Governing Habits

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Vyacheslav was one of the first patients I met at the addiction hospital. As we sat under the cracked and water-stained walls of a small examination room, the fifty-year-old factory worker described his stay at the hospital as part of a cycle. Every year Vyacheslav went on a drinking binge, which always ended with his being voluntarily hospitalized. During his month at the hospital, Vyacheslav’s physicians detoxified his body with intravenously delivered vitamins as well as a heavy pharmacological regimen, including the liberal use of tranquilizers and antipsychotics, a treatment protocol that had changed little since the Soviet period (Fleming 1996; Ivanets 2001; Fleming, Bradbeer, and Green 2001; Elovich 2008).

Before discharging him from the hospital, Vyacheslav’s physicians gave him an injection (colloquially known as a torpedo), which, they told him, contained a long-acting form of disulfiram—a drug that induces a heightened sensitivity to alcohol—that would remain in his bloodstream for a year. Vyacheslav did not pretend to understand how the medication worked—that was the job of the specialists. “There’s also a special injection
they can give you in your vein,” he explained, adding, with deference to the authority of his clinicians, “It’s all figured out by the professors so that it gradually dissolves.” He knew that his body had been somehow modified, rendered incapable of processing alcohol, and he knew that drinking in this state posed a grave danger to his health, perhaps even to his life.

And so, as he explained, Vyacheslav always waited until the course of the torpedo was over before embarking upon another binge. Once he had tried another procedure: the physicians had implanted a capsule under his skin, which they said would slowly release disulfiram for five years. That time Vyacheslav had not been able to wait it out: “I didn’t drink for two and a half years. Then I paid them and had the implant removed [rasshilsia].” Typically this cycle repeated itself every year, he told me, with no evident regret or concern. Vyacheslav explained that, along with his family, he was successfully managing his tendency to indulge in drink, although he added that abstaining from alcohol noticeably dampened his social life.

Vyacheslav described his torpedo as a physiologically based treatment, which was more or less the way that physicians depicted it in conversations with patients and advertisements. However, later that week Anton Denisovich, Vyacheslav’s physician, gave me a radically different account of the treatment. When I asked him about the forms of longer-term treatment offered to patients at the hospital, he explained, “Mainly it is khimzashchita or placebo therapy, or we orient them toward rehabilitation programs.” By this point in my fieldwork, I knew that khimzashchita, which literally translates as “chemical protection,” was an umbrella term used to refer to different forms of disulfiram treatment, including Vyacheslav’s injection and his subdermal implantation. I had also read in an English-language medical journal that Russian narcologists sometimes used “placebo therapy.” However, none of the physicians I had spoken to had mentioned it, and I was surprised at Anton Denisovich’s depiction of disulfiram therapy in this way. “Can you explain khimzashchita?” I asked. “How should I explain it to you? As if you were a patient?” asked Anton Denisovich and then began without waiting for an answer:

We inject the medication disulfiram. It comes in different forms: intravenous, capsule form, or subdermal implantation. All of these forms are long-acting. If the medication is taken intravenously or orally, it dissolves in the stomach and ends up in the bloodstream and then enters the body’s
tissues, combines with proteins in the liver . . . and for a certain period of
time this medicine remains in the bloodstream. This medication cannot be
taken with alcohol, as it blocks the enzymes that break down alcohol. If a
patient on this medication drinks and alcohol enters his bloodstream, the
possible side effects are dangerous to his health or life-threatening. It can
be anything from a flushing or reddening of the face to serious or crippling
consequences or even death. . . . This is told to the patient and he signs a
paper explaining that he understands the procedure. And then the proce-
dure takes place.

I was confused. “Then why is it placebo therapy?” Anton Denisovich
hesitated awkwardly for a moment, perhaps realizing that he was about to
reveal a minor professional secret. “Well,” he resumed, “because it is. . . .
Because, as you understand, all patients cannot take these substances, in
part because some of them won’t wait out the entire period, and this would
just be dangerous for them. So it’s better to give him a placebo and give him
the gift of several months of sober life than to inject the real medication.”

As I gradually learned through conversations with narcologists at the
hospital and in commercial clinics over the subsequent months, it is com-
mon practice to inject or implant patients with neutral substances (often
vitamins or saline) in place of disulfiram. Moreover, as narcologists see it,
whether or not they use active disulfiram, the therapies they refer to as
khimzashchita rely heavily on suggestion and have more in common with
hypnosis than with neurochemically based interventions. When they did
not describe it as placebo therapy, as Anton Denisovich had done, most
narcologists characterized khimzashchita as a form of psychotherapy and
emphasized its parallels with a technique known as emotional-stress psy-
chotherapy, or _kodirovanie_ (coding). Like khimzashchita, kodirovanie is
a therapy meant to keep patients from drinking by seemingly convinc-
ing them that their bodies have been altered so as to make the consump-
tion of alcohol harmful or fatal. Unlike khimzashchita, kodirovanie does
not involve the ingestion, injection, or implantation of any substance at
all. Instead, the therapist is said to alter the patient’s brain through his
actions, which sometimes involve vigorous physical manipulations and a
strict ritual structure. Both narcologists and their patients often implicitly
acknowledged the similarities between khimzashchita and kodirovanie
by classifying them together. Proponents of the therapies have called
them “mediating psychotherapy” (*oposredovannaia psikhoterapiia*) in print, and many patients refer to both types of treatment as kodirovanie (Entin 1991, 132).

It is difficult to overstate the ubiquity of such clinical technologies in post-Soviet Russia. The Kazan-based psychiatrist Vladimir Mendelevich (2004), an avid opponent of khimzashchita and kodirovanie, reports that such methods “constitute up to 80 percent of all treatment methods offered by official and unofficial Russian narcology” (see also Ivanets 2001; Sofronov 2003). In 2004, both methods were heavily advertised in the medical pages of free newspapers that were regularly stuffed into the mailboxes of Petersburgers. Russian-language online forums on alcoholism and addiction are filled with questions posted by patients anxious to understand how these methods work and to ascertain their efficacy. In both the state-run and commercial clinics where I conducted fieldwork, the vast majority of long-term treatments offered to patients relied on mechanisms of suggestion and conditioning. In addition to khimzashchita and kodirovanie, these included emotional-stress psychotherapy, subliminal suggestion, and several recently imported methods, such as neuro-linguistic programming (NLP) and Eriksonian hypnosis.

In addition to being widespread, these therapies are highly contested in Russia, condemned on a variety of clinical, ethical, and political grounds. They are criticized by proponents of Alcoholics Anonymous for ignoring the underlying emotional and spiritual roots of alcoholism and by advocates of harm reduction for being falsely represented as “cures” for a chronic disease (Mendelevich 2004). Even many clinicians who offer khimzashchita or kodirovanie point out that while these methods are often successful in facilitating short-term remissions, patients rarely see the need to supplement them with longer-term psychosocial interventions, leading to a cycle of decreasingly successful and increasingly short remissions (Valentik 2001, 244; Sofronov 2003). Not surprisingly, visiting Western European and North American physicians have criticized what they see as these treatments’ disregard for a normative model of patient autonomy; instead of treating patients as autonomous, rational, and potentially self-knowing individuals, these methods are described as relying on people’s ignorance and belief to frighten them into sobriety (Finn 2005; Parfitt 2006). Noting that the effectiveness of therapies such as khimzashchita or kodirovanie “depends on the therapeutic ability of those who dispense” them, “as well
as the patient’s and their relatives belief in miracle cures,” a team of British and Russian physicians argued during the mid-1990s that this belief “has directed attention away from more progressive psychological approaches and has weakened patients’ confidence in their ability to overcome dependency by becoming aware of the problem and mobilizing their own will and intelligence” (Fleming, Meyroyan, and Klimova 1994, 359). According to such accounts, the mechanism underlying khimzashchita and kordirovanie is very simple: it consists of the physician’s convincingly telling his patient, “If you drink—you die” (Chepurnaya and Etkind 2006).

The theme of fear as a motivator in such clinical technologies was often linked to political or culturalist interpretations about which methods were more appropriate for Russian or post-Soviet people. Alexander Germanovich, a toxicologist working at a commercial clinic offering alcohol detoxification and rehabilitation, often employed khimzashchita in his own clinical practice. His explanation was representative, not simply because he drew a clear analogy between the clinical encounter and the relationship between citizens and their state but also because of the emphasis he placed on the centrality of fear to khimzashchita.

[In addition to the purely chemical effect, there is a suggestive effect. A suggestive-stress [suggesstivnoe-stressevoe] effect. Suggestion [vnushenie] to the person that all of this [drinking] is dangerous and not allowed. Of course this is all built on fear. In America this is probably used rarely—implantation, because there the personality [lichnost] of the patient and his potential possibilities [vozmozhnestei] are taken into account much more than in Russia. This is characteristic for us, that we treat people differently—both medicine and the state. People have much less freedom of choice among methods of treatment here. In America, they are mainly oriented toward “counseling” [spoken in English], you know this, toward self-help groups. Russia is gradually moving in that direction, it will also get there eventually. Khimzashchita is, of course, yesterday’s method.

Like others, this doctor focused on the element of fear as a motivating factor in khimzashchita to draw an analogy with “Russian” relations of authority: a comparison that was sometimes drawn in political terms—as a legacy of totalitarianism—and sometimes through the lens of cultural arguments about “Russian culture and mentality.” Underlying such arguments was a stereotyped figure of the Soviet subject: stripped of its
individual self through the hypnotic power of the physician or state and dependent on that authoritative figure to solve its problems. Although many narcologists complained about the passivity of patients who wanted quick fixes and silver bullet treatments for their addiction (complaints often infused with an analogy of patients as wards of the welfare state), opponents of aversive methods argued that physicians fostered such passivity for their own monetary gain.

Such characterizations of khimzashchita and kodirovanie as techniques by which money-hungry and amoral physicians scare unwitting patients out of drinking, as throwbacks to Soviet relations of authority or as modes of biopolitical social control (Chepurnaya and Etkind 2006), fail to capture the complexity of clinical logics, institutional concatenations, and domestic modes of governance that have allowed these modes of treatment to become as ubiquitous as they are in contemporary Russia. Of course, rapacious physicians with pecuniary motives are certainly part of the story, and individual motivations aside, the therapies described in this chapter have depended on, and helped to reinforce, clinical encounters premised on a steeply hierarchical physician-patient relationship. Yet focusing exclusively on such interpretations obscures a number of issues that are central to understanding the continued prevalence of khimzashchita and kodirovanie and their roles in the lives of countless drinkers and their families.

Chief among these is the relationship of these therapeutic technologies to the subjectivity or the self of patients. North Americans are accustomed to the idea that treatments for alcoholism and drug addiction either demand that patients conceive of themselves as persons of a certain sort or teach them to do so. It is not simply that 12-step programs like Alcoholics Anonymous—which are certainly the most culturally visible forms of long-term treatment for alcoholism in North America—require people to publicly self-identify as “alcoholics” and “addicts” and to narrate their life stories appropriately (Cain 1991; Wilcox 1998). Rather, as Laurence Kirmayer has argued, various systems of psychotherapy depend “on implicit models of the self, which in turn, are based on cultural concepts of the person” (2007, 232). Such models of the self are implicit in certain capacities that most psychotherapies demand of patients. Sometimes grouped under the rubric of “psychological mindedness,” these include a capacity to articulate one’s life story according to particular narrative conventions; an awareness of oneself as possessing an unconscious—the
linguistic corollary of which Summerson Carr has called an “ideology of inner reference” (2006); a capacity for self-reflection; an ability to recognize and identify one’s emotional responses to experiences; and a desire “to accept and handle increased responsibility for the self” (Kirmayer 2007, 236). Even psychopharmaceuticals—which are often described as undercutting this psychological model of the self—are often conceived of by their North American consumers as technologies through which the “true self” is rendered accessible or transformed (Elliott 2004; Saris 2008, 266n4).

