressively pursuing new markets for the tablets in China.

The spurious nature of Indivior's safety concerns and the other actions it took to discontinue the tablets during this period did not go unnoticed. From 2017 to 2021, Indivior and Reckitt Benckiser were embroiled in lawsuits related to these practices; they ultimately settled these suits for nearly $2 billion (USDJ 2020). Yet, within a few months of settling, Indivior's stock was rising after former CEO Shaun Thaxter was released from a six-month prison sentence

related to this market strategy. As an article in the *Financial Times*' weekly magazine, *Investors' Chronicle*, put it at the close of an article on Indivior's prospects in 2021, "The opioid epidemic is here to stay. Buy" (Sants 2021).

Buprenorphine is undoubtedly an important tool for clinicians caring for people with substance use disorders. Yet, as with many pharmaceuticals, Suboxone's circulation is partly driven by profit and runs along tracks of concealment, secrecy, and deception. Pharmaceuticals have an important role to play in the treatment of many disorders, including OUD, but they can also lead us into a logic of pharmaceuticalized biopolitics in which the only means of intervention is medication and the only measure of success, survival (Biehl 2007). Crucially, for the purposes of the arguments we are advancing here, this logic of pharmaceuticalization is also central to the process of transforming illness and suffering into a site for value creation (Dumit 2012; Gaudilliere and Sunder Rajan 2021).

Painkillers

Alongside this circulation of Suboxone across different scales, there is a deeper, more visceral level of circulation that also needs to be acknowledged: the embodied circulation of Suboxone itself. More specifically, the way it moves into and through the body's interior, delivering its particular brand of analgesic relief. This notion of analgesic relief brings to the fore one of the key anthropological questions at the heart of the opioid epidemic: What does it mean to treat and experience pain, particularly as medicalization intrudes into ever-wider territories of human experience (Jackson 2008; Luhrmann 2001; Schlosser and Hoffer 2012)?

As a distinct field of medical knowledge and clinical practice, pain medicine has been committed to articulating pain as an observable disorder of the body, an objective "fact" that can be pinpointed and resolved through empirical techniques. And yet pain remains slippery, constantly resisting attempts to transform it into a discrete and measurable phenomenon. Pain is constituted by ambiguity, inconstancy, and ambivalence (Good et al. 1992). These uncertainties produce tensions at the interpersonal level and at the institutional level—the question of who "deserves" pain medication is now inseparably tangled up with broader moral anxieties regarding addiction's looming shadow over America's body politic (Wailoo 2015). The result is that the US health care system is now pervaded with a culture of suspicion toward pain, a suspicion that can all too easily develop into outright hostility toward people who use substances, who often serve as convenient "pleasure seeking" strawmen on which to project these institutionalized anxieties (Crowley-Matoka and True 2012; Goldstone 2018).

Significantly, though, prescription rates for opioids like OxyContin have declined in relation to these anxieties, yet the "pain" of OUD is afforded the same therapeutic logic—namely that pain is an individual, biological disorder (Acker 2002; Campbell 2007; Valverde 1998), located in the body, in the brain's faulty or damaged circuitry (Raikhel 2015). OUD thus becomes unyoked from its social, political, and existential conditions (Zigon 2019). But the pain at the heart of the Appalachian opioid epidemic is about more than that of each individual body. It encompasses the endemic precarity, structural decay, and socioeconomic defeat that has been metastasizing through the region since the 1980s (Dasgupta, Beletsky, and Ciccarone 2018). This situation has left many people stuck in chronic conditions of existential distress and temporal stagnation, caught between a nostalgia for a past that no longer exists and a future that no longer seems open with possibility. Given this historical context, and the fact that many in the region have been subjected to decades of literally backbreaking work, it is unsurprising that so many people in these communities should have gravitated toward substances that promise to relieve pain.

This article speaks to how the circulation of Suboxone allows people to negotiate not only their own pain but also the pain of intimate others. In this way pain emerges not so much as an individual bodily or psychological crisis but as a profoundly relational phenomenon, establishing the moral dimensions within which family members acknowledge and respond to one another in moments of acute need (Fullwiley 2010; Livingston 2012). Yet these acts of care present problems in office-based opioid treatment settings. While substitution therapies shift the moral goalposts some distance from the emergency room, where suspicious clinicians may fear being duped by the illegitimate pain of "undeserving" "addicts," new questions emerge. The question is no longer whether a person is taking some kind of opioid, which is a given, or indeed a prerequisite. The question is, rather, *how* they are taking it—that is, whether the person follows established treatment regimens that explicitly forbid its circulation between people, through logics of sale or care.

