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ORIGINAL PAPER

Post-Soviet Placebos: Epistemology and Authority in Russian Treatments for Alcoholism

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Abstract The dominant modalities of treatment for alcoholism in Russia are suggestion-based methods developed by narcology—the subspecialty of Russian psychiatry which deals with addiction. A particularly popular method is the use of disulfiram—an alcohol antagonist—for which narcologists commonly substitute neutral substances. Drawing on 14 months of fieldwork at narcological clinics in St. Petersburg, this article examines the epistemological and institutional conditions which facilitate this practice of "placebo therapy." I argue that narcologists' embrace of such treatments has been shaped by a clinical style of reasoning specific to a Soviet and post-Soviet psychiatry, itself the product of contested Soviet politics over the knowledge of the mind and brain. This style of reasoning has facilitated narcologists' understanding of disulfiram as a behavioral, rather than a pharmacological, treatment and has disposed them to amplify patients' responses through attention to the performative aspects of the clinical encounter and through management of the treatment's broader reputation as an effective therapy. Moreover, such therapies have generally depended upon, and helped to reinforce, clinical encounters premised on a steeply hierarchical physician–patient relationship.

Keywords Alcoholism · Substance dependence treatment · Addiction medicine · Placebo · Pharmaceuticals · Russian psychiatry

Introduction

During Russia's period of intense social ferment over the 1990s and early 2000s, rates of alcohol dependence and alcohol-related harm increased substantially, at the

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same time that mortality rose sharply and male life expectancy dropped precipitously (Leon et al. 1997, 2007; Nemtsov 2002; Notzon et al. 1998). While the precise mechanisms have been widely debated, epidemiologists and public health researchers generally agree that alcohol consumption, abuse and dependence contributed greatly to these alarming health outcomes (Demin and Demina 1998; Cockerham 2000; Field and Twigg 2000; Dmitrieva et al. 2002). What is more, while these epidemiological changes were taking place, the Russian state was withdrawing from the interventionist public health role which the Soviet Union had played in governing alcohol and its consumption.[1] One effect of this withdrawal was to render alcoholism, previously treated as a social disease, increasingly individualized and medicalized by default. Thus even while biomedical explanations of heavy alcohol consumption remain unpopular among many laypeople in Russia, medical (and quasi-medical) treatments have gained significance as the primary means by which alcoholism is governed.[2]

A particularly popular and prevalent mode of treatment is the use of injected or implanted depot disulfiram—an alcohol antagonist—which narcologists (as specialists in addiction medicine are known in Russia) commonly substitute with chemically neutral substances. While narcologists represent this therapy to patients as *khimzashchita* (which literally translates as "chemical protection")—a potent pharmacological treatment which renders their bodies unable to process alcohol—privately they often describe the method as "placebo therapy" and emphasize its reliance on mechanisms of suggestion (*vnushenie*). Such clinical techniques have been used in Russia since the 1950s, and according to some sources, *khimzashchita* and closely related methods currently make up the majority of long-term interventions for alcoholism offered by narcologists (Ivanets 2001; Sofronov 2003; Mendelevich 2005).[3]

Such therapies are also highly contested in Russia: condemned on a variety of clinical, ethical, and political grounds. They are criticized by proponents of Twelve Step therapies for ignoring the underlying emotional and spiritual roots of alcoholism and by advocates of harm reduction for being falsely represented as "cures" for a chronic disease (Mendelevich 2005). Even many clinicians who administer *khimzashchita* point out that, while it is often successful in facilitating short-term remissions, patients rarely see the need to supplement it with longer-term psychosocial interventions—leading to a cycle of decreasingly successful and

[1] The final and most notable intervention was the antialcohol campaign which ran during the first half of Mikhail Gorbachev's tenure as General Secretary, from May 1985 into 1988, and was characterized by a prohibitionist stance on alcohol consumption (White 1996; Reitan 2001).

[2] Illicit drugs, on the other hand, have been the object of increasingly stringent state policies and well-funded interventions in Russia since the early 2000s. Most of this activity has focused on opiates and has taken a criminalizing/law enforcement approach, particularly since the inception of the Federal Drug Control Agency in 2003 (Orlova 2009).

[3] Mendelevich (2005) reports the results of a survey showing that such methods "constitute up to 80% of all treatment methods offered by official and unofficial Russian narcology." While I did not conduct a systematic survey, a range of related suggestion-based methods—including disulfiram, coding, emotional-stress psychotherapy, neurolinguistic programming (NLP), Eriksonian hypnosis and subliminal suggestion—made up the vast majority of treatments offered at governmental and commercial clinics I visited.

increasingly short remissions (Valentik 2001, p. 244; Sofronov 2003). Not surprisingly critiques made by visiting Western European and North American physicians have often focused on the disregard which such treatments seem to show for a normative model of patient autonomy; instead of treating patients as autonomous, rational and (potentially) self-knowing individuals, these methods are said to rely on "people's ignorance" and their "belief" to frighten them into sobriety (Fleming et al. 1994; Finn 2005; Parfitt 2006). According to such accounts, the mechanism underlying *khimzashchita* is very simple; it consists of the physician convincingly telling his patient, "If you drink—you die" (Chepurnaya and Etkind 2006, par. 2).

In this article, I draw on historical and ethnographic research to examine why, despite such critiques, *khimzashchita* remains a popular form of treatment among physicians and patients in contemporary Russia. In particular, I trace how disulfiram treatment in Russia has been shaped by a clinical style of reasoning specific to a Soviet and post-Soviet professional ethnopsychiatry, itself the product of contested Soviet intellectual and institutional politics over the knowledge of the mind and brain.[4] I argue that this style of reasoning has facilitated narcologists' understanding of disulfiram as a behavioral, rather than a pharmacological, treatment and has disposed them to amplify patients' responses through attention to the performative aspects of the clinical encounter as well as through management of *khimzashchita*'s broader reputation as an effective therapy. Moreover, I suggest that, with a few exceptions, such therapies have depended on, and helped to reinforce, clinical encounters premised on a steeply hierarchical physician–patient relationship.

Over the past two decades medical anthropologists have increasingly drawn attention to the circulation and meaning of medicines, and their articulation with various lay and professional models of causation, idioms of distress, healing systems and local understandings of efficacy, as well as their place in global political economies of health (van der Geest and Whyte 1988; Etkin 1992; Whyte et al. 2002; Petryna et al. 2006). This focus on medicines has been particularly significant for scholars who have traced how the biologization of psychiatry has—along with the neoliberal transformation of health care in many countries—facilitated a growing emphasis on pharmaceutical interventions for mental illnesses (Healy 1997; Shorter 1998; Luhrmann 2000; Biehl 2004; Lakoff 2006; Rose 2007). While alcoholism and addiction have resisted subsumption under the aegis of biomedicine or psychiatry for much longer—at least in the English-speaking world (Valverde 1998)—over recent years there has been great excitement in some quarters of the medical community about pharmacological treatments for addiction, including drugs which dampen the neurochemical effects of opiates or alcohol and those which reduce sensations of craving (Valverde 2003; O'Brien 2005; Lovell 2006; Vrecko 2006b).

[4] Throughout this article, I use the notion of "style of reasoning" drawn from the work of Fleck (1979[1935]) by Hacking (1992) and further elaborated by Young (1995, 2000). A style of reasoning, Young (2000) writes, "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" (p. 158).

Surveying these developments Nikolas Rose and other social scientists have argued that as neurobiological ways of thinking about and acting on human beings diffuse beyond the laboratory, a somatic understanding of the self is increasingly displacing the psychological or identity-based subject of the twentieth-century (Rose 2003, 2007; Vrecko 2006a, b). This "neurochemical personhood" is linked by Rose to a characteristically neoliberal way of governing pathological behavior and—in the case of addiction—desire. The new norm is not just the self-maximizing individual but one who internalizes functions once carried out by a sovereign state or social institutions, assuming responsibility for the management of his or her own susceptibilities and desires (Rose 2003).

However, as anthropologists and historians have shown, there is reason to be skeptical of arguments which ascribe such an epochal and unidirectional shift in personhood and self-governance to neuroscience and psychiatry.[5] At the very least, it is clear that psychiatry's diagnostic categories and modes of treatment are questioned and contested, or subtly transformed, as they move from experimental to clinical settings or from one cultural setting to another (Kleinman 1982; Gaines 1992a; Lee 1999; Skultans 2003; Lakoff 2006; Schull 2006; Lloyd 2008; Kitanaka 2008; Saris 2008). A clear-cut narrative of the rise of the "somatic self" is also undercut by accounts examining the mind/brain distinctions and constructions of personhood underlying various professional ethnopsychiatries (Gaines 1992b; Young 1995; Miresco and Kirmayer 2006). The Russian practice of *khimzashchita* is particularly significant to these debates because it so clearly calls into question a number of distinctions which prevail in North American clinical practice, as well as in much of the social science literature: not only the distinction between the somatic and the psychological, but also that between pharmacology and psychotherapy, and between medication and placebo.

The article is organized as follows: after a brief description of my research methods and St. Petersburg's Addiction Hospital as a fieldwork setting, I present the case of a patient receiving disulfiram treatment at the hospital. To explore the particularities of this treatment modality I draw on the English-language medical literature on disulfiram. I then examine how disulfiram was taken up in the Soviet Union, tracing the development of a neurophysiological style of reasoning in Soviet psychiatry and its application to treatments for alcoholism. In the following sections I describe the clinical use of *khimzashchita*, examining both physicians' and patients' conceptions of the treatment. Finally I examine how the treatment has both depended on and reinforced hierarchy in the doctor–patient relationship and discuss how this has changed in the transition to the post-Soviet political and economic order. The article ends with a consideration of the implications of the case of *khimzashchita* for the anthropology of psychiatry.

