Governing Habits

Raikhel, Eugene

Published by Cornell University Press

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

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Introduction

1. Much Foucault-inspired literature on health focuses on medicalization, understood as a particular mode of knowledge and intervention underpinned by the specialist authority of the medical profession (Foucault 1980; Petersen and Bunton 1997). This literature typically examines the ways in which the framing of human experience (particularly experiences of suffering) by the dominant paradigms of biomedicine tend to obfuscate or erase social and political meanings and implications, thereby shaping and reinforcing existing arrangements of power and distributions of resources. The conceptual key to such analyses is precisely not that physicians act as puppets for a repressive power of the state or a particular class (as Marxist analyses would have it) but that medicalization functions as a form of productive power underwritten by the professional autonomy, expertise, and knowledge of physicians. Medicalized discursive and institutional practices are thus one particular form of biopower—that is, they are a form of political rationality and practice focused on “fostering life” and regulating populations (Foucault 1980).

2. As historians of science and medicine have shown, today’s chronic, relapsing brain disease model is just the most recent in a long series of attempts to conceptualize addiction to alcohol, opi- ates, or other drugs as a disease (Acker 2002; Campbell 2007; Valverde 1998). While these models share certain characteristics, they invoke distinct loci and mechanisms of addictiveness and privilege different forms of intervention and lines of scientific research; in addition, all have been shaped both by their contemporary political and social milieu and by the styles of thought prevailing in contemporaneous scientific communities (Berridge 2013; Courtwright 2005; Gusfield 1996;
Vrecko 2010b). If there is one red thread running through this literature, it is the idea that experts arguing for disease models have, since the nineteenth century, represented themselves as “‘moral entrepreneurs’ or ‘moral pioneers’ [seeking] to change public policy and shift popular perceptions” (Campbell 2013, 239) of addiction as moral failing or deviance. While some of this research emphasizes continuity—tracing a process of medicalization, an expansion of the addiction concepts’ applicability, or a genealogy of “the disease model”—much of the recent literature highlights the divergent ways in which addiction (as well as its objects and subjects) has been framed in medicalized terms.

3. In a set of observations that can be generalized to other clinical settings, Van der Geest and Finkler (2004) note the widespread perception of hospitals as spaces where the practices of contemporary biomedicine are conducted and reproduced in a relatively uniform manner, regardless of local context. However, as work conducted on the anthropology of biomedicine over the past twenty-five years has shown, this perception of uniformity and relative homogeneity is better understood as the ideology of biomedicine.

4. Most of the names used in this book are pseudonyms. In order to simply demarcate the roles of different informants, I use first names (such as Vyacheslav or Pavel) to indicate patients and 12-step counselors and first names along with patronymics (Anton Denisovich, Alexander Sergeevich) to mark most physicians. Because the first name/patronymic combination is a relatively formal type of address, typically used to mark respect or social distance in Russian, its use runs the risk of essentializing the distinction between physicians and patients; but this naming system also gives a sense of the interpersonal hierarchy at play in most St. Petersburg clinics. I have used the actual names of those few figures who have already been written about in the media; they are identified by their first and last names (e.g., Sergei Tikhomirov).

5. Given physicians’ generally high level of authority in the hospital, relative to patients, this selection of interviewees led me to question patients’ capacity to give consent under such conditions. See Vieda Skultans’s discussion of a similar quandary during her fieldwork with psychiatrists and their patients in Latvia (2005, 496).

6. While anyone is allowed to attend AA meetings designated “open,” “closed” meetings are restricted to those who are already members or believe they “have a problem with alcohol” (Wilcox 1998, 48).

1. States of Crisis

1. This slippage is somewhat masked for English readers by the fact that both russkii (which refers to the language and nationality) and rossiskii (which refers to the Russian Federation) are translated as “Russian.”

2. As I discuss in chapter 2, such use of antipsychotics has been justified by the theory, influential in Russian narcology, that understands addictive craving as a kind of “over-valued idea” or even a phenomenon approximating a delusion (Mendelevich 2013).

3. It is important to note that shifts between formal and familiar registers—primarily marked through the second-person pronouns ty and vy—can have a range of meanings and effects, depending on the situation and the relative social position of the speakers. Thus the familiar ty can be used not only to convey a closeness of relations but also to demean someone or highlight his or her subordination.

4. The legal category that most closely approximated these colloquial and quasi-clinical categories of abjection, was BOMZh, which stands for “Without a Fixed Place of Residence” (Bez Opredelennogo Mesto Zhitelstvo) and refers to persons who lack a residency registration. The contemporary Russian residency registration—still referred to by most people as propiska, its Soviet name—is often described as the latest version of a state technology for the surveilling, managing and restricting the mobility of populations that dates to Peter I’s introduction of internal
passports during the early eighteenth century. Reestablished in 1932, the propiska system became the linchpin of the Soviet “mobility regime” and the means by which the party-state sought to settle nomadic populations, organize labor power, enforce military conscription, control urban immigration, and deliver social services (Stephenson 2006). While most of the punitive elements of this system—including various laws aimed at “vagrants” and “parasites”—were abolished in the early 1990s, the Russian registration system continues to link social citizenship—in the form of access to health care, legal employment, education, and pensions—to residency. There is, of course, some flexibility to the system—as many of the patients in the narcological hospital lacked registrations but were still allowed to access its resources. Yet on a day-to-day basis, the administrative category BOMZh was perhaps less salient to these patients than the everyday notion of bomzh and its associations with dirt, disorder, and moral bankruptcy (Höjdestrand 2009).

5. In Russia, rates of HIV/AIDS remained relatively low until the mid-1990s, when highly processed heroin began to displace various types of opiates made from poppy straw—in a pattern that directly followed the spread of “hard currency” markets throughout the country (Paoli 2002). For the first fifteen years of the epidemic, injection drug use was responsible for the vast majority of HIV transmission in Russia. For example, public health researchers estimated that in 1997 between 74 and 90 percent of new HIV infections in the Russian Federation originated in injection drug use (Atlani et al. 2000). By 2012 this figure had dropped to below 60 percent (Federal AIDS Center 2012). Heroin remains the most commonly used drug in Russia, with some recent estimates putting the number of injectors at 1.5 million or even higher; over one-third are likely to be HIV-positive (Goliusov et al. 2008; UNODC 2011).

