

For lack of wanting: Discourses of desire in Ukrainian opiate substitution therapy programs

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Abstract

Available treatments for addiction and substance abuse in Ukraine have been shaped by the economic, political, and social shifts that have followed the country's independence. The introduction of methadone-based opiate substitution therapy (OST) for opiate addicts is especially representative of this. Biomedical paradigms of addiction, its etiology, and its treatment, promoted and paid for by international donors and elite global health entities, are being met by Ukrainian notions of personhood and psychology in both public discourse and clinical settings. Ukrainian physicians who work in OST programs frequently reference desire (желание) as the most significant factor in determining the success or failure of treatment. They refer to a desire to be treated, desire to get better, desire to live. The moralized imperative to possess this desire to get better is, in many ways, a reflection of how addiction and the addicted psyche is constructed and understood in the Ukrainian context. By exploring discourses of desire in narratives of addiction and treatment, I examine how notions of psychology, will, and self-control intersect, shaping the subjectivity, agency, and daily experiences of this vulnerable population.

Keywords

desire, disease narrative, drug addiction, methadone, opiate substitution therapy, Ukraine

Timur¹ complains of terrible dreams. He sleeps badly. His body is often weak and he suffers frequent fevers. He has tried various strategies for easing his symptoms: first methadone from the clinic, then *shirka*² from the street, and now tramadol³

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from a pharmacy that, for one reason or another, continues to sell to him. None of these solutions has remained effective for very long. After a while, he says, things always get bad again.

Timur is enrolled in one of his region's few methadone-based opiate substitution therapy (OST) programs, a treatment program for opiate addiction that provides a daily regimen of a synthetic, medical-grade opiates meant to take the place of illegal narcotics. On paper, he is a free man. He is no longer in jail. Serious troubles with the police are a thing of the past. He no longer wakes up worrying about where his next dose will come from or whether his body will hold out long enough to find one. "My mornings have become peaceful," he says. This is a positive change. His evenings, however, are not so pleasant. This is when the headaches come, followed by the fevers, the weakness, and, finally, the dreams. "My dose [of methadone] right now—it's not enough," he complains. "It doesn't hold me up anymore."

When he first began receiving OST at the AIDS center in his hometown, Timur was given 40 mg of methadone per day. Soon after, he started feeling badly, and his doctor (a kind, middle-aged man whose patients call him by his formal name, Alexey Sergeevich) agreed to increase his dose. "We are here to help them," Alexey once told me. "There is no reason for them to suffer when they are in our care." As they worked to manage his symptoms, Timur's dose crept up, bit by bit, until he reached 150 mg, the upper limit of what his clinic is allowed to prescribe.

"Obviously the point is not to raise your dose, but to lower it," Timur observed. "At these levels, I'm worried about my liver." Unfortunately, his persistent withdrawal symptoms don't present him a very convincing case for lowering his dose either. Now that he's reached the maximum methadone allowance, he has been trying out additional cocktails of opioid analgesics—like *shirka* and tramadol—in the hopes of finding a regimen that will work. His mornings are spent commuting to the AIDS center for his methadone, and his afternoons are spent seeking out other things to help him get through the night. Timur claims that he would like to quit, but the drugs have too much control over his body.

Timur is a problematic patient. He frustrates his doctor and nurses; however, the root of their frustration does not seem to be his overt self-administration of street drugs in addition to the methadone. It seems clear that the staff of his OST clinic are well aware of, and reluctantly tolerate, Timur's extracurricular activities. They do not chastise him. Instead, they pity him and wonder how to resolve the real issue that lies underneath: his lack of desire to be treated.

This article addresses narratives of desire that are produced in the therapeutic environment of the OST clinic and reproduced by OST clinicians and patients in Ukraine. It considers the ways in which appeals to the presence or absence of different forms of "desire" fit into local understandings of the social and psychological mechanisms of addiction. Ethnographic data presented here is based on 14 months of qualitative research conducted between 2010 and 2013 among Ukraine's internationally funded HIV prevention and harm reduction projects,

within which OST is a central element. I map out a model of addiction that is popular among the medical professionals operating Ukraine's OST programs as well as the individual prognoses and treatment trajectories that are contingent upon that model. In my analysis, I pay close attention to the local values, histories, and structures that give shape to the physical and social body that medical practice and therapeutic spaces attempt to render.

