Governing Habits

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On a bitterly cold and windy February morning, I walked through an industrial district in northern St. Petersburg with Mikhail Venediktovich to visit the addiction clinic that he directed. More than others involved in addiction management, Mikhail Venediktovich had actively fostered contacts among local social scientists; when I met him at a sociological institute, he had invited me to visit and possibly conduct fieldwork at his clinic. With his spectacles, goatee, tweeds, and modest mannerisms, Mikhail Venediktovich cut the figure of an academic more than a clinician or public health worker. He had in fact received his education not in medicine but in engineering and systems analysis, and he had worked during the final years of the Soviet Union in the energy sector. After going a year without pay at a research institute during the mid-1990s, Mikhail Venediktovich had founded a medical services firm along with a few acquaintances. At first the firm offered only ambulatory detoxification; additional services and inpatient facilities were added gradually. The clinic was officially called the Bekhterev Therapeutic-Prophylactic Medical Center, but everyone
referred to it simply as the Bekhterev Center. This institution had no formal affiliation with the city’s leading center for psychiatric research, the Bekhterev Psychoneurological Research Institute. It simply partook of the positive associations that potential clients might have with the early twentieth-century Petersburg psychiatrist Vladimir Bekhterev (or the institute), although this branding would eventually become a great source of trouble for Mikhail Venediktovich.

Mikhail Venediktovich did not portray his motives in opening the center in lofty terms of social good. He spoke openly of the clinic as a commercial venture: “I got into this absolutely by chance; there was the possibility of making some money and it was something new and interesting for me.” At the same time, Mikhail Venediktovich was able to carry over something of his training in analysis of systems and infrastructure. Having adopted the issue of addiction as his own, he approached it not simply as a commercial opportunity but as a general sphere for social intervention. For instance, along with several others, he drafted a proposal for a municipal methadone program during the late 1990s. While the Bekhterev Center primarily offered alcohol and drug detoxification on a commercial basis (along with a variety of other medical services), during the late 1990s Mikhail Venediktovich founded Healthy Future, a noncommercial foundation that ran a rehabilitation program for drug addicts and carried out some prevention-oriented programs. The two organizations were legally distinct but were housed in the same building, and profits from the commercial clinic were sometimes used to help fund Healthy Future.

Detoxification at the center followed by a full course of rehabilitation cost about fifty thousand rubles (more than $1,700 at the time), an amount which ensured that the vast majority of patients came from the new professional or business classes. Workers at the center heavily encouraged their patients to complete their educations (the vast majority of heroin addicts in St. Petersburg are under twenty-five). While many counselors employed 12-step methods, Mikhail Venediktovich and members of his staff took issue with certain ideas central to Narcotics Anonymous—such as “once an addict, always an addict,” a notion they felt only discouraged their patients, given the high stigmatization of drug addiction in Russia.

As we walked toward the center under the shadow of idle smokestacks and past rows of stacked shipping containers, Mikhail Venediktovich complained about his wasted morning. He had spent several hours at a meeting
devoted to public health issues with a group of representatives from the municipal government, all of whom, he argued, were solely concerned with amassing money and power for themselves. “The municipal government gets worse with every election,” he said bitterly. “There are fewer and fewer decent [prilichnyii] people in it. Everyone is bought [kuplennyi].” The nongovernmental organization (NGO) sector, on the other hand, was, in Mikhail Venediktovich’s opinion, filled with well-intentioned but largely unprofessional and ineffectual people. Mikhail Venediktovich deeply valued professionalism and thus was wary not only of local antiaddiction organizations made up of mothers of drug addicts, but even of the former or recovering addicts whom his center hired as counselors.

No sooner had we entered the center than Mikhail Venediktovich was approached by a medical worker. “Did they tell you?” she asked. “There are about fifteen people upstairs.” A crisis was unfolding at the center. On the main floor of the clinic a crowd of people was jammed into the office of the medical director while several clusters of large men in leather jackets stood idly in the hallway nearby. Thinking that a large group of patients had shown up and needed to be registered, I sat down on a couch in the hallway. Several minutes later, Mikhail Venediktovich emerged from the office and called me in. “Please pay very close attention to everything that goes on here,” he requested. Suddenly conscripted into the role of witness, I needed a while to sort through three or four simultaneously shouted conversations to understand what was happening. A stocky woman, who turned out to be the director of the rehabilitation program, was standing behind a desk vigorously telling a uniformed officer that she would not sign the document he was waving at her. Another officer, wearing a badge around his neck, was demanding to see other documents from a doctor who kept repeating, “We’re doctors. Are we hurting anyone here? Are we causing anyone harm?”

Throughout that day, most of which I spent in the director’s office watching the crisis unfold, and over the following weeks I learned that this was only one battle in an ongoing commercial war being waged between Mikhail Venediktovich’s center and another addiction clinic. That morning the center’s administrators had been visited by two separate, and ostensibly unrelated, groups of people. One was a visit by two agents of the Federal Service for the Control of the Drugs Trade (Federal’naia sluzhba po kontroliu po oborotom narkotikov) (FSKN), the recently formed
federal “supra-agency” charged with carrying out all aspects of a war on drugs, who claimed to be conducting a surprise inspection of the center’s license. The other was a clerk of an arbitration court delivering a decision allowing the seizure of certain items of medical equipment pending a lawsuit. He was accompanied by the representatives of a private security company and a group of “movers,” who were supposedly meant to participate in this seizure but in fact—argued the physicians—were there to intimidate them and their patients.

Though this lawsuit emerged from a series of events and changes in the center’s legal status, which I describe below, Mikhail Venediktovich and his colleagues were sure that both visits had been orchestrated by one of their principal competitors. As I later learned, this competitor had previously been a business partner of Mikhail Venediktovich’s involved in the Bekhterev Center. After the two had split, both continued to claim the brand name “Bekhterev Center” and the associated logo. The scene I witnessed, the physicians explained, was one in a series of attempts by this other Bekhterev clinic to shut down their operation.