As I learned in my conversations with Vyacheslav and other patients at the addiction hospital, khimzashchita and kodirovanie are different in this regard, not because they ask patients to conceptualize a different sort of self but because they scarcely seem concerned at all with the self or its transformation. Vyacheslav did not identify himself as an alcoholic. And though his physician described him as suffering from a biologically based disorder, recognizable through somatic symptoms, neither did Vyacheslav speak of himself as suffering from a brain-based disorder. In large part, this is because the methods of behavioral modification that make up narcology’s clinical armamentarium do not encourage patients to identify in this way. Rather than transforming patients’ subjectivities, these methods work by harnessing their preexisting ideas, beliefs, and affects—with an end result that is experienced as a change in behavior or practice without a change or transformation of the self.

In order to understand how this may be, it is necessary to take another historical excursus. In describing the project that he calls—drawing on Michel Foucault (1983)—“historical ontology,” Ian Hacking writes of being motivated by an “obscure conjecture that when it comes to philosophy, many of our perplexities arise from the ways in which a space of possible ideas has been formed” (2002, 26). The genealogical solution with which Hacking, along with many others (e.g., Young 1995), addresses these problems is useful not only to philosophy in the disciplinary sense but also to the perplexities of everyday forms of life posed by fieldwork. In this case, understanding khimzashchita and kodirovanie as they are practiced today requires that we trace their origins to Soviet psychiatry’s clinical style of reasoning, discussed in chapter 2. Here I return briefly to that history to examine how the instantiation of Pavlovian theories in mid-twentieth-century Soviet scientific, medical, and penal institutions formed a space of possible ideas from which khimzashchita and kodirovanie emerged.
When asked to describe khimzashchita and kodirovanie in the simplest of terms, many narcologists in St. Petersburg explained that these were “psychotherapeutic” methods. At first I found this rather confusing because neither of these methods looked like what I understood psychotherapy to mean—that is, some long-term talk-based intervention during the course of which a patient gains insight into his or her condition. As many social critics and historians have pointed out, the prevalence of this general understanding of psychotherapy in North America attests to the deep influence that Freud’s psychoanalytic ideas continue to exert (Campbell 2007, 20–28; Illouz 2008). While the dominance of explicitly psychoanalytic ideas in psychiatry and popular culture alike is said to have been toppled in the 1970s and ’80s by biological psychiatry, many North American assumptions about psychological interventions and subjectivity continue to reflect a Freudian legacy.

It is in this regard—in having followed a Pavlovian, rather than a Freudian, path during the early to mid-twentieth century—that Soviet psychiatrists and narcologists diverged most noticeably from their North American (and to a somewhat lesser extent, their Western European) counterparts. Though the theory of psychoanalysis became anathema in the Soviet Union from the early 1930s onward, alternative theories of the unconscious as well as modes of psychotherapy continued to be developed, particularly during the post-Stalin period. Theoretical work on “the psyche” was revived with Alexander Luria’s neuropsychology and S. L. Rubinstein’s writings on consciousness (Graham 1987; Joravsky 1989; Miller 1998). This period also saw the appearance of increasingly sophisticated Soviet critiques of psychoanalysis (which, with the coming of the Cold War, became emblematic of American and Western European “bourgeois psychotherapy”), exposing discerning readers (those able to “read through” to the notions being critiqued) to the ideas of Freud, Jung, Adler, and even Erich Fromm and Jacques Lacan (Miller 1998). Other Soviet researchers and clinicians, such as Dmitri Uznadze (1886–1950) and Vladimir N. Miasishchev (1893–1973), a Leningrad psychiatrist and director of the Bekhterev Psychoneurological Research Institute, developed explicitly nonpsychoanalytic theories of the unconscious (ibid.).
In regard to clinical interventions, however, with a few notable exceptions—and a parallel tradition of “rational psychotherapy”—the majority of techniques framed as psychotherapy during the Soviet period employed mechanisms of hypnosis and suggestion (Wortis 1950, 88; Kirm
man 1966; Segal 1975; Lauterbach 1984; Etkind 1997b). While hypno-
sis had been widely used in psychiatry during the nineteenth century, it increasingly lost favor in psychoanalytic circles, as well as in the transna-
tional psychiatric community, during the twentieth. In tsarist Russia it was used with some frequency as a treatment for alcoholism (Herlihy 2002).
Yet throughout the early Soviet period, researchers continued to use tech-
niques of suggestion, emphasizing their basis in the physiological reflex theories developed by Pavlov and Vladimir Bekhterev.

Hypnosis and suggestion were central to the research of Bekhterev, an eclectic psychiatrist who studied with Jean-Marie Charcot and developed a theory of “associative reflexes” in many ways parallel to Pavlov’s (Kozulin 1984; Valsiner 2001). Bekhterev ([1897] 1998) viewed suggestion as a fund-
damental way in which human beings communicated and influenced one another, and he drew on crowd theory and notions of “moral contagion” in developing a social theory with suggestion at its core. Often described in the Soviet literature as the “founder of Russian psychotherapy” (Pla-
tonov 1959, 11), Bekhterev grounded his interest in psychotherapy firmly in a physiological theory of reflexes. His influence on the development of Soviet psychotherapy is often described by reference to a group of therapies known as “the Bekhterev triad”: explanation, hypnosis, and autosugges-
tion (Babayan 1985). Notably, Bekhterev was also deeply involved in con-
temporary social debates around alcohol and drunkenness and frequently used hypnosis to treat alcoholism.

Ironically, the ideas of Bekhterev, who was significantly more engaged in progressive politics than Pavlov and welcomed the Bolsheviks’ assump-
tion of power in 1917, fell out of official favor during the late 1920s (Joravsky 1989). And though his legacy was partly restored during the post-Stalin period, when it proved particularly important for the “Len-
ingrad school” of Soviet psychiatry, it was the dominance of Pavlov’s theories that accorded legitimacy to practices of hypnotic suggestion and, less directly, placebo therapy, by reframing them in entirely physiological terms (Chertok 1981, 11). In elaborating his theory of higher nervous activ-
ity, Pavlov relied on the notions of excitation, inhibition, and equilibrium
to describe basic processes taking place in the nervous system, which he correlated with experimental evidence produced through conditioning. For Pavlov, inhibition encompassed all processes that weakened conditioned reflexes, and was dividable into the categories of “external inhibition,” “internal inhibition,” and the inhibition associated with sleep (Smith 1992, 200–201). Pavlov described hypnosis as a transitory state that resulted when the inhibitory process that led to sleep occurred to a less extensive degree (Platonov 1959; Pavlov 1994, 84). Further, he argued that “suggestion in hypnosis can be rightly interpreted as such a phase of inhibition when weak conditioned stimuli (words) produce a greater effect than the evidently stronger and real external stimuli” (Pavlov 1994, 85). In other words, Pavlov conceptualized hypnosis as a state of consciousness that facilitates suggestibility.

This account helped to render hypnosis scientifically legitimate by placing it firmly in the realm of the material, allowing it to be incorporated into mainstream psychiatry (Slobodianik 1963; Hoskovec 1967; Babayan and Shashina 1985, 99). A Soviet textbook on psychiatry claimed that “[the strictly objective Pavlovian method of investigating higher nervous activity dispelled the fog of mystery and the subjective psychological conceptions that had for so long wrapped the problem of hypnosis in darkness]” (Babayan 1985, 99). Pavlov’s theories also led to the development of various clinical interventions that were generally categorized as psychotherapy.

Whether one interpreted such accounts as reductive or as dialectical, Pavlov’s theories helped to render hypnosis scientifically legitimate, allowing it to be incorporated into mainstream psychiatry (Babayan and Gonopolsky 1985; Babayan and Shashina 1985; Rozhnov and Burno 1987). In helping to legitimate hypnosis, the Pavlovian dominance in psychiatry led to the development of multiple suggestion-based interventions categorized as psychotherapy. Indeed, throughout much of the Soviet period, psychotherapy was synonymous either with rational psychotherapy or with methods based on suggestion (Wortis 1950, 88; Lauterbach 1984; Etkind 1997b). These methods included various types of individual and group hypnosis; “direct suggestion,” in which the patient remains in a waking state and is aware of the procedure; “indirect suggestion”; and techniques of autosuggestion and the “autogenous training” developed by German therapists (Lauterbach
1984, 81). As I describe below, such methods made up the majority of long-term interventions used to treat alcoholism in the Soviet Union.

**Engineering Aversion: Conditional-Reflex Treatment as Therapy and Punishment**

Eugene Zubkov, an émigré narcologist who has become active in the 12-step movement in Russia, spent one of our first meetings detailing the various ills of Russian narcology. His critique was based largely on first-hand experience: Zubkov had received his medical degree in the late 1970s, just as narcology was taking shape, and had spent much of the following decade working at the Bekhterev Psychoneurological Research Institute. Out of the various treatments that emerged from this discipline, he identified conditional-reflex therapy—sometimes referred to as “apomorphine treatment”—most closely with the Soviet period.

It was invented by a professor of the Serbskii Institute, Ivan Vassiliivich Strel’chuk, for which he received the Stalin Prize. I remember this very well: I used it. Apomorphine is a substance that, when injected, makes you vomit. They’d ask what kind of alcoholism a person has: vodka, beer or whatever. Then the person would drink this substance, the doctor would give him apomorphine and in forty-five seconds he would throw up. During the next session, he drinks a glass of cognac and they give him apomorphine and he vomits into a tub. Thirty or forty people would gather in a room and they all puked.

In itself, the idea of inducing a physical aversion to alcohol in patients was far from new. An early version of aversive therapy against alcoholism was employed by the pioneering American physician Benjamin Rush during the 1780s (White 1998, 4), and during the twentieth century, apomorphine therapy was used against alcohol and drug addiction by British physician John Dent, whom William Burroughs credited with breaking his addiction to heroin (Dent 1949; Burroughs 1957).

Soviet medical researchers, however, grounded their efforts in Pavlov’s theory of higher nervous activity. In Pavlovian terms the idea was to condition a reflex to the taste, smell, sight, or mention of alcohol based
on the unconditional or instinctual reflex to an unpleasant stimulus. After initial attempts using electrical shock, researchers settled in 1933 on the use of emetics like apomorphine to condition subjects so that they experienced a nausea reflex upon tasting or smelling alcohol (Sluchevsky and Friken 1933; Zhislin and Lukomskii 1963). This was a direct translation to humans in the clinic of the work conducted twenty years earlier in Pavlov’s laboratory, where researchers had used apomorphine to condition laboratory dogs to gag in response to a particular sound (Zhislin and Lukomskii 1963). The project of carrying over such clinical practices from animals to humans had been seen as a complex one by Pavlov and his collaborators, in part because it required one to assume a radically simplified model of human behavior (or at least some aspects of it). Reflex action of the sort demonstrated in Pavlov’s laboratory worked on the level of a body outside (or beneath) the sphere of conscious thought, willed action, and morality (Todes 2002).