[5] Others have questioned the supposed novelty of the "somatic self." As Nancy Campbell (2007) notes, in describing the broad popularity of psychotropic medications in North America from the late 1950s onward, "We have been 'becoming neurochemical selves' for a long time" (p. 247, n. 3).

Research Methods and Ethnographic Setting

This article is based on 14 months of fieldwork at a number of addiction treatment facilities in St. Petersburg, Russia, conducted between 2002 and 2004. The bulk of the material presented here was specifically drawn from interviews and observations conducted at the municipal Narcological Service. These include 30 interviews with patients and 24 with physicians in the service, as well as numerous informal interactions and conversations. In addition to the Narcological Service, I conducted fieldwork at one commercial addiction clinic and a charitable Twelve Step-based rehabilitation center, where I also spoke to physicians, counselors, and patients about their experiences with *khimzashchita* and similar treatment modalities. I also interviewed several narcologists and psychiatrists in private practice, sat in on a series of training lectures on narcology for physicians, attended open sessions of Alcoholics Anonymous and observed séances conducted by a self-proclaimed "Orthodox psychotherapist." Finally, I conducted extensive textual research in the Russian-language scientific and medical literature on addiction and its treatment. Throughout the article, I employ such textual sources to situate current clinical technologies in relation to the categories and styles of reasoning prevalent in Soviet psychiatry and narcology.

The project was approved by the Institutional Review Board of my home institution at the time (Princeton University) as well as by the St. Petersburg Department of Public Health. In order to ensure the confidentiality of informants, all of the patients and physicians whom I interviewed at the Narcological Service have been given pseudonyms or general appellations (i.e., "older narcologist"), and some identifying details have been changed.[6] While I refer to physicians who have made their views known in previous publications by their real names (Alexander Sofronov), I do not ascribe to these physicians any statements substantively beyond those they have already made in print.

During the time this research was being carried out, St. Petersburg's Narcological Service consisted of dispensaries in each of the city's administrative districts (*raiony*) and a central 500-bed Municipal Addiction Hospital (*Gorodskaia narkologicheskaia bol'nitsa*) to which patients were sent for hospitalization. While many aspects of addiction treatment in Russia had been radically transformed during the 1990s, the overall structure of the state-funded network had not changed significantly since the 1970s when the Soviet narcological system was established. This Soviet system had been a hybrid, made up of both medical institutions run by the Ministry of Health and penal/therapeutic ones administered by the Ministry of Internal Affairs, the seat of Soviet police organs. While these institutions were instantiations of distinct disciplinary and professional ideologies about the nature, etiology and appropriate treatments of alcoholism, the notion of alcoholism as a

[6] To demarcate the roles of different informants, I have used first names (such as Vyacheslav, Pavel, or Sasha) to indicate patients and Twelve Step counselors and first names along with patronymics (e.g., Anton Denisovich, Alexander Sergeevich) to mark most physicians. The first name/patronymic combination is a relatively formal type of address typically used to mark respect or social distance in Russian. While running the risk of essentializing the distinction between physicians and patients, this naming system gives a sense of the interpersonal hierarchy in play at most St. Petersburg clinics.

problem of public order saturated the entire system (Beliaev and Lezhepetsova 1977; Solomon 1978; Babayan and Gonopolsky 1985; Segal 1990). Noncriminal alcoholics and those who resisted the "compulsory treatment" (*prinuditel'noe lechenie*) at hospitals and clinics could be committed for 1–2 years in explicitly penal institutions called Therapeutic-Labor Profilactories (LTPs; *Lechebno-trudovye profilaktorii*), which were modeled on labor colonies and prison camps (Tkachevskii 1974, p. 39; Sytinsky and Gurevitch 1976). Beginning in the late 1970s, the narcological system grew rapidly, reaching its peak of funding and access to resources during the final Soviet antialcohol campaign in 1985–1988.

By the time of my first visit to the hospital in 2003, certain elements of the narcological system had changed profoundly, while others reflected a striking continuity with the Soviet period. Shortly after the fall of the Soviet Union, the Russian Federation had moved to dismantle the explicitly punitive elements of the system. LTPs were formally disbanded in 1994, the same year that involuntary hospitalization for noncriminal alcoholics was outlawed (White 1996; Entin et al. 1997; Gilinsky and Zobnev 1998). Physicians at the hospital recounted how, throughout the 1990s and early 2000s, they had struggled to manage the increasing numbers of alcoholic patients as well as the sudden rise in injected heroin use (which was accompanied by a rapid spread of HIV infection) (Heimer et al. 2007; Leon et al. 2007).

These efforts were made all the more difficult by the severe budgetary cutbacks the system experienced in connection with the dismantling of the Soviet-administered economy generally and the restructuring of the health-care sector in particular (Egorov 1997; Twigg 1998). This meant that, while basic treatment remained free of charge, the hospital had begun to charge for various additional services. Shortages of medications and staff were also common. Physicians often complained of having to spend over half their time on paperwork because they lacked computers or administrative support.

Vyacheslav and the *Torpedo*: Cycles of Treatment

While interviewing patients at the Addiction Hospital, I met Vyacheslav, a portly factory worker in his fifties. He was, in some ways, a typical patient, although, unlike many others, he lived in a communal apartment with his wife. Since the hospital was one of the only institutions in the city which offered detoxification and treatment free of charge, it attracted many patients who had lost their homes and means of employment; at least half of the patients on most wards were homeless. As we sat in a small examination room, Vyacheslav told me that his son had died in the army 6 years earlier; recently his daughter had given birth to her own children. Vyacheslav gestured toward his motivation for sobriety in describing his new familial role: "I'm already a grandfather, but still I continue to drink." He described his stay at the hospital as part of a yearly cycle. Each year he would go on a drinking binge (*zapoi*), at the end of which he would be persuaded by his wife to return to the hospital.

Like other patients arriving at the hospital, Vyacheslav was typically treated for a period of 1 month. Most of the hospital's nine wards rely on treatment protocols similar to those used during the Soviet period (Fleming et al. 2001). Detoxification takes place with the aid of intravenously delivered vitamins as well as a heavy pharmacological regimen, including the liberal use of tranquilizers and antipsychotics (Fleming 1996; Ivanets 2001). Following the completion of detoxification and prior to his discharge from the hospital, Vyacheslav received an injection (colloquially known as a *torpedo*) which, he was told, would keep disulfiram in his bloodstream over the course of a year. Fearing the negative effects of drinking with the substance in his body, Vyacheslav explained that he always waited until the course of the *torpedo* was over before embarking on another binge. Once, he had tried another procedure: the physicians had implanted a capsule under his skin which was said to slowly release disulfiram for five years. That time Vyacheslav hadn't been able to wait it out: "I didn't drink for two and a half years. Then I paid them and had the implant removed (*rasshilsia*). That's it."

Typically this cycle repeated itself every year, he explained, without excessive regret or concern. Of his wife, Vyacheslav explained, "When I'm drunk we don't have any quarrels. She understands that even if I'm drunk every single day, even for a month, that eventually I'll come to and say, 'Let's go to Vassilievskii.'[7] She understands that if she tried to push me it will just be harder on the nerves." While he felt that abstaining from alcohol noticeably dampened his social life, Vyacheslav also argued that he and his family had successfully learned to manage his tendency to indulge in drink.

Vyacheslav's description of *khimzashchita* as a physiologically based treatment closely resembled its depictions by physicians in conversations with patients and in (nonspecialist) publications and advertisements. "There's also a special injection they can give you in your vein," he explained, adding, with a clear deference to the authority of medical professionals: "It's all figured out by the professors so that it gradually dissolves. And the capsules: they get stuck to something inside you and also gradually dissolve." Yet, as narcologists explained to me (sometimes reluctantly), it is common practice to inject or implant patients with neutral substances (often vitamins or saline) in place of disulfiram. Moreover, as narcologists saw it, whether or not active disulfiram is used, *khimzashchita* relies heavily on suggestion and has more in common with hypnosis therapies than with neurochemically based interventions.

Indeed when I brought up *khimzashchita* in my conversations with narcologists, some initially represented it as a pharmacological treatment, while others depicted it as "psychotherapy." Irina Valentinovna, a narcologist on the acute ward of the Addiction Hospital explained it this way:

> *Khimzashchita* is a psychotherapeutic method. In principle, we give a regular—you can give a placebo—this depends on the personality of the patient—and either we use a placebo or the chemical…. I give you this medication. I give you a prohibition [*zapret*] through personal psychotherapy

[7] The Addiction Hospital is located on Vasilievskii Island, one of the main islands of central St. Petersburg.

> [*lichnostnaia psikhoterapiia*]: for a certain period of time you don't have the right to consume alcohol [*spirtnoe*]. If he waits through the period, then we do another one. His self-image rises.

While it was clear that *khimzashchita* was meant to help facilitate what narcologists called periods of "remission" (sobriety) for patients, it seemed, based on Irina Valentinovna's description, that the chemical content of the medication (disulfiram or "placebo") mattered less than the meanings enacted by the narcologist and her clinical tools. I found myself both troubled by the deception seemingly entailed by this blithe equation of "placebo" with disulfiram and fascinated by the questions it raised. Was *khimzashchita* a somatic or a psychological treatment? More importantly, why did this distinction seem to matter so little to the narcologists I spoke to? To answer these questions, it important to first review the medical literature on disulfiram treatment and to examine how this therapy was taken up in the Soviet Union.