When I began my research, I assumed—very naively as it turned out—that treatment and intervention into substance abuse would vary across what I thought would be relatively clear-cut distinctions between certain sectors—namely, the state, market, and civil society. In other words, I thought that state-run or state-funded clinical settings would differ in fundamental ways from commercial ones, which in turn would be distinct from not-for-profit or charitable institutions. And though such distinctions were not insignificant, it became quickly clear to me that they were blurred and crosscut to such a degree that they seemed to conceal more than they revealed about the operation of addiction treatment services in St. Petersburg. State-funded clinics contained units that functioned effectively as commercial entities; for-profit clinics like Mikhail Venediktovich’s were often partnered with NGO entities; and the managers of charitable centers worked to improve the recognition of their brand. People participated in multiple spheres as well: narcologists in the state system moonlighted in private practice, and patients regularly cycled between treatments in various types of institutions (at least as long as they could afford it). Moreover, many physicians, administrators, and other participants in various clinical institutions that were legally understood as municipal, commercial, or charitable conceptualized themselves as all operating in a market in which
their institutions competed for patients with other institutions regardless of their formal sector.

In this chapter I interpret the movements of practitioners, patients, and money across these varied institutions as part of what Vinh-Kim Nguyen has called a therapeutic economy, which he defines as “the totality of therapeutic options in a given location, as well as the rationale underlying these patterns of resort by which these therapies are accessed” (2005, 126). In what follows I use this concept to highlight the relations of exchange and regimes of value underpinning the domain of treatment for alcoholism in St. Petersburg, tracing its transformation from a state socialist political economy of favors and access to an irregularly regulated market. In the next chapter I continue to build on the idea in my discussion of therapeutic legitimacy, showing how talk about therapeutic methods and enactments of belief, affect, and volition are seen by narcologists as shaping their clinical efficacy.

A Market of Favors

Eugene Zubkov, a narcologist who had become a major proponent of Alcoholics Anonymous during the 1990s, ascribed many of the problems of contemporary Russian narcology to the way in which the Soviet political economy shaped the doctor-patient relationship:

[During the Soviet period] Russia was a market of favors. Money on its own, without contacts, had no value. You had to have the opportunity to spend that money. So all of narcology was shaped as a market of favors, and doctors were heavily interested in having control over the patient [zainteresovan s kontrol'iam nad bol'nym]: a situation which hasn’t changed. The doctor was paid very little, and so he wanted his own contact in the store where clothes were sold, and so on.

Zubkov’s characterization evoked several aspects of the political economy of Soviet medicine as well as the particular form that the professional authority of physicians took under these conditions.

Michele Rivkin-Fish (2005) has argued that the systemic analysis of state socialist political economy developed by Katherine Verdery helps to
explain the healthcare field as well. In Verdery’s terms, this means that the state monopolized the means of health production (all the infrastructure of the medical system, as well as the system of medical education) and controlled the distribution of medical services. Simultaneously the state sought to legitimate this appropriation through its ideology of “socialist paternalism,” claiming to provide for its citizens’ needs by redistributing goods and services (1996, 26). In the case of health care, the party-state claimed to guarantee its citizens the universal provision of medical care without direct charge. While this claim, often exhibited as evidence for the achievements of socialism, arguably had a profound effect on the development of redistributive “welfare state” institutions in Western Europe and North America (particularly in the climate of the Cold War), its effect on the legitimacy of the Soviet state among its own citizens was rather double-edged (Rivkin-Fish 2005, 23–24). Though patients were by no means conceptualized as consumers, Verdery’s (1996) argument that “the [socialist] system’s organization exacerbated consumer desire by further frustrating it and thereby making it the focus of effort, resistance and discontent” is key here as well. For in the same way that promises of material plenty often served to underscore the shortages experienced by many citizens, the state’s promises of universal health care also served to heighten the frustrations caused by shortages of medical supplies and services and long queues for many procedures, as well as clinical encounters often perceived as impersonal and brusque (Davis 1989; Verdery 1996). Additionally, the claim of “free of charge” medical services was not strictly true, even in official terms, as patients paid for prescription drugs (albeit at heavily subsidized prices); as I discuss below, an entire sphere of payments for health services circulated outside official acknowledgment (Ryan 1978, 28).

The roots of patients’ frustrations also lay in the institutional structure of the medical system. Like other state sectors, the healthcare system that emerged during the mid-1930s in the Soviet Union was characterized by a highly bureaucratized and hierarchical set of institutional relationships that ran from the Ministry of Health (itself answering to the executive committee of the Communist Party) to republic-level ministries to regional and city ministries, all the way down to the microdistrict (uchastok)—the level on which medical care was provided to residents (Field 1967; Ryan 1978; Rivkin-Fish 2005). The provision of material and human resources to these units, as well as their expected outputs, was laid out in plans developed by
an agency of the Ministry of Health, as well as by a department of Gosplan, the central planning agency (Davis 1989, 239). While the party-state’s five-year plans set health-related goals based on demographic measurements (such as the lowering of mortality and morbidity rates during the 1970s and ’80s), the metrics used to measure success within the Health Ministry’s plans were often disconnected from such outcomes: they concerned the quantities of medical personnel or hospital beds or focused on the number of procedures conducted rather than their quality or effectiveness (Field 1967; Davis 1989; McKeehan 2005).¹

Simultaneously, the very same structural aspects of the Soviet health care system made it more difficult for centrally produced plans to be fulfilled. First of all, the system of official healthcare provision was far from simple. Rather than a single network, there were several: two separate “closed” networks (zakrytyi set’) of clinics existed for members of the party elite and employees in prioritized industries, and even the “open” networks (obshchii set’) designated for everyone else differed depending on whether they were situated in a large city, a small city, or a rural setting (Davis 1989, 242). Of course, an entirely separate network of healthcare facilities existed to serve the military. The sheer scale and complexity of this system was often more than the limited resources of the central planning offices could handle; even according to their own criteria of success, some things simply fell by the wayside (Davis 1989, 239).² These tendencies were further exacerbated by the fact that health care was funded according to what some analysts have called the “residual principle,” receiving whatever funds were left over in the central budget after appropriations were made for high-priority sectors like the military and heavy industry (Sheiman 1994).³

In part because of these conditions, various informal or unofficial economies flourished in the Soviet medical sector, as they did in much of the rest of the system (Grossman 1977; Sampson 1987; Verdery 1996; Ledeneva 1998). Like the ubiquity of shortages and queues, various “shadow economies” and informal institutions of exchange were further symptoms of a system in which political and social capital, rather than economic capital, was the most valued resource (Bourdieu 1986). In the absence of officially recognized private property and given the state’s monopoly on legitimate production and distribution, rights of use or access were worth more than those of ownership. As Zubkov put it, “Money on its own,
without contacts, had no value. You had to have the opportunity to spend the money.” Physicians therefore sought to create long-standing relationships, often based as much on mutual obligation or friendship as on the exercise of their professional authority. Patients for their part often drew upon extensive acquaintance networks, taking part in a practice colloquially known as blat, not only to obtain certain scarce medications but often to receive a type of care that they viewed as motivated by personal interest and attention (rather than bureaucratic obligation) on the part of physicians (Ledeneva 1998). This kind of phenomenon has continued to characterize much of contemporary Russian health exchanges since the dismantling of the planned economy (Salmi 2003; Rivkin-Fish 2005).

