Governing Habits
Raikhel, Eugene

Published by Cornell University Press

Raikhel, Eugene.
Governing Habits: Treating Alcoholism in the Post-Soviet Clinic.

For additional information about this book
https://muse.jhu.edu/book/57571

For content related to this chapter
https://muse.jhu.edu/related_content?type=book&id=2075035
Elena Andreevna looked up from the pile of forms and other paperwork that covered her desk and sighed. It was only ten o’clock in the morning, but she already looked tired. She had spent the half hour before my arrival trying to convince a patient not to discharge himself from her ward. “This one insisted that he mainly drank beer, so I explained to him that beer contains estrogens and continuous consumption leads men to lose their libido,” she said. In the end the patient had walked out, more or less telling Elena Andreevna that she could “treat herself!”

She had been working as a narcologist-psychiatrist since the mid-1990s, initially at the oblast’ hospital, where she had first seen the consumption of surrogate alcohol in epic proportions and had witnessed the replacement of homemade opiates by processed heroin as the preferred drug of her younger patients. Like many narcologists, Elena Andreevna understood the changes she saw in the clinic as closely linked to the turbulence of Russia’s early post-Soviet years, a consequence of what she sometimes called a “double morality.” “What can we expect a man to do when he
Assembling Narcology

has no work and there is alcohol everywhere, and additionally when he expects that the state should give him everything?” she asked. “The state took everything away and didn’t return anything. Yeltsin—I saw him as one of the bandits—and Chubais too. The people [narod] ended up entirely disoriented and abandoned in this situation.” Irina Vassieleva, a narcologist whose desk sat on the opposite side of the office, took this moment to add that Yeltsin’s own habitual drunkenness had not helped them in making the case for sobriety to their patients. “You never see Putin like this,” she continued, making a distinction (endlessly repeated in print and conversation) that implicitly drew together the images of Yeltsin’s dissolute personal behavior, his perceived weakness as a leader, and what she called contemporary society’s “lack of discipline” (razpushchennost’) on the one hand and on the other hand, Putin’s sobriety, his seeming resoluteness, his embodiment of an ideal of masculine strength, and the more general sense that everyday life was finally beginning to normalize.

Many of those conversations we would have later. That morning Elena Andreevna just raised an eyebrow at her colleague and continued speaking. Still frustrated by her encounter with the patient, she picked up the document that he had signed to discharge himself from the hospital, explaining,

Under Soviet power [Sovetskoi vlasti] this wouldn’t have been possible; it was stricter then. After all, alcoholism and drug addiction [narkomaniia] need to be approached not only with voluntary treatment but also with some degree of compulsory [prinuditelnogo] treatment. In the past the collective [kollektiv], the party [partkom], could send him [away] and it was very uncomfortable to drink back then. And the register [uchët] at the dispensary was much more strict. Now unfortunately, this system, for various ideological [ideinyi] reasons like human rights [prava cheloveka]—the system is destroyed and everything is worse. And now many people looking at our old medical system are thinking—the Americans included—to build something like what the Soviet Union had. So not everything was bad. And the Alcoholics Anonymous movement was stronger then.

Many clinicians gave similarly sweeping accounts of the Soviet past during our first meetings, perhaps prompted as much by their awareness of my Americanness as by my questions, and by this point I was accustomed to them. I was also becoming increasingly familiar with expressions of what sounded like a longing for the social norms and institutional structures
of the Soviet narcological system—in particular for its compulsory elements—made by narcologists, some of whom were far too young to have experienced these norms or institutions firsthand. Yet Elena Andreevna’s account was still striking in its tone and affective intensity, a vision of Soviet narcology as strict and effective so totalizing that it incorporated any interventions toward which she was positively disposed, such as AA (which in fact had been introduced to the Soviet Union only in 1987 and had grown and become more visible in Russia only in the 1990s [Critchlow 2000a]).

Yet as I spent more time listening to Elena Andreevna and her colleagues over the following months, I began to see something more than nostalgia in their accounts of the Soviet narcological system. While many of these narcologists described the Soviet system as characterized by a continuity of care that was largely dependent on its use of surveillance and social control, what struck me as even more significant was their fundamental emphasis on its orderedness. Ilya Sergeevich, a clinician who worked in one of the city’s outpatient narcological dispensaries, said it best: “Everything was planned and written out,” he told me once. “There was an algorithm.” At the time I was also researching the history of narcology and the narcological system, and this emphasis on there having been an order to things seemed to have an affinity with the diagrams of the narcological system that appeared in Soviet textbooks on the subject: rectangles of different sizes, representing different kinds of institutions, are connected to one another by straight lines. The relationship between the institutions is not immediately clear in these diagrams, but it is clear that some hierarchy exists and that the parts of the system work together as a single entity.

Katherine Verdery has argued that if we take seriously Marx’s observation about the centrality of commodity fetishism to market economies, then it is important to remember that “socialist systems too had a form of fetishism: plan fetishism, which produced the illusion of agency and obscured the anarchy and chaos that actually took place behind the scenes” (1996, 4). What Verdery describes here is not so much the concrete process of planning (for that see Collier 2011) as the plan as a kind of ideology or imaginary. I came to understand the retrospective accounts of Elena Andreevna, Ilya Sergeevich, and others in this way: not only as depictions of an imagined past that in part serves certain purposes in the present but also as an articulation of the Soviet narcological system as intention or plan. In other words, these clinicians were describing a small corner of a thoroughly
planned system that could be remembered, at least by some participants, not in terms of concrete lived experience but precisely in the idealized abstraction of plans and blueprints. While seeing the past through rose-colored glasses, they were also seeing it “like a state” (Scott 1998).

In this chapter, I draw on Ilya Sergeevich’s account of the algorithm, as well as those of others, and also on documentary and secondary sources, both to describe the history and shape of Soviet narcology as a domain of knowledge, expertise, and intervention and to reflect on the many traces of that system in the present, particularly its uses by contemporary actors. My own view of narcology and the narcological system lies closer to the metaphor with which I opened this book—that of the hospital building itself as an aggregation of reused and retrofitted materials and spaces. As this chapter and the following one will make clear, narcology was similarly an aggregation of infrastructures, concepts, styles of reasoning, and therapies. The narcological system that took form during the mid- to late 1970s was also made up of distinct kinds of institutions, some of which—like the inpatient hospital, the outpatient clinic, and the labor colony—were instantiations of distinct ideas about alcoholism and drunkenness, which in turn were often linked to the history of particular forms of expertise and knowledge. What held these various institutions together conceptually was the plan itself—their arrangement into a coordinated and interlocking system.