This analysis is germane not only to the treatment of drug addiction but also to the greater public health project of reversing the spread of HIV and other communicable diseases in three distinct ways. First, the therapeutic logic of OST is grounded in the idea that addiction is a disease situated in the physical or psychological state of the individual (Bourgois, 2000; Bourgois & Schonberg, 2009; Campbell, 2007; Campbell & Shaw, 2008; Hunt & Barker, 1999). This view works to obscure larger social and structural factors that shape drug use behaviors on an individual and a community level (cf. Bourgois, 2003; Spradley, 1968). It also has the ability to render invisible the fact that psychological and behavioral interventions for addiction constitute disciplinary technologies that act upon the body politic, "the regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference" (Scheper-Hughes & Lock, 1987, pp. 7–8). It is, therefore, important to attend to the ways in which clinical perspectives on addiction are professionally and historically situated, lest these paradigms be taken for granted and their social consequences avoid critical evaluation.

Second, clinic-based addiction treatment programs are governed by a system of medical ethics that is inextricably bound up with locally salient ideas about social identity and personhood. Like so many other "wide-net" public health interventions, OST programs are usually designed to capture individuals displaying certain types of troublesome behavior or embodying specific forms of social deviance. In turn, exiting the problematic realm of addiction by submitting oneself to treatment is a move equally entangled with social position and discourses of identity. It constitutes a form of work upon the self that Tomas Matza has described as "a means of sorting value and of ascribing and managing social difference and futures, but also of healing and care" (2012, p. 804). In other words, therapeutic trajectories in Ukrainian OST programs are bound up in value-laden social paradigms that determine what makes someone a socially appropriate subject (Carroll, 2011). For addicted patients, much more than their physical or mental health is on the line.

Third, the illness narratives that are produced and reproduced as part of the therapeutic process can be, intentionally or unintentionally, spoon-fed to patients. Drug addicts in OST treatment are often presented with a standard clinical narrative of what is happening to them with little regard to how their own views of their physical states and chemical dependencies may differ. There is a significant body of literature in critical medical anthropology that focuses on tensions between actors in medical and therapeutic settings where social values and meanings of illness diverge (Erickson, 2007; Pylypa, 2008). Arguably, the best case for concern over

the co-occurrence of multiple, contradictory narratives has been made by Arthur Kleinman (1988), who has forcefully shown that incompatibilities in the explanatory models adopted by clinicians and those adopted by patients can have a direct and potentially negative impact on the patient's health outcome. Therefore, failing to map out and attend to the multiple discourses present in the therapeutic encounter can jeopardize a patient's treatment success and, by extension, their social future.

Above all, I argue that, in the context of the Ukrainian OST clinic, professional claims regarding the presence or absence of a patient's desire to be treated have far-reaching social and moral effects. These claims bolster the validity of OST as a modality of treatment and determine the personal availability of individual drug users to the mechanisms of that treatment. They leave little room, however, for alternative assessments—least of all the self-assessments of patients who perceive their addiction as a practical difficulty, not a psychological one. The result, as this study shows, is that many addicted persons ultimately reject interpretations of their addiction and treatment trajectories that contradict their own lived experiences. In so doing, they also reject the medical authority that seeks to shape their clinical behaviors and their social engagement, developing their own treatment strategies and implementing them as best as they can within the confines of their OST program. It is hardly a surprise, then, that “success” on OST appears so difficult to achieve.

Soviet legacies in contemporary drug treatment

Below, I outline the cultural values that have historically characterized professional approaches to addiction in the Soviet medical system—from which the contemporary Ukrainian medical system emerged—especially the emphasis on individual “will,” which was seen as a lynchpin characteristic in the nature of addiction and patients' therapeutic trajectories. It is well established in anthropological literature that patterns of addiction are driven by social and structural factors, and that the characteristics and meanings of drug use behaviors are largely determined by the cultural context (Becker, 1963; Bourgois, 2003; Bourgois & Schonberg, 2009; Brave Heart, 2003; Pilkington, 2007; Spradley, 1968). Even the most broadly accepted case definitions of chemical dependence—those found in the DSM-5 (American Psychiatric Association, 2013) and the ICD-10 (World Health Organization, 1992)—rely on culturally bound moral values, such as how much time one spends acquiring drugs or persistent use despite social consequences (Glasser, 2011). This fact is highly pertinent in light of Mariana Valverde's observation that “scholarly literature on alcoholism and addiction . . . tends to repeat [an] ahistorical and ethnocentric perspective” (1998, p. 18). It is deceptively easy, she argues, to overlook how social and moral values have shaped contemporary beliefs about addiction. In response, anthropologists often view medical interventions for controlling or policing addiction's undesirable elements as socially adapted technologies of governance cloaked in the appearance of the scientifically concrete (Bourgois, 2000; Campbell, 2007).