Disulfiram Treatment: Nonspecific Pharmacology

While the literature on placebo phenomena shows clearly that *all* medications induce both specific and nonspecific effects—as well as interactions between these effects—disulfiram's mode of therapeutic action makes these interactions particularly clear (Price et al. 2008). Often referred to in Russia as *teturam*, *Esperal*, or Antabuse,[8] disulfiram prevents the body from fully processing alcohol. By blocking the action of aldehyde dehydrogenase, a key enzyme in the metabolic pathway of ethanol, the drug causes a buildup of the toxic by-product acetaldehyde, with extremely unpleasant consequences for patients. Rather than the pleasurable effects of alcohol intoxication, people with active disulfiram in their bodies experience flushing, nausea and high blood pressure soon after drinking—referred to in the medical literature as a disulfiram–ethanol reaction (DER) (Eneanya et al. 1981; Kenna et al. 2004; Mann 2004). Thus as the authors of one review explain, "When taken in an adequate dose, disulfiram usually deters the drinking of alcohol *by the threat or experience of an unpleasant reaction*" (Brewer et al. 2000, p. 329; emphasis added). Often recommended as an adjunct to psychosocial treatment programs, disulfiram is used to facilitate periods of sobriety during which patients can develop a "sober life-style" (p. 329).

While it is often portrayed as the first pharmacological treatment for alcoholism to have been developed, the mechanism underlying disulfiram's effects has been described and classified in several significantly different ways, and these accounts are linked to specific clinical uses of the drug. Researchers framing disulfiram as a pharmacological—rather than a behavioral—treatment (particularly its early proponents) often described it as a "sensitizing" drug (e.g., Hald and Jacobsen

[8] Derived from the full chemical name—tetraethylthiuram disulfide—*teturam* or *tiuram* are names 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.

1948; Martensen-Larsen 1948; Ivanets 2001). Conversely, contemporary researchers argue that, unlike more recently developed pharmacological treatments for alcoholism, such as naltrexone and acamprosate, the efficacy of which is based on a neurochemical dampening of patients' craving, the effects of disulfiram are psychologically mediated (Kenna et al. 2004).

However, even the specific mechanism underlying this psychological mediation has been described in various ways, ranging from "aversion" to "stress" to "suggestion." Again, these explanations reference distinct clinical applications. For example, disulfiram treatment was first conceived of as a form of aversion therapy: "tests" or demonstrations of its effects were carried out on patients who were given doses of ethanol to drink shortly after consuming the drug (Suh et al. 2006). As I argue below, this link to aversion therapy is important in understanding the role disulfiram has played in Russian alcoholism treatment. While some researchers still argue that disulfiram is meant to "create an aversion to alcohol, rather than modulate its neurochemical effects" (Mann 2004, p. 489), others emphasize that it has immediate effects on behavior "by replacing delayed with immediate negative consequences" (Heather 1989, p. 471). In either case, we can conclude that it is a patient's anticipation or memory—whether conscious, unconscious or bodily—of an unpleasant or frightening experience which is meant to change his or her behavior.

Over the past 70 years disulfiram has played divergent roles in the public health and medical systems of various countries, reflecting differences in ethnopsychiatric models of alcohol dependence, institutional and political economic conditions and notions about individual volition and personal responsibility (Chick and Brewer 1999). For example, while it continues to serve as the cornerstone of alcoholism treatment in Denmark, the prevalence of its use in North America has long since waned (White 1998; Steffen 2005). Although many studies have shown disulfiram therapy to be a potentially effective means of increasing the lengths of patients' remissions, adherence represents the major obstacle to efficacy (Fuller and Gordis 2004; Suh et al. 2006). Once ingested, the medication remains at chemically active levels for only several days, which means that patients must take the drug regularly for the threat of an adverse reaction to alcohol to remain (Eneanya et al. 1981; Brewer et al. 2000:331). While this may not represent a problem for highly motivated patients, for many others the challenge of adhering to this treatment is as great as that of abstaining from alcohol itself (Valverde 1998, p. 99; Steffen 2005, p. 180). Not surprisingly, disulfiram therapy seems to be most effective when a relative or clinician is able to monitor or supervise the patient's consumption of the medication (Brewer et al. 2000; Fuller and Gordis 2004). The issue of compliance has also 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 (O'Farrell et al. 1995; White 1998, p. 227; Brewer et al. 2000, pp. 332–336; Steffen 2005). For this reason the treatment is depicted by critics as one which requires an unacceptable level of coercion or social control (Steffen 2005, pp. 184–185).

In a different attempt to manage this problem of treatment adherence, the method of implanting capsules of disulfiram subcutaneously was developed in France during the 1950s (Kline and Kingstone 1977; White 1998, p. 228). Here agency for adherence was shifted from either the patient or his or her caretaker and structured into the implant, which was meant to gradually release the chemical into the bloodstream. However, numerous clinical studies have shown that commercially available implants release detectable levels of disulfiram into the patient's bloodstream for only a short period of time (Johnsen and Morland 1992; Brewer et al. 2000). In other words, after the first week following the implantation of the disulfiram, patients are highly unlikely to suffer from a DER. At the same time, since the early 1970s, researchers studying disulfiram implants have noted their effectiveness relative to unsupervised oral disulfiram, and most have agreed that such effects were due to a "psychological rather than a pharmacological deterrent" (Malcolm et al. 1974, p 488; Kline and Kingstone 1977). The authors of one review summarize the clinical findings on implants this way: "All pharmacological treatments have nonspecific or placebo effects as well as pharmacological effects. Disulfiram is no exception" (Brewer et al. 2000, p. 331).

As a pharmacological therapy which seems to work primarily by nonpharmacological means, disulfiram occupies an uneasy position in the biomedical literature and clinical practice. With a few exceptions, most researchers writing in the English-language literature refer to disulfiram as having "nonspecific or placebo effects" with some trepidation, or as evidence for its overall *ineffectiveness*. In part, this has to do with the deeply ambivalent attitude which most of biomedicine has taken toward treatment outcomes which are not attributable to a specific material cause, as well as to the subjective dimensions of human experience (Kirmayer 2006; Thompson et al. 2009).

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]" (Harrington 2006, p. 185, 2008). Harrington (2006) argues that these epistemological and moral anxieties were brought together in the nineteenth-century concept of "suggestion"—"the 'capacity to transform an idea directly and automatically into a sensation or movement'" (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 as a sham at worst and as an intervention with no physiological basis used to mollify "difficult" patients at best (Harrington 2006).[9] In the case of disulfiram, this

[9] In addition to these epistemological issues, the role of placebos at the center of the clinical trial apparatus poses an additional methodological challenge for the investigation of treatments which may have largely nonspecific effects. Even when researchers acknowledge the relative effectiveness of disulfiram, they often find themselves bound by an inability to demonstrate this effectiveness according to the dictates of their professional and institutional criteria: "Since it is the psychological deterrent effect of [disulfiram] rather than its biological effect that is useful, it is difficult to envisage how its efficacy could be demonstrated in a classical double-blind, placebo-controlled trial" (Mann 2004, p. 489).

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 which results from disulfiram therapy is a change in behavior which can be conceptualized as mediated by both conscious and unconscious mental processes.[10]

While clinical phenomena, variously described as "suggestion," "placebo," or "nonspecific effects," have long posed an epistemological challenge for a somatically grounded biomedicine, many of the narcologists I spoke to in St. Petersburg emphasized precisely these aspects of disulfiram treatment. Narcologists like Irina Valentinovna explicitly described *khimzashchita* as "placebo therapy" or as a treatment which depends on mechanisms of suggestion (*vnushenie*). As one physician working in a commercial addiction clinic put it, "In addition to the purely chemical effect [of disulfiram], there is a suggestive effect [*effekt vnushenia*]." Why were narcologists seemingly less troubled by the epistemological problems posed by placebo therapy than many of their Western European and North American peers? I suggest that we cannot answer this question without examining *khimzashchita* as a product of Soviet narcology's neurophysiological logic and a particular clinical style of reasoning. Indeed, I argue that narcologists' clinical reasoning is shaped, at least in part, by a Russian/Soviet genealogy of ideas about suggestion and healing which is radically different from its counterpart in the English-speaking world.

A Logic of Reflexes: Suggestion in the Soviet Sciences of the Mind and Brain

While narcology was only developed as a distinct subspecialty during the 1970s, many of its therapeutic methods and styles of thought were developed much earlier, under the aegis of Soviet psychiatry. Along with other sciences of the mind and brain in the Soviet Union, psychiatry had been deeply affected by the politically shaped dominance of Pavlov's theory of "higher nervous activity." During the early Soviet period, the relationship between physiology and psychology was an extremely contentious ideological issue, primarily because it represented a sphere of knowledge in which Marxists hoped to link their understanding of human beings as historical actors with an objective science of humans as material beings (Joravsky 1989; Smith 1992, p. 191). This was largely approached through the concepts of dialectical materialism. In this context Pavlov's reflex theory was not simply an example of a concrete behavioral mechanism, but a way of conceptualizing the "dialectical" relationship between human biology and the environment (Graham

[10] Because the intended effects of *khimzashchita* are behavioral (abstinence) rather than physiological, some readers of previous versions of this article have asked whether it is appropriate to call it "placebo therapy." In this paper, *khimzashchita* is discussed as a placebo or suggestion-based therapy because these were the terms used by narcologists in St. Petersburg. Additionally, it is worth noting that Soviet psychiatry's interpretation of both placebo effects and hypnotic suggestion through the framework of conditioned reflexes blurred distinctions between behavioral and physiological effects. Of course, all clinical interventions also shape behavior through the way in which they are prescribed and dispensed or through the institutional arrangements within which they are embedded. Indeed, Saris (2008) has argued that such a transformation of behavior is the primary aim of another putatively pharmacological treatment for addiction—namely, methadone maintenance therapy (pp. 260–261).