Fiscal Crises

During the final years of the Soviet Union and just after its collapse, legislators and health administrators discussed how the Russian nationalized system of health care was to be reformed. These discussions, which continued throughout the 1990s, focused in part on the optimal form of governance for health care: specifically the right balance between markets and state regulation. In general, the market principle was never questioned as an appropriate mechanism for the healthcare: opponents of radical marketization based their arguments on questions of fairness rather than arguing against the principle of commodifying health services (Rivkin-Fish 2005). During the initial drafting of healthcare legislation in the early 1990s, the concept of a state-administered economy was seen as so discredited that officials did not consider drawing upon systems such as the British National Health Service as a model, opting instead for an amalgam of the US and Canadian systems (McKeehan 1995). The Health Insurance Act, which was signed into law in April 1993, provided for parallel systems of insurance: mandatory (which would provide a basic level of care) and voluntary (paid for by individuals and employers, this was to be the institutional basis for a nascent medical insurance industry). The act, which was heavily promoted by the World Bank, mandated the creation of mandatory health insurance funds (fondy), a set of independent, nonprofit agencies that would act as mediators between the state, employers, commercial insurance companies, and healthcare providers.
Not surprisingly, the result of the rapid switch to this system was not the creation of a healthcare system operating on the ideal principles of market competition but the development of parallel systems of highly commercialized medicine and institutions that still function somewhat as they did during the Soviet period. With inflation spiraling upward throughout the 1990s, and particularly in the wake of the 1998 monetary crisis, fiscal resources were unable to keep up with the costs of providing the minimum levels of care that the mandatory insurance system promised as a right to Russian citizens. Thus in Leningrad Oblast the cost of providing mandated obligatory care in 1994 was 86 billion rubles, at the same time that the district government’s entire budget was 95 billion (Twigg 1998, 596). On a national level, public health spending had dropped to 2.9 percent of the GDP by 1998, a level that covered only 75 percent of the estimated costs of mandated care (Balabanova, Falkingham, and McKee 2003, 2124).

In addition to inadequate—or misplaced—funding, aspects of the institutional and spatial structure of the system worked against the ideals of the new system. In many (perhaps most) parts of Russia, Soviet-era hospitals and polyclinics retained their territorial monopoly on healthcare provision, entirely undercutting the possibility for competition. Legislation that prohibited privately owned clinics from participating in the obligatory insurance system also hampered the ideal market that reformers had envisioned (Twigg 1998).

The situation was somewhat different in specialties such as narcology and psychiatry, which treated what were categorized as “socially significant illnesses” (sotsial’no znachimye bolezni) and thus were funded not from insurance but directly from the budget (Galkin 1996, 73). While a parallel system of “social funds” was proposed to fund mental health and addiction treatment, the system was even slower in taking shape than the mandatory medical insurance program. (Significant federal attention to the narcological system was not paid until 2010, when an effort toward “modernization” was initiated [Narcology Research Institute 2012].) All of this accounts for the overall contraction of the state narcological system during the 1990s. It is worth remembering that the relative impact of these budgetary contractions was perhaps greater in the narcological system, which had received a major fiscal boost just a few years prior during the anti-alcohol campaign.

In addition to the demise of the LTPs during the early 1990s, the entire system of clinics attached to manufacturing enterprises in St. Petersburg
was closed as the managers of newly privatized factories sought to shed unprofitable units. For narcologists, this was significant in that this system of “industrial narcology” had arguably accounted for the largest portion of inpatient beds (Egorov 1997). While outpatient clinics remained in each of St. Petersburg’s twenty-one administrative districts, as well as in the central addiction hospital to which they funneled patients, many district governments (such as Amur, Volgograd, and Kirov oblasts and the Tuvin Autonomous Republic) shut down their narcological systems entirely (11). These closings were reflected in the overall statistics for Russia, in which the total number of state narcological dispensaries dropped from around 325 in 1988 to 217 in 1997; the number of inpatient beds and narcologists fell to 33,707 and 3,827–41 and 74 percent of their respective 1988 levels (Egorov 1997, 9–10).7 While many regions have also been opening or reorganizing their narcological services (with a visible movement toward institutionally separate networks for adults and adolescents), these units remaining in the state system experienced an intense shortage of funding during the 1990s and early 2000s. To be sure, there have been new funds in recent years—particularly those aimed specifically toward the treatment of drug addiction. This does not in itself suggest a solution, however, as arguably it has precisely been the coexistence of deeply underfunded institutions alongside unusual opportunities for personal enrichment that has fostered much of the disciplinary confusion and self-recrimination in narcology.

Self-Financing Units

Shortages of funding in the narcological system were exacerbated by the fact that, starting from the late 1980s with the emergence of medical cooperatives and increasingly in the 1990s, the state system was effectively competing with multiple commercial clinics, which sprang up to provide various addiction-related services. As they became partly or largely self-financing (khозрасчетный), physicians and administrators in the state narcological service sought to keep their institutions going in much the same way as did actors in other sectors. Retaining the institutional structure of a state organization, hospitals and clinics, as well as individual wards and networks of physicians, began to function as commercial enterprises,
charging patients directly for their services. While this was to some degree a continuation of Soviet practices, in which the medical system was shot through both with cash payments and with informal exchanges of favors and access, both the degree and tenor of these exchanges altered during the post-Soviet period. They encompassed both officially sanctioned practices and those that were formally illegal. As we shall see, they also carried a newfound urgency in post-Soviet narcology: on the one hand, institutions and their employees faced the real possibility of fiscal crisis with consequences such as the nonpayment of salaries; on the other hand, the possibilities for personal enrichment were far greater than they had ever been. Narcology became a sphere of medicine in which both of these motivations were to play a role, one in which the extremes of fiscal shortage and lavish wealth appeared in disconcertingly close proximity to one another.