Legal provisions for compulsory treatment (принудительное лечение), as well as the penal institutions into which chronic alcoholics were funneled, had been shaped by a Soviet conception (partly shared by biomedical practitioners and criminologists) of drunkenness as a habit that led to and underlay a physiological addiction to alcohol (Zenevich 1967; Connor 1972). As institutions exclusively devoted to the treatment of addicts began to be formed in the 1960s, and as an independent narcological service took shape during the following decade (in the wake of an anti-alcohol campaign), such ideas about drunkenness and alcoholism (which were rarely distinguished in nonspecialist writings) fostered a strong preference for techniques employing stigma, shaming, and other forms of social control as preventive means. For those addicts deemed chronic cases or who presented particular affronts to the “social order [общественный порядок] or the rules of socialist communal life [общественное],” isolation in special institutions and compulsory treatment were mandated (Connor 1972; Tkachevskii 1974, 38; Beliaev and Lezhepetsova 1977).
This newly independent medical network required its own contingent of specialists; thus an additional series of government decrees legally created the medical specialty of “psychiatrist-narcologist” and mandated the creation of university departments, curricula, and texts for the training of physicians in this new specialty (Beliaev and Lezhepetsova 1977; Babayan and Gonopolsky 1985). Narcology had previously existed as a subspecialty of psychiatry, and even its newly independent form was conceived of as a sort of adjunct specialization, as the hyphenated name suggested (Galkin 2004). Thus the disciplinary assumptions of this nascent field were largely those of its parent: primarily, a dominance of a neurophysiological paradigm. I examine how Russian addiction medicine has been shaped by a clinical style of reasoning specific to a Soviet and post-Soviet professional psychiatry, itself the product of contested Soviet intellectual and institutional politics over the knowledge of the mind and brain. I argue that whereas psychosocial explanations and interventions played a central role in governing addiction in Western Europe and North America for much of the twentieth century, late Soviet addiction medicine was based on a very particular biomedical model, which claimed its origins in Pavlov’s physiology of reflexes; it helped to shape the prominence of therapeutic methods for alcoholism based on mechanisms of aversion and suggestion.

Thus Soviet narcology was a hybrid discipline, shaped both by internal scientific and clinical discourses (which employed a neurophysiological paradigm to explain the mechanisms though not the etiology of alcoholism) and by the juridical notions that underlay its institutional organization (which conceptualized addiction in relation to problems of social order). And if the clinic was a particularly key site for the exercise of authority for narcologists, this authority was dependent upon a set of relationships and institutions that stretched far beyond the clinic—indeed, that were situated at the cusp of the relationship between the family and the clinic, the public and the private.

Problematizing Alcohol

Yet before addressing these questions, it is important to step back even further, to ask how alcohol has been problematized in Russia over the past two hundred years. Understanding how alcohol has been variously
constituted as a problem in Russia requires tracing briefly the ways in which the habits of individuals and customs of collectivities have crossed with the regulatory gaze of the state and the missionary aspirations of social groups around this substance.

Particularly important here is the strain in the literature on drinking and alcoholism in Russia that has focused on the relationship between patterns of consumption and the political economy of alcohol, primarily vodka. This literature (which itself varies vastly in its tone and aims) foregrounds the links between the social meanings (or use-values) of alcohol and the key role it has played in the tsarist (and Soviet) state’s generation of fiscal revenues (Christian 1990; Herlihy 2002; Takala 2002; Makinen and Reitan 2006; Transchel 2006). As such histories explain, the nineteenth-century tsarist state used a variety of institutional arrangements to provide for up to one-third of its total revenues from the taxation of alcohol production and sales. By the turn of the century, an otherwise politically disparate range of critics of the tsarist autocracy agreed on the charge that the state was profiting financially from the suffering of its subjects through the vodka monopoly (Phillips 2000; Herlihy 2002). While bureaucrats attempted to advocate moderate drinking through an official temperance organization, physicians, members of the clergy, and temperance advocates used alcoholism as a legitimate means to assert themselves politically (Herlihy 2002, 136).

For officials of the Bolshevik state, who in 1917 inherited a dry law instituted at the outbreak of World War I, the conflict between fiscal and public health prerogatives was even greater. In debates among socialists about the proper conduct and everyday culture of proletarians in the nascent workers’ state, heavy drinking figured as both a symptom and a buttress of capitalist class relations. Along with brawling, gambling, swearing, and “hooliganism,” it was destined to be given up for more kul’turnyi (cultured) pursuits by new Soviet men, a development the Bolsheviks attempted to facilitate through a temperance campaign waged by its Society for the Struggle with Alcoholism [Obschestvo po bor’be s alkogolizmom] (Phillips 2000; Transchel 2006). During the mid-1920s, however, fiscal concerns won out over those of health and culture: the prohibition was lifted in 1924, and a new state monopoly on alcohol sales was instituted. At a press conference the following year, Stalin explained the decision: “What is better, the yoke of foreign capital or the sale of vodka? This is the question
facing us. Naturally we will opt for vodka because we believe that if we have to get a bit dirty for the sake of the victory of the proletariat and the peasantry, we will take this extreme measure in the interest of our cause” (quoted in Transchel 2006, 149). By 1931 Soviet temperance organizations were either disbanded or reoriented around the goal of supporting the first five-year plan (Transchel 2006). While drunkenness certainly continued to be discouraged by the party during the 1930s—indeed, prior to the mass purges of 1937, habitual drunkenness was the most common reason given for dismissal from the party—workers were now encouraged to reward themselves for their hard work with a drink (Gronow 2003; Hoffmann 2003).