1987, p. 163; Joravsky 1989; Petryna 2002, p. 162). In practice, however, this may have often meant a reduction of psychology to physiology, of mind to brain—or more precisely—of personhood to reflex action.

The ascendance of Pavlovian theory in the Soviet sciences of the mind and brain began after a brief period of revolutionary utopianism during the early 1920s when a variety of approaches and schools—including psychoanalysis—coexisted. During the period known as the Great Break (marked by the start of massive industrialization projects and the collectivization of agriculture in the late 1920s), Stalin and other Party leaders sharply departed from an earlier conciliatory policy toward professionals and initiated a program of cultural revolution intended to create a new class of Soviet (nonbourgeois) specialists whose orientation was meant to coincide with those of the party-state (Fitzpatrick 1992). This cardinal turn in policy set the stage for the creation of a Soviet psychiatry which would, in its broad contours, persist at least until the late 1980s (Calloway 1992; Skultans 1997, 2003). Psychoanalysis as well as various Russian psychological schools were increasingly condemned as "idealist," while Pavlov's reflex theory was promoted in increasingly forceful terms (Todes 1995; Etkind 1997a; Miller 1998). This movement culminated after WWII in a series of conferences on physiology, psychiatry and psychology (held between 1950 and 1952) at which Pavlov's doctrine was enshrined into the pantheon of Soviet socialism as an objective foundation for the sciences of the mind and brain (Joravsky 1989, p. 413; Windholz 1997). While the post-Stalin period saw a resurgence of interest in psychology and theories of consciousness, the influence of the now-officialized Pavlovian doctrine on clinical psychiatry extended well past this period, in part due to the prominent institutional posts held by its adherents, in part to the persistence of treatments which had been developed during that period and in part to the ways it shaped subsequent disciplinary assumptions and styles of thinking in psychiatry (Segal 1975; cf. Fleck 1978[1935], p. 20).

One commonly overlooked consequence of the dominance of Pavlov's theories was the legitimacy it accorded to practices of suggestion, hypnosis and, less directly, placebo therapy, by reframing them in entirely physiological terms (Chertok 1981, p. 11). In elaborating his theory of higher nervous activity, Pavlov relied on the notions of excitation, inhibition and equilibrium to describe basic processes taking place in the nervous system, which he correlated with experimental evidence produced through conditioning. For Pavlov, inhibition encompassed all processes which weakened conditioned reflexes, and was distinguishable into the categories of "external inhibition," "internal inhibition" and the inhibition associated with sleep (Smith 1992, pp. 200–201). Pavlov described hypnosis as a transitory state which resulted when the inhibitory process that led to sleep occurred to a less extensive degree (Platonov 1959; Pavlov 1994[1925], p. 84). Further, he argued that "suggestion in hypnosis can be rightly interpreted as such a phase of inhibition when weak conditioned stimuli (words) produce a greater effect than the evidently stronger and real external stimuli" (p. 85). In other words, hypnosis was understood as a state of consciousness which facilitated suggestibility.

This account helped to render hypnosis scientifically legitimate by placing it firmly in the realm of the material, allowing it to be incorporated into mainstream psychiatry (Slobodianik 1963; Hoskovec 1967; Babayan and Shashina 1985, p. 99).

Pavlov's theories also led to the development of various clinical interventions which were generally categorized as "psychotherapy."[11] This clinical application of hypnosis emerged partly from the theory itself: for Pavlov sleep and hypnosis were forms of inhibition which were "protective"—a notion which also facilitated the widespread use of sleep therapy in Soviet psychiatry (Wortis 1950, p. 161).

Of course it is difficult, if not impossible, to ascertain whether clinicians of the time used suggestion-based therapies because they actually thought of them in dialectical terms. It seems just as likely that practicing clinicians were willing to employ techniques such as hypnosis and placebo therapy precisely because they did not conceptualize them as "mind" acting on "body," but simply as "body" acting on "body." For these physicians, physiology may have been a sphere of explanation which extended to, and subsumed (or somaticized), "mind," thus rendering moot the seeming paradox of hypnosis. In either case, a conception of human biology which was undoubtedly ideological also had practical consequences for clinicians in that it rendered suggestion and placebo effects thinkable.

Moreover, once therapeutic methods based on these effects received official sanction, they arguably became part of an institutional logic generally immune to such epistemological concerns. Thus with a few notable exceptions and a parallel tradition of rational psychotherapy, the majority of techniques framed as "psychotherapy" during the Soviet period employed mechanisms of hypnosis and suggestion (Wortis 1950, p. 88; Kirman 1966; Segal 1975; Lauterbach 1984; Etkind 1997b). By the 1970s, these methods encompassed a range of techniques, including individual and group hypnosis, more and less directive forms of suggestion, as well as "direct suggestion," in which the patient remains in a waking state, "indirect suggestion" (which included the use of placebos) and techniques of autosuggestion (Lauterbach 1984, p. 81).

Somatic Suggestions

The Danish developers of disulfiram therapy had initially employed it as a form of aversion therapy, and this style of treatment fell on particularly fertile ground in the Soviet Union (Hald and Jacobsen 1948; Martensen-Larsen 1948). During the late 1940s, when Soviet medical researchers first began to experiment with disulfiram (contemporaneously with researchers in Scandinavia and North America), their model for thinking about treatment for "chronic alcoholism" was a method developed some 15 years earlier: conditional-reflex therapy, sometimes referred to as "apomorphine treatment." While the idea of inducing a physical aversion to alcohol in patients was not new in itself, Soviet medical researchers had grounded their efforts in Pavlov's theories: after initial attempts using electrical shock, they settled in 1933 on the use of emetics like apomorphine, to condition subjects so that they experienced a nausea reflex upon tasting or smelling alcohol (Sluchevsky and

[11] Hypnosis and suggestion were also central to the research of Vladimir Bekhterev, the eclectic psychiatrist who developed a theory of "associative reflexes" in many ways parallel to Pavlov's, and who is often described in the Soviet literature as the "founder of Russian psychotherapy" (Platonov 1959, p. 11).

Friken 1933; Zhislin and Lukomskii 1963). Between the 1940s and the 1980s in the Soviet Union, conditional-reflex therapy was a recommended mode of clinical treatment for alcoholism, given pride of place in textbooks as a first-line therapy for use after detoxification and mandated at LTPs and other penal institutions (Shtereva 1980; Babayan and Gonopolsky 1985).[12] Even following the post-Stalin liberalization of science, conditional-reflex therapy remained prevalent in Soviet psychiatry and narcology because it complemented the needs of planners and administrators.[13]

When disulfiram was introduced in the Soviet Union, use of the therapy was modeled after that of conditional-reflex therapy: indeed, many of the earliest publications about disulfiram in the Soviet medical literature were authored by Ivan Vasil'evich Strel'chuk, who also developed widely employed protocols for apomorphine treatment, some using methods of hypnotic suggestion (Strel'chuk 1951, 1952; Miroshnichenko et al. 2001, p. 139). Patients were not simply told of the potential negative effects of drinking alcohol while on the drug; these effects were demonstrated to them in physician-administered "tests" (Strel'chuk 1952; Babayan and Gonopolsky 1985). Moreover, disulfiram treatment was seen as developing in the patients a "negative conditioned reflex to alcohol," and this reflex was observed even in "patients who had not taken antabuse in nearly a year" (Strel'chuk 1952, p. 49). In other words, the notion that patients might have the intended physiological reaction to disulfiram in the absence of the drug itself was present almost from the inception of its use in the Soviet Union. It is thus not surprising that, by the late 1960s, Soviet researchers were reporting clinical experiments with the use of placebo therapy, literally the replacement of the drug with a saline solution or vitamins (Ialovoi 1968). While this was originally intended for patients for whom the drug was contraindicated, the use of such placebo therapy became increasingly widespread (Fleming et al. 1994).

Subdermal implants of the French Esperal quickly became the most popular application of disulfiram: patients would have a capsule implanted behind their shoulder blade and warned of possible adverse effects from taking alcohol for a period of from one to five years (Fleming et al. 1994). While other placebo therapies were also used, such as the "tablet" and the "*torpedo*" (these were represented to patients as oral and intravenous forms of "long-acting" disulfiram, respectively), implantation was by far the most popular (Chepurnaya and Etkind 2006). Among patients and relatives the therapy was referred to colloquially as an "implant" (*podshivka*), and patients would commonly say, "I was implanted" (*menia podshili*). Narcologists referred to all of these variants of disulfiram or placebo therapy as *khimzashchita*. Such treatment remained extremely common among patients I spoke to in 2004, and some returned regularly for repeat implantations.

If disulfiram treatment had first been conceptualized in the Soviet Union as an aversive treatment like conditional-reflex therapy, its transformation into *khimzashchita* involved several key shifts. Where conditional-reflex therapy hinged on patients'

[12] The use of apomorphine treatment was not confined to the Soviet Union, although its use was less widespread elsewhere (Dent 1949; Lemere 1987; White 1998, pp. 106–108).

