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Robert Ian Duncan

Therapeutic Landscapes and the Public Health Conceptualization of Alcohol-Related

Illness in Moscow, Russia

Robert Ian Duncan

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Reading Committee:

Craig ZumBrunnen, Chair

Michael P. Brown

Kathleen Braden

Program Authorized to Offer Degree:

Department of Geography

University of Washington

Abstract

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Robert Ian Duncan

Chair of the Supervisory Committee:
Professor Craig ZumBrunnen
Department of Geography

In this dissertation, I argue that therapeutic landscapes for treating alcohol-related illnesses in Russia are key locations for the negotiation of alcohol-related illnesses as public health problems. I contend that therapeutic landscapes are centrally important in shaping public health understandings of alcohol-related illnesses in Russia. I demonstrate that therapeutic landscapes are not only places with significant health importance and unique healing qualities. Instead, such spaces and places are productive of health geographies and public health discourses. I base my argument as an extension of therapeutic landscape analysis and an examination of contrasting approaches to dealing with alcohol related illnesses in Russia: narcology, the 12 steps, and New Public

Health. I specifically show how rehabilitation and illness are both materially and discursively constructed in each therapeutic landscape. In doing so, I link the practices in each landscape to the broader structural public health conceptualizations of alcohol-related illness.

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PREFACE

The impetus for this project emerged from a broad interest in the geography of Russia's demographic challenges. The manner in which Russia's population has changed and the underlying factors that have contributed to shortened life spans and increased public health problems is one of the most important stories of the contemporary era. Yet the overall issue of Russia's demographic challenges, whether a crisis or not, is an enormous and complex issue entangled in numerous historical, economic, social, and geographic contexts. Therefore, this dissertation aims to explore a small part of the story.

Alcohol is a primary contributor to a range of health problems for the Russian population. From alcohol poisoning, to accidental deaths, to heart disease, alcohol consumption plays a central role in reducing individual life spans and exacerbating morbidity. The aspect of alcohol and its impact on the population I have sought to understand in writing this dissertation centers upon how alcohol is conceived as a public health phenomenon in Russia.

Illnesses related to alcohol are understood differently across cultures and communities, and perceptions of how alcohol contributes to illness also change over time. As Russia's population health has been a central issue in relation to the broader concerns over the demographic crisis, the position of alcohol as a factor in

morbidity and mortality is altering. The ways in which public health subjects are constructed in relation to alcohol-related illness is partly dependent upon medical and health processes that are situated in particular spaces and places. I have sought to examine the geography of the changing public health/alcohol relationship, by looking at places of recovery and treatment for alcohol-related illnesses. In examining such places, I demonstrate how the underlying concepts of alcohol as a public health issue have been shaped in spaces and places of recovery.

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*To My Parents,
Robert and Kathleen Duncan*

Chapter I

Introduction

Treatment (for alcoholism) usually occurs in stages: the first phase of treatment is reduced to interrupting of the binge, overcoming abstention disorders, and conducting a clinical examination. One of the most important moments of the first stage is to establish psychotherapeutic contact with the patient and those closest to him. At the second stage, proceed with an active anti-alcohol treatment in order to develop an aversion to alcohol and a consistent suppression of the craving for alcohol. The third phase includes maintenance and anti-recidivism treatment. The fourth stage can be designated as the stage of rehabilitation, the restoration of the personal and social status of the patient.

-From ***Osnovy Narkologii (Foundations of Narcology)*** (Burkin and Goranskaja 2002, 70)

Across the world, there already exist examples of solutions to the problem of dependency, and any successfully working scheme of rehabilitation uses one or another version of the therapeutic community. That is, a community where the participants deal with personal problems in close collaboration with and in service to one another, realizing the principle that "by helping others - you help yourself." Thus, there are profound changes in personality, a person recognizes in himself a value system, gains experience of awareness of his mistakes and of the honest actions to correct them.

-From *"My gotovy delit'sia opytom"* ("We are ready to share our experiences") (Protsenko and Zernov 2005, 4)

The above quotes illustrate the different ways that alcohol-related illness and treatment are framed in Russian society. Moreover, the quotes underscore the tensions that emerge when a society attempts to resolve questions of individual health and behavior. Taken from a textbook for students studying narcology, the Russian science of addiction, the first quote emphasizes the priority of treating and curing drug addicts and alcoholics. The second quote comes from a text written by a staff member and patient from

a rehabilitation center outside of Moscow. This latter quote draws from a 12-step program of Alcoholics Anonymous (AA) grounded within Russian Orthodox religious principles. On the surface, the two viewpoints are similar in their focus on rehabilitation and recovery in treating those afflicted by addiction or alcoholism. However, upon closer analysis of the two perspectives, a significant contrast can be discerned in how alcoholism, addiction, and rehabilitation are understood as health issues. In fact, the contemporary landscape of public health in Russia is riddled with contrasting practices and ideas for treating alcohol-related illnesses. Such practices and ideas contrast not only in terms of what it means to be addicted to alcohol, or being alcoholic, but also what it means to be treated, rehabilitated, and health.

In this dissertation, I argue that therapeutic landscapes for treating alcohol-related illnesses in Russia are key locations for the negotiation of alcohol-related illnesses as public health problems. That is, I contend that therapeutic landscapes are centrally important in shaping public health understandings of alcohol-related illnesses in Russia. By public health, I am referring to the health of the general population, and those strategies involved in fostering the health of the population (Curtis, Riva, and Rosenberg 2010).

The issue of alcohol as a public health problem is historically complex (Aksenov 2007; Herlihy 1990; 2002; White 1996). Excessive drinking and its deleterious effects have long been understood in Russia as a public health problem (Nemtsov 2006; Editorial 2010; Tapilina 2006; Volzhenina 2008). In particular, within the Russian public health field there

has been a focus on how to prevent addiction to alcohol, which is viewed as the most serious alcohol-related illness (Kirn 1987a; Elovich and Drucker 2008). In this sense, public health officials focus on limiting the unhealthy effects of alcohol consumption by eliminating excessive consumption associated with alcoholism. During the Soviet period, the science of narcology developed as a means to understand addiction to psycho-active substances like alcohol (Elovich and Drucker 2008; Mendelevich 2004a). After the collapse of the Soviet Union, alternate methods for dealing with addiction emerged (Raikhel 2010). In the contemporary era, Russia has witnessed the emergence of contrasting views on how the consumption of alcohol is a public health problem. At the same time, this current period in Russia has witnessed differing views on the concept of addiction and alcohol-related illnesses in general. I maintain that understanding the future of how alcohol-related illnesses will be treated in Russia hinges on processes and practices that are currently ongoing in the therapeutic landscapes where patients are treated.

This dissertation is an intervention in the geographic literature regarding the analytical approach of therapeutic landscapes (Williams 1999a; Conradson 2003a; Gesler 2005). By exploring the Russian therapeutic landscapes of alcohol-related illness, I argue that such landscapes play an integral role in negotiating how alcohol is understood as a public health problem. I contend that therapeutic landscapes are not only places with significant health importance and unique healing qualities. Rather, I assert that such spaces and places are productive of health geographies and public health discourses. I base my argument about and extension of therapeutic landscape analysis on an

examination of contrasting approaches to dealing with alcohol related illnesses in Russia: narcology, the 12 steps, and New Public Health. I specifically show how rehabilitation and illness are both materially and discursively constructed in each therapeutic landscape. In doing so, I link the practices in each landscape to the broader structural public health conceptualizations of alcohol-related illness.

Central to this dissertation is a case study that analyzes therapeutic landscapes for dealing with alcohol-related illnesses in Russia. This case study calls to attention the linkages between the therapeutic landscape and larger public health problematizations of alcohol-related illness. In particular, I focus on three locations that illustrate the prevailing tensions surrounding how alcohol is understood as a public health problem in Russia. Specifically, I examine narcological spaces, a clinic undergoing reform based on Western public health principles, and a 12-step at a Russian Orthodox Church based rehabilitation center. I focus on the landscapes of each of these locations by way of an analysis of their constitutive institutions and processes. At the same time, I examine interviews carried out with public health professionals, namely counselors, social workers, nurses, and doctors. I also examine interviews with individuals undergoing treatment for alcohol-related illness. During the course of my field research, I interviewed 26 individuals. In total, these diverse interviews act as primary sources for understanding how therapeutic landscapes shape conceptualizations of alcohol-related illnesses. In addition to carrying out interviews, I also collected textual evidence from participating organizations, their own publications, including websites, and gathered materials from public health archives.

As mentioned earlier, the central contention of my dissertation is that therapeutic landscapes are productive of public health processes and transformations. Therefore, therapeutic landscapes are not merely repositories for health experiences or just reflective of dominant public health discourses and practices. Consequently, my intervention into health geography, in general, and therapeutic landscapes, in particular, is based in part on bringing therapeutic landscape analysis into dialogue with more critical health geography analyses. In this respect, I put therapeutic landscape literature in dialogue with work carried out by geographers critical of what has been termed the New Public Health (or NPH) (Petersen and Lupton 1996; Brown 2000b). NPH is a term used to describe a series of transformations in the sphere of public health, particularly in the West. The central critique of NPH by geographers and others is that larger public health transformations are not merely institutional changes, but changes in the fundamental understandings of health and healthy subjects (Brown and Burges Watson 2009; Moon, Kearns, and Joseph 2006; Brown 2003). I draw from such critiques as I explore how therapeutic landscapes are linked with broader public health transformations. I also consider these critiques in my analysis of how therapeutic landscapes work towards discursively and materially shaping rehabilitating subjects to align with Russian public health transformations.

Following the lead of geographers criticizing NPH literature, I refer to the theoretical contributions of Michel Foucault. In particular, I draw from Foucault's concepts of discourse, governmentality and biopower. Discourse analysis is a means of

examining texts, practices, and symbols in an attempt to understand the interconnections between the places and social structures (Rose 2011). Geographers have focused on discourse analysis to understand how space and place are active in the construction of meaning in society. Governmentality is Foucault's concept of how people manage themselves and conduct their lives without direct physical coercion, but still in the interest of the state. Geographers study governmentality to understand why and how social processes are practiced in diverse spaces and places of modern society. Finally, biopower refers to the interest of the state in fostering the growth of populations. Biopower directly converges with studies of public health in geography, as public health as an institution reflects broader structural processes and transformations in state and society (Legg 2005; Brown and Knopp 2010; Legg and Brown 2013). By applying these three analytical approaches to studies of therapeutic landscapes, I attempt to show how therapeutic landscapes are not only places wherein people are treated or rehabilitated, but also how such practices are simultaneously contextualized and productive of broader public health processes.

Organization of the Dissertation

In this dissertation, I examine contrasting therapeutic landscapes for dealing with alcohol-related illnesses in Russia. The primary contribution I present in this dissertation by examining such therapeutic landscapes, is to extend the therapeutic landscape literature into a discussion with broader public health processes and institutions. In addressing how to extend the therapeutic landscape literature, and how therapeutic

landscapes in Russia inform larger public health conceptualizations of alcohol-related illnesses in Russia, I structure this dissertation around six chapters. I have organized these chapters to reflect the central arguments of my overall thesis, that the conceptualization of alcohol-related illness in Russian public health is partially influenced by processes and practices ongoing in therapeutic landscapes for treating alcohol-related illnesses.

In the first section of this dissertation, I focus on two basic conceptualizations for treating alcohol-related illnesses in Russia, narcology and Alcoholics Anonymous (AA). I concentrate on the therapeutic landscapes of both narcology and AA. I examine how each mode of treatment relies on particular conceptualizations of alcohol-related illness, and each in turn constructs the process of rehabilitation differently. The second section is a more traditional example of a case study. Accordingly, in this second section, I focus on two therapeutic landscapes and the manner in which these spaces are connected with larger public health processes. These therapeutic landscapes constitute the main case studies in this dissertation. The first case study focuses on a clinic in Moscow, and its incorporation of public health approaches to alcohol-related illness. I address how the clinic and its approaches run counter to narcological perspectives. The second case study concerns a rehabilitation center for alcoholism and drug addiction located in the suburbs of Moscow. The rehabilitation center is affiliated with the Orthodox Church and uses the 12-step process as the basis for its treatment strategy.

In this dissertation, I examine the perspectives and practices of professionals, workers, and advocates working in Russia's public health field regarding their roles. The

study is comprised of interviews with individuals involved in public health in Russia's Moscow *Oblast* (District or Province), and in the city of Moscow, as well as research from textual sources documenting the work of federal and local government ministries of health and social services.

In chapter two, I provide a literature review describing the methodological underpinnings of my dissertation. Moreover, this literature review presents my contributions to therapeutic landscape analysis (Williams 1999a; 1999b; Conradson 2003a; 2005). My primary argument is that geographers employing therapeutic landscape analysis insufficiently connect the places and experiences of health and rehabilitation with the broader structural processes and transformations of public health. By linking these places and experiences with structural processes and changes in public health, one is better positioned to link the therapeutic landscape to broader public health processes. At the same time, by acknowledging these linkages one can elucidate the manner in which small-scale health processes come to influence and shape larger ones. In constructing my argument, I rely on critiques of NPH and health geography work that draws from Michel Foucault's concepts of governmentality, biopower, and discourse (Petersen and Lupton 1996; Lupton 1995; Brown and Knopp 2010; Legg 2006; Brown and Burges Watson 2009). Foucault's work in geography has been critical to understanding how structural processes in institutions like public health, come to be understood and transformed at various scales, including the therapeutic landscape. Before turning to these considerations in geographic work, I first focus the literature review on the sub-discipline of health geography. I trace

the roots of the arguments that brought about health geography in the early 1990s (Kearns and Moon 2002; Kearns 1995). I then describe therapeutic landscape approaches to understanding health related issues. In describing the therapeutic landscape approach, I identify the shortcomings of the literature. I also argue that therapeutic landscape literature should incorporate NPH critiques, and particularly governmentality and biopower in analyses of health and place.

In chapter three, I present the methodology for my overall research, including my fieldwork, and analysis. I initially envisioned my research question concerning alcohol related-illnesses in Russia as an idiographic problem. Therefore, I determined that a qualitative approach would best provide the evidence I required. This approach to my research is informed by existing therapeutic landscape studies that mainly rely upon interviews and survey analysis, as well as textual and historical documentation. The primary task in developing an understanding of how Russia's therapeutic landscapes dealt with alcohol-related illnesses was to gather interview data from primary actors within the landscapes themselves. I therefore explain how I established contact with subjects in the field, and what approaches I used to collect data. Finally, I discuss the concept of discourse analysis in order to explain how I carried out my data analysis (Rose 2011).

In chapter four, I discuss Alcoholics Anonymous and its presence in Russia. AA is a relatively recent but widespread presence in Russia. Groups can be found in public and private treatment programs, as well as in clinics and hospitals (Ekho Moskvyy 2010;

Volzhenina 2008; Radio “Maiak” 2009). AA plays an important role in how alcohol is problematized as an issue in Russia. The problematization of alcoholism in AA discourses and practices contrasts sharply with Russia's narcological sciences. Whereas narcology seeks to cure the alcoholic of a physical disease and a psychiatric affliction, AA proposes a condition that is incurable and managed best not through medical intervention, but via self-control aided by a strong community and adherence to the 12-steps (White 1998; Valverde and White-Mair 1999). In examining AA, I focus on how the therapeutic landscape of AA operates through governmentality in a bifurcated manner. First, I examine the meeting in AA and how it is a space for disciplining member through rote practice and surveillance. Next, I examine the alcoholic identity of the AA member as a discourse that propagates a constant performance of governmentalizing behavior. I explore how the disciplinary practices of AA shape how alcoholism is conceptualized by its members. By examining the experiences of subjects who have been involved in AA, my objective is to establish the significance of AA's contribution to public health in Russia.

In chapter five, I then discuss Russia's narcology system. Narcology is the Russian science of addiction which forms the foundation of the primary public health response for treating alcohol-related illnesses (Babayan and Gonopol'skii 1987; Burkin and Goranskaja 2002; Vankon and Vankon 2007; Elovich and Drucker 2008). It constitutes the most widespread set of treatments available in Russia. Narcological science considers alcohol-related illnesses and addiction to be psychiatric problems (Raikhel 2010; 2011). From this standpoint, alcohol-related illness and addiction are perceived as treatable through a

combination of detoxification, chemical aversion therapy, and hypnotic suggestion. I demonstrate how the underlying principles of narcology have shaped a contemporary public health landscape replete with punitive measures for coping with addicts and alcoholics. By examining narcology's therapeutic landscapes, I also show how narcological treatments have materially and discursively shaped the public health response to alcohol-related illness in Russia.

In chapter six, I discuss the treatment practices at a neighborhood clinic in Moscow. As part of this effort, I examine the clinic as a therapeutic landscape shaped in part by NPH concepts (NAN 2012). To this end, I address how NPH discourse shapes alcohol as a Russian public health problem. I also focus on the clinic staff shape and their relationship to NPH discourse. In doing so, I demonstrate how the therapeutic landscape of the clinic and the activities of the clinic staff are biopolitical focal points in the negotiation of alcohol as a Russian public health matter.

In chapter seven, I turn my attention to a rehabilitation center in the suburbs of Moscow. The center is a residential treatment program. Residents stay for an extended period of time at this center and receive counseling and psychological assistance. The therapeutic landscape of the treatment center represents an alternative to previously discussed programs for coping with alcoholism and addiction. Such centers are emerging as significant places in the understanding and negotiation of alcohol as a public health problem.

In chapter eight I put forth my conclusion and an analysis of my dissertation. I review the case studies I collected and re-summarize the analyses I constructed in each chapter. By doing so, I show that the therapeutic landscape model for geographic analysis is a critical tool in studying health geography. Particularly, it can be a powerful means of demonstrating how health places and experiences are tied into broader public health processes and transformations. Ultimately, such an expansion of the therapeutic landscape approach to studying geographies of health is significant in helping to untangle the fraught and complicated issue of treating alcohol-related illness in Russia.

In examining these therapeutic landscapes, I argue for extending the literature in geography that focuses upon places of care and rehabilitation. Specifically, I contend that therapeutic landscapes are intrinsically connected to broader public health processes and institutions. As such, in examining the therapeutic landscapes for treating alcohol-related illnesses in Russia, I argue that not only do the landscapes reflect conceptualizations of illness and recovery; therapeutic landscapes are also productive of public health ideas about alcohol and alcohol-related illnesses as public health problems.

CHAPTER II

Theoretical Framework

In this chapter, I trace the theoretical groundings of my dissertation. As part of this, I discuss how my dissertation fits within the sub-discipline of health geography, specifically by approaching my research from a therapeutic landscape perspective. I address the gaps in the therapeutic landscape literature, and how my dissertation seeks to fill in those gaps.

As mentioned in the introductory chapter, my overall research examines therapeutic landscapes in Russia that relate to alcohol-related illnesses. As such, my research draws from the work of health geographers who use the idea of therapeutic landscape to describe diverse places of care and recovery (Gesler 1992; Williams 1999a). Therapeutic landscape approaches rely on both ethnographic and textual methods to better understand and relate the health aspects of a landscape or place (Williams 1999a). A key strength of the therapeutic landscape literature has been its ability to position the geographic concept of place within broader issues of health and medicine. As a result, therapeutic landscape literature has offered an opportunity to better understand how place relates to health and medicine, as well as issues of care and recovery (Gesler 2005), including in places that may not readily be viewed as therapeutic (Conradson 2005; Deverteuil and Andrews 2007). Therapeutic landscapes provide a useful perspective for analyzing and explaining health geographies in settings similar to those I encountered in my field research, including rehabilitation centers and health clinics. I document the

process of care, recovery, and rehabilitation through an emphasis on place and individual experience (Gesler 2005). Through this approach, places and their therapeutic attributes can be better understood. Health geographers use the framework of the therapeutic landscape to trace the relationships between health, place, identity/subjectivity, and care (English, Wilson, and Keller-Olaman 2008).

Despite the potential that therapeutic landscapes hold for health geography research, the concept and its application have proven to be limited. I argue that much of the literature does not attempt to analyze or critique how therapeutic landscapes relate to broader public health processes and transformations. For instance, in focusing primarily on place and the phenomenology of health and care experience, authors ignore the ways in which therapeutic landscapes are embedded within public health discourses and institutions. I argue that therapeutic landscapes should be recognized for the role they play in how particular illnesses and the process of recovery may be conceptualized in public health contexts. In this sense, practices within therapeutic landscapes help shape discourses about illness and disease, just as those landscapes are in turn shaped by public health discourse. Consequently, therapeutic landscapes that treat alcohol-related illness can influence public health discourse on alcohol-related illness. Keeping the above points in mind, the primary contribution of my dissertation is premised on the assertion that analyzing therapeutic landscapes in Russia is critical to understanding how alcohol-related illnesses have become a public health problem. I therefore demonstrate that

therapeutic landscapes are productive spaces that shape and are shaped by public health discourses and subjectivities.

I broaden the therapeutic landscape concept by interpreting the relationship to public health process through ideas from health geography literature critical of NPH (Brown 2000b; Brown 2003; Moon, Kearns, and Joseph 2006). NPH describes recent reforms in the sphere of public health and subsequent critiques concerning the moral and ethical foundations of health in society (Lupton 1995). Critiques of NPH from within health geography have commented on how public health discourse is critical in shaping subjects in health geography (Parr 2006; Philo, Parr, and Burns 2005). Geographers who critically interrogate NPH draw extensively from the works of Michel Foucault. In particular, these scholars demonstrate the ways in which Foucault's theories on discourse, governmentality, and biopower elucidate the social implications of contemporary public health transformations (Philo 2005b; Brown and Knopp 2010; Legg 2005). As Russian public health and the therapeutic landscapes for treating alcohol-related illnesses are currently undergoing transformations, Foucault's ideas and critiques of NPH provide a means of interpreting and understanding the outcomes of these emergent landscapes.