In the political climate of the 1930s, however, the airing of such doubts about the applicability of Pavlov’s findings to human beings was difficult, and potentially dangerous. And whereas conditional-reflex therapy remained a fairly marginal phenomenon in most of Europe and North America,3 in the Soviet Union it became one of the primary techniques for the clinical treatment of alcoholism, and it remained prevalent until the late 1980s. In late Soviet narcology textbooks conditional-reflex therapy was given pride of place as a first-line therapy for use after detoxification, and it was instated as a recommended means of treatment in narcological clinics through the country (Babayan and Gonopolsky 1985).

In its most widely used form, credited to the psychiatrist Ivan V. Strel’chuk, the treatment was meant to create an aversion not only to alcohol as a substance but also to the broader context of drinking practices. A popular textbook encouraged physicians to replicate a typical setting for alcoholic sociality in the clinic:

A “drinking setting” is created, i.e., tables are laid with sandwiches, beverages are placed on the tables, and sometimes a bar with a counter is set up, its cupboards displaying bottles with alcoholic beverage labels. Sessions are held simultaneously with several patients. . . . A patient is given sandwiches to eat and two cups of warm tea to drink. An initially determined dose of apomorphine is injected subcutaneously while the patient is given a glass
with his “favorite beverage” to hold. The patient smells the drink, rinses his mouth, and about 5–20 minutes before the onset of vomiting drinks half of the beverage. After the injection the vomiting reaction usually lasts 2–30 minutes. Within this time the patient drinks up the remaining portion of the alcoholic beverage. (Babayan and Gonopolskii, 220)

Some opponents of the method argued that this led patients to develop an aversion that was much broader than initially intended. As Zubkov explained, “It worked, but what would happen: You go to a banquet and they pour cognac—what happens? You’re walking down the street and you run into the doctor who treated you with apomorphine. Immediately you vomit all over the doctor.” As a proponent of Alcoholics Anonymous, Zubkov of course had a particularly strong stake in undermining the legitimacy of conditional-reflex therapy. And yet his negative depiction of the technique notably hinges not on its lack of effectiveness but on its obviation of the patient’s conscious agency. In Zubkov’s somewhat sensationalized account, conditional-reflex therapy worked (perhaps too well) but failed in that it figured the patient as a bundle of reflexes.

Unsurprisingly, the treatment was extremely unpopular with patients. During his brief periods of freedom Sasha had experienced a variety of treatments for alcoholism, including conditional-reflex therapy:

In 1980, I was in a psychiatric hospital, and they started to treat me with so-called apomorphine. They gave me three injections in the shoulder, gave me some vodka to smell and gave a small bit to drink, which caused spasms of nausea. But after three or four courses, the doctors stopped this because my organism couldn’t go through it. I was turning green, and I was feeling nauseous, not so much because of the vodka they had me smell or drink, but because the poison itself [apomorphine] had a horrible effect on me. So they said it was contraindicated for me.

Because the effectiveness of the therapy was thought to depend on the extreme unpleasantness of the experience, conditional-reflex therapy fit particularly well into the institutions of Soviet narcology that functioned under a logic of coercion. Thus while it was recommended in the general narcology service, the use of conditional-reflex therapy was mandated in punitive institutions such as the therapeutic-labor prophylactories. Tamara Metelkina, a narcologist who currently runs a small noncommercial
addiction rehabilitation center outside St. Petersburg, worked during the mid-1980s in a spetskombinatura—a clinic attached to a factory to which recidivists were committed. At the time, the use of conditional-reflex therapy was also mandated in such institutions.

Even by the textbooks of the time, it was clear to me that the patient must be motivated to be treated by this method—a situation you obviously didn’t have in the spetskombinatura. . . . Often it was not alcoholism that these people had but “lifestyle drunkenness” [bytovoe p’ianstvo]. There were psychopaths and sociopaths, and it was very difficult to get into contact with these people. They saw me as a police figure. Nevertheless, I started to do some psychotherapy and some group therapy. . . . Then as soon as we started to do the conditional-reflex therapy all of the contacts were broken. People would rather go to prison than go through these procedures.\textsuperscript{5}

Metelkina argued that the treatment was both deeply unethical—“I felt that it went against the Hippocratic oath of ‘do no harm,’”—and, even by its own criteria, ineffective: “The patients never developed the reflex.” Yet her chief concern was that while conditional-reflex therapy was assumed by its proponents to work on an amoral and precognitive animal body—as she put it, “This only made sense on the level of a dog or a rat”—in fact, any potential effectiveness depended on patients’ motivation. This blindness of the therapy, and of the institution surrounding it, to the psyche of the patient was particularly demoralizing for Metelkina, who had originally trained as a physician with the intention of practicing psychotherapy, which she envisioned as requiring adequate intersubjective contact with patients. Conditional-reflex therapy shattered the fragile ties she had begun to cultivate with her psychopaths and sociopaths and eviscerated of any significant meaning the distinctions between therapy and punishment and between physician and police figure.

The appeal of conditional-reflex therapy for officials who were police figures, by formal position and by disposition, is not difficult to imagine. Less obvious are the sources of the technique’s popularity with public health officials and many physicians. For one thing, during a period when political elites sought to portray the autonomy and difference of Soviet science from “bourgeois science,” conditional-reflex therapy could be claimed as largely, if not wholly, a domestic development. Not only
was the therapy based on Pavlov’s theory of reflexes, but in an official culture highly focused on the applicability of science, it served as a clear demonstration that this theory could bear practical applications (Zhislin and Lukomskii 1963). Moreover, conditional-reflex therapy was consistent with the dominant medical conceptions of behavior. Since the theory of reflexes functioned as the officially condoned paradigm for understanding the mechanism through which behavior was learned, clinical techniques that sought to condition new reflexes appeared to be promising means for controlling unwanted habits. More specifically, conditional-reflex therapy seemed to restore and generalize the primary diagnostic sign of alcoholism: the loss of the vomiting reflex.

The technique was also easily adaptable to use with large groups of patients, presumably making it attractive both to ideologists and to planners interested in economies of scale. Not only did this method make the technology amenable to use in large hospitals and penal institutions by allowing several physicians to simultaneously treat dozens of patients, but the groups were thought to bolster the conditioning effect of the procedure. Grigorii Mikhailovich, the medical director of the addiction hospital, explained, “There were apomorphine sessions—there were these special rooms, give everyone a swab to smell, inject everyone, and everyone puked, all in a choir—a communist choir.” This narcologist’s depiction was only half joking: forms of group therapy were often described as congruent with Soviet values of collectivism (Babayan 1985, 98).

By the time of my fieldwork, conditional-reflex therapy was no longer in use in St. Petersburg. Along with labor colonies for alcoholics and laws allowing for compulsory treatment, it had been swept away during the brief period of the early 1990s when an enthusiasm for liberalism and human rights reigned in Russia. However, it persisted as an institutional memory, frequently evoked by narcologists in conversations about the relative failings and merits of their profession during the Soviet period. Often, drawing a distinction between the therapy and the conditions under which it had been practiced was a way of retrospectively distinguishing narcology from punishment and policing, an attempt to salvage an ethical stance for medicine. Thus while some narcologists claimed that conditional-reflex therapy was entirely ineffective or that it worked “too well,” Grigorii Mikhailovich felt that it had simply been practiced under the wrong clinical conditions:
And this conditional-reflex therapy did not hold for long. At first the treatment worked very well. Very well. But then when people got some experience. . . . The alcoholics—many of them were forced into this method of treatment. In other words, without his agreement and conviction—but just in those times of the LTP. . . . You should have convinced people of this—that this method would help them. But when it was forced, he didn’t have conviction and after that they would destroy this reflex. So a good method was discredited, because there wasn’t a normal selection [of patients].

For Grigorii Mikhailovich, conditional-reflex therapy had become discredited because of improper patient selection: instead of being performed on motivated patients who had consented to the treatment, the method had been used on those committed to compulsory hospitalization and treatment. Moreover, his concern over the discrediting of conditional-reflex therapy reflects a broader set of issues that Russian narcologists grapple with. For him, and for many other narcologists, a therapy’s effectiveness is wrapped up not only with medical criteria of pathology and wellness or even with issues of consent but with the clinical settings within which it circulates and the legal categories that facilitate their existence. Such concerns reveal not only the importance of the legitimacy of therapies to patients and physicians alike but the degree to which this legitimacy often depends on the institutional contexts and political meanings with which those therapies are associated.

Somatic Suggestions

As I have mentioned, when I brought up khimzashchita—the umbrella term for disulfiram-based interventions—in my conversations with narcologists, some initially represented it as a pharmacological treatment, while others depicted it as psychotherapy. Irina Valentinovna, a narcologist in the acute ward of the addiction hospital explained it this way:

Khimzashchita is a psychotherapeutic method. In principle, we give a regular [medication]—you can also give a placebo—this depends on the personality of the patient—and either we use a placebo or the chemical. . . . I give you this medication. I give you a prohibition [zapret] through personal psychotherapy [lichnostnaia psikhoterapiia]: for a certain period of time you
don’t have the right to consume alcohol [spirtmoe]. If he waits through the period, then we do another one. His self-image rises.

While it was clear that khimzashchita was meant to help facilitate what narcologists called periods of “remission” (sobriety) for patients, it seemed from Irina Valentinovna’s description that the chemical content of the medication (disulfiram or placebo) mattered less than the meanings enacted by the narcologist and her clinical tools. I found myself both troubled by the deception seemingly entailed by this blithe equation of placebo with disulfiram and fascinated by the questions it raised. Was khimzashchita a somatic or a psychological treatment?

As depicted to patients and the public, khimzashchita relies on the effects of disulfiram, a chemical often referred to in Russia as teturam or Esperal’, and elsewhere as Antabuse. Disulfiram prevents the body from fully processing alcohol. By blocking the action of aldehyde dehydrogenase, a key enzyme in the metabolic pathway of ethanol, the drug causes a buildup of the toxic by-product acetaldehyde, with extremely unpleasant consequences for patients. Rather than the pleasurable effects of alcohol intoxication, people with active disulfiram in their bodies experience flushing, nausea, and high blood pressure soon after drinking—referred to in the medical literature as a disulfiram-ethanol reaction (DER) (Kenna, McGearry, and Swift 2004; Mann 2004).

The aversive physiological effects of disulfiram, which was originally used in the manufacture of synthetic rubber, had been common knowledge to those in the industry but were first noted by medical researchers in the mid-1930s (Williams 1937). A decade later two Danish researchers accidentally rediscovered these effects and subsequently developed the chemical as a treatment for alcoholism (Hald and Jacobsen 1948; Martensen-Larsen 1948; White 1998, 226–27). Over the subsequent seventy years disulfiram has played divergent roles in the public health and medical systems of various countries, reflecting differences in local psychiatric models of alcohol dependence and institutional and political economic conditions as well as notions about individual willpower and personal responsibility (Chick and Brewer 1999). For example, while it continues to serve as the cornerstone of alcoholism treatment in Denmark, the prevalence of its use in North America has long since waned (White 1998; Steffen 2005).
Though disulfiram is often portrayed as the first pharmacological treatment for alcoholism, the mechanism underlying its effects has been described and classified in several significantly different ways, and these accounts are linked to specific clinical uses of the drug. Researchers framing disulfiram as a pharmacological rather than a behavioral treatment—particularly its early proponents—often described it as a “sensitizing” drug (e.g., Hald and Jacobsen 1948; Martensen-Larsen 1948; Ivanets 2001). Conversely, contemporary researchers argue that unlike more recently developed pharmacological treatments for alcoholism, such as naltrexone and acamprosate, the efficacy of which is based on a neurochemical dampening of patients’ craving, the effects of disulfiram are psychologically mediated (Kenna, McGeary, and Swift 2004). Some researchers argue that disulfiram is meant to “create an aversion to alcohol, rather than modulate its neurochemical effects” (Mann 2004, 489), while others emphasize that it has immediate effects on behavior “by replacing delayed with immediate negative consequences” (Heather 1989, 471). In either case, we can conclude that it is a patient’s anticipation or memory—whether conscious, unconscious, or bodily—of an unpleasant or frightening experience that is meant to change his behavior. As the authors of one English-language review argue, “When taken in an adequate dose, disulfiram usually deters the drinking of alcohol by the threat or experience of an unpleasant reaction” (Brewer, Meyers, and Johnsen 2000, 329, emphasis added).

