Narkomania

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If you are traveling through Eastern Europe by train, you will have to book a ticket in one of three different classes on the train. These three types of railroad car have all been around (both literally and figuratively) since the Soviet period. Understanding the distinctions between them is especially important if you are taking an overnight train, as the sleeping arrangements they offer are very different. A limited number of high-speed commuter trains have been accommodating intercity passengers since about 2012 (which, once the mechanical issue that caused them to break down on the tracks and strand hundreds of passengers in the middle of nowhere in the dead of winter was corrected, proved to be very convenient). Most ordinary trains, however, plug along at a top speed of about 30 mph. As a result, a significant proportion of train trips in Ukraine are, by default, overnight journeys.

The premium, first-class car is called lyuks. It is pronounced like the last syllable of the English word “deluxe,” but with a distinctly Ukrainian swivel on the “u.” In these cars, passengers are assigned berths in two-person cabins, which are furnished with a soft, cushioned bench seat along each wall,
one facing the direction of travel, the other facing the caboose. At night, these bench seats convert into comfortable beds with quality linens for sleeping. While I was conducting my research, these tickets cost the equivalent of USD 100–150, depending on the length of the trip.

The second-class car, kupe (a cognate of the French word “coupé”), also features closed cabins and bench seats that convert into beds. However, these cabins accommodate four passengers, not two. For these two additional riders, bunks are affixed to the wall at about eye level on either side of the cabin. These cabins also come equipped with a stereo speaker built into the wall that plays Ukrainian folk music, which you may or may not be able to switch off depending on the condition of the volume controls in your cabin. These tickets typically sold for USD 20–30 each.

The third-class train cars offer a different kind of experience altogether. These cars, called platzkart, offer the same double berths found in the kupe cars. However, the “cabins” in platzkart are completely open. The cabin doors and at least ten inches of the bench-seat cots have been cut away to make room for an interior pathway that runs down the length of the middle of the car. On the other side of the aisle from the truncated bunks, in the remaining two feet between the footpath and the windows of the train car, two narrower bunks are affixed lengthwise against the train’s exterior wall, allowing for a total of six people to be stowed in the space typically allotted to a single cabin. Personal privacy in platzkart is virtually nonexistent, and one rarely dares walk down the aisle at night, least of all to the treacherous toilet, for fear of ocular injury from the protruding feet of sleeping passengers. For this style of overnight accommodation, the cost of a ticket was typically about USD 8—a significant savings compared to the first- and second-class options.

Platzkart cars are noisy and crowded. Before passengers quiet down for the night—if they quiet down at all—platzkart is a scene of much eating, drinking, and merrymaking. Some Ukrainians consume food on trains the way Americans do in movie theaters—which is to say, constantly, but with more alcohol (see Wanner 2010, 4). On one occasion, I was traveling in platzkart from Kyiv to Minsk with an American boyfriend. We shared a sleeping area with another man and his wife—we on the berths above, they below. The husband perceived this matter of distributing food on trains to be a very serious one—so much so that he stood up in the middle of the night as we were passing through the fields outside of Homel’ and began making a
terrible scene. Equally driven by moral dilemma, generosity, and vodka, he admonished himself for failing to properly orient the poor foreigners to Ukrainian culture. “Gospodi! Ia im ne obiasnil chto takoe poezdni uzhin!” (Dear God! I never told them about train supper!) He then began shaking my startled boyfriend awake and gently but insistently smacking him in the face with sausages and baked apples.

Perhaps this was the sort of insult to my dignity the cashier at the train station in Kyiv envisioned, years later, when I told her my preferred seat assignment on a train to Odessa. Or perhaps she feared something worse. It was not unheard of for wallets to disappear, for women to be harassed, for foreigners to be taken advantage of by passengers with less diplomatic intentions than the fellow with the baked apples. On this particular day, I was standing at her window in the central train station making plans to travel to Odessa with Sergey, a public health advocate I had met only two days earlier. He was a program consultant who advised MAT clinics across Ukraine, helping them to improve their client services and program management skills. He was making site visits to several organizations in the southern regions of Ukraine and invited me to accompany him on his trip. He had already purchased his own tickets by the time we were introduced, so he gave me his seat number and asked me to reserve a space—any available space—in the same car. When I relayed these instructions to the cashier at the ticket booth in Kyiv, she pulled up Sergey’s reservation, and her eyes widened. She then pursed her lips and furrowed her brow with palpable discontent. “De-vushka,” she said. “Eto . . . platzkart.” (Miss. This is in platzkart.)

Despite my best efforts, I was unable to assure her of my familiarity with the Ukrainian rail system, that the foreign woman in front of her had been riding platzkart for nearly eight years, and that this option could not strike fear into my heart. “You are a woman traveling apart from your companion,” she said. “It’s no good. Lots of no-good people there. Tell him to change his ticket so that you can both be in kupe.” I nominally agreed to do as she said, largely for the sake of ending this conversation, but I insisted on booking the ticket I had already requested. After all, I was still planning to use it. I told her I would have my friend change both of our tickets together when we arrived at the station for our trip the next day.

