On a spring afternoon in mid-2004, I sat leafing through a photo album with Nikolai—an active member of the Alcoholics Anonymous (AA) community in St. Petersburg, who had, until recently, served as a substance abuse counselor at a rehabilitation center where I was conducting fieldwork. Nikolai had invited me for lunch at his home, a relatively spacious (by St. Petersburg standards) one-bedroom apartment in one of the city’s socialist-built concrete-block northern residential districts (spal’nye raiony). However, my visit had coincided with a pediatrician’s house call, and so we sat on the couch looking at photographs from Nikolai’s trip to the United States, while his two-year-old daughter tottered between us and the bedroom, where her mother and grandmother spoke to the physician. An animated movie played on a wide-screen television, which, along with a DVD player and new stereo system, sat on a sleek cabinet system.

This might have been an unremarkable domestic scene—a snapshot of the rising middle class in urban post-Soviet Russia—but for the fact that Nikolai had, several years previously, been committed to a high-security
hospital for the criminally insane after being found not responsible for a death that occurred while he was heavily intoxicated. His release and the subsequent radical transformation of practically every aspect of his life were both closely tied to his self-identification as an alcoholic, to the set of technologies that both afforded and demanded that identification, and to the network of associations this had opened for him. Moreover, the technologies and associations that allowed for Nikolai’s successful rehabilitation (reabilitatsii)—particularly AA itself—were more than simply local, in the most concrete sense. Nikolai corresponded over e-mail with an American AA sponsor from Florida, his travel to the United States had been for the purpose of receiving training as a substance abuse counselor, and the rehabilitation center where he had long worked was funded largely by an ex-tobacco executive from Connecticut. Yet to characterize the conditions that had facilitated the utter transformation of Nikolai’s life as global or transnational is grossly inadequate. Similarly, narrating the story as one of traveling or circulating technologies—in which American techniques for recovery from addiction arrive in Russia—obscures the processes taking place largely in St. Petersburg, as well as the multiple crosscutting forms of movement taking place.¹

However, more than simply a question of movement or circulation, or one of healing for that matter, technologies of rehabilitation such as those of AA carry a particular significance in that they explicitly aim to transform conduct and behavior and perhaps produce new kinds of people in the process (Cain 1991; Zigon 2010). That is, while many seemingly “selfless” technologies—particularly medical technologies—“inadvertently act as technologies of the self” by, for example, “modify[ing] embodied experience and chang[ing] the trajectory of an illness” (Lock and Nguyen 2010, 284), techniques like AA’s 12-step program directly reference emergent milieus because they seek to rehabilitate those suffering from alcoholism into particular kinds of people—namely, recovering alcoholics. Specifically, AA and similar technologies foster association and sociality around illness status and employ this association as a means to transforming their members.

Scholars have offered contrasting arguments about the broader social and political meanings of these transformations. While some have categorized AA as a technology of the self that promotes the self-management and “responsibilization” of individuals (Rimke 2000)—and thus tacitly
participate in a sociopolitical project of neoliberalism—others have suggested that the fellowship’s emphasis on surrender, individual powerlessness, perpetual recovery, and mutual help puts AA in tension with an ethos of individual autonomy and personal enterprise (Valverde and White-Mair 1999).  

Such questions are particularly pertinent in Russia, where the introduction of Alcoholics Anonymous coincided with a period of profound social and political-economic change, which demanded that people radically transform their everyday lives and practices, if not their inner lives. Moreover, while proponents of AA generally assume the universality of alcoholic experiences and depict their organization as a culturally neutral fellowship, AA is widely perceived in Russia as a US import, as Nikolai’s story suggests, and this has bolstered its tacit associations with neoliberal forms of governance. Since the first groups were founded during the late Soviet period, various Russian critics have depicted AA as a cult or sect, a Trojan horse for Protestantism, or a threat to the professional sphere of addiction medicine.

Rather than framing AA simply as a set of confessional technologies of the self or a self-help program, as many arguments have done, in this chapter I emphasize it as what I call an “illness sodality”—an association for mutual help based on the common identification of members around their experience of suffering and addiction. I do so in order to focus on the ways that the transformation of subjectivity is tied up with shifts both in forms of sociality in which members engage and in the specific webs of association into which they are drawn. Indeed, I argue that it is these concrete associations between persons and institutions, some spanning significant geographical and social distances, and their articulation with older, more localized networks, that so radically open the horizons of possibility for members like Nikolai, even as they remain inaccessible to others.

Following their principal traditions, 12-step groups are not formally centralized organizations, and the international AA organization is careful not to impinge upon the institutional autonomy of the groups (Kurtz 1979; Mäkelä et al. 1996). For this reason, there is not a single narrative of the arrival of AA in Russia, as separate groups formed in different places under somewhat different circumstances. Thus I make my argument by tracing the development of one particular AA network or community, at the center of which was the House of Hope on the Hill (HOH) (Dom Nadezhdy na Gore), a free-of-charge 12-step based alcoholism
rehabilitation center located on the outskirts of St. Petersburg, where Nikolai once worked. Examining the story of the foundation of HOH, I focus here on the ways in which a motley group of wealthy American sponsors, Russian psychiatrists, Orthodox clergymen, and members of the cultural intelligentsia navigated the contradictions and tensions surrounding the 12-step program, working to domesticate Russian AA. I then return to the story of Nikolai, tracing his rehabilitation through a 12-step program based in a high-security hospital for the criminally insane and into the HOH community. Finally, I reflect on the rehabilitation of AA members like Nikolai in relation to more general issues of (self-)governance in contemporary Russia and consider the framing of AA as an illness sodality in light of anthropological work on biological and social citizenship.

In this chapter I explore AA in contemporary Russia (and beyond) as an illness sodality. In borrowing the term “sodality” from mid-twentieth-century American anthropologists such as Robert Lowie, I seek to highlight several aspects of the technologies and forms of sociality that so profoundly transformed Nikolai’s life. Whereas Lowie used the term as a “convenient lumber room for a great variety of associations,” ranging from the YMCA and bridge clubs to West African secret societies and Cree military organizations (1948, 294), here I refer more specifically to associations for mutual help based on the mutual identification of members around experiences of suffering and illness. I return to discuss AA as an illness sodality more thoroughly below, but here I mention several significant issues that this framing is meant to highlight.

First of all, my emphasis is on AA neither simply as a set of technologies of the self nor as an identity but as a concrete network of relations and associations held together through the work of these technologies and identifications. Mariana Valverde has aptly pointed to a tension at the heart of AA practice, between two forms of self-governance: (1) a set of pragmatic behaviorally oriented techniques for maintaining sobriety that she calls “a cobbled together, low-theory, unsystematic system for habit reform” (1998, 140), and (2) an identity-based form of self-governance linked to the notion of alcoholism as a disease. These two modes of self-governance have distinct manifestations, and the techniques of AA and the 12-step program sometimes circulate independently of the addict or alcoholic as a kind of person or identity. Here I emphasize the ways in which such
flows of technologies and categories of identification are linked to concrete associations of people.