As a pharmacological therapy that seems to work primarily by non-pharmacological means, disulfiram occupies an uneasy position in the biomedical literature and clinical practice. With a few exceptions, most researchers writing in the English-language literature refer to disulfiram as having “nonspecific or placebo effects” with some trepidation, or as evidence for its overall ineffectiveness. In part, this has to do with the deeply ambivalent attitude that most of biomedicine has taken toward treatment outcomes that are not attributable to a specific material cause, as well as to the subjective dimensions of human experience (Harrington 2006, 2008; Kirmayer 2006).  

As I have argued, however, the Russian/Soviet genealogy of ideas about suggestion and healing is radically different from its counterpart in the English-speaking world, and this had important consequences for the reception of disulfiram in the Soviet Union. The Danish developers of disulfiram therapy had initially employed it as a form of aversion therapy,
and this style of treatment fell on particularly fertile ground in the Soviet Union (Hald and Jacobsen 1948; Martensen-Larsen 1948). When Soviet medical researchers first began to experiment with disulfiram during the late 1940s, their model for thinking about treatment for chronic alcoholism was conditional-reflex therapy. Indeed, many of the earliest publications about disulfiram in the Soviet medical literature were authored by the aforementioned Ivan Vasil’evich Strel’chuk (Strel’chuk 1951, 1952; Miroshnichenko, Pelipas, and Ivanets 2001, 139). Not only were patients told of the potential negative effects of drinking alcohol while on the drug, but these effects were demonstrated to them in physician-administered tests (Strel’chuk 1952; Babayan and Gonopolsky 1985). Writing at the height of the Pavlovian orthodoxy in Soviet psychiatry, Strel’chuk added that the drug induced in patients a “negative conditioned reflex to alcohol,” and this reflex was observed even in “patients who had not taken Antabuse in nearly a year” (Strel’chuk 1952, 49). In other words, Pavlovian psychiatry’s style of reasoning allowed researchers to conceive of patients as having the intended physiological reaction to disulfiram in the absence of the drug itself.

This awareness of physical effects without chemical intervention gave Soviet medical researchers and clinicians a means of managing one of disulfiram’s major shortcomings as a therapy—namely, the problem of compliance. Although many studies have shown disulfiram therapy to be a potentially effective means of increasing the lengths of patients’ remissions, adherence represents the major obstacle to efficacy (Fuller and Gordis 2004; Suh et al. 2006). Once ingested, the medication remains at chemically active levels for only several days, which means that patients must take the drug regularly in order for the threat of an adverse reaction to alcohol to remain (Eneanya et al. 1981; Brewer, Meyers, and Johnsen 2000, 331). While this may not represent a problem for highly motivated patients, for many others the challenge of adhering to this treatment is as great as that of abstaining from alcohol itself (Valverde 1998, 99; Steffen 2005, 180). In general, disulfiram therapy is most effective when a relative or clinician is able to monitor or supervise the patient’s consumption of the medication (Brewer, Meyers, and Johnsen 2000; Fuller and Gordis 2004). 9

However, in the absence of a need for the chemical itself, the issue of compliance became potentially more manageable. Strel’chuk’s negative conditioned reflex to alcohol would persist regardless of one’s daily
motivation because it was conceptualized as operating on a bodily level. It is perhaps not altogether surprising that by the late 1960s, Soviet researchers were reporting clinical experiments with the use of placebo therapy, literally the replacement of the drug with a saline solution or vitamins (Ialovoi 1968). This was originally intended for patients for whom the drug was contraindicated, but the use of such placebo-therapy became increasingly widespread over the following decades (Fleming, Meyroyan, and Klimova 1994).

In a different attempt to manage this problem of treatment adherence, the method of implanting capsules of disulfiram subcutaneously was developed in France during the 1950s (Kline and Kingstone 1977; White 1998, 228). Here agency for adherence was shifted from either the patient or his caretaker and structured into the implant, which was meant to gradually release the chemical into the bloodstream. Significantly, clinical studies have shown that no disulfiram or ALDH inhibition is detectable in patients soon after the insertion of commercially available implants (Johnsen and Morland 1992; Brewer, Meyers, and Johnsen 2000). In other words, after the first week following the implantation of the disulfiram capsule, patients are highly unlikely to suffer from a DER. At the same time, since the early 1970s, researchers studying disulfiram implants have noted their effectiveness relative to unsupervised oral disulfiram, and most have agreed that such effects were due to a “psychological rather than a pharmacological deterrent” (Malcolm, Madden, and Williams 1974, 488; Kline and Kingstone 1977).

In the Soviet Union subdermal implants of the French Esperal’ quickly became the most popular application of disulfiram: patients would have a capsule implanted behind their shoulder blades and warned of possible adverse effects from taking alcohol for a period from one to five years (Fleming, Meyroyan, and Klimova 1994). While other placebo therapies were also used, such as the tablet and the torpedo (these were represented to patients as oral and intravenous forms of long-acting disulfiram, respectively), implantation was by far the most popular (Chepurnaya and Etkind 2006). Among patients and relatives the therapy was referred to colloquially as an “implant” (podshivka), and patients would commonly say, “I was implanted” (menia podshili). Such treatment remained extremely common among patients I spoke to in 2004, and some returned regularly for repeat implantations.
In short, whereas clinical phenomena described as suggestion, placebo, or nonspecific effects have long posed an epistemological challenge for a somatically grounded biomedicine, many of the narcologists I spoke to in St. Petersburg emphasized precisely these aspects of disulfiram treatment. Narcologists such as Irina Valentinovna explicitly described khimzashchita as placebo therapy or as a treatment that depends on mechanisms of suggestion (*vnushenie*). As one physician working in a commercial addiction clinic put it, “In addition to the purely chemical effect [of disulfiram], there is an effect of suggestion *Effekt vnusheniiia*.”

However, clinical interpretations of disulfiram treatment had also shifted subtly throughout the Soviet period. Although the treatment had first been conceptualized in the Soviet Union as an aversive treatment like conditional-reflex therapy, its transformation into khimzashchita involved several key shifts. Whereas conditional-reflex therapy hinged on patients’ bodily memories of past experiences, khimzashchita worked on their anticipation of potential future consequences. Moreover, while the former depended on a behavioral response to stimuli administered within the walls of the clinic, the latter transposed the source of this stimulus into patients’ own bodies, in the form of implantations or injections. Underlying these was an even more fundamental conceptual shift: whereas conditional reflex therapy depicted the patient as a body responsive to inherently meaningless stimuli, khimzashchita assumed a subject replete with expectations, emotions, and beliefs. This way of thinking about khimzashchita foregrounded its similarities to the popular mode of treatment called kodirovanie—a treatment that had emerged from the same clinical styles of reasoning.

**Kodirovanie: Dovzhenko’s Gift**

The direct antecedent to kodirovanie was emotional-stress psychotherapy, developed by the psychiatrist and medical administrator Vladimir Evgen’ievich Rozhnov during the 1970s. Rozhnov wrote widely on psychotherapy and hypnosis. In two books aimed at an educated lay audience (*Prophets and Miracle-Workers: Studies of Mysticism and Hypnosis: From Ancient Time to Our Day*), he traced the familiar narrative of hypnosis and faith healing from Mesmer through Charcot but placed his own work on
hypnotic suggestion in the line of objective research following the thinking of Pavlov and Bekhterev (Rozhnov 1977; Rozhnov and Rozhnova 1987). In his writings on psychotherapy for clinicians, Rozhnov argued that partly as a result of the research on trauma that emerged from the Great Patriotic War (World War II), physiologists had come to understand that “stress is not only negative, but may be positive as well” (Babayan 1985, 111). In emotional-stress psychotherapy, “the physician, displaying a beneficial worry in his interactions with the patient, sets off in the latter a healing emotional reaction, at the basis of which lies stress as an exertion of the organism’s adaptive strengths” (Rozhnov and Burno 1987). In practice, this “stress response,” which Rozhnov was careful to distinguish from “fear,” was induced in a number of ways, ranging from alternating hot and cold baths to treatment with emetics (along the lines of conditional-reflex therapy) to the words of the therapist (Rozhnov 1989). Much of Rozhnov’s clinical research focused on applying this theoretical framework to the treatment of alcoholics (Rozhnov 1987).

The method that came to be known specifically as kodirovanie, however, was not Rozhnov’s but a technique developed during the 1970s by Alexander Romanovich Dovzhenko (1918–95), a physician working in Feodosia, a town on the Crimean peninsula (Miroshnichenko, Pelipas, and Ivanets 2001). Dovzhenko described his technique as an “express” method of emotional-stress psychotherapy, which he claimed yielded positive results after a single session. The method was similar to khimzashchita in its structure and underlying assumptions about the person. Writing in the main Soviet psychiatric journal during the late 1980s, Dovzhenko and his colleagues stated, “It is suggested to patients [bolnym vnushaetsia] that the efforts of doctor, with the help of a set of “hypnotic” and physiogenic actions on their brains, will create a stable center of excited nerve cells, which from the moment of “coding” will block their craving for alcohol for a given length of time—1 year, 5, 10, 25 years or longer” (Dovzhenko et al. 1988, 94). Typically, patients were subsequently warned of the dire or deadly consequences of drinking before the end of the code and encouraged to come in for “decoding” if they decided to drink (Fleming, Meyroyan, and Klimova 1994).

Dovzhenko created a local following for himself in Feodosia during the 1970s and early ’80s, with patients traveling there for treatment from throughout the Soviet Union. His method soon gained official sanction by
the Soviet Ministry of Health, and it gained increasing popularity in the mid-1980s, particularly in the wake of the anti-alcohol campaign, when Dovzhenko claimed in print to have obtained over 68 percent efficacy (number of patients in remission one year after the therapy) (Dovzhenko et al. 1988). These claims did not go unchallenged. In medical journals Dovzhenko’s method was dismissed as quick-fix quackery by proponents of Rozhnov’s emotional-stress psychotherapy, while others came to the defense of the treatment (Voskresenskii 1990; Entin 1991; Lipgart, Goloburda, and Ivanov 1991). Despite these controversies, the use of Dovzhenko’s method became increasingly common; during the early 1990s, nearly 10 percent of patients on narcological registers in Russia were counted as receiving a treatment of this kind—a figure that was almost certainly an underestimate (Entin et al. 1997). Dovzhenko also received ample official recognition: he was named a People’s Doctor of the USSR, and after his death in 1995 a monument to his memory was erected in Feodosia. Since then a number of Dovzhenko’s students (several of whom are also his family members) have plied their trade throughout the former Soviet Union, all making adjustments to the method while claiming authority through their association with the late master (Dovzhenko 1994; Grigoriev 2002).