The cashier saw my ruse. Rather than relieving her concerns, my statements simply reinvigorated her insistence that platzkart was no place for a woman like me to be. She appealed to my emotions, to my fear, to my pride.
She didn’t just want me to heed her advice. She wanted me to really want a different ticket. I understood perfectly well what she needed to be satisfied: a sincere, believable statement that I was abandoning this platzkart idea for good. Unfortunately for both of us, I am a terrible liar. In the end, she shook her head and sighed with resignation as I walked away from the counter with my third-class ticket in hand. God help that American woman, she must have thought. There’s no telling what trouble she’ll fall into.

This chapter is about wanting. It is about the kinds of desire that someone may or may not feel in any meaningful sense but that they are, in one moment or another, obligated to display—the same kind of desire that the cashier selling train tickets hoped I would externalize at her behest. Much like an American child who is taught to smile wide and say “thank you!” when opening a gift they do not want, Ukrainians are often obliged to engage in the praxis of desire as is mandated by their social situation. It is often thought, for example, that a person must truly desire a particular outcome in order to make that outcome manifest. Barren mothers must want to have children. Bullied children must want to be resilient and strong. Young women boarding trains must want to protect their dignity against the denizens of platzkart. Otherwise, their indifference will be their downfall. Similarly, I was frequently told throughout my research that people in MAT programs must truly want to “get better,” otherwise they would never achieve true success in defeating their “addiction.”

In this chapter, I describe the narratives of desire that were produced in MAT clinics and reproduced by MAT clinicians and patients in their conversations with me. As Nikolas Rose has observed, “The role of biomedical authority here is not to encourage the passive and compliant patienthood of a previous form of medical citizenship. Citizenship is to be active” (Rose 2007, 143). In these clinics, an “active” social citizen is one who actively desires to regain his or her health. Here, I consider the ways in which appeals to the presence or absence of different forms of “desire” fit into local understandings of the social and psychological mechanisms of “addiction” that circulated in and beyond these clinical spaces. I map out a model of “addiction” that is popular among the medical professionals operating Ukraine’s MAT programs and the individual prognoses that are contingent on that model. In these moments, we see the “addiction imaginary” seeping through the cracks in professional biomedical discourse. It fills in the gaps in clinical definitions of substance use disorder whenever standardized symptomatologies
lack the richness and depth of real human experience. Put another way, when social understandings of “addictive” behaviors do not line up with contemporary theories of individual will, a model of “addiction”—of what it is and what it does—that tackles this incommensurability head-on must be produced.

This is, in fact, the very premise of the “addiction imaginary” concept: notions of “addiction” do not automatically follow the emergence or evolution of substance use behaviors. Rather, “addiction,” as an individual state, only appears in a culture’s ethopolitical repertoire when abstract theories of individual will and concrete observations of consciousness-altering substance use behaviors appear to be incompatible. Culturally constructed notions of “addiction” (i.e., “addiction imaginaries”) must be generated to resolve the philosophical quandaries that substance use behaviors have raised. In their capacity as medical professionals, the clinicians who work in MAT and other harm reduction programs understand quite well how opioids affect the body and the brain. In their capacity as social beings, however, they gravitate, as all people do, toward personal, relatable, narrative understandings of what their patients are going through. Thus, even in the standardized world of the clinical, the culturally determined content of narkomaniia in contemporary Ukraine can be discerned.

**Soviet Legacies in Contemporary Drug Treatment**

In the early Soviet period, two theories of “addiction” fought for prominence among medical professionals. Both theories understood “addictive” behaviors as mediated by a person’s relationship with the external environment, but one focused on the social exterior and the other on the psychological interior of the drug-dependent patient. The first of these, which I refer to as the “social etiology of addiction,” aligned with the foundational principles of Soviet medicine as established at the First All-Russian Congress of Medical-Sanitary Sections in June 1918. At that time, leaders in the Soviet medical field were especially concerned with “the influence of the economic and social conditions of life on the health of the population and on the means to improve that health” (Solomon 1989, 255). It was thus decided that the medical system would achieve disease prevention through appropriate social and sanitary measures. This social orientation dovetailed with the broader po-
litical view that the Bolshevik Revolution “[had] eliminated the basic antagonistic contradictions between the socioeconomic structure and the health of the people, and thus did away with the basic source of illness for the workers” (Field 1967, 39). Under this rubric, drug use behaviors were not characterized as the result of individual failings or moral weakness. Rather, they were believed to arise, as all diseases did, as a direct result of the destructive social and economic realities of capitalism.

Interestingly, this thinking led to the brief operation of a methadone-based MAT program in Leningrad in the 1930s. A physician named Kantorovich offered this therapy on an experimental basis, taking in allegedly “incurable” opioid-dependent patients whom he believed still displayed the potential to become productive members of society again (Latypov 2011, 11). Kantorovich claimed that nearly 70 percent of the patients enrolled in this program achieved “good” or “satisfactory” results, as measured by the patient’s maintenance of family relationships and stability of employment, a claim that flew in the face of the contemporary view (based on the same logic) that people with chronic opioid use disorder who continued their drug use even under the liberating conditions of communism did, in fact, suffer from a “moral disability,” that they were “lacking will” and were therefore useless to both country and society (Latypov 2011, 11).