Second, as I have mentioned, the notion of illness sodality foregrounds the idea that identification over experience of illness or suffering is meant to cut across or supersede other forms of identification—national, ethnic, class. It is important to note that in fact this is not always the case. Not only is it theoretically nearly impossible for any form of identification to supersede others in such a totalizing way, but, as my account of the efforts of Russian AA proponents to domesticate the fellowship should make clear, associations between the 12-step program and the United States are not so easily overcome. Interestingly, while numerous scholarly accounts have examined how processes of self-transformation in AA are linked to the construal and performance of autobiographical narratives, less attention has been paid to the processes of identification that such storytelling engenders (although see Kurtz 1979, 60–61).⁵

Robert Lowie argued that “by making cooperation a reality beyond the narrow confines of the blood tie they pave the way, in principle at least, for a wider integration, whether in the form of a state or of a supernational religion” (1948, 316, quoted in Boon 1982, 103). Setting aside his gesture to a developmental trajectory, here Lowie points to the imbrication of sodalities with other institutions, particularly the state. These are particularly significant in a setting such as contemporary Russia, where informal practices of exchange and highly personalized ties have long played a key role (Ledeneva 1998, 2006). As I discuss in greater depth below, the interpenetration of such networks and associations with the institutions of the Russian state complicates any interpretation of AA or other illness sodalities either as incubators of civil society (Critchlow 2000b) or as producers of neoliberal subjects (Zigon 2010).

Fieldwork and Identification in Alcoholics Anonymous

To get to the House of Hope, you have to travel half an hour by suburban train to a village on the city’s outskirts. I first visited on a Sunday in January, and a crowd of downhill skiers disembarked at the station; a slope had recently been opened nearby, attracting more visitors to the once-sleepy station. From there the House is another forty-five minutes by foot
(or longer in ankle-deep snow), past farm fields, traditionally styled Russian village houses, newer dachas, and several half-built minimansions. Though HOH’s geographic location on the city’s margins mirrors its position in the field of addiction medicine—compared with the addiction hospital’s centrality—the material condition of its building reflects its relative youth and modest prosperity: an unremarkable red brick structure, newly constructed and well kept.

As I mentioned in the introduction, my first contact with the House of Hope community took place in New York, where I was put in touch with Eugene Zubkov, a Russian American psychiatrist who shuttled between the United States and Russia while serving as a director for HOH from afar. Zubkov expressed an enthusiasm for my project—and about my potential help in translating and fund-raising for the House—and arranged for my fieldwork at the House. Back in St. Petersburg, I was given extensive access to the center. I was allowed to interview patients, join them for their lectures and conversations, and sit in on meetings with the counseling staff. The only restriction was that I was not allowed to sit in on group therapy or closed 12-step group meetings. This restriction reflected the staff’s efforts to protect patients’ privacy, but it also reflected AA traditions, according to which closed meetings are limited to those who are already members or believe they “have a problem with alcohol” (Wilcox 1998, 48). As I soon learned, however, questions of my own identification in relation to AA and alcoholism extended far beyond the issue of attending closed groups.

The practices of AA and other 12-step programs require specific kinds of self-identification from participants. One longtime substance abuse counselor in St. Petersburg told me that for him self-identification as an addict was more than a prerequisite to rehabilitation: it was central to the entire process of the 12 steps. Not only does AA function as a technology of self-transformation, in which participants gradually learn to narrate their life histories in a way that enables them to self-identify as alcoholics or addicts, but it also encourages another sort of identification: that of individual members with one another through their common experiences (Rudy 1986, 18–42; Denzin 1987, 74; Cain 1991). These two types of identification are linked: telling one’s story at an AA meeting is not only a means for the speaker to narrate his or her experience and receive support, but it also allows listeners—particularly new members—to reflect upon their own common experiences.6
Like the American rehab centers on which it was modeled, the House of Hope offered a program run primarily by recovering alcoholics and addicts. Some of the trained psychologists identified not as alcoholics but as codependent (sozavisimyi), a category that has entered Russia with the arrival of 12-step therapy. Originally a term from the 12-step movement that designated an illness in its own right—behavior by family members, typically wives, that supported or, in the language of the program, “enabled” their husbands’ alcoholism—codependency has entered the discourse of North American popular psychology as, in its more extreme forms, a pathologization of almost any social relationships that abrogate individual autonomy or rights (Haaken 1993; Borovoy 2001, 98). At HOH codependency was a key category, ratifying the inclusion of a number of nonalcoholics into the therapeutic community. For instance, several members of the support staff, who at first had no particular affinity for the program, had gradually learned the language and culture of the 12 steps and had begun to think of themselves as codependent in the broad sense of the term (they did not have family members who abused alcohol). One had gone on to receive training as a substance abuse counselor. The category of codependency thus allowed members of the HOH community to constitute themselves as parts of a household or family unit linked by experiences of dependence and recovery.

Because AA groups are generally restricted to people suffering from alcoholism and because their definition of those individuals is based largely on self-identification and self-ascription, they present a particular challenge for ethnographic research. If several social positions are available for ethnographers to occupy in most clinical institutions, the legitimate options in groups such as AA are at once more limited and more flexible. The structure of AA meetings, moreover, makes it very difficult for a visitor not to declare his or her relationship to the program and thus almost impossible not to get “caught up in it,” as Jeanne Favret-Saada writes of her fieldwork on witchcraft in rural France (1990, 191). Indeed, on my very first visit to the House on the Hill I attended an open AA meeting, during which a visiting speaker presented his story of decline and recovery to the group. As we each introduced ourselves to the group, using the familiar formula—“Hello, I’m X and I’m an alcoholic”—I found I was the only person in the room to simply say, “Hello, I’m Eugene.” Telling myself that a disingenuous identification would be
patronizing to the patients and staff, I continued to introduce myself this way for a few months.

However, several members of the House community persistently refused to accept my disavowal of alcoholism. Eduard was particularly insistent. A burly man with a wide and friendly face, Eduard had spent a decade of his life drinking heavily and barely holding down a series of short-term jobs. When he had finally been persuaded by relatives to go through treatment at the House of Hope, he was so taken with the program that he eventually became a substance abuse counselor. He presented himself as a simple guy and enjoyed gently poking fun at the House’s supporters among “intellectuals and bohemians.” On several occasions when we rode the train together, Eduard asked me why I had decided to study alcoholism. I explained as best I could but found myself relying on what sounded like tired clichés (alcoholism represented such a profound public health crisis in Russia, etc.), especially when compared with his firsthand experiences.

As I spoke, I realized that I had never been asked this question at the addiction hospital. To be sure, the physicians there took for granted the importance of alcoholism as a problem in contemporary Russia, as did Eduard. What was strikingly different in these two field sites was how my interlocutors thought about the connections between personal experience and research interests. At the hospital, the physicians treated me as a kind of colleague, an emissary of “international science.” If researchers agreed that alcoholism was an important topic for study, there was no further reason to question my choice; whatever other motivations I might have had, they were extraneous and irrelevant to many of the narcologists. Eduard, in contrast, was asking (indirectly at first) whether my (conscious or unconscious) motivation for choosing to research alcoholism treatment was my own (presumably unacknowledged) addiction. I thought I recognized Eduard’s intention because I had already been asked this question, in the same way—not in Russia but in the United States, before my fieldwork began.

When I had told fellow anthropologists about my project, many initially asked whether I had experienced alcoholism in my family. At the time, I had assumed that the impetus for these questions was specific to anthropology (and its neighboring disciplines). For anyone socialized into the assumptions of contemporary academic anthropology, the notion that
our research interests are shaped by biographical particularities has become something of a platitude. I was already, like many colleagues of my generation, carrying out my first project in a place where I had familial ties, so it was perhaps easy to extrapolate a similar personal connection to my thematic focus. In the field, as I attempted to answer Eduard’s questions, my colleagues’ questions took on a slightly different meaning. It was not only the anthropological creed of reflexivity that made a link between one’s life’s work and one’s personal experiences seem self-evident: the same presupposition was woven through the amalgam of self-help techniques and pop psychology that makes up much of the American therapeutic culture. More specifically, this idea testified to the influence that the 12-step movement has had on North American assumptions, as illustrated by the familiar figure of the recovering addict turned substance abuse counselor. However, Eduard’s questions were forcing me to encounter this idea in unfamiliar territory.