Thus while the municipal hospital’s role in the city’s system of addiction treatment provision was to provide services free of charge, in fact it also offered a number of services for a price. As Lyudmila Petrovna, a narcologist in the hospital’s acute care ward, explained,

Of course we have a portion of the services that are for pay. Without these the hospital simply wouldn’t be able to survive. Also, I want to say, psychotherapy does not have the right to be free, the person values only that which he pays for. Seriously. We have the “budgetary” [budzhetnyi] patients: those who have lost everything and whom we still have to help somehow. And we of course have the self-financing beds: the spaces are better, the medications are more expensive; not better but more expensive. And for these people we can prescribe certain antidepressants that are a bit more expensive.

While the majority of patients at the hospital fell into the budgetary category, some paid three thousand rubles (equivalent to $100 at the time) to stay in a separate room rather than stay with the rest of the patients in spaces with eight or more cots. The hospital also offered a short course of detoxification (three days), similar to services provided by many of the city’s commercial clinics. Yet most of the hospital’s narcologists insisted that the main difference between the for-fee and free services, as well as between the hospital in general and its commercial competitors, lay in cosmetic conditions (vneshnoe uslovie).
Alexander Sergeeivich argued that it was primarily for this reason that the hospital failed to attract more middle-income patients or professionals:

Mainly this hospital is set up for people without a very high social status or low financial state. . . . Rather, it was designed for everyone but somehow the powers that be [vlasti] aren’t trying to make it amenable to people who are used to . . . to comfort, to more or less adequate conditions. Although these people end up here too, but rarely. Because the treatment here and in the commercial clinics is not significantly different. The main difference is in the appearance of the conditions.

Reiterating the point, his colleague gestured toward the crumbling plaster wall above his desk: “You see the state of it.” Such a concern with material conditions had led administrators at the alcoholism ward of the Bekhterev Psychoneurological Research Institute to initiate construction of a separate set of “elite rooms.” While the institute was primarily devoted to clinical research and was administratively separate from the municipal addiction service, as a state-financed institution it faced a similar set of budgetary constraints. Although all the patients there paid a relatively small fee (sixty rubles per day) for inpatient treatment, the administrators recognized that some could and would pay significantly more for elite treatment, a strategy that drew upon the widespread commercial practice of offering tiered services by price, most often consisting of a special VIP level above the normal range of services.8

Privacy Commodified

While material conditions were certainly a part of what distinguished khozraschetnyi services from budgetary ones, another important difference lay in the fact that patients were able to pay for “anonymity.” The existence of this service can be traced to the institution of the narcological register, described in the previous chapter. During the 1990s, state and municipal clinics treating addiction began to offer patients the possibility of treatment without registration, for a price (Galkin 1996). This became the legally sanctioned practice of every clinic in the municipal network in St. Petersburg. Part of its justification was that similar anonymous services were already available in commercial clinics. Since the laws barring those on the register from owning guns or receiving driver’s licenses remained
unchanged, the result was the creation of a two-tiered system, with very different degrees of state surveillance. Treatment was nominally free of charge for those who would accept having their names on the register, while others, who paid, could escape the penalties and restrictions. From the point of view of some physicians and public health reformers, this system served to further penalize the socially marginalized and poor. Others pointed out that the practices of anonymity made it more difficult to hold physicians legally accountable for their actions.

Even those physicians who defended the practice did so in a guilty tone, insisting that anonymous treatment simply capitalized on a (now unjustified) suspicion that some patients had of the state service. For instance, the administrator Grigorii Mikhailovich assured me that the confidentiality of patients’ records and doctor-patient privilege was guaranteed by the sixty-first article of the 1993 General Law on Health Care of the Russian Federation (Tsyboulsky 2001, 259; see also Tichtchenko and Yudin 2000, 230). Nevertheless, he explained, “The fear that someone will tell someone or get the information—this still lives.” Thus the addiction hospital provided the service of anonymous treatment, which was “easier for [the patients], and easier for us, because we get extra money,” he added, laughing. Yet in the same breath Grigorii Mikhailovich recounted recent attempts by police to access the register, undercutting his argument that confidentiality is secured by a new post-Soviet legal regime: “Just before the three hundredth anniversary [of St. Petersburg], I was sending away policemen. . . . One of them wrote to me saying, ‘Give us the lists of the people who have been treated here.’ And I replied . . . ‘You won’t get any lists.’”

Deliberately or not, Grigorii Mikhailovich’s account laid bare the institutional incentives for narcologists to stoke fears of such unscrupulous policemen, thereby bolstering the “need” for anonymous treatment. Grigorii Mikhailovich acknowledged that the current demand for anonymous treatment grew partly out of the punitive character of the Soviet system; in his view, “This is what the anonymous treatment is connected to: the fact that there was this punitive system.” Yet it was in the interest of physicians like Grigorii Mikhailovich to perpetuate the notion that the confidentiality of patients’ records was still not secure. In other words, in order for narcologists to create a demand for anonymous service, patients had to be continually reminded that their information might fall into the wrong hands and led to fear that legal protections of confidentiality and doctor-patient privilege were weak. Given the lack of institutional protections
for privacy during the Soviet period and the continued vulnerability of personal information to theft or sale during post-Soviet years, it was not difficult to convince patients of the need for anonymous service.¹⁰

**Murder in the Clinic**

As I have argued, narcology was created as a specialty by the Soviet state under conditions that encouraged physicians with an economic motivation to enter it. Given the low (official) pay of physicians relative to other workers in the Soviet period, any financial incentives were able to attract professionals from various medical specialties to narcology. The rapid commercialization of narcology during the 1990s encouraged this tendency, particularly since it coincided with a period of intense economic depression. For physicians or medical researchers whose small salaries were often delinquent or delayed for years, the promise of a specialty with a higher pay scale was clearly attractive. Though most of the narcologists I spoke to said they had entered medicine for a variety of reasons (many came from families of physicians), almost all explained that they had chosen narcology in particular for financial reasons. “At the moment, in Russia, it’s rather profitable to work specifically as a narcologist,” Anton Dmitrievich explained. Since narcologists in the state service continued to receive salary bonuses above those given to psychiatrists (which in turn made psychiatry higher-paying than general practice), he was willing to leave behind the higher prestige of psychiatry to work with addictions. “If not, I would have stayed in big psychiatry.” The self-financing services described above also increased the salaries of narcologists.