A central reason for the success of Dovzhenko’s method was its amenability to commodification at a particular moment in late Soviet history. Portraits of Dovzhenko often depict him in a clinician’s white coat, embroidered with his initials, D.A.R., which, when read as a word—dar—means “gift” in Russian. As we shall see, this notion of the therapy as a gift from clinician to patient was central to the meanings ascribed to kodirovanie and particularly to the way that the clinician’s will or agency was depicted as acting on or over that of the patient. However, the notion of kodirovanie as gift also has a highly ironic undertone, as the method was first popularized during the period of perestroika when cooperatives became the first officially sanctioned profit-generating entities in the Soviet Union since the New Economic Policy of the early 1920s. With its promise of a rapid and simple treatment for alcoholism, as well as one that could be applied to auditoriums of patients, Dovzhenko’s method was quickly seized upon by pioneers of for-profit medicine and soon became closely associated with commercial narcology.

Narcologists have suggested that the early commercial success of kodirovanie was facilitated by the general fascination with mass hypnosis that
flourished during the final years of the Soviet Union (Sofronov 2003). The most memorable representative of this period was the mass hypnotist Anatolii Kashpirovsky (also trained as a medical doctor), who conducted his séances in packed auditoriums (Lindquist 2005, 36). While some cultural critics and observers have interpreted this phenomenon as a case of elite-engineered distraction for the masses, others have regarded it more broadly as symptom of “an unstable time of apocalyptic expectations” (Et-kind 1997a, 119).

Though a sudden interest in all things spiritual and esoteric is typically associated with the perestroika period, many scholars have shown that such practices had been slowly percolating for years under late socialism. Not only was interest in Russian folk culture and Orthodoxy slowly growing during the 1970s (often framed in terms of legitimate social movements, connected to ecological conservation and historical preservation), but interest in yoga and Eastern philosophies was also developing (in the former case, at least partly facilitated by the Soviet Union’s strategic relationship with India). During the late 1970s several Soviet authors began to publish texts on such topics—an interest fed by officially sanctioned work on hypnosis, suggestion, and “autotraining” (Lauterbach 1984; Honey 2006; Lindquist 2005, 30–33).

In either case, even as such phenomena lost their luster of newness during the 1990s, they became increasingly institutionalized and rooted (forming into more coherent movements), and they had particularly profound effects on narcology as a social and discursive field. At the same time as the institutional basis emerged for the establishment of social movements based on these spiritual and religious worldviews, it became possible to commodify these practices—in the form of various healing services. Suddenly official narcology found itself competing with a variety of different practitioners. The anxiety that this combination of nonbiomedical healing and commercial medicine aroused in many narcologists is evident in this (entirely typical) excerpt from a professional article:

A strong competitor to the state narcological service has appeared: in the guise of physicians in private practice, folk healers [narodnykh iselitelet], sorcerers [koldunov], shamans, psychics [eksrasensov] and other enterprising agents, offering sufferers such services and guarantees that a serious doctor couldn’t dream of: 100% curing [izlechenie] after one séance, “guaranteed by
a patent of the Russian Federation”; treatment without the knowledge or consent of the patient (which, by the way, is a breach of article 32 of “Legislation of the Russian Federation on the protection of citizens’ health”); the fantastic “narkodel,”12 and much much more. (Egorov 1996, 68)

Though more established Russian institutions such as the Orthodox Church have also begun to offer addiction counseling and rehabilitation, they have been much slower in doing so than the myriad of small spiritual groups and practitioners representing relatively new faiths and ideologies. It is important to note that throughout the 1990s a somewhat hysterical discourse surrounding the burgeoning number of “cults” and “totalitarian sects” was prevalent in Russia, driven both by a concern over the unscrupulous practices of certain religious groups and by the Orthodox Church’s strong antisectarian campaign (Egortsev 1997; Borenstein 1999). The Church of Scientology, with its explicit antipsychiatric ideology and special drug addiction rehabilitation program, was a particularly strong source of anxiety for narcologists and public health officials alike.

Jean and John Comaroff (1999) have described a seemingly global upwelling of witchcraft epidemics, pyramid schemes, spirit possession, and moral panics as symptoms of what they called “occult economies”—inchoate articulations of discontent in postcolonial and postsocialist societies with the mysteriousness and immateriality of global capitalism by those who find the wealth produced in this process unattainable. Whereas these phenomena echoed earlier practices documented by ethnographers—through which people domesticated or resisted novel and threatening political economic forms, such as wage labor and money (Taussig 1980; Ong 1988; Parry and Bloch 1989)—occult economies emerged in “societies in which an optimistic faith in free enterprise encounters, for the first time, the realities of neoliberal economics” (Comaroff and Comaroff 1999, 294). Arguably, what unites these phenomena is not so much their supernatural or occult character as their evocation of a social world manipulated by invisible agents. It is in this sense that Katherine Verdery compared talk about mafia in postsocialist Europe (as distinct from the practices of using force to accumulate capital) to talk about witchcraft, as “a way of attributing difficult social problems to malevolent and unseen forces” (1996, 220).

Such discourses can be interpreted not only in this diagnostic mode but also, insofar as they articulate ideas about agency, authority, and social
change, in terms of the way they shape the meaning of therapeutic methods and thus bear very concretely on the clinical setting. In this sense, debates about the ethical—and indeed political—significance of therapies become an important aspect of a broader therapeutic economy. Indeed, politically tinged ascriptions of agency have figured centrally in debates about the correct or incorrect uses of kodirovanie, as well as the ways in which different practitioners have transformed the technique. In short, while the flourishing of late and post-Soviet practices of mass hypnosis and interest in the occult fueled the popularity of kodirovanie for a certain time, it also created a problem of legitimacy for its practitioners, as we shall see.

Performing and Materializing Therapy

Though most narcologists who practiced kodirovanie or khimzashchita did not think of themselves as engaged in the same line of work as someone like Kashpirovsky, they were especially attentive to the performative elements of the clinical encounter and how the meanings that patients ascribed to clinical objects and substances shaped the effectiveness of therapies. For example, both khimzashchita and kodirovanie procedures began with the narcologist’s describing the treatment to his patient. As Anton Denisovich made clear when he explained khimzashchita to me as he would have to a patient, delivering a compelling depiction of the treatment’s physiological effects was particularly important. Of course, as Anton Denisovich himself acknowledged, his description of the treatment was often untrue in a referential sense, as he often used placebos in place of disulfiram. Like other narcologists, he treated such descriptions as means of fostering in the patient a particular belief (that a chemical agent in his body has made the consumption of alcohol potentially deadly), an accompanying affective state (that of fear, stress, or concern), and a consequent behavioral change (abstinence). Perhaps most important, a central idea implicit in such treatments is that clinical effectiveness depends on patients’ belief in this “truth” about their bodies, a condition that the statements are meant to bolster.

Similarly, the forms that patients are subsequently asked to sign in order to acknowledge that they understand the procedure and its risks often function performatively, as props that aid the physician in delivering the intended effect as much as contracts meant to inform the patient and
verify his consent. Thus, regarding these “signed papers warning patients about the health- and life-threatening consequences that can occur in the event of alcohol consumption during the duration of a ‘code,’” the authors of an article defending narcological therapies explained that “one should not view these papers as fraud, easily unmasked by patients,” adding that they have a “psychotherapeutic” character (Entin et al. 1997, 73–74).

After these key preliminary steps, the clinical interaction at the core of the treatment takes place. Many clinicians emphasized the significance of ritually marking the beginning of the patient’s sobriety in a clearly defined manner. “To code a patient [zakodirovat’],” explained one narcologist, “is to bring him into a hypnotic trance and to build in [provesti] a certain stopping place [istantovochnyi moment].” Such a temporal demarcation is particularly important in the case of kodirovanie, and a protocol for carrying it out was included in Dovzhenko’s description of his method: “The doctor closes the patient’s eyes with his hand, and pushes the patient’s head back with his other hand. For 2–5 sec he presses on the supraorbital region until pain is produced, and then he sprays ethyl chloride into the patient’s mouth, producing various somatic symptoms” (Fleming, Meyroran, and Klimova 1994, 360; cf. Elovich 2008, 14–15).

Alexander Sergeevich, a narcologist at the addiction hospital, explained in strikingly clear terms how such a clinical performance is key to that stage of khimzashchita and kodirovanie alike:

> Everything hinges on one short action, either in kodirovanie or in our methods of placebo therapy: in other words a small ritual [malen’kii ritual’chik]. Either a touching of hands to the head, some kind of words, the use of some substance that gives a sensation: maybe a local anesthetic is poured into the throat. This ritual just signifies a point in time when the period of sobriety begins. This exists in all versions of psychotherapy.

It is worth noting that, like others at St. Petersburg’s addiction hospital, Alexander Sergeevich did not regard himself as an “alternative” practitioner but rather as a mainstream psychiatrist-narcologist. His account further highlights the degree to which the disciplinary assumptions of narcology attuned clinicians to view performance as part of their practice. Alexander Sergeevich emphasized the importance of ritual form over content (physical contact, words, and substance are interchangeable) in
producing a meaningful temporal demarcation of a new period of sobriety for patients. Under this logic, narcologists’ and patients’ preference for implantations and injections over daily self-administered tablets takes on an additional significance, since such methods of application allow for yearly or half-yearly markings of “sober time.”

Whereas kodirovanie relies on the charisma ascribed to the practitioner himself or herself, in the case of khimzashchita, the source of what Daniel Moerman (2002) has called the “meaning response” lies largely in the implant, injection, or tablet itself, or, more precisely, in the set of meanings given to the drug. Thus many of the patients with whom I discussed khimzashchita repeatedly spoke about the material aspects of the treatment: the size of the ampoules, the place on their bodies where Esperal’ was implanted, the mode of administration—patients ascribed particular meanings to all these characteristics, which in turn mediated their assumptions about the potential efficacy of the therapy. “They have ampoules, about this size and bigger ones,” Vyacheslav explained when I asked him to describe the treatment, indicating the size with his fingers. Torpedo injections were typically dyed a bright pink or blue to signify their chemical potency (Fleming, Meyroyan, and Klimova 1994, 360). The mode of administration was certainly important as well: the fact that patients and their families generally preferred implants to injections, which in turn they preferred to tablets, suggests that more physically invasive methods of administration may also have been associated with greater efficacy or potency. At the same time that they replaced disulfiram with vitamin C, saline, or other neutral substances, narcologists used various methods to reinforce patients’ interpretation of the treatment as chemically potent. A narcologist interviewed by Chepurnaya and Etkind (2006) explained that he sometimes carried out sham surgery on patients—making and sewing up an incision without implanting anything—and then prescribed chemically active disulfiram tablets, telling the patients they were taking an antibiotic.

Patients also recognized the objects and substances used in khimzashchita as commodities, and they often linked the drug’s potency and value to its geographical point of production. One such account came from Sasha, a patient in his late forties first described in chapter 1, who had spent the majority of his life imprisoned for acts (mainly burglary) committed while intoxicated. Sasha was a typical candidate for implanted disulfiram, the mode of treatment that was particularly popular for
those categorized as noncompliant by their relatives or physicians. Sasha recounted how, after a drinking binge landed him in the hospital during the early 1980s, his mother had suggested that he try an Esperal’ implantation. Obtaining imported pharmaceuticals (Esperal’ was manufactured in France) during the Soviet period typically meant circumventing formal channels to draw on extensive networks of contacts—a practice known as blat—and Sasha’s mother had ordered the implant through a physician friend (Ledeneva 1998). As was the case with many goods and services, the scarcity of such pharmaceuticals, the effort and access required to obtain them, as well as their place of origin, all added to their value—and in this case, their perceived potency.