During World War II and afterwards the state continued to rely heavily on alcohol sales as a source of revenue. Between 1940 and 1945 vodka rose from 12 to 38 percent of the state’s total ruble intake from trade (providing one-sixth of the state’s income); by the end of the war it had again become the state’s largest single revenue source (Hessler 2001). While reliable statistics were concealed in the following decades (from 1963 until 1988 the annual statistical handbook on the economy in the Russian Soviet Republic subsumed alcohol into a category called “other foodstuffs” along with other beverages, ice cream, coffee, and mushrooms), researchers have estimated that the production and sale of alcohol products doubled between 1960 and 1980 (Treml 1982; Takala 2002). Public health researchers have argued that this resulted in a steady increase in rates of alcohol consumption, particularly among working-class men, and a complementary steady decline in average life expectancy rates (Segal 1990; Leon et al. 1997; Cockerham 2000). And while published health-related statistics were also manipulated to conceal these trends, beginning in the 1960s there were repeated calls, particularly from medical professionals and academics, for measures to lower levels of consumption (S. White 1996). As we shall see, this was the setting in which the narcological system began to take shape.

Disease States

When narcologists and psychiatrists during the late Soviet period wrote about chronic alcoholism as a disease, they typically elided etiological arguments and focused on physiological mechanisms; chronic alcoholism
referred more to the pathological consequences of regular, long-term heavy drinking than it did to a phenomenon linked to a bodily or psychological predisposition (Strel’chuk 1954; Galina 1968). However, expert conceptualizations of alcoholism in the Soviet Union had not always been so narrow, nor had they always been monopolized by psychiatry.

From the Bolshevik Revolution through the 1920s the Soviet Commissariat of Public Health promoted investigations and interventions that examined the social etiology of illness under the rubrics of social- and psychohygiene (Sirotkina 2002). For Soviet social hygienists alcoholism was a “social disease” in that the social component of its development and “transmission” was held to be the primary one (S. Solomon 1989, 257). Specifically, social hygienists focused on the role played by such factors as stress, family background, wage level, and the drinker’s “level of culture [kul’turnost’].” The negative political implications of widening these “environmental factors” to a point at which they might have constituted a critique of Soviet society may have led many hygienists to focus on the “micro-social environment” of the family or immediate community (Solomon 1989).

Although social hygienists’ and psychiatrists’ views of disease were not inherently mutually exclusive, their drastically divergent object of study led them to recommend very different forms of intervention, fostering a professional rivalry over so-called lifestyle alcoholics (Joravsky 1989; S. Solomon 1989). Thus social hygienists argued that lifestyle alcoholics were to be resocialized and their habits transformed through a series of measures focused on public education (S. Solomon 1989). Additionally, social hygienists and sympathizing psychiatrists advocated the treatment of alcoholics through outpatient dispensaries, an approach which clashed with that of most psychiatrists who viewed alcoholics as a subset of their broader contingent of mental patients, whom they preferred to treat in hospitals or isolated psychiatric colonies (S. Solomon 1989, 266). Ultimately, social hygienists’ claim to produce authoritative knowledge and treatment for lifestyle alcoholics was short-lived. In April 1927, the Soviet government issued a decree allowing drinkers categorized as “socially dangerous” to receive treatment without consent, effectively creating a legal equivalence between mental illness and alcoholism, and by 1930 the party-state had stopped funding social research on alcoholism (S. Solomon 1989, 1990).
The eclipse of social hygiene by psychiatry in the management of alcoholism came at the same time that the latter was becoming increasingly dominated by a Pavlovian neurophysiology. Pavlovian theory had come to dominate the Soviet sciences of the mind and brain following a brief period in the early 1920s when a variety of schools and research traditions coexisted—including psychoanalysis. By this time many leading Bolsheviks already saw Pavlov’s theories as politically valuable. The relationship between physiology and psychology was deeply contentious and ideologically significant, because it was in this sphere of knowledge that Marxists hoped to link their understanding of human beings as historical actors with an objective science of humans as material beings (Joravsky 1989; R. Smith 1992, 191). This project could not be achieved by a simple reduction of psychology to physiology; instead, it was attempted through the concepts and language of dialectical materialism. Ivan Pavlov’s reflex theory was taken up in this context, not simply as an example of a concrete behavioral mechanism (as it was largely interpreted outside the USSR) but as a way of framing the relationship between human biology and the environment as “dialectical” (Graham 1987, 163; Joravsky 1989). Thus, although Pavlov’s own politics were viewed as “reactionary” (until his rapprochement with the Soviet regime during the mid-1930s), his doctrine was embraced by the Bolsheviks and praised in 1924 by Nikolai Bukharin (at the time a leading party ideologist) as a “weapon from the iron arsenal of materialism” (quoted in Joravsky 1989, 212).

When mass industrialization and the collectivization of agriculture were instituted late in the decade, Stalin and other party leaders shifted away from their previously conciliatory policy toward professionals and initiated the project of creating a cadre of specialists whose primary allegiance would be to the party-state rather than to their professional group (Fitzpatrick 1992). This shift in policy set the stage for the creation of a Soviet psychiatry that would, in its broad contours, persist at least until the late 1980s (Calloway 1992; Skultans 1997, 2003). Psychoanalysis, as well as various Russian psychological schools, was increasingly condemned as “idealist,” while Pavlov’s theory of conditioned reflexes was promoted in increasingly forceful terms (Todes 1995; Etkind 1997a; Miller 1998). Soon after the official endorsement of Trofim Lysenko’s anti-Mendelian theories of heredity, a series of conferences on physiology, psychiatry, and psychology was held (between 1950 and 1952) at which Pavlov’s doctrine was
declared the objective foundation for the Soviet sciences of the mind and brain, and scientists who had previously dissented publicly “confessed” their errors (Joravsky 1989, 413; Windholz 1997; Zajicek 2009).

Although the research of Soviet psychiatrists and physiologists during the post-Stalin period became increasingly removed from orthodox reflex theory, representatives of the Pavlovian school retained powerful institutional positions in psychiatry (Segal 1975). Moreover, the psychiatry that emerged from this context was still broadly neuro-neurophysiological in its outlook. While an alternative Leningrad school, made up of many of Bekhterev’s students, advanced a framework that emphasized environmental factors, the dominant Moscow school foregrounded biology in its understanding of mental illness. The official school of Soviet psychiatry also emphasized longitudinal and dimensional approaches to mental illness states (Wortis 1950; Babayan and Shashina 1985; Calloway 1992). Psychiatrists and physiologists representing such approaches, such as Andrei V. Snezhnevskii (the clinician who presided over Soviet psychiatry from the early 1950s to the mid-1980s), held the primary administrative positions in clinical and research organizations dealing with mental illness. This arrangement strongly shaped the forms of treatment that patients received. For instance, even though psychology reemerged as a discipline during the post-Stalin period, until the late 1980s only psychiatrists were legally entitled to practice psychotherapy (Etkind 1997b).