6. Such sweeping culturalist arguments (made by Russian elites as often as by visitors) were one of a number of Orientalizing (and self-Orientalizing) discourses that, as Larry Wolff (1994) has argued, served to demarcate Eastern Europe as a space of backwardness.

7. While contemporary accounts are generally more astute, many tacitly employ the accounts of early European travelers to Russia as evidence of the timelessness of Russian heavy drinking practices. Indeed, as Simpura and Levin have argued, two basic mythic narratives have prevailed in many discussions of Russian drinking and alcohol. According to one, “the Russians and alcohol, and vodka in particular, have lived in a harmony where the benefits have been rich and the damages negligible. . . . A side-plot in that story consists of the efforts of evil rulers to bring discipline into this inherently harmless relationship” (1997, 13). The opposite (but closely linked) mythic narrative assumes that “Russians are particularly prone to excessive drinking, with particularly detrimental consequences in production and reproduction” (ibid.). Yet even this narrative has another shade of meaning, for, as Simpura and Levin point out, it is often assumed that “that excessive drinking is but another of the hardships the Russians have to undergo,” and that “these hardships also refine the Russians into a deeper understanding of life, into spheres that are inaccessible to those more blessed with well-being” (ibid.).

8. Significantly, the popular perception of narcotic drug use as a solely post-Soviet problem overlooks the fact that the USSR experienced a significant epidemic of drug use during the 1920s and ’30s (Latypov 2011; Vasilyev 2012).

9. By the mid-1990s some of these groups had transformed from their emergence several years earlier as protection rackets into semilegal and legal security organizations and had come to be widely perceived as agents of much-needed social order (Yurchak 1999).

10. As Dale Pesmen eloquently puts it, in the process of sitting and drinking together “work was transformed into rest, business into community, exchange into help, and vice versa through fluidity, leakage, and formal similarities between economic and emotional solidarities” (2000, 181). But see Doug Rogers 2005, 69, on women in his rural field site in the Urals who distinguish between drinking that has some instrumental or productive aspect and spur-of-the-moment carousing.
11. As some observers have argued, this campaign demonstrated the ideological and dispositional kinship of Gorbachev with his sponsor, the late general secretary Yuri Andropov. It was during Andropov’s brief rule during the early 1980s that various campaigns had been spearheaded against corruption, theft from the state, and other crimes against the Soviet state and society. It was also during this time that a new discussion about alcoholism was initiated in the press (S. White 1996; M. Levine 1999).

12. As two Soviet educators wrote during the late 1970s, “Boys being raised without a father either internalize ‘female’-type behaviors or create a distorted notion of male behaviors as antagonistically opposed to female behaviors and reject everything that their mothers try to instill into them. In both cases, there forms a vulgarized notion of male behaviors as aggressive, uncouth, harsh, and cruel . . . in an expressly belligerent sense” (Isaev and Kagan 1979, 29; quoted in Zdravomysova and Temkina 2012).

2. Assembling Narcology

1. As many anthropologists of postsocialism have shown, expressions and enactments of nostalgia for various aspects of the socialist past have been commonplace—if not ubiquitous—over the past twenty years (Berdahl 1999; Boyer 2006; Todorova and Gille 2010).

2. In what follows, I will focus primarily on “official narcology,” the branch that predominates in the state-funded addiction treatment service, central research institutes in Moscow and St. Petersburg, and the Ministry of Health. Because of the high level of centralization in Soviet medicine, much of this account may serve for former Soviet republics other than Russia as well.

3. Throughout this book, I use the notion of “style of reasoning” drawn from the work of Ludwik Fleck (1979) by Ian Hacking (1992). As Allan Young describes it concisely, a style of reasoning “is composed of ideas, practices, raw materials, technologies and objects . . . . It is a characteristically self-authenticating way of making facts, in that it generates its own truth conditions,” (2000, 158).

4. Foucault wrote about problematization as “the ensemble of discursive and nondiscursive practices that make something enter into the play of true and false and constitute it as an object of thought” (1966, 670, quoted in Rabinow 2003, 18). Paul Rabinow adds that “a problematization . . . is both a kind of general historical and social situation . . . as well as a nexus of responses to that situation . . . . The domain of problematization is constituted by and through economic conditions, scientific knowledges, political actors, and other related vectors” (2003, 19).

5. Such accounts typically begin with the establishment of kabaks (taverns that distilled their own vodka) by Ivan IV during the 1540s (Christian 1990). From the institution of the state-run kabaks in the sixteenth century, the Russian state employed a number of institutional arrangements to extract value from the production and sale of vodka. (These were paralleled by the restriction of production or trade outside state-regulated circuits; from 1660 non-nobles were prohibited from distilling for private use.) By the early eighteenth century taxes on the production and sale of vodka accounted for 10 percent of state revenues; by the nineteenth century vodka had become the largest single source of income for the Imperial Treasury, bringing in up to one-third of ordinary revenues. Such levels were, to some degree, connected to the fiscal structure of the imperial state; vodka was not the only substance that was taxed. Until the mid-eighteenth century, the taxation of salt provided comparable levels of income. As Christian and others have argued, the state’s increasing fiscal dependence on revenues from vodka in particular played a significant role in transforming the drinking practices of villagers, peasants, and serfs. Since kabaks were able to generate a higher profit from distilled liquor than from beer or mead, they promoted the consumption of vodka over lighter alcoholic drinks through pricing (Christian 1990; Takala 2002).