Throughout the early Soviet period, two etiologies of drug abuse and addictive behavior fought for prominence: one focused on the social exterior and the other on the psychological interior of the addict. Both of these approaches sought to articulate the relationship between environment and addictive behavior and, in so doing, prescribe an appropriate response. The first of these, which can be called the “social etiology” of addiction, aligned with the foundational principles of Soviet medicine as established at the 1st All Russian Congress of Medical-Sanitary Sections in June 1918. It was decided at this congress that emphasis was to be placed on the prevention of disease via appropriate sanitary and social measures. At this time, leaders in the medical field were especially concerned with “the influence of the economic and social conditions of life on the health of the population and on the means to improve that health” (Solomon, 1989, p. 255). This social orientation fell in line with the larger view that the Bolshevik Revolution “eliminated the basic antagonistic contradictions between the socioeconomic structure and the health of the people, and thus did away with the basic source of illness for the workers” (Field, 1967, p. 39). In other words, substance abuse and addiction were not caused by individual failings; they arose as a result of harsh or oppressive social and economic environments.

Interestingly, this logic led to the brief implementation of an opioid maintenance program in Leningrad in the 1930s. A physician named Kantorovich initiated a maintenance program on an experimental basis, taking in those allegedly “incurable” patients who, he believed, still displayed the “potential” to become productive members of society once more (Latypov, 2011, p. 11). Kantorovich’s claim that nearly 70% of the patients enrolled in his maintenance program achieved “good” or “satisfactory” results, as measured by the patient’s maintenance of family relationships and the stability of employment, flew in the face of the alternative view, which stipulated that opiate addicts did, in fact, suffer from a “moral disability,” that they were “lacking will” and therefore useless to both country and society (Latypov, 2011, p. 11). The alleged implication of Kantorovich’s findings was that most so-called “incurable” addicts do possess the will to reintegrate into society, provided the obstacles that prevent them from doing so are successfully managed. He insisted that recovery is possible with the right tools and the personal will to achieve it.

This approach ultimately lost the ideological battle when the Soviet medical establishment adopted psychologist Ivan Pavlov’s concept of the conditional reflex for its theoretical foundation. As the pioneer of this concept, Pavlov defined the conditional reflex as an automatic response to certain stimuli that becomes physiologically hardwired in the brain due to repeated exposure to and neurological analysis and synthesis of those stimuli (Chilingaryan, 1999). Though this focus on individual physiology departed from the socially oriented Marxist approach to public health, it succeeded in articulating a more concrete and traceable connection between the environment and specific pathologies where Marxist theories failed. For example, in 1925, Soviet psychologist Mark Sereisky used Pavlov’s ideas to argue that most addicts have a predisposition—a “pre-narcotic

personality”—and simply need a trigger, such as a first dose of morphine, to awaken the *narkomannyi* reflex, the psychological “hook” that drives addicts’ compulsive behavior (Latypov, 2011, p. 7). The broad acceptance of Pavlovian ideas into Soviet psychology encouraged clinicians to suspect that if certain stimuli can trigger addictive behaviors, then different, therapeutically controlled stimuli might be able to repress or control them. A particularly striking example of such a therapeutic approach is “coding” [кодирование], which consists of an attempt to physically rewire the addict’s brain by exposing them to substance-use-discouraging physical and psychological stimuli of various kinds, ranging from antagonistic pharmaceuticals to performance, misinformation, and even deception in the health care setting (Murney, 2009; Raikhel, 2010).

Though Pavlov’s ideas focus entirely on the effect of exogenous factors on human biology and behavior, Eugene Raikhel’s work (2010) on the contemporary use of coding and placebo therapy for alcohol addiction in Russia reveals that the patient’s motivation for sobriety is considered central to the efficacy of the treatment. Remarking on the fear- or aversion-based techniques designed to steer the patient’s behavior away from alcohol consumption, Raikhel has called this treatment a “prosthesis of the will, [which allows] for a change in behavior without a change in the self” (2013, p. 190). Many of the most successful patients return regularly to renew their exposure to the drugs or processes that avert their desire to consume, using treatment protocols as “pragmatic aids for the care of the self that bolster the motivations for sobriety” (2013, p. 210). Coding is not understood as successful due to external stimuli reshaping behavior on its own; rather, the desire of the patient to seek out those stimuli and, in doing so, reshape their own reflexes becomes the primary mechanism of recovery.