By working with Foucault's theories, geographers have attempted to show how state policies and practices, like those in public health, operate along lines of power in a dispersed manner, shaping both subjects and geographies (Crampton and Elden 2006). Geographers show that such lines of power operate at various scales, including at the scale of the everyday life of the subject. With respect to my research, these settings include local

level public health settings, which include health care providers and the subjects receiving treatment for alcohol-related illness. As I show, both health care providers and individuals help to reproduce and negotiate policies of public health and alcohol regulation. As I draw from geographic scholarship that implements Foucault's ideas, it is my objective to broaden the application of therapeutic landscape as a methodological approach in geography, by focusing on how therapeutic landscapes are constituted of such subjects, processes, and discourses.

That is, by engaging with therapeutic landscapes within the context of NPH criticism, I demonstrate that on one level, therapeutic landscapes are the product of health discourses. That is, their geographies are shaped by health ideas and concepts. However, on another level, they are productive spaces. In other words, the processes and practices within the therapeutic landscape broadly influence public health concepts and geographies, particularly concerning the conceptualization in public health of alcohol-related illnesses. As I address later, the manner in which I focus on discursively productive health spaces reflects work by such geographers as Michael Brown who has written about the importance of place and space in the negotiation of public health discourses and institutions.

It is my contention that NPH critiques can show how therapeutic landscapes are not only informed by larger health processes and health geographies, but are also productive of those same processes and geographies. To this end, I emphasize the stress that NPH critiques place on the role of discourse in my analysis of therapeutic landscape.

I focus on how discourse is central to the idea of recovery, and how the processes and practices within the therapeutic landscape impact larger public health processes. In doing so, I believe that emphasizing the relationship of NPH to therapeutic landscapes helps to draw out the recursive relationship between the two concepts. In this sense, the critiques in this dissertation offer an opportunity to understand how broader structural processes shape therapeutic landscapes. At the same time, these critiques also show how therapeutic landscapes influence numerous health processes and health geographies.

I continue this chapter by first discussing health geography as a sub-discipline. As part of this, I address how the emergence of therapeutic landscape literature coincided with the development of health geography. It is for this reason that a consideration of the emergence of health geography as a sub-discipline is central to understanding therapeutic landscape analysis. I next move from a discussion of health geography to a focused examination of therapeutic landscape literature. To this end, I consider the various developments in therapeutic landscape literature and identify the limitations of the literature. Moreover, I emphasize that therapeutic landscape literature must stress more forcefully the relationship of landscapes to broader processes and health geographies. When taking into account this dissertation, it is important to understand that the theoretical and conceptual bases are informed by health geography literature that addresses the politics of public health and health care, especially in respect to NPH. I therefore follow my discussion on health geography with a consideration of NPH.

As I address NPH I draw particular attention to the underlying Foucauldian theories of governmentality and biopower, which are addressed in much of the NPH and health geography literature. As I show, the operationalization of Foucault's theories in criticisms of NPH, as well as in recent health geography literature, is critical for expanding therapeutic landscape analysis. I conclude this chapter by situating my critiques within the context of my dissertation. I also address how the therapeutic landscapes that pertain to recovering from alcohol-related illnesses in Russia are critical in shaping the public health conceptualization of alcohol-related illness itself.

Health Geography

In the early 1990s, geographers Wil Gesler and Robin Kearns published a series of articles that argued the importance of foregrounding place in medical geography (Gesler 1992; Gesler 1995; Kearns 1993; Kearns and Moon 2002). These articles in part stemmed from critiques put forth by Gesler and Kearns (2001) and others concerning the lack of attention paid to place and identity in the field of medical geography. These critiques of medical geography coincided with a broader disciplinary change for geography, known as the "cultural turn." A key part of the changes with the cultural turn included integrating insights from both post-modern and post-structural theories (Philo 2000a; Cosgrove and Jackson 1987). Geographers critical of medical geography drew from the theoretical perspectives that emerged during the cultural turn. In using critical theoretical perspectives, these geographers' critiques of medical geography centered heavily on the concept of objectivity (Moon 1990; Jones and Moon 1993). At the same time, a set of

parallel developing critiques took shape in geographic literature on health and medicine. These additional critiques focused not only on the relevance of place in medical geography, but also on the social impact of structural changes in public health on individuals and communities (Moon, Kearns, and Joseph 2006). These critiques therefore maintained that medical geography was ignoring other important ways for understanding issues concerning health and health care.

It is out of these critiques that the sub-discipline of health geography emerged. The early works of the newly established sub-discipline emphasized the areas regarded as having been overlooked by medical geography. Specifically, they focused on identity and place, as well as the political aspects of medical epistemologies and practices (Kearns 1993; Brown 1997; Gesler 1992; Gesler 1995; Williams 1999b). As an example, Isabel Dyck's work on women's health emphasized the importance of both health and identity in women's health experiences (Moss and Dyck 1996; Dyck and Dossa 2007). Moreover, Michael Brown's early and later work extensively considered the intersection of health issues and political geography in his examinations of AIDS (1997), hospice care (2003; 2004), and sexually transmitted illnesses (Brown and Knopp 2010).

In the decades since Kearns, Gesler, and others offered their initial critiques of medical geography, the health geography literature has become more nuanced. This is exemplified in health geography research devoted to understanding the significance of place and scale and their relationship to health policy, health status, and health experiences (Andrews and Moon 2005; Cummins et al. 2007; Curtis and Rees Jones 1998;

Del Casino 2004; Dyck and Dossa 2007; Grady and McLafferty 2007; Macintyre, Ellaway, and Cummins 2002; Poland et al. 2005). In addition, health geographers have also worked to draw closer attention to the various geographies involved with the experience of health and disease (Arcury et al. 2005; Asthana et al. 2002; Brown 2003; Duncan, Jones, and Moon 1993; Dyck 1995a; 1995b; Gesler 2005). These refinements in health geographic works demonstrate the continual engagement with newer theoretical perspectives into the sub-discipline.

The integration of newer ways of approaching and understanding health geography themes and concepts has contributed to other related changes within the sub-discipline. Most notably, changes within the sub-discipline have spurred on the creation of newer research questions and the use of newer research and analytic methods (Craddock 2000a; Gesler 1995; Longhurst 1995). This is exemplified in the work of Susan Craddock, who employed discursive analysis in her examination of health policies in turn of the century San Francisco (Craddock 2000b). Of particular interest to her research was how these policies were selectively applied to the city's Chinese-American community.

The conceptual and methodological changes within health geography helps to explain the manner in which newer health geographic works focused on the health-related characteristics of place. In this sense, health geographers have investigated the meaning of health facilities for communities, as well as the individual experiences of health and disease (Wakefield and McMullan 2005; Crooks and Chouinard 2006; Dyck 2006; Moon, Kearns, and Joseph 2006; Parr 2000; Poland et al. 2005; Brown 2003).

Furthermore, the increased emphasis on the subjective interpretation of health care issues, has resulted in examining health-related factors at smaller scales, including the home and the body (Mee 2009; Conradson 2005; Longhurst 2004). For example, Robyn Longhurst (2005) has written extensively on the place and politics of bodies in health geography. Finally, with the emphasis by certain health geographers on the importance of meaning and experience in their work, qualitative methods in health geography have taken on greater importance. As an example, health geographers have both relied on and examined the contributions of methods such as interviews, focus groups, and ethnography (Kesby 2000; Parr 2007; Wiles, Rosenberg, and Kearns 2005; Wilton 1999).

These efforts at relying on different methods to better understand the relationship between health and geography have informed the development of therapeutic landscapes as an area within health geography, on which I elaborate in the next section. Keeping in mind the different developments in health geography I argue that therapeutic landscape literature must integrate these concepts and approaches in order to strengthen its contributions to the sub-discipline. In the next section, I first provide an overview of the therapeutic landscape literature and then address its limitations. I follow my criticism by demonstrating how working with Foucault's concepts of discourse, governmentality, and biopower offer an opportunity to extend the therapeutic landscape approach. Specifically, these contributions of Foucault help to show the broader connections of therapeutic landscapes to larger public health issues.

Therapeutic landscape

As mentioned earlier, work on therapeutic landscapes emerged at the same time that health geography was taking form. Therapeutic landscape analysis initially emerged in health geography as an additional method for broadening geographic inquiry into issues of health beyond the scope of medical geography. Moreover, the original impetus to focus on the landscape in health geography followed Wil Gesler's (1992) article on the necessity of critically evaluating medical geography. In his early and subsequent work on therapeutic landscapes Gesler, along with others, turned to the idea of the landscape as a means of incorporating social theories. In this respect, these geographers referenced the same theories driving interest in the cultural turn and the emerging field of health geography.

Geographer Allison Williams (1999a, 2) explains what constitutes a therapeutic landscape in the following quote: "therapeutic landscapes are those changing places, settings, situations, locales, and milieus that encompass the physical, psychological and social environments associated with treatment or healing." In this quote, Williams identifies several cornerstones of therapeutic landscapes literature. First, places and experience are central health concepts. Second, therapy in such places can be conceived in a broad spectrum. Finally, places are associated with healing. Williams also identifies that it is the meaning of the places and the subjective experience of the person undergoing health and medical processes that are of particular importance in understanding how health processes take place.

There has been a steady stream of work on therapeutic landscapes since Gesler's 1992 article. One area in which the concept of therapeutic landscape has been applied includes examinations of issues of mental health, wherein scholars have focused on the quality of particular settings and places in mitigating mental illness (Curtis 2007; Gesler 1993; Laws 2009). Geographers have also focused their attention on places frequently associated with or having a reputation for healing (Conradson 2005). In yet another area, therapeutic landscape literature has been used in documenting the role of place in aiding recovery from chronic illness (Milligan, Gatrell, and Bingley 2004; English, Wilson, and Keller-Olaman 2008). Finally, therapeutic landscapes have also been an important factor in understanding the history of health care and public health. In this sense, it has been argued that the knowing about the history of public health and medicine is key to understanding the formation of some early landscapes of modern medicine (Foley, Wheeler, and Kearns 2011).

Therapeutic landscape analysis is notable for its approach and methodology as well as for the previously mentioned foci. Like other areas of health geography, therapeutic landscape research uses ethnographic approaches to understand places of care and recovery. For example, in Allison Williams' work on home health care workers in Ontario (Williams 1999b), she interviews subjects at length about their impressions concerning the relationship between health and place. The use of ethnographic methods in this work has been critical for integrating place-based analysis with other issues of health and medicine, including issues of care and recovery. In this manner, the therapeutic

landscape is a means for understanding health processes at work in places like rehabilitation centers and health clinics. The importance of these therapeutic landscapes is not only limited to the fact that they are health places, but also because they provide an opportunity to examine how such places are experienced. It is from these interrelated interests concerning places and their therapeutic attributes that health geographers have traced the relationships between health, place, identity/subjectivity, and care.

Several branches of the therapeutic landscape literature have become particularly useful in the course of writing this dissertation. Evans and Andrews' (Andrews and Evans 2008) article focuses on the role of health care workers in the production of therapeutic landscapes. The authors argue that health geographers have largely ignored the work involved in care; thus, they maintain that this represents a problematic lacuna in the sub-discipline. They contend that by not taking into account the work of health care, geographers are ignoring how health care spaces and places are produced. For Evans and Andrews, overlooking the work involved in health care leads to little to no examination of the broader shape and structure of health and health care geographies.

Of particular interest in my own work has been the current trend within therapeutic landscape literature that focuses on landscapes designed to aid in care and recovery for addiction-related illnesses. Wilton and DeVerteuil's (2006) article on AA groups in California presents a discussion on the relationship of therapeutic landscapes to governmentality. Governmentality, as I discuss later in this chapter, is the Foucauldian concept of governing from a distance. Governmentality is important in therapeutic

landscapes of addiction and alcohol treatment in general, as it provides a means for understanding how people come to govern themselves and their addictions. The authors focus on the therapeutic landscape of an alcohol recovery program as a place of governmental regulatory processes that affect bodies and create subjects. Their understanding of governmentality is infused with discussions of population, health, and the logic of governance, as well as the potential for techniques of government to produce positive and negative effects. Furthermore, their article seeks to complement literatures on therapeutic landscapes by evoking the multiple scales at which health is acted upon in the context of the recovery program, such as the group meeting and the neighborhood. The theoretic and conceptual bases of Wilton and DeVerteuil's article provides a model for my own work. Specifically, the authors offer a framework to think through the health and politics of treating addiction in regards to therapeutic landscapes of alcohol and public health, which I attempt to employ in the Russian context.

Despite the contributions of Wilton and DeVerteuil, I remain critical of their argument and the therapeutic landscape literature in general. I do not believe existing research in this area goes far enough in making linkages between therapeutic landscapes and larger scale public health processes, institutions, and transformations. Therapeutic landscapes must be recognized for the manner in which they materially and discursively shape illness and recovery as conceptualized in public health contexts. In this sense, practices within therapeutic landscapes help shape discourses about illness and disease, just as those landscape are in turn shaped by public health discourse. As such, a central

element of my critique is that more attention needs to be paid toward the discursive elements of the therapeutic landscape and how such elements are linked to public health processes and transformations.

Doing so requires addressing therapeutic landscapes from a position informed by critiques of NPH as addressed below. Governmentality in the therapeutic landscape must be considered not only as a matter of individual or self-conduct, but rather as a connection between self-government and public health processes and transformations. Furthermore, in order to more fully understand such public health processes and transformations, I turn to Foucault's concept of biopower. Incorporating Foucault's analytic of biopower, and its related concept bio-politics, contextualizes the governmentalizing aspects of the therapeutic landscape, and linkages in the therapeutic landscape to larger health processes. Addressing the therapeutic landscape in terms of biopower demonstrates how public health is a political rationalization that underpins the governmentalizing aspects of therapeutic landscapes. In the following section, I address how NPH critiques incorporate Foucault's ideas on discourse, governmentality, and biopower in their criticism of public health transformations. I then employ their methods and criticism in opening up therapeutic landscape analysis to a wider array of analytical tools for understanding its connections to public health.

New Public Health

The concept of the therapeutic landscape offers much potential for explaining issues of addiction and recovery. However, therapeutic landscape approaches are limited

because they do not take into account the connections between landscapes and larger structural health processes. In lieu of this gap, I believe that NPH critiques present an important contribution that can extend geographic work on therapeutic landscapes. NPH critiques take as the object of their analysis the structural changes and transformations in Public Health institutions and processes. I argue that NPH criticism can therefore inform therapeutic landscape literature by situating landscapes within a broader public health context. Furthermore, as I discuss in this section, NPH critiques offer the opportunity to demonstrate how therapeutic landscapes are productive of public health geographies and discourses, and not just reflective of them.

Critiques of NPH focus on employing Foucault's concepts of discourse, governmentality, and biopower to elucidate the political effects of public health transformations and processes. As mentioned above, such ideas extend therapeutic landscape literature by drawing forth the linkages between the therapeutic landscape and larger public health processes and transformations. I argue for expanding the therapeutic landscape literature by incorporating the research and observations of health geographers whose critiques focus on NPH and public health reform. In this section, I examine the emergence of NPH critiques and their employment in geographical analysis. I focus specifically on concepts of biopower and governmentality in an effort to demonstrate how therapeutic landscapes are linked to larger health processes and productive of public health discourses and transformations.

NPH critiques emerged in the 1980s and 1990s in areas of sociology and public health research (Lupton 1995). Critiques resulted from research in health studies examining the institution of public health, and the implications and underlying principles of health reform, particularly in Western contexts. Public health has been identified as having changed from a field concerned with the management of diseases to one concerned with lifestyles, risks, and health decision-making.

Two notable critics of NPH are sociologists Alan Petersen and Deborah Lupton (Petersen and Lupton 1996). Petersen and Lupton introduce Foucauldian analysis in examining late Twentieth Century transformations in public health. In particular, they demonstrate that the changes in public health have been emblematic of a shift in the maintenance of 'populations' and the emergence of a health-based morality as the basis for governing said populations. Such a transformation, the development of a health-based morality for governing populations, is significant in that it places upon the subjects within the population a moral obligation to govern themselves in a healthy manner.

Peterson and Lupton, as well as others carrying out NPH analyses, have been attracted to Foucault's work because of the insights he offers. The authors perceive that Foucault's theories offer a post-structural perspective that challenges traditional state theory, which tends to theorize a monolithic state. Moreover, critics of traditional state theory identify that the state is constructed as a primary actor that exercises power in a top-down manner (Jessop 1990a; Jessop 1990b; Painter and Goodwin 1995; Painter 2006). In contrast, Foucault theorized that power cannot be understood as a thing that can be

possessed and controlled by individuals or institutions (Burchell, Gordon, and Miller 1991; Dean 1999; Foucault 1973; 1977; 1984; 1980a; 2003a; Larner and Walters 2004; Lemke 2002).

Instead, Foucault identified that power manifests across space through the activities of self-disciplining subjects (Brown 2003). Foucault developed his theory of governmentality in order to explain how the practice of governing populations and individuals takes place at a distance. For Foucault, governmentality was a useful analytic for demonstrating how people come to regulate themselves and their bodies in terms of health.

Geographers have identified Foucault's ideas concerning governmentality as helpful for understanding spatial processes. For example, geographers have noted the ways in which governmentality is inherently scalar in its conceptualization of power. Hence, governmentality lends itself to geographic examinations of the interplay of power, distance, and scale. The various interests of governmentality have offered important insights in geographic work on NPH, because such research attempts to understand how public health regulation can be communicated and reproduced at the individual level. Moreover, Foucault's concept of governmentality has been used as an approach among geographers whose research centers on issues such as discourse, power, state theory, health, and citizenship among other issues (Brown 2000a; Brown 2000b; Brown and Duncan 2000; Legg 2005; Moon and Brown 2000; Parr 2004; Philo 2000b; 2005a; Raco 2003).

With respect to health geography, the interest in governmentality has specifically coalesced in part around NPH criticisms. Consequently, health geographers have drawn from governmentality in examinations of health spaces, as well as considerations of the mechanisms through which governments come to identify healthy bodies and spaces (Bell, Brown, and Faire 2006; Braun 2007; Brown 2000a; Brown 2006; 2003; Brown and Duncan 2000; 2002; Craddock 2000a; Fusco 2006; Gesler 1995; Gillespie 2002; Moran 2005; Philo 2000b; Philo and Parr 2004; Smith and Easterlow 2005). Furthermore, geographic perspectives on health that employ governmentality have focused on the role of public health, health care, and health insurance as disciplining activities.

As mentioned earlier, the concept of governmentality has gained only limited recognition in analyses on therapeutic landscapes. Yet, the therapeutic landscape is an excellent example of a geographic phenomenon in which the governmentalizing aspects of public health discourses are materialized. Subjects of therapeutic landscapes actively engage and reproduce health discourses directed at developing healthy behaviors and rehabilitating the subject. Particularly in issues of addiction, the rehabilitation of the subject into an individual who is capable of self-regulation is reason enough to treat therapeutic landscapes as significant elements of a larger project in the governmentalizing context of public health processes and institutions.

At the same time, criticism of NPH processes and transformations rests upon an analysis of the broader context in which governmentality operates. That is, critics seek to understand the political and social aims of public health and the objects of government.

Governmentality analyses, such as critiques of NPH, pivot on the linkages between governmentality strategies and rationalities of government. Lupton and Petersen (1996) stress the relationship between neo-liberal rationality and governmentality in their examinations of public health transformations. Specifically, they argue that neo-liberal transformations of public health are based on an underlying interest of producing subjects who self-regulate in terms of their health. In producing subjects, who self-regulate according to neoliberal discourses, scholars also identify that NPH transformations simultaneously expand the reach and influence of actual state regulatory bodies or institutions. In attempting to understand state rationales for particular modes of regulation and government like public health, Foucault developed the concept of biopower as a means of interpretation and analysis. In this respect, critics of NPH have turned to Foucault's concept of biopower and how it provides an analytical lens for understanding the public health landscape.

Biopower is a part of Foucault's larger work on governmentality, as well as the history of the state, and the workings of power in government and society. It is by way of the concept of biopower that Foucault ascribes the relationship between the state and the lives of individuals (Foucault 1980b; 2003b; Dean 1999; Kohrman 1999; 2003; 2004; 2005). At the same time, the concept of biopower describes the manner in which individuals materialize power/knowledge couplings. For Foucault, the tensions of power and knowledge are manifested through specific practices that reproduce discourses of biopower (Brown 2000b). Referring to broader historical processes, Foucault also

elaborates that biopower is a part of the major transformations in government by which the “right to take life or let live was replaced by a power to foster life or disallow it to the point of death (Foucault 1980b, 1:138).” That is, Foucault’s concept of biopower describes the movement away from sovereign power that can punish and execute subjects, to a state concern for fostering the growth of population. Biopower is therefore a fundamental aspect of the state’s ability to ‘govern from a distance’ (Lemke 2002; Osborne 1997; Pallot 2005). Gastaldo (1997, 115) aptly describes biopower as, “a subtle, constant and ubiquitous power over life.” When taking into account the objectives of biopower, it is therefore understandable why it is a critical concept for understanding public health and its transformations. Specifically, biopower is relevant to public health changes as it offers the possibility to examine the linkages between the state, health, and population.