[13] By the time of my fieldwork, apomorphine therapy was no longer in use in St. Petersburg.

bodily memories of past experiences, *khimzashchita* worked on their anticipation of potential future consequences. Moreover, while the former depended on a behavioral response to stimuli administered within the walls of the clinic, the latter transposed the source of this stimulus into patients' own bodies. Underlying these was an even more fundamental conceptual shift: whereas conditional-reflex therapy depicted the patient as a body responsive to inherently meaningless stimuli, *khimzashchita* assumed a subject replete with expectations, emotions and beliefs.

Most narcologists described *khimzashchita* as a form of psychotherapy and emphasized its parallels with a type of hypnosis known as emotional-stress psychotherapy or "coding" (*kodirovanie*). Developed during the 1970s by Alexander Romanovich Dovzhenko, a physician working in Crimea, coding was a variation on other forms of hypnotic treatment for alcoholism (e.g., Rozhnov and Burno 1987). It became popular as a "rapid" form of therapy during the 1980s and 1990s, often in an extremely commercialized form where it was depicted as a magic-bullet cure (Dovzhenko et al. 1988; Miroshnichenko et al. 2001, p. 79). Like *khimzashchita*, coding is a therapy meant to keep patients from drinking seemingly by convincing them that their brains have been altered so as to make the consumption of alcohol harmful or fatal. Unlike *khimzashchita* however, coding does not involve the ingestion, injection or implantation of any substance at all, and it is the therapist who "alters" the patient's brain through his or her actions. Narcologists and patients alike often implicitly acknowledged the similarities between *khimzashchita* and coding by classifying them together. Proponents of the therapies have called them "mediating psychotherapy" (*oposredovannaia psikhoterapiia*) in print, and many patients refer to both types of treatment as coding (Entin 1991, p. 132). In addition to highlighting the fact that purportedly disulfiram-based treatments are viewed as entirely suggestion-based (rather than physiologically active) therapies, this classification also foregrounds a number of formal similarities between the clinical techniques.

"A Small Ritual": Making Placebo Therapy Effective

Not only did an education in narcology or psychiatry shape Russian physicians' acceptance (relative to their North American colleagues) of hypnosis and placebo therapy as viable treatments, but also it made them particularly attentive to the links among the performative elements of the clinical encounter, the patients' belief and knowledge and the effectiveness of therapies. For narcologists, the *khimzashchita* procedure begins with their description of the treatment to their patients, during which they must deliver a compelling depiction of its physiological effects. I asked Anton Denisovich, the young physician who ran the ward where Vyacheslav was being treated, to explain *khimzashchita* as he would to a patient:

> We inject the medication disulfiram. It comes in different forms: intravenous, capsule form or subdermal implantation. All of these forms are long-acting. If the medication is taken intravenously or orally it dissolves in the stomach and ends up in the blood stream and then enters the body's tissues, combines with

> proteins in the liver … and for a certain period of time this medicine remains in the bloodstream. This medication cannot be taken with alcohol as it blocks the enzymes which break down alcohol. If a patient on this medication drinks and alcohol enters his bloodstream the possible side-effects are dangerous to his health or life-threatening. It can be anything from a flushing or reddening of the face, to serious or crippling consequences, or even death…. This is told to the patient and he signs a paper explaining that he understands the procedure. And then the procedure takes place.

As Anton Denisovich himself acknowledged, this statement was often untrue in a referential sense, as he often used placebos in place of disulfiram. Like other narcologists, he treated the statement as a perlocutionary speech act meant to foster in the patient a particular belief (that a chemical agent in his body has made the consumption of alcohol potentially deadly), an accompanying affective state (that of fear, stress or concern) and a consequent behavioral change (abstinence).[14] Perhaps most importantly, a central idea implicit in such treatments is that clinical effectiveness depends on patients' belief in this "truth" about their bodies, a condition which the statements are meant to bolster. Even the "paper" which patients sign to acknowledge that they "understand the procedure" often functions performatively, as a prop which aids the physician in delivering the intended effect, as much as a contract meant to inform patients and verify their consent.

Following these key preliminary steps, the clinical interaction at the core of *khimzashchita* takes place. Alexander Sergeevich, a narcologist at the Addiction Hospital, explained in strikingly clear terms how crucial a clinical performance is to this stage of *khimzashchita* (and related treatments):

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

It is worth noting that, like others at St. Petersburg's Addiction Hospital, Alexander Sergeevich did not regard himself as an "alternative" practitioner but, rather, as a mainstream psychiatrist–narcologist. His account further highlights the degree to which the disciplinary assumptions of narcology attuned clinicians to view performance as part of their practice. Alexander Sergeevich emphasized the importance of ritual form over content (physical contact, words or substance are interchangeable) in producing a meaningful temporal demarcation of a new "period of sobriety" for patients. Following this logic, narcologists' and patients' preference for implantations and injections over daily self-administered tablets takes on an

[14] While he was perhaps more frank in our conversations than other physicians, Anton Denisovich was in no way unusual as a physician. If anything, he was seen as an exemplary and especially promising clinician. Described by the hospital's medical director as a young star, Anton Denisovich had been appointed the head of his ward only 4 years after completing his MD in 2000.

additional significance, since such methods of application allow for yearly or half-yearly markings of "sober time."[15]

Many of the patients with whom I discussed *khimzashchita* repeatedly spoke about the material aspects of the treatment: the size of the ampoules, the place on their bodies where *Esperal*' was implanted, the mode of administration—patients ascribed particular meanings to all of these characteristics, which in turn mediated their assumptions about the potential efficacy of the therapy. "They have ampoules, about this size and bigger ones," Vyacheslav explained when I asked him to describe the treatment, indicating the size with his fingers. *Torpedo* injections were typically dyed a bright pink or blue to signify their chemical potency (Fleming et al. 1994, p. 360). The mode of administration was certainly important as well: the fact that patients and their families generally preferred implants to injections, which, in turn, they favored over tablets, suggests that more physically invasive methods of administration may also have been associated with greater efficacy or potency. At the same time that they replaced disulfiram with vitamin C, saline or other neutral substances, narcologists used various methods to reinforce patients' interpretation of the treatment as being chemically potent. A narcologist interviewed by Chepurnaya and Etkind (2006, par. 9) explained that he sometimes carried out sham surgery on patients—making and sewing up an incision without implanting anything—and then prescribed chemically active disulfiram tablets, telling patients they were taking an antibiotic.

Patients also recognized the objects and substances used in *khimzashchita* as commodities and they often linked a drug's potency and value to its geographical point of production. One such account came from Sasha, a slight, gaunt man in his late 40s from a working-class family, who had spent the majority of his life imprisoned for acts (mainly burglary) committed while intoxicated. Sasha was a typical candidate for implanted disulfiram, the mode of treatment which was particularly popular for those categorized as noncompliant by their relatives or physicians.

> Then I ended up in the hospital again. My mother had some friends who were doctors and they said, "Let's give you an implantation of Esperal." I said "Mom, what is this?" and she explained it all to me, and so I agreed to it. For five years. They ordered this Esperal through the head doctor. I went through a full physical and then I had to bring a petition from my workplace [*khodataistvo*] and they implanted me [*menia podshili*]. I didn't drink for a year and a half. During that time I entered the institute for ship-building, and didn't drink. And then I had a relapse when a friend of mine died, with the same type of implant. Somehow I started to think, "Maybe nothing will happen to me." And I had a relapse. They had to revive me, but I survived.

Obtaining imported pharmaceuticals (in this case the French Esperal) during the Soviet period typically meant circumventing formal channels to draw on extensive

[15] This temporal aspect of the treatment also complemented the way in which the heavy consumption of alcohol was conceptualized by many patients in St. Petersburg. Patients I met at various institutions rarely spoke in terms of "consuming" or "drinking" alcohol. Most referred to "entering" and "exiting" drinking binges (*zapoii*), in a way which suggested a separate time and space. While the phenomenon of drinking binges is prominent in the international medical literature on alcoholism, this local vernacular understanding of a binge—and the set of practices it described—was clearly distinct from the medical one.

networks of contacts, a practice known as *blat* (Ledeneva 1998). As was the case with many goods and services, the scarcity of such pharmaceuticals, the effort and access required to obtain them and their place of origin all added to their value—and, in this case, their perceived potency.

By the 2000s, the availability of these substances had changed (typically the chief obstacle for patients was now a lack of money rather than a lack of access), but many patients and physicians continued to ascribe greater potency to implants imported from France or elsewhere over their domestic equivalents. One patient recounted the choice he had heard a doctor offering an acquaintance: "[The narcologist] says: 'I can give you our domestic [*otechestvennaia*] *khimzashchita*—it costs 1,900 rubles [about $65 in 2004]. I can't guarantee that it will work, if you drink that something will happen. Or I can put in the French one—that one costs [significantly more]. This is a 100% variant.'" In ascribing greater potency to imported disulfiram over the Russian-made variety, physicians and patients employed a common form of postsocialist consumer judgment which links material value to an object's geographical place of production (Patico 2005). Moreover, they implicitly translated commodity value into a judgment of potential clinical value or efficacy.

Secrets and the Management of Belief

Khimzashchita was a delicate topic for many narcologists. While some spoke about the use of "placebo therapy" without trepidation, in other cases bringing up the topic of placebos led to awkward pauses or attempts to circumvent the question. During one conversation with two narcologists who worked on the same ward, the older of the two brought up the topic of disulfiram, explaining to me that "here it is still used."