It is unsurprising, given this history, that clinicians operating Ukraine’s OST programs today have forged interpretations of OST as a treatment that embraces patient volition as a central and necessary element of success. OST first appeared in Ukraine as an HIV control strategy in 2004 (Bojko, Dvoriak, & Altice, 2013, p. 1), and has remained reliant on—and under the influence of—international donors (especially the Global Fund to Fight AIDS, Tuberculosis and Malaria) ever since.⁴ However, local (not international) ideas about addiction remain dominant in Ukraine’s clinical settings. Even the evidentiary logic by which the efficacy of OST as a treatment mechanism has been established, the authority of statistical evidence over clinical expertise, is not widely accepted among the Ukrainian clinicians (Carroll, 2013; Dunn, 2008). As the following sections will reveal, many clinicians perceive addiction as a context-dependent battle between the conscious desires of the addict and the drug-seeking behaviors that they find necessary. OST is interpreted, in turn, as a tool with the capacity to intervene in this conflict. Each patient’s personal battle is one that, with the right support and scaffolding, can be won if they possess a conscious desire to change. It is a battle, however, that *can’t* be won without the conscious desire to change, and the success or failure of OST as an intervention is a direct measure of individual will.

The discourse of desire

There are two common ways to discuss “wanting” in the Russian language, the language of choice for all but a few of the patients and clinicians I interviewed.⁵ The first is to use the verb хотеть (*khoret'*), which means, “to want.” One can use this verb to indicate very straightforward desires such as “I want to become a teacher” (Russian: Я хочу стать учителем) or “I want milk in my coffee” (Russian: Я хочу кофе с молоком). The other way is to use not a verb but a noun: желание (*zhelanie*). In English, the word желание (*zhelanie*) means “desire.” It also means “wanting,” or “longing,” or “will.” It lends itself to the same kind of poetic license in Russian as it does in English. You can ascribe to someone желание умереть (*zhelanie umeret'*), a death wish. It is possible to гореть желанием (*goret' zhelaniem*), to burn with desire. The Russian language even shares the idiom было бы желание, а умение найдётся (*bylo by zhelanie, a umenie naidyotsya*), where there is a will, there is a way.

The distinction between these two modes of representation is important. While it is possible to want (Russian: хотеть) or not want (Russian: не хотеть) something without great moral consequence, desire (Russian: желание) is a much more innate human characteristic without which there would be little drive to act at all. The absence of desire is indifference. Thus, to accuse addicts of having or not having the desire to be treated is, in essence, to assert that they are either driven, morally active persons or passive, indifferent, emotionally unengaged persons who are beyond help. The actions of Alexey Sergeevich's *shirka*-using OST patient Timur—his ardent refusal to decrease his dose and his unwillingness to comply with the OST program's prohibitions against the use of street drugs—fall squarely into the discursive realm of желание (*zhelanie*). Timur has been told how to treat his addiction. He has been given the tools that he needs to do so. Yet his problematic drug use persists. The problem, his doctors say, is not that he is physically incapable of quitting. Instead, Timur's behavior is iconic of a problem that clinicians claim plagues so many of their clients. Timur suffers from a lack of desire—a lack of желание (*zhelanie*).

Nearly every clinician I have met in Ukraine has complained to me about the lack of желание (*zhelanie*), the lack of this conscious desire to change, among some or all of their addicted patients, especially those who do not specialize in addiction treatment. The head doctor of an HIV clinic near Kyiv once threw up his hands in exasperation when I asked about the number of AIDS deaths among injection drug users. “These deaths,” he said, “are related to the anti-social element. They strove directly to the grave. They had no desire to live [Russian: У них желания жить не было]!” A tuberculosis specialist in a different hospital voiced a similar complaint. As I sat in her office, she scowled and looked behind me to a group of men milling outside the entryway of her department. “Doctors tell them to come here [to this office to receive antituberculosis pills],” she said,

[B]ut they just hang out, they talk in the hallway, and then they leave. They are alcoholics, drug users. They have no desire. [Russian: Желания нету]. Maybe the wife already died, the daughter is already sick. It's all the same to them. They need narcotics to deal with their psychological problems. That's addiction.