6. A campaign to revive what Stalin called “the fashion for money” accompanied this shift. While the new policy was interpreted by the sociologist Nicholas Timasheff and others as central
evidence of a “great retreat,” later accounts of the Stalin period have rejected this argument and have taken the statements of the regime more seriously. Thus David Hoffmann argues that the shift in the mid-1930s was tied not to the abandonment of socialism but to its supposed realization. Noting Stalin’s declaration at the seventeenth party congress that socialism had been built and the vestiges of capitalism “rooted out,” Hoffman argues that institutions and values that may previously have been suspect as bourgeois were now available to bolster socialism. “No longer was it necessary to use iconoclasm to attack bourgeois culture, now that the economic basis and social classes that had spawned that culture had been eliminated in the Soviet Union” (2003, 6).

7. While I discuss the distinctions that specialist discourses on narcology drew between such categories as alcoholism and chronic alcoholism in the following section, popularizing texts of the 1960s and ’70s (even those authored by physicians) often failed to distinguish between drunkenness and alcoholism altogether (Zenevich 1967).

8. Susan Gross Solomon (1989, 1990) argues that while social hygienists avoided making the kinds of broad social critiques that their researches may have facilitated, their emphasis on gradual adaptation, moderation, and voluntary resocialization clashed with the ethic of impatience and speed, as well as the belief in the unlimited possibilities of sheer willpower championed during the 1930s industrialization. At a more fundamental level, whereas hygienists’ depiction of alcoholism as a social disease conferred primary responsibility on the Soviet state, psychiatrists’ definition of it as a mental pathology placed this responsibility more fully on the patient.

9. This sentiment epitomized the affinities between Pavlov’s theories and the Bolsheviks’ dispositions regarding materialism, mind, and consciousness. David Joravsky argues that party leaders simply persisted in the unexamined assumption (by then prevalent in radical circles for some fifty years) “that reduction to physiology was the only way for psychology to become a science” and added to this the assumption “that Pavlov’s school was leading the way” (1989, 212). All of this discussion was very general and unspecific: there is no evidence that any of the Russian Marxists were aware of the actual arguments underlying the early twentieth-century rejection of the concept of mind (185). This of course is hardly surprising. Given their practice-oriented dispositions and consumed as they were with the tasks of building a revolutionary organization, seizing state power, and reconstructing the institutions of governance, even the more thoughtful Bolsheviks had little time for squaring their theories of human action with those being developed in the human sciences.

10. Following a longitudinal approach, Soviet psychiatrists were more likely to base their diagnoses on the changing course of a patient’s symptoms over time than they were to examine only those symptoms presented during a single clinical encounter. Calloway (1992) notes that the preference for longitudinal diagnosis was facilitated not only by theoretical factors but also by institutional ones: namely, the fact that mental illness care was coordinated through dispensaries, which were responsible for overseeing territorially bounded patient populations. A dimensional approach to mental disease in turn assumes a continuum of possible states, ranging from relatively healthy ones through different forms marked as pathology. Such an understanding of illness has been described as fitting well with a nominalist conception of disease generally.

11. Snezhnevskii was vaulted to power from relative obscurity in the late 1940s, during the midst of a xenophobic campaign to create a Soviet Russian psychiatry and root out cosmopolitanism (code language for Jewishness). In 1950 he was appointed director of the Serbskii Institute and soon afterward chief of psychiatry at the Central Institute for Postgraduate Medical Training. Rival schools of thought avoided publishing overt criticisms of Snezhnevskii’s concept of schizophrenia (Joravsky 1989).

12. The dominant argument was simply that alcoholism was one of many social ills (poverty, prostitution, and crime among them) that were inevitably fostered by capitalist relations of production (Galina 1968, 6). By radically transforming these social roots of alcoholism, many
texts argued, the construction of socialism would, by definition, eradicate such phenomena. While such claims were patently absurd by the 1950s and '60s (after more than two decades of life under socialism, according to official definitions), the questions that they raised were avoided in public discourse.

By the 1970s and '80s some Soviet commentators were distinguishing the “primary social roots” (exploitative relations of production), which fed alcoholism under capitalism, from the “secondary” ones, which explained its persistence under socialism: “people’s habits and norms” (priyazhki i nray) (Beisenov 1981, 12). Thus, perhaps it was not surprising that the broad conclusions reached by these researchers were similar to those of the social hygienists: heavy drinking, or alcohol abuse, was depicted as a learned behavior, or habit, born out of the drinker’s relationships in his “microsocial environment” (mikrosotsial’naiia sreda) (Zenevich 1967; Galina 1968, 50–58; Tkachevskii 1974, 37).

13. Despite its somewhat confusing name, many Russian narcologists refer specifically to alcohol abstinence syndrome rather than withdrawal, indexing the Soviet scientific origins of the former. As described during the late 1920s and early '30s by the Soviet neurophysiologist S. G. Zhislin (1959), “abstinence syndrome” (abstitentnyi sindrom)—sometimes referred to as “hangover syndrome” (pokhmel’nyi sindrom)—is characterized by tremors, sweats, and difficulty sleeping. Ivanets (2001) argues that Zhislin’s work went unnoticed overseas, until it was essentially replicated as withdrawal syndrome by American researchers during the 1950s.

14. The crime of “hooliganism” had been created in 1922 primarily to address the “consequences” of intoxication such as brawls and disturbances of the “public order” (Solomon 1978, 91). This labile category, which was applied to acts ranging from public swearing to fighting to destroying state property, was defined in the criminal code as “intentional actions violating the public order [obshchestvennyi poriadok] in a coarse manner and expressing a clear disrespect for society [obshchestvu].” (Kirichenko 1967, 5; Solomon 1978, 194). Although discussions of hooliganism often related it to intoxication, this legal category encompassed only “public” spaces, excluding similar disturbances in domestic spaces or even communal apartments (Solomon 1978). This is one of many seemingly minor ways in which new public-private distinctions were being drawn in the Soviet Union during the 1950s and '60s. An increasingly important theme in the historical and ethnographic literature on socialism and postsocialism is the question of how spaces or practices outside the purview of the party-state (or indistinguishable to its gaze) emerged (Yurchak 2006).

15. In fact, the initial legal basis for giving compulsory treatment to addicts categorized as “socially dangerous” had been laid by a 1927 decree. However, the specific provisions and institutions for carrying out such treatment were not developed until this point in the post-Stalin period (Babayan and Gonopolsky 1985; Solomon 1989).