I was not mistaken about Eduard’s intentions. After I collected his life story—over the course of several afternoons in his apartment—he confronted me directly: “Tell me, Eugene. Are you sure you don’t have a problem?” There were many addictions, he explained; the dependence to which I was failing to own up wasn’t necessarily on alcohol. I told him that no, everything was fine, he needn’t be concerned; but I was irritated at his insistence. Over the following weeks, I increasingly felt that my behavior was being observed by people at the House, and I found myself disavowing an addict identification more deliberately and vehemently than I had done before. At a dinner for the House of Hope’s American donors, I joined one other person at the table in ordering a glass of wine.

Late in the spring I accompanied Eduard and several other counselors to a celebration for a nearby 12-step group. At the registration for the event, everyone was asked his or her “status”—the appropriate response being one’s illness identity (alcoholic, drug addict) and one’s period of sobriety (e.g., sober for two years). As I pondered an appropriate answer, Eduard stepped in to explain, “He’s codependent.” I had never thought of introducing myself this way, but by this point considering myself codependent was beginning to have a certain logic. Could not my fieldwork relationships with Eduard and others at the House of Hope be understood in this way? I was, after all, getting pulled into relationships with my informants in ways I had not expected, and I was reacting to their demands in ways that I judged (from the standpoint of an imagined ideal ethnographer)
to be at best withdrawn and at worst dismissive. More important, the notion of identifying me as codependent meant something to Eduard and other members of the HOH community: it placed me in a legitimate and understandable category and relationship to them. (Somewhat more troubling was the implication that my interest in the House of Hope, and my research itself, was pathological—that I was addicted to studying addicts and needed help.) Nevertheless, at the next open meeting I attended, I introduced myself as codependent.

Exporting Sobriety

The House of Hope and the community that surrounded it had its origins in a unique institutional and political economic conjunction that emerged from the mid-1980s anti-alcohol campaign on the one hand and the opening of Eastern European markets to American companies on the other. Although the overall emphasis of the campaign that became closely associated with Gorbachev’s name was on supply reduction, it involved other measures, such as the development of a national temperance organization and the increased funding of narcology. The campaign also coincided with Gorbachev’s shift to a policy of outreach toward the first world, and beginning in 1987 glasnost came together with the anti-alcohol effort in a series of joint Soviet-US conferences on alcoholism that brought experts on addiction from the United States to the Soviet Union.

Among these visitors were officials representing the General Service Office of Alcoholics Anonymous in New York as well as several clergymen who made a concerted effort to promote AA in the Soviet Union. These meetings led to the establishment of early Soviet AA groups such as the New Beginners in Moscow in 1987 and Almaz in Leningrad slightly afterward (Burke 1990). Although these early meetings were framed by the diplomatic trope of mutual learning and exchange, the flow of knowledge and technologies rapidly became one-directional. After touring Soviet treatment facilities and speaking to physicians and patients, most Anglo-American addiction specialists and 12-step proponents concluded that prevailing modes of long-term treatment offered by official Soviet addiction medicine were ineffective, backward, and unethical (A.B. 1991; Harris-Orffut 1995). Bringing 12-step programs to
Russia thus became part of a broader late 1980s and early 1990s project of importing various first-world institutions and technologies deemed more effective than state socialist ones. Underlying this project, for many promoters of AA in Russia, was a strong sense of moral righteousness born of the conviction that their method was the *only* way for alcoholics to be saved from imminent death.

The motives of Louis Bantle, the founder of HOH, were more complicated still. Bantle, the longtime CEO of U.S. Tobacco and a self-described recovering alcoholic, had been involved in the joint US-Soviet conferences on alcoholism. Significantly, Bantle was known in both business and public health circles for leading his corporation’s successful effort to create a broader market segment for its so-called smokeless tobacco (Denny 1993; Wyckham 1999). Over the following several years as his corporation began to develop business contacts aimed at opening Eastern European markets to its products, Bantle focused much of his philanthropic effort on propagating AA in Russia.

Setting aside the issues of Bantle’s personal motives for pursuing this particular form of philanthropy, it is worth noting that his simultaneous promotion of an addictive substance and the technology for managing addiction is not simply a matter of differently conceptualized substances (in addition to smokeless tobacco, UST also marketed wine in Eastern Europe). Rather, it indexes AA’s elective affinity with a particular type of liberalism as well as its historical origins in the post-temperance United States. According to AA’s “disease model” of alcoholism, it is not alcohol as a substance that poses a moral problem or threat (as prohibitionist temperance movements in both the United states and Soviet Union argued) but the fact that a certain group of people suffer from a chronic illness that makes them incapable of drinking in moderation (Jellinek 1960; Gusfield 1996, 192–96). Such a model is clearly compatible with a liberal political and economic disposition in regard to alcohol and its consumption, as well as more broadly. Implicit in the steps, traditions, and practices of AA is the notion that the management of addiction is not the responsibility of a disciplining and prohibiting state but that of individuals banded together into a group of mutual interest and help (Kurtz 1979; Valverde 1998). Whether such assumptions would hold in the context of post-Soviet Russia would soon become the topic of numerous debates as Bantle moved ahead with his philanthropic project.
In 1992, Bantle hired Eugene Zubkov, who had recently emigrated to the United States, to manage this philanthropic operation. Zubkov was particularly well suited to play the role of cultural broker for 12-step programs in Russia, both because of his professional background and because of his network of acquaintances. Zubkov had worked for nearly a decade at the Bekhterev Psychoneurological Research Institute, specializing in adolescent and legal psychiatry. In addition to his professional ties, Zubkov had extensive contacts among the local cultural intelligentsia, particularly among St. Petersburg’s informal art and rock music movements, and these contacts played a central role in his initial plan to promote AA in Russia.

Zubkov’s approach to the project was informal and highly personalistic: drawing upon his own contacts, he hoped to knit various informal networks of post-Soviet society into AA’s sprawling global illness sodality. He argued that three primary factors distinguished the social context of AA in the United States from that of Russia during the early 1990s: the respective roles played by professional medicine and religious organizations and the level of stigma associated with alcoholism. Consequently, Zubkov decided to target three groups—physicians, members of the Orthodox clergy, and well-known members of the cultural intelligentsia—by bringing representative members of each to the United States to tour rehabilitation centers and undergo training for substance abuse counselors. While Zubkov’s plan was based on his analysis of the state of alcoholism treatment in Russia at the time, it also drew on the history of AA in the United States, where alliances between medical and religious figures were key in the development of the programs, and their endorsement by well-known public figures such as Betty Ford were important to their legitimation (Kurtz 1979). Zubkov hoped that his existing contacts among narcologists and in the St. Petersburg visual art and rock scene would help him bolster the legitimacy of AA among members of the medical establishment and cultural intelligentsia and thereby the general public.