Clinicians who work directly with OST patients perceive the same pattern among their patients; however, they are much more delicate about applying meaning to each individual case. One social worker, who has been advocating for the expansion of OST in his region since it first became legal in 2006, elaborated on this distinction as follows:

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

This taxonomy was repeated to me with different words but similar content by many other clinicians. Within this framework, clinicians engage the individual will as a quasi-diagnostic category. If you have it, you will get better. If you don't, you won't. Interestingly, the ability of the drugs distributed by OST programs to effect change is also determined by a patient's position in this schema. Treatment efficacy is seen as modulated by the desires of each individual patient to be a subject of that treatment. OST, then, is not exactly a “prosthesis of the will” (Raikhel, 2013). Rather, it is perceived as an *extension* of the will.

According to the paradigm of addiction embraced by international health organizations (World Health Organization, 2004), OST does not operate by engaging individual desire. Rather, it works by shutting desires off. The dominant international view holds that OST “works” by “‘block[ing]’ the euphoric effects of heroin, thereby discouraging illicit use and thereby relieving the user of the need or desire to seek heroin” (Mattick, Breen, Kimber, & Davoli, 2009, p. 5). OST is often considered a form of “harm reduction,” an approach that “frame[s] substance use practices in terms of a series of choices around consumption along a range of possible actions, from the most harmful (e.g., sharing needles) to the least harmful (abstinence)” (Lovell, 2013, p. 145). By blocking euphoria and simplifying the logistics of staving off withdrawal symptoms, OST, according to this framework, engages with drug users as rational actors, aiming to alter their behavior by

reshaping the factors that affect their decision-making. In this view, each patient's internal desires are relevant only insofar as the desire to use drugs is successfully modulated by the intervention, rather than the intervention being modulated by desire. Thus, in the international ideal, OST serves as a disciplinary technology for limiting and controlling desires and, by extension, controlling behaviors linked to those desires.

Though the establishment of OST programs on the basis of this an approach would seem to unseat patient desire from its central role in patient recovery, the diagnostic value of "desire" has remained powerfully salient in Ukraine. Certain practical understandings of desire—the patient's social volition to seek treatment and regain an acceptable level of sociability—are fundamental to professional understandings of addiction in Ukraine and have been for nearly a century. This mode of thought is an inextricable element of the Ukrainian context in which international standards for OST must be—and have become—situated. Standardized protocols may shape the daily activities of the clinic, informing processes like patient tracking, diagnostic procedures, and direct observation of treatment, but the structure that these standards prescribe forms only the background against which doctors and patients carry on their own discourse with each other about what OST can accomplish and how patients should make themselves available to this treatment in order to achieve success. In particular, Ukrainian doctors make especially strong claims to expertise on the clinical management of addiction based upon their alleged familiarity with desire and indifference in their patients. They have spent enough time with such patients, many claim, that they can identify desire when it is present and note its absence when it is not. For me to gain a better understanding of just how important desire really is, I was often told, I would also have to learn to read these signs—to see as they did past the words and behaviors of their patients into their motivations. This would help me see what addiction truly is and what OST can do about it.

The interpretation of wanting

My first practical lesson in "reading" a patient's desire came from a man named Sergey Tonenko, a program consultant who has advised substitution therapy programs across Ukraine. Sergey invited me to accompany him on a number of his visits to various OST sites. He introduced me to clinicians and NGO leaders in a number of cities and provided me with an informed perspective on how these different medical and social service entities interact with each other. During the fall of 2012, I spent several weeks visiting eight OST sites, located in five different cities, in Sergey's company. Our first journey together took us to an OST clinic in a tuberculosis hospital located in a southern region of Ukraine, whose enclosed grounds overlooked the rugged shore of the Black Sea.

Before entering the hospital, at the request of the head physician, we purchased simple masks to protect vulnerable patients in the hospital from any infections we might have brought with us. We crossed the street in front of the hospital, entered a

little basement pharmacy, and stood in line for our turn with the pharmacist at the window. As we waited, the woman at the front of the line completed her purchase and walked passed us towards the door. Her fist was clenched tightly around her newly acquired goods. Sergey whispered “It makes me so sad to see that.” When I responded with a confused look, he explained what he had seen in her hand. “She is buying needles and eye drops. It was tropicamide. This is common here. Drug users will drink it, or sometimes inject it. I don’t know what it is supposed to do, but lots of people use it.” Tropicamide is an anticholinergic eye drop that is frequently used to dilate the pupil during eye exams. Anecdotal evidence collected during the course of my research indicates that tropicamide may act as a mild hallucinogen or that it may amplify the effects of opiates, even when opiate-receptor blockers, such as those used to decrease the euphoric effects of prescription methadone, are ingested. Once Sergey and I purchased our masks, we hurried back across the street to the hospital. We were accepted graciously onto the hospital grounds. Sergey greeted the staff affectionately, and I was properly introduced. Tea and cookies were distributed, and Sergey conducted the necessary business of his official site visit, which included a brief survey with the doctors and an inventory check.