In his work, Foucault elaborated that biopower can be broken down into two additional concepts, bio-politics and anatomo-politics. However, Foucault made clear that bio-politics and anatomo-politics should not be viewed as exclusive categories. Instead, these two concepts should be understood as two poles of a biopower continuum (Braun 2007; Foucault 2003c; Gastaldo 1997). Foucault specified that bio-politics is specifically “...a form of politics entailing the administration of life of populations (Dean 1999) or a concern with the ‘species body’ (i.e., a group or population). Hence, bio-politics entails an “...entire series of interventions and regulatory controls” (Foucault 1980b), through which the administration of population was achieved. In the context of academic scholarship bio-politics is most often referenced to in discussions concerning the governmentality of

populations through discourses of nation, race, and gender (Anagnost 2004; 2006; Brown 2000a; Stoler 1995; 2002). For example, in Anne-Marie Stoler's (1995), *Race and the Education of Desire*, she address how race and education in the colonial Dutch East Indies were deployed as a means of governing and defining diverse populations. Foucault added that part of bio-political imperative is the establishment of statistical biological norms against which individuals are assessed and quantified to determine their relationship vis-à-vis the state (Hacking 1991). In this sense, an individual is known and perceived by the state through various quantifiable data. The quantification and normalization of health has taken form in government through such institutions as public health and the census.

Whereas bio-politics focuses on the mechanisms through which populations became regulated, anatamo-politics is concerned with "the body as machine" (Foucault 1980b). Anatamo-politics is a concept more concerned with efficiently integrating the body into economy and society through direct disciplinary action in locations such as the barracks, the school, and the family (Gastaldo 1997). In such contexts, direct physical action is intended to train and condition individuals to conduct themselves in particular ways that adhere to regulatory frameworks. Anatamo-politics is discussed far less than bio-politics, although the reason for this is never directly addressed in much of the literature (Brown and Knopp 2006; Braun 2007; Dean 1999; Gastaldo 1997; Legg 2005; Ong 2006). A possible explanation is found in Foucault's assertion that bio-politics emerged in the later Nineteenth Century as a step beyond anatamo-politics (Foucault 2003c, 243). That is, efforts at directly disciplining bodies were not so much replaced, as relegated by more

sophisticated methods of regulation of populations. In this sense, bio-politics came to encompass practices of anatamo-politics.

The bio-political form of biopower describes how governments became involved in fostering the growth of populations, as an aspect of concomitant process of economic development (Foucault 2003b). The ability of the government to foster population growth entails the development of methods for quantifying the life of the population, which were developed by different institutions including the social sciences (Hacking 1991). The quantitative techniques associated with biopower emerged largely in the context of 19th Century liberal conceptions of state, economic, and social spheres (Dean 1999). Foucault argues that this emergence of biopower in the liberal context was extremely important in the history of modern societies, because biopower allowed for the rationalization of government involvement in peoples' lives. As mentioned earlier, Petersen and Lupton (1996) specifically focused on the neo-liberal aspects of peoples' lives and analyzed how rationalities of neo-liberalism underscored transformations in public health institutions.

More recently questions concerning biopower and bio-politics have been pushed to the fore by different works in geography (Brown and Knopp 2010; Legg 2006; Philo 2005b). These studies focus on the question of biopower in terms of social, cultural and political geographies (Barnett 2001; Brown 2000b; Brown 2000a; 2003; Buckingham 2006; Cooper 2006; Crush 1994; Driver 1994; Elden 2006b; 2007; Graham 1998b; Koskela 2000; Legg 2005; 2006; Moon and Brown 2000; Painter and Philo 1995; Pallot 2005; Philo 1987; 1992; 2000b; 2005c; Philo and Parr 2000; Rose-Redwood 2006; Simonsen 1996). In

particular, there has been the recognition on the part of political (and particularly population) geographers that the disposition, context, fluidity, and particularly the scale of biopower is a central element to the functioning of governmentality. For this reason, geographers have argued that these aspects of biopower require greater attention (Boyle 2004; Brown and Knopp 2006; Buckingham 2006; Cooper 2006; Elden 2006b; 2007; Findlay 2005; Findlay and Boyle 2007; Legg 2006; Philo 2005b; Ó Tuathail and Dahlman 2006). To this end, geographer Stephen Legg (2006) recently argued that studying the different scales at which bio-politics occur helps us understand how regulatory regimes are spatialized. By considering the spatialization of regulatory regimes across scale, connections can be drawn between broader regime contexts and specific local and individual situations.

Biopower has in this manner become a part of geographers' broader interests in understanding governmentality. Geographers acknowledge that bio-politics is a form of knowledge through which individuals are identified as and come to understand themselves as a part of a population (Brown 2000b). In terms of NPH critiques, the introduction of biopower as an organizing theme has significantly influenced how geographers understand public health transformations. In this sense, when considering the therapeutic landscape and its governmentalizing potential, it becomes clear that the context within which rehabilitation and therapy are contextualized not only in anatomo-political terms but also bio-political. Therefore, biopower must be considered a central

element of understanding linkages between therapeutic landscapes and structural public health processes, institutions, and their transformations.

At the same time, according to Foucault, the object of biopower, whether it is the individual body or the population, is never stable. That is, biopower is a temporally/spatially situated concept and is constantly rearticulated as a result of actions in the context of changing discourses and power/knowledge couplings. Therefore, the spaces defined by biopower are mutable and not static. Furthermore, such spaces of governance are acted upon not only from a distance but also across different scales, and at the level of the population (species body) as well as the body. The body, in this sense, is not only a construct of anatomo-politics, the body as machine, rather the body is also a site for the materialization of bio-political discourse. In this manner, I emphasize that therapeutic landscapes are not repositories of bio-political discourse, but instead they are productive spaces where the bio-political discourse and governmentality intersect and materialize configurations of NPH regulations, processes, and institutions, as well as their transformations. As a result, such sites of manifestation of governance and the processes ongoing within them, can also influence structural public health transformations.

Conclusion

In this chapter, I have discussed the theoretical groundings of my dissertation. In particular, I have focused on how my dissertation fits within the sub-discipline of health geography, and specifically how I use a therapeutic landscape perspective. I have sought

to point out significant gaps in the current therapeutic landscape literature, and addressed how my dissertation seeks to fill in those gaps.

To reiterate, the therapeutic landscapes perspective for analyzing and explaining health geographies provides an accommodating framework for understanding processes in settings similar to those I encountered in my field research, including rehabilitation centers and health clinics. Therapeutic landscape analysis focuses on care, recovery, and rehabilitation with an emphasis on place and individual experience (Gesler 2005). Health geographers use therapeutic landscapes to trace the relationships between health, place, identity/subjectivity, and care (English, Wilson, and Keller-Olaman 2008).

I argue, however, that conceptually, as well as in practice, therapeutic landscape geographies have proven to be limited in their scope and scale. Therapeutic landscapes must be brought into dialogue with broader public health processes and transformations. In particular, I argue in my dissertation that therapeutic landscapes should be recognized for the role they play in how particular illnesses and the process of recovery may be conceptualized in public health contexts. That is, therapeutic landscape processes shape discourses about illness and disease. As such, therapeutic landscapes can influence public health discourse on illness. Therefore, the primary contribution of my dissertation is premised on the assertion that analyzing therapeutic landscapes in Russia is critical to understanding how alcohol-related illnesses are conceptualized as public health problems, because therapeutic landscapes are productive spaces that shape and are shaped by public health discourses and subjectivities.

Chapter III

Methodology

In this chapter I discuss the methodology and methods that inform my research, fieldwork and analysis. I begin by outlining my argument concerning the relationship of therapeutic landscapes to Russian public health responses for alcohol-related illnesses. I do so as a means of contextualizing the framework I used to collect data and conceptualize my dissertation research. Moreover, I discuss how therapeutic landscape analysis informs my approach to research and field methods, including the approaches I used for interviewing study participants. I then detail the empirical foci of my research, and explain how such foci fit within my overall dissertation argument. To this end, I outline the organization of my research and detail the methods, techniques, and instruments I employed to gather data. Following my summary of the plan of research, I discuss the progress of my research after I arrived in the field. In this respect, I explain the goals of my fieldwork and how these goals changed during the course of my time in the field. I then address the manner in which my research accomplished the goal of answering my original research question, in what ways it was less successful, and consider how it could have been improved. Finally, I address the various challenges I met in the field, and how they affected my research in general. In particular, I focus on barriers to access that presented themselves during my fieldwork. In providing this overview of my research, fieldwork, and analysis, my goal is to show the underlying methodological framework and the methods I used to frame the role of therapeutic landscapes in Russia's public

health treatment of alcohol related illnesses. I illustrate that therapeutic landscape approaches are a significant methodological approach for understanding linkages between place, experience and broader public health processes.

Research Framework

In this dissertation, I argue that the process by which alcohol is becoming a public health problem in Russia has been negotiated through a series of therapeutic landscapes. In particular, I focus on contrasting public health approaches to dealing with addiction and alcohol-related illness and how these approaches are shaped by recovery as conceived of within therapeutic landscapes. In shaping recovery, the processes at the therapeutic landscapes in question also present contrasting conceptualizations of alcohol-related illness as a public health problem. In this sense, my broader objective is to demonstrate how geography, framed here through therapeutic landscapes plays a role in public health transformation by shaping conceptualizations of illness and recovery. In demonstrating how geography plays a role in public health transformations, this dissertation builds off of health geography approaches to research and analysis. The objective of this chapter, therefore, is specifically to identify the geographic methods I employed in my fieldwork and analysis.

In demonstrating the role of geography in shaping public health transformations regarding alcohol-related illnesses, I examined therapeutic landscapes associated with treatment for addiction and alcohol related illness in Russia. The places I focused on were the bases for case studies in which I focused on collecting information that aided in

understanding and analyzing such landscapes symbolically and materially. As I describe later, such efforts reflect methods incorporated in therapeutic landscape studies by authors such as Robin Kearns and Ross Barnett (1999; 2000) in their explorations of therapeutic landscapes and symbolism in Auckland's Children's Hospital. In general, such approaches can be characterized as idiographic, in that they focus on case studies to explain or provide insight into broader social patterns associated with the therapeutic landscape (Babbie 2012).

The methods I used to carry out my research mirror are grounded primarily in therapeutic landscape analysis. As I mentioned earlier, I adopt methods similar to those initiated in the 1990s by geographers like Allison Williams (1999a; 2008) and Wil Gesler (1992; 2005). Such methods are generally qualitative in approach, focusing on ethnographic methods including unstructured and semi-structured interviews. For example, in Allison Williams' work with home-health workers in Ontario (Williams 1999b; 2006; Williams and Cutchin 2002). Moreover, therapeutic landscape literature tends to also focus on archival and textual research, for example by using historical sources as a basis for landscape interpretation (Mohan 1999). In concentrating on qualitative methods, either through interviews or textual sources, geographers collect information that is essential in drawing out the concept of place (Milligan and Wiles 2010). In this sense, therapeutic landscape analysis favors qualitative approaches because they help focus on the aspects of place that play a role in care and recovery. My research framework therefore provided a structure that guided my collection of qualitative data.

In this sense, therapeutic landscape analysis informed my decision-making process in terms of potential sites of research and potential informants.

In constructing the case studies, I initially sought to conduct guided interviews with individuals who were central in treating alcohol-related illnesses such as doctors of narcology, social workers, psychiatrists, psychologists, and volunteers in treatment centers. By seeking interviews with such individuals, I wanted to examine how public health professionals in Russia treated and perceived alcohol-related illness. In many ways, my approach constitutes an institutional ethnography (Babbie 2012, 295), wherein the interviews were focused on elucidating power relations and functions within the therapeutic landscape by gaining insight from those working in the public health sector. In this sense, I focused on engaging with public health professionals because their actions are central to shaping therapeutic landscapes. In doing so, I attempted to approach the material in a manner similar to geographers who have focused on the production of therapeutic landscapes (Andrews and Evans 2008; Curtis et al. 2007; Hoyez 2007). As such, I focused a good part of my research on medical professionals who specialized in treating alcohol-related illnesses. As I explain later in this chapter, the pool of subjects I considered central to the construction of therapeutic landscapes for treating alcohol-related illness would expand during my time in the field. That is, I also interviewed individuals who had received treatment for alcohol-related illnesses in Russia, as individuals who receive treatment play a central role in the production of therapeutic landscapes. By interviewing both the health professionals and care recipients, I sought to capture completely the

complexities of the therapeutic landscapes I encountered. In the following section, I focus on the approaches I employed in the field in order to collect data and gather materials and interviews. In doing so, I consider my motivations for using these approaches.

Site Selection

I conducted my field-work in Moscow city and oblast, Russia (see figure 1). I chose Russia as my study site out of a dual interest in public health responses to alcohol-related harm and the ongoing demographic crisis (Feshbach 2001; 2003; 2005). In particular, I wanted to ascertain the extent to which public health services were involved in the mitigation of mortality and morbidity rates related to alcohol-related illness.



Figure 1 – The respective locations of Moscow Oblast and City within Russia

As others have noted, Russia's government has increasingly sought to reduce the health impacts of alcohol on the Russian population (Putin 2005; 2006; 2009;

Radzikhovskii 2006; Radio "Maiak" 2006; Papernaya 2009; Golloher 2009; Bentley 2009; Levy 2009; Medvedev 2009; RIA Novosti 2009a; 2009b; 2009c; 2010; von Twickel 2010). The high rate of alcohol consumption in Russia has been recognized as directly contributing to drastically poor health outcomes including heart disease, suicide, accidents, and violence (Khalturina and Korotaev 2008; Nilssen et al. 2005; Leon et al. 2007). Poor health outcomes in Russia are primary factors in the country's negative population trends, more commonly termed 'the demographic crisis' (Nemtsov 2006; Mesle and Shkolnikov 1995; Shkolnikov et al. 1998; Notzon et al. 1998; Cockerham 2000). Over the past ten years, the government has initiated programs directed at reversing the demographic crisis. However, such programs have mainly focused on the promotion of higher birth rates and improving primary health service and infrastructure (von Twickel 2010; Radio "Maiak" 2006; Kazantsev 2007). State strategies focusing on alcohol-related health are only recently being acted upon for role they play in exacerbating the demographic crisis (*Strategiia Profilaktiki i Kontroliia Neinfektsionnykh Zabolevanii i Travmatizma v Rossiiskoi Federatsii* 2008; Vishnevskii, Kvasha, and Kharkova 2005; Oganov and Maslennikova 2006).

Geographers and health researchers interested in Russia have long focused on the nation's demographic and health problems (Moran 2005; Round 2005; Twigg 2001; Twigg 2005; Feshbach 2005; Rivkin-Fish 1999; 2000; 2004; 2005). Traditionally, geographers have focused on the demographic crisis primarily in statistical terms, thereby hoping to gain insight into the causes of the crisis as well as forecast its potential social, political, and

economic impacts (Feshbach 1994; Demko and Fuchs 1984; Demko, Ioffe, and Zayonchkovskaya 1999; Heleniak 2003; 1995). Geographers who have analyzed Russia's health problems have focused on a broad range of public health issues and their interconnections with the demographic crisis (Moran 2005; Twigg 2005; 1999; Marples 1999; Lohlein, Jutting, and Wehrheim 2003). Moreover, recent scholarship has argued for extending our understanding of both the demographic crisis and health problems by suggesting geographers diversify the scales of analysis (Field 2005). In this sense, geographers are referring to the need to not only examine local scales more closely, but also how local, regional, and national scales interact with each other. Geographers arguing for scalar analysis maintain that such an approach can improve our understanding of the overall geography of the demographic crisis, health related issues, and the complexities of the relationship between the two. In the case of this dissertation, I argue for connecting the smaller scale therapeutic landscapes of treatment for alcohol-related illnesses, with the larger scale public health approaches. While the main contribution of this dissertation is to highlight the geographical linkages between therapeutic landscapes and larger public health processes and transformation, I believe this dissertation is also an important contribution to the geographical understanding of Russia's contemporary struggles with population decline and alcohol-related illness.

In focusing on such a large issue, I wanted to narrow down a study area in which my analytical goals could be achieved. Therefore, I chose Moscow as the location of my study site because of its accessibility compared with other cities and regions in Russia, as

well as for its larger service availability in terms of alcohol treatment options (Tragakes and Lessof 2003). Other cities and regions in Russia may have offered sites of public health treatment options and strategies for dealing with alcohol related illness that were more typical in terms of geographic distribution. However, I chose Moscow because of the diversity of treatment options, and, as previously mentioned, the greater accessibility for accomplishing field work.

Data Collection

The primary mode of data collection and observation for my field work was the semi-guided in-depth interview. Specifically, I used in-depth interviews to find out about public health professionals' experiences in treating alcohol-related harm. In general, I asked public health professionals about their training and experiences in treating alcohol related illness, and also their perspectives on treatment methods available in Russia. Moreover, I relied on ethnographic field methods, including participant observation and taking field notes to develop a thorough understanding of activities in Russian therapeutic landscapes related to alcohol-related harm. Additionally, I used in-depth interviews to find out about the experiences and perspectives of individuals who were recovering from alcohol-related illnesses or who were undergoing treatment for addiction. Finally, I collected textual material that reflected therapeutic landscape processes and discourse such as pamphlets and literature produced by both public health-oriented Non-Governmental Organizations (NGOs) as well as public health institutions.

I primarily collected in-depth qualitative data to document the practices and perceptions of public health professionals, workers, and advocates involved with the treatment of alcohol-related illnesses and alcohol education programs in Moscow, Russia. In-depth qualitative data were central to my study, as they documented how the practices and perceptions of public health professionals were central in constructing the therapeutic landscape of alcohol-related illness recovery in Russia. I collected the primary qualitative data using a combination of guided and semi-structured interviews with workers, professionals, and advocates in the public health field. I gathered supporting secondary data (including archival research concerning demographics and government policy) from local, national, and international sources while in the field. Such sources include the WHO database on alcohol policy and demographics and related publications (Monteiro 2001; World Health Organization Substance Abuse 2004; WHO Regional Office for Europe 2006), publicly available information concerning Russia alcohol laws (Bektashev and Assotsiatsiia iuridicheskii tsentr 2004), the Russian statistical service, GosKomStat (www.gks.ru), and Moscow city information on narcological dispensaries (www.mosgorzdrav.ru).

I also conducted archival research and carried out informational interviews with key informants who worked in the public health field. I used both of these approaches in order to document the relationship between the public health sector and the treatment of alcohol-related illnesses in Russia. In addition to collecting data on the relationship

between public health and alcohol abuse in Russia, I focused my research on how Russia public health institutions have responded to the impacts of alcohol abuse.

The archival research phase of the project provided important contextual and background information for the interview phases of my research. Specifically, the archival research phase of the project provided context concerning demographic and policy issues related to alcohol-related illness as a public health problem in Russia and Moscow. Interviews with key informants also provided contacts for future research. Additional secondary data were gathered from state and non-profit sources: The Russian Public Health Ministry, The Moscow City Health Department, the statistical bureau of the Russian Federation, NAN (No to Alcoholism and Narcotics—a national NGO headquartered in Moscow), the Open Health Institute (an international NGO with offices in Moscow), and AFEW (AIDS Foundation East-West—an international NGO with offices in Moscow). These diverse sources assisted in providing further context regarding policy issues surrounding the treatment of addiction in Russia, as well as information regarding the variety of treatment options available in Russia.

In this sense, my approach was designed to reflect methods practiced not only by geographers focusing on therapeutic landscapes, but also health geographers who broadly employ both archival and ethnographic research. Health geographers, such as Moreno and Curti (2012) in their examination of drug courts focus on exploring the social dimensions of health spaces and places by research documentation as well as the human experience. Brown and Knopp (2010) in their study of sexual health in World War II-era

Seattle focus on materials produced in public health campaigns and how they shape subjectivities and geographies of health care. Others focus on how individual experiences in particular landscapes relate to their recovery (Parr, Philo, and Burns 2004; Philo, Parr, and Burns 2005). Therefore, by relying on both archival and ethnographic research I attempt to create a more complete picture of public health transformations in Russia.

Potential key informants were identified and contacted by telephone, as well as written correspondence, including email. I recruited these individuals for interviews through my initial connections and by using a word-of-mouth or “snowball” method. Snowball sampling is a method of sampling whereby interviewed subjects provide names or contact information for additional subjects (Babbie 2012). Therefore, when carrying out my research I asked participants and contacts if they could identify other potential informants who might be interested in participating in this study.

Once I established contact with potential informants, I explained my research goals. I then discussed my overall research project and its goals with the potential informants. Additionally, I explained to potential informants the process of informed consent and confidentiality. Several research participants were interviewed in their official capacities. Participants were informed that although general job and organization descriptions would be used in the research, names and personal information would not appear without express written permission. After providing the participant an explanation of their rights and obtaining permission, interviews took place in the informant’s place of work and were either tape-recorded or written down. All

respondents were informed of their right not to be tape-recorded, or to refuse to answer any questions. Participants were informed that they had the right to review their responses on tape or by transcript, and to amend previous answers they provided in previous interviews. Overall, I conducted 30-45 minute semi-guided interviews with fifteen public health workers. In addition, I also conducted 45-60 minute guided interviews with six public health professionals. The primary goal in these interviews was to investigate participants' positions, professional and personal, regarding the relationship of public health in Russia to the problem of alcohol abuse at the national, regional, and local level. Additionally, these interviews were also a means of finding out the procedures and strategies that were used by the interviewees and their institutions to approach the treatment of alcohol-related illnesses. As I address below, I also conducted six semi-structured interviews with residents at a rehabilitation center, who were undergoing treatment for addiction.