Despite their higher pay relative to that of other physicians in the state service, narcologists were quick to point out that they made far less than their colleagues in commercial clinics or private practice. Indeed, commercial narcology was often used as a temporary professional destination for physicians seeking to earn quick money. On the other hand, narcologists starting out in the state system were paid an official salary of about four thousand rubles a month (approximately $150). As one physician put it, “That’s about how the state values the labor of a narcologist.”

And yet, at least for some of those at the top of the hierarchy in the state service, this salary was only the tip of the iceberg, only a small portion of
the money they made through various services. While most narcologists saw the potential for personal enrichment in what was formally a commercial sector, the degree to which the commercial and state sectors were entangled with each other became clear with a prominent story involving the head doctor of the addiction hospital, Sergei Tikhomirov.

On August 26, 2004, the deputy director of the hospital, Larisa Artyukhovskaia, was killed by a bomb that had been left at the doorway to her apartment. A similar remote-controlled device was found near Tikhomirov’s apartment, leading the procurator’s office to initiate a broad investigation into the conflicts over control of the narcology business in the city. Early in October, none other than Tikhomirov himself was arrested and charged with the incitement of the murder of his deputy. Arrested along with him were Marat Dreizin, the director of a commercial narcological center, and Pavel Beliaev, an employee of the city’s pathological-anatomical bureau (which oversees the morgues), known in the St. Petersburg underworld as “Pasha-Kvadrat.” Beliaev was known as the head of a criminal group, the members of which were employed as orderlies in the city’s morgues, earning them the name the “gang of orderlies” (grupirovka sanitarov).

According to journalistic reports of the police investigation, Tikhomirov had developed a particularly lucrative business on the basis of his position as the northwest district’s head narcologist. One of his duties in this position was the licensing of commercial narcology clinics (for the treatment of alcoholism), a service for which he apparently charged approximately $2,000. Additional funds reportedly came from the anonymous treatment of wealthy drug addicts. Reports differed on whether Artyukhovskaia, who was in charge of the hospital’s finances, had refused to participate in Tikhomirov’s business or whether she had simply refused to share the profits she herself stole from the hospital. In either case, investigators charged that Tikhomirov had arranged for the orderlies to carry out Artyukhovskaia’s murder and, in order to clear himself of potential guilt, to make a seeming attempt on his own life. Also under question were the circumstances under which Tikhomirov had assumed his post in the first place: his predecessor had resigned after being severely beaten and threatened with bombs (Andreev 2004; Bezrukova 2006; Tumakova 2004).

Yet given how commonplace practices such as Tikhomirov’s selling of licenses have been in recent years, it seems possible that he and Artyukhovskaia
had clashed over some other, perhaps more profitable schemes. As media articles on the affair suggested, this spate of violent attacks associated with St. Petersburg narcology probably would not have occurred before increasing levels of (both state and private) funding began to appear for drug addiction treatment.

Two Clinics and the Power of the State

Mikhail Venediktovich’s troubles had begun several years prior to the incident that I happened to witness. As he told it, he had noticed recurring discrepancies in the accounting books for the Bekhterev Center and suspected that his partner was embezzling funds. After several confrontations failed to correct the situation, Mikhail Venediktovich and his partner decided to divide the business between them. The idea, at least as he portrayed it in hindsight, was that each of the new clinics would be given a new name. Their advertisements, ubiquitous in the medical pages of free newspapers that were stuffed on a weekly basis into the mailboxes of Petersburgers, were also adorned by logos that were barely distinguishable. Both portrayed an open hand with either a single figure or a family group silhouetted in the palm. While Teplitstskii’s Bekhterev Center offered a range of medical services, including gynecology and cardiology, both clinics specialized in addiction: specifically detoxification and treatment of withdrawal symptoms, as well as longer-term rehabilitation.

They were far from the only clinics offering such services: detoxification continues to be one of the most crowded and profitable parts of the commercial medical sector in the city. Between the mid-1990s and early 2000s, hundreds of organizations were licensed to carry out narcological services of one kind or another in Moscow and St. Petersburg (Egorov 1997, 9). The free newspapers, as well as other venues for relatively inexpensive advertising, were filled with advertisements for “rapid ending of binges” and “removing of [drug] withdrawals,” many claiming to complete such procedures over the course of “six to eight hours.” Such clinics also typically advertised longer-term aversive therapies such as disulfiram implantations and coding (described in the following chapter), and many offered ambulatory house calls. Some also offered treatment for other phenomena framed as addictions, such as smoking and compulsive gambling.
Many narcologists admitted that these services often acted as revolving doors for patients. For drinkers this meant “breaking a binge,” allowing them to resume their consumption; for heroin users, such services were seen as a means to simply lower the dose they needed to take to obtain a high. At least for drinkers, detoxification services seemed keyed to particular local practices of consumption, albeit ones that were conceptualized as pathological.

Patients in various institutions rarely spoke in terms of consuming or drinking alcohol. Most referred to entering and exiting drinking binges, in a way that suggested a separate time and space. Both patients and physicians spoke about binges in terms of their length—three days, two weeks, two months—but patients in particular depicted them as definitely demarcated states or spaces: one clearly knew when one entered a binge as well as when one emerged from it. While the phenomenon of drinking binges is prominent in international medical literature on alcoholism, this local vernacular understanding of a binge—and the practices it described—was clearly distinct from the medical one. Clinics offering detoxification services then were less interested in propagating a medicalized terminology or understanding of sustained drinking bouts than in capitalizing on the meanings of such practices among lay populations.

Addiction clinics also benefited from the popular perception of a heroin epidemic overtaking Russia’s youth, which became widespread during the mid- to late 1990s. While the increase in intravenous drug use among young people, and the concomitant spread of HIV infection, was very real indeed, the mass media representation of this phenomenon was often keyed in a hysterical and moralistic tone that some sociologists have referred to as a “moral panic” (Thompson 1998; Meylakhs 2009). Thus although alcohol-related deaths far outnumbered those associated with drug use in Russia, policymakers and public health administrators began to increasingly emphasize narcotics as a primary site for state intervention (Mendelevich 2004). If alcoholism was often portrayed as a timeless national tragedy, as old as Russia itself, drug use (rarely distinguished from drug addiction) was depicted as a new and frightening foreign scourge. Just as it had been during the 1920s, another period of radical social upheaval in Russia, drug use was discursively linked to images of “deviance” to a far greater degree than alcoholism, justifying a greater role for legal and penal state agencies in the matter.
At the same time as little effort was being made to regulate services targeted toward drinkers, efforts were being made to place the treatment of drug users under the aegis of state supervision. One of the results of these efforts was the 2002 creation of the FSKN. Whereas previous narcotics agencies had existed in the Russian Federation during the 1990s, the FSKN was distinguished by its size (it reportedly began with some forty thousand staff members), its institutional autonomy from federal ministries, and the scope of its mission, which ranged from policing narco trafficking and carrying out anti-drug-use propaganda to regulating the provision of treatment for drug addiction (Butler 2003).