The recruitment of OST patients for interviews began on this trip, as on every trip I made to each new clinic, with a phone call. I, or sometimes a local contact (in this case, Sergey), would speak briefly to the clinic’s head physician about my research and schedule a meeting to request the physician’s assistance in recruiting patients. I hoped that each doctor could tell clients about my research and offer them a chance to contact me if interested. Often, clients were intrigued by my presence and approached me independently to ask about my work and offer their personal perspectives on addiction and OST. The first patient we met in this fashion was a young woman who had been lingering in the hallway drinking free coffee with a nurse. Intrigued by our presence, she let herself into the doctor’s office to see who we were. As she strode confidently through the door, I immediately recognized her as the woman we had seen just moments prior, purchasing needles and tropicamide at the pharmacy.

She told us that her name was Lyuda. She had only been part of the program for a year and a half—not very long compared to some of the other patients there. She was frustrated with the program.

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

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

L: I had a baby. I can't tell you if I am a good mom or a bad mom, but I try. And I do this in order to spend time with her—nearly all my time, not counting the 2 hours I spend coming here every day. I joined the program so that I could be with her.

Interestingly, Lyuda displays characteristics associated with two different “types” of drug users—according to the clinical taxonomy described earlier. On the one hand, she articulates her decision-making in such a way that highlights how she has prioritized her motherly duties. She needs to spend time with her daughter, so she has taken steps to reduce the portion of her day that she spends acquiring narcotics by switching over to a quick and reliable source: OST. Her decision to begin treatment constitutes a management strategy designed to keep her multiple priorities in order. She was sacrificing the attention she gives to one (her addiction) so that she can afford greater attention to the other (her daughter). The disparaging assessment of the TB nurse, who insisted, “they have no will . . . It's all the same to them [because] that's addiction” does not easily apply in this case. By prioritizing her duties to her child over some of the immediate necessities of her opiate dependence, Lyuda is testifying to her possession of the very desire that clinicians say addicts need in order to recover.

On the other hand, through her extracurricular drug use, Lyuda is also strategically controlling the effects of methadone on her body. By adding tropicamide (and perhaps other substances) to her regimen, she is taking steps to alter, adjust, or amplify how she feels on the methadone. Her attachment to the physiological effects of her controlled opiate regimen is obvious in the actions she takes to modulate and maintain them. This is part of the risk of getting caught: not only could she be punished by the program staff, she would also have to overcome the stigma that accompanies an unwillingness to bear the physical effects of decreasing her methadone. She would have to face the consequences of being labeled “indifferent.”

As our conversation continued, Lyuda voiced skepticism about OST as a mechanism for treating addiction and subsequently ending one's drug use. She clearly articulated her position that the *desire* to quit was not sufficient for overcoming her dependency, despite her participation in OST and regardless of how serious or deeply held that desire might be.

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

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

JC: What is it, then, that you would like to gain for yourself?

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

JC: If you felt able to, would you want to quit taking methadone entirely?

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

JC: What do you mean by "ready" to quit? What does "ready" mean?

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

Lyuda was the first person I heard speak about feeling "stuck" in an OST program, unable to change or to quit, but she was far from the last. Gaining an understanding of local paradigms of addiction was one of the primary goals of my research, so I always inquired about the treatment plans that addicts had designed for themselves. I asked about what quitting methadone would signify for them, about what it meant to be "ready." I asked how they would be able to recognize if and when they ever were. My questions were met with a constant refrain: "I want to quit, but I'm just not ready." The significance of this phrase was compounded by each new patient who uttered it.

What struck me about this particular moment at the TB hospital, and what Sergey tried to drive home to me as we left the clinic that day, was the conflict that Lyuda, the loving mother who topped off her methadone with tropicamide, presented to her medical providers. Both Sergey and Lyuda's physician at the OST clinic tried to coach my interpretation of this encounter, telling me that Lyuda will not be successful in her efforts to maintain control over her competing familial and chemical obligations. I was especially encouraged to see Lyuda as deceiving herself. She may talk about her daughter and claim a desire to live peacefully with her family, but this just isn't realistic. She would never be able to quit using drugs until she *really wanted to*; her tropicamide use is evidence that she doesn't. She's not letting herself be treated; she's just as addicted as her first day in the clinic 18 months ago.