As mentioned earlier in this dissertation, the central objective of my research was to gain primary data on the roles that public health workers and professionals play in attempts to intervene in the problem of alcohol abuse on the societal level. Moreover, I was also interested in finding out the role of public health workers and professionals in educating and informing the public on the dangers of alcohol abuse. In addition, I sought to understand how they understood their roles in helping to inform policy decisions at various levels of government. Consequently, I focused on uncovering how individual perceptions and approaches towards alcohol abuse in Russian helped shape alcohol

policy and public health approaches. I also focused on learning how decisions in public health are informed by public debates surrounding the alcohol issue.

In the following section, I construct a brief narrative of my experience in the field. The research narrative describes the course of my work in the field as well as changes that occurred during my project. While the goals of my research and the focus of my overall project remained the same, at least one significant change occurred during my fieldwork that caused me to update my objectives and project goals.

Research Narrative

In June 2008, I arrived in Moscow. My initial questions were centered on examining the public health response in Russia to alcohol-related illness. I was interested in how the public health response to alcohol-related illness was shaped by bio-political concerns over Russia's demographic crisis. I sought to concentrate on how public health actors participated in treatment for alcohol related illness, and how they perceived their roles in treating individuals suffering from alcohol-related illness. Soon after my arrival, I began the process of gathering informational interviews. I looked into potential contacts that would help me to better understand the question of alcohol-related harm and answer my research questions. I began by contacting the organization titled *No to Alcoholism and Drug Addiction* (NAN), a Russian NGO focused on education and prevention in terms of alcohol-related illness. During interviews with informants at NAN, I discussed the overall state of treatment for alcohol-related illnesses in Russia. My conversations and interviews with the staff at NAN led to a series of interviews at a local Moscow clinic. At the local

clinic, I interviewed staff about their involvement in treatment and care for alcohol-related illnesses. Furthermore, contacts at the clinic connected me with professionals who were trained in narcology, the official Russian public health treatment approach to alcoholism and addiction. My observations and interviews at NAN and its affiliated clinic helped to provide a great deal of information concerning the clinic treatment process for alcohol-related illnesses.

Additionally, I was able to contact members of the NGO community in Russia who were connected with international aid agencies, such as USAID. Through these contacts, I examined and analyzed the transformations of treatment methods in Russian public health. At the same time, I pursued contacts to other domestic and international NGOs engaged in treatment for alcohol-related illnesses. For example, I was able to contact the assistant director of *Stariy Svet* (Old World), an Orthodox Church affiliated NGO focused on addiction treatment. Through my contacts with *Stariy Svet* I was able to interview individuals engaged in treatment of alcohol-related illness who were not directly affiliated with the official Russian medical establishment. Interviewing individuals outside the official medical establishment was central in understanding the processes of treatment for alcohol-related illness in Russia that were emerging without direct state involvement.

Furthermore, contact with *Stariy Svet* allowed me to have access to their rehabilitation center and its facilities. Although the question of rehabilitation was not originally a part of my proposed research, I decided to incorporate the rehabilitation

center into my fieldwork. My fieldwork at the rehabilitation center produced a significant transformation of my overall project. Initially, I intended to limit my dissertation research to health care professionals who engaged in treatment of alcohol-related illness. Then, after meeting with residents at the rehabilitation center, I realized my proposed fieldwork did not incorporate the perspectives of those individuals who were recovering from alcohol-related illness. During the course of my informational interviews, it became clear that the responsibility of recovery and treatment for alcohol-related illness in Russia, and therefore, the shaping of the therapeutic landscape in this regard, was dependent on the practices of the individuals who were themselves actively engaged in treatment and recovery.

As such, I made the appropriate modifications to my IRB forms and scripts. The resulting observations and data collected from my engagement with the center's staff and clients proved to be an important source of information and insight regarding Russia's treatment landscapes for alcohol-related illnesses. The fieldwork that I carried out at the center also provided me with an important window from which I could observe the incorporation of 12-step processes into Russian treatment strategies.

The following section examines the manner in which I analyzed the data collected during the course of my field research. Specifically, I focus on my use of discourse analysis as a means of understanding the materials and interviews I gathered. I decided upon using discourse analysis for interpreting the materials and interviews I gathered, because of the manner in which discursive analysis allows for the examination of broad

connections between the productive space of the therapeutic landscape and the practices of the people involved.

Analysis

Once I completed my fieldwork, I employed discourse analysis to understand and interpret the collected interview data, field observations and other research related texts. I chose discursive analysis as an analytic approach because it allowed me to examine the broad connections between the productive spaces of therapeutic landscapes, the practices of individuals I interviewed, and materials I collected in the field.

As per Rose (Rose 2011, 190), discourse is a critical to understanding social process and institutions:

“... (discourse) refers to groups of statements that structure the way a thing is thought, and the way we act on the basis of that thinking. In other words, discourse is a particular knowledge about the world which shapes how the world is understood and how things are done in it.”

In this sense, discourse, as Fairclough claims (2003), is an irreducible aspect of the social fabric which requires analysis if we seek to understand social relations and inequalities. The practice of analyzing and making sense of discourse is therefore geared toward examining the texts, speech, and practices of subjects as a means of drawing forth meaning, thus closely connecting with institutional ethnography as mentioned above. More specifically, discourse analysis for Rose (2011, 227) is, “concerned with the production (of materials) by, and their reiteration of, particular institutions and their practices, and their production of particular human subjects.” In this sense, then,

discourse analysis as I employed it was a means of examining the texts, practices, and symbols of the therapeutic landscapes in which I collected data. Through discourse analysis, I sought to understand the interconnections between the places where treatment was practiced and the larger public health conceptualization of alcohol-related illness.

Interviews provided insight into the experiences of individuals who underwent treatment for addiction and alcohol-related illness. In carrying out my analysis, I was interested in understanding the role of verbal communication and written text in reflecting individuals' interpretations of their experiences in therapeutic landscapes. Consequently, I focused on how both verbal and written materials demonstrated underlying public health discourses, and how they productively shaped perceptions on addiction and recovery. In this sense, discourse analysis proved useful as it is concerned with the analysis of dialogue and texts in social contexts (Fairclough, Mulderrig, and Wodak 2011; Phillips and Hardy 2002; Rose 2011). Additionally, discourse analysis allowed me to draw out the manner in which dialogue and text provide insight into social relations. In this manner, interviews and pamphlets helped me to understand how public health professionals and individuals receiving treatment conceptualize alcohol-related illness and its treatment.

Textual materials I gathered included publications from alcohol treatment centers, which advertised services, as well as public health materials that were used for promoting awareness concerning alcoholism and addiction. Materials included public health brochures, as well as pamphlets for the recovery center discussed later in chapter seven.

The materials provided context concerning the broader public health conceptualization of alcohol-related illnesses and treatment in Russia. They were important for understanding the public health messages conveyed to individuals seeking or receiving treatment, as well as family members who often are the first to explore treatment options. In this sense, materials reflect and represent various, often competing, conceptualizations of how alcohol-related illnesses can be identified and treated, and in some cases cured. Such materials provided important complements to interviews, as they provided additional discursive representations of the role therapeutic aims and goals of programs in Russia.

I selected these materials because they communicate the discourses and practices of recovery. In this manner, such materials helped textually illustrate the therapeutic landscape through representations of treatment. I relied on discourse analysis of such materials in order to show how various public health organizations represent and conceptualize alcohol-related illnesses and treatment options. Discourse analysis was a useful approach for helping me to understand many of the underlying public health assumptions and generalizations about alcohol-related illnesses and treatment in Russia.

Methodological Compromises

Throughout the process of collecting materials from the field and data analysis, I attempted to follow a rigorous and systematic approach. At times, however, I was not always able to achieve what I had hoped. Unfortunately, it was not feasible for me to engage in all the diverse areas encompassed by therapeutic landscapes for treating alcohol-related illness in Russia. Particularly, I was not able to connect with a sufficient

number of professionals who practiced strictly narcological approaches to treat alcohol addiction. Although I was able to engage with professionals who practiced narcology in some modified form, I was not able to interview any narcologists or observe any narcological facilities other than those connected with the NAN organization. During my time in the field, I was unable to establish a connection with any narcologists in the city or the oblast. The Russian narcological service is the largest treatment practice available. The limited number of narcological professionals I engaged with presents a significant lacuna in the research data I collected. My analysis of the narcological service in the context of this project has attempted to overcome this weakness by drawing from previous studies, the perspectives of several interviewees, and publicly available information about narcology's history and practices.

Conclusion

In this chapter I discussed the methodology and methods that inform my research, fieldwork and analysis. I began by outlining my argument concerning the relationship of therapeutic landscapes to Russian public health responses for alcohol-related illnesses. I did so as a means of contextualizing the framework I used to collect data and conceptualize my dissertation research. Moreover, I discussed how therapeutic landscape analysis informs my approach to research and field methods, including the approaches I used for interviewing study participants. I then detailed the empirical foci of my research, and explained how such foci fit within my overall dissertation argument. To this end, I outlined the organization of my research and detailed the methods, techniques, and

instruments I employed to gather data. Following my summary of the plan of research, I discussed the progress of my research after I arrived in the field. In this respect, I explained the goals of my field work and how these goals changed during the course of my time in the field. I then addressed the manner in which my research accomplished the goal of answering my original research question, in what ways it was less successful, and considered how it could have been improved. Finally, I also addressed the various challenges I met in the field, and how they affected my research in general. In providing this overview of my research, fieldwork, and analysis, my goal has been to show the underlying methodological framework and the methods I used to frame the role of therapeutic landscapes in Russia's public health treatment of alcohol related illnesses.

CHAPTER IV

Alcoholics Anonymous and Russian public health

This chapter examines the therapeutic landscape of Alcoholics Anonymous (AA) programs in Russia and their role in the production of alcoholic identities and concepts of rehabilitation.¹ AA is an emergent means of alcoholism treatment in Russia (Raikhel 2010). While not as widespread as in other countries, AA forms the basis for some public and private treatment programs in Russia (Green, Holloway, and Fleming 2000). AA groups can be found throughout Russia, and in a variety of public health settings, including clinics and hospitals (The Lancet 2009). In this chapter, I argue that AA plays a significant role in how alcohol is problematized as a public health issue in Russia. The problematization of alcoholism through AA discourses and practices presents a significant alternative to Russia's mainstream narcology approach, which I discuss in the following chapter. Moreover, the therapeutic landscape of AA relies on a specific set of governmentalizing practices. In examining the therapeutic landscapes of AA, I show how AA uses disciplinary practices to shape conceptualizations of alcoholism for its members. At the same time, the experiences and accounts of those who have relied on AA help to show the significance of AA's contribution to public health in Russia. Specifically, I argue that AA is critical in the production of therapeutic landscapes within Russian public health geographies. At the same time, AA groups and members work together to reproduce and reinforce AA discourse and practices within hospitals, clinics, and other

¹ I focus specifically here on Alcoholics Anonymous, and not 12-step programs in general.

areas throughout Russia. By way of these conduits, AA systematically works towards the production of therapeutic landscapes. The production of therapeutic landscapes that are specific to AA leads to the formation of distinct public health geographies where AA methods and practices are key components of the recovery process. With these last points in mind, this chapter seeks to explain how AA therapeutic landscapes impact contemporary Russian public health by shaping conceptualizations of alcohol-related illnesses and treatment.

I begin this chapter with an overview of the history of AA and the 12 step-program. My objective in providing this overview is to establish the underlying pastoral elements of AA as a technique of governmentality. It is my contention that the governmentality aspects of AA can be traced back to its foundations. Indeed, the tenets of AA have changed little over the years. To this end, the organization's goals emphasize the important role of the self and identity in maintaining sobriety (White 1998). I will give attention to this role as I address the relevance of Foucault's concept of governmentality to understanding the therapeutic landscape of AA.

As part of my discussion on the governmentality aspects of the therapeutic landscape of AA, I focus my attention on three distinct areas. First, I address how discipline operates at group meetings. Indeed, it is at these meetings that members affirm their alcoholism and discuss their efforts at working through the 12-steps (Valverde and White-Mair 1999). As such, I describe how the therapeutic landscape of the meeting reinforces disciplinary practices for members and their conceptualizations of alcoholism

(Wilton and DeVerteuil 2006). In addition, I demonstrate how AA also spatializes members' daily lives outside the group, as they constantly evaluate their lives in the context of their recovery (Hensel, Haakenson, and Mohatt 2003; Valverde and White-Mair 1999). Moreover, in the context of both meetings and their daily lives, members perform an alcoholic identity in which they come to embody AA discourses of healing and recovery (Brandes 2002). Consequently, I show that the therapeutic landscape of AA presents a heavily governmentalized space, where members are in a constant state of self-regulation and self-surveillance. In my consideration of the governmentalizing aspects of the AA meetings and members' daily lives, I establish an initial disciplinary therapeutic landscape of AA, which is critical for understanding the operation of AA in Russia.

In order to thoroughly examine the impact of AA's therapeutic landscapes on Russian public health, I begin by discussing the history of AA within Russia. As I explain, the slow and sometimes troubled introduction of AA into Russia is central in understanding how AA is viewed and critiqued in Russia. Moreover, the history of AA in Russia reveals how alcoholics are popularly and clinically stigmatized in Russian society (White 1996; Raikhel 2010). I consider this process of stigmatization, which is partly grounded in the perception of AA as a Western phenomenon. Understanding the ways in which AA is perceived in Russia helps to explain why it has experienced difficult and slow growth in Russia. Furthermore, demonstrating the troubled history of AA in Russia helps elucidate the influence of narcology on public health in Russia. That is, many of the obstacles to AA expansion in Russia are outgrowths of narcological

conceptualizations of alcohol-related illness and their predominance in Russian public health.

As part of my examination of the contemporary therapeutic landscape of AA in Russia, I focus on the different spaces through which AA produces self-governing subjects. In this respect, I focus on the experiences of Russians who are AA members. At the same time, I also focus on geographic aspects of AA through which surveillance, regulation and discipline take place, particularly the AA meeting. Through examining both participants and the geographies of surveillance, I highlight how the discourse of AA shapes participants' views of their own alcohol-related experiences. I simultaneously illustrate the connections of power and discipline that give structure to Russia's geography of public health and alcohol. I argue that understanding the geography of AA is central to understanding the geographies of Russia's public health response to alcohol abuse in general. Specifically, an analysis of AA establishes a distinct therapeutic landscape for treating alcohol abuse in places such as the addiction clinic and rehabilitation center.

The Alcoholics Anonymous Program

The history of AA is central to understanding not only how governmentality figures into AA practices, but also why the introduction of AA has been so problematic in Russia. Alcoholics Anonymous was founded in Akron, Ohio in 1935 (White 1998). The foundation of AA is based upon the rejection of medical and political trends in the discourse of alcoholism. In the political sense, AA was founded as a rejection of American

temperance politics (White 1998, 127). That is, AA was founded as an explicitly apolitical 'fellowship' that eschewed political activism. In the post-prohibition era, AA distanced itself and its adherents from the temperance movement. The temperance movement had succeeded in passing the prohibition amendment, but the failure of prohibition spelled the end of the temperance movement's political influence. As a result, throughout its history and into the contemporary period, AA members and groups have not advocated any particular policy toward alcohol regulation.

Moreover, AA was founded as an alternative to contemporary treatment methods. Such contemporary methods focused on "drying-out" in hospitals or sanatoria and psychoanalysis, which the founders of AA considered to be a misguided understanding of the addiction experience (White 1998, 79). Early to mid-century disease models of alcoholism sought to identify the pathology of alcoholism as an illness, locating the root cause in the brain and psyche of the individual. The construction of the illness in such a manner allowed for the conjecture of cures for addiction based on behavioral or physiological modification of the patient through chemical or psychological treatment. Consequently, AA promotes an understanding of alcoholism that focuses on the construction of an alcoholic identity grounded in spirituality (White 1998, 175). In this sense, the will of the individual is seen as paramount in controlling addiction, rather than transcending or curing it. In other words, AA discourse puts forth that the alcoholic must acknowledge addiction as a permanent and incurable part of his or her identity. From the standpoint of AA, alcoholism is therefore a lifelong condition that requires constant

observation. This constant observation extends to the “self”, which requires constant spiritual, physical, and emotional maintenance, to achieve long-term sobriety and health.

The AA founders formally structured the concept of the 12-steps as the long-term maintenance of self in the interest of sobriety. The 12-steps represent a process through which an individual attempts to understand his or her own identity as an addict or alcoholic, and in doing so attempt to control their addictive behavior. A central requirement for individuals practicing the 12 steps is regular participation in AA meetings with other self-identified addicts. In meeting together, testifying, and witnessing, addiction members reaffirm their attempts to stay sober, as well as the permanence of their addiction. Hence, each meeting is an affirmation of AA discourse and an alcoholic identity. At the same time, AA members are supposed to adhere to the 12-steps not just in meetings or in the company of other members, but also in everyday life. As this last point suggests, AA and the 12-steps promote a self-conscious form of reflexive behavior, in which all circumstances or social occasions, are translated through the 12-steps and alcoholic identity.

There have been two developments associated with the 12-steps since their earliest publication. First, the 12-step model has been transposed and adopted to treat other addictions besides alcoholism (White 1998, 279). That is, the 12-steps are no longer synonymous with Alcoholics Anonymous. At present, there are 12-step groups for narcotics users, gamblers, and sex-addicts among other addictions. Second, the 12 step program was used as a foundation for a number of treatment and recovery centers (White

1998, 199). The Minnesota Model, for example, which is a systematic set of guidelines for creating a rehabilitative treatment center or clinic, establishes a setting for addicts to participate in the 12-steps, while also providing additional participation and expertise from medical professionals and social workers. The development of the Minnesota Model and the spread of the 12-steps to other addictions has had important implications for the spread of treatment methods in Russia, as I will describe in the later chapter on rehabilitation centers.

AA in Russia

The history of the introduction and growth of AA and the 12-steps in Russia demonstrates how public health conceptualizations of alcoholism significantly shape treatment models. Indeed, the AA philosophy and practice is fundamentally opposed to narcology, the Russian science of addiction. I discuss in chapter 5 how narcology treats alcoholism as a curable psychiatric condition, and therefore in opposition to AA's long-term maintenance methods. Various stigmas attached to AA still linger in Russia and play an important role in participants' views of themselves, and the problem of alcohol in Russia, in general (Raikhel 2010; 2011).

Alcoholics Anonymous meetings were first introduced into Russia during the late 1980s (Garelik 1989; Keller 1987). Some attribute the emergence of AA in Russia to a cultural exchange between the US and the USSR. Specifically, some Russian AA members believe that Russia's initial AA group was sponsored by evangelical participants from the US and individuals inside the USSR, who were already familiar with the AA (White 1996).

However, others believe that the 12-step methods were introduced into the Soviet Union through Finnish participants (Garelik 1989). That said, it is largely accepted that the initial AA group to form in Russia and in the Soviet Union was a group that named itself "New Beginnings" in Moscow during the late 1980s (Webb 1992).

The 12-step model and AA was initially greeted with suspicion by the Soviet authorities, in part because of its religious foundations. At the same time, Soviet authorities were also wary of the model's emphasis on the actions of the individual (White 1996; Keller 1987). Because of state opposition, AA groups did not successfully form in Russia until the 1980s. One key factor that allowed for AA to make inroads into Russian society were Gorbachev era reforms (Keller 1987). During this period, the government focused on reducing alcohol consumption in general, which resulted in reduced opposition to AA's presence. Therefore, AA groups were allowed to form on a limited basis.

Moreover, the collapse of the Soviet Union in 1991 spurred growth in the number of AA groups and other 12-step programs. Since then, there has been a steady increase in AA membership and the number of groups meeting throughout Russia (Fleming 1996). The majority of 12-step groups are located in Moscow, but others have emerged across the country in smaller cities like St. Petersburg. During the time I carried out my fieldwork, the original Moscow AA group celebrated its 20th Anniversary by hosting a large open meeting in Moscow. While AA has experienced steady expansion during the past two decades, its visibility is limited. In fact, during several interviews participants

remarked that there are comparatively few groups meeting in Russia, when compared to countries in the West. As an example, one interviewee from Tambov, a city of close to 300,000 people in European Russia noted that he had never heard of AA before it was introduced to him in his rehabilitation program. He also added that no groups were located in the city (Resident A, 08-28-2008). Participant interviews indicate that while AA has a notable presence in cities like Moscow, it has an uneven distribution throughout the country.

The uneven growth of AA can also be explained by the stigma attached to the concept of alcoholism as well as suspicions concerning AA as an organization. Such stigma can be explained by misgivings towards AA within the medical community, as well as in broader social contexts. As an outgrowth of a Protestant Western society, AA is sometimes viewed as a cult-like threat to Russian Orthodoxy and to Russian culture in general (Raikhel 2010). I address objections to AA more thoroughly in chapter seven. Moreover, AA is sometimes criticized as a conveyance of destructive Western values and American individualism, which threaten traditional Russian ideas of community.²

Furthermore, the AA construction of alcoholism as a disease runs counter to the established narcology narrative of alcoholism (Elovich and Drucker 2008). One of the key ways in which AA understands alcoholism as disease is by recognizing that it is intertwined with an individual's identity. This perception of alcoholism is at odds with

² AA as a threat to Russian cultural values, is a criticism usually based around the emphasis of the individual in AA and its incompatibility with the Russian communal mythos, where the individual is second to the community.

the narcological position that alcoholism is curable. However, both AA and narcology identify the individual's selfishness as a root cause of addiction in the first place. This view towards selfishness came out in interviews I carried out in my field research. For instance, an interviewee who participated in AA for several months explained to me that his initial inability to stop drinking was a result of his own selfishness (Resident B, 08/28/2008). In one sense, the participant is demonstrating the internalization of the tenets of AA discourse. For the participant, a constant self-surveillance combined with prescribed 12-step practices, is the only guard against a return to his or her alcoholic nature. The participant is governmentalized in terms of behavior and perception of self. At the same time, there is also evidence that popular perceptions of alcoholism and addiction in Russia, which are shaped narcological perspectives, are also informed by this belief that the behavior of addicts and alcoholics stems from selfishness. In a separate interview, one person described alcoholics as egotistical, and that they could quit if they wanted to (Interview, 07/12/08). The participant clearly perceives alcoholism as a matter of selfishness, but unlike the AA discourse concept of alcoholism, the participant views alcoholism as a matter of will power and not one of engrained identity.