By 2000 the availability of these substances had changed (typically the chief obstacle for patients was now a lack of money rather than a lack of access), but many patients and physicians continued to ascribe greater potency to implants imported from France or elsewhere than to their domestic equivalents. One patient recounted the choice he had heard a doctor offering an acquaintance: “[The narcologist] says: ‘I can give you our domestic [otechestvennaia] khimzashchita—it costs 1,900 rubles [about $65]. I can’t guarantee that it will work, if you drink that something will happen. Or I can put in the French one—that one costs [significantly more]. This is a 100 percent variant.’” In ascribing greater potency to imported disulfiram over the Russian-made variety, physicians and patients employed a common form of postsocialist consumer judgment that links material value to an object’s geographical place of production (Patico 2002). Moreover, they implicitly translated commodity value into a judgment of potential clinical value or efficacy. This logic was encouraged by narcologists who spoke about the value and price of khimzashchita as a clinical consideration. Its cost was often linked to the length of time for which the patient was prohibited from drinking, and some physicians described the cost of a therapy as an important element motivating patients to take their sobriety more seriously (Chepurnaya and Etkind 2006, par. 32).

Professional Nuances

Among the therapies offered at the addiction hospital, khimzashchita was a particularly delicate topic for many narcologists. While some spoke
about the use of placebo therapy without trepidation, in many cases bringing up the topic of placebos led to moments of doubt—during which physicians assessed whether I already knew about placebo therapy, or what I knew. These moments were repeated in many of my interviews. There were awkward pauses and pained glances. When the subject came up during one conversation with two narcologists who worked in the same ward, the younger of the two repeatedly tried to move the conversation on, explaining that the difference between chemically active disulfiram and placebo was a meaningless technical detail, telling me, “These are already professional nuances.” His older colleague, however, explained that the difference was significant and that it depended “on the psychological particularities of the patient.” Some patients, he went on, either were afraid of the treatment or for some other reason were not suited for it. “A better fit for them is emotional-stress psychotherapy, which is accompanied by the application of, essentially a placebo.”

Indeed, narcologists offered a number of explanations for how they chose to give patients neutral substances in place of disulfiram, suggesting a subtle moral and social calculus that underlay their reasoning about clinical effectiveness. Decisions to administer neutral substances were underpinned by judgments of particular patients and their capacity for adherence. A strong disulfiram reaction could indeed be deadly to some patients, and narcologists often sought to mitigate risks to their patients, as well as their own potential liability, by using placebo therapy. Although most verifiable accounts of patients dying from a DER seemed to be clear cases of negligence of the part of physicians, narcologists at the hospital framed noncompliant patients as the primary source of risk.

Judgments about patients’ potential for adherence in turn drew upon a categorization of patients based on their familial resources as well as an ascribed level of “social decline.” In a 2001 textbook, Russia’s head narcologist, Nikolai Ivanets, recommends the use of disulfiram only for the small contingent of patients who remain “socially conserved” (sotsial’no sokhranen), and argues against its use for the vast majority, which he characterizes as “the asocial type [asotsial’nyi tip] of alcoholic” (2001, 113–14). Narcologists I spoke to articulated a similar logic. For the physicians, this way of thinking rendered their perceptions of respectability and social status clinically relevant, as indexes of a patient’s potential adherence. Socially conserved patients included those who had not (yet) lost their jobs
or contact with their family members; they were viewed as having greater motivation for sobriety but also as possessing greater social and familial resources to facilitate adherence. “The real medications have so many side effects,” explained one narcologist. “We give it if there is a mother or a wife who strictly makes sure that the patient is taking the medication. Then we give it.” In other words, the use of chemical disulfiram in the clinic was often seen as dependent on a complementary (typically gendered) arrangement for its management in a domestic space.

**Therapeutic Legitimacy and the Management of Belief**

Whereas using disulfiram entailed certain risks for a particular category of patients, the efficacy of both placebo therapy and hypnosis or kodirovanie was also seen by narcologists as highly variable. Some argued that these methods were more effective among certain types of patients, typically identifiable by certain psychological characteristics. For narcologists, patients’ suggestibility could be conceptualized as either an individual disposition or a generational characteristic. Older patients, or “Soviet people,” were often described as being more suggestible than younger people, an ascription that draws on a common stereotype of the sovok or Homo Sovieticus as conformist and prone to manipulation by political propaganda.

At times, such patients were described in terms of their tendency or capacity for belief or faith (vera). Indeed, narcologists partook of a particular concept of belief that, as Byron Good has argued, is central to the empiricist paradigm underlying the “folk epistemology” of biomedicine (1994, 5). Implicitly dichotomizing belief and knowledge, most narcologists cast themselves as rational actors who “know” in contrast to patients who merely “believe.” The disciplinary assumptions and clinical techniques of narcologists may have fostered a particular attention to the relationship between this belief and the effectiveness of khimzashchita and kodirovanie.

Even further, some physicians characterized belief in particular therapies as a sort of nonrenewable resource requiring careful management. Alexander Sofronov (2003), a well-respected professor of psychiatry at St. Petersburg’s Military Medical Academy, argues that the popularity (among patients) of modes of treatment such as khimzashchita hinders the
advancement of methods accepted throughout the world, particularly the
12-step program and the therapeutic community model. Sofronov describes
clinical technologies of khimzashchita and kodirovanie as “explanatory
medicine” (обясненная медицина), in which the patient’s only source of
knowledge or information is assumed to be the physician: “The way we
explain it is how they’ll be treated” (4). When I asked him to elaborate
on this notion, he evoked a trope of a premodern medicine dependent on
belief, referring to a scene from Don Quixote in which two physicians argue
over the days of the week on which bloodletting is effective. As he saw it,
narcology’s focus on explanatory medicine derived from the secrecy that
had surrounded alcoholism during the Soviet period: “Because the stigma
of alcoholism was high, no one would brag about going to see a psychia-
trist or narcologist in the way they would about a famous heart specialist.
Within this climate patients had little choice but to believe in what the
physicians told them.”

Despite his misgivings, Sofronov regarded methods such as khimzash-
chita and kodirovanie in a highly pragmatic way. During a conversation
in his office, he posed a rhetorical question about the popularity of such
treatments: “Should we undermine this belief? Absolutely not!” While
Sofronov thought that explanatory medicine blocked the growth of more
effective modes of treatment, he also worried that the latter were not yet
adequately developed or available to patients in Russia. Not only was it
unethical to undermine patients’ faith in khimzashchita under such condi-
tions, but, as Sofronov implied, belief in the efficacy of treatments needed
to be carefully managed.

In other words, if the effectiveness of khimzashchita and kodirovanie
hinged partly on narcologists’ skills of persuasion and performance in
their face-to-face encounters with patients, it was equally dependent—as
the physicians saw it—on their successful management of the treatments’
broader representation to various publics as a pharmacological therapy,
and as an effective one at that. This work of building and maintaining
the treatment’s legitimacy took place not only during narcologists’ bedside
chats with their patients but also in conversations with family members,
in debates on the pages of medical journals and newspapers, and in argu-
ments or offhand remarks made to this ethnographer.

For example, when I asked Vyacheslav’s physician, Anton Deniso-
vich, whether he ever administered chemical disulfiram, he replied, “You
understand that we can’t give every single person the placebo, because we’ll discredit the method that way.” Not only did this answer suggest a widespread anxiety that khimzashchita might easily lose its effectiveness by becoming associated with placebo therapy among patients, but his statement was itself aimed at maintaining the legitimacy of the therapy. Whether chemical disulfiram was ever used or not, it seemed that it was important to tell me that it was, at least sometimes, lest I depict the entire therapy as a sham, as others had done.

In working to legitimate khimzashchita and kodirovanie, physicians used multiple strategies, ranging from quoting statistics of efficacy (typically percentages of patients achieving year-long sobriety) to constructing origin stories for treatment modalities that linked them to Russia and depicted them as culturally appropriate. For example, the argument was sometimes made that it was appropriate for physicians to employ their professional authority to frighten patients because this clinical relationship reflected a particularly Russian form of authority. Moreover, as narcology in 2003–4 was a thoroughly commercialized sphere of medicine, in which practitioners competed fiercely for patients, claims about the efficacy of one’s methods and medications were often interspersed with disparaging comments about one’s competitors as manipulators, cult leaders, quacks, or even mentally ill. “You know he’s a schizophrenic,” exclaimed one physician at the hospital when I told her of my visit to a psychiatrist who incorporated spiritual and occult imagery into his practice.

Moreover, as we have seen, narcologists saw the therapeutic legitimacy of their methods as closely tied to the historical and institutional associations of those methods. As numerous narcologists explained to me, a treatment modality could easily be “discredited” through improper use—as Grigorii Mikhailovich argued had been the case with conditional-reflex therapy. Of course there was a time-tested strategy for dealing with this problem: distinguishing oneself from one’s competitors as the bearer of the true method. This is what one psychiatrist in private practice did when he explained to me that his use of subliminal suggestion methods represented one of the few clinical uses of the real technology. The attempts of others he described, ironically enough, as “placebo therapy at best.” Such strategies were particularly evident in the use of kodirovanie, in part because of the method’s association with commercial mass hypnosis and unscrupulous practitioners.
The Healing Vow

On a Sunday morning during the summer of 2004 I attended a therapeutic session hosted by Grigorii Grigoriev, a self-styled “Orthodox psychotherapist” and his organization, the International Institute for Human Reserve Potential. More than fifty people sat waiting for the session to begin in the auditorium of a children’s music school rented for the afternoon by the institute. Most, though not all, of the potential patients were men in their forties and were, almost as a rule, accompanied by relatives: in front of me sat a mother and son, to my left a husband, wife, and little boy of about six. In St. Petersburg, Grigoriev is known as a student of Dovzhenko’s who has blended the scientism of the original method into a performance that draws heavily on Russian Orthodox language and symbolism.

Grigoriev’s session began with a preliminary lecture delivered by an assistant—Dr. Vladimir Bolt, a short and stocky physician wearing a white coat and name badge. In Dovzhenko’s original protocol for kodirovanie this phase was identified as group suggestion, during which patients were told about the basis of the therapy they were about to undergo. Bolt, who spoke with the pitch and cadence of an untrained public speaker, reflected some of the subtle shifts that had been made by Grigoriev in the original coding technique. In a move that both distanced him from increasing attacks on the legitimacy of kodirovanie and branded his technique as distinct, Grigoriev had dropped use of the term “coding” several years earlier; he called his therapy “the healing vow” (tselebnyi zarok). This therapy, Bolt assured his listeners (in a refrain that would be often repeated that afternoon), was different from khimzashchita: this was a form of psychotherapy. Nor was the method based on fear, he continued: “We don’t want to frighten you. The idea is not to scare you with the negative consequences of breaking the vow, although there have been negative consequences to people’s health, even death, and there will be, among people who break the vow.”

Having delivered this dubious assurance, Bolt launched into a speech that portrayed alcohol consumption and addiction as poisons to the Russian national body and signs of an overall post-Soviet “degradation.” Perhaps intending to distract the audience from the commercial nature of the meeting over which he was presiding, Bolt blamed the thousands of yearly deaths from alcohol poisoning on “the industry of lies” (industriia obmana)
that profited. Then there was a break during which patients paid for the treatment.