The institutional imperative of the FSKN to monopolize authority in its given sphere, as well as its role in Vladimir Putin’s much-vaunted goal of rebuilding the “vertical” of state power, was well articulated by a representative of the agency who spoke at a workshop for substance-abuse NGOs I attended in December 2003. To the concern of other workshop participants, the agent argued that “if an organization is effective, you need to pull it closer to power [надо пригивать его к власти] and give it particular goals to fulfill.”

Many narcologists viewed the creation of this agency as an attempt by those in the spheres of criminal justice and security to assert a conception of drug addiction as primarily a problem of public order over a medical one. In pointing out the essentially punitive character of the organization, some cited reports that the majority of FSKN agents had previously worked in the recently dismantled federal agency for tax collection. Some also noted that the agency’s first director, Victor Cherkessov, had made his career in the KGB “chasing dissidents.” At the same time, both recognized that they would eventually have no choice but to deal with the organization and that its existence meant that certain laws, already on the books, would now be enforced.

For instance, a federal law on narcotic substances passed in 1998 specifies that “the treatment of patients suffering from drug addiction is to be conducted only in institutions of the state and municipal health system.” While several physicians I spoke to mentioned this law, it was interpreted for me by Grigorii Mikhailovich, the medical administrator at the municipal addiction hospital. He argued that this law primarily represented the views of people in the state’s security organs [прокурорские органы]. Not only did it make him uneasy by defining drug addiction in legal rather
than medical terms, but the clause in question stemmed from a misplaced anxiety about physicians selling narcotics. “These guys from the FSKN seem to have nothing better to do than to chase after doctors—they need to be dealing with drug trafficking! A couple of weeks ago, one of my doctors got a visit from two large young men asking her to sell them drugs—clearly an undercover operation carried out by these guys.” Of course such anxieties were not entirely misplaced: when I arrived in his office that day, Grigorii Mikhailovich had been on the phone dealing with an incident involving a narcologist who had been selling prescriptions.

However, rather than spurning the entire notion of the state’s remonopolizing treatment for drug addiction, Grigorii Mikhailovich emphasized the imprecisions of a law “written by people who are not medical specialists”:

The problem is in the definition of treatment [lechenie]: it isn’t clear what “treatment” is. It seems that the people who wrote this law had in mind a situation where I give you a tablet. They don’t, for instance, include psychotherapy in their understanding of treatment. And only some forms of “treatment,” even when it is strictly defined in such medical terms, are included here. For instance, vitamin therapy, or therapy to treat all kinds of other illnesses which might accompany addiction, is not included.

Grigorii Mikhailovich implied that this vagueness of definition could make it easy for commercial clinics to get around the formal objectives of the law at the same time as it facilitated the unfair penalization of other clinics for practicing forms of treatment not included in the law’s intent. More generally, it was not so much the wording as the broader institutional context that facilitated the use of this law, as well as the actors it mobilized, as an extension of commercial competition by other means.

**Anything Is Possible: Commercial War**

After the creation of the FSKN, Mikhail Venediktovich and his associates decided it was in their best interests to follow the requirements of the 1998 law. This meant reconstituting their business as a municipal institution, which they did in the autumn of 2003 with the support of a government
committee. In this new legal incarnation (its third) the Bekhterev Center was meant to receive funding from the municipal budget to help reduce the cost of addiction treatment, thereby making it accessible to a broader group of potential patients. When these funds were not forthcoming, the center began to treat patients for drug addiction under the auspices of the municipal institution.

Within a month things began to get ugly. Unbeknownst to Mikhail Venediktovich and his colleagues, their “municipal institution” was declared null at a meeting of the local government committee that had originally authorized it. A “liquidating committee” was formed and supposedly charged with recovering certain pieces of medical equipment. In December 2003, clinical workers were taken by surprise when a group of men, some of them dressed in camouflage, representing the liquidating committee arrived at the center, shut down its operations, and escorted both physicians and patients—many of whom were heavily drugged by their ongoing detoxification—out of the building. Since this initial raid had no legal basis, the center’s work was only briefly interrupted.

However, when the liquidating committee returned in February 2004, on the day I happened to be visiting, its visit was framed in legal terms. A lawsuit had been filed in an arbitration court by representatives of the municipal committee that had entered into a contract with the Bekhterev Center. The committee laid claim to various pieces of medical equipment and medicines, which it claimed had been purchased through the municipal budget. As the center’s lawyer explained to me, the Russian arbitration codex includes a special provision for cases involving property disputes that allows for property held by the defendant to be seized and held, pending a trial, presumably to prevent him from selling or hiding it. All of this can take place before the defendant is even notified that a suit has been filed against him. In this case, the plaintiffs had asked the court to deny the defendants access to their building, to seize the property in question, and to have it held with the plaintiffs. While the court had apparently refused the first of these requests, it had granted the second and third.

To Mikhail Venediktovich, his coworkers, and their lawyer, this was another sure sign that the court had been “bought.” The lawyer in particular felt that such a decision was unprecedented, and, along with the doctors, he discussed how much money their competitor must have spent to buy this decision. Their conviction about the roots of the lawsuit was bolstered
by the appearance of agents from the FSKN, who had scheduled a surprise inspection of the center that very day. I spent much of that day in the office of the center’s stocky medical director, Yuri Nikolaevich, as he, along with the nervy bald toxicologist Alexander Germanovich, the lawyer, Mikhail Venediktovich, and others chain-smoked out of communal cigarette packs and developed strategies for dealing with the dual onslaught.