E.R.:	This is mainly implantation?
Younger narcologist:	Implantation or intravenous injection—
Older narcologist:	No, intravenous, this is already called emotional-stress psychotherapy. This doesn't involve the use of disulfiram.
E.R.:	Why? What's the difference?
Younger narcologist:	Well, these are already professional nuances. But basically, there are three methods of taking the medication—either tablets, implantation or intravenous.
Older narcologist:	Here there is a difference which depends on the psychological particularities of the patient.… The active substance, disulfiram is applied only in one form—implantation. [*sic*] But … sometimes people are either a little afraid of this, everyone has there own particularities, and they aren't suited for this. A better fit for them is emotional-stress psychotherapy, which is accompanied by the application of, essentially a placebo.

Here the younger narcologist, seemingly unsure of how to deal with the issue of placebo therapy, attempted to portray the difference between the use of a physiologically active substance and a placebo as a meaningless technical detail: "professional nuances." While his older colleague was ready to bring me in on the professional secret, he was at pains to emphasize that active disulfiram was used in implantations.

Once they knew I was in on their secret, narcologists offered a number of explanations for how they chose to give patients neutral substances in place of disulfiram, suggesting a subtle moral and social calculus which underlay their reasoning about clinical effectiveness. Anton Denisovich explained: "As you understand all patients cannot take these substances, in part because some of them won't wait out the entire period, and this will just be dangerous for them. So it's better to give him a placebo and give him the gift of several months of sober life, than to inject the real medication." While I discuss this framing of the placebo as a gift at greater length below, it is worth noting that decisions to administer neutral substances were underpinned by judgments of particular patients and their capacity for adherence. A strong DER could indeed be deadly to some patients, and narcologists often sought to mitigate risks to their patients, as well as their own potential liability, by using placebo therapy. Although most verifiable accounts of patients dying from a DER seemed to be clear cases of negligence on the part of physicians, narcologists at the hospital depicted noncompliant patients as the primary source of risk.[16]

Judgments about patients' potential for adherence, in turn, drew on a categorization of patients based on their familial resources as well as an ascribed level of "social decline." In a recent textbook, Russia's head narcologist Ivanets (2001) recommends the use of disulfiram only for the small contingent of patients who remain "socially conserved" (*sotsial'no sokhranen*) and argues against its use for the vast majority, which he characterizes as "the asocial type [*asotsial'nyi tip*] of alcoholic" (pp. 113–114). Narcologists I spoke to articulated a similar logic. For the physicians, this way of thinking rendered their perceptions of respectability and social status clinically relevant, as indices of a patient's potential adherence. "Socially conserved" patients included those who had not (yet) lost their jobs or contact with their family members; they were viewed as having greater motivation for sobriety, but also as possessing greater social and familial resources to facilitate adherence. "The real medications have so many side-effects," explained one narcologist. "We give it if there is a mother or a wife who strictly makes sure that the patient is taking the medication. Then we give it." In other words, the use of chemical disulfiram at the clinic was often seen as being dependent on a complementary (typically gendered) arrangement for its management in a domestic space.[17]

[16] Most cases of patient deaths after disulfiram implantation or injection involved commercial enterprises which 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 procedure.

[17] This clinical style of reasoning also drew on and fed into a widely circulating discourse about 'the social,' which has its own deeply Soviet genealogy. Both physicians and patients themselves spoke about

If using disulfiram was especially risky for a particular category of patients, the efficacy of placebo therapy was also seen by narcologists as highly variable. Some argued that placebo therapy was more effective among certain types of patients, typically identifiable by particular psychological characteristics. For narcologists, patients' suggestibility could be conceptualized as either an individual disposition or a generational characteristic. Older patients or "Soviet people" were often described as being more suggestible than younger people, an ascription which draws on a common stereotype of the *sovok* or *Homo sovieticus* as conformist and prone to manipulation by political propaganda (cf. Oushakine 2000).

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

Even further, some physicians characterized "belief" in particular therapies as a sort of nonrenewable resource requiring careful management. In a recent paper, Alexander Sofronov (2003), a well-respected professor of psychiatry at St. Petersburg's Military Medical Academy, argues that the popularity (among patients) of modes of treatment such as *khimzashchita* hinders the advancement of methods accepted throughout the world, particularly the Twelve Step program and the therapeutic community model. Sofronov (2003) describes clinical technologies of *khimzashchita* and similar methods as "explanatory medicine" (*ob"iasnennaia meditsina*), in which the patient's only source of knowledge or information is assumed to be the physician: "The way we explain it is how they'll be treated" (p. 4). Despite his misgivings, Sofronov regarded methods such as *khimzashchita* in a highly pragmatic way. During a conversation in his office, Sofronov posed a rhetorical question about the popularity of such treatments: "Should we undermine this belief (*vera*)? Absolutely not!" While Sofronov thought that "explanatory medicine" blocked the growth of more effective modes of treatment, he also worried that the latter were not yet adequately developed or available to patients in Russia. Not only was it unethical to undermine patients' faith in *khimzashchita* under such conditions, but also, as Sofronov implied, belief in the efficacy of treatments needed to be carefully managed.

In other words, if the effectiveness of *khimzashchita* hinged partly on narcologists' skills of persuasion and performance in their face-to-face encounters with patients, it was equally dependent—as the physicians saw it—on their successful management of its broader representation to various publics as a

Footnote 17 continued
the position of particular persons vis-à-vis "society"—as being still within it, outside of it or, more rarely, re-entering it. The implication was that patients described as "socially destroyed" or "declassed" not only had lost contact with their relatives and friends, or had lost their previous standing, but were beyond the boundaries of the social altogether.

pharmacological treatment, and as an effective one at that. This work of building and maintaining the treatment's legitimacy took place not only during narcologists' bedside chats with their patients, but also in conversations with family members, in debates on the pages of medical journals and newspapers, and in arguments or offhand remarks made to this ethnographer.

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

In working to legitimate *khimzashchita* physicians used multiple strategies, ranging from quoting statistics of efficacy (typically percentages of patients achieving year-long sobriety) to constructing origin stories for treatment modalities which linked them to Russia and depicted them as culturally appropriate. For example, the argument was sometimes made that it was appropriate for physicians to employ their professional authority to frighten patients because this clinical relationship reflected a particularly "Russian" form of authority. Moreover, as narcology in 2003–2004 was a thoroughly commercialized sphere of medicine, in which practitioners competed fiercely for patients, claims about the efficacy of one's methods and medications were often interspersed with disparaging comments about one's competitors as manipulators, cult leaders, quacks or even mentally ill. One psychiatrist in private practice explained to me that his use of subliminal suggestion methods represented one of the few clinical uses of the "real" technology. The attempts of others he described, ironically enough, as "placebo therapy at best."

Doubts, Rumors, and Fears: Patients' Ideas About *Khimzashchita*

What effect did narcologists' efforts have on patients' understanding of *khimzashchita*? The answer often had to do both with a particular patient's prior experiences in treatment and with the broader social context of his or her life. While patients' descriptions of *khimzashchita* ranged from confused to compliant to defiant to desperate to cynical, it was most often the patients with jobs and intact families—those likely to be viewed as potentially compliant—who spoke about the treatment in a manner likely to be understood as "believing" by their physicians. For example, Gleb, a middle-aged working-class patient on Anton Denisovich's ward, explained that he had been given a *torpedo* in the past, but had not been able to wait until it ran its course, and had begun drinking. He added that nothing happened as a result of his drinking during the course of the *torpedo*. Yet the fact that he had, contrary to the assurances of his narcologist, survived this relapse without any consequences did not lead Gleb to doubt the potential dangerousness of *khimzashchita*:

> Before you take it you sign a paper saying that if you drink, the doctors are not responsible for what happens to you. You get it for a year, then you have to wait it out for a year. If you do it, you want to live. It's fine if it kills you: better that than it paralyzing you or something. *We don't know with these drugs.* That would be worse. So each person needs to use his brain. [Emphasis added]

Gleb's description evokes the state of uncertainty experienced by many patients with regard to the risks of *khimzashchita*. Indeed, many stories circulated in St. Petersburg about deaths caused by disulfiram. Some of these were offered by narcologists as condemnations of the rapacious commercial practices of their colleagues. Others had the quality of rumors or warnings: accounts by patients or their relatives told about acquaintances who had died because of *khimzashchita.* I was also told apocryphal stories which attributed the death of popular Soviet singer Vladimir Vysotsky in 1980 to a particularly serious disulfiram reaction. Many patients also spoke about the importance of having an implant removed before beginning to drink (Chepurnaya and Etkind 2006). Whatever the intentions of people who circulated such rumors, the narratives themselves played an important part in reinforcing the idea of *khimzashchita*'s potency among laypeople.

However, for every story about the chemical potency of the treatment, there was another which attested to its *ineffectiveness* or offered a technique for counteracting disulfiram's effects. Dmitri, a Twelve Step counselor, showed me the scars which implantations of Esperal had left on his body and explained that he had never waited through the term of the implant and never had one removed.

> I would just start to drink. And nothing happened. Besides that, I knew that nothing would happen: everyone was constantly talking about this. They'd say, "Forget it, just drink a little lemon juice." There were all of these means to counteract it that they'd give out right away, even while you were still in the ward, getting ready for the operation. Even though I would wave these ideas away, they would sink in somewhere.

Physicians recounted their own stories (typically told in a comic mode) about patients who tried to manually remove or destroy their implants by tearing at their shoulders or striking their backs with sticks. All of these narratives contributed to patients' pervasive sense of uncertainty surrounding *khimzashchita*.