With respect to the idea of treatment, the two approaches distinguish themselves. AA does not propose a cure. In contrast, narcology criticizes identifying oneself as an alcoholic in the first place. Identifying oneself as an alcoholic is to reject the possibility of a cure. In addition, the narcological perspective maintains that identifying oneself as an alcoholic serves to perpetuate egocentric behavior. Because views of narcology are deeply

entrenched in Russian society, the act of identifying oneself as an alcoholic, in the AA sense, is deeply problematic. To reiterate, the person who calls him or herself alcoholic is perceived not as someone overcoming an illness, but someone who is selfish and self-pitying.

The stigmatization of AA along with its perceived cultural alien-ness helps to explain its slow growth in Russia. Nevertheless, AA membership has grown steadily in the post-Soviet period. In fact, AA now has a presence in narcological settings, which suggests that the stigma of the organization may be waning. Typically, AA programs can be found in larger cities such as Moscow and St. Petersburg, as opposed to regional centers.

The discipline of AA

In this section I address the complex disciplinary system of AA's therapeutic landscape. I focus on the practices of surveillance, regulation, and discipline associated with participation in AA. I consider these factors and the practices they entail to be central in the construction of the AA therapeutic landscape. I use examples from my fieldwork, including interviews with Russian 12-step participants, to elucidate the aforementioned practices. As I demonstrate below, participation in AA shapes members' perceptions of their alcoholism and the narrative of their recovery. In developing an AA influenced perception of alcoholism and self-narrative of addiction, the landscape required for rehabilitation is shaped and molded. By examining the factors that contribute to the production of the AA therapeutic landscape, I foreground the ways in which AA shapes

attitudes towards alcoholism. I first begin this section by addressing the broader disciplinary aspects of AA as a system of governmentality. That is, AA is a discursive system that shapes behavior of its participants through repetitious acts of self-surveillance and performances of identity (Dean 1999). I explore the governmentality aspects of AA by examining therapeutic landscapes in which the alcoholic identity is performed. In this respect, I separate the AA therapeutic landscape into two sections, the AA meeting and the alcoholic body. While closely interconnected, the meeting and the body diverge in the manner in which they shape or materialize governmentality among AA members. By way of participating in meetings and practicing the twelve steps, members work *in situ* towards inhabiting and materializing the discursive therapeutic landscape of AA. However, as described below, the expectation of the alcoholic identity is that the individual remain constantly aware and embody alcoholic tendencies or practices, thereby transforming the governmentality practiced at the meeting into an everyday performance. By looking at the meeting and the alcoholic identity, AA fosters a governmentalizing therapeutic landscape among its members not only in the setting of the meeting, but in everyday life as well.

The AA meeting serves as a space where participants account for their actions as alcoholics and affirm their alcoholic identities (Valverde 1998; Valverde and White-Mair 1999; White 1998). In this sense, the meeting is a therapeutic landscape where one is expected to address how their lived experiences dovetail with their alcoholic identity. In other words, it is believed that acknowledging the interplay of lived experience and

alcoholic identity are critical to recovery and maintaining sobriety. Moreover, the acknowledgment of life and identity also work towards reinforcing the therapeutic landscape of the meeting as a disciplinary context that manifests the governmentalizing practices of AA.

Sociologist Marianna Valverde (1998, 125–137) identifies six techniques of self-management that are keys to the governmentalizing project of AA meetings: powerlessness, anonymity, no cross-talk, telling one's story, a higher power, slogans. Each technique represents an important aspect of the AA meeting that guides personal and group conduct, and how members relate to the AA program in general. Powerlessness ascribes to members the permanence of their alcoholism, and the need to always be aware of the condition. Anonymity attempts to lessen the stigma of associating with AA, but also introduces an element of egalitarianism to the meeting. In this sense, while no member may be more important than the others, all members' opinions and observations are supposedly equally weighted. Cross-talk is the habit of criticizing or judging other members, especially during their narratives. I discuss this particular technique later in the chapter. Telling one's story is the act of narrating one's journey to joining AA and acknowledging their alcoholism. While not exactly a confession, it amounts to an accounting of a member's experience with alcoholism. Higher Power refers to an absolutory outside force that members are encouraged to acknowledge and look toward in order to draw strength in managing their alcoholism. Finally, slogans represent reiterations, throughout the meeting and members' lives, of advice and discourse that are

designed to focus the attention of the alcoholic on the permanency of his or her condition and the constant need to muster the strength of will to stay sober.

The reiterations of each of these six techniques form the foundation of the self-regulation philosophy of AA and the alcoholic-identity. Each of the six techniques represent a manner in which the subject and other AA members open themselves up to criticism, scrutiny, and therefore a form of regulation and surveillance. Simultaneously, such practices are designed to affirm their alcoholic identities and discipline behavior. As each member practices the above techniques, they simultaneously are regulating themselves and other members according to a code of conduct intended to shape their daily lives. The meeting in this sense, represents a therapeutic landscape characterized by a relatively strict and formal set of disciplinary practices.

The act of self-disciplining and opening oneself to others is negotiated in a specific manner. Frequently, AA members recount their life story as it relates to their alcoholism. In addition, members often speak of the path they took to discover their alcoholic identity (White 1998). This testimonial process parallels parochial aspects of governmentality. In this respect, the act of accounting for one's daily and weekly struggles manifests a confession of powerlessness in terms of addiction. This practice brings to mind Foucault's discussion on the origins of governmentality, rooted in the parochialism of religious confession (Foucault 1978). As Foucault identified, confession amounts to a form of critical self-evaluation. In other words, confession is an act through which the individual can focus intently on his or her acts. Furthermore, interpersonal dialogue with other alcoholics

is a significant disciplinary factor at the meeting. Together, the act of self-evaluation and the witnessing of the accounts of other members work to implicitly affirm a discourse specific to AA (Valverde 1998). Central to this discourse are the narrative's moral arc, which contextualizes individual life stories within the context of the 12-steps. Taking into account the aforementioned points, the therapeutic landscape of the AA meeting is a highly governmentalized setting where members engage in constant self-evaluation and regulation through accounting of action.

In contrast to the constant self-evaluation at the meeting, "Cross-talk" is not allowed (White 1998; Valverde and White-Mair 1999). "Cross-talk" refers to a variety of meeting behaviors including: interrupting a speaker, speaking out of turn, giving advice in the meeting, or more importantly, open criticism by meeting attendees of another individual's self-reported actions. Yet members effectively open themselves up to criticism and reprimand from other members, particularly those who speak from experience (and by extension, authority). Experience in this case is a matter of where an individual is in terms of the 12 steps. As such, the narrative and dialogue presented in AA meetings parallel Foucault's observations on the practice of confessing. Both the meeting and the church forms of confession, open up the individual and his or her experiences to evaluation by others. Such evaluation promotes a parochial form of governmentality as previously discussed. The therapeutic landscape of the meeting is therefore an explicit conflation of rehabilitation with moral evaluation.

As the parochial aspects of the meeting demonstrate, the production of the therapeutic landscape through the AA meeting shapes the interpretation of an individual's understanding of alcoholism and rehabilitation. In this sense, while personal judgment is not allowed in the AA meeting, members do respond to each other and evaluate each other's conduct. The structure of the meeting interjects authority into the therapeutic landscape by subjecting members to evaluation by each other based upon the precepts of the 12-steps. In addition, AA meetings and 12-step guidelines tend to place more authority with members who have experience, because they have remained sober over a long period of time, or have they processed through all the 12 steps. While there is an egalitarianism embedded in AA, in practice there are hierarchies in meetings and amongst members in part because of the weight of experience.

The authoritative dimension to AA, and the relative importance of experience within the context of the 12-steps demonstrates how AA discourse consistently challenges medical accounts of alcoholism. The individual relinquishes control and understanding of his or her addiction to a higher power. Hence, with experience and understanding within the 12-steps framework, the individual gains authority over diagnosis and treatment. The understanding of alcoholism as experiential precludes a medical diagnosis, so the individual via the 12-steps gains a greater understanding of his or her condition than doctors or mental health specialists. That is, a doctor can never understand alcoholism or addiction because individual experience and the higher power exist outside and above the medical purview. As such, medical authority is rendered secondary in the

journey toward sobriety. Individual recovery within the context of AA serves as a testament to the effectiveness of the 12-step model and the ineffectiveness of the medical community.

Geographers have similarly observed connections between geography, governmentality, and alcoholism in AA meetings, but in the context of rehabilitation centers, as opposed to independent group meetings. Wilton and DeVerteuil (2006; 2009) examine rehab contexts that were distinct outgrowths of the 12-steps program. Significantly, the two identify the spaces of practice within the rehab community. That is, rehab centers focus on shaping the day-to-day lives of their clients in a manner that creates a framework to mold sober behavior. The shaping of everyday life is considered key to rehabilitation. Wilton and DeVerteuil argue that such sites are key for carrying out governmental activities, namely surveillance and discipline. As the rehab center constructs a disciplinary framework for the client to recover from addiction, there is a close-in level of monitoring and self-monitoring on the part of the client. The rehab center offers a lengthy period of time wherein the discipline and surveillance practices of 12-step can be extended, beyond what would be typical of the regular AA group meeting. Furthermore, in most rehabilitation centers there are additional medical facilities and mental health services integrated into therapeutic landscape. Consequently, Wilton and DeVerteuil's analysis of the geographies of AA and 12-step programs is an imperfect comparison with AA groups in general. However, the characterization of discipline within rehabilitation therapeutic landscapes is useful in characterizing the geography of

12-step programs in general, as it explicitly links the AA therapeutic landscape with its disciplinary goals. That is, the disciplinary aspects of the AA meeting as a therapeutic landscape are evident in the practices and performances of its members. AA members attending the meeting reproduce and reinforce specific AA discourse concerning self-evaluation and self-regulation. Such actions serve as critical disciplinary and governmentalizing forces on participants. As I discuss below, the impact on the participants is manifest not only in the development and maintenance of an alcoholic identity, but also in their daily lives.

In exploring the links between the geography and governmentality of an AA meeting as a therapeutic landscape, we can categorize an interrelated set of practices within the space of the meeting. However, AA presents a hybrid series of techniques and approaches designed to broadly manage alcohol consumption among members (Valverde 1998; Valverde and White-Mair 1999). A key part of this hybrid technique is the construction of an alcoholic identity that centers on a conceptualization of alcoholism as both incurable and a fundamental part of the subject. Yet at the same time, the alcoholic identity is put forth as one designed to empower an individual, who is powerless in regards to his or her own permanent alcoholic condition. In this sense, AA and the 12-step model hinges on the problematization of the individual as opposed to the substance, as well as the societal acceptance of drinking. From this standpoint, the individual becomes the focus of governance.

The 12-steps are a set of self-regulatory practices designed to expedite the practice of self-regulation for addiction. Members intone, follow, and ultimately embody the 12-steps as a means of guiding and managing their addiction identities. As such, AA principles form a set of disciplinary practices that are similar to those which Foucault describes in his concept of governmentality (Barry, Osborne, and Rose 1996). To reiterate, governmentality as per-Foucault represents a complex means of regulating individual behavior. Through the 12-steps and the alcoholic identity, the governmentality aspects of AA are at work in the daily life of the individual as well as in the meetings they attend. The alcoholic identity is performed and takes shape in the everyday life of the individual in a set of strategies and practices that Marianna Valverde calls “the territorialization of the self” (Valverde 1998). In this sense, the body is colonized by an identity of alcoholism wherein the participant is performing the role of the alcoholic as well as the practices required of sobriety.

For Valverde, the territorialization of the self, and the embodiment of the alcoholic identity, is situated within spaces of habit. Territorialization of the self, to reiterate, describes the manner in which everyday life of the individual, his or her practices and strategies for living, is a performance that shapes the alcoholic identity. Habits then, are seen by Valverde as practices that occupy the body in the absence of drinking alcohol. Valverde describes habit as a bridge between body and practice, wherein the repetition of speech and action, including the act of testimonial as an alcoholic, reinforce a territorialization of the alcoholic identity (Valverde 1998). In this sense, habits can include

the repetition of the twelve steps and the performances involved in group meeting, which I address later. However, they also include such practices as smoking or drinking coffee, acts that occupy the body with activity in place of drinking. Therefore, self-disciplining activities that manage habit are a key part of understanding alcoholic identity, because they are governmentalizing behaviors that form the core of the territorialization of the self. Habitual actions such as smoking or drinking coffee by AA members are designed to replace a tendency to consume alcohol with alternate practices that occur through the body. Within such actions are fundamental aspects of governmentality, wherein the subject is constantly performing self-surveillance and self-regulation. Such observations are mirrored in the work of other geographers who focus on embodied practices and their connections to governmentality (Brown and Burges Watson 2009). Geographers such as Michael Brown (1997) have focused on governmentality in examining AIDS/HIV and citizenship, while Susan Craddock employed governmentality in looking at race and disease in early 20th Century San Francisco (Craddock 2000b).

Habit can therefore be understood as a series of practices through which the body materializes as governmentalized space. The body and the will of the individual are in this sense problematized by AA discourse. They are constructed as sources of risk, but also as means for overcoming alcoholism. Engaging with alternative habits is seen as an effective means of controlling alcoholism. At the same time, the cultivation of specific habits to replace drinking is not conflated with an overall avoidance of a situation where alcohol may be present. Significantly, AA members in their efforts to avoid drinking may

avoid social situations such as parties or gatherings. Instead, members often go to meetings, call their sponsors, or go to church or work. However, members are urged in meetings and by sponsors not to avoid social gatherings, even if alcohol is present. Within the context of AA and the 12-steps, members are told that they should view social occasions as a chance to practice exerting their will to sobriety. In this sense, AA discourse manifests a tension into the alcoholic identity, wherein the subject may be forced to embody alternative habits while being acutely aware of the risk. Through this tension, the subject engages in the governmentalizing actions of self-surveillance and self-regulation, though the regulating discourse is the 12-steps and AA discourse, and not a public health discourse.

The challenges brought about by the process of self-disciplining were described to me in the context of one interview. In particular, this participant described the contrast between his before and after identity, as he worked towards becoming sober. He related to me how the transformation from alcoholic to sober was synonymous with changing from a wild animal to a real person, and a recovery of their soul (interview):

Resident B: But for me, But for me, I have it the other way around. The sick person - who has alcoholism or drug addiction - his emotions outweigh (his rationality). First there are emotions, feelings, and only then - the mind.

Interviewer: Yes.

Resident B: It should be completely opposite. That is, the mind must ... must prevail and should control the feelings, so we do not jump around like wild beasts.

Interviewer: I see.

Resident B: So as to this - to this here, I could say, I'm trying to learn. I cannot do this by myself - to figure out this formula. Only by talking to people with the same, the same problems, with experts and relying on the will of God, only then will I be able. (08/28/2008)

The interviewee presented a strong notion of transformation through a narrative of rediscovered control. For the interviewee, transformation was achieved by asserting self-control over lifestyle and habit, and only via enablement from 12-steps discourse. As mentioned earlier, the interviewee's remarks echo notions of self-regulation and surveillance discussed by Foucault. He stresses the importance of working to correct behavior through monitoring himself and the surveillance of his fellow rehabilitation residents. In geographical terms, the central importance placed on practicing a constant state of self-control impacts the development of the therapeutic landscape on several levels. The therapeutic landscape as framed by AA is not a static place. Instead the AA therapeutic landscape manifests through the embodied practices of the subject. That is, the perpetuation of AA practices in everyday life also represents an ongoing production by the subject of a therapeutic landscape. Geographers have to a certain extent examined the therapeutic landscape and its various scales (Conradson 2003a; Wilton and DeVerteuil 2006). Conradson in particular suggested that the therapeutic landscape must be considered at a variety of scales, and therefore the body. As such, examining how AA promotes an everyday therapeutic landscape that governmentalizes the alcoholic body via the methods discussed above, we can extend therapeutic landscape literature by incorporating analytically the scale of the body.

I continue to explore the impact of the 12-steps and AA discourses are having in Russian therapeutic landscapes in chapter seven, when I discuss the rehabilitation center I visited. In doing so, I take a closer look at how AA discourse has been incorporated into therapeutic landscapes in Russia, and the influence it has had upon conceptualizations of alcohol-related illness. However, through an examination of AA in general, which has been the primary focus of this chapter, I have emphasized the significance and uniqueness of AA and the 12-steps for public health conceptualizations of Russia. In the preceding section in particular, I have identified that AA and the 12 steps present a distinct governmentalizing series of practices and discourses that do not fit easily in the Russian public health context. In the following chapter, I explore in more depth the Russian public health system of narcology that is in many ways an antithesis of AA and 12-step programs.

Conclusion

The main goal of this chapter has been to examine how AA and 12-step programs play a significant role in the problematization of alcohol as a public health issue in Russia. I sought to demonstrate as such by showing how AA and 12-step programs work through various geographies to discipline and regulate subjects. The therapeutic landscape of AA relies on a specific set of governmentalizing practices. In examining the therapeutic landscapes of AA, I show how AA uses disciplinary practices to shape conceptualizations of alcoholism for its members.

I focused particularly on highlighting the role of AA in the production of alcoholic identities and how it shapes concepts of rehabilitation. The experiences of those who have

relied on AA show the significance of AA's contribution to public health in Russia. That is, AA is critical in the production of therapeutic landscapes within Russian public health geographies. AA therapeutic landscapes are systematically reproduced as AA groups and members work together to reproduce and reinforce discourse and practices within hospitals, clinics, and other areas throughout Russia. As I have shown, the production of therapeutic landscapes that are specific to AA leads to the formation of distinct public health geographies where AA methods and practices are key components of the recovery process. I therefore sought to explain how AA therapeutic landscapes impact contemporary Russian public health by shaping conceptualizations of alcohol-related illnesses and treatment.

I began this chapter by discussing the history of AA and the 12 steps-program. In doing so, I demonstrated how entrenched governmentality aspects of AA can be traced back to its foundations. I also discussed the history of AA within Russia. Understanding the ways in which AA is perceived in Russia helps to explain why it has experienced difficult and slow growth in Russia. Furthermore, demonstrating the troubled history of AA in Russia helps elucidate the influence of narcology on public health in Russia. That is, many of the obstacles to AA expansion in Russia are outgrowths of narcological conceptualizations of alcohol-related illness and their predominance in Russian public health.

Finally, I focused on the different spaces through which AA produces self-governing subjects. In this respect, I looked at the experiences of Russians who are AA

members. At the same time, I also focus on geographic aspects of AA through which surveillance, regulation and discipline take place, particularly the AA meeting. Through examining both participants and the geographies of surveillance, I highlight how the discourse of AA shapes participants views of their own alcohol-related experiences. I simultaneously illustrate the connections of power and discipline that give structure to Russia's geography of public health and alcohol. I argue that understanding the geography of AA is central to understanding the geographies of Russia's public health response to alcohol abuse in general. Specifically, an analysis of AA establishes a distinct therapeutic landscape for treating alcohol abuse in places such as the addiction clinic and rehabilitation center.

Chapter V

Narcology

In this chapter, I examine the therapeutic landscapes of Russian narcology. Narcology is the Russian science of addiction, and the most common treatment approach in Russia for alcohol-related illnesses (Elovich and Drucker 2008). Narcological approaches to dealing with alcohol related illnesses are based upon a particular understanding of alcoholism and addiction, and treat addiction through a combination of detoxification, chemical aversion therapy, and hypnotic suggestion (Babayan and Gonopol'skii 1987; Mendelevich 2004a; Raikhel 2010). Such approaches underpin treatment practices focused on substance abuse throughout Russia (Fleming, Meyroyan, and Klimova 1994). By examining narcology's therapeutic landscapes, I show how narcological treatments have materially and discursively shaped the public health response to alcohol-related illness in Russia.

In part, narcological therapeutic landscapes are physically restricted to clinical settings, particularly the narcological hospital and the narcological dispensary. As I discuss below, the physical treatment of addiction in narcology is wholly contained within a medical setting. However, I also demonstrate that such strictly bounded treatment settings, combined with the narcology's underlying focus on individual treatment, have had an impact on society at large and public health related issues in particular. As I argue, narcological approaches have restricted public health responses to alcoholism in Russia. That is, narcology has critically shaped perceptions in Russian society of alcohol related

illnesses. In particular, I argue that narcology has complicated the contemporary development of Russia's public health response to alcohol-related illness through particular flawed conceptualizations of alcoholism and addiction as the central components of alcohol-related illnesses. That is, the discourses and practices of narcology limit the extent to which alcohol-related illnesses can be conceptualized as a public health problem. I argue that such limitations are the product of a bio-politics of addiction and alcoholism in narcology that stresses individual responsibility for alcohol-related illnesses while simultaneously silencing the role of social and environmental factors. Such emphasis on the individual fault has had the added effect of justifying punitive treatment methods for dealing with alcohol-related illness. The narcological therapeutic landscape therefore has had a long history of focusing on the individual and combining treatment with punishment. Just as important, however, is that the impact of narcological science in shaping alcohol-related illnesses through a stigmatized conceptualization of alcoholism that has been broadly discursively and materially influential.