Whatever its provenance, the effects of this day’s events were based on much more than the formal legal basis of a lawsuit and a regulatory agency’s inspection. Both visits had the strong performative effect of intimidating the center’s administrators—or at least were perceived as attempts to intimidate by threat of force and to display the power and influence of the person behind the scenes who was pulling strings to make it all happen. This was particularly true in the case of the leather-jacketed movers, whom Mikhail Venediktovich and others essentially interpreted as representatives of a security agency—synonymous with a bandit or mafia group.

The phenomenon of such raids was a common feature of the Russian business world throughout the 1990s and early 2000s. As I learned from other acquaintances, it was colloquially known as “maski show”—originally the name of a mime troupe—but applied in this case because of the ski masks typically worn by raiding security personnel. This form of attack, with an added element of threat added by the visible wielding of guns, was used equally in conflicts between businessmen and by the state in crackdowns on the conglomerates of several so-called oligarchs during Putin’s administration. The trope of hidden identities is central to the performative effects of this form of power, in that people experiencing such raids initially do not know whether the security people bursting in the door are agents of the state, of their own firm, or of a competing firm or are simply a bandit group. Rather than relying on the authority conferred by the legitimizing face of the law, the very power of this tactic lies in masking and blurring the institutional identification of those wielding force.

As Vadim Volkov (2002) argues, this blurring has a structural and social basis in that throughout the 1990s, so-called mafia groups performed many of the functions typically carried out by the (in this case, absent) state. The groups, which Volkov calls violent entrepreneurs (they convert violence or force, or the threat of it, into capital), function in basically the same way whether they are illegal mafia groups, legal private protection agencies (themselves made up of former state protection agencies), or current
state employees—providing protection and ensuring that contracts are honored. In other words, a similar relationship of protection and patronage, known as a *krysha* (roof), can be provided by a security group (either formally legal or not), a particular state agency, or a network of actors connected by personal ties and debts that often crosscut these institutional boundaries.

The organizers of the raid on the Bekhterev Center certainly drew upon such tactics even as they attempted to frame it as a legitimate legal action. Though none of the movers wore a mask, they categorically refused to give their names or show identification when asked by Mikhail Venediktovich. At the same time, even the attempt at a seemingly legal process in this case raises the question of whether a certain legitimacy of the state has been successfully reconstructed in recent years. If this is the case, then—as we shall see—it is perhaps less legitimacy in the classic sense, connoting practices of good governance and rule of law, than a conviction that the state (more specifically, certain of its agencies) is once again becoming the most powerful of kryshas, the most potent and reliable source of protection.

Of the two attacks suffered by the center that day, the surprise inspection was more easily dealt with. The main FSKN agent, wearing a federal badge around his neck, couched his demands entirely in a formal and bureaucratic logic. When one of the clinicians initially protested the inspection, claiming, “We’re not harming anyone,” he responded, “Actually we come across plenty of doctors who claim that they keep illegal drugs on hand simply to help patients through withdrawal.” When the physicians produced a photocopy of the center’s license, the agent was not pleased: “I need to see the original license. This photocopy doesn’t mean anything to me unless it’s notarized.” When Mikhail Venediktovich pointedly asked him why his inspection was occurring on the same day as the attempted seizure of equipment, the agent assumed the rhetoric of a powerless bureaucrat: “I’m just a clerk, I’m just carrying out my boss’s orders,” although he later acknowledged, “This is some war you guys have going on here.”

At this point Yuri Nikolaevich decided to take a more conciliatory approach and to engage the agent. He offered him tea and chatted with him for nearly an hour. The two exchanged stories about the troubles the Scientologists were causing to Russian narcology. Yuri Nikolaevich asked the agent for advice regarding the finer points of the new agency’s regulatory
regime. The agent, for his part, was very interested in making sure that the center was not carrying out subdermal implantations of naltrexone, an opiate antagonist (similar therapies are described in the next chapter), a technique that was, at the time, not approved by the Ministry of Health. Seemingly appeased, the agent sat at a desk and wrote his report out in longhand. After everything, his only formal complaint was the lack of the original copy of the center’s license—which the physicians promised to bring to him the following day—and a missing tag on the safe that held controlled medications.

As he prepared to leave, the agent recounted several stories about seizing illegal drugs in ambulances. He argued that a number of drugs currently classified as uncontrolled should be reclassified as narcotics and complained about the flow of such substances from Ukraine and Belarus, where he claimed regulation was lighter. After he had left, Yuri Nikolaevich said to Alexander Germanovich, “Don’t you think I handled that well? He came in here all excited, but when I talked to him, he calmed down.” Alexander Germanovich was having none of this and launched into a short tirade about the effects of such a punitive understanding of addiction on public health. “It’s because of people like him that young people addicted to drugs are contracting HIV and dying of overdoses.”

Having dealt with the agent, the center’s administrators still had the other half of the crisis on their hands. As they saw it, the problem was potentially deeper than the document from the arbitration court suggested. For one, they insisted that the equipment claimed by the municipal committee had not been purchased by the city’s funds: in fact, the list of property exceeded anything that the center actually had on hand. The real problem did not lie with the potential seizure of medical equipment. The various defibrillators, electrocardiographs, blood-pressure monitors, and cots could easily be replaced. However, the doctors feared that the seizure of this equipment was only the first step in a broader strategy by their competitor to shut them down entirely.

Medical licenses in Russia are granted according to the particular clinical specialty or type of care being practiced. Whether it applies to narcology, cardiology, or gynecology, a medical license stipulates certain standards, including particular pieces of equipment and medicines, which a clinic must have on site. The Bekhterev Center’s physicians and administrators worried that immediately after a seizure of their equipment they
might receive a surprise visit from the licensing bureau, which, finding certain required items to be missing, would revoke their license.

For this reason, the physicians’ main goal was to make sure they ended the day with the infrastructure required to practice. Simply replacing equipment was not enough: since the court’s decision listed more items than the clinic owned, any new equipment could simply be seized on the following day. In other words, it was also necessary to provide documentation proving that each piece of new equipment did not belong to the municipal organization. “We don’t have the receipts for these electrocardiographs,” Yuri Nikolaevich exclaimed. “We bought them years ago. If you come to my house and claim my refrigerator, how am I going to prove that it’s mine?” The administrators discussed whether the best course of action was to write up backdated letters documenting the receipt of medical equipment as “gifts” from one of the doctors or simply to lock all the materials in the gynecology ward, an area that, everyone agreed, even the movers would refrain from entering. The only moment of levity that day occurred while the doctors decided which pieces of equipment they were prepared to forfeit. Taking out a “broken” blood-pressure monitor, Alexander Germanovich disconnected the display dial, explaining, “This is the most expensive part.” In its place he connected a pump, creating an absurd device that consisted of tubing connecting two rubber pumps: “We’ll give them this,” he laughed.