**Physicians, Clergymen, and Resistance to AA**

By the time I met him in 2003, Zubkov was somewhat disappointed with the results of this early project in regard to physicians and clergy members.
A key sticking point with many physicians, and narcologists in particular, seems to have been a central characteristic of AA as an illness sodality—its nonprofessionalism and its ambivalent stance toward formally acquired expertise about alcoholism. Opposition to 12-step groups on this basis was evident among some prominent narcologists even in the first decade of the 2000s, at the same time as many other physicians praised the groups and directed their patients to them. For instance, in 2004 a well-known narcologist dismissed AA in a newspaper interview as “anonymous brotherhoods, where there are no doctors, as ‘only a drug addict will help another drug addict.” “In that case,” he asked, in an aside that infuriated many local AA members, should we say that only “a schizophrenia patient will help another schizophrenia patient?” (Dyleva 2004b, 11). For his part, Zubkov emphasized the difficulties Russian physicians had in taking on the role of “wounded healer” expected of substance abuse counselors. “It’s easier for a doctor to get drunk than to come to a meeting with his patients,” he opined. “So they die, they drink themselves away [spivaiutia], they turn into idiots—but to tell a patient that he’s an alcoholic and meet him in a group, that he can’t do.” AA’s elevation of fellow-suffering experience over expertise and its requirement that physicians participate on a par with other members, if at all, struck at the particularly prominent role that physicians’ authority played in narcology, at a moment when that authority was being threatened on several fronts. Though actual relationships between clinicians and patients varied widely, it is clear that AA’s ambivalence toward expertise fueled some narcologists’ sense of their profession as under threat.

If the overall level of enthusiasm for AA among narcologists was less than Zubkov and other promoters had hoped, support among clergy members was initially mixed as well. Although 12-step groups were officially blessed by Patriarch Alexei II in 1993, there was continued opposition from other clergy members. In addition to worries that AA was closely bound to American Protestantism and might be used as a cover for proselytizing was a more diffuse fear identification of it as a cult with the associated concerns about zombification and a loss of personal agency. In 1990s 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). Such worries surfaced in many media depictions of AA, for
instance: “The formula, according to which AA group meetings take place (the preamble, a moment of silence, the repetition of the 12 steps and 12 traditions, reading from the textbook), already suggests zombification” (Kolomeiskaia 1999). This kind of anxiety was evident among laypeople as well, and several patients told me that their initial impression of AA had been shaped by the prevalent discourse about sects and cults. As one patient I met at St. Petersburg’s Municipal Addiction Hospital, who had been through the rehabilitation program at HOH, put it, “This ritual: we weren’t ready for it. . . . They invited me to come back . . . but I had a negative feeling about it.”

More recently, 12-step and other therapeutic techniques have been taken up by rehabilitation programs run by the Orthodox Church (as well as by other religious groups)—in some cases adapted and imbued with specifically Orthodox content (Wanner 2007; Zigon 2010). Such adaptations infuriated many of the active members in the St. Petersburg AA movement, who argued, “There’s no reason to change the steps!” Zubkov argued strongly against such efforts to “make this program specifically Russian,” explaining that “the format can change, but not the substance.”

**We Don’t Want to Defeat Anybody**

Zubkov and Bantle’s efforts were more immediately successful with their contingent of cultural intelligentsia patients, perhaps in part because, unlike physicians and clergymen, these patients did not see AA as posing a threat to their professional status or cultural capital. Indeed, for some of Zubkov’s intelligentsia patients, AA became a means of successfully transforming their rapidly depreciating Soviet cultural capital. While outspoken supporters of AA in Russia included the well-known rock musicians Yuri Shevchuk of DDT and “Dyusha” Romanov of Akvarium, this was particularly the case for members of the Mit’ki, an artists’ group that had become well known in the 1980s as “anti-establishment” figures partly for their enactment of a heroic drunkenness. In retrospect, Dmitri Shagin, one of the artists most central to the group, as well as the chief proponent of AA among them, argued that in the drunkenness of the Mit’ki “there was a kind of passive protest against everything that we didn’t like about the Soviet style of life [sovetskom obraze zhizni]. We created the slogan: ‘We
answer to the Red Terror with delirium tremens”’ (Na krasn’yi terror otvetim beloi goriachkoi) (Nikitinskii 2004).11

Zubkov emphasized that the timing had been particularly successful. In his words, during the early 1990s “everyone was drinking and dying. To die from alcohol was considered a heroic act.” In 1993 Zubkov brought Shagin and the painter and writer Vladimir Shinkarev (who had written Mit’ki, an unofficial manifesto of the group) to the United States for substance abuse treatment. After their return to St. Petersburg, the two went public with their alcoholism. Shagin became particularly closely involved in the AA movement, establishing an AA group that meets in part of the Mit’ki studio space and working on behalf of HOH once it was established. In his conversations with the press and in their own writings, Shagin represented what had previously been an ethos of heavy drinking as a disease and advocated Alcoholics Anonymous not only as a treatment but as a program for a new way of life (Shagin 1999). As Zubkov said of the Mit’ki: “They made a lifestyle out of this, a lifestyle which they propagandize. Of course, this was a commercial device. They kept their popularity and they helped us.”

Indeed, though their initial motivations were certainly personal, the transformation of the entire artists’ group into “sober Mit’ki,” was arguably as useful for their adaptation to post-Soviet conditions as artists as it was to the goals of their American sponsors. The Mit’ki had crafted their particular artistic image and disposition firmly within the cultural politics of late socialism. In addition to their pseudonaive visual artworks and semiabsurdist writings, their drunkenness was at the core of their public image—as much performance as lifestyle. With the end of state socialism, the signifiers of Soviet respectability, in relation to which the Mit’ki defined themselves, were radically transformed as well. By transforming themselves in this cardinal way, the Mit’ki were able to reestablish themselves in the 1990s—precisely by capitalizing on the paradoxical nature of the sober Mitek image. Even in 2004, more than ten years after Shagin and others had given up drinking, articles in the mass media played up this irony with titles such as “Mitki without port wine” (Mit’ki bez portveina).

Moreover, the HOH and AA placed the Mit’ki and members of the St. Petersburg rock scene into some association—however tenuous—with a number of performers and celebrities who have publicly linked themselves to issues of substance dependence and its treatment. Most notably,
Eric Clapton visited HOH while performing in St. Petersburg in the early 2000s, an event that was fondly remembered by Shagin and the counselors at the center alike. Of course, there were limits to the degree to which an illness sodality like AA opened up such rarefied networks, and some members of the HOH community might have overestimated its potential for advancing their own ambitions. In my role as unofficial translator for Zubkov, I revised several letters written by a rock guitarist recently emigrated from Russia to the United States, who was unsuccessfully attempting to get himself included in a music festival organized by Clapton to benefit his Antigua-based Crossroads Centre for substance dependence.

Conversely, visible links with the Mit’ki helped to domesticate HOH’s brand, as one counselor put it. Several patients at HOH explained to me that their initial fears about AA’s being a sect were allayed by its local association with the Mit’ki. The Mit’ki did more than provide familiar faces to prospective AA members. A speaker at one of the AA meetings held in the Mit’ki studio space explained how her impression of the program was shaped by their involvement: “I thought to myself, ‘These are alcoholics? These are intellectuals of the highest class!’ (Eto intelligentsiia vyshego klassa!)” In other words, the Mit’ki served as objects of identification for prospective AA members who viewed themselves as members of the cultural intelligentsia and others who perhaps questioned the respectability of the program. That this artists’ group, which earned its fame through something like a punk aesthetic, could become a source of respectability is only somewhat ironic: in middle age the Mit’ki—like many other artists—had reformulated and commodified their aesthetic—their drunken past providing a patina of authenticity to their new sober image.

The House and Its Family

During the midnineties, as sponsoring numerous individuals from Russia on treatment/study trips to rehabilitation centers in the United States increasingly looked like a financially unsustainable strategy, Bantle and Zubkov began to plan a rehabilitation center that would be based in St. Petersburg. After a false start in another location, in 1997 Bantle purchased a parcel of land located near a village about half an hour by suburban train from St. Petersburg. The twenty-eight-day inpatient residential
therapeutic program established at what became the House of Hope was modeled on several rehabilitation centers in the United States and generally on a program known as the Minnesota Model.