The dominance of neurophysiology in psychiatry—and the politicization of genetics—facilitated a focus on the functional mechanisms of addiction and away from its etiology, whether social or hereditary. This avoidance of etiological arguments was also shaped by the political sensitivity of alcoholism itself. Whether they were criminologists or psychiatrists, Soviet writers on alcoholism found themselves constrained in similar ways. On the one hand, they drew on Marxist arguments to bolster their contention that various forms of deviance were a fundamentally social phenomenon; on the other hand, the risk of articulating an overt critique constrained the sphere of the social to which this etiology could be ascribed. At least until the 1970s, popular and specialist texts alike continued to describe alcoholism as a “vestige of capitalism” (Galina 1968).

Without recourse to etiological arguments, Soviet psychiatry focused more closely on the mechanisms underlying alcoholism—and particularly on alcoholic psychoses—than on the motivations or explanations of
the behaviors leading to alcohol consumption. At the peak of Pavlovian orthodoxy in the sciences of the mind and brain it was sometimes argued that chronic alcoholism was simply a conditioned set of reflexes. In other words, if heavy drinking or alcoholism was a learned behavior, the theory of conditional reflexes was used to explain how that behavior was learned but not why it took place in the first place (Janousek and Sirotkina 2003, 438). Even well into the 1960s chronic alcoholism was often referred to in somewhat tautological terms, as in this popularizing medical text entitled *Harmful Habit or Disease? (Vrednaia Privychka ili Bolezn?):* “At the root of chronic alcoholism lies lifestyle drunkenness, conditioned by various factors, fed by traditions and customs. The systematic consumption of alcoholic drinks that emerges on this basis leads to a singular passion for alcohol, accompanied by numerous disturbances to one’s health, that is, to chronic alcoholism” (Zenevich 1967, 20).

The legacy of Pavlovian thinking in narcology extended to diagnostics as well. In fact, it was in this sphere that I first encountered it during my conversations with narcologists. For instance, when I asked him about the symptoms or signs that distinguish alcohol dependence, the medical director of the municipal addiction hospital, explained,

> The dependence syndrome: there are several criteria according to which you can clearly tell that a person can’t live without alcohol or some psychotropic substance, that he needs systematic use. . . . One of the signs is when the so-called defensive reflex has been lost. If you drink too much you have a hangover, and if you try to drink a little more you feel nauseated. If you are nauseated, that means your defensive vomiting reflex is working. That means you’re not an alcoholic. If the reflex is lost, then this is already alcoholism. A person in this state just needs to drink and he’s fine. A person who’s not an alcoholic—even if people put pressure on him and say—comrade, just drink a little beer—just from the sound of it he gets nauseated. This is one of the signs, the symptom—the vomiting reflex, through which you can categorize all people into alcoholics and nonalcoholics.

Like other practicing narcologists I spoke to, this physician identified the vomiting reflex as the primary criterion for a diagnosis of alcohol dependence. In part because of its congruence with Pavlov’s theory of reflexes, this marker was mentioned in late Soviet textbooks as coinciding with the beginning of the first stage of alcoholism (Babayan and Gonopolsky 1985, 100).
Textbooks on narcology written throughout the Soviet period generally referred to a progressive “three-stage” schema of alcoholism, distinguishing between an initial “mild, neurasthenic” stage, during which the patient experienced no physical cravings for alcohol; a second stage, characterized by a psychological obsession and physical craving, a plateauing of tolerance; and a third “terminal, severe, encephalopathic” stage (100–109). In his Lectures on Narcology, Nikolai Ivanets, the country’s head narcologist during the 1990s and early 2000s, argues that this schema, which employed diagnostic criteria such as the loss of a vomiting reflex, defined alcoholism significantly more broadly than does contemporary Russian narcology, by including under its aegis the phenomenon of “alcohol abuse” (слюпотрепление), or “problem drinking” (here Ivanets borrows and literally translates the Anglo-American terminology). In other words, more recent diagnostic criteria—namely, those of the World Health Organization’s International Classification of Diseases (ICD)—draw a bright line between biological “dependence” and “abuse,” the latter a category that to some degree maps onto the popular notion of drunkenness (пьянство) (Ivanets 2001, 48).

Moreover, Ivanets emphasizes that under the new set of diagnostic criteria, the loss of the vomiting reflex, as well as the entire first stage of alcoholism, belongs to the “pre-clinical stage of the illness” (2001, 47). Along with an increased tolerance for alcohol, the loss of the vomiting reflex is simply a sign that the patient has ingested high levels of alcohol over a long period of time. Neither indicates physical dependence, the cardinal sign of which is “alcohol abstinence syndrome,” described in Anglo-American literature as “withdrawal syndrome” (48).

While Ivanets writes that the abstinence syndrome was not widely accepted as the primary diagnostic marker of dependence in the Soviet Union until the 1950s or ’60s (48–49), even in 2004 some narcologists referred to the earlier diagnostic criteria.

Yet by the mid-1990s, researchers in Russian narcology were arguing for a new conceptualization of alcoholism—or more specifically, “alcohol dependence” [alkogol’naia zavisimost’]. This new paradigm, which was first developed by Vladimir Altschuler—a researcher at the Narcology Research Institute in Moscow—in a 1994 monograph, describes “pathological desire” [патологические влечения] as the most important of several syndromes that make up substance dependence [зavisимост’ ot psykhoaktivnykh veschestv]. While many Soviet psychiatrists wrote about compulsive forms of craving, Altschuler’s definition is distinct. Specifically, he
argues that this craving or desire is psychopathological and that it manifests in what is sometimes called an overvalued idea that the consumption of a particular psychoactive substance is necessary (Altschuler 1994). As some critics of this conception have argued, this “doctrine” of “pathological desire” effectively categorizes addiction as a quasi-psychosis, a categorization with significant consequences for therapy and institutional care (Mendelevich 2013).