16. As Solomon explains, the planned campaign against the “roots” of heavy drinking was preempted and scuttled by a campaign against hooliganism initiated by the Ministry for the Defense of the Social Order (MOOP). Since the anti-hooliganism campaign was perceived by security officials as a “repressive measure,” the call for extending compulsory treatment to non-criminal alcoholics was the only recommendation that fit into the goals of this campaign. Solomon suggests that this turn of events may have reflected the strength of MOOP (and related security ministries such as the MVD) relative to other organs of the Soviet state, such as the supreme court (1978, 88).

17. The broader anti-alcohol measures (cuts in production, propaganda) were initiated five years later, in 1972, with a joint decision by the Communist Party’s Central Committee and the USSR Council of Ministers: “On measures to step up the drive against drunkenness and alcoholism.” A nationwide network of commissions was established to oversee the campaign (Tkachevskii 1974, 30).
18. During the 1990s the number of sobering-up centers decreased rapidly. The system was shut down entirely in 2011.

19. Field attributes the creation of “medical microdistricts” and a system of care based on these districts as the ground-level unit of organization to the zemstvo reform of 1864. “A microdistrict (uchastok), a territorial or geographic unit for the delivery of medical care, was designed to provide complete and comprehensive medical coverage for the population. The basic organizational medical nucleus was an outpatient clinic to which was added, later, a small hospital” (1967, 22).

20. For accounts of the genesis and use of the propiska system by the Soviet party-state, including its role in “fixing” national identities see Matthews 1993; Kotkin 1995; Popov 1995; Shearer 2004. On the post-Soviet effects of the system, particularly for those left without documents or housing, see Höjdestrand 2009.

21. Zona is a Soviet term used to denote detention and prison colonies, often located in Siberia, the Far East, or the circumpolar regions of Russia; it is often used more or less interchangeably with the term “gulag.”


3. Selling Sobriety

1. Similarly, the funding of hospitals according to their ability to fill a given number of beds and polyclinics according to their capacity created an incentive for specialists to carry out more procedures than they might have otherwise. Thus, during the 1980s the USSR had an average of 2.8 days of hospital stay per person annually, as opposed to 1.2 in the United States (where the deregulation of medical insurance was simultaneously promoting the opposite effect) (Twigg 1998).

2. Other systemic tendencies of the planned economy affected the healthcare sector as well. Like other units or firms within the socialist economy, hospitals and polyclinics operated under what Janos Kornai (1992) and other economists have called “soft budget constraints”: that is, conditions under which a fiscal failure leads not to bankruptcy but to a firm’s being bailed out by the state. Simultaneously, socialist managers were pressed to fulfill and overfulfill quotas and goals of the plan, a task that placed them in competition with other firms for limited material resources. These two conditions combined to create an incentive for socialist managers to hoard supplies, pad their budgets, and request more than they needed from the center, as well as to circumvent official channels of distribution by exchanging directly with other firms. These dynamics created shortages throughout the socialist economy, which only fueled the same dynamic (Berliner 1957; Kornai 1992; Verdery 1996, 21–22). Moreover, such practices of hoarding extended to human resources, as managers (anticipating no-shows or underqualified employees) often requested more specialists than they needed from the centralized system that assigned university graduates to jobs (Solnick 1998, 135–36).

3. Additionally, the share of the national budget allotted for health dropped from 6.5 percent in 1965 to 4.6 percent in 1985: translated into a percentage of estimated GNP, this amounted to something in the range of 3 to 2 percent (Davis 1989, 246; Rivkin-Fish 2005). Physicians’ salaries were typically only 70 to 80 percent of an average manual worker’s pay, one of the factors that led to the increasing feminization of the Soviet medical labor force: women accounted for 76 percent of the labor force in this sector in 1950, a figure that had climbed to 80 percent by the late 1990s (Ryan 1978, 42, 1990, 22; Schecter 2000, 89).
4. Soviet laws mandating employment also fostered a brisk market (which has also persisted into the present day) in the “sickness certificates” that provided a legitimate excuse for missing work (Ryan 1978, 117–25; Field 1991). Universal male conscription and ubiquitous practices of hazing (dedovshchina) created a similar market in physicians’ statements attesting to a young man’s physical or mental lack of fitness for military duty (Solnick 1998, 181; Elkner 2004).

5. The eighty-eight regional funds and the single federal fund were to receive their primary financing from income-based contributions made by employers: 3.4 percent for a regional fund and .2 percent for the federal one (Sheiman 1994). In most cases the funds were meant to act not as insurance providers but as independent regulators of the insurance system; they would finance commercial insurance companies, which in turn would develop contracts with local hospitals, clinics, and medical practices. Competition in this system was to take place at two levels: consumers would have a choice of insurance companies vying for their business, and hospitals and clinics would compete for contracts with insurance companies. Additionally, the system retained a strong element of state support: the health care of those citizens who were unemployed or retired would be financed by the federal fund or by municipal governments’ contributions to the mandatory funds. The federal fund was meant both to equalize funding across regions and to support medical care that was deemed particularly significant—including oncology, tuberculosis, and some STDs (Sheiman 1994; McKeehan 1995; Twigg 1998).

6. Moreover, the rapid decentralization of health care has arguably resulted in eighty-eight separate healthcare systems—each structurally and functionally different from the others. Critics have argued that this has to do both with the inadequate regulation of the market in some areas and with an excessive devolution of authority in others (Twigg 1998). One essential problem lay in the fact that much of the money meant to finance clinics and hospitals never reached them; rather, it disappeared or remained in the insurance funds. Thus throughout the 1990s, only 30–35 percent of healthcare financing came from the mandatory insurance funds (Balabanova, Falkingham, and McKee 2003; Rivkin-Fish 2005). At the same time cash-strapped municipal governments, expecting that these payments would be forthcoming, began to slash their health budgets, leaving hospitals and clinics in a financial bind.