Developed at several inpatient psychiatric and therapeutic treatment centers in Minnesota during the late 1940s and 1950s, the model is an institutionally based rehabilitation program with 12-step techniques and group meetings at its core (Anderson, McGovern, and DuPont 1999). Sharing the concept of chemical dependence as a chronic disease that cannot be cured, the Minnesota model aims to help patients develop a new lifestyle to live with their condition. Patients at the House of Hope take part in AA meetings and reading groups based on working through the 12 steps, as well as lectures on aspects of the program, mostly run by counselors who are recovering addicts or alcoholics. Unlike AA groups, however, which are restricted to fellow sufferers, institutions based on the Minnesota Model have a multiprofessional staff—which may include psychiatrists and psychologists who do not identify as alcoholics (Cook 1988). As I have mentioned, codependency worked as a category, ratifying the inclusion of a number of nonalcoholics into the therapeutic community, including several trained psychologists who ran the rehabilitation program.

An important part of the Minnesota Model, moreover, entails the constitution of a particular therapeutic milieu that is meant to contribute to patients’ recovery. At the HOH, patients participated in work assignments (preparing food, washing dishes, chopping wood, etc.), and patients and staff participated in a weekly community meeting at which interpersonal grievances were aired and logistical problems were discussed. Finally, as in other Minnesota model centers, HOH ran a family therapy program to which it invited the close family members of patients residing at the center.

Overall the aim of HOH’s twenty-eight-day program is to acquaint its patients with the 12 steps and AA. It uses the 12-step program as a technology of self-transformation, aiming to teach patients to recognize, articulate, and manage their emotions and to gain insight into their conditions (e.g., Zigon 2010). A key goal of the program is to motivate patients to attend AA group meetings in St. Petersburg or elsewhere (a problem for those residing in some remote parts of Russia): indeed, these mutual help groups are meant to function as a sort of aftercare, and patients are encouraged to attend meetings daily for the first three months after finishing the
inpatient program. When I conducted my fieldwork in 2004, HOH was the only center in the St. Petersburg area providing free-of-charge rehabilitation for alcoholism. Though the place it occupied in the local field of addiction treatment providers had long mirrored its geographic location on the margins of the city, the House was gaining legitimacy and attention.

**Domesticating Russian Alcoholics Anonymous**

Proponents of AA generally assume the universality of alcoholic experiences and argue that their program constitutes a social technology with equally universal effectiveness: the assumption is that AA is a kind of blueprint that can be enacted anywhere with only minor adaptations. This notion of AA as culturally neutral is paralleled by the program’s spiritual ecumenism. In its official literature, AA is framed as a fellowship of self-identifying alcoholics that, although spiritual in its outlook, is not formally associated with any particular religion.

However, social scientists have long noted that the assumptions about self and sociality implicit in AA’s practices and traditions are at least somewhat specific to the historical setting within which they were developed—namely, (1) a particular strain of Anglo-American Protestantism and (2) the social and intellectual context of the post-temperance Depression-era United States (Kurtz 1979; Antze 1987; Falby 2003). AA was founded in the United States during the mid-1930s, and many of its concepts were developed on the basis of tenets central to the Oxford Group, an evangelical movement that focused on psychological interpretations of self, was committed to spiritual awakening through social interaction in a group, and was sometimes represented as a return to the ethos of early Christianity (Kurtz 1979; Falby 2003). As the fellowship gained in popularity in the United States during the 1940s and ’50s, and later throughout the world, efforts to navigate religious and cultural difference decidedly shaped the program (for example, the ecumenism underlying the emphasis on a “higher power”), although they typically emphasized cultural difference only as a barrier to the ultimate recognition of identity among fellow suffering alcoholics. Nevertheless, the international diffusion of AA occurred first to English-speaking and Nordic mainly Protestant countries and only subsequently to majority-Catholic states—particularly those in southern
Europe and Latin America—and non-Christian Asian countries (Makela 1991; Makela et al. 1996).

This tension between a claim to a cross-cultural identification based on fellow suffering and the perceptions of cultural particularity in the program was played out in the efforts of Russian AA supporters to promote the fellowship. Thus when I asked AA participants in St. Petersburg about local differences in their practice, nearly all argued that their shared identification as fellow sufferers trumped any national or cultural differences: “Alcoholics are the same everywhere,” they invariably said. Or as one local AA participant told a journalist, “For alcoholism neither nationality, nor age, nor social position exists” (Fomenko 2002). Dmitri Shagin repeatedly made similar arguments in interviews with journalists: “As far as the famous ‘Russian drunkenness’ goes, this is also a myth, as you start to understand when you’ve spent some time with alcoholics from other countries. Alcoholics are everywhere alcoholics, whether in Russia, in America or in Africa. And we are all brothers” (Nikitinskii 2004). While such arguments emphasized the basis of the AA fellowship in identification with others over common experiences of being alcoholics, others compared the program more explicitly to biomedical techniques. “You want to say that a diabetic in America is ill in a different way [po drugomu boleet?]” asked one of the substance abuse counselors at HOH, evoking the commonly used reference of diabetes as a model of chronic illness. “The alcoholic is the same,” she added. Another counselor made an even more direct comparison to biomedicine when I asked him about local differences in practice: “I try not to theorize. It works, that’s what is important for me. When I take an Analgin pill, I don’t ask what it’s made out of. I don’t take it apart under the microscope. I just put it in my mouth and that’s it . . . it’s the same here. It works, that’s what matters to me.” Here AA is depicted as another medical technology working on the “normal body” of biomedicine (Lock and Nyugen 2010, 32–33).

And yet at other moments AA was identified locally by many of its participants explicitly or implicitly as an American program. For instance, nearly every Russian speaker associated with the program in St. Petersburg pronounced the name of the program “Ay-Ay”—that is, in the English pronunciation rather than the Russian “Ah-Ah.” This awareness of the program as American seemed particularly tangible at HOH, in part because of the close links that the center maintained with United States-based institutions.
Counselors working at the HOH had the opportunity to visit and train at several rehabilitation centers on the East Coast, and many described their journey almost as a kind of pilgrimage. When I first met Nikolai, he described how he had been asked about the purpose of his trip by a US consular worker during his visa interview. “I said to him ‘I’m going to the homeland [rodina] of AA.’ And the man asked me, ‘What’s the first step of AA?’ and when I answered, ‘We admitted that we were powerless over alcohol—that our lives had become unmanageable,’ he stepped out from behind his desk, shook my hand and said, ‘Welcome to the United States.’” As much as Nikolai’s story suggested the personal significance that the United States held for him as the origin of AA, it also evoked the perception, held by many in Russia, that the program was particularly American. Nikolai also linked himself to the origins of the fellowship, proudly explaining that his sponsor—a more experienced member who provides guidance—lived in Florida (they communicated by e-mail) and that through the institution of sponsorship he was genealogically linked to Bill Wilson, one of the founders of AA (“He was my sponsor’s sponsor’s sponsor’s sponsor”).