This is not simply one scientific conceptualization of addiction among many; rather it is one that has received significant institutional support in Russia. Altschuler’s definition of addiction appears in officially sanctioned textbooks for the training of narcologists, and has been used as the basis for developing a strategy for treating opiate addiction legally enshrined in standards of care. This involves the heavy use of antipsychotic and antidepressant medications during detoxification and after. Second, it has often been argued that if craving is like a psychosis, addiction should be treated legally in the same way as are serious “psychiatric” disorders such as schizophrenia. Finally, critics argue that this conception of addiction helps to support a long-standing Russian state policy that unequivocally rejects opiate-substitution therapy and other harm reduction approaches (Mendelevich 2013).

Assembling Narcology

By the time the Soviet narcological system was established in 1975, many of its constituent institutions and bodies of knowledge were already in place and had been for several decades. Many of the institutions had been founded during one of the periodic campaigns that the Soviet party-state mounted in 1958, 1967, and again in 1972 against alcoholism, drunkenness, and the range of crimes against “public order” grouped under the diffuse rubric of “hooliganism” (Kirichenko 1967; Connor 1972; Tkachevskii 1974). These campaigns in turn had particular social and institutional roots, related to (often conflicting) assumptions about drinking, addiction, and crime made in several expert discourses but equally to the way in which party-state power was exercised during the late Soviet period.

A number of historians have argued that expert discourses became increasingly important to the new forms of state power in the Soviet Union after Stalin’s death in 1953. With the relative (and this is key) decrease in the use of overtly repressive techniques of domination (such
Assembling Narcology

new modes of productive and disciplinary power became increasingly important as the party-state sought to create self-regulating subjects who had internalized a sense of communist morality (Kharkhordin 1999). Of course, many of the arguments made in the moralizing discourses of the 1960s were nothing new. From the mid-1930s onward, the Stalinist project of kul’turnost’ (itself a revamped and Sovietized version of prerevolutionary norms regarding propriety, culture, and self-advancement) presented a diffuse set of behavioral ideals for upwardly striving Soviets, which included norms of “cultured drinking” (Fitzpatrick 1992, 1999; Volkov 2000; Hoffman 2003). However, beginning with the de-Stalinization campaign and the return to “Leninist norms” championed by Khrushchev in the late 1950s, these discourses were increasingly bolstered and produced by specialist disciplines such as psychology and criminology, which had been, respectively, disallowed or unable to significantly influence policy for more than thirty years (Connor 1972; P. Solomon 1978; Graham 1987). Thus the 1960s and ’70s saw not only an expansion of Soviet specialist discourses on drunkenness, hooliganism, and other forms of social deviance but their increased influence in shaping policy decisions (P. Solomon 1978; M. Levine 1999).

However, while legal specialists and security officials disagreed over “the right combination of educational and repressive measures” necessary to combat the related ills of alcoholism and crime, in multiple debates that took place during these decades, compulsory treatment for noncriminal alcoholics emerged as a measure that everyone seemed to agree upon (P. Solomon 1978, 83). As one leading jurist wrote, “This compulsory influence [vozdeistvie] is one means of socially protecting . . . the interests of society [obshchestva]” (Tkachevskii 1974, 38).

The specific institutional germs of the narcological system were sown in the wake of a late 1950s campaign against drunkenness. During this time of de-Stalinization, laws dating from the 1930s, which mandated a minimum of one-year sentences for hooliganism, were liberalized, and restrictions were enacted on the sale and production of alcoholic beverages (Solomon 1978, 81). The campaign spurred calls for the development of special institutions for the isolation of chronic alcoholics (from both jurists and physicians), and the first of these therapeutic-labor prophylactories (lechebno-trudovoe profilaktoriya] (hereafter LTP) was opened six years
later in the Kazakh SSR (Connor 1972, 67; Babayan and Gonopolsky 1985, Budartseva 2002; Pozdniaev 2005). Since compulsory treatment for alcoholism could be ordered only in criminal cases involving an intoxicated defendant, the question emerged of effectively extending this law to non-criminal alcoholics.\textsuperscript{15} A recommendation to establish compulsory treatment made by the supreme court to the presidium of the Supreme Soviet led to the establishment of a working commission charged with drafting policy recommendations for the “struggle against drunkenness and alcoholism.” Though the commission, which was chaired by a prominent criminologist and included sociologists, lawyers, and psychiatrists, suggested a series of measures to reduce the production of hard liquor and to campaign in schools against alcoholism, only its recommendation regarding compulsory treatment was carried out (P. Solomon 1978, 83–88).\textsuperscript{16}

Thus a 1967 Supreme Soviet decree both simplified the procedures for commitment and broadened the category of persons to whom they were applicable (Connor 1972, 66). According to this decree (reinstated and strengthened in 1974), the system of LTPs was meant for those who “resist treatment or continue in their drunkenness following treatment, those who disrupt labor discipline, social order [obshchestvennyii poriadok], or the rules of socialist communal life [obshchezhitiia]” (Tkachevskii 1974, 38).\textsuperscript{17} A parallel 1974 order extended provisions for compulsory treatment to drug addicts who refused treatment (Gilinskii and Zobnev 1998). Over the following years LTPs began to be constructed around Moscow.