In evaluating narcology's therapeutic landscape, I focus first on its origins as a branch of Soviet psychiatry. The emergence of narcology from Soviet psychiatry helps explain the preeminence of individual responsibility in portraying issues of alcoholism and addiction, and a concurrent de-emphasis on environmental and social determinants. In this sense, by describing the origins of narcology and its therapeutic landscapes, I establish the underlying bio-politics of Russia's contemporary public health response to alcohol-related illness. As I describe below, the narcological emphasis on personal

responsibility, fomented in the political context of Soviet society, shaped alcohol-related illness as a moral hazard (Raikhel 2010). The immorality of alcohol related-illness validated the construction of therapeutic landscapes that stressed punitive approaches toward treatment subjects (Mendelevich 2004a). Such punitive approaches to alcohol-related illness materialized through hospitals and dispensaries, as well as through workplace reporting and rehabilitation labor camps (White 1996; Gilinskiy and Zobnev 1998). As I argue below, punitive approaches to alcohol-related illnesses were further emphasized within therapeutic landscapes via the narcological perspective of addiction in general. The implementation of the narcology service, combined with Soviet policing strategies, further shaped perspectives on substance abuse as criminal behavior and mental illness. At the same time, I demonstrate the manner in which narcology established the discursive and material boundaries around concepts of alcohol-related illness that are crucial in the contemporary public health sphere.

In order to understand how narcological therapeutic landscape have shaped contemporary public health perceptions, I examine the experiences of individuals who have either received or provided narcological treatment for alcohol-related illnesses. I focus on the experiences of subjects and practitioners in order to elucidate the practices and discourses of the contemporary therapeutic landscape of narcology. I also examine narcological approaches used in private clinics to deal with alcohol and addiction, such as *kodirivanie* (coding - a form of hypnotic suggestion) (Parfitt 2006; Raikhel 2010; Babayan and Gonopol'skii 1987). In examining individual experiences and contemporary spaces of

treatment, I discuss how the narcology system continues to emphasize individual approaches to dealing with addiction. In doing so, I demonstrate how discourses and practices of treatment in narcology's therapeutic landscapes are central to the conceptualization of alcohol-related illnesses in Russia. Furthermore, in investigating narcology's therapeutic landscape, I evaluate how its discourses and practices, particularly in regards to alcoholism and addiction, have produced limitations on Russia's public health response to alcohol-related illnesses.

I conclude by addressing briefly some of the recent changes regarding treatment for alcohol-related illness that have occurred in the therapeutic landscape of narcology. In particular, the emergence of AA in hospitals and narcology dispensaries signals that narcology is undergoing a reevaluation, albeit limited, of the concepts of addiction and alcoholism. I examine how narcological perspectives on addiction have changed incrementally and how some narcologists are adopting new treatment methods, which incorporate social and environmental determinants of alcohol-related illness. I demonstrate that the limitations narcology places on public health approaches to dealing with alcohol-related illness are neither static nor inflexible, and instead they are slowly changing to incorporate social and environmental perspectives regarding alcohol-related illness.

The science of narcology

In this section I focus on the history of Russian narcology. I first focus on describing the role narcological discourse played in shaping treatment methods during

the Soviet period. I demonstrate the manner in which the science of narcology discursively and materially constructed alcoholism and alcohol abuse. Specifically, I emphasize the way in which narcology problematized addiction through concepts of alcoholism and alcohol abuse, and how such efforts led treatments in psychiatric hospitals and dispensaries. Furthermore, I demonstrate how the emergence of punitive treatment approaches informed by narcology reinforced concepts of alcoholism and abuse, and were shaped by therapeutic landscapes and public health conceptualizations of alcohol. In doing so, I argue that narcology's problematization of alcoholism implicitly prevents the contemporary extension of public health interventions beyond the dispensary and the hospital.

The foundations of narcology are rooted in Soviet psychiatric circles of the 1920s and 1930s. During this period, Soviet psychiatry focused on Ivan Pavlov's understanding of the link between mind and body (Graham 1998a; Petryna 2002). While Pavlov was not directly interested in explaining addiction, his theories formed the basis for psychiatrists to address addiction and alcoholism as mental and behavioral disorders (Raikhel 2010). The Pavlovian diagnosis and treatment model heavily emphasized aversion therapy and hypnotic suggestion as a means of curing the patient of addiction. Pavlov's theories in the early Soviet period set the stage for the heavy usage of aversion therapy and suggestion that would become hallmarks of Russian narcology and shape the narcological therapeutic landscape.

The rise to preeminence of psychiatry and Pavlov's theories in early Soviet alcoholism and addiction studies was a product of the political circumstances of the period (Beer 2007; 2008; Graham 1998a; Petryna 2002; Raikhel 2010; 2011). In the post-Revolutionary period, there were numerous competing ideas regarding alcohol as a public health problem. Some models identified social and environmental factors, including poverty and living conditions, as the root of a majority of alcoholic cases (Beer 2008). In this sense, scientists argued that class and standard of living played a key role in predicting the likelihood of alcoholic behavior. In contrast, psychiatric and disease model advocates maintained that alcoholism was a psychosis that required medical care. That is, the ultimate source of the alcoholism was not environmental and social, but internal and biological. Adherents of this latter perspective identified alcoholism as a disease or mental illness that could be cured. Those who emphasized the disease and mental illness diagnosis drew upon Pavlov's experimentation and analysis of behavior. A mental health or psychiatric diagnosis of alcoholism downplayed social factors as influential in producing alcoholic behavior. Causal factors were instead placed within the psyche of the individual.

The emphasis on individual illness contrasted sharply with the early Soviet state's communist ideology that emphasized societal conditions and class difference as the root of health problems (Graham 1993; Beer 2008). However, by the end of the 1930s, the Pavlovian psychiatric explanation for alcoholism was ascendant in Soviet public health despite this apparent conflict between scientific explanation and political ideology. In

essence, by the end of the 1930s, the social model was not politically salient in the ideological structure of the Soviet system (Beer 2008). Since alcoholism had not been eliminated by the Soviet state, any public health model that focused on social conditions was inherently an indictment of the Soviet system itself.

The psychiatric model based on Pavlov's theories instead emphasized a link between mind and body. The Pavlovian explanation of the addiction and alcoholism problem excused the state from responsibility by pointing to inherent biological and psychological problems on the part of the individual (Petryna 2002; Beer 2008; Rechel et al. 2011b). Therefore, narcologists focused on treating the mind to affect the body, specifically through the subconscious and the power of suggestion (Elovich and Drucker 2008). The primacy of the narcological approach to treating alcohol abuse and alcoholism shaped Soviet public health approaches to addiction in general. Informed by narcology, therapeutic landscapes emerged in the Soviet period that were primarily focused on psychiatric hospital treatment (Fleming 1991). The psychiatric hospital was a location in which the body and behavior could be simultaneously controlled. The therapeutic landscape for alcohol related illnesses was therefore established and spatialized in the specific health geography of the hospital. As I address later, the early therapeutic landscape of the hospital would broadly influence the contemporary narcology approach to treatment. Besides, the specific space of the hospital, however, narcology was also productive of unique treatment methods such as 'coding', which I describe next.

The narcological approach to treating alcoholism is most clearly represented in the process of 'coding', or *kodirivanie*. 'Coding' describes a narcology treatment process whereby a patient undergoes treatment to 'cure' addiction, through a combination of aversion therapy, chemical treatment, and post-hypnotic suggestion (Raikhel 2010; Elovich and Drucker 2008; Mendelevich 2004b). The process of coding reinforces the anatomo-political aspect of narcological treatment by stressing direct physical discipline of the patient in an effort to affect behavior. In this manner, we can see the anatomo-political impact of medicine as described by Foucault (2003b), wherein he describes the direct physical application of authority on the subject. In particular, we can see in the process of coding the construction of an alcoholic body by the science of narcology. By alcoholic body, I mean that the space of the hospital and the coding clinic provided a geographical nexus wherein the discourse and practice converged to materialize an idealized alcohol subject that was particularly understood through the body. Therefore, the therapeutic landscape of narcology, in both hospitals and coding, was productive of not only a discourse of alcoholism and abuse, but also alcoholic subjects. Such subjects came to not only be understood as alcoholic or deviant, but also understand themselves and their relationship to alcohol through narcological discourse.

Furthermore, we see the health geographic process, the control over space and its infusion of authority, wherein the treatment and perception of the disease are co-constitutive (Brown and Knopp 2010). The narcological therapeutic landscape based on coding is constituted wholly within the clinical setting wherein therapy is dispensed

through medical authority. In fact, treatment for alcohol abuse and alcoholism is conceived of as possible only under the supervision of medical authority. The therapeutic landscape of coding and narcology in general simultaneously establishes alcoholism as the illness by way of establishing the limitations of alcoholism treatment, so that treatment is conceptually restricted to the clinical setting.

As described above, narcology shaped alcohol-related illnesses through the contexts of alcohol abuse and alcoholism. In doing so, the geography of treatment, whether via detoxification at the hospital or through coding, also shaped the issue of alcohol as a social issue. Additionally, the discourse of narcology also therefore shaped broader responses in society to alcohol-related illnesses. As the emergence of the psychiatric explanation for alcoholism demonstrates, throughout the Soviet period, addiction and alcohol-related illnesses were politically and ideologically shaded. The biology of the individual, rather than the social environment was the target of narcology. As a result, treatments developed wherein individuals diagnosed with alcohol related problems were seen as responsible for their own condition. In practice, the Soviet narcological perspective grew into a moral framework for understanding alcohol abuse and addiction in general. The Soviet moral framework of narcology presented alcoholism as a personal fault predicated on biological and psychiatric inadequacy (Mendelevich 2004a; 2007a). The focus of narcology's therapeutic landscape was curing addiction and restoring the 'will' of the individual (Raikhel 2011). In this sense, addiction was morally and politically stigmatized and conflated with selfishness and egoism. As a result, the

political and moral stigmatization of alcoholism further validated legal responses and punishments for addiction. The alcoholic body became a site of punitive governance and abuse, as the subject was constructed as a threat to society.

To reiterate, narcology's moral framework emphasized the psychiatric and biological determinants of addiction, and placed social (especially Soviet society) and environmental determinants of disease in an unassailable position, epidemiologically speaking. The social sphere instead was constructed as threatened by the disease of addiction, and not a contributor or cause of the condition (Beer 2007). The alcoholic individual, as the embodiment of addiction, was therefore a threat to society. Alcoholics were legally codified as anti-social parasites. For example, in a 1961 legal decree, "On strengthening the fight with people who avoid community service and lead anti-social parasitic lifestyles" (Presidium RSFSR 1961)³, the Soviet government presents the condition of alcoholism as explicitly threatening form of social deviancy. Alcoholics and alcohol consumption therefore became the focus of not only medical discipline, but juridical discipline as well (Fleming 1991; Gilinskiy and Zobnev 1998; White 1996).

In this sense, we see the development of a bio-politics of addiction, wherein a moral framework surrounding the condition of addiction is developed within the context of population health (Lupton 1995; Petersen and Lupton 1996). The emergence of a bio-politics of health in the Soviet period is similar to that discussed in critiques of NPH, in

³ Alcoholic consumption is directly identified in the law as the primary cause of "anti-social parasitic lifestyles": "The parasitic existence of these individuals, as a rule, is accompanied by drunkenness, corruption and the violation of rules of socialist society, negatively affecting other unstable members of society."

that a broader risk to the population becomes a rationale for a series of social interventions. In particular, the bio-politics of addiction as developed through narcology allowed for a broad anatomo-political response to substance abuse in general, and alcohol specifically. An antagonistic state response toward addiction emerged in which therapeutic landscapes were rationalized in ways that penalized the alcoholic or addicted body and continued to influence contemporary public health.

To reiterate, the moral stigma attached to alcoholism by narcology validated punitive approaches to alcoholics, addicts, and excessive drinking by Soviet authorities. Three common practices highlight the punitive nature of the Soviet attitude toward alcoholism and binge drinking: workplace reporting, the police drunk tank, and the labor rehabilitation camp. During the Soviet period, treatment for alcoholism was not anonymous. Soviet authorities reported individuals in treatment, voluntary or compulsory, to their place of work. Workplace reporting held the potential of causing further disciplinary actions for the individual as well as public humiliation. In this sense, workplace reporting stigmatized treatment for addiction and alcoholism, as it became recognized as a public device for shaming and disciplining individuals. The history of workplace reporting has been argued as a reason why Russians remain reluctant to seek help for substance abuse (Clinic staff meeting, 08/17/2008). While not a therapeutic landscape per se, the practice of workplace reporting illustrates the punitive attitude of the state toward alcoholism and alcohol abuse, and its efforts to mold behavior in the population.

In addition to workplace reporting, the police drunk tank further exemplifies the punitive approach of the state to alcoholism and alcohol abuse in general. The drunk tank has been a primary punitive response to dealing with alcoholics and public drunkenness in Soviet and Russian history (Fleming 1991; Connor 1972). Just as with treatment cases, the authorities were obliged to report individuals to their workplaces if they had been picked up for drunkenness (Volunteer, 08/23/2008). Incarceration at the drunk tank similarly served the additional purpose of providing a platform for publicly shaming alcoholics and alcohol abusers (Mendelevich 2004a). Both the drunk tank and medical treatment in the Soviet period established the precedent wherein alcohol abuse was a condition to be penalized rather than treated.

The punitive approach to alcoholism and alcohol abuse further evolved in 1960s. Regional Soviet authorities began opening labor camps for addicts in response to addiction and alcoholism problems. Therapeutic-Labor Prevention camps (LTP)⁴, as they were called, were designed to treat addiction through forced labor (Fleming 1991; Kirn 1987; Anderson and Hibbs 1992; Salus International Health Institute et al. 1997). Labor was viewed medically as a viable means of curing individuals of addiction, and LTP were seen as important centers for curing addiction (Babayan and Gonopol'skii 1987). The incarceration of individuals suffering from addiction or alcoholism was seen as valid because such individuals were engaged in criminal behavior. As geographers and others

⁴ LTP is an abbreviation for Lechebno-Trudovoi Profilaktirii/*Лечебно-Трудовой Профилактирий* (Therapeutic-Labor Prevention)

studying the Soviet period have noted, forced labor was rationalized as a crucial form of moral and political rehabilitation (Graham 1993; Petryna 2002; Connor 1972; Round 2006; DeVerteuil & Andrews 2007). The LTP system therefore, provides an additional illustration of how the Soviet state dealt with alcoholic related illnesses. The medically problematized subject, the alcoholic body, was also an object of moral sickness as well. The conflation discursively of the medical and the moral helped establish the foundation for the establishment of the LTP system. Within the LTP system a strict disciplinary regulation of deviancy could take place. While the LTP system was closed in 1994, there have been calls to reopen the system, most recently by the Chief Medical Officer and Head of the Federal Service for Consumer Protection and Welfare (*Rospotrebnadzor/ Роспотребнадзор*) Gennady Onishchenko (RIA Novosti 2012).⁵ Onishchenko's position on restarting the LTP system reinforces the perception that narcological diagnoses of alcohol abuse and alcoholism focus only on individual deviance rather than complex social issues.

In the examples of the police detox tank, the LTP camp, the psychiatric hospital, and workplace reporting we see how the narcology shaped the therapeutic landscapes that were dependent on punitive forms of anatomo-politics. That is, in such spaces, if we follow Foucault, the object of treatment and discipline through direct physical action is designed to reform an individual into normal activity and behavior (Foucault 1995; 2003b). In all the above spaces, the disciplinary action exists to have impact on the

⁵ Onishchenko claimed that a recent UN report endorsed the return of the LTP system, although the report made no explicit mention of the camps or the LTP system.

alcoholic body; a space sanctioned for strict punishment and behavior modification (Elden 2006a; 2007; Garmany 2009). Such punitive geographies of alcohol-related behavior served as methods of bio-political control of the population, demonstrating the risk of unsanctioned behavior. The role of anatomo-politics in medical institutions closely mirrors geographers' analyses of public health geographies. In this sense, work by geographers Michael Brown and Larry Knopp (2010) in their work on STD treatment in mid-Twentieth Century Seattle address the restrictive measures taken to affect bodies viewed as dangerous to the general population. Also, Rob Kitchin and Una Crowley (2008) address the anatomo-political factors at work in Irish Magdalene asylums, and their goal of constructing particular femininities. In both examples, as with the therapeutic landscapes that emerged from narcology, the goal of discipline emerges as a key means of establishing medical effect upon problematized behavior.

The punitive therapeutic landscapes of narcology that developed during the Soviet period have had important ramifications for contemporary Russian public health. In particular, narcological perspectives have helped reinforce notions of alcohol abuse and alcoholism as criminal behavior. Furthermore, by emphasizing the criminality of alcoholism and alcohol abuse, the narcology system reinforces obstacles to constructing alcohol as a public health hazard. That is, the earlier role during the Soviet period of the juridical management of problem drinking, signifies the difficulty in categorizing alcohol abuse and alcoholism as public health problems. Instead, the consumption of alcohol is an individual problem, and the extent of public health involvement is limited to the

treatment of addiction and poisoning. As I demonstrate in the following section, the carryover of narcological perspectives and therapeutic landscapes into the contemporary moment has had broad impacts for Russian public health approaches to treating alcoholism and alcohol abuse.

The contemporary narcology system

In this section, I describe contemporary narcology's therapeutic landscapes. In doing so, I begin with the emergence of the narcology service in the late Soviet period during the 1970s and 1980s. The current narcology service has directly inherited many of the institutions and practices that emerged during the Soviet period (Fleming, Meyroyan, and Klimova 1994; Fleming 1996; Vankon and Vankon 2007; Zobin 2007). Treatment practices at narcological therapeutic landscapes continue to treat alcoholism as a problem of individual psychosis. In doing so, contemporary narcological practices discursively construct boundaries and limitations around public health conceptualizations of treatment. In examining the contemporary therapeutic landscapes of narcology, I identify the manner in which narcological discourse forecloses discussion of expanded public health responses to alcohol-related illnesses. I describe the contemporary narcological therapeutic landscape by focusing on the experiences of individuals who have been treated or worked in the narcology system. In particular, I focus on individuals treated by coding, in order to demonstrate the materialization of narcological limits to treatment. I conclude by identifying several ways in which narcological therapeutic landscapes are beginning to change under the influence of New Public Health (NPH) transformations

and AA-influenced self-help groups. Despite such developments, I argue that narcological discourse and practice complicate the expansion and transformation of public health approaches to alcohol-related illnesses.

The Soviet period of public health from the 1920s to the 1960s witnessed the development of narcological sciences (Babayan and Gonopol'skii 1987; Waters and Thom 2008; Kozulin 1984). Beginning in the 1970s, narcological sciences were coordinated into a broader official narcology service (Kirn 1987; Fleming 1991). The narcology service was initiated and expanded as Soviet authorities struggled to cope with the impacts of drug and alcohol problems in Soviet society. The impact of substance abuse in general, and alcohol abuse specifically, on the population was blamed for demographic and economic problems (Feshbach 1984; Feshbach 1982; White 1996). Earlier public health efforts designed to mitigate the impact of alcohol abuse on the population, such as psychiatric hospitals and the LTP system, proved ineffectual (Fleming 1991). It was in this context that the number of existing psychiatric hospitals was expanded and combined with a network of special narcological clinics, called dispensaries, designed to deal with Russia's burgeoning addiction problem. Narcology dispensaries are neighborhood service points where ambulatory cases are diagnosed and referred to hospital specialists; patients can also come and pick up medications and go to follow up appointments (Babayan and Gonopol'skii 1987). Narcology hospitals, in contrast, are sites designated for primary treatment, primarily the detoxification of patients. The narcology system grew throughout the 1970s. During the 1980s, the number of narcology hospitals and dispensaries greatly

increased in conjunction with Gorbachev's anti-drug and alcohol campaign (White 1996). At the same time, the Soviet government continued to rely on the LTP camps, as well as workplace reporting for treatment or incarceration, in an attempt to discipline the population into lower rates of consumption.

The inauguration of the narcology service witnessed an expansion in the number of psychiatric hospitals as well as narcology dispensaries. In such locations, narcological methods for dealing with alcoholism focused on treatment methods previously discussed: a combination of detoxification, chemical aversion therapy, and hypnotic suggestion. The hospitals and the dispensaries were places where the deviancy of the alcoholic or addict was medically confirmed and the goal of narcology, its cure, was to resolve the underlying psychiatric deviancy. In the same way that Soviet public health constructed the addict or alcoholic as a biological problem and a social deviant, the patient at the narcology hospital was treated as one (Beer 2007; 2008). Therefore, the expansion of narcology treatment via the narcology service, particularly via the neighborhood clinics, did not change the underlying assumptions about alcohol-related illnesses in general.

Since the collapse of the Soviet Union, narcology has remained focused on treating addiction and alcoholism with ideas grounded in Soviet period (Elovich and Drucker 2008). The psychiatric basis for narcological approaches has remained consistent. As such, the primary approach of the narcology service is psychiatric treatment. Typically, treatment occurs at the hospital, where individuals are subject to a series of aversion-based and hypnotic therapies. Significantly, however, the LTP camps were closed in 1994

(Salus International Health Institute et al. 1997). The closure of the camps signaled an end to labor-based initiatives for treating alcoholism, but as I discuss below, it did not change the underlying limiting nature of the narcology service, nor did it remove the moral stigma attached to alcoholism that developed across years of punitive responses by the state (Mendelevich 2004b). Additionally, a growing number of private clinics that provide treatment are based upon narcological methods (Raikhel 2010; 2011). In this sense, the therapeutic landscape of narcology has expanded by becoming available as a privately offered treatment method. However, as I demonstrate below, such treatment further reinforces the significant punitive aspects employed by narcological methods.