These issues of whether AA was an American program or a culturally neutral one arose often in public discussions of the movement, with opponents often citing AA’s origins to argue against its suitability for Russia. For example, one newspaper article quoted a psychologist who stated that “the model itself is a purely American invention which shouldn’t have been carried over onto Russian soil without making various adaptations. This program doesn’t work for the Russian mind [mentalitet]” (Kolomeiskaia 1999). Many early discussions of AA in Russia emphasized the difficulty that persons supposedly enculturated with official Soviet atheism would have with the notion of a higher power. In order to facilitate this transition, many AA proponents in Russia have used the common (rather Durkheimian) notion of identifying the higher power with the group itself. Dealing with such issues seemed to be a particular difficulty for some of the narcologists and physicians taking part in the program.15

Significantly, opposing arguments regarding the cultural or social appropriateness of AA were often made as well: arguments to the effect that AA was, for one reason or another, particularly suited to the Russian context. For instance, some media accounts have described AA as an “American in origin, but entirely Russian in spirit, technology of heart-to-heart [po
dusham] conversations” (Bansovich 2001). Similarly, the head substance abuse psychiatrist for Moscow argued in an interview that “the first step is to understand one’s powerlessness over alcohol or drugs. At its core it reminds one of the Orthodox confession and in this sense it successfully translates to the Russian mentality” (Fomenkova 2000).

At HOH the association with the United States cut both ways. Whereas the perceived Americanness of AA lent the therapy legitimacy in the eyes of some patients, others were suspicious of the foreign connection. Aside from patients, Zubkov felt that the perception of the center as American by local administrators and bureaucrats was not particularly conducive to its long-term survival in Putin’s Russia. An important part of domesticating AA had to do with associating the program with Orthodoxy while respecting its formally nondenominational character. In addition to fostering informal links with local Orthodox clergy, this meant introducing certain explicitly religious elements to the House’s program, such as an Orthodox chapel where weekly services are held. At the same time, the program continued to be practiced according to its international nondenominational precepts, and it was emphasized that religious services were formally optional for patients undergoing rehabilitation at the center.

Additionally, Zubkov was on a continual, and somewhat futile, hunt for Russian sources of funding, which he felt would bolster its standing as a domestic institution. Local businesses, he argued, were not interested in donating money to and thus becoming associated with a rehabilitation center for alcoholics. A newspaper report on HOH quoted a businessman stating, “I’d sooner flush my dough down the toilet than give it to the alkies” (Barabash 2006). In fact, when Zubkov was able to secure funding from a Russian businessman in 2003, it was only on the condition that he remain anonymous (Barabash 2006). Significantly, even this was possible only through the cultivation of personal ties: a friend of Zubkov’s with a relatively high position in Putin’s administration had apparently directed the businessman to make the donation.

A Psychiatric Hospital of a Special Type

I first met Nikolai at St. Petersburg’s Psychiatric Hospital of a Special Type under Intensive Surveillance, where he was once interned. The
institution is located on the Vyborg bank of St. Petersburg, several minutes on trolley bus from the Finland Station. A century ago this was a solidly working-class district as well as home to a significant number of factories, some of which have left their names to neighborhood streets. The hospital sits on Artillery Street (former patients often refer to the hospital itself as Arsenal’naia), down the block from a former asphalt and concrete factory and across the way from a women’s prison (zhenskii izoliator). From its construction in 1913 until the establishment of the special psychiatric hospital in the early 1950s, the forbidding beige brick building also housed female prisoners.

I had been invited to visit the special hospital through Zubkov. The hospital’s director, Victor Styazhkin, had a long-standing relationship with HOH, and his hospital housed a unique program that Zubkov encouraged me to visit: a 12-step-based rehabilitation program for men convicted of having committed violent crimes, all of whom had major psychiatric diagnoses. Though wary of the sensationalistic terms Zubkov used in describing the hospital—“He’s got a hospital full of maniacs, serial killers, and psychos!”—I made an appointment to meet with Styazhkin.

A brick wall topped with barbed wire surrounding the hospital compound was the first sign of a total institution that, to a visitor expecting closed-circuit cameras and radio-monitored ankle bracelets, seemed both overtly menacing and deceptively quaint. I found my entrance to the hospital slowed not by computer scans of my passport or even metal detectors but by the dulling familiarity of queues and paperwork (and this with an invitation from the hospital’s director). Having spoken to Styazhkin earlier that morning, I made the mistake of entering the hospital directly through the main door. An older woman, dressed in the requisite green smock of a hospital attendant (sanitar) stopped mopping the concrete floor to tell me I’d need to get an entrance pass (propusk). To obtain this document, I had to leave the main entrance and reenter the building through an unmarked side door that, though it looked as if it might lead to a toolshed, opened onto a waiting room painted an incongruous dirty pink. Here visitors to the hospital sat on benches or milled about as an attending guard, a young woman, filled out the paperwork allowing them to enter the hospital or give food and gifts to patients. A gendered division of security labor in the hospital seemed to place women behind glass windows, checking passes and interacting with visitors, while young men were assigned
to guard entrances and exits and escort patients and visitors through the grounds. Next to the guard’s office hung a notice (signed by Styazhkin) listing items forbidden to patients: powdered mashed potatoes, hot soups, glass containers. The text of a nearby form revealed the range of expected relationships between patients and visitors: “I am bringing _____ for my (circle one) husband/son/brother/relative.” A middle-aged woman ahead of me in the queue handed items for a patient through the small window to the guard, who checked them off a list and placed them in a burlap sack: cheese, crackers, bread, jam, and three address books. “Why so many?” asked the guard. “I don’t know,” the woman replied, visibly flustered, “I’ve had it up to here with his requests.” An old man meandered around the room, waiting for a discrepancy with his passport to be cleared up. It took another call from my cell phone to the hospital director to get the necessary pass.

Several minutes later, having left my passport at the main entrance and been escorted across the hospital grounds by a young uniformed conscript, I sat in one of the modernist leather armchairs in Victor Styazhkin’s well-appointed office while he chain-smoked and told me about the hospital and its role in the Russian criminal justice system. The special hospital is one of seven institutions for the criminally insane in Russia, which, he explained, belong to the highest of four categories of security—categories that match the severity of both the crimes committed by its patients and the mental illnesses with which they are diagnosed. Styazhkin described the criteria by which patients ended up in the hospital in comparative terms: “They must be mentally ill and not responsible [не ответственны], nonculpable [невменяемый]. The system here is a little different from the US. Here if a person carries out a crime in a state of nonculpability [невменяемости]—he goes free of punishment. In the US he might be punished; here he is freed from punishment and goes for compulsory treatment [принудительно лечение]. And depending on the severity of the crime and the severity of the illness, these are the four levels of security.”

When I later told friends and acquaintances in St. Petersburg (who had nothing to do with addiction treatment) about my visits to the special hospital, their reactions most commonly assumed that the majority of patients did not belong there—although for two completely different reasons. Most of my friends immediately speculated that the patients were malingering in order to avoid prison—an assumption that drew upon the
common knowledge of young men simulating psychiatric symptoms in order to avoid conscription into the army, during both the late and post-Soviet periods. Zurab, a heavy metal guitarist, even described his own brief stint under observation in a psychiatric hospital: “It was great. We would go outside wearing our patients’ robes and we could do anything without any consequences. You could scream in a policeman’s face and he couldn’t do anything to you. You’re a psikh!” Paradoxically, the other association that many acquaintances had with the special hospital had to do with another nonclinical use of diagnosis—in this case, the commitment of political dissidents during the late Soviet period.