These debates on the *how* of Suboxone administration finally bring us back to where this article began: to Tripp's forearms. When asked by Josh about her preference for injecting Suboxone, Tripp said,

> It didn't use to be all the time, but this has been the longest period of consecutive injecting. [. . .] Being stuck in a really low mood, depression or whatever, has been a big part—everything that has been happening with Bruce . . . with the kids, not having a job, being broke. The feeling when you inject, it's just more instantaneous . . . like you get a more immediate relief—it takes you out of yourself, makes you forget everything for a while.

As Burraway (2018) has argued, self-inflicted forgetting through drug use can be a means of both coping with and

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escaping from, however briefly, the otherwise painful memories and existential crises that interfere with a person's ability to perdure. The sensorial intensity of injection—the increased speed and potency of the delivery—amplifies this amnesiac relief, despite claims that the drug's pharmacology would prevent such experiences. As Tripp's description reveals, this relief is not only about staving off dopesickness; it is tangled up in the need to hold in abeyance the sense of despair she feels regarding the turbulent state of her most important relationships. As outlined earlier, this relational turbulence—notably the loss of her children—is inexorably connected to deeper conditions of economic precarity, material scarcity, and carceral governance; a situation Tripp articulates through the mooded language of stuckness and depression. Notice, though, where Tripp locates her low mood and the need to alleviate it through intravenous drug use: in the unstable state of her most intimate social relations and her ongoing economic distress, not in the short-circuiting of her internal brain chemistry. In this way, Tripp's sense of "being stuck" (Buer, Leukefeld, and Havens 2016) in a depressive trough differs from what might be reported by someone suffering from a mood disorder. Yet a psychiatrist would likely give primacy to Tripp's language of depression over her language of stuckness, culminating in a psychomedical diagnosis of individualized mood disorder, which would pay little credence to the broader existential condition that she finds herself caught up in. Hers is indeed an existential mood, an indeterminate and emergent atmospheric condition that both shapes and discloses the way she attunes herself to the situations she finds herself caught up in (Throop 2017; Zigon 2019). In this sense, Tripp's "stuckness" discloses the broader conditions of precarity that constitute her being-in-the-world and attunes her to the needle that is the most profound technology of relief available.

Ultimately, this form of attuned relief and the hypodermic circulation it entails is irreconcilable with not one but two of the worlds in which she is embedded. Tripp's mother's abhorrence of injecting leads Tripp to go to great lengths to cover up her needle marks—concealing a truth that, if revealed, would severely disrupt their relationship. Furthermore, not only are the injection marks across her skin potential sites of intrafamilial conflict, but they also contravene her ability to comply with institutionalized demands for proper patienthood. In a previous MAT clinic, staff routinely checked for injection sites, which, if discovered, would lead her to being taken off Suboxone films or pills and moved onto Bunavail, a transmucosal form of the drug that is tucked inside the lining of the cheek, its texture making it extremely difficult to process for injection. Tripp described the sensation of taking Bunavail as like "chewing on a loogie"; her repulsion was married with a sense of indignation over the way her body was being surveilled and morally evaluated. As far as she was concerned, how she took her medicine shouldn't be any of their business.

And yet, epidemiologically speaking, it is exactly their business—the "riskiness" of injection often serves as the fulcrum on which "good" medicines become "bad" drugs. Being forced to "chew the loogie," then, is both a medical intervention and a disciplinary one, effectively punishing Tripp for being noncompliant and making "bad" choices, the underlying idea being that she has abused her licit therapy and turned it into an illicit, risky, and thus irresponsible pleasure. This approach to clinical surveillance shores up the creation of value by pharmaceutical companies that seek after ever "smarter" smart drugs (Netherland and Hansen 2017). These new drugs hold a great advantage for companies like Indivior because they allow them to compete against cheaper generics, thus making diversion and its prevention a site for unique forms of value generation.

In the end, Tripp found the ratcheting surveillance and disciplinary measures too much, quitting that clinic and moving elsewhere. In seeking a new clinic, Tripp has been forced to travel across the state line in Tennessee. At the time of this research, prescribers taking insurance were few and far between in southwest Virginia, so people seeking treatment either sought care at cash clinics (Van Zee and Fiellin 2019) or traveled out of state to find physicians willing to take their insurance. Providers willing to take insurance argue that because so few treatment providers take insurance, diversion is likely increased in two ways. First, on the supply side, patients seeking care in cash clinics are often given higher doses than necessary, enabling their patients to pay for their treatment by selling part of their medication. Second, on the demand side, the lack of accessible treatment increases the demand for diverted Suboxone sourced outside licit clinical settings.