This “social etiology” ultimately fell out of favor and was succeeded by Pavlovian theories rooted in the concept of the conditional reflex. Psychologist Ivan Pavlov defined the conditional reflex as an automatic response to external stimuli that becomes physically hardwired in the brain through neurological analysis and synthesis of that stimuli (Chilingaryan 1999). Though this focus on individual physiology appears to depart from the social etiology of human disease derived from Bolshevik politics, it nevertheless succeeded in articulating a concrete link between the environment and specific pathologies where the explanatory powers of purely social theories failed. For example, in 1925, Soviet psychologist Mark Sereisky used Pavlov’s ideas to argue that most people who use drugs possess predisposing factors—a “prenarcotic personality”—and simply needed a trigger, such as a first dose of morphine, to awaken the “addictive reflex,” the psychological “hook” that drives compulsive behavior (Latypov 2011, 7). These theories led Soviet clinicians to suspect that if certain stimuli can trigger addictive behaviors, then different, therapeutically controlled stimuli might be able to repress or eliminate them.
A particularly striking example of such a therapeutic approach is “coding” (Rus: *kodirovannie*). This term applies to a variety of therapeutic services, each of which constitutes an attempt to physically rewire a patient’s brain by exposing that patient to substance use-discouraging physical and psychological stimuli of various kinds. These practices, typically carried out by a physician, include the delivery of antagonistic pharmaceuticals, clinical performances about the dangers of drinking alcohol or taking drugs while in treatment, and even deliberate deception and chicanery in the health-care setting (Murney 2009; Raikhel 2010). Though this treatment appears to many Ukrainians as a form of charlatanism, many others nevertheless continue to place faith in this procedure and are able to point to family members for whom “coding therapy” has proved to be of enormous help.

Eugene Raikhel’s ethnographic research on coding therapy for alcohol addiction in Russia demonstrates that, above all, a patient’s motivation for sobriety (which is different than their will to stay sober) largely determines the success of coding treatment (Raikhel 2010). Raikhel argues that the fear- or aversion-based techniques meant to steer a patient’s behavior away from alcohol consumption acts as a sort of “prosthesis of the will, [which allows] for a change in behavior without a change in the self” (Raikhel 2013, 190). Many of the most successful coding patients, those who have been able to abstain from alcohol entirely, return to their clinician regularly to renew their exposure to the drugs or clinical processes that avert their desire to consume, using treatment protocols as “pragmatic aids for the care of the self that bolster the motivations for sobriety” (Raikhel 2013, 210). Thus, coding “works” as a treatment for alcoholism not because external stimuli alone reshape behavior; rather, the desire of the patient to seek out such stimuli and, in doing so, accept the clinicians will as a “prosthesis” or replacement of their own, reshapes their own reflexes and is seen as the primary mechanism of recovery.

The notion that substance use stems from pathological disorders of the will exists far beyond the borders of Ukraine. Historian Marianna Valverde has painstakingly documented this idea in Western cultures across generations, arguing that the dominant twentieth-century view of “addiction” is fundamentally rooted in the idea of a disease of, or deficiency of, the will (1998). She further observes that “scholarly literature on alcoholism and addiction . . . tends to repeat [an] ahistorical and ethnocentric perspective” (1998, 18), and thereby repeats this trope of a troubled will again and again.
Consider, for example, the words of Asa Hutchinson, who was serving as the head of the U.S. Drug Enforcement Agency as he wrote this:

Drug users become slaves to their habits. They are no longer able to contribute to the community. They do not have healthy relationships with their families. They are no longer able to use their full potential to create ideas or to energetically contribute to society, which is the genius of democracy. They are weakened by the mind-numbing effects of drugs. The entire soul of our society is weakened and our democracy is diminished by drug use. (Hutchinson 2002)

In the large slice of American culture that Hutchinson’s views represent, drug use is perceived not as a potentially self-making or social-network-mediating activity, as described in chapter 1, but as a de-humanizing, isolating practice that destroys one’s sense of self. Linguistic anthropologist Summerson Carr has observed this very logic at work in American talk-therapy programs for people who use drugs, where treatment modalities are intended to recover patients’ “true selves,” which are believed to be buried underneath thick, impenetrable layers of anger and denial (2010).

Both this popular American view and the Soviet/Pavlovian view of “addiction” have placed the originating pathology of people who use drugs in the realm of individual will. The similarities largely end here, however. The dominant American view of “addiction” is motivated by spiritual, emotional, metaphorical modes of thought. The image of one’s “true self” buried under a layer of denial is certainly visually evocative, but it is impossible to say what this could even mean in a biological or clinical sense. The Pavlovian view, by contrast, very clearly translates the development of habits and behaviors into physiological terms. The “free will” of the substance using individual declines, according to this view, because competing habits have become so “hardwired” in the brain that thinking or acting outside of those habits becomes an increasingly difficult task to accomplish. The differences between these two “addiction imaginaries” are rooted, therefore, in how each culture understands individual will to operate. Therefore, Soviet responses to substance use (such as coding, incarceration, and forced labor camps) arguably tell us more about how Soviet culture perceived the nature of human will than it does about the psychology or biology of “addiction.” Further, “addiction imaginaries” that perceive MAT to be a useful intervention for opioid use
disorder will equally illuminate theories of the will and of the mind belonging to the cultures in which they have developed.