7. By 2000 the number of beds had further declined, to 30,233 (Ivanets 2001). In 2012 there were only 101 narcological dispensaries left and 24,250 beds (Narcology Research Institute 2012).

8. For instance, a local movie theater catering to middle- to high-income people offered VIP viewings of films for about three times the price of regular tickets. They were screened in a small hall containing only five pairs of plush seats, each of them equipped with a button allowing viewers to silently summon a waitress.

9. Many thanks to Daniel Alexandrov for suggesting this interpretation of anonymous treatment and the register.

10. The lack of protection of privacy was linked to a number of concrete factors, including the conduct of medical consultations. Vieda Skultans writes that in Soviet Latvia psychiatric consultations “lacked the privacy with which they are associated in the West. Access to consulting rooms is seldom restricted to a doctor and her patient. Besides the prescribing nurse who shares the consulting room, other staff and, indeed, patients frequently interrupt an ongoing consultation. . . . Patients were, until recently, in charge of their own notes. In such contexts, problems are publicly shared” (2003, 498).

11. Dreizin had also had a sordid past—in 2002 his clinic lost its license when the head of the city’s licensing bureau was accused of receiving bribes from him. A bomb subsequently went off near this official’s home.

12. The man who had held the position of head narcologist for the northwest district prior to Tikhomirov, Leonid Shpilenia, was attacked several times, in his account because he refused to sell licenses. Shpilenia had been in the post of head narcologist for only two months when in March 2003 he was severely beaten; in June of that year, two attempts on his life were made by
bomb. Upon Shpilenia’s resignation, the post went to his deputy, Tikhomirov. Other attacks and intimidations surrounded the doctor. Originally when Shpilenia was appointed head narcologist, a Natalia Kulikova was named his deputy. However, days before she could assume the post, she had been attacked by an acid-wielding assailant as she approached her home. Tikhomirov was named to the post instead. Soon thereafter, two other narcologists resigned from the addiction hospital after receiving death threats (Andreev 2004; Bezrukova 2006; Tumakova 2004).

13. The seminar, “Propaganda for a Healthy Lifestyle and Drug Use Prevention: Different Understandings, Common Interests?,” was held on December 9, 2003, at the Center for the Development of Noncommercial Organizations in St. Petersburg.


15. The argument is not that the state has been taken over by the mafia but that it has lost its monopoly on legitimate violence and become one of many actors providing similar services (Volkov 2002).

4. Prostheses for the Will

1. In the case of pharmaceutical interventions, patients’ self-identification and their conceptualization of their illness play a somewhat different role in the treatment process. While it is not intrinsically necessary for patients to conceive of their problems as originating in their brains in order for psychopharmaceutical interventions to work effectively, they are in fact encouraged to think this way for several reasons: to produce demand for pharmacological products, to increase compliance with pharmacological treatment regimens, and to ensure a relationship of trust and mutual understanding between physician and patient under an ethical regime of patient autonomy. Thus while many actual patients may continue to think about themselves and their distress in a variety of different terms, it might be fair to say that the ideal patient implicit in the imagination of many biologically oriented psychiatrists is one who conceptualizes her symptoms as stemming from a neurochemical imbalance (Dumit 2003).

2. As practiced in the Soviet Union, “rational psychotherapy” emphasized the role of the physician as a mentor-like figure who explained to the patient the ways in which his thinking was illogical. Alexander Etkind suggests that the belief in the rationality of the mentally ill underpinning this branch of psychotherapy leads to a displacement of responsibility onto the patient, and therefore something close to a “punitive psychiatry” (1994, 70). It is worth noting that while such an approach may be deeply divergent from psychodynamic ones, it is not so different from cognitive-behavioral therapies so popular in the United States. More important, Soviet writers argued that the effectiveness of rational psychotherapy depended on an unequal relation of authority between physician and patient, often emphasizing the requirement that the former be “intellectually superior” (Lauterbach 1984, 61–69).

3. During the 1930s, Walter Voegtlin, a gastroenterologist who had studied with Pavlov, established a sanitarium in Seattle for the treatment of alcoholism by conditional-reflex therapy. Along with several other self-styled “alternative clinics” throughout the United States and United Kingdom, this institution—now known as the Schick-Shadel Hospital—continues to treat addiction using aversion therapy (Lemere 1987; White 1998, 106–8).

4. This was the term used by social hygienists to describe those patients whose illness was primarily explicable by reference to “social factors” and who would benefit from the outpatient treatment they advocated (Solomon 1989).

5. Indeed, even textbook protocols suggest the punitive character of the technique. A course of treatment with procedures like the one described above included “15–20 daily sessions” (Babayan and Gonorpsky 1985, 221). The fact that the effectiveness of the therapy was thought to hinge on the extreme unpleasantness of the experience meant that narcologists were effectively
 encouraged to place the health of their patients in danger (at least temporarily): “Nausea and vomiting begin about ten minutes later, but the patient must be compelled to take additional portions of alcohol, which in turn causes repeated painful retching spasms. . . . It should remembered, however, that each session may end in pronounced, and at times severe, states of cardiovascular insufficiency, occasionally even reaching the state of collapse. Hemorrhage from the esophagus and stomach due to the rupture of small vessels and epileptic seizures are also possible. Therefore, a first-aid kit should be fitted with all the essential drugs and kept at hand” (224).

6. Derived from the full chemical name—Tetraethylthiuram disulfide—*teturat* or *tiuram* is a name used for disulfiram in Russian (Sereiskii 1952; Eneanya et al. 1981). Antabuse is the trademarked name of disulfiram. Esperal is a brand name for disulfiram produced by the French pharmaceutical company Sanofi-Aventis, but in Russia “Esperal” typically refers specifically to disulfiram implants.

7. When it is used, disulfiram is typically recommended as an adjunct to psychosocial treatment programs, used to facilitate periods of sobriety during which patients can develop a “sober life-style” (Brewer, Meyers, and Johnsen 2000, 329).