In attempting to understand the limiting aspects of narcology's therapeutic landscapes I focus on the experiences of individuals treated at narcology hospitals and dispensaries. Interviewees' perceptions of their experiences at narcology service centers were varied. However, all the individuals I interviewed who had been treated at one or more narcological hospitals or dispensaries, expressed that the attitude among the staff played a significant role in their experiences. In this respect, study participants were referring to how they were treated within the therapeutic landscape.

Perceptions of narcology varied among interviewees. A volunteer at a private rehabilitation center, who had been treated for drug addiction in a Moscow hospital in the 1980s, generalized narcological hospitals as poorly run places of physical and emotional abuse (Volunteer, 08/23/2008), mirroring comments by Fleming (1991) in his account of his tour of Soviet narcology facilities. This perception was echoed by Resident

D (2008), who joined the conversation, and characterized the staff at a hospital in St. Petersburg where he was treated for alcohol addiction as scornful toward their patients. Both the volunteer and Resident D recounted that nurses and doctors regularly told patients that they were selfish and a waste of resources (interview 2008). Additionally, both participants identified that there were no additional supporting services once the detoxification program was complete, excepting court orders that mandated regular visits to dispensaries for progress evaluation. The lack of additional resources affirms observations in other assessments of the narcology system (e.g., Mendelevich, (2004b), by authors critical of the narcological service's refusal to expand support services to recovering addicts. According to Resident D, these attributes were not uncommon in regional treatment centers. He characterized the narcology hospital for Moscow Oblast' (as opposed to the city) as poorly equipped and staffed (interview 2008).⁶

In contrast, several interviewees described that the treatment services offered in Moscow as being more advanced (Polyatykin 2008; Protsenko 2008). For example, Hospital 19 in Moscow was characterized by several interviewees as a better institution to receive services, despite lacking resources. Specifically, Hospital 19 was characterized by clinic staff interviewees as using a broader approach toward treatment and recovery than other rehabilitation facilities in Moscow. As part of this broader approach, Hospital

⁶ Resident D had been in a narcology ward in St. Petersburg, while the volunteer experienced treatment during the early 1980s. As such, their claims could not be verified during my fieldwork. However, both claimed to have experience visiting the Moscow Oblast' narcology hospital and working with recovering addicts who had received treatment there. Additionally, the subjects' views were informed by their grounding in Orthodox Christian belief, which may have colored their impressions of institutions associated with the Soviet State.

19 integrated Western approaches to substance abuse and addiction with narcological approaches. Consequently, patients at Hospital 19 had access to additional services besides basic detoxification and coding. In that sense, Hospital 19 served as a place that can connect patients with resources for staying sober such as AA groups, NGOs focused on helping recovering addicts, or rehab centers. Some of the transformations in the Moscow city hospitals were initiated in the 1990s. During 1996, the Moscow city government mandated the extension of patient services, like AA, to all narcology clinics and hospitals (Salus International Health Institute et al. 1997). In this effort, the Moscow Health Department initiated an approach to treating addiction and alcoholism that extended counseling and AA services. As of yet, such services are only available at Hospital 19 and the narcology clinics in the Southwestern District, which I address in chapter six.

Hospital 19 was regarded as exceptional, and narcology hospitals and clinics in other areas of Russia were characterized as poor in terms of resources and services. The claims made by interviewees mirror findings by other scholars in the field (Elovich and Drucker 2008; Mendelevich 2004b). The reports produced by these scholars characterize narcology hospitals as akin to prisons, where physical abuse is frequent. In this sense, there is blatant punitive anatomo-politics in the narcology therapeutic setting, wherein individuals are not only blamed, but physically punished for their condition.

Resident B, however, provided a contrasting assessment in relating his positive experiences in narcological treatment at a regional hospital. He characterized staff as open

to employing or recommending other options for recovery, including religious charities or 12-step programs. Despite providing limited services, he described the staff as caring and friendly, and invested in his recovery. The following excerpt is from an interview with Resident B who stayed at a hospital in Vladimir (a city northeast of Moscow), and helps to illustrate such positive experiences:

My doctors remembered me, and they were very cordial ... they felt for me. I was in the hospital at my own request - I asked them for the 21 day treatment, and I asked not to be discharged, because I was afraid to go outside - I was there two and a half months...The doctors - the doctors, well, they were supportive. Although they officially had no right to keep me more than 21 days, but they did so at their own risk, they helped me.
(Resident B, 08/28/2008)

As the interviewee describes above, he had a positive experience at the hospital and was treated well by the staff, whom he characterized as sympathetic. He even claims they violated administrative policies by allowing him to stay longer than the 21-day limit. At the same time, however, his experiences also highlight important factors about the fundamental principles of the narcology service. First, the therapeutic landscape of narcology is limited to the clinical setting. Not only could Resident B not remain at the center, there were no further treatment options offered to him when he was discharged. Again, the standard approach to treatment within the narcology framework is to focus treatment in clinical settings only (Mendelevich 2004b; Elovich and Drucker 2008). In his description of his experience at the hospital, Resident B later relayed his fear of being discharged:

By request... by request of the patient - (the stay) can be extended. So, I asked, he - extended. I explained to (the doctor) that I'm afraid I'll break again, drink, I'm very afraid of delirium tremens, and simply, well, I understood that I was no longer in control. And in the hospital there was at least some control over me. So, the staff was very friendly (Resident B, 08/28/2008).

In this quote Resident B identifies his appreciation for the staff and their overall positive disposition towards him. However, he also expresses his desire that he had remained under supervision, which highlights the anatomo-political aspects of the hospital. That is, the subject is the focus of control and surveillance.

Nevertheless, the narcology system has also shown some evidence of change in regards to treatment. For example, Resident B also noted that he was able to apply to his present rehab program because of a priest on the premises of the recovery ward. To reiterate, a central complication of narcology is its focus on treating the patient and curing alcoholism almost entirely within in a hospital or clinic setting. The therapeutic landscape of narcology is therefore limited to the clinic and the hospital without any additional support services available beyond the clinical setting. Furthermore, narcological discourse limits public health engagement with alcoholism, such as AA for example. The following quote from a resident at a rehabilitation clinic, who had been treated in a narcology hospital for alcoholism, illustrates the limits of narcological therapeutic landscapes:

And two years ago (2006) I was already on the grounds of alcoholism - frequent binges, I could drink a lot then, I could drink for a month straight- I was already beginning to have ... beginning to have hallucinations. Psychosis, delirium tremens ...Well, the first time, then, I ended up in the narco-dispensary- in the hospital. Well, then, when I left - fully treated, the doctors, well, they sort of helped, but ... but

alcoholism is that sort of illness, medicine is powerless! And alone, I could not deal with it. (Resident B, 08/27/2008)

In the above quote, Resident B describes his experience with narcological treatment. The therapeutic landscape of narcology consists of treating the patient for delirium tremens and then releasing him. Significantly, the resident's view of alcoholism and medicine is grounded in Alcoholics Anonymous discourse, as at the time he was participating in a 12-step program. Therefore, his narration provides a significant bias against narcological medicine, in that he does not recognize that any medicine can truly treat alcoholism. However, he also addresses the limits to narcological therapeutic landscapes. In this sense, his experience illustrates the limited nature of treatment by stressing the bounded nature of the landscape. Only within the clinical setting of narcology is treatment for alcoholism practiced, and narcology offers no treatment beyond what occurs at the hospital or clinic. Consequently, the therapeutic landscape for narcology is limited. That is, the therapeutic landscape of narcology is fully contained within the clinical setting. At the same time, narcology limits the growth of public health approaches to treating alcohol abuse and alcoholism because it does not recognize the significance of social and environmental factors. As conceptualizations about alcoholism in Russia change, especially under the influence of NPH and AA (as I address in later chapters), the narcology service has been increasingly criticized as an inadequate response to alcoholism because it ignores the social context and reduces the problem of alcohol related harm to individual biology (Raikhel 2011; Elovich and Drucker 2008; Mendelevich 2004b; 2007a).

The limits of narcology, treating the individual and then letting them go, is most clearly represented in the case of the coding process. Characterized as *khimzashchita* (literally chemo-defense) (Raikhel 2010), the process is part placebo therapy and part psychological suggestion. *Khimzashchita* demonstrates the limited nature of narcology by stressing treatment as a process that is totally dependent upon clinical expertise and the subject's submission to medical authority. Several authors have reported on the reliance of post-Soviet narcologists on suggestive therapies in combination with chemical treatments that are actually placebos (Kirn 1987; Elovich and Drucker 2008). Several interviewees had already undergone treatment with placebo therapy, which they referred to as the *torpedo*. The following statement from an interview with one study participant is worth quoting at length in order to illustrate the coding process and the typical experience of an individual with narcology-based methods of treatment. Resident C lives in a rehabilitation clinic, which I address more thoroughly in chapter six. In the first part of the interview, he discusses the beginning of the coding process at a private clinic:

Well, specifically with me, - a narcologist-woman worked with me - no, they were not indifferent, but, basically, how to say? ... Well, it seemed to me, that for her - it was all the same - like a conveyor belt. One person after the other and she led them into the office and to all of them - the same thing, to all - the same thing. Of course, in her words that: "So, you will see that with your brain, it will be like this, that you will die, that all alcohol is poison from now on." So. And with another I - in another room I was talking with the narcologist. He said: "It depends," he said, "on you. These injections," he said - "this is only your impression." So. "The injections, he said ... affect nothing!" That is, it is your perception. So, if you yourself believe that it really affects you, you might ... And, on the other hand, he said, this, he said, well - it is your perception. Although I signed off - they give you a form that you have been warned that something might happen

to you. That is, it is self-deception. Auto-suggestion, almost hypnotized (Resident C, 08/27/2008).

There are several important factors to take away from his description. Resident C is responding to a question I raised about his treatment at the dispensary. As I address later in this chapter, there is a wide range of individual experiences in narcology. Some interviewees expressed their gratefulness for the care they received, some observed indifference, and others found themselves treated poorly. The diversity of such accounts does not contradict the general anatomo-political nature of the narcology system. In that sense, the therapeutic landscape produced in the coding process positions the patient as the object of intrusive medical discipline.

Of additional importance in the above quote is the participant's description of being introduced to the coding process. He describes his initial interactions with two medical staff and additional patients. In doing so, he relates a significant contrast in the reported speech of the two medical staffers. The first narcologist reinforces the effectiveness of aversion therapy and coding by stressing the danger of using alcohol for the participants following the coding process. It is common practice for narcologists to inform the patient that, after being coded, they will die if they consume alcohol (Kirn 1987; Babayan and Gonopol'skii 1987; Vankon and Vankon 2007; Raikhel 2010). Again, coding is a combination of aversion and suggestive fear-based treatment that draws attention to psychological and existential threats to patients. In this sense, narcology represents a

harsh disciplinary process that acts upon the body, again foregrounding anatomo-political practices as essential to the therapeutic landscape.

However, Resident C explains that the second clinic doctor stated that the coding process is a matter of perception on the part of the patient. In particular, Resident C reports being told by the doctor that the injections are essentially ineffectual. The injections Resident C refers to in the quote are colloquially called *torpedo*, and as I mentioned earlier, usually are placebos. That said, clients are told that these injections contain vitamins to cleanse the body of toxins, and also alcohol antagonists, chemicals that make the client allergic to alcohol. In the case of Resident C, however, the second doctor informed him that the *torpedo* was a placebo, and that coding was a matter of perception. The incorporation of the coding process into the narcological therapeutic landscape also included significant suggestive practices in which the patient participates. Resident C discussed signing forms that release the rehabilitation staff from any responsibility of potential injury or death to residents as a result of the coding process. By recusing the rehabilitation staff of fault, the form reinforces the medical authority of the narcologists and the coding process. That is, the production of risk through the form's warning of possible injury or death serves as a means of reinforcing the authenticity of the procedure, if only by disguising the placebo aspect of the treatment.

Despite his acknowledgment that coding relied on a placebo, Resident C explained that he elected to participate in the process. Furthermore, he noted that the treatment

worked on him, if only for a short while. Later on during the interview, he elaborated further on the process of coding and also on his personal experiences with coding:

Resident C: That is, you pay, anonymously, they don't take cards or anything. There are these types of services and that's it. And then she (the doctor) explained what's happening with my brain, that - that's it - "you are an alcoholic, we will now clean out your body, we'll do it with this shot here, and, so, your brain will work." Well, that's how she conducted the conversation, several conversations, while they cleaned my blood with all these vitamins. I arrived, she talked with me, explained that after this injection, I was forbidden even to look at spirits, so as not to provoke a reaction and not even to eat really -- anything. And it is better not to communicate with alcoholics, so as not to provoke a reaction. That's how it went. Yes. It lasted two weeks.

Interviewer: Two weeks?

Resident C: Yes. I was told: for three years - for three years, this injection will work. Three years. So. But he said: "If you start to use - you will go crazy right away then you may die, if you use." Two weeks - so - well, I began to use again.

Interviewer: That is, after two weeks of you - again?

Resident C: Two weeks passed, yes, and then - on my birthday. You could say - out of fear, out of fear that at first I refused, of course, like: "No-no-no." But then I thought: "Let's just have a little drink - what could happen?" I used - like it was nothing. Like that, I was red, I became red, got hot, I remember how it was. I went outside, smoked, and then - yet-another-still, and then I began to drink even vodka, right that same evening. And that's it. It was all gone (Resident C, 08/28/2008).

Most notably, Resident C describes above the cleansing process whereby the staff injected him with vitamins and an alcohol antagonist that would produce a fatal reaction if he drank alcohol. Despite general claims about *torpedoes*, it is not always clear if the *torpedo* actually contains an antagonist or if it is a placebo (Raikhel 2010). Resident C's reported

reaction of becoming hot and red has been suggested by medical professionals to be part of the psychosomatic response to the coding process rather than a biological response to a chemical antagonist.

Moreover, Resident C's interview identifies that the central aspect of the coding process is the establishment of an antagonistic relationship between the patient and the substance in question. In particular, the patient is informed of potential of harm as a means of producing a cure for his or her condition. The prospect of harm or even death is a central aspect of the punitive process of narcology, wherein the solution to alcoholism is the treatment of the individual. The coding process therefore reinforces the perception of alcoholism in Russian society as an individual problem, and often a matter of personal inadequacy on the part of the patient.

Conclusion

In this chapter, I have examined the therapeutic landscapes of Russian narcology. I demonstrated how narcology has materially and discursively shaped the public health response to alcohol-related illness in Russia. I first discussed the history of narcological science and its links to Soviet politics. In particular I sought to demonstrate how narcology constructed the public health response to alcohol-related illness through the construction of the alcoholic body. A site that could be productive in constructing a public health response. The alcoholic body as constructed in narcology became the sight of intense anatomo- and bio-political regulation and discipline. I then examined the recent history of the narcology service that emerged in the 1970s as a broad institutional effort to deal

with addiction and alcoholism in the Soviet Union. In the final section of this chapter I sought to show how contemporary treatment strategies in narcology have shaped therapeutic landscapes in Russia. Furthermore, I sought to demonstrate the impact that narcology historically and contemporaneously has had upon public health conceptualizations of alcohol related illness.

As I argue, narcological approaches have restricted public health responses to alcoholism in Russia. That is, narcology has critically shaped perceptions in Russian society of alcohol related illnesses. In particular, I argue that narcology has complicated the contemporary development of Russia's public health response to alcohol-related illness through particular flawed conceptualizations of alcoholism and addiction as the central components of alcohol-related illnesses. That is, the discourses and practices of narcology limit the extent to which alcohol-related illnesses can be conceptualized as a public health problem. I argue that such limitations are the product of a bio-politics of addiction and alcoholism in narcology that stresses individual responsibility for alcohol-related illnesses while simultaneously silencing the role of social and environmental factors. Such emphasis on the individual fault has had the added effect of justifying punitive treatment methods for dealing with alcohol-related illness. The narcological therapeutic landscape therefore has had a long history of focusing on the individual and combining treatment with punishment. Just as important, however, is that the impact of narcological science in shaping alcohol-related illnesses through a stigmatized

conceptualization of alcoholism that has been broadly discursively and materially influential.

I began this chapter with an examination into the origins of narcology as a branch of Soviet psychiatry. Doing so highlighted the central importance of individual responsibility in portraying issues of alcoholism and addiction. Furthermore, looking at the historical context in which narcology developed highlighted the de-emphasis on environmental and social determinants of alcohol-related illness. In describing the origins of narcology and its therapeutic landscapes, I established the underlying bio-politics of Russia's contemporary public health response to alcohol-related illness. In particular, alcohol related illness became shaded as a moral failing. The immorality of alcohol related-illness informed a therapeutic landscape based on punitive attitudes and approaches toward treatment. I documented the punitive therapeutic landscape development of the narcological approach through the establishment of hospitals, dispensaries, work-place reporting, and rehabilitation labor camp.

I then examined the implementation of the narcology service, a formal network of specialized hospitals and dispensaries focused on treating addiction. Combined with Soviet policing strategies, the narcology system further shaped perspectives on substance abuse as criminal behavior and mental illness. As such, I demonstrated how the growth of the narcology service established the discursive and material boundaries around concepts of alcohol-related illness that remain important in the contemporary public health sphere.

I followed my examination of the narcological service, I turned to focus on the therapeutic landscapes of contemporary narcology. By examining narcology's therapeutic landscapes, I show how narcological treatments have materially and discursively shaped the public health response to alcohol-related illness in Russia. Current narcological approaches to dealing with alcohol related illnesses are based upon a particular understanding of alcoholism and addiction, and treat addiction through a combination of detoxification, chemical aversion therapy, and hypnotic suggestion. Furthermore, I discussed how narcological therapeutic landscapes are physically restricted to clinical settings, particularly the narcological hospital and the narcological dispensary. I also demonstrate that such restricted treatment settings, and narcology's underlying focus on individual treatment, have broadly shaped public health regard for alcohol-related illness.

To understand therapeutic landscapes of narcology, I focused on the experiences of individuals who either received or provided narcological treatment. By focusing on the experiences of subjects and practitioners, I elucidated the practices and discourses of the contemporary therapeutic landscape of narcology. Furthermore, I examined narcological approaches used in private clinics, such as *kodirivanie*. I also discussed how the narcology system continues to emphasize individual approaches to dealing with addiction. In doing so, I demonstrate how narcology's therapeutic landscapes play a role in the conceptualization of alcohol-related illnesses in Russia, and how narcology has produced limitations on Russia's public health response to alcohol-related illnesses.

I concluded by looking at recent changes to treatment in the therapeutic landscape of narcology. AA has emerged in hospitals and narcology dispensaries, signaling that narcology is undergoing some transformation. I also demonstrated that narcological perspectives have changed incrementally as some narcologists adopt new treatment methods informed by social and environmental determinants.

CHAPTER VI

The Local Clinic

In the following chapter, I examine a neighborhood clinic in Moscow that provides addiction treatment and family mental health services. I focus on how this clinic represents a therapeutic landscape shaped in part by NPH concepts. By looking at the clinic as a therapeutic landscape, I address the extent and limitation of NPH transformations regarding the construction of alcohol as a Russian public health problem. In particular, I focus on how practices and perspectives of the clinic staff shape and have been shaped by NPH concepts. I demonstrate the conflicting and overlapping geographies of public health practices in Russia regarding alcohol, and how these geographies emerge in public health places. In doing so, I demonstrate how the therapeutic landscape of the clinic and the activities of the clinic staff are therefore biopolitical focal points in the negotiation of alcohol as a Russian public health matter.

The clinic, which I refer to throughout the chapter as the YZAO⁷ clinic, is a part of a larger YZAO network of municipal narcology clinics and public health professionals within Moscow's southwestern district (shown below in Figure 1 as district 7).

⁷ YZAO stands for Yuzhno-Zapadnoi Administrativnii Okrug (*Южно-Западной Административный Округ*), or Southwestern Administrative District.