Keen to avoid problems at this new clinic, Tripp took steps to disguise her injecting. According to other patients at her new clinic who have been "caught red-handed," the penalty typically involves having their daily dosage cut down and—depending on what prescription cycle they are on—being made to return to the clinic more frequently to refill that prescription. This practice exacerbates anxiety for those who are disciplined in this way. For one, it multiplies the risk of withdrawal. Perhaps more importantly, it also limits economic opportunities and places strain on family-based moral economies. By limiting the circulation of Suboxone within the family, such disciplinary practices also increase the likelihood that someone within the network will need to seek Suboxone on the black market, opening them up to the possibility of carceral intervention. Perhaps most ironically, it would have increased the likelihood that Tripp switched to intravenous use, since she often used injection as a way to stretch her supply given that the precise volume

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control offered by the syringe enabled her to maximize what she had on hand.

In short, if the intended effect of these disciplinary measures is to coerce patients into compliance and responsibility, what actually tends to happen is that patients simply become more cunning and creative in how they negotiate these moments of clinical scrutiny. Tripp, for example, might cut down on her injection rates on the two days before clinic to minimize any visible marks. Or, if she doesn't want to do that, she'll inject (with help from Bruce if required) into more "discreet places" that can be more easily covered up; this could be between the toes, the back of the calf, or the neck. Though these cover-up tactics are more or less identical to those Tripp employs to hide her injecting from her mother, they speak to a very different set of moral anxieties and interpersonal demands. In the clinical space, Tripp's cover-ups, though in one sense recognizable as noncompliance, are more immediately about her taking a kind of control over her condition. As a form of self-regulation, her injection and concealment can be understood as medication-management tactics that respond to her particular existential needs (Schlosser 2018).

That said, with respect to her mother, the discretionary techniques Tripp enacts on her body are bound up in a different moral register, with very different interpersonal stakes. While the clinician and Sally-Anne are both concerned with the risk that needles carry in terms of spreading potentially deadly blood-borne infections, the former's concern is rooted primarily in quantitative distributions of epidemiological risk.[8] For Sally-Anne, though, the only number that matters is her daughter. The thought of losing her child to a dirty needle is so unthinkable that it can often produce responses that border on the frenzied. If a clinician uncovers evidence of injection, Tripp can be disciplined in ways that, as we have illustrated, can frustrate her by curtailing her sense of autonomy. Frustrating though this might be, the interpersonal stakes are small. The risks of discovery, then, and the breakdown in relationships thus entailed, are not something that Tripp is going to lose much sleep over. Her mother, though, is a different story. In this story, the interpersonal stakes skyrocket; the singularity, depth, and intimacy of their relationship radically altering the scale and intensity of the risk. Trapped, on one side, between her need to seek therapeutic relief on her own terms and, on the other, the need to avoid being disciplined by the clinic and to avoid what would be a catastrophic collapse of her relationship with her mother, Tripp continues to negotiate this catch-22, through careful acts of concealment.

Working within moral economies of care

Tripp is not alone in her practices of concealment. As Suboxone circulates throughout the region, continually looping in and out of different social, moral, and institutional domains to create and respond to a tangled mesh of pain and care, it relies on a slippery substrate of secrecy and cover-ups.

While these moral economies of concealment create certain difficulties for those treating patients with OUD, the recognition of these moral economies can allow health care providers to work more effectively within them. For example, when Tripp ultimately disclosed that she was sharing medications with her mother to her provider at her new clinic, the provider did not initiate a round of discipline. Instead, this provider understood that people feel compelled to care for their kin and partners by sharing their medication. He openly discussed this moral obligation with people and invited them to bring their partners, parents, and other loved ones into the clinic to enroll as patients. And he did the same for people seeking to buy Suboxone from patients as they emerged into the clinic parking lot. A few months after the moment that opened this article, Tripp brought Sally-Anne to the clinic with her with the encouragement of the clinic director. Instead of choosing the path of increased pharmaceutical surveillance, he instead chooses to work within, rather than against, this moral economy of care.