8. Anne Harrington has argued that the roots of twentieth-century skepticism toward placebos emerged when epistemological concerns regarding the existence of invisible forces such as “animal magnetism” intertwined with moral anxieties provoked by the notion of “a weak and impressionable mind (i.e., the patient’s) [coming] under the thrall of a strong and persuasive personality [i.e., the doctor’s or healer’s]” (2006, 185; 2008). Harrington argues that the epistemological and moral anxieties were brought together in the concept of “suggestion”—“the capacity to transform an idea directly and automatically into a sensation or movement” (2006, 185). Soon thereafter, with the rise of drug-based therapies during the early to mid-twentieth century, the practice of giving patients chemically neutral pills became increasingly viewed by medical opinion at worst as a sham and at best as something with no physiological basis used to mollify “difficult” patients (ibid.). In the case of disulfiram, this epistemological ambiguity is compounded by the fact that unlike placebo analgesia or changes mediated by the immune system, the locus of disulfiram’s nonspecific effect is particularly unclear. Sobriety that results from disulfiram therapy is a change in behavior that can be conceptualized as mediated by both conscious and unconscious mental processes.

9. The issue of compliance has been addressed by embedding disulfiram treatment into a number of institutional structures and coupling it with behavioral technologies in which patients’ agency is closely delimited or curtailed—such as parole, probation, or dispensation of the drug at specialized clinics (White 1998, 227; Brewer, Meyers, and Johnsen 2000, 332–36; Steffen 2005). For this reason the treatment is depicted by critics as one that requires an unacceptable level of coercion or social control (Steffen 2005, 184–15).

10. Rozhnov directed the All-Union Psychotherapeutic Center and was head of the Department of Psychotherapy at the Central Institute of Advanced Medical Training (Babayan 1985). As was often the case in Soviet medicine, the most widely promoted therapies were also ones developed by persons at the top of their respective institutional hierarchies.

11. Rozhnov ascribes this argument to the Canadian researcher Hans Selye. In a thesis that Rozhnov explains influenced the development of emotional-stress psychotherapy, Selye argues that “stress” “may not mean only destruction, but also creation, be not only pathogenic but also sanogenic; in short, life itself is stress, while complete freedom from stress, according to Selye, is death” (Babayan 1985, 111).

12. This may be a misnaming of “Narkonon,” the therapeutic and rehabilitation system developed by the Church of Scientology (Atak and Dvorkin 1996).

13. Most of the cases of patient deaths after disulfiram therapy involved commercial enterprises that offered the service of at-home disulfiram treatment. This procedure was sometimes carried out without checking the patient’s current blood alcohol level, and the house-call teams often left immediately after completing the treatment.
14. Keenly aware of the negative connotations that the term “coding” has taken on, Grigoriev (2002) categorically rejects this appellation, arguing that the technique should be more accurately called decoding, in that the code refers to DNA and to the genetic predisposition to alcoholism. Grigoriev adds that Dovzhenko’s method was important in the development of Russian narcology in that it made clear the necessity of cooperation between the church and medicine.

15. Another relatively common practice in Soviet psychiatry and narcology, the injection of sulfazine increased patients’ body temperatures to 40°C and was used as a form of aversion therapy.

16. As Summerson Carr (2013) has argued, much of the literature on addiction therapeutics—and indeed much of the work in medical anthropology on therapeutics more generally—has focused on the production of neoliberal subjects. One important vein of research has developed a Foucauldian interpretation of addiction therapeutics and interventions as “technologies of the self” (Valverde 1998). According to many of these arguments, nineteenth-century US and British ideas of addictions as “diseases of the will”—translated in the twentieth century into “impairments of choice”—arose and continue to stand in a mutually constitutive relationship to free will or unfettered choice (Seddon 2007; Sedgwick 1993; Valverde 1998). To put it in very rough terms, the addict was seen as one who was unable to align his actions with his intentions because of a weakness or failure of the will, which was conceptualized as a human capacity alongside reason and emotion. As Eve Sedgwick pointed out in a highly influential essay, such formulations of addiction resonate deeply with the problematics of capitalism in its consumer phase, with its exhortations to the free, willing subject to compulsively consume (1993).

17. At its basis, the method involved putting the patient into a trance state (in the past Kalashnikov had used the mild hallucinogen ketamine, but after it became illegal, he had switched to a strong antihistamine) and showing her images on a computer interspersed with “subliminal suggestions.” Using this method, Kalashnikov explained, “Alcohol is associated symbolically with something negative—like a sharp object, a nail, for instance.”

18. Indeed, in Pelevin’s novel Chapaev i Pustota (translated into English as Buddha’s Little Finger), a psychiatrist refers to his mode of treatment, which involves putting patients into drug-induced trances, as the “Kanashnikov method.” Veller, apparently a friend of Kalashnikov, writes about his practice in his book of stories, Gonets iz Pize.


5. Rehabilitation from Abroad

1. The issue of how to interpret the kind of movement that characterizes Nikolai’s story—whether it is movement of people, money, or technologies—has been central to discussions among anthropologists for well over a decade. Most recently, debates about cultural homogenization and localization that took place under the rubrics of “transnationalism,” “globalization,” and the “global” have been joined by discussions of “global assemblages”—a term that seeks to acknowledge both the radically mobile character of certain elements (particularly tools of rationalization such as standards and software code) and the mutability and contingency of others (such as ethical orientations and personalistic relationships) (Ong and Collier 2005).

2. For example, Valverde and White-Mair argue that while “AA members are perpetually in recovery, always working on their souls . . . they do not imagine they will ever remake themselves from scratch, by contrast to the neoliberal illusion that the poor can become business executives by sheer willpower. AA goes so far as to challenge American individualism by regarding exaggerated views of one’s power as part of the very illness of alcoholism” (1999, 401).

3. Although no surveys of AA in Russia have been conducted (and the informal nature of the organizations makes this a difficult proposition), by the time of my research, there were at least
ten AA groups in St. Petersburg with more than 150 members, at least thirty groups in Moscow, and according to some estimates, as many as three hundred groups throughout the Russian Federation (Critchlow 2000b). In addition to multiple groups in large cities such as Nizhni Novgorod and Kazan, AA members were active in small cities in European Russia such as Kostrroma and Ivanovo. Other 12-step-based mutual-help groups, such as Narcotics Anonymous, and groups for codependent family members, such as Al-Anon, were also becoming increasingly popular in larger cities. In Moscow, a city then rife with casinos and automatic slot machines, Gamblers Anonymous groups were also being formed.