These institutions were to be only one part of a broader system of narcological institutions: a decision passed in 1975 ordered the establishment of a narcological system independent of the existing system for psychiatric treatment (Babayan and Gonopolsky 1985). While it had the effect of acknowledging the importance of alcoholism as a public health issue, the creation of the narcological service was also driven by pragmatic concerns: for the past years psychiatrists had been complaining that increasing numbers of alcoholics were filling up beds in mental hospitals, leaving little room for patients suffering from other illnesses (Galkin 2004). Although this decision originated in the Ministry of Health, the new system was meant to cut across the jurisdictions of particular ministries: the new network of addiction-treatment clinics and hospitals would be part of the Ministry of Health; the LTPs and the sobering-up stations (vytrezviteli) would remain under the aegis of the Ministry of Internal Affairs.
In addition to mandating the creation of this network, the Ministry of Health passed an additional set of provisions to produce medical workers to run it, in effect creating the “new” medical specialty of narco-logy. Although the term “narco-logy” was not new (courses and textbooks on the topic had existed for decades), prior to 1975 the specialty of “psychiatrist-narcologist” had not existed as a legally recognized and certifiable position in the Soviet medical system. Of course the legal designation of such a hybridized profession indexed the way that narco-logy continued to be viewed institutionally as an adjunct discipline to psychiatry (Galkin 2004). And yet during the late 1970s, and then again in the mid-1980s during the final Soviet anti-alcohol campaign, departments of narco-logy (institutionally distinct from psychiatry) were established at medical schools throughout the country (Babayan and Gonopolsky 1985). In the mid-1980s an independent institute for narco-logical research was established in Moscow (S. White 1996). To attract physicians to what was recognized as an undesirable specialty, incentives were created for physicians choosing to enter narco-logy, mainly in the form of reduced hours and material benefits beyond those already approved for psychiatrists (Babayan and Gonopolsky 1985). During this early period, specialist retraining for those who already had medical degrees took place over the course of months and did not require additional coursework or clinical practice in psychiatry (Galkin 2004). Narcologists and psychiatrists I spoke to who remembered this period recalled the enormous influx of physicians from various specialties into narco-logy: some debated the relative value of dividing narco-logy from psychiatry, even to a limited degree, while others questioned the professionalism and knowledge of those who had been attracted to narco-logy at the time.

Isolation, Surveillance, and Compulsory Treatment

The narco-logical system that emerged during the late 1970s as a result of these decisions was a complex of different institutions, themselves instantiations of distinct disciplinary and professional ideologies about the nature, etiology, and appropriate treatments of alcoholism. The narco-logical system’s organization included different institutions meant to address a
typology of heavy drinkers, alcoholics, and addicts that roughly mapped onto narcologists’ three-stage theory of alcoholism. The first of these was the network of narcological dispensaries on the district (raion) level, which employed the social hygienists’ ideal of treating lifestyle drunkards on an outpatient basis. More serious cases of prolonged intoxication, or those presenting greater problems to their families or in the workplace, could be taken for treatment for one month in the municipal addiction hospital—the organizational shape, predispositions, and priorities of which owed much to the psychiatric hospital or asylum. (Patients suffering from delirium tremens [belaia goriachka] or alcoholic psychoses continued to be treated in the parallel system of psychiatric hospitals). “Recidivists” could be committed to a narcological clinic attached to a manufacturing enterprise (narkologicheskiy stotsionar pri promyshlennoi predpriiatei), known colloquially as a spetskombinatura. Such institutions had proliferated during the early to mid-1970s: in 1975 and ’76 alone twenty-seven had opened in Leningrad under the aegis of the city’s addiction hospital (Beliaev and Lezhepetsova 1977). According to some accounts, they accounted for the majority of narcological clinics in the Soviet Union when the system was at its largest (Entin et al. 1997). Finally, so-called chronic alcoholics or addicts could be sent to LTPs, which were clearly modeled on labor colonies and prison camps (Babayan and Gonopolsky 1985; Tkachevskii 1990). While this list leaves out several institutions, it should illustrate a key point: though they emerged from separate discourses, medical diagnostic criteria for alcoholism and juridical criteria regarding socially dangerous drinkers mapped closely onto one another.

Moreover, as many narcologists saw it, the Soviet system was effective precisely because it created practices of surveillance over addicts that ran well beyond the narcologist and policeman into the domestic sphere (Elovich 2008). As Ilya Sergeevich argued, coworkers and family members played a positive role as disciplining agents of the public health system:

The doctor played a secondary role [in sending a patient for compulsory treatment], the decision was made either by the family or, let’s say, relations of production. If people saw that he was coming home or to work in who knows what condition, on Monday, once, twice, then he would get a warning. Then they would send him to a specialist, and say, until you bring proof that you’ve entered [the register] and that you’re being treated and
that there is a guaranteed remission, you aren’t allowed [back to work]. The person lost his qualification. The person felt himself pressured in other way, for instance in the queue for an apartment. In other words he would literally cut himself and his family out of society. And this worked very distinctly. And the first ones to be on guard were of course the wife, the mother, the father, the children. All you needed was a declaration, whether he wanted it or didn’t want it, that didn’t matter. If the family thought that papa dear or grandpa was acting inadequately, that was it.

Specifically, Ilya Sergeevich referred to the legal provisions that allowed not only family members but also coworkers or neighbors to initiate the proceedings that would result in a person’s commitment to an LTP. Additionally, given the typical gendering of such things, it was usually wives or mothers who played this role of surveillance. Combined with the feminization of the medical labor force, as well as that part of the administrative bureaucracy that dealt with social issues (obshchestvennost’), this dynamic served to further a common view (one that has gained particular momentum in postsocialist debates throughout Eurasia and Eastern Europe), which associated the interests of women with those of the socialist state (Gal and Kligman 2000, 8).

A similar function of surveillance and social control was played by the sobering-up centers (meditsinskii vyitrezviteli), where people found intoxicated in public were brought by the militsiia for an overnight stay. Though these centers were nominally medical, they were administered and staffed primarily by police (as they continued to be in the post-Soviet period) (Tkachevskii 1974; Gerasimova and Zubov 1991). Officially a night in the vytrezvitel’ was meant to result in a notice to one’s place of work: an arrangement that clearly facilitated police extraction of fines beyond those officially mandated (Tkachevskii 1990, 63). During the Soviet period the sobering-up centers, like medical facilities, were sometimes subject to pressures to fill quotas, which were dubious indexes of success, such as the demand by central planners of the Turkmen SSR that 3,300 people be serviced over the course of 1962 in the capital city of Ashkhabad (Connor 1972, 60). Though people brought in to the vytrezvitel’ were meant to have their blood-alcohol level tested, this procedure was routinely flouted. One narcologist who had once worked as a medical assistant in a vytrezvitel’ told me about how, instead of conducting multiple individual blood
tests, he and his colleagues would often “get lazy . . . take blood from ten people,” mix it together, and “check all their blood all at once.” While one might interpret this simply as an anomaly, arguably it stands more as an index of a system that was less interested in accuracy than it was in exerting a general kind of social control. In other words, in practice the vytrezvitel’ system was meant to function as part of the wider network of institutions exerting a kind of social pressure on potential drinkers—the threat being that of getting pulled into the vytrezvitel’ regardless of whether or not one was in fact drunk.\textsuperscript{18}