Given all this, it is unsurprising that MAT programs in contemporary Ukraine are sites where new interpretations of drug use and treatment are forged: interpretations that embrace the will of the patients as a necessary element for medical success. Many clinicians perceive “addiction” to be a context-dependent battle between the conscious desires of the “addict” and the drug-seeking behaviors they display. MAT is interpreted, in turn, as a tool with the capacity to intervene in this conflict. Each patient’s personal battle is one that, with the right support and scaffolding, can be won if the patient possesses a conscious desire to win it. It is a battle, however, that can’t be won without this conscious desire. This makes the success or failure of MAT as an intervention a direct measure of the strength and appropriateness of a patient’s individual will—of how sincerely the person wants to be healthy.

What the Patient Wants

There are two ways to discuss “wanting” in Ukraine. The first is a verb: khotet’ in the Russian language and khotyty in Ukrainian. These verbs, very simply, mean “to want.” One can use them to indicate very straightforward desires such as “I want to become a teacher” or “I want milk in my coffee.” Wanting can also be discussed with a noun: zhelanie in Russian, bazhannia in Ukrainian. Zhelanie/bazhannia can be translated as “desire” or “wanting” or “longing” or “will.” It lends itself to the same kind of poetic license in these languages as it does in English. For example, in Russian, you can ascribe to someone zhelanie umerit’, a death wish. It is possible to goret’ zhelaniem, to burn with desire. The distinction between the meanings of these two words is important. While it is possible to want (Rus: khotet’ / Ukr: khotyty) or not want (Rus: ne khotet’ / Ukr: ne khotyty) something without great moral consequence, desire or will (Rus: zhelanie / Ukr: bazhannia) is a much more fundamental human characteristic. To declare that a person who uses drugs does or does not have the desire to be treated is to assert that someone is either a driven, morally active person or a passive, indifferent, emotionally disengaged individual who is beyond professional help.

On the other end of this emotional spectrum, the concept of “indifference” (Ukr: baiduzhist’ / Rus: ravnodushie) represents the absence of socially appro-
appropriate “wanting.” It is, in fact, considered to be a social ill in its own right. For example, when I would casually complain to my friends about various difficulties I had encountered throughout my day, they would diligently assign blame to the indifference of others. The cashier at the post office was indifferent to the fact that I needed help buying postage for my parcel. The owner of the BMW who parked across the sidewalk in front of my building was indifferent to the needs of pedestrians. The huffy responses I received from the cashier at the train station who wanted me to move out of platzkart can also be explained with an appeal to indifference—not hers, but my own. She was terribly frustrated by my lack of desire to improve my situation. She surely believed I was destructively indifferent to my own well-being.

The visible behaviors of people who use drugs in Ukraine are frequently attributed to pathological levels of indifference or, often, the lack of any desires, even self-serving ones. Subsequently, the active cultivation of desire is generally perceived to be the core therapeutic strategy engaged by MAT clinicians. These ideas were well-illustrated by the case of Timur, a young man in his mid-thirties whom I met in his MAT clinic in L’viv. Timur had been a patient at this clinic for a long time. The care he received was steady,
but the details of his treatment were always in flux. He had a hard time settling his body into the physical routine of methadone. When he first began receiving MAT at the AIDS center in his hometown, Timur was given 40 mg of methadone per day. Soon after, he started feeling badly, and his doctor agreed to increase his dose. As they worked to manage his symptoms, Timur’s dose crept up, bit by bit, until he reached 150 mg, the upper limit of what his doctor is allowed to prescribe.

When I met him, Timur had already been receiving 150 mg of daily methadone for some time. He complained of body pains, trouble sleeping, and frequent fevers. “My dose [of methadone] right now—it’s not enough,” he told me. “It doesn’t hold me up anymore.” The severity of his discomfort motivated him to seek out new strategies for relief. He began by supplementing his MAT drugs with shirka from the street. When this stopped working, he began purchasing tramadol from a local pharmacy. He took some each evening to keep withdrawal symptoms from sneaking back in. “Obviously the point is not to raise your dose, but to lower it,” Timur observed. “At these levels, I’m worried about my liver.” Timur firmly insisted, on multiple occasions, that he genuinely wanted to quit, but the drugs, he said, had too strong a hold on his body.

During a long stay in L’viv in the fall of 2013, I had the opportunity to discuss Timur’s situation with his doctor, Alexey. Though this was never overtly confirmed, I was given the impression that Alexey was at least strongly suspicious of, if not quite aware of, Timur’s extracurricular drug use. It was also made clear to me that Timur’s actions—his ardent refusal to decrease his dose and his unwillingness to comply with the MAT program’s prohibitions against the use of illicit drugs—fell squarely into the discursive realm of zhelanie/bazhannia. Timur had been told how to treat his “addiction.” He had been given the tools that he needs to do so. Yet his problematic drug use persisted. The problem, Alexey said, was not that Timur was physically incapable of quitting. Instead, Timur was too ambivalent—too indifferent—to progress through his treatment. Timur, Alexey told me, suffers from a lack of desire. In fact, Timur could not even be described as baiduzhii, or indifferent, because this would indicate a lack of socially appropriate desire—a lack of desire for justice and well-being in the community. One can be baiduzhii and still maintain immoral or self-serving desires. Timur, however, stood accused of having no desires at all.