4. Valverde argues that the latter “fits the familiar Foucaultian pattern of identity-based governance” (1998, 140). The idea of an essentialized alcoholic identity is made clear in a frequently cited distinction between so-called dry drunks—people who have achieved sobriety yet continue to think and behave “alcoholically”—and those who have attained true sobriety or serenity and put grandiosity and resentments behind them (Kurtz 1979, 123). Thus while many of AA’s techniques seem focused largely on behavior and its effects, eschewing a concern with the underlying roots of addiction, the emphasis on a complete and thoroughgoing change in self makes the program fully consonant with various stratigraphic conceptions of subjectivity—whether a Christian concern with the salvation of the soul or a depth psychology focus on insight or what Summerson Carr has called a linguistic “ideology of inner reference” (2006, 634).

5. Scholarly work on the practices of AA and other 12-step programs has closely examined how processes of self-transformation are linked to autobiographical narrative. Typically such narratives follow a script embedded in the AA literature: increasingly out-of-control drinking, losses and social isolation, hitting bottom, joining AA and recovery (Cain 1991; Hanninen and Koski-Jannes 1999; Humphreys 2000).

6. There are of course many varying interpretations of the processes central to healing and self-transformation in AA and other 12-step programs. For the purposes of this argument, it is worth noting that many participants—unlike the counselor mentioned above—may not view identification as an important element in the program, focusing instead on the values of humility or surrender or the modest techniques for living, such as “one day at a time” (Valverde 1998, 135–37; Wilcox 1998, 83–107). Others have interpreted the transformative aspects of AA in much more gradualistic terms as a spiritual awakening modeled on Protestant theology (Antze 1987, 173) or a radical epistemological shift away from a pathological Cartesian dualism (Bateson 1971).

7. Many researchers—including me—have dealt with this issue by attending open meetings and conducting in-depth conversations or interviews with group members outside the group setting (Mäkelä et al. 1996; Valverde 1998). David Rudy represented himself to the members of AA groups he attended for sixteen months not as an alcoholic but as a “sociologist interested in finding out about AA” (1986, 2), and he gradually progressed from being viewed as “a tolerated intruder, an outsider, to a near-member” (3). Members of the AA group Stanley Brandes studied in Mexico City allowed him to participate in meetings although he did not identify as an alcoholic, categorizing him as an “Admirer of Alcoholics Anonymous” (AAA) (2002, xv). On the other hand, Danny Wilcox was drawn to conduct an ethnography of AA only after a period of having experienced it as a recovering alcoholic (1998, 20–29).

8. Under Bantle’s leadership, U.S. Tobacco had employed a number of advertising and sales-based strategies to successfully expand the market for smokeless tobacco from a core demographic of older blue-collar men to teenagers and athletes (Denny 1993; Wyckham 1999).

9. Several HOH counselors argued that the only reason people in the program relapsed was that they had failed to properly follow the practices outlined for them. One former counselor put it this way: “As Father Martin told us at Ashley [a rehab center in the United States], the program is not a salad bar [shvedskii stol]. You can’t pick and choose what you want and leave the rest.”

10. See Yurchak 2006 for an extended discussion of the Mit’ki.
11. This joke is somewhat lost in translation. The colloquial term for delirium tremens—
belaiagoriachka—literally means “white fever.”

12. This sentiment pointed to something of a paradox at the heart of the Mit'ki’s new project
as spokesmen for AA. On the one hand, they were certainly doing the work of reducing a stigma
attached to alcoholism. At the same time, it was never quite as simple as that—given the degree
to which heavy drinking, alcoholism, and even mental illness have all been associated in a quasi-
romantic myth about creativity in Russia (also a familiar theme in many European discursive tra-
ditions), the notion of the Mit'ki quitting the bottle could cut both ways. Indeed, while almost
every educated person in St. Petersburg knew about the Mit'ki, many did not know about their
new sober incarnation. When I told several friends about Shagin’s involvement with the House
of Hope, they immediately added that it made sense because his art was no longer interesting or
compelling in the way it had been.

13. Though it was developed independently, this element of the Minnesota model shares
many characteristics of the therapeutic community model developed in the United States and
United Kingdom to address addiction and mental illness in the wake of deinstitutionalization
(Cook 1988).

14. For example, even in his semiofficial history of AA, Ernest Kurtz notes that during the
1950s and ’60s, “the impression of both sociologists and casual observers was that most regulars
at meetings had hit the rocks of alcoholism from one of two related directions: the frustration of
efforts at upward mobility—preeminently a lower middle class affliction; or the pains of perceived
downward mobility” (1979, 133).

15. As one narcologist explained, “The most difficult thing was the acceptance of god, the
higher power. And the idea that the higher power is not necessarily god was helpful. This was an
epochal change for me as well, because I was raised in an entirely atheistic family. So I started to
work out a philosophical background for the higher power for myself. It was not an easy process.
The higher power is an all-human reason, it is nothingness. . . . Indeed, something has an influence
on us, it depends what you call it.”

16. The narcologist Alexander Sofronov made a related though somewhat different claim,
arguing that the social and economic conditions of contemporary Russia were closer to that of the
United States during the Depression, when AA was developed.