Yet such moments did not hide the intense anxiety Alexander Germanovich expressed throughout the day. A professor of narcology and toxicology at the university, he had, like many other academics, begun practicing in a commercial clinic in order to supplement his small and irregularly paid salary. Yet as the official director of Bekhterev’s municipal institution during its brief existence, he had already had criminal proceedings initiated against him for illegally treating drug addicts. During a half hour of relative calm that day, he told Yuri Nikolaevich and me that he was considering leaving narcology altogether. “Too many unlikable [nepriятные] people.” Moreover, he emphasized that the “disorder [bespredel] we were witnessing not only characterized this medical specialty but Russia as a whole. “You see what kind of legal system we have?” His tirades, themselves typical of Russian speech genres that link tropes of “total collapse” to an ethic of virtuous suffering, grew only more intense once he learned that I was visiting from the United States (Ries 1997).
Although the lawyer came up with his own strategies, which included filing suit against the security company for lost revenues, in the end the Bekhterev Center emerged from this episode in its commercial war through the intervention of its own patrons. At one point during the day, there was talk of Mikhail Venediktovich’s calling up his own “unlikable people.” Soon a jovial man in his fifties, wearing a black jacket and carrying a string of worry beads, arrived in the office and vigorously shook everyone’s hand. Introduced by Mikhail Venediktovich to the court officer as the center’s technical director, the man spent much of that afternoon negotiating with the representatives of the liquidating committee as well as, apparently, the competing clinic. Toward the late afternoon he had worked out a compromise according to which the equipment would remain at the Bekhterev Center; the liquidators were allowed to leave one guard in the building to make sure nothing was removed.

Back in the office, he instructed the physicians to write up an account of that day’s events and enclose it in a letter of complaint to a particular representative of United Russia, the pro-Putin coalition party that had swept the parliamentary elections two months earlier. In a moment that played out uncannily like a political ad, Alexander Germanovich intoned, “There is no future for Russia, no future.” To this, the technical director, who at that moment was jotting down the contact information for the United Russia deputy, replied, “You’re wrong. Russia has a future.” The unspoken subtext, as I interpreted it, was not so much a matter of political party affiliation as of whether a system of institutional authority based on personal ties and patronage could still evoke the vision of a future worth putting one’s hopes on.

Within the following days, assistance arrived through the personal intervention of St. Petersburg’s head narcologist, Vladimir Nikolaenko. In an open letter addressed to the city’s then governor, Valentina Matviienko, Nikolaenko argued that particularly in light of the “deficit of beds” in the municipal addiction clinic, “the actions of the head of the liquidating committee . . . undermine the existing system of narcological services” (Dyleva 2004a, 10). It was not clear to me whether Nikolaenko’s ties to the center predated this event or whether it represented his assumption of a new role as patron. In either case, this relationship between the Bekhterev Center and the city’s head narcologist was further cemented in the following months when the center agreed to conduct clinical tests.
of an experimental system Nikolaenko had devised for the treatment of addiction.

There were other long-term aftereffects of the raid. When I visited the Bekhterev Center a month later, Mikhail Venediktovich had just been released from the hospital after suffering a mild heart attack. As we discussed my research into the local differences of addiction medicine in St. Petersburg, he insisted that there were no “real differences,” only “differences in conditions”:

Here there’s always something. The last time they came from the FSKN, all the guy could find was that we didn’t have the appropriate tags on the safe that we keep controlled substances in. And then he said, well you should have contacted me in advance so we could have worked something out. And this means that they are basically offering to act as a krysha. And you know how many agencies there are competing for that role? There’s the sanitary epidemiological service, the licensing committee, the fire marshals. . . . In every other country the way that licensing works is that a professional organization of physicians or whoever establishes certain criteria and gives licenses to its members. Here we don’t have anything of that sort—medical licensing is carried out by a state agency—and basically, it’s another situation in which you have to pay a fairly large sum of money.

At the same time, he was ready to work with the new agency: after all, what choice did he have? “Sure, they’ll be stealing an enormous amount of our money, but at least we’ll be able to continue our work.”

Like many other Petersburgers I spoke to, Mikhail Venediktovich spoke of a world in which a logic of fundamental economic interest and profit seeking could explain everyone’s actions. In such a world, the commodity substances and objects of addiction—vodka, beer, heroin, gambling machines—were seen as following the same circuits, underpinned by the same market logic, as the clinical interventions that sought to manage addiction. Though there was nothing particularly unusual about this insight, it was made repeatedly by people working in the clinical sphere as a kind of commentary on the absurdities of the addiction treatment market (cf. Schüll 2012). For instance, Mikhail Venediktovich argued that the hyperinflated costs of drug tests made it “more profitable to sell drug tests than to sell drugs.” An acquaintance active in the 12-step movement repeated an apocryphal story about drug dealers in the city who opened
their own treatment centers so as to make money from the entire circuit of addiction and its treatment. At the same time, Mikhail Venediktovich and others relied on personalizing strategies to manage what they perceived as a rapacious market (Rivkin-Fish 2005).

An interesting postscript to the Bekhterev Center raid emerged several months later when I came across an article in a local newspaper describing the events. The article was written by a reporter who had not been present on that day but had subsequently interviewed Mikhail Venediktovich and other members of the staff. I recalled that during the course of that day, Mikhail Venediktovich had asked me about my impressions of the events I was witnessing. Unable to come up with much, I mumbled something about never having seen anything of the sort in the United States. The title of the article, “Treat Drug Addicts? No, ‘Bloody’ [‘mochit’] Narcologists,” made ironic reference to President Putin’s assertion that he would similarly “bloody,” or destroy, Chechen separatists. (This unabashed use of an argot seemingly shared by the criminal world and its pursuers in the security sphere was often referred to by members of the intelligentsia as evidence both of the president’s “lack of culture” and of his “KGB mentality.”) The article opened with a brief description of the February raid, followed by this statement: “An accidental witness of these events, an American citizen, a graduate student at Yale [sic] University, Mr. Raikhel, thinks that such a situation is unthinkable, impossible, in any case in the setting of the USA. But here [u nas] anything is possible!” (Dyleva 2004a, 10).