Nearly every clinician I have met in Ukraine, whether or not they have worked directly with MAT programs, has confessed frustration with the ab-
sence of any conscious desire to change in some or all of their patients who use drugs. This frustration was especially common among those with specialties outside the realm of substance use disorder. The head doctor of an HIV clinic near Kyiv once threw up his hands in exasperation when I asked about HIV-related deaths among patients with a history of injection drug use. “These deaths,” he said, “are related to the anti-social element. They drove themselves straight into their graves. They had no desire to live!” A nurse in a Kyiv TB hospital voiced a similar complaint. As I sat in her office, she scowled at a group of men milling in the entryway outside her department. “Doctors tell them to come here [to this office to receive anti-TB pills],” she said, “but they just hang out, they talk in the hallway, and then they leave. They are alcoholics, ‘addicts’ [Rus: alkogoliki, narkomany]. They have no desire [Rus: u nikh net zhelaniia]. Maybe the wife already died, the daughter is already sick. It’s all the same to them. They need narcotics to deal with their psychological problems. That’s addiction [Rus: narkomania].”

Those who worked directly with MAT patients perceived the same pattern among their patients; however, I found these clinicians to be much more delicate in their interpretation of each individual case. For example, the director of an outreach program in Mykolaiv, a man who had been passionately advocating for the expansion of MAT in his region since it first became available in 2006, explained to me that different levels of personal desire result in different “kinds” of people who use drugs:

It is important to understand that there are three kinds of “addicts” [narkomany]. First, there are those who used street drugs, but managed to fully substitute those street drugs with methadone. They slowly lowered their dose, and eventually quit. But remember, even after they quit, they are still addicts. There is no such thing as a former “addict” [Rus: byeshikh narkomanov ne byvaiut]. Second, there are those who don’t even think about quitting. They like to keep their methadone regimen at the maximum dose—maybe 150 mg—rather than working to slowly decrease it. They may want to quit, but they are too afraid—afraid that they will return to narcotics on the street and completely relapse. The last group is those who never think about quitting methadone and never plan on quitting street drugs either. They continue to use whatever they want the whole time they are on methadone—things like shirka.

Many other clinicians explained substance use disorder to me through similar taxonomies of disease. Through these distinctions, an individual’s will
became a quasi-diagnostic tool for determining the severity of a patient’s condition. If you have this desire, you will get better; if you don’t, you won’t. The ability of MAT programs to affect change in their patients is, therefore, largely determined by a given patient’s level of desire to be helped. A strong desire to heal can turn up the dial of treatment efficacy, helping MAT to carry a patient to social and clinical success. MAT, then, is not exactly a “prosthesis of the will,” as Eugene Raikhel has described in regard to coding therapy for alcoholism (Raikhel 2013). Rather, MAT is perceived to function, in some ways, as an extension of the individual will, a way to develop and grow the “seed” of will that clinicians have sought to impart to each of their patients.

This specific, desire-based etiology of substance use disorder that appears in Ukrainian clinics is a radical departure from the perspectives on addiction and MAT held by the international community. According to these more broadly accepted models, MAT does not produce its therapeutic effect by engaging individual desires. Rather, it works by shutting desires off (WHO 2004a). This dominant view holds that MAT works by “‘block[ing]’ the euphoric effects of heroin (see chapter 1), thereby discouraging illicit use and thereby relieving the user of the need or desire to seek heroin” (Mattick et al. 2009). By blocking euphoria and simplifying the logistics of staving off withdrawal symptoms, MAT, in this view, frames people who use drugs as fundamentally rational actors and aims to alter their behavior through the rebalancing of factors that affect their decision-making processes. Each patient’s internal desires are relevant only insofar as the desire to use drugs is successfully modulated by the intervention, rather than the intervention being modulated by desire.

Instead of reproducing this internationally accepted discourse with fidelity to its core principles, Ukrainian clinicians have integrated the clinical logics and practices of MAT into the local “addiction imaginary.” Many clinicians, for example, have made especially strong claims about their expertise on the clinical management of “addiction” based on their alleged familiarity with the lack of desire and will in their patients. They have spent enough time with such patients, these claims go, to identify these features when they are present and note their absence when they are not. For me to gain a better understanding of just how important desire really is, I was often told, I would also have to learn to read these signs—to see as they did past the words and behaviors of their patients into the motivations that drive them. This would help me see what “addiction” truly is and what MAT can do about it.
The Interpretation of Wanting

My first practical lesson in “reading” a patient’s desire came from Sergey while we were on one of our voyages through southern Ukraine. As we were traveling together, he introduced me to numerous clinicians and NGO leaders and provided me with an informed perspective on how these different medical and social services interact with each other. We visited a total of eight MAT sites in four different regions, including what was then the Autonomous Republic of Crimea. Our first journey, the one I booked through the incredulous cashier, was to Odessa, was when we paid several visits to Alexandra Nikolaeva’s MAT clinic in the central TB hospital.