17. The insanity rule given in Chapter 21 of the Criminal Code of the Russian Federation
(1997) reads: “A subject is not responsible for criminal offense, if at the time of commission of
the socially dangerous act, he was in the state of insanity and was unable to appreciate the factual
nature and social dangerousness of his act (or inaction) or control his actions as a result of chronic
mental illness, temporary mental illness, mental deficiency or other pathological mental distur-
bance” (quoted in Bukhanovsky and Gleyzer 2001). Like many of the American insanity tests, this
rule includes both a cognitive and a volitional aspect. The rule of nonculpability can be fulfilled
by a subject who is either lacking in cognitive capacity to appreciate the factual nature and social
dangerousness of his act or in volitional capacity to control his actions. Commentators have noted
that this definition of insanity is in fact stricter than, for instance, the Model Penal Code’s insanity
test: whereas the Russian penal code requires that the person totally lack (cognitive or volitional)
capacity, the American test requires only a “substantial” lack (Bukhanovsky and Gleyzer 2001).
Both Russian and American systems also allow for temporary mental illnesses, which are con-
ceived of as transitory states.

18. As David Joravsky suggests, in the vast majority of ordinary cases, the decision whether to
track offenders into the psychiatric system for treatment or into the penal system for punishment
was influenced more by the respective professional dispositions of forensic psychiatrists, legal offi-
cials, and political administrators. Throughout Soviet history, he argues, legal officials tended to
be suspicious of the category of nonculpability, suspecting psychiatrists of “coddling criminals
under the pretense of treating sick people” (1989, 416).
19. Those declared nonculpable also lost various rights accorded to defendants in criminal cases: they could not be party to legal documents, and they could be denied information regarding the charges filed against them (Smith and Oleszczuk 1996, 32–33). Critics further noted that the 1967 and 1970 codes regulating criminal commitment left the definition of “social danger” entirely open and that an earlier 1956 instruction on forensic psychiatry allowed (in exceptional cases) for examinations to be conducted in the absence of the patient. (The relevant documents were the “Instruction on Compulsory Treatment of the Mentally Ill Who Have Committed Socially Dangerous Acts” of February 14, 1967, and the Ministry of Public Health Instruction “Forensic Psychiatric Examination in the USSR” of October 27, 1970; see Smith and Oleszczuk 1996, 148, 151.) Add to this the fact that the Soviet legal system afforded defendants the right to a lawyer only after the psychiatric examination, and the lack of any clear provision for appeal of commitment, and a picture emerges of Soviet institutions that were structured so as to facilitate the overuse of nonculpability findings (Smith and Oleszczuk 1996).

20. Following the first prominent case of General Pyotr Grigorenko, there was a slew of public accusations, and eventually memoirs written by former political prisoners appeared on shelves in the United States and United Kingdom. While this entire discussion was heavily refracted through the murky glass of Cold War politics, the participants often had more at stake at home than they did across the ocean. In other words, the discussion of Soviet psychiatric abuses was not simply more fodder for ideological warfare and geopolitical realpolitik. It was that, to be sure, but more as well. For American and British participants in the discussion, Soviet psychiatry at times came to stand for everything about their own psychiatric institutions and practices that, depending on one’s view, needed reform, revolution, or repeal (Belkin 1999).

21. Much discussion focused on the typology of schizophrenia developed by A.V. Snezhnevskii, the clinician who presided over Soviet psychiatry from the early 1950s to the mid-1980s in much the same way as Lysenko did over genetics. Snezhnevskii held schizophrenia to be a hereditary disease that developed into one of three courses or states—continuous, intermittent, or transitory. It was the last of these that provoked the most controversy, the idea being that although the patient’s symptoms had disappeared, he was still a schizophrenic and could be diagnosed in the absence of any presenting symptoms (Joravsky 1989, 429–31). “Even as a result of complete recovery the organism does not return entirely to the condition that preceded the disease,” explained Snezhnevskii (341). Though such criteria certainly led to more diagnoses of schizophrenia, the dominance of Snezhnevskii’s school had much to do with developments unrelated to the political utility of their disease categories (420–38).

22. Both the last Soviet criminal code and the Russian criminal code of 1996 specifically address the issue of intoxication, the latter stating that “a person committing a crime in a state of intoxication, brought about by the use of alcohol, narcotics or other inebriating [odurmanivaiush-chik] substances, is subject to criminal responsibility” (Russian Criminal Codex 1996, pt. 1, chap. 4, art. 23, reprinted in Zharikov 1999, 389; on Soviet law, see Morozov and Kalashnik 1971). Nonculpability is, however, extended to those who commit crimes in a mental state characterized as a “psychosis”—including delirium tremens and “alcoholic paranoia,” as well as the somewhat atypical case of pathological intoxication. In other words, psychosis is the descriptive category used to distinguish from all other drinking offenders those who fulfill the requirements of the nonculpability test mentioned above.

23. Such instrumental use of diagnoses validates the notion that however stigmatizing public identification as an addict may be in contemporary Russia, it is much less so than identification as a mentally ill person. Grigorii, a 12-step counselor who estimated that he had spent a total of four years in psychiatric hospitals during the Soviet period, said he saw the effects that the delegitimation of psychiatry had on his own patients’ dispositions: “Everything having to do with psychiatry—I think that all of our patients have this problem—whenever there is this prefix psych...
for me as a Soviet person, for a long time it was better to die than to become a mentally ill person [psikh-bolnym].”

24. As Cristiana Giordano has argued, the proliferation of such concepts risks “creating a surplus of characteristics linked to citizenship that may in the end void the term of its explicative power” (2008, 589).

Conclusion

1. I use the metaphor of translation here in the sense it has been developed in anthropology—to suggest a movement between two domains that can never be completely commensurable and that effects particular changes in each of the domains.

2. It should be clear that I am in no way suggesting a lack of medical multiplicity or hybridization of therapies or that all (or even most) physicians or patients devote themselves to certain therapies to the exclusion of others. This is the case in certain situations more than others: for instance, patients who have gone through the 12-step program tend to be at best dismissive of khimzashchita and kodirovanie. Doctors, activists, and counselors deeply involved in the 12-step movement were even less likely to give the favored narcological therapies any credit at all. These are, after all, people engaged in the work of building the therapeutic legitimacy of 12 steps. Physicians who had less of a direct stake in the success of Alcoholics or Narcotics Anonymous were often much more ecumenical. While some were certainly skeptical of AA and thought of it as undercutting their authority, other narcologists I spoke to were supportive of the 12-step programs as suitable for certain patients, though not for others.