The metaphysics of addiction

Many months into our acquaintance, Sergey and I found ourselves sitting across his kitchen table, eating linden flower honey from the jar with a spoon and once again discussing the so-called successes and failures in OST that he had witnessed throughout his career. Sergey quietly pondered my questions about what makes OST "successful" for some drug users and not for others. I had asked him these

questions dozens of times, and, by then, they had become almost rhetorical—part of our regular exercise of thinking through what he believed addicts were really up to in these programs. “Of course you have to have the desire to change your behavior,” he said, switching from Russian to English, which he often did to emphasize a point. He said:

Drug users, they must have this desire to quit, because the behavior is bad. But the sin—the consequence—of this behavior is that it destroys your constitution—the thing inside of you that should be the strongest. So, when you are addicted, you understand. You know what is happening to you. But you can do nothing about it.

What Sergey was working so hard to articulate is a psychological profile of addiction based upon a dualistic understanding of human consciousness. He explained that addiction is characterized by the inability to act upon one’s inner desires. You want to quit, but you have lost the self-control needed to do so. He explained that each one of us possesses a mind, a body, and a metaphysical connection between the two. When we are sober, all three elements are strong and intact. When we use drugs or alcohol, one or more of them becomes compromised.

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

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

When people are involved in substance abuse, he argued, their mind, their will, loses its ability to act upon them the way they want it to. As they become more and more addicted, drug users are able to see themselves losing control. They may even retain their desire to be in control, to live their lives, to maintain their relationships, but they are unable to. This is why both professional treatment *and* the desire to be treated are necessary for overcoming addiction.

A Ukrainian harm reduction activist named Svetlana articulated this same logic to me. She described this weakened connection between mind and body as an illness in one’s soul. She explained,

We know that a doctor can only help with 10%. The other 90% is for you to work on. This is true for any disease, everywhere. A drug-addict is an ill person: ill psychologically, physically, and in the soul. Their soul is ill. But they can’t just sit and wait. They have to go to NA groups, therapy, look for the way out.

If they have no desire, she insisted, their situation will never improve; however, if they maintain an internal desire to change their lives, or if a skilled psychologist or social worker is able to generate such desire within them, then drug treatment—including substitution therapy—can be the last piece of the puzzle. It is a necessary step towards realizing those desires, and a step that addicts must actively seek. They have to want to find that help.

After hearing these professionals map out the psychological and emotional terrain of addiction in this way, I began seeing echoes of these ideas in my interviews with OST patients. For example, I met a woman in an OST program in Kyiv who explained her initiation into drug use with a similar gap between her desires for herself and her personal control over her drug use:

When I started, we had no drug addicts in our village. I had no idea that I would end up like this, living the life that I'm living now. You know, there are some people who like drinking. They like the feeling. I don't. I never enjoyed the feeling of being drunk. I did other things. But the purpose of all of it is just to relax a bit, right? But, unfortunately, it wasn't that kind of relaxation. It alters your perception of reality, making everything fluffy around the edges. And you have these moments where you realize that you're tired of all of it, tired of using, but you go out looking for more just the same. You hunt, you buy, you cook, you shoot it up. You're even doing it when you have no veins left, even after you've been sitting for 2 or 3 hours looking for a place where the needle will hit.

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

Reflections

International protocols for the implementation of OST may be considered a hegemonic discourse. As Erin Koch has noted in her analysis of standardized tuberculosis treatment in the Republic of Georgia, "the cultural, historical, and institutional processes within which standardized [international] medical protocols and standards are made and circulated globally are rendered invisible"

(2013, p. 58). However, Koch's ultimate position, and mine as well, is that these standards constitute an ideal that can be attempted in all places but achieved in none. As these international approaches move across national, cultural, and geographic boundaries, they will become situated within local discourses that fit or contradict these ideals to varying degrees. International paradigms will necessarily be reinterpreted and incorporated into the local context wherever they go. Ukraine is no exception.