On our first day there, at Alexandra’s request, Sergey and I purchased cheap surgical masks to protect vulnerable patients in the hospitals from any infections we may have brought with us. We strolled down the street across from the hospital gates and entered a little basement pharmacy on the corner. In typical Ukrainian pharmacies, products are kept behind the counter, requiring one to talk to a pharmacist before assessing their inventory and deciding what to buy. As we took our place in line and waited our turn with the pharmacist at the window, the woman at the front of the line completed her purchase and walked passed us toward the door. Her fists were clenched tightly around her newly acquired goods. Sergey turned to me and whispered, “It makes me so sad to see that. She is buying needles and eyedrops.” When I expressed confusion about the eye drops, he explained, “It was tropicamide. This is common here. They will drink it, or sometimes inject it. I don’t know what it is supposed to do, but lots of people use it.”

Tropicamide is an anticholinergic eyedrop. It is most commonly used to dilate pupils during eye exams. This drug was never intended for use by injection. Therefore, no medical research has been carried out on the effects or consequences of consuming tropicamide in this way. Anecdotal evidence collected from social workers and MAT patients during the course of my research supports the conclusion that tropicamide is a mild hallucinogen that amplifies or modulates the effects of opioids. The drops themselves are not very expensive and require no prescription to buy. They are quite accessible to anyone who wants them.

Once Sergey and I had acquired masks at the pharmacy, we turned around and hurried back across the street to the hospital. Alexandra accepted us
graciously. Sergey greeted the entire staff with affection. I was properly introduced and allowed to pet half a dozen or so feral cats that were napping in her office. The first order of business was small talk over a generous offering of tea and cookies. After appetites, social and gastronomical, had been sated, Sergey conducted the necessary business of his official site visit, which included a brief survey with the doctors and an inventory check. I munched on a walnut cookie and sat back to observe the clinic in motion.

The first patient we encountered during our stay was a young woman. She had been lingering in the clinic’s hallway drinking coffee with a nurse while Sergey and I chatted with the psychologist. Intrigued by our presence, she let herself into the doctor’s office to see who we were. As she strode confidently through the door, I immediately recognized her as the woman we had just seen in the pharmacy buying tropicamide. Her name, I soon learned, was Lyuda. At the time of our first meeting, she had only been part of the program for a year and a half—not very long compared to some of the other patients there. She agreed to a formal interview, and took it as an opportunity to share some of her frustrations with the program.

L: Do I like [MAT]? No. At the beginning, when I first came here, I thought it would solve all my problems. Like, I didn’t have to hunt for money, didn’t have to find drugs on the street. I just came here, took my pills, and went about my business. But after a while . . . well, I can’t go anywhere. Not even on weekends, just to visit anyone. It doesn’t even matter where. I can’t. Because every morning, even on New Years Day, January 1, everyone else is asleep, and I, like a fool—forgive me—I get up and I come here. So, at the beginning it’s nice, but it’s this vicious circle. And I can’t quit. I can’t go without this [methadone] . . . psychologically it’s very hard.

JC: And how did you come to the decision to start this treatment in the first place?

L: I had a baby. I can’t tell you if I am a good mom or a bad mom, but I try. And I do this in order to spend time with her—nearly all my time, not counting the two hours I spend coming here every day. I joined this program so that I could be with her.
Interestingly, through these comments, Lyuda displayed the characteristics of two different “types” of *narkomany*—according to the taxonomy described to me by the social worker in Mykolaiv. On the one hand, she articulated her decision making in a way that highlighted the prioritization of her motherly duties and her will to fulfill them. She needs to spend time with her daughter, so she has taken steps to reduce the portion of her day that she spends acquiring narcotics by switching over to a quicker and more reliable source: MAT. Her decision to begin treatment constituted a practical strategy for managing her multiple priorities: she sacrificed the attention she gave to one (her substance use) so that she could afford greater attention to another (her daughter). The disparaging assessment of the TB nurse, who insisted that *narkomany* “have no will. . . . It’s all the same to them [because] that’s addiction [Rus: *narkomaniia*]” does not describe Lyuda well. By prioritizing her duties to her child over some of the immediate necessities of her substance use, Lyuda is testifying to her desire to be socially responsible—the very desire that clinicians say their patients need in order to recover.

On the other hand, Lyuda is also strategically controlling the effects of MAT on her body. By adding tropicamide (and perhaps other substances) to her regimen, she is taking steps to alter, adjust, or amplify how she feels on opioids—even when her regimen is strictly controlled—is obvious in the actions she takes to modulate and maintain them. This is part of the risk of getting caught using other drugs: not only could she lose privileges in the program or the trust of her clinicians, she would also be saddled with the social stigma of someone unwilling to bear the physical effects of decreasing her opioid use with methadone. She would have to face the consequences of being labeled an “indifferent” patient, a judgment that could have consequences regarding her perceived value as a person and her fitness as a mother.

Lyuda voiced skepticism about MAT as a mechanism for treating her substance use disorder and subsequently ending her drug use all together. She clearly articulated her opinion that the *desire* to quit was not sufficient for overcoming her habits, regardless of how strong or deeply held that desire may be:

**jc:** How would you describe, in your own words, the goals of this program?

**L:** To lower . . . I mean, the program gives people . . . we try to live like normal, healthy people. But the truth is that we don’t
always succeed. Because the brain of an “addict” [Rus: nar-koman] is always searching for a high, and here there’s no high [Rus: net kaifa]. Here it’s just, like, I take my pills and I feel fine. Nothing hurts, I sleep regularly, I eat regularly, and everything’s fine. And the whole time your dose is decreasing down to that minimum and then you’re already going without and we live like normal people. But the reality is that this takes a really long time. A year. Two. It depends on the person. I’ve already been here for a year and a half and I’m not ready to give it up.