**Dispenserization and the Register**

A night in the sobering-up center during the Soviet period was meant to be followed by a trip to a psychoneurological or, after 1976 in Leningrad, narcological dispensary or outpatient clinic (Beliaev and Lezhepetsova 1977). Here the authority of narcologists was buttressed by the institution of dispenserization and the narcological register (narkologicheskii uchët). The register was essentially a list of patients diagnosed with a particular addiction kept by each district-level dispensary and was a key element linking the narcological service both to a residentially based system of urban governance and to the state’s systems for medical surveillance and control (Babayan and Gonopolosky 1985).\textsuperscript{19} Similar registers existed for other illnesses such as tuberculosis and, more recently, HIV/AIDS.

Like other medical services, treatments for addiction were provided by local dispensaries based on an individual’s propiska, a document that combined the functions of a residence permit with those of an internal passport. The propiska system (originally a tsarist technology of internal passports that was revived in 1933) was, and continues to be, a means by which the state attempted to control urban in-migration.\textsuperscript{20} (Of course this system gave rise to a brisk market in permits, as well as fictitious marriages arranged to obtain them, well before the post-Soviet period). The link between the register and this residency system, by means of dispenserization, provided a grid through which state actors attempted to manage the health of populations.

For narcologists, dispenserization and the register functioned as means of tracking patients under their care. Field has characterized this
as “an important service . . . of a preventative nature” in that it allowed “the systematic observation and periodic examination both of patients with an identified condition and of healthy groups” (1967, 139–40). For public health administrators, the register operated as a means of “quality control,” in the words of one narcologist, a source of statistics and a quantifiable measure of the output of narcologists’ labor. While it is true that these statistics were rarely publicized, they were not always obscured from interested professionals, as has often been suggested of Soviet statistics. For instance, a 1977 publication of the Bekhterev Psychoneurological Research Institute gave the following breakdown of patients on the city’s narcological register: 24 percent are being treated “systematically,” 27.6 percent “drink following treatment and refuse follow-up treatment (but show no signs of pronounced social degradation),” 18.7 percent “require compulsory treatment,” and 4.9 percent suffer from “pronounced alcoholic encephalopathy and psychoses . . . and require periodic treatment in psychiatric hospitals” (Beliaev and Lezhepetsova 1977, 14). (Of course these figures are somewhat compromised by the authors’ failure to report the total number of patients.) As important as the numbers are the categories being employed, for they suggest that public health officials’ cardinal concerns in regard to the register were precisely the sorting of patients along a gradient of increasing debilitation and social exclusion and, presumably, their subsequent placement into appropriate institutions. In short, the narcological register functioned as one quantified criterion according to which a dispensary could be measured as fulfilling or failing to live up to the expectations of centrally produced plans; it also served as a means of surveilling and sorting patients into clinically significant categories.

For patients themselves, the register had a distinct set of consequences. Patients on the register were unable to receive a permit for a gun or a driver’s license and were prohibited from working in a number of occupations and from traveling abroad. Once on the register, one’s name remained there for three years (Tkachevskii 1974, 1990; Gilinskii and Zobnev 1998). In short, the register was meant to keep addicts away from potentially dangerous situations, and the threat of appearing on it was to act as a deterrent to potential alcoholics as well. Physicians also had the authority to require patients on the register to return for inpatient treatment and could call upon the police to bring in recalcitrant patients. As we shall see, the
narcological register, in a transformed capacity, has come to play an important role in the commercialization of post-Soviet Russian narcology.

Institutional Memory

I met Ilya Sergeevich at the district dispensary, where he worked as a narcologist for children and adolescents. He had been trained as a child psychiatrist in Leningrad but subsequently had worked for much of the 1980s in an LTP. As he explained, “I worked mainly in the far north, but it was a special contingent [of patients] [spetskontingent]. . . . It was a penal colony [zona] and a special institution [spetsuchrezhdenie] where we treated alcoholics and drug addicts. At the time, during the years of Soviet power [vlast’], we had compulsory treatment, as we called it.” When the LTPs had been closed down in the early 1990s, he and a colleague had returned to St. Petersburg and found positions in the city’s narcological service.

Like many other narcologists, Ilya Sergeevich was quick to voice his discontent with the current state of affairs in his specialty. As he saw it, compulsory treatment had been the linchpin of a Soviet narcological system that had both successfully provided medical care for patients and shaped their conduct, largely through various modes of social control and surveillance. The key problem with the contemporary situation in narcology, he argued, was the lack of “any possibility to confine or limit [ogranichit’] the patient in a situation where he doesn’t allow—not just his family—but himself to live.” Whereas under the Soviet system, compulsory treatment allowed physicians to “isolate this person, at least until he comes to himself and then [allow him to] decide will he or not [accept treatment],” under conditions of voluntary treatment, which had been instituted around the same time the LTPs were shuttered, patients were unlikely to come for treatment until they were in an advanced state of decline:

Now there’s voluntary treatment. And so what happens? Until things haven’t gotten very bad for this person, until the illness hasn’t taken him to who knows what places, [we don’t see him] . . . And we tell him that this is a mental illness, chronic and progressive. Do we wait until tomorrow when he accepts this fact and comes to us? This never happens. Over the past ten years we’ve had more patients in serious decline, more difficult patients.
How does it all turn out? The person has gone to as many places as possible, used the services of private or government doctors. . . . Only when nothing is left in his soul, no health, no psyche to acknowledge his situation, then the only choice left is to return to us . . . and to do what? If not to receive charity then social [help]. The state takes this debris [oskoly] on itself when taking in this patient, because there has already been a diametric progression. . . . It takes too much material and moral expense on the part of clinicians to bring these people back to life.

For Ilya Sergeevich, compulsory treatment had been a necessary tool with which the state could fulfill what he understood as a central set of social obligations.