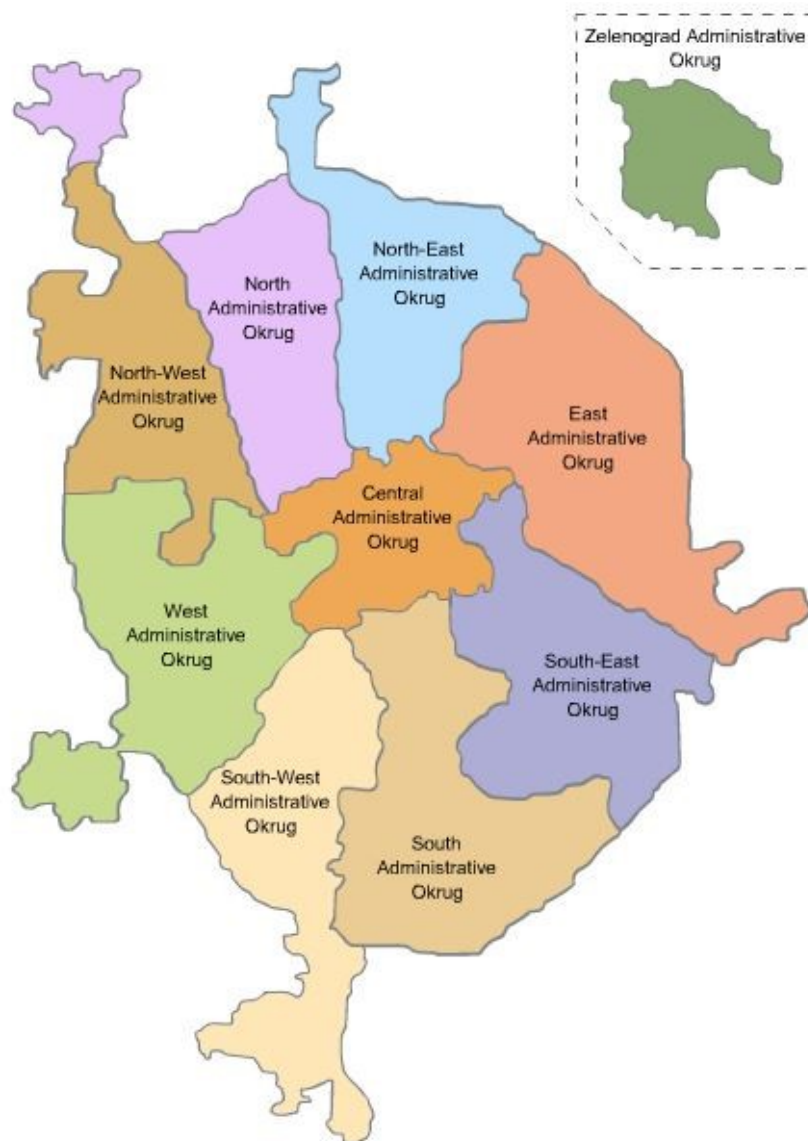


Figure 2 - A map of the administrative districts of the city of Moscow (“Moscow - Moscow International Portal :: Administrative and Territorial Divisions of Moscow” 2013)

The staff of the clinic and the district health administration have introduced approaches to dealing with alcohol and addiction that are informed by NPH (NPH) and depart from established narcology approaches. The emergence of NPH concepts in the clinical setting marks a significant departure from contemporary Russian public health

approaches to dealing with alcohol and addiction that are based on narcology. To reiterate, the narcology approach to dealing with alcohol and narcotics as public health matters focuses foremost on incarceration and punishment. As I describe below, unlike narcology's overall punitive approach to alcohol and addiction, NPH concepts emphasize risk, education, and prevention (Petersen and Lupton 1996). The YZAO clinic offers a hybrid of treatments that include 12-step methods along with counseling and mental health services. The clinic's efforts represent an important shift in the bio-political imagination of alcohol as a public health issue in Russia, as emphasis shifts from punishment to prevention.

The YZAO clinic also represents a fundamental departure from the predominant clinic model in Russia, which is left over from the Soviet period (Curtis, Petukhova, and Tackett 1995). The Soviet model limits clinic activities to primary care, direct treatment, and referral (Rechel et al. 2011b). In contrast, the YZAO clinic provides additional services designed to provide mental health services at the clinic, space for 12-step meetings, and engagements with educational outreach. Therefore, the emergence of NPH through the clinic is not only a departure from narcology and the introduction of new ideas about alcohol as a public health concern; it also represents a geographic reimagining of how public health spaces and places play a role in dealing with addiction issues.

In particular, this chapter demonstrates that the transition away from narcology and the Soviet clinic model, to a NPH clinic model represents a shift in the spatialization of public health responses to alcohol abuse in Russia. In this respect, space and place are

reframed by staff efforts to inform individuals and families about risk and behavior, as opposed to both the traditional clinic model of primary care, direct treatment, and referral; and opposed also to the narcology methods of punishment and incarceration. In this sense, I demonstrate how NPH as a bio-political rationale is a spatial process intricately connected to and produced through public health spaces and practices (Brown and Knopp 2010; Andrews and Evans 2008; Wilton and DeVerteuil 2006; 2009).

In emphasizing how the clinic's therapeutic landscape is enmeshed in NPH concepts, I focus on the emergence of risk in the discourse and practices of the clinic staff (Petersen and Lupton 1996; Foucault 2003b; Andrews and Evans 2008). I examine the reframing of the clinic as a place for modeling behavior and as a therapeutic landscape wherein individuals and families can reshape ideas of care. As I argue, the introduction of NPH is a transition in how public health subjects are conceptualized and how alcohol is problematized as a public health problem. Furthermore, NPH represents a transformation in how public health subjects recovering from alcohol related harm conceptualize themselves. That is, the clinic represents a center for the introduction of health related governmentality (Foucault 2003b). Methods of self-regulation include increasing efforts by the staff at health education, counseling, observation and documentation, as well as portraying the clinic as a care-based environment. The emergence of NPH geographies and governmentality in the Russian clinic represents a change not only in public health practices, but also in addiction and alcohol treatment.

I begin this chapter with a brief history of the group “No to Alcoholism and Drug Addiction” (NAN)⁸, a Russian non-profit established in 1987 that has since evolved into a health reform advocacy group. I describe how NAN motivated the reform of the YZAO clinic network discussed in this chapter. NAN represents a focal point for the introduction of NPH reforms into Russia's public health sphere. Understanding how NPH has been introduced into Russian public health is central in demonstrating the uneven process of public health transformation in Russia.

I then focus on the attitudes and practices of the staff employed at the YZAO clinic affiliate of the larger YZAO health network, and how they approach and rationalize treatment. In particular, I examine how they incorporate NPH themes of prevention and risk into their work. The materialization of NPH practices in the YZAO clinic helps to elucidate the geography of Russia's public health in transition by demonstrating how public health spaces and places play roles in the reproduction of health discourse and practice (Andrews and Evans 2008). In other words, the reproduction of NPH practices ultimately help shape the clinic and governmentalize spaces beyond the clinic, as people transfer knowledge of healthy behavior and risk into practice. In addition, I focus on how risk is encapsulated in the practices of the clinic staff: specifically in the form of education and care. For example, risk discourse and practice is partly materialized in efforts to expand the health education mission of the staff. Furthermore, risk discourse and practice emerge through the staff's efforts to inform people of the services available at the YZAO

⁸ *Нет Алкоголизму и Наркомании* (Net Alkogolizmu i Narkomanii)

clinic. Finally, the staff work to construct the clinic as a place to confront addiction, transforming the clinic space into a place of care. By looking at how clinic workers approach risk through care and education, I describe how NPH practices are being reproduced and incorporated into the geography of Russian public health. In doing so, the YZAO clinic represents a bio-political shift in how alcohol is constructed as a public health issue in Russia.

I conclude the chapter by addressing the ways in which the clinic staff has not been able to operate in a manner consistent with NPH practices. By this I mean that although important transformations have taken place in the clinic, it still remains a space in transition where older Soviet methods are still employed, and further transformations are hindered by lack of funding. To this end, the uneven transformation of health geography in the clinic underscores Foucault's arguments about uneven transformations in governmentality (Foucault 2003b). In this instance, the uneven progress of change in alcohol treatment strategies in Russia, and in Russia's public health sector in general, is emblematic of the unique geographies that emerge contextually from historical and geographic circumstance. The research for this chapter is based on a series of interviews with clinic staff and administrators, as well as interviews with staff from the non-profit "No to Alcoholism and Drug Addiction" (NAN).

NAN - No to Alcoholics and Drug Addiction

In this section I address the history of "No to Alcoholism and Drug Addiction" (NAN), a Russian public health non-profit organization. In exploring the history and

current workings of NAN, I attempt to show the organization's role in introducing NPH methods to clinics in Southwestern Moscow. By examining NAN's history, I demonstrate how public health responses to alcohol abuse in Russia have been changing and transforming for some time. Information about NAN was obtained from their website (www.nan.ru), and from an interview with associate director, Sergei Polyatykin.

NAN was founded in 1987 as a Soviet program designed to deter drug and alcohol abuse among youth (NAN 2012). At that time, drug use had increased because of a growth in heroin trade during the Afghan war (Polyatykin 2008). Drug use had always been an issue in the Soviet Union, but prior to the 1980s the problem was prescription drug abuse, rather than illicit drug abuse (White 1996; Polyatykin 2008). The emergence of Soviet anti-drug efforts coincided with the introduction of Mikhail Gorbachev's program to reduce alcohol abuse through limited prohibition. NAN was predominately a propaganda campaign meant to mobilize anti-drug and alcohol abuse efforts (Polyatykin 2008).

Following the collapse of the Soviet Union in 1991, NAN continued on as a non-governmental organization (NGO). The head of NAN, Oleg Zykov, transformed the mission of the organization to focus on social matters of public health, including addiction, juvenile justice, and health care reform (ibid). In terms of health care reform, NAN has advocated the introduction of NPH models of prevention and deterrence. Specifically, NAN has advocated risk-based models of prevention on issues of drug abuse (NAN 2012; Polyatykin 2008). Interest in NPH approaches stem from Zykov's work with Western public health perspectives on drug and alcohol abuse. Their activities have

included national-scale educational programs aimed at adolescents and health professionals, policy papers on how to approach drug and alcohol addiction as a public health matter, and critiques of popular domestic methods for treating addiction like *kodirivanie* and folk medicine, which I describe below (NAN 2012). In particular, NAN focuses on developing and training staff in strategies for dealing with drug and alcohol abuse, and their related health outcomes (Polyatykin 2008).

Significantly, the program has met with resistance in the public health establishment (Polyatykin 2008). Doctors and health professionals trained in Soviet methods were described as often being against adopting Western public health methods. In the following quote, a psychologist on the YZAO staff describes her own attempts at leading a NAN seminar for training public health professionals in treating addiction and alcoholism with a combination of counseling and 12-step methods:

...at the beginning of a seminar - there is great resistance. Especially, when present at the seminar are specialists in this field, for example doctors of narcology or teachers. Very ... very great resistance, that is - among teachers. Or - some people from the Committee on Drug Control. So, if these types of people show up from such departments - the Interior Ministry, there may be some there, these services - from the KDN (Commission on Juvenile Affairs) - That's when high resistance can happen at the beginning. Sometimes people even say: "We are not interested, we do not understand in general - why did we come, we won't come any more!" Yet, nevertheless, for some reason they come back, and at the end of the seminar absolutely amazing things happen - especially when there are recovering addicts and specialists at the seminar. First - there is such strong opposition, and by the end of the seminar - it's just, well, I do not know, love. And doctors say: "We will now send everyone to your program, we understand - how important this is and necessary" (Interview, Psychologist, 08-28-2008).

This quote is significant not only because it demonstrates the type of opposition to NPH methods among the Russian public health establishment, but also because it demonstrates a certain amount of efficacy in NAN's efforts to reform public health practices in Russia. Typically, Western methods like harm reduction are viewed as misguided, immoral, and dangerous because they condone a limited amount of illegal and unhealthy activity (Elovich and Drucker 2008; Nadezhdin 2011). In particular, harm-reduction strategies were, and continue to be, seen as state sponsored addiction (Bobrova et al. 2006; Rhodes et al. 2010; Elovich and Drucker 2008). Such arguments closely mirror criticisms seen in the Western public health context (Rhodes et al. 2010; Rhodes et al. 2006). In the same interview, the clinician identified public health in Russia as suffering from professional and institutional inertia.

It seems to me that the greatest resistance, both in treatment and learning, is from those people who have, well, sort of, more ... education, first, higher (education), yes, and who consider themselves sufficiently smart in this area, knowledgeable professionals. It is very hard for them somehow ... this new point of view ... to get on some new points of view, to consider some kind of new direction, some new vision, so as it were, to look at this problem from another angle. It is difficult for them (Interview, Psychologist, 08-28-2008).

In the above quote, the psychologist identifies that resistance to adopting NPH methods is often strongest within Russia's medical institutions because many of its practitioners are set in their ways. In this sense, public health institutions such as narcology were seen as inherently conservative and against any change in practice.

The presence of such resistance in high level public health circles has extensively delayed the introduction of Western public health methods concerning addiction into Russia (Khalturina and Korotaev 2008; Levintova 2007; Rhodes et al. 2010). Nevertheless, the NAN sponsored reforms have gone forward, albeit at the small scale of one Moscow district.

Currently, the primary mission of NAN is the training of medical professionals in risk-management evaluation for addiction (Polyatykin 2008). Such training is done in person through scheduled sessions and workshops. The sessions can be conducted on-site at the clinic requesting assistance from NAN. In such cases, a member of NAN will visit the clinic and lead a training session. Training scenarios cover subjects such as juvenile justice, risk-assessment, dealing with parents, and how to organize a clinic to better handle addiction cases (NAN 2012). In doing so, NAN is clearly an important conduit for NPH methods in Russian public health, as it seeks to train and inform staff in issues of risk and health.

In addition to training health professionals, a main focus of NAN is the distribution of a range of educational and policy materials. Some of the materials are information materials that are accessible online (www.nan.ru). Materials produced by regional offices, Novosibirsk in this case, include "What should you do if someone in your family is an alcoholic or drug addict?" (Volzhenina 2008). The pamphlet distributed by the Novosibirsk regional office lists symptoms that would indicate to the parent that their son or daughter is an addict. It also gives information on how to approach their child, how

to contact support services for the addict and the parent, and stories of other addicts and parents who have used such services. The Novosibirsk office also offers free counseling as an alternative to *kodirivanie* (cip.nsk.su 2009). Figure 2 below is a copy of a flyer produced by NAN-Novosibirsk inviting relatives and family members of alcoholics, drug and gambling addicts to contact the organization for free counseling services. Although I do not have information on the methods used to distribute such information, interviews with staff at the local clinic in Moscow suggest some common practices may exist. Distribution by staff and volunteers occurred at schools, pamphlets are available in the clinic, posted in public areas, and distributed at information sessions.

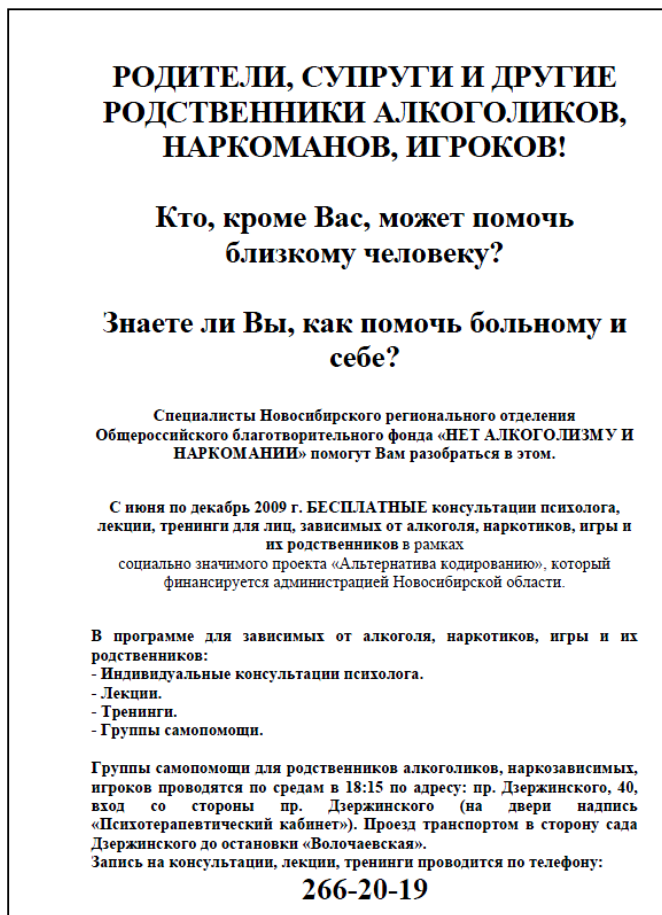


Figure 2 - A NAN flier advertising free consultations "PARENTS, SPOUSES AND OTHER RELATIVES OF ALCOHOLICS, DRUG ADDICTS, AND GAMBLING ADDICTS! Who, besides you, can help those near to you? Do you know how to help the sick and yourself?"

Other materials produced by NAN include articles designed to give guidance to health professionals on how to deal with addiction. Such pamphlets and articles include information on how to conduct risk assessment and evaluation of individuals. They also discuss the value of 12-step programs and attempt to dispel myths about substitution-therapy and harm-reduction strategies. Such materials are intended for public health professionals in administrative and medical positions. Such materials further underscore

the NPH orientation of NAN by demonstrating the organization's focus on education and communication.

Much of the above activity, including publication distribution and educational outreach, occurs at the national scale. There are NAN offices in several Russian regions. However, as mentioned earlier, NAN is also engaged in a reform program in the Southwest district of Moscow. The reform program is designed to adopt Western style approaches to dealing with domestic violence, drug and alcohol abuse, and health issues related to addiction.

Clinic treatment: options and strategies

In this section I explore the introduction of risk and related NPH reforms into the YZAO clinic via the practices of care, education, and outreach by the YZAO clinic staff. I demonstrate that such practices transform the YZAO clinic space by reproducing NPH practices.

The introduction by NAN of NPH associated reforms has produced fundamental transformations in the YZAO clinic, which had been based on the pre-existing Soviet clinic model. In the Soviet model, the clinic was a center for primary care, annual physicals, and vaccination (Cockerham 1997). This model grew out of a necessity in the Soviet period to extend primary health care to the entire population. During this time the concern among public health officials was in preventing disease outbreak and providing local monitoring of public health among the population (Cockerham 1997; Field and Twigg 2000). While Western public health monitoring expanded during the 20th Century to encompass issues

of prevention and risk, the Soviet model remained constant in its primary care focus (Rechel et al. 2011b).

The clinic model established in the Soviet-era persists today throughout Russia (Rechel et al. 2011b). Hospital practices such as detoxification and aversion therapy, as mentioned in the previous chapter, and clinic practices, including coding and specialist referral, are designed to provide primary health care. Typically, as has been described in other public health analyses of Russia, this also means that the clinics serve as funnels to hospitalization (Raikhel 2010). That is, at the clinic, people are often referred to medical specialists or hospitals. In this sense, the clinic in contemporary Russia has not historically been a site for care as understood in the Western sense, or as described in recent public health analyses by geographers (Curtis et al. 2009). The contrast between NPH-based clinic models and Soviet clinic models can be demonstrated in the focus on primary care in the case of the latter, and in the former, a focus on combining primary care with education and care-based approaches that attempt to generate preventative habits in the population (Petersen and Lupton 1996). Geographical analyses of public health transformation (Brown 1999) have demonstrated the association of NPH transformations with the emergence of spaces dedicated to education concerning risk as well as spaces of care (Curtis et al. 2009; Curtis et al. 2007). As I address in the next section, the manner in which NPH discourse and practices are mobilized in the YZAO clinic represent important spatial transformations in Russian public health.

Before I elaborate on the YZAO clinic it is important to first explain that in Moscow, the city public health network is managed at the district level, while affiliates operate in neighborhoods (Polyatykin 2008). Within a particular district of the city, one can find a series of clinics that focus on primary health care, narcological care, or family care. The larger Southwestern Moscow District (YZAO - Yuzhno-Zapadnoi Administrativnii Okrug (*Южно-Западной Административный Округ*)) health administration is a network of clinics that offer a diverse range of services. Clinics offer primary and specialized care to neighborhood residents. Specialized care includes children's services, family planning, and narcotics dispensaries. During the course of my research, I interviewed staff at a YZAO affiliated clinic. The clinic is furthermore an affiliate of the main YZAO narcology clinic, and the main narcology clinic is the headquarters of NAN. The YZAO clinic I focused on specialized in narcology as well family mental health services.

As discussed in the previous section, the primary sites for the treatment of alcohol abuse and alcoholism in Russia are the narcology clinic and hospital. As an affiliate of the YZAO narcology clinic and NAN, this clinic is specifically oriented to deal with family mental health issues and addiction issues. They offer services from general practitioners as well as counseling by licensed psychologists, psychiatrists, and social workers. Furthermore, they sponsor meetings and provide space for 12-step programs for alcoholism, drug addiction, and for family members of addicts or alcoholics (Staff interview 07-23-08).

The clinic I visited was on the first level of a larger residential complex, as shown in Figure 1. The only exterior indication or sign was a small plaque next to the entrance that identified the office as a narcology and family mental health clinic. Typically, clinics are not distinguishable from the rest of the built environment or residential landscape. They are architecturally similar and even if they are not included in a residential building as was the case with this clinic, the buildings they occupy are unremarkable.



Figure 3 - The front office of the narcology clinic

The office had a main entry way with five rooms on the inside for offices and patient diagnoses. There were two extra rooms for holding support group meetings. Finally, there was a common room for the staff. The clinic in general was clean and well maintained, but it was clear from comments by the staff that the clinic was dealing with a shortage of funds and out of date technology:

So you probably have noticed here the state of our clinic. So, the problem is to make repairs. We have no computers. We have two computers in the entire center, and besides one - it's just in general, I do not know, last century, so to speak. One - more or less. We do not have internet. We only just got a fax machine recently. We have no photocopier. We have, well, just about, that's all there is, it's antediluvian. We have to fight for everything. Everything that happens some way is extracted, pursued. Because it ... healthcare ... health care-education, unfortunately, that we have now - is in a very difficult position (Interview, Psychologist, 08-28-2008).

This staff member's comments clearly indicate frustration with the level of funding put toward health facilities, and also indicate a level of frustration at the limitations such conditions place on the efforts of the clinic staff. In this sense however, the clinic was not necessarily different from many other public health care facilities in Russia (Aris 2005; Coker, Atun, and McKee 2004).

During the intake process, clients are interviewed by staff and directed to possible specialists for their specific medical issue: a general practitioner, a psychologist, psychiatrist, or a social worker trained in mental health issues (Interview, Doctor, 08-28-2008). In contrast, the narcology system supports an intake model focused on referral; directing patients from clinics to specialty hospitals (Elovich and Drucker 2008; Rechel et al. 2011a). Staff members at the YZAO clinic emphasize treatment of behavioral aspects of health issues, particularly as they are related to substance misuse. Moreover, the intake process reflects the emergence of NPH in two ways. First, patients are directed to locally available services that are provided at the clinic and that are focused on treatment of addiction. Second, the reduced number of referrals reflects the NPH move away