JC: What is it, then, that you would like to gain for yourself?
L: For myself? Honestly? I’d like to wake up in the morning and know that I’m healthy. But that morning won’t be coming anytime soon. Because every morning I wake up with just one thought on my mind: I need to get dressed and head out for this place . . . but I’m really tired of it.

JC: If you felt able to, would you want to quit taking methadone entirely?
L: I want to, but I’m not psychologically ready for it. I just know that if I go off the methadone, maybe a week will go by, not more, and I’ll start looking for street drugs again. Cause, here [pointing to her chest], it’s not just physical, here [pointing again to her chest] it’s more important than you could even think.

JC: What do you mean by “ready” to quit? What does “ready” mean?
L: Ready to quit and live like normal people. I can’t say that I’m ready because I’m still craving the next high all the time . . . in my head. I struggle with it. I have this daughter who is growing up so fast, and I am very well aware that I need to stop, but it hasn’t happened for me.

Lyuda was the first person I heard speak about feeling “stuck” in treatment, unable to change or to quit, but she was far from the last. Understanding the “addiction imaginary” possessed by people who use drugs was one of the primary goals of my research, so I always inquired about the treatment plans they had designed for themselves. My questions were met with a
constant refrain of “I want to quit, but I’m just not ready.” The significance of this simple phrase was reiterated each time a new person uttered it.

What struck me about this particular moment at the clinic in Odessa, and what Sergey made efforts to drive home to me as we left the clinic that day, was the conflict that Lyuda, the loving mother who topped off her methadone with tropicamide, presented to her medical providers. Both Sergey and Lyuda’s psychologist attempted to coach my interpretation of this encounter, telling me that Lyuda will not be successful in her efforts to maintain control over her competing familial and chemical obligations. They especially encouraged me to see that Lyuda was deceiving herself. “You know she’s lying to herself, right?” Sergey asked. She may have talked about her daughter and claimed that she wants to live peacefully with her family, but, in the estimation of the medical professionals around her, this was a far cry from reality. She would never be able to quit using drugs until she really wanted to, and her tropicamide use was evidence that she didn’t really want to. She was not letting herself be treated. She remained indifferent. She was just as “addicted” then, one and a half years into the MAT program, as she was on her first day.

The Metaphysics of Addiction

Many months into our acquaintance, Sergey and I found ourselves sitting across his kitchen table in Kyiv’s Osokorky district, eating linden flower honey straight out of the jar with a spoon and once again discussing his work experiences and our beliefs about “addiction.” Sergey quietly pondered my questions about what makes MAT successful for some and not for others. I had asked him these questions dozens of times and, by then, they had become almost rhetorical—part of our regular exercise of thinking through what he believed drug-using patients were really up to in these programs. “Of course you have to have the desire to change your behavior,” he said, switching from Russian to English, which he often did to emphasize a point. He continued: “Narkomania, they must have this desire to quit, because the behavior is bad. But the sin—the consequence—of this behavior is that it destroys your constitution—the thing inside of you that should be the strongest. So, when you are addicted, you understand. You know what is happening to you. But you can do nothing about it.” “Addiction,” he carefully
explained, is characterized by the inability to act upon one’s inner desires. You want to quit, but you have lost the self-control needed to do so. He described each person’s psyche as a three-part structure: a mind, a body, and a metaphysical connection between the two. When we are sober, all three elements are strong and intact. When we use drugs or alcohol, one or more of them becomes compromised.

He also explained that clinical professionals are able to intervene upon this troubling situation by generating and then capturing the desire of a patient. It is that very desire, in fact, that many treatment professionals hope their efforts will have an effect on. As Sergey explained:

If someone is seeking rehabilitation with a psychologist, their success will depend on their motivation. They must want to change. The psychologist cannot do all of the work. But the patient cannot get better without the help of the psychologist. Sometimes the patient is motivated inside and just needs to find help. Other times, the psychologist must be skilled at generating their interest, building their desire, lighting a fire in you to change your ways.

When people are engaged in drug use, he argued, their mind, their will, loses its ability to control their actions and behaviors the way they want it to. As they become more and more dependent, people are able to see themselves losing control. They may even retain their desire to be in control, to live their lives, to maintain their relationships, but they are unable to do so. This is why both professional treatment and the desire to be treated are necessary for overcoming addiction.

After hearing Sergey and other clinical professionals map out the psychological and emotional terrain of “addiction” in this way, I began seeing echoes of these ideas in my interviews with MAT patients. Mariya, who was receiving treatment in Kyiv, described a similar gap between her desires for herself and her personal control over her drug use:

You know, there are some people who like drinking. They like the feeling. I don’t. I never enjoyed the feeling of being drunk. I did other things. But the purpose of all of it is just to relax a bit, right? But, unfortunately, it wasn’t that kind of relaxation. It alters your perception of reality, making everything fluffy around the edges. And you have these moments where you realize that you’re tired of all of it, tired of using, but you go out looking for more just the
same. You hunt, you buy, you cook, you shoot it up. You’re even doing it when
you have no veins left, even after you’ve been sitting for two or three hours
looking for a place where the needle will hit.