As we consider the multiple anxieties regarding the diversion of Suboxone, we would do well to consider that intrafamilial moral economies almost certainly constitute a significant component of this illicit or "abusive" circulation. This fact points to the difficulties of using diversion as an inflection point where Suboxone "use" becomes Suboxone "abuse," amplifying the point that most diverted Suboxone is used for therapeutic purposes (Carroll, Rich, and Green 2018). Our work here builds on earlier critiques of the use/abuse dichotomy by showing how it diverts attention from the complex means through which families, in times of great scarcity and endemic pain, have come to depend on the moral economy to look after themselves and one another.

Notes

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1. This article is part of an ethnographic study of substance use disorder and related medical and religious interventions in southwest Virginia and northeast Tennessee conducted by Josh Burraway, China Scherz, and Abigail Mack. Since 2019 we have conducted ethnographic fieldwork at an outpatient treatment program that provides medication-assisted treatment (MAT) to people with OUD and at five nondenominational churches, which each aim to address substance use disorders through forms of spiritual and pastoral intervention. Through these sites we have made connections to people with whom we have regularly visited, often coming

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to know members of their families and broader networks. The study has relied on ethnographic field methods including participant observation, ethnographic interviews, and the co-construction of illness narratives (Emerson, Fretz, and Shaw 2011; Groleau, Young, and Kirmayer 2006). We used a person-centered approach aimed at developing a deep understanding of a small number of people during many interactions (Levy and Hollan 1998). While Scherz is the PI on the project and visited Tripp and Bruce and the clinic where they receive MAT on several occasions from 2019 to 2022, the majority of the fieldwork for this article was carried out by Josh Burraway from 2019 to 2020. To protect the confidentiality of those who participated in the study, we use pseudonyms for personal names and place-names. The names of public figures and corporations have been left unchanged.

2. Since Thompson's (1971) original work on the grain riots of 18th-century England, the concept of the moral economy has been used to explain peasant rebellions in Southeast Asia (Scott 1976), flows of "assistive violence" in the America inner city (Karandinos et al. 2014), organ transplantation (Kierans 2018), the deployment of financial instruments in contexts of economic crisis (Gkintidis 2016), and projects of self-modulation in spaces where religious tradition and neoliberal capitalism intersect (Tripp 2006), to name but a handful of instances. This deluge has, however, also prompted criticisms of trivialization. Several scholars have suggested that the idea has become drained of analytical potency, cheapened as it has been by a kind of anthropological mass production (Edelman 2012; Palomera and Vetta 2016). Carrier (2017) has tried to clarify the term by focusing on the embeddedness of economic systems in particular histories, moving "the moral" part of the moral economy away from universalizing visions of morality, toward a conceptualization of morality as an intrinsically unstable, fluctuating, and culturally variable aspect of life.

3. This disproportionate focus on urban settings can be understood as part of a broader historical trend in the social scientific study of addiction that has its roots in urban sociology. These seminal sociological accounts, in their rich descriptions of selling, buying, sharing, and consuming drugs, demonstrated that these practices are foundational to the daily lives of vulnerable and marginalized people (Feldman 1968; Fiddle 1967; Partridge 1973; Preble and Casey 1969).

4. While a full discussion of racial dynamics in Appalachia is beyond the scope of this article, we want to note that Tripp and her family are White. The US Census estimates that in her county 91.4 percent of people identify as White, 1.2 percent as Latino, 5.8 percent as Black, 0.2 percent as American Indian, 0.4 percent as Asian, 1.1 percent as two or more races.

5. This is a relatively high price for diverted Suboxone as compared with prices in the northeastern United States. This may be because the availability of treatment is so limited. Expanded access to treatment would likely increase supply and decrease demand, thus driving down the price.

6. This claim was also made for OxyContin, morphine, and heroin. The distributors of each claimed to have discovered a safer medication that could replace those that came before (Campbell and Lovell 2012).

7. Orphan drug status is given by the FDA to drugs that treat rare diseases. It incentivizes pharmaceutical companies to create drugs that would likely be unprofitable and whose development costs would be difficult to recover. While addiction is not a rare disease, Reckitt Benckiser used the cost recovery principle to argue that it might not recoup its investment because methadone has lower manufacturing costs (Campbell and Lovell 2012, 135).

8. This is not to diminish the deep relational empathy required to be an effective and compassionate clinician. Rather, it is to merely point out that the epistemologies of epidemiology and public health intrinsically locate risk in the plural, rather than the existentially singular.

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