Ironically, the patients who received placebo therapy because they were categorized as noncompliant were the very ones who were least likely to give credence to the potential efficacy of narcology's treatments. Eduard, an unemployed man in his mid-30s, whom I met at the hospital, was one such patient. During the late Soviet period, Eduard had worked as a *fartsovshchik*, a black-market dealer of goods from capitalist countries such as blue jeans, but he had been unable to maintain steady work for several years. When I spoke to him, his arm was bandaged from a burn he had received while cooking drunk. Eduard was doubtful of any therapies, and described how he had seen another patient receive an Esperal implantation, which her physician explained was foolproof option: "If you don't want to live you can just drink a glass of beer and you won't be here any longer." However, Eduard continued, after the patients' discharge, "*One week later* they

bring her back—after a week-long binge already! Almost comatose. So all these *khimzashchity* are complete nonsense." Eduard could easily have interpreted his acquaintance's serious condition upon her return to the hospital as an indication that the disulfiram had been active and potent. Instead, he emphasized that this patient had—however narrowly—survived her binge, despite the assurances of her physician, as evidence that the treatment was "complete nonsense." It is particularly interesting to compare this account to that of Gleb (described above), who did not doubt the potential dangerousness of *khimzashchita*, despite having experienced no physiological effects as a result of a previous *torpedo*. Unlike Eduard, who was living on the margins of homelessness, Gleb resided with his family. Like Vyacheslav, Gleb had integrated *khimzashchita* into his domestic life.

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

For instance, Alexander Sergeeivich explained how some patients used fear as a means of self-management. "The mechanism [underlying *khimzashchita*] is simply fear," he explained, but added that one also needed a motivation to become sober. "If he doesn't have this, then even fear won't hold him back." Part of the physician's work, as Alexander Sergeeivich saw it, was rendering this fear meaningful to the patient, making sure that it took hold. He added, "Many of [the patients], either openly or not, approach the doctor with the request, 'Put this fear of consuming [alcohol] into me.' Because many of them understand that nothing else will hold them back, only this kind of fear." It was not just physicians who made such arguments. Dmitri, the Twelve Step counselor, described to me how he had once voluntarily returned to a psychiatric hospital for a repeat of a sulfazine injection[18]—which he described as a "punishment" rather than a "treatment." "I said, do this thing to me one more time. I ask him voluntarily; I want to remember this state [*sostoianie*], this horrible state, I want to experience it and remember it, so that I'll always remember it." Such accounts suggest that the model patient for *khimzashchita* and related methods is not the unknowing dupe of narcologists, but the patient who successfully integrates these clinical technologies into a process of self-management and discipline.

Dependencies: Power, Professional Authority, and the Clinical Encounter

In their article on *khimzashchita* and related therapies, Chepurnaya and Etkind (2006) argue that these modes of treatment represent an "instrumentalization of

[18] Another relatively common practice in Soviet psychiatry and narcology, the injection of sulfazine caused patients to experience severe pain and fever, and was used as a form of aversion therapy.

death" to the purpose of controlling the behavior of others. As they see it, *khimzashchita*—and particularly disulfiram implantation or *podshivka*—is a particularly "extreme" disciplinary practice in that it requires patients to enter into a seemingly contractual and voluntary relationship with their physicians, in which patients agree to death as a potential consequence of their breaking the contract.[19] These elements also make the treatment representative of "those disciplinary practices which were characteristic for late Soviet society and which have been inherited by post-Soviet Russia" (Chepurnaya and Etkind 2006, par. 4). Moreover, Chepurnaya and Etkind suggest that, paradoxically, *khimzashchita* harnessed the informal practices central to Soviet society (e.g., rumors, networks of acquaintances) to bring deviant and unruly individuals voluntarily under the power of the party-state. They develop this argument by drawing on the political and social theories of Thomas Hobbes and Emile Durkheim. In agreeing to a disulfiram implant, alcoholics put themselves under the power of a Hobbesian sovereign; however, the power of the implant can only be created and sustained by the continuous reiteration of belief by a Durkheimian collectivity (Hobbes 1998[1651]; Durkheim 2001[1912]).

While this interpretation nicely captures the thoroughly social character of *khimzashchita*, as well as its similarities to other authority-establishing practices, it provides few tools for thinking through the contentiousness and contestation of these therapies. This is not to say that physicians' use of their professional authority in the clinical encounter (and beyond) is not implicated in *khimzashchita.* Indeed, such treatments have depended on, and helped to reinforce, clinical encounters premised on a steeply hierarchical physician–patient relationship. Not only did narcologists frequently make direct reference to their professional status in their conversations with patients and their families, but the entire process of *khimzashchita* depended on patients' ascription of authority to their physicians. However, since the legitimacy of narcology as a medical specialty was deeply contested, such ascriptions varied greatly depending on the patient and on the ability of the physician to embody this authoritativeness. Many of the older male patients, such as Vyacheslav, expressed a strong deference to the specialist authority of physicians in matters of medication: "It's all figured out by the professors so that it gradually dissolves." Yet there were always patients like Eduard who viewed narcologists as motivated entirely by pecuniary concerns. Particularly because of the contentiousness of this medical specialty, it is important to look beyond the charisma of individual physicians or the symbolic power of white coats and surgical scalpels, to examine the institutional context in which narcologists staked their claims to professional authority.

As Rivkin-Fish (2005) has argued, physicians' specialist authority took on a different shape in the Soviet Union than in liberal Western European and North American states (pp. 23–28). While the Soviet party-state celebrated the specialist power of medicine, it also undercut physicians' bases of corporate power or autonomy by dissolving pre-Revolutionary professional associations (Field 1991).

[19] Chepurnaya and Etkind attribute this character of *khimzashchita* to the fact that, unlike the disciplinary practices described by Foucault (1977), it emerged from an illiberal society rather than a liberal one.

Not only did physicians become employees of state agencies, but their potential claim to a class- or status-based differentiation was curtailed through the scaling of medical wages below those of industrial workers (Ryan 1990, p. 22). Mark Field (1991) has suggested that the simultaneous constraint of physicians' political and economic power and the promotion of their disciplinary power created a situation in which the clinic took on added importance as a key site for the exercise of professional authority (p. 53). Within the walls of the clinic the physician's authority was meant to be unquestioned, with no patients' rights movements or legal means to challenge clinicians' "symbolic power of expertise" (Rivkin-Fish 2005, p. 26).

This dynamic was arguably intensified in the case of specialties such as psychiatry and narcology, which were more heavily dependent than others on the party-state for their authority. In the case of narcology, this had to do with the fact that the subspecialty was a direct product of Soviet policies and campaigns regarding public order and health. Indeed the professional designation of "psychiatrist-narcologist" was only created in 1975, when the narcological system was established and when the Ministry of Health funded the establishment of narcology departments at medical schools throughout the country (Babayan and Gonopolsky 1985, p. 47; Galkin 2004).[20] Additionally, the clinical sites of narcology and psychiatry were closely interwoven with institutions of the legal system, and psychiatrists and narcologists had the authority to commit patients or recommend compulsory treatment (Tkachevskii 1974, 1990).

These close institutional links to the state created a paradoxical set of conditions for Soviet physicians, and for narcologists in particular. While their ability to call on the state's means of coercion gave narcologists a means to manage patients, it also undermined physicians' "legitimacy as healers" (Rivkin-Fish 2005, p. 26). Several narcologists who had practiced during the Soviet period with patients undergoing "compulsory treatment" explained the extremely deleterious effect that such perceptions had on their attempts to establish trusting relationships with patients, especially those with histories of detention. Thus, like other Soviet physicians, narcologists often drew on various means of social exchange to personalize their relationships with certain patients and to distance themselves from associations with bureaucratic authority (Rivkin-Fish 2005).[21]

During the 1990s, three broad changes—all linked to broader post-Soviet political and economic transformations—had significant effects on the institutional space in which narcologists and their patients negotiated their clinical relationships.

[20] Although the term "narcology" was not new (courses and textbooks on the topic had existed for decades), prior to 1975 the specialty of "psychiatrist–narcologist" had not existed as a legally recognized and certifiable position in the Soviet medical system (Galkin 2004). The number of number of psychiatrist–narcologists rose from some 1,200 in 1976 to nearly 9,000 in 1987 (Ivanets et al. 1992, p. 13; Fleming 1996).

[21] Although it often involves exchanges of material value, such exchange activity—which is still prevalent in much of the post-Soviet health-care system—was seen as falling under a separate moral economy from the exchange of money for services. While the latter are often characterized as bribes (*vziatki*), exchanges which are mediated by networks of acquaintance (*svoii*) are described by their participants as being motivated by a desire for medical care which is personalized and not delivered by a physician fulfilling his or her professional obligation as a civil servant (Salmi 2003; Rivkin-Fish 2005).

First of all, during this time narcologists lost the near-monopoly over the clinical knowledge and treatment of addiction which they held during the Soviet period and found themselves competing with a number of methods and movements: some "imported" (like Alcoholics Anonymous [AA] and Scientology) and others "homegrown" (like the Orthodox Church) (Critchlow 2000; Lindquist 2005; Zigon 2008). While many nonbiomedical practitioners borrowed heavily from narcological therapies, hybridizing them and thereby blurring the clear distinctions between official narcology and "alternative medicine," others were either, like some AA proponents, only grudgingly tolerant of the state-run service or, like the Scientologists, devoted to an explicitly antipsychiatric and antinarcological agenda. Thus when narcologists spoke about the effectiveness of their treatments and the need to maintain patients' belief in them, they conceptualized themselves as operating in this broader discursive field, where the very legitimacy of their specialty was constantly being called into question.

