Conclusion

This book has examined the ways in which the clinical management of alcoholism has changed over the critical period of post-Soviet transformation in Russia, focusing on the implications of these changes for practitioners and patients. Taking narcology as a domain of knowledge, ethics, and intervention, it raises a number of questions regarding the place of truth and ethics, responsibility, personal autonomy, beneficence, and obligation in the processes that make up this domain. In what follows I bring together a number of the themes and arguments developed in the book.

First, the book examines the translation of clinical ideas and technologies along several vectors: (1) interventions and institutions developed during the Soviet period are retooled for post-Soviet times; (2) clinical technologies originating in the United States are translated into a Russian setting; (3) a constant translation between expert and lay spheres of knowledge takes place; and (4) social and political meanings and processes are translated into clinical and commercial value.1 I argue that since the late 1980s, the field of clinical and public health addiction management has
undergone two distinct but closely related shifts. The more remarked-on of these is the shift from a state socialist political economy (characterized by competition among firms for scarce resources and exchanges of favors [blat]) to an unevenly regulated market in which state, commercial, and nongovernmental clinical institutions compete for patients (Verdery 1996; Ledeneva 1998; Salmi 2003). The second shift took place in the political economy of knowledge regarding addiction and its treatment. Late Soviet narcology was based in a very particular biomedical model, which claimed its origins in Ivan Pavlov’s physiology of reflexes (Babayan and Gonopolsky 1985; Joravsky 1989). Though by the 1970s and ’80s, the actual research and treatment conducted under this banner often ignored Pavlov’s work, late Soviet medicine defined addiction in overwhelmingly biological terms and made heavy use of behavioral treatment methods, such as the alcohol antagonist disulfiram and emotional-stress psychotherapy (Ivanets 2002). At the same time that Russian narcology has developed closer ties to the international medical and scientific communities, its practitioners have increasingly found themselves competing with imported methods and movements, ranging from Alcoholics Anonymous to Scientology.

In tracing these translations, I have focused on the practices through which clinicians and other practitioners produce and manage what I call “therapeutic legitimacy.” As Margaret Lock and Vinh-Kim Nguyen have written, “in addition to the mastery of biomedical technologies, practitioner-selfhood encompasses the political and social processes that confer therapeutic legitimacy. The power to heal is not only a result of individual prowess, but the social relations that accrue to those endowed with therapeutic authority” (2010, 291). As I have suggested throughout this book, such social relations and processes extend far beyond formal criteria of training and credentialing. Indeed, highlighting therapeutic legitimacy draws our attention to the diffuse and informal processes through which efficacious healing is enacted. Throughout this book, but particularly in chapter 4, I have thus traced how therapeutic legitimacy is produced and managed in face-to-face interactions between clinicians and patients, as well as in the broader discursive arenas of the media and in the slippery domain of rumor.

One of the aims of this argument is to move away from using analytic frameworks that narcologists (and their non-Russian colleagues) typically
deploy in their own discourses: biomedicine versus alternative or complementary medicine, manipulative methods versus humane ones. Aversive treatments were often depicted by their detractors as Soviet, authoritarian, and manipulative, and depicted as fostering dependence, by contrast with 12-step programs and psychodynamic therapy, which were cast as humanistic and depicted as fostering autonomy and independence. In response, proponents of khimzashchita and kodirovanie argued that these therapies did confer agency onto patients and that they were more appropriate to the Russian culture and mentality. Although I am not suggesting any substantive relationship between modes of political authority and clinical techniques, attempts to create or bolster such associations were clearly an important strategy used by practitioners in building or undermining the legitimacy of various therapies. In other words, I have examined how these very labels are employed in the process of building legitimacy for certain methods over others. Thus contemporary Russian debates about and struggles over appropriate interventions into the problems of addiction evoke the broader institutional, political, and historical contexts within which these therapies and interventions are embedded.

This book gives attention not only to the accounts of physicians but also to those of patients, specifically arguing that while many narcologists have an interest in portraying hypnosis as a powerful and authoritative technology, patients undergoing such treatments do not experience themselves as controlled by some external agency or by something akin to political persuasion. Rather, many patients see treatments such as hypnosis as actually affording them relatively more autonomy—both in their everyday lives and in their self-conceptions—than 12-step methods, which require of adherents a full self-transformation, somewhat like a religious conversion. While relationships of dependency do develop between physicians and their patients, these have less to do with any particular clinical methods than with the overall social trajectories of patients’ lives.

Patients have been caught in a web of institutional and discursive practices—the forensic, the legal, the rehabilitative, the spiritual. The figures of personhood and responsibility that inhered in those practices differed from, and at times clashed with, one another. Whereas some of these practices were enacted by psychiatrists, narcologists, counselors, and healers ascribing certain forms of personhood (and certain claims about responsibility) to patients, others were taken up, rehearsed, struggled with,
modified, and sometimes claimed by the patients themselves. Indeed, I have suggested that one key distinction between the therapeutic methods I call prostheses for the will and 12-step methods is the degree to which the latter are part of an ongoing process of acting to become a person of a certain sort. This is a process not without a potential for irony, tension, and failure, yet one that has an elective affinity with the cultural logic of neoliberalism.

Ultimately, I have suggested that patients’ different experiences and understandings of therapeutic modalities had as much to do with the broader configuration of institutions and relationships (both inside and outside the clinic) within which any particular instance of the treatment took place as they did with the particularities of the therapies themselves. The addiction therapies discussed here highlight how the efficacy of all treatment is shaped by elements, including chemical effects and patients’ interpretations of those effects, clinical performances and relationships, clinicians’ styles of reasoning and local research traditions, and the institutional and political economic settings of treatment. Moreover, such a perspective suggests how partial and incomplete an understanding of any clinical intervention is when it is reduced to a therapeutic protocol, a reduction that depends on the assumption that clinical technologies are discrete, portable, and transposable between contexts with little transformation. As the movement of clinical knowledge, substances, and techniques becomes ever more ubiquitous and far-reaching, it is increasingly important for anthropologists of medicine and psychiatry to explore the processes and mechanisms that link patients’ treatment experiences to the material, discursive, performative, and institutional elements of which all interventions are composed.