During the 1970s and early ’80s, the special hospital in what was then Leningrad became somewhat notorious for its involvement in the story about Soviet psychiatry most widely known in the Anglophone world: the use of forensic psychiatry against prominent political dissidents. This practice of diagnosing political nonconformists as mentally ill and committing them to psychiatric hospitals seems to have emerged specifically as a late Soviet phenomenon that accelerated during the Brezhnev years (Etkind 1994). (Indeed, during an earlier period, commitment to a psychiatric hospital may have been seen by legal officials as a means of evading much harsher forms of punishment.) Most of the dissidents diagnosed as mentally ill and thus nonculpable were accused of violating articles 70 and 190–91 of the Soviet Penal Code, which forbade anti-Soviet agitation and dissemination of propaganda defamatory to the state (Gordon and Meux 1994). Though courts were required to specify a period of imprisonment, commitment to one of the special hospitals was open-ended, left to the discretion of psychiatrists.

The overriding focus that the Cold War debates placed on the political abuse of psychiatry arguably removed attention from the increasing levels of normal institutionalizations taking place at the time (Joravsky 1989, 418). Indeed, between 1955 and 1975, a period marked in the United States by massive deinstitutionalization and decrease of inpatient services for the mentally ill, the number of Soviet psychiatric hospital beds grew from 106,500 to 312,600 (432). Additionally, the same legal frameworks and diagnostic categories that facilitated the commitment of political dissidents also made it easier for ordinary citizens to lock away unwanted relatives—sometimes after paying off a psychiatrist (Field 1991).
Yet, as is once again the case today, accounts of politically motivated commitments trumped any interest in more systemic or everyday problems of inpatient psychiatry in Russia. Starting in the early 1970s, first-person accounts of Soviet political dissidents who had been declared mentally ill and committed began to circulate widely outside the Soviet Union, along with writings by dissident psychiatrists such as Semyon Gluzman, who provided counterdiagnoses. Taken up into the polarizing logic of Cold War politics, this issue quickly reversed the generally respectful and interested disposition that North American and British psychiatrists had held toward their Soviet counterparts over the previous two decades (Belkin 1999).

Repeated condemnation by the international scientific community led the Soviet All-Union Society of Psychiatrists to withdraw from the World Psychiatric Association (WPA) in 1983 rather than risk being expelled. Five years later, with perestroika under way, a number of reforms were made, including the shift of the high-security psychiatric hospitals from under the aegis of the Ministry of Internal Affairs to that of the Ministry of Health, and the Soviet psychiatric society was provisionally readmitted to the WPA the following year (Smith and Oleszczuk 1996).

During this period Styazhkin, who had worked at the hospital since the late 1970s, had been one of the first psychiatrists to make public his hospital’s dossiers on several prominent political prisoners, and he had participated in international conferences on Soviet psychiatric abuse. Indeed, because it was situated in what was then Leningrad, the special hospital housed a disproportionate share of prominent political prisoners, and by the late 1990s newspaper articles about the hospital would quote Styazhkin listing the dissidents who had passed through the hospital almost as a badge of honor: Victor Bukovsky, General Pyotr Grigorenko, Vladimir Borisov, Victor Fainberg, Esenin-Volpin:

“By the way, many of them remember their stay in the hospital with great warmth,” says Victor Styazhkin, and as proof relates the following story. In 1992 Victor Dmitrievich went to New York for a conference of psychiatrists. There, a friend introduced him to the wife of the general-dissident [Grigorenko]. She invited Styazhkin home and fed him a hearty borscht. And then she gratefully said, “Pete never said anything bad about your hospital. He said that everyone there treated him benevolently enough. Of course, that’s compared to other similar institutions.” (Orlov 2005)
When I asked Styazhkin which diagnoses patients in the hospital tended to have, he explained, “Seventy to 78 percent are schizophrenia.” “That’s by the old classification,” he added, referring to the Soviet nosological system that had, several years earlier, been officially replaced by the WHO’s International Classification of Diseases. Schizophrenia was the diagnosis given to the majority of people committed to Soviet psychiatric hospitals, and indeed Cold War critics argued that Soviet categories of mental illness—particularly a “transitory” variant of schizophrenia that could be diagnosed in the absence of any presenting symptoms—facilitated the purposeful misdiagnosis of political dissidents (Joravsky 1989, 429–31).

“According to the new [nosology],” Styazhkin explained, these formerly schizophrenic patients were diagnosed with schizo-type or schizo-affective disorders. And the rest are about the same [proportions]: oligophrenia, psychopathy, epilepsy, organic illnesses of the brain, traumas.” However, as he continued, 80 percent of the crimes committed by patients in the hospital were committed in a state of drug or alcohol intoxication, and 52 percent of these patients suffered from substance dependence (Kazakovtsev, Styazhkin, and Tarasevich 2002).

This had been the initial justification for the program that was the original purpose of my visit: the 12-step-based rehabilitation program housed in the hospital’s Ward 12. As Styazhkin explained, the program had not simply been created at the instigation of 12-step activists in Russia but had been modeled after one in a corrections system undergoing a drastic neoliberal transformation of its own: “At the origins of our 12-step program was Bob Kennington from CCA [Corrections Corporation of America]. [There is] a large private prison in Nashville and about half of the prisoners are in the program—I’ve been there myself. We liked the program a lot—I was there with the prosecutor, who in his time oversaw the carrying out of the law here. [Kennington] was then invited here and he worked with our coworkers.”

Like HOH, this program was based on the Minnesota Model, which meant that the entire therapeutic milieu was understood as key to patients’ recovery (J. Spicer 1993). While the program includes medication, social work, psychotherapy, and work therapy (the ward maintains a small computer cluster and woodshop for patients), the weight of therapeutic work is placed on the 12-step group meetings that take place in the ward. The group itself, called Mirror (Zerkalo) meets
three times a week—of the hospital’s 650 patients, approximately 75 take part. In a program based on patients’ self-identification as addicts, Styazhkin emphasized the importance of employing addiction counselors who not only identified as recovering addicts but had been inmates as well. “What we found useful in Kennington’s [CCA] program is that he attracts former patients—people who’ve been freed—to participate. . . . This makes the work more effective. Because when the doctor says that drinking is bad for you, then inside the patient the thought arises: ‘Have you ever tried drinking like this?’ At the meetings I’ve attended—I think this is very useful.”

It was precisely this aspect of the 12-step program—its autonomy from the practices and knowledge of biomedicine and psychiatry—that created the greatest obstacles for Styazhkin. The resistance of medical personnel to a program that to some degree placed the authority of physicians below that of fellow sufferers and overtly blended techniques seen as psychotherapeutic with those seen as spiritual was perhaps fueled more by a strong and increasingly embattled ethic of professional authority and expertise than by any Soviet legacy of atheism or materialism. Yet Styazhkin seemed to have prevailed whether by persuasion (he had organized a series of lectures on addiction treatment for the hospital staff), example (his own involvement with the House of Hope included presiding over the dedication of the chapel), or the exercise of his authority (he emphasized that he had no superiors at the hospital and answered directly to the Ministry of Health), and the hospital was now regularly visited by addiction counselors.

Styazhkin and the physicians who ran the program emphasized the successful rehabilitation to society of the patients who had completed the program and been released from the hospital (a psychologist on the ward referred to them as “our alumni” [nashi vyipuskniki]): many of them were working now. Often patients were released from the hospital and transferred to another rehabilitation program: more than forty had been transferred to the House of Hope. Others lived for a while in a halfway house established by the doctors and counselors. Unlike the general population of patients, who tended to be released in three years, patients from the program were released in half that time.