In her work on contemporary Russian magic, Galina Lindquist (2006) shows that practitioners often employ multiple strategies to legitimate their practice, simultaneously foregrounding their personal charisma, drawing on sources of official biomedical legitimacy (for instance, emphasizing their degrees as medical doctors), and emphasizing the roots of their authority in traditional Russian medicine or their association with “the occult.” On stage in front of the audience of potential patients, Grigoriev used all these strategies to great effect. Unlike the stilted and mumbling Dr. Bolt, Grigoriev immediately entered into a dialogue with his audience, speaking fluidly and seemingly off-the-cuff (although in fact he stuck quite closely to the published version of his lecture). The reaction of the audience was clear: they laughed at the appropriate moments, answered when asked questions, and listened intently throughout. Grigoriev’s presentation was literally divided into two parts: he gave one, which concerned the medical hazards of alcoholism, wearing a white coat; for the second lecture, in which he equated physiological craving with the “temptation of Satan,” he emerged in an all-black suit that, along with his long beard of the type worn by Orthodox priests, suggested a religious persona.

After the lectures, patients lined up outside several rooms for the individual portion of the coding therapy. Grigoriev allowed me to sit in the back of the room where he saw patients: “We have nothing to hide!” he exclaimed. To transform the atmosphere of the room, which was used during the week for music lessons and was largely taken up by two grand pianos, Grigoriev burned incense, which thickened the air with pungent smoke. Through the haze, I watched his black-clothed figure as he stood above a patient, murmuring a prayer, carrying out his amended version of the coding ritual.

Grigoriev had preserved the structure of Dovzhenko’s ritual but replaced the biomedical representations entirely with religious ones drawn from official Russian Orthodoxy. After a short consultation with each patient, he began by reading a prayer in Church Slavonic. He did this very rapidly, standing over the seated patient while pressing his or her temples with his fingers. When the prayer was finished, he intoned, “Now you are released from the craving for alcohol [drugs; gambling]. Now you have made an oath [zarok] not to drink for [a given length of time].” Many of the
men had vowed not to drink for the rest of their lives. Grigoriev concluded this ritual by making the sign of the cross over the patient’s face with a small pencil (“in the name of the Father, Son and Holy Ghost”) and touching their heads lightly with an anointing brush.

**A Clinical Cult of Personality**

Grigoriev’s adaptation of the technique was more than a hybridization of scientific and religious symbolism; it addressed commonly voiced and politically inflected concerns regarding how kodirovanie framed the agency of patients. In their original protocol for kodirovanie, Dovzhenko and his colleagues described one of the goals of the therapy as the “formation of a ‘cult of personality’ around the doctor-psychotherapist [and] the illustration of the unique capabilities of his will-power” (1988, 94). While he purposefully employed the term used by Khrushchev to denounce Stalin’s rule, Dovzhenko did not draw attention to its pejorative connotations. Rather, he suggested that this structure of authority, based on a particular form of charismatic authority, could be harnessed for therapeutic purposes. It was a matter not only of convincing the patient of the physician’s personal power but of structuring a clinical relationship that ascribed all agency over the illness to the therapist. “The semantic ground for this method is the formula suggested to the patient, which can be summed up as ‘not your (the patient’s), but my (psychotherapist’s) will frees you of this ailment [nedug]’” (95).

Some psychiatrists, such as Eugene Zubkov, dismissed the claims of kodirovanie as irrational: “What kind of code can they put in your head? It was all nonsense [Bred vsë eto bylo]. But for some reason everyone bought it.” Yet a more commonly heard criticism simultaneously concerned ethics and efficacy. For instance, in their trenchant critique of narcology a Russian and British team drew on Dovzhenko’s protocol to suggest that kodirovanie manipulated patients, leaving them with no sense of personal responsibility for their recovery. While the immediate concern of this argument was the lack of patient autonomy in the clinical encounter, Dovzhenko’s reference to the cult of personality (and its citation in such critiques) raised the political trope of hypnotist as dictator. In an article about late Soviet psychotherapy, the cultural historian Alexander Etkind (himself
trained as a psychologist at the Bekhterev Psychoneurological Research Institute) signals the deep genealogy of this trope in European thought, arguing that “hypnosis is obviously akin to the psychological mechanisms used to implement totalitarian power. It was not without reason that Freud compared a leader’s power over the mob to a hypnotist’s sway over his patient” (1997a, 118–19). In post-Soviet Russia such anxieties about agency and images of persons controlled from without often clustered around the figure of the cult leader (antisectarian literature reinforced this link in condemning totalitarian cults). Some patients and newspaper articles also referred to kodirovanie as a form of zombification (zombirovanie), another term common in discussions of cults.

Responding to such arguments, post-Soviet proponents and adapters of kodirovanie and other forms of hypnotic suggestion often reframe the therapy as one that ascribes agency to patients as autonomous persons. Writing in response to the article by Fleming’s group (which had been translated and republished in the journal Questions of Narcology), a Russian team argued that the late Dovzhenko had used “mistaken” language and that criticizing his clinical technology by reference the original protocol was like “describing a contemporary engine using as one’s evidence the patent received by German engineer R. Diesel for his invention of an engine in 1892” (Entin et al. 1997, 73). Rather than undercutting the patients’ agency, they suggested that the core of what they called “mediating psychotherapy” (oposredovannaia psikhoterapiia, a term encompassing kodirovanie and khimzashchita) was that “the patient himself sets the length of time the drug or ‘code’ will act, that is, in advance he ‘programs’ himself, so to speak, for a given period of time, against the use of alcohol, agrees to this voluntarily and is inclined to begin with to carry out the responsibilities he has taken upon himself” (72). Drawing on the metaphor of brain as computer, the authors conceptualized the patient’s agency or willpower as separate from the hardware of his brain, allowing him to “program his sobriety” (73).

While they continued to employ methods based on suggestive hypnosis and trance, many of the practitioners I met in the early 2000s had gone a step further and removed any mention of coding from their practice. A psychiatrist with a successful private practice who treated addiction through “body-oriented psychotherapy,” suggestion, and his own “extraordinary powers” made this point in strikingly clear terms: “We don’t use hypnosis:
this person stays fully conscious. He is in a state where he can get up and leave at any time. . . . Hypnosis is placing the will of the patient under the will of the physician. The main postulate of our work is that you are a free, independent, autonomous person.”

Grigoriev’s adaptation of kodirovanie dealt with these issues of agency in a slightly different way, by re-framing the technique to (have at least the appearance of) a form of pastoral care. In his book Healing with the Word (Istselemy Slovom) Grigoriev legitimates this retooling with a revisionist history of kodirovanie. Arguing that Dovzhenko was an Orthodox believer forced by Soviet ideology to frame his method in a scientistic register, Grigoriev traces kodirovanie to techniques used prior to 1917 in the Alexander Nevsky sobriety brotherhood (Grigoriev 2002; Herlihy 2002). In doing so, Grigoriev suggests that Dovzhenko replaced the sermon with a clinical conversation, the service with a general séance, the confessional with an individualized meeting with the doctor, and the vow (zarok) of sobriety on the cross with a voluntary promise of the patient to the doctor not to drink for a certain period of time. Grigoriev claims simply to have returned each element of this method to its original form. He writes that Dovzhenko considered alcoholism a disease of the will and that his method was meant to strengthen (ukrepl′) the will and reorient it from “serving Satan to penitence before the Savior” (Grigoriev 2002).

Although these changing depictions of physicians’ and patients’ relative agency may have had some limited bearing on clinical encounters and relationships in practice, their effects were heavily mediated by the social and economic capital of particular patients. To examine the variation in these relationships it is worth returning to the statement made by Anton Denisovich in describing his rationale for substituting neutral substances for disulfiram: “So it’s better to give him a placebo and give him the gift of several months of sober life than to inject the real medication.” Many analyses of the clinical relationship have examined the meanings and effects of gifts given by patients to their physicians, particularly in Russia, where such practices as common (e.g., Salmi 2003). In this case, Anton Denisovich—echoing Dovzhenko’s imagery of care as gift—reversed these terms in describing his care for some patients through the metaphor of gifting, and arguably evoked many of the ambiguities of power and authority in the narcological clinical encounter. Like many narcologists, Anton Denisovich depicted himself as operating under an ethics of benevolence that, at
times, was explicitly distinguished from a bureaucratic ethical regime of informed consent.

Such a dynamic was particularly evident with the most “hopeless” cases—patients viewed as abject, “declassed,” or socially marginalized. Although such patients’ relationships with physicians could be characterized as beneficent, critics of khimzashchita were more likely to label them paternalistic or even clientelistic. As a psychiatrist who worked promoting Alcoholics Anonymous in Russia put it, “Under the conditions of the market, the job of the doctor is to attach the patient to himself [privezat′ k sebe bol’nogo], to make the patient dependent on him. And underlying this is the market and financial situation.” Indeed, physicians’ relationships with certain patients could be characterized as having a quality of dependency. Narcologists often instructed patients that they would have to return to the same practitioner if they decided to end their sobriety early by having a code or implant removed. In the case of patients for whom the only alternative to the hospital was life on the streets and in shelters, such dependencies could become particularly strong. Narcologists allowed some patients to reside at the hospital, occasionally discharging and readmitting them in order to comply with official limits on periods of hospitalization. Many of these patients performed menial tasks around the hospital; they spoke about their physicians in deeply deferential and respectful terms. Such relationships of dependence and moral indebtedness stood in stark contrast to those that narcologists maintained with patients who had relatively greater social and economic capital. These clinical interactions were structured more like commodity relationships, in which there was an exchange of alienable services for money and each party walked away with no obligations to the other.

In St. Petersburg during the period of my fieldwork, there was a distinct tension between the extremes of clinical care as beneficent gift or as commercial exchange. This tension reflected the themes of agency and responsibility, framed in opposing terms of dependence versus autonomy, which underlay many debates about addiction treatments in Russia during the 1990s and early 2000s. More broadly, the clinical relationship between narcologist and patient can be viewed in the context of the complex Russian political and social order under Putin, in which self-responsibility, initiative, and personal sovereignty continue to be affirmed as necessary traits within the economic sphere, even as markedly illiberal relationships
of beneficence and obligation are affirmed within the political sphere (Rivkin-Fish 2005; Matza 2009). At the hospital and in other therapeutic spaces, however, the distinction between gift- and commodity-like clinical relationships was largely mediated by patients’ social and economic capital, itself linked to the—often downward—trajectories of their lives.

Rumors, Doubts, and Productive Uncertainty

While some narcologists spoke about belief as a resource that they needed to manage with care, uncertainty seemed equally, if not more, productive an affect in the workings of both khimzashchita and kodirovanie. For example, Gleb, a middle-aged working-class patient in Anton Denisovich’s ward, explained that he had been given a torpedo in the past but had not been able to wait until it ran its course and had begun drinking. He added that nothing happened as a result of his drinking during the course of the torpedo. Yet the fact that he had, contrary to the assurances of his narcologist, survived this relapse without any consequences did not lead Gleb to doubt the potential dangerousness of khimzashchita: “Before you take it you sign a paper saying that if you drink, the doctors are not responsible for what happens to you. You get it for a year, then you have to wait it out for a year. If you do it, you want to live. It’s fine if it kills you: better than it paralyzing you or something. We don’t know with these drugs. That would be worse. So each person needs to use his brain” (emphasis added). Gleb’s description evokes the state of uncertainty experienced by many patients in regard to the risks of khimzashchita. Indeed, many stories circulated in St. Petersburg about deaths caused by disulfiram. Some of these were offered by narcologists as condemnations of the rapacious commercial practices of their colleagues. Others had the quality of rumors or warnings: accounts by patients or their relatives told about acquaintances who had died because of khimzashchita. It was well known that the popular Soviet singer Vladimir Vysotsky had undergone implantations of Esperal’ in attempts to control his drinking, and several apocryphal stories attributed his death in 1980 to a particularly serious disulfiram reaction. Many patients also spoke about the importance of having an implant removed before beginning to drink (Chepurnaya and Etkind 2006). Whatever the intentions of people who circulated such rumors, the narratives
themselves played an important part in reinforcing the idea of khimzashchita’s potency.