The crux of this system was the legal category of compulsory treatment, which was used primarily to commit patients to LTPs. In the language employed by narcologists, these conditions mapped roughly onto the group of patients belonging to the third stage of so-called chronic alcoholism (Babayan and Gonopolsky 1985). If the figures given above are to be trusted, narcologists believed that a sizable proportion of patients (at least one-fifth of those on the register) belonged to this stage or could be categorized in this way. The percentage that actually ended up in LTPs was much lower: in the 1980s this was about 3 percent of the three million who were on narcological registers at the time. Yet in absolute numbers this amounted to a significant figure: at least 112,000 inmates in 272 institutions in 1988 (S. White 1996; Entin et al. 1997).22

Ilya Sergeevich emphasized how a commitment to an LTP required the collaboration of family members, physicians, police, and occasionally fellow workers:

And if, God forbid, during this period [of observation] there was a relapse, who would come and tell us? Of course the family. That he went to go drink with his friends and the wife says, that’s it tomorrow. . . . And if the person refused, then what authority could be drawn on? The doctor didn’t hospitalize him, nor did his wife. A call would go out to the station house for accompaniment by a policeman [militsianer] and . . . if we saw that the person was not agreeing to any conditions, doesn’t need work, doesn’t need family, says I’ll just drink, then we would gather a council. First he went through the hospital, and then if there was a relapse, only then to the LTP. Where a year, half a year, two years was the maximum period: this was already dependent on his behavior, his desire to be treated.
Indeed, though a commitment to an LTP required the decision of a court, as well as the recommendation of a medical committee, proceedings could be initiated by family members or neighbors, and there was no requirement for a lawyer to represent the potential patient/inmate. Thus it not surprising that when the Soviet media began to publish criticisms of various institutions during the late 1980s, reports abounded of family members “abusing” the committal procedure (S. White 1996, 155). Moreover, no procedure existed for inmates to challenge their commitment or to receive compensation. In some cases, investigations yielded evidence of committals taking place in order to fulfill plans—that is, a promised quota of patient/inmates (156).

LTPs, which were administered by the same ministry (Internal Affairs) that oversaw the extensive Soviet network of labor and prison colonies, were modeled on these penal institutions in that they too combined confinement with compulsory labor. All employees, including physicians, wore uniforms with epaulets, and the camps were surrounded by barbed wire. While the security regime was less stringent than that of prison camps (guards at LTPs apparently did not carry firearms), attempts to escape an LTP were treated as a criminal offense (Connor 1972, 66–67; S. White 1996, 156).

During the late 1980s the effectiveness of LTPs began to come under scrutiny. The anti-alcohol campaign of 1986–88 had opened additional funding for the system, and the push to crack down on drunkenness led to high levels of incarceration—but because these efforts took place during a time when the policy of glasnost was making public calls for official accountability more prevalent, the LTPs also faced greater pressure to live up to high expectations for rehabilitating inmates. Many public health and party officials were seemingly disappointed with the official results. In one relatively successful center, 20 percent of the inmates were sober after the first year and 13 percent after the second, while the comparable figures for the entire country were closer to 2 or 3 percent (S. White 1996, 158). Moreover, there was evidence that the institutions acted as spaces where patients became exposed to criminal networks and practices (157). By the late 1980s there were reports of inmates at various centers striking, in some cases violently breaking out of the LTP, in others peacefully demanding that treatment for alcoholism be carried out by the Ministry of Health rather than Internal Affairs (156). In response to these pressures, regulations at LTPs
were somewhat liberalized in 1988—efforts were made to facilitate a less formal and restrictive atmosphere, patients were allowed freer movement, and changes were made in the committal procedures, allowing patients representation by a lawyer (158). However, these measures seemed only to exacerbate the problems at the centers: for instance, in one of the LTPs in Moscow only 137 of 1,200 registered patients showed up after the reform (159).

As they were increasingly seen as ineffective and repressive institutions—out of sync with the contemporary valorization of human rights (prava cheloveka)—in 1991 the Russian Supreme Soviet began the process of dismantling the system, ordering the release of alcoholics committed only because they had refused compulsory treatment (S. White 1996, 159). In 1993 the federal law “On psychiatric help and guarantees of civil rights in carrying it out” removed the legal basis for involuntary hospitalization of noncriminal addicts. The following year the LTPs were formally disbanded (Entin et al. 1997; S. White 1996). At least some of the facilities were transformed into remand prisons or “investigatory isolators” (SIZO), where suspects are held while awaiting trial, and others into different kinds of prison colonies.23

During the 1990s and early 2000s, the LTPs and the legal provisions for compulsory treatment, along with certain types of treatment (described in chapter 4), came to represent the core of the Soviet narcological system. As they have been remembered and represented again and again, their meanings have shifted within the changing images of a now-demonized, now-valorized Soviet past. Grigorii Mikhailovich attributed the reluctance of many patients to use the state narcological services to the legacy of the LTPs: “After these LTPs, the fear that someone might be sent there pushed people to feel, when the commercial structures emerged, that you shouldn’t go to a doctor in the state service.” Like other emblems of the Soviet period, LTPs have also become, in contemporary discourse, a shorthand for the imagined effectiveness of strong state authority, with calls for their revival arising in discussions of alcoholism, drug abuse, AIDS, crime, and public order (Pozdniaev 2005). Among the narcologists I spoke to, the notion of reviving some type of compulsory treatment was strikingly prevalent. Such sentiments of nostalgia are often interpreted as signs of persistent Soviet or authoritarian relations of authority or as remnants or imprints of the Soviet “political culture.”
Yet as I have suggested throughout this chapter, placing these arguments into the context of narcology’s institutional origins in the 1970s and its rapid transformation during the late 1980s and 1990s may suggest a different interpretation of such accounts. First of all, narcologists who express support for compulsory treatment for their patients may be referring to a variety of different and divergent programs and institutions. Additionally, such arguments might be interpreted as voicings of frustration over a fundamental disciplinary crisis, expressed in the readily available register of nostalgia. Narcologists’ clinical authority was heavily bolstered by Soviet legal provisions for compulsory treatment, as well as the broader intermeshing of medical and juridical organizations in the Soviet narcological service. As the following chapter explains, these elements were dismantled at roughly the same time as the discipline lost its monopoly on the production of knowledge about and treatment of addiction and as the state-funded medical sector took significant blows to its funding and medical services became increasingly commodified.