The link between the addiction-oriented 12-step program and the patients’ presence at the hospital was not entirely straightforward in that neither a diagnosis of alcohol nor one of opiate dependence would render a
defendant in a criminal case nonculpable according to the Russian Federation’s Criminal Code. (If anything, intoxication and addiction are treated as aggravating circumstances.) Rather, nonculpability usually depended on having carried out a crime in a psychotic state, and more than 70 percent of the patients in the hospital were diagnosed with either schizophrenia or a schizoaffective disorder. And yet one of the psychiatrists argued that “very few people commit their crime in a state of psychosis,” and Styazhkin explained that 80 percent of the crimes committed by patients in the hospital were committed in a state of drug or alcohol intoxication, and 52 percent of these patients suffered from substance dependence (Kazakovtsev, Styazhkin, and Tarasevich 2002). The psychiatrists viewed many of these patients’ addictions as precipitated by self-medication. “They tell us, ‘When I drink the voices in my head stop,’” explained one clinician on the ward.

In order to allow release from the hospital, the law required that there be an “elimination or lowering” of patients’ social dangerousness, yet both Styazhkin and the ward psychiatrists emphasized that what they looked for was “a more or less critical relationship to the illness.” “This is an important part of the program,” Styazhkin explained, “A critical relationship to the illness, a critical relationship to his own social status. For us, it’s a good sign if a patient enters the program. As a doctor, then I understand that he is beginning to understand his own problems.” However, he added, “We always tell the participants—that participation in the program is good for you, but it won’t be the main reason for your release [vypiski]. This is a program for you, your life.” One of the ward psychiatrists added, “The 12-step program creates a conscious relationship to oneself [osoznannoe otnoshenie k sebe] and [the patients] see that they are not alone or unique. The patient is active.”

Here, the 12-step program was viewed instrumentally by the clinicians as a means of managing the stigma of severe mental illness by replacing it with alcoholism as a kind of proxy illness or form of self-identification. As Styazhkin put it in a journal article about the program, “It is often easier for the patient to acknowledge that he is an alcoholic or drug addict than a mentally ill person, and in this way to carry over all of his psychological problems onto the plane of alcoholism or drug addiction” (Kazakovtsev, Styazhkin, and Tarasevich 2002, 17). Self-identifying as an alcoholic was meant to be the first step in a general process of self-reflection, insight, and
improvement, which for the psychiatrists and the hospital director had as its end an ideal of rehabilitation—of reintegration of the patients into a particular vision of the social. According to this logic, the seeming lack of fit between diagnoses and methods of rehabilitation—the fact that no one was sent to the hospital because of a diagnosis of alcohol dependence—was no incongruity at all but a technique for managing the effects of stigma. And yet this framing of addict self-identification was deeply in tension with the way that this identification was understood by Nikolai and other counselors and participants in the program.

**Psychotherapy with God**

Nikolai was often described as the ultimate success story of both the program in Styazhkin’s hospital and HOH. He had been committed to the hospital after years of arrests and hospitalizations related to his drinking. He had been one of the first patient-inmates through the 12-step program at the hospital, and like those who followed him he was transferred upon discharge to the House of Hope. Over the following five years, he had gradually risen to become one of the head addiction counselors there and had completed a training course in upstate New York.

For Nikolai, embracing the 12-step program was inextricable from trying to live “a Christian life.” While this meant a certain level of involvement with organized Orthodox Christianity, the AA movement and its practices seemed to figure as the central source of religious institutionalism in his life. Like other St. Petersburgers I met who were involved in AA, Nikolai spoke about having a spiritual (духовный) outlook and approach to life rather than a religious (религиозный) one. When I asked him what living a Christian life meant, Nikolai emphasized that it was more than simply “re-entering society”—something that might be seen as a basic goal of rehabilitation programs. As he put it, “Everyone has a purpose, a God-given purpose, that’s more than just working, getting married and having children.” At this point, while describing the fourth step—which requires members to make a “fearless and searching moral inventory” of themselves—Nikolai evoked the hybrid therapeutic and spiritual character of AA’s practices, explaining, “It’s like the most amazing psychotherapy, but where the psychotherapist is God.”
Within the network surrounding the House of Hope, Nikolai served as both a charismatic leader and a model of recovery—a “miracle” in the words of an American donor. The hospital director emphasized Nikolai’s transformation: “Of course when he first came to us, Nikolai was more an animal than a person.” While no longer working as a counselor, Nikolai continued to lead AA group meetings in the city and work as a social worker at the special hospital. Along with his friend Andrei, he organized a series of concerts that brought musical performers in HOH’s social network to the hospital. Nikolai also acted as an unofficial liaison between the rehabilitation program at the hospital and HOH, arranging for patients to be admitted to the rehabilitation center and shuttling them to the center on the outskirts of St. Petersburg. Moreover, Nikolai’s close involvement with these groups brought him into contact with the American sponsors of HOH, as well as with the Mit’ki and other cultural figures associated with the center, in a set of relationships that blended friendship, recovery, and business. This network also provided Nikolai with the resources to reconstruct a family. I knew that he had been married before and that his teenage son was addicted to drugs. He had met Vera, his present wife, after his release at a 12-step group meeting in the city; she was a recovering drug addict at least ten years his junior.

What did it mean for Nikolai to identify as an alcoholic? Within the social network of 12-step programs and their adherents, this identification provided him with a valuable source of symbolic capital. In addition to being released from the hospital, he gained access to a set of therapeutic techniques in which (despite a lack of formal higher education) he could claim not only expertise but a privileged position (in relation to sober psychiatrists) as a “fellow sufferer.” And though he was certainly not accepted as an equal by intelligentsia members of AA, he was able to circulate among them and to benefit from a network of contacts that spanned class distinctions as well as national borders. Despite all of this, Nikolai and other patients did not frame their identifications as means to other ends but as ends in themselves.

Rehabilitation, Citizenship, and Sodality

In radically extending the parameters of Nikolai’s life by means of his identification with an illness, AA’s rehabilitative techniques have a
family resemblance to the numerous phenomena anthropologists have lately described under the rubric of “citizenship.” Building on Paul Rabinow’s (1992) notion of a sociality constructed around a now technically manipulable biology, which itself of course was an elaboration of Foucault’s concept of biopower, scholars have described varieties of “biological citizenship” (including “therapeutic” and “pharmaceutical” citizenship)—claims to rights and privileges made to state and nonstate organizations on the basis of illness status or biological fact. A particular set of conditions underlies the otherwise varied cases described under the rubric of biological citizenship—whether in the case of Ukrainians claiming disability status due to their exposure to radiation during the Chernobyl disaster (Petryna 2002), AIDS activists in Brazil or Burkina Faso working to access antiretroviral medications (Biehl 2007; Nguyen 2005), or refugees from North Africa claiming asylum in France on the basis of marks of torture and trauma (Fassin 2007; Ticktin 2010). In Vinh-Kim Nguyen’s felicitous phrasing, underlying all these cases are the conditions of “a neoliberal world in which illness claims carry more weight than those based on poverty, injustice, or structural violence” (2005, 143). While such concepts of citizenship illuminate significant ways in which illness and health increasingly mediate the claims people make on various governing institutions, there are a number of compelling reasons for developing a more differentiated terminology for thinking about the politics of life and health in the contemporary world.  

In this chapter I have proposed the notion of the illness sodality as one step in this direction. Cases such as that of AA in Russia highlight several phenomena that a language of citizenship deemphasizes or even fails to capture. These include the hybrid secular-spiritual character of associations such as AA and their deliberate dissociation from any projects of institutional governance, welfare provision, or claims to rights or resources. This does not mean that such associations are in fact unrelated to such projects. Illness sodalities such as AA may overlap with projects of citizenship, but unlike these—and unlike patient advocacy groups—they are not explicitly concerned with any projects of institutional governance, whether carried out by the state, NGOs, or other transnational actors.