For every story about the chemical potency of the treatment, however, there was another that attested to its ineffectiveness as a technique for countering disulfiram’s effects. Dmitri, a 12-step counselor, showed me the scars that implantations of Esperal’ had left on his body and explained that he had never waited through the term of the implant and never had one removed. “I would just start to drink. And nothing happened. Besides that, I knew that nothing would happen: everyone was constantly talking about this. They’d say, ‘Forget it, just drink a little lemon juice.’ There were all of these means to counteract it that they’d give out right away, even while you were still in the ward, getting ready for the operation. Even though I would wave these ideas away, they would sink in somewhere.” Physicians recounted their own stories (typically told in a comic mode) about patients who tried to manually remove or destroy their implants by tearing at their shoulders or striking their backs with sticks.

Other patients characterized khimzashchita and kodirovanie as “nonsense” and “fraud.” Eduard, an unemployed man in his midthirties, whom I met at the hospital, was one such patient. During the late Soviet period Eduard had worked as a fartsovshchik, a black market dealer of goods from capitalist countries such as blue jeans, but he had been unable to maintain steady work for several years. When I spoke to him, his arm was bandaged from a burn he had received while cooking drunk. Eduard was doubtful of any therapies and described how he had become disenchanted with kodirovanie:

I went to the hypnotist [kodirovshchik]. He seemed all right, his office very nice, Euro-standard. So, how did I figure out that this was all fraud? Because when we were doing the last séance, he says to me: “Remember: blindness, paralysis, death. Anything can happen [if you drink]. If you want, come back and I’ll remove the code. Don’t do anything on your own by any means. Now my assistant will help me.” A nurse comes in. In her pocket she has a little flashlight—I immediately noticed this. So the doctor mumbles and mumbles and then grabs my throat. He pushes me back and forth, back and forth and then I see a flash in my eyes. “That’s it, you’re coded. You saw the flash?” I said, “Yes, I saw it.” “That is your code.” I wanted to say to him, “Did you see the flashlight in her pocket?” But I decided not to say anything.
All these narratives contributed to patients’ pervasive sense of uncertainty surrounding khimzashchita. Moreover, as Olga Chepurnaya and Alexander Etkind (2006) argue, in this manner, khimzashchita—as well as kodirovanie—harnessed the informal practices central to Soviet society (e.g., rumors, networks of acquaintances) to bring deviant and unruly individuals voluntarily under the power of the party-state. Though the political stakes are somewhat different in post-Soviet Russia, the uncertainty produced by the circulation of such rumors—whether they depicted these therapies as potent and effective or as inert and powerless—allowed them to remain viable. And yet, for narcologists the possibility always remained that this productive uncertainty might dissipate and a therapy would become discredited.

Ironically, the patients like Eduard who received placebo therapy because they were categorized as noncompliant were the very ones who were least likely to give credence to the potential efficacy of narcology’s treatments. It is particularly interesting to compare Eduard’s account with that of Gleb, who did not doubt the potential dangerousness of khimzashchita, despite having experienced no physiological effects as a result of a previous torpedo. Unlike Eduard, who was living on the margins of homelessness, Gleb resided with his family. Like Vyacheslav, Gleb had integrated khimzashchita into his domestic life.

As the contrasting accounts of Gleb and Eduard suggest, patients’ dispositions toward the efficacy of these two therapies may be more shaped by the overall contexts of their lives, their motivations and hopes for sobriety, and the legitimacy they accord to medical institutions than by specific experiences of efficacy or lack thereof. Indeed, though the standard account suggested that khimzashchita relied on patients’ fear, which in turn depended on their belief in its potency, most narcologists also emphasized that the treatment worked only for patients who were, like Gleb and Vyacheslav, adequately motivated for other reasons.

For instance, Alexander Sergeevich explained how some patients used fear as a means of self-management. “The mechanism [underlying khimzashchita] is simply fear,” he explained, but he added that one also needed a motivation to become sober. “If he doesn’t have this then even fear won’t hold him back.” Part of the physician’s work, as Alexander Sergeevich saw it, was rendering this fear meaningful to the patient, making sure that it took hold. He added, “Many of [the patients], either openly or not,
approach the doctor with the request, ‘Put this fear of consuming [alcohol] into me.’ Because many of them understand that nothing else will hold them back, only this kind of fear.” It was not only physicians who made such arguments. Dmitri, the 12-step counselor, described to me how he had once voluntarily returned to a psychiatric hospital for a repeat of a sulfazine injection— which he described as a “punishment” rather than a “treatment.” “I said, do this thing to me one more time. I ask him voluntarily; I want to remember this state [sostoianie], this horrible state, I want to experience it and remember it, so that I’ll always remember it.” Such accounts suggest that the model patient for khimzashchita and kodirovanie is not the unknowing dupe of narcologists but the patient who successfully integrates these clinical technologies into a process of self-management and discipline.

Prostheses for the Will

Vyacheslav was the kind of patient narcologists saw as ideal for a method like khimzashchita. He was, as they put it, relatively “socially conserved.” His ties with his family were intact, and along with his wife he had a routine for managing his compliance with the therapy at home. He was of a generation and class that was generally more deferential to the professional authority of physicians than were younger and wealthier patients. Narcologists’ talk of motivation was perhaps the closest most of them came to speaking of volition or the will—and unlike those patients who spoke only of their losses, Vyacheslav had social ties motivating him to sobriety.

However, just as important were the ways that Vyacheslav spoke about himself—and how he did not speak about himself. Not surprisingly, he did not characterize his drinking problem as a chemical imbalance to be modulated. Nor did he articulate an illness-based addict identity—as advocated by 12-step programs—and speak of himself as “an alcoholic” or for that matter speak about “alcoholism” as an illness or all-encompassing category at all. Rather, to the degree that he wanted to speak about the treatment at all, Vyacheslav described himself simply as someone who was managing his drinking binges.

Though it would be easy to view such an attitude through the analytic of addiction as a disease of denial, I suggest that the fact that these therapies
make such few claims on patients’ selves or identities only increases their appeal to those post-Soviet people wary of totalizing frameworks of self-transformation. While some patients found methods such as the torpedo or kodirovanie useless as a means of achieving even temporary sobriety, and others passed through cycles of increasingly brief remission, at least for some, like Vyacheslav, narcology’s methods worked as prostheses for the will: pragmatic aids that bolstered personal motivations for sobriety. The reason for these differences between patients had less to do with anything specific to the treatment protocol than with the broader configuration of institutions and relationships (both inside and outside the clinic) within which any particular instance of the treatment took place. Yet other patients, as we shall see in the following chapter, were attracted precisely to the self-transformative techniques of the 12-step program.16

The Red Feather

Early on in my fieldwork I was introduced to Boris Kalashnikov, a psychiatrist in private practice who specialized in treating addiction through subliminal suggestion on patients in a drug-induced state of relaxation.17 In addition to this technique, which he called body-oriented psychotherapy, Kalashnikov treated patients using what he called “bio-energy” methods, which, he explained, were based on “my personal abilities” (moi lichnye sposobnosti). “I’ve had more experiences with the paranormal than should be statistically explainable,” he told me, proceeding to describe his ability to “effect electricity from a distance.” Dr. Kalashnikov seemed intent on building, proving, or legitimizing his charismatic authority in other ways as well. On his website at the time, visitors found two images of Dr. Kalashnikov. In the first, captioned “This is I, how I am,” the doctor sits at his desk in a leather jacket; the second photograph, captioned “And for this you have to strive,” shows him shirtless and tanned, standing on a sunny beach near a yacht. These images of wealth and success were bolstered by other claims to prestige, such as Kalashnikov’s assertion that he appears in literary form in the prose of two well-known authors: Victor Pelevin and Mikhail Veller.18

As I prepared to leave, Kalashnikov asked me about my training in anthropology and then, to my surprise, eagerly explained that he had been
heavily influenced by Claude Levi-Strauss’s *Structural Anthropology*. In fact, he continued, he kept a copy of the book as bedside reading. “Yes, the bit about the shaman and the red feather . . .” he mused. As he was in a hurry to see his next patient, my conversation with Dr. Kalashnikov unfortunately ended there, and I was unable to meet with him a second time.

In the original text—the chapter “The Sorcerer and His Magic” from *Structural Anthropology*—the detail of the red feather is a key trope in a story about a Kwakiutl Indian who, skeptical of the reality of shamans’ power, learns the arts himself. The red feather is a piece of bloody down that the shaman holds inside his mouth, and spits out and presents to the patient and others “as the pathological foreign body extracted as a result of his sucking and manipulations” (Levi-Strauss 1963, 175). Along with “The Effectiveness of Symbols,” this chapter of Levi-Strauss is often cited by medical anthropologists and cultural psychiatrists as a forerunner of research on “symbolic efficacy” and “contextual healing” (Kirmayer 1993; Csordas 1993). And though this framework, with a particularly close focus on the healing ritual itself, might have served as my conceptual tool kit for understanding the clinical work of narcologists—including practitioners of kodirovanie—Kalashnikov’s evocation of Levi-Strauss (both in our conversation and in print) pointed to processes that transcended the clinical setting.

As he becomes an accomplished healer and increasingly has a stake in the effectiveness of his powers, the shaman protagonist of Levi-Strauss’s narrative is unable to maintain his initial degree of skepticism. Moreover, his challenge to other shamans is interpreted as undercutting their particular curative abilities, not the possibility of shamanic healing as such. Similarly, in articles with titles such as “Why I am against kodirovanie,” Kalashnikov (2001) repeatedly described the majority of his colleagues as frauds. “Ninety-five percent of the narcology market is a swindle [moshen-nichestvo],” he told me. Although these were statements made to strengthen Kalashnikov’s own therapeutic legitimacy even as they undermined that of his rivals, they did not strike at the assumptions underlying the possibility for therapies like kodirovanie to be effective. This was skepticism that sought to advertise and market services, not to disenchant.

Additionally, the intended audience for such arguments was not exclusively (or even primarily) made up of potential patients, echoing Levi-Strauss’s depiction of shamanism as “founded on a threefold experience”
(1963, 179): that of the shaman, that of the person experiencing the sickness, and “that of the public, who also participate in the cure, experiencing an enthusiasm and an intellectual satisfaction which produce collective support, which in turn inaugurates a new cycle” (ibid.). It is the significance of this reception of a therapy’s procedures and representations—and clinicians’ work to shape that reception—that I have focused on in this chapter. While such work is often not acknowledged by clinicians as falling within their professional purview, I have suggested that narcologists in Russia are particularly sensitive to such issues and that they view the effectiveness of their treatments as dependent on a number of factors, including not only individual patients’ motivation for sobriety but also their belief or faith in these very techniques. As the following chapter will show, proponents of the 12-step program were also highly sensitive to the legitimacy of their method.