OST clinicians in Ukraine are adopting a clear and prescriptive interpretation of the medical terrain where addiction, psychology, and personhood intersect. People like Timur and Lyuda, however, are levying their own claims as well. They both are quick to take ownership of their self-management strategies and to defend the validity of their efforts. It is clear, though, that these strategies, whether they are seen as attempts to simplify logistics or deliberate moves towards socially acceptable citizenship, are not equally valued by their medical authorities. Throughout his time in as an OST patient, Timur has displayed complex and creative treatment-seeking behaviors. He goes by his clinic at 10:00 a.m., like clockwork, every day. He is a regular visitor of his city's other harm reduction programs. He is open and honest with all of the social workers that interact with him. He takes medical consultations when they are offered. Yet he is not seen by OST professionals as having any desire to improve his situation. Similarly, Lyuda's claims of motherly duty are rendered invalid because she is a mother who uses drugs. Her tropicamide use is taken as a sign of her indifference to her health and well-being, rather than an attempt to exert more control over her physical and mental state.

If we consider the premise that addicts become defined and targeted by public interventions like OST because something about them is socially problematic, it is logical to expect that the addict's recovery will be defined by their reentry into the social fabric as a less problematic agent. E. Summerson Carr has observed this logic in American treatment programs where addicts are considered troublesome because they are epistemologically problematic (2010). They are seen as unable to recognize their own personal states and are, therefore, unable to produce honest, unfiltered speech that reflects those inner states. Since the problem is that they cannot be trusted, addicts' treatment trajectory, if successful, will be defined by the emergence of appropriately regulated speech. In Ukraine, addicts are seen as problematic and dangerous not only because addiction, as many clinicians claim, can only arise in someone who is indifferent. Indifference disconnects people from their primary social relationships. That lack of integration is what makes them troublesome, and it is what treatment efforts aim to resolve.

The theory that addiction traps the will by forcing the addict to lose control of himself reaches far throughout the biomedical sphere and even the popular imagination in Ukraine, ascribing meaning to a vast array of behaviors, urges, and states of consciousness. Timur and Lyuda's persistence, though, reveal the cracks around the edges of this theory. They show that the dominant psychological approach to addiction treatment in these crucial programs captures only a part of the lived experiences that they hope to influence. Ultimately, the clinical paradigm of

addiction that has taken hold among the professionals operating Ukraine's OST programs must be understood as a discourse that exists in concert with the diverse narratives, strategies, and identities that drug users adopt to manage their bodies, their identities, and their lives. A failure to recognize this will hinder the ability of OST programs to produce positive outcomes among the patient population. It will leave many addicted persons, especially those who do not share this clinical view of themselves, effectively on their own to develop strategies for making sense of their experiences and making peace with their bodies, physical and social.

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Notes

1. All proper names have been replaced with pseudonyms.
2. Shirka (Russian: ширка) is a commonly used street drug in Ukraine. It is made by processing homegrown poppy straw with an anhydride and other solvents to extract the opium content. The resulting product is a high-volume (somewhat diluted) and allegedly "softer" alternative to heroin.
3. A pharmaceutical opioid analgesic similar to codeine.
4. OST programs across Ukraine are supported by Global Fund grants as part of the nation-wide HIV control strategy. For this reason, OST programs are often housed in regional HIV/AIDS centers, as well as in regional tuberculosis hospitals, as HIV/TB coinfection is common. Despite sharing its premises with these larger health care institutions, legal and financial regulations require that OST services be physically separated from other hospital services. Separate, controlled rooms must be designated for the storage and distribution of OST drugs, meaning that patients with a dual or triple diagnosis must go to one part of the facility to receive antiretroviral or antituberculosis medication and then to another part of the facility to receive their daily dose of OST. Certain oblasts

of Ukraine offer methadone in a syrup form by prescription for patients who can prove hardship or an immediate need to travel, but the vast majority of patients must receive their drugs under the direct observation of a nurse in the clinic to which they are assigned on a daily basis.

5. Though Ukrainian is the official language of Ukraine, many residents are native speakers of the Russian language and the majority of Ukrainian citizens are, to varying degrees, bilingual. Though the reality of language politics in Ukraine is more nuanced and complicated, the situation is often generalized as follows: Ukrainian is more often the common language for public interaction in rural areas and in western urban centers; Russian is more often the common language for public interaction in eastern regions and central and eastern urban centers. In some places, especially in the capital city of Kyiv, it is not uncommon to hear conversations take place in both languages, with one person speaking in Russian and another responding in Ukrainian (for more on this topic see Bilaniuk, 2004, 2005; Chumak-Horbatsch, 1999; Friedman, 2010). Because much of the data presented in this article was collected in central, southern, and southeast regions of Ukraine, where Ukrainian is often taught or engaged only as a second language, the linguistic elements of this analysis have been grounded in the Russian language and the repeated vernacular (especially the use of the word *желание* [*zhelanie*]) used by clinicians and patients alike to reference the symbolic terrain of desire.

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