This frustration, this sense of wanting to stop but simply having no control
over one’s use, is also apparent in Timur’s recollection of his path in and out
of different hospitals and treatment programs. “The point is not to raise your
dose,” he said. “But to lower it . . . I want to quit, but [the narcotics] are holding
on too tightly to my body.” Timur claims that he has a desire, but the
nature of “addiction” makes it impossible for him to regain the control he needs
to make that desire a reality. A key difference, however, is that these patients
insist that they possess the desire to quit in spite of their failure to do well on
MAT. For them, MAT can intervene on their daily logistical troubles, but
not on the root psychological or biological elements of their drug use. As
their clinicians mark them as failures, blaming their difficulties on a deep-
seated indifference, patients frame their entire lived experience with drug
use as saturated with unmet desires. They insist that, in the face of all this,
they are doing the best that they can.

The Neighbor’s Boy

As Sergey and I traveled around Ukraine together, we typically stayed in pri-
vately owned apartments, which were leased out on a nightly basis. This is a
common practice for travelers in Eastern Europe, far predating the advent
of “gig economy” travel services in the United States. When we arrived
in the city of Kherson in the summer of 2013, we called around until we
found an available flat and met the owner in the courtyard of the building
where we would stay. Our interaction was typical. She gave us a tour of the
place, wrote down the Wi-Fi password, and showed us the how to properly
shake the handle on the toilet to keep the water from overflowing. When she
asked us what we were doing in town, Sergey told her outright that we were
there to visit the HIV hospital and discuss MAT, a treatment for substance
use disorder, with the clinicians there. Sergey was always quite straightfor-
ward with things like this, paying no mind to the perceived social indig-
nity he invited into “pleasant conversation” each time he mentioned these
stigmatized topics.
Our temporary landlord wasn’t scandalized by the comment; she was enraged. She told us that there were bad people at that hospital. She told us that a neighbor’s boy—a good boy—went in for some kind of care, and the doctors “hooked” him on drugs and destroyed his family. Based on her description, neither Sergey nor I were ever able to gain a clear understanding of this young man’s situation: why he had sought help, what he was being treated for, whether or not he had been using drugs to begin with. These pertinent details notwithstanding, our landlord’s great distress that this young man was now “on drugs” and “lost” to his family and the community, was deep and palpable. He was taken, caught, consumed by these powerful substances. For the landlord, it was a tragedy of epic proportions. Sergey tried to respond to some of her accusations regarding the hospital and its staff, but he quickly relented, seeing that he was only upsetting her further.

The idea that “addiction” traps the will by forcing people to lose control of themselves looms large in the Ukrainian popular imagination, ascribing meaning to a vast array of behaviors, urges, and states of consciousness. Our landlord in Kherson put these ideas into action. In her mind, her neighbor’s son had been robbed of his free will by being given and then “hooked” on drugs. Likewise, many clinicians characterized patients who are struggling or are failing to progress into abstinence from illicit drug use as lacking the fundamental desire to do so. Timur and Lyuda’s insistence to the contrary, though, reveals the holes in this theory. Their testimonies show that the dominant psychological approach to substance use disorder in these crucial programs captures only some of the lived experiences they are meant to influence. Just as the accounting and audit practices endorsed by international donor institutions are transmuted into locally meaningful and useful bookkeeping systems (see chapter 2), so international approaches to harm reduction and treatment for substance use disorder also become situated within local discourses as they move across national and cultural boundaries.

At the time of my research, MAT clinicians in Ukraine were adopting a clear and prescriptive interpretation of this medical terrain where “addiction,” psychology, and personhood intersect. Opioid-dependent people are seen as problematic and dangerous because “addiction,” as many clinicians claim, can only arise in someone who is indifferent or lacks desire. Desire, in this view, is what connects people to their primary social roles and relationships. As a population that has been perceived as living in constant contradiction to those roles and relationships, people who use drugs require a unified explanation
for their apparent pathology if they are to be socially understood. And if desire is seen as the first thing that motivates people into relationships, then the postulate that “addicts” fall out of those relationships due to a lack of desire would, in this view, make a good deal of sense. “Addiction” is, therefore, viewed as a negative state, because this lack of integration is what makes “addicts” troublesome, and it is precisely this that treatment efforts aim to resolve.

Patients like Timur and Lyuda, however, levied their own claims as well. They were both quick to take ownership of their self-management strategies and to defend the validity of their efforts. They presented themselves not as indifferent but as actively engaged in their own strategies of self-care. In other words, the clinical paradigm of “addiction” that has taken hold among the professionals operating Ukraine’s MAT programs must be understood as a discourse that exists in concert, and occasionally in conflict, with a variety of strategies that people who use drugs adopt to manage their bodies, their identities, and their lives. However, as the remainder of this book will argue, there are many more who reject the possibility of such reintegration, whose “addiction imaginary” considers people who use drugs to be social “others” who need to be contained, controlled, and even eliminated for the welfare of the state and the subjects it governs.