The second broad change was the transformation of narcology from part of the state socialist political economy of medical services into an unevenly regulated market. The speed and depth of this commercialization were driven partly by the fact that narcology offered physicians opportunities for profit during a period of intense economic depression. In 2004, narcologists in the state service were paid more than many of their colleagues in other specialties—this was meant to be official remuneration for the difficulty of their work—while the potential for profit in commercial narcology (or unofficial services in the state sector) was so great that competition between physicians and clinics occasionally turned into violent commercial war, with the involvement of *mafiya* groups (Raikhel 2009, p. 227, n. 1). For physicians or medical researchers whose small salaries were often delinquent or delayed for months at a time, the promise of a specialty with even a modestly higher pay scale was clearly attractive. While most of the narcologists I spoke to had entered medicine with a variety of motivations, almost all explained that they had chosen to specialize in narcology for financial reasons.

This commercialization was directly linked to treatment methods such as *khimzashchita*, which represented one of the main sources of additional income for physicians working in the state-run network. Not only did the treatment become openly commodified during the 1990s, but narcologists spoke about its value and price as a clinical consideration. For example, the cost of *khimzashchita* was often linked to the length of time for which the patient was prohibited from drinking, and some physicians described the cost of a therapy as an important element motivating patients to take their sobriety more seriously (Chepurnaya and Etkind 2006, par. 32). Finally, when they injected or implanted patients with a placebo, or when they charged an exorbitant price for disulfiram to represent it as a new medication, narcologists were the ones who pocketed the difference in cost.

The final change to narcologists' professional authority came with the abolishment of compulsory treatment laws—part of a broader effort to introduce protections for human rights and to import principles of patient autonomy to post-Soviet Russia. Indeed, patients at the Narcological Hospital in 2003–2004 generally needed only to inform their physicians in writing in order to end their treatment and be discharged. Overall, narcologists' attitudes toward this shift were ambivalent and

varied greatly, depending on the individual clinicians and the circumstances in which they found themselves at a particular time. Many emphasized that the success of treatments such as *khimzashchita* depended largely on patients' motivation and complained about the passivity of patients who wanted "quick fixes" (complaints which were often infused with the image of patients as wards of the welfare state). Other narcologists—and sometimes even the same ones—groused about the need to convince patients to stay in treatment, and spoke of the Soviet period with nostalgia. Perhaps more significantly, even when they spoke about the importance of motivation, many narcologists seemed to regard the success of *khimzashchita* as being dependent on a performance of a charismatic authority which fostered patients' beliefs of their healer's uniqueness, rather than their own agency.

All three of these broad changes—the arrival of new forms of addiction treatment and rehabilitation, the commercialization of narcology and the demise of compulsory treatment—shifted the grounds for clinical relationships, so that they took very different forms, depending on the social conditions and financial means of particular patients. To examine the variation in these relationships it is worth returning to the statement made by Anton Denisovich in describing his rationale for substituting neutral substances for disulfiram: "So it's better to give him a placebo and give him the gift of several months of sober life, than to inject the real medication." Many analyses of the clinical relationship have examined the meanings and effects of gifts given by patients to their physicians, particularly in Russia, where such practices as common (e.g., Salmi 2003). In this case, Anton Denisovich reversed these terms in describing his care for some patients through the metaphor of gifting—and arguably evoked many of the ambiguities of power and authority in the narcological clinical encounter. Like many narcologists, Anton Denisovich depicted himself as operating under an ethics of benevolence which, at times, was explicitly distinguished from a bureaucratic ethical regime of informed consent (Kelly 2003).

Such a dynamic was particular evident with the most "hopeless" cases—patients viewed as abject, "declassed" or socially marginalized. Although such patients' relationships with physicians could be characterized as beneficent, critics of *khimzashchita* were more likely to label them paternalistic or even clientelistic. As a psychiatrist who worked promoting AA in Russia put it, "Under the conditions of the market, the job of the doctor is to attach the patient to himself [*privezat' k sebe bol'nogo*], to make the patient dependent on him. And underlying this is the market and financial situation." Indeed, physicians' relationships with certain patients could be characterized as having a quality of dependence. Narcologists often instructed patients that they would have to return to the same practitioner were they to decide to end their sobriety early by having a code or implant removed. In the case of patients for whom the only alternative to the hospital was life on the streets and in shelters, such dependencies could become particularly strong. Narcologists allowed some patients to reside at the hospital, occasionally discharging and readmitting them to comply with official limits on periods of hospitalization. Many of these patients performed menial tasks around the hospital; they spoke about their physicians in deeply deferential and respectful terms. Such relationships of dependence and moral indebtedness stood in stark contrast to those which

narcologists maintained with patients who had relatively greater social and economic capital. These clinical interactions were structured more like commodity relationships, in which there was an exchange of alienable services for money, and each party walked away with no obligations to the other.

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

Conclusion: Radical Measures or Pragmatic Means

Throughout this article I have traced the reasons for the continued prevalence of *khimzashchita* and other suggestion-based methods of treatment for alcoholism in Russia. I have argued that, in part, such methods arose from a professional ethnopsychiatry characterized by a particular neurophysiological style of reasoning, originally grounded in a "dialectical" interpretation of Pavlov's theory of "higher nervous activity," but since then transformed into a pragmatic materialism. Narcologists view the effectiveness of such treatments as being dependent on a number of factors, including not only individual patients' motivation for sobriety, but also their "belief" or "faith" in these very techniques. While physicians' attentiveness to the legitimacy of their therapies is shaped by a particular clinical logic, at stake is the broader legitimacy of their specialty as well as its commercial viability. Moreover, as they draw on their professional and institutional authority to magnify the effects of *khimzashchita*, narcologists often reinforce a steeply hierarchical clinical relationship—particularly when they work with patients who have few social or economic resources of their own.

There is, however, a caveat in that, despite its continued prevalence, many narcologists I spoke to described *khimzashchita* as "a thing of the past." The collapse of the USSR, and the subsequent reintegration of narcologists into transnational professional networks, brought them into contact not only with psychosocial models of addiction treatment, but also with the biologizing trends sweeping global psychiatry. Even as various forms of talk therapy have experienced an efflorescence in post-Soviet Russia (Matza 2009), broadly biological styles of reasoning in Russian psychiatry have been reinforced by this dovetailing of geopolitical rupture and disciplinary shift. Thus it was not so surprising that some narcologists I spoke to

articulated a disdain for *khimzashchita* and a hope for therapies which would "cure" alcoholism through biological means. When I asked Vyacheslav's doctor, Anton Denisovich, which methods of treatment or rehabilitation he found most effective, he explained:

> Out of what now exists in the sphere of rehabilitation—these are all palliative measures, not radical ones. The future is certainly with psychopharmacology in this situation, as I see it. If we look far ahead, either neurosurgery or genetics, I don't know, but with some kind of radical measures. Psychotherapy can only more or less lengthen the remission.

Denisovich's future-oriented notion of "radical measures" which might completely "cure" addiction echoed many North American biological psychiatrists' hopes for an effective pharmacological treatment of addiction. However, the tension between this hope and Denisovich's daily work at the Addiction Hospital, where he continued to employ *khimzashchita* regularly, reflected the uneasy and paradoxical disposition of many narcologists with regard to their clinical techniques. Whatever their aspirations, narcologists in Russia continue to work in a setting shaped by institutional, political–economic and cultural vectors conducive to the persistence of methods such as *khimzashchita*.

What broader conclusions can we then draw from the case of disulfiram therapy in Russia? For one, this narrative calls into question the argument that a somatic notion of the self follows from a thoroughly biologically based psychiatry. In the case of Russian addiction medicine, a style of reasoning which privileged biological explanations did not produce treatments which encouraged patients to think of their drinking problems as imbalances to be modulated. Nor did most patients who received narcology's behavior modification treatments articulate an illness-based addict identity, as advocated by Twelve Step programs. Vyacheslav did not speak of himself as "an alcoholic," but as someone who was managing his drinking binges. Thus, in what may seem a paradox from the purview of North American psychiatry, in Russia a neurophysiological style of reasoning facilitated the dominance of treatments which relied on largely psychological mechanisms, and which seemed to make few claims on patients' selves or identities.

Was *khimzashchita*—by any criteria—an effective treatment? While I do not address this question through the analytic of clinical efficacy, I have suggested that while some patients found it useless as a means of achieving even temporary sobriety, and others passed through cycles of increasingly brief remission, at least for some, like Vyacheslav, *khimzashchita* worked as a pragmatic aid for the care of the self which bolstered personal motivations for sobriety. The reason for these differences had less to do with anything specific to the treatment protocol than with the broader configuration of institutions and relationships (both inside and outside the clinic) within which any particular instance of the treatment took place.

It is in this sense that the case of Russian disulfiram treatment also demonstrates vividly that "chemical" and "placebo" effects, or the social and pharmacological lives of medicines, cannot be disentangled as easily as some anthropologists have suggested (Whyte et al. 2002). The addiction therapies discussed here highlight how the efficacy of *all* ostensibly pharmacological treatments is shaped by elements,

including chemical effects and patients' interpretations of those effects, clinical performances and relationships, clinicians' styles of reasoning and local research traditions and the institutional and political–economic settings of treatment. Moreover, such a perspective suggests how partial and incomplete an understanding of any clinical intervention results when it is reduced to a therapeutic protocol, a reduction which depends on the assumption that clinical technologies are discrete, portable and transposable between contexts, with little transformation.[22] As the movement of clinical knowledge, substances and techniques become ever more ubiquitous and far-reaching, it is increasingly important for anthropologists of medicine and psychiatry to explore the processes and mechanisms which link patients' treatment experiences to the material, discursive, performative and institutional elements of which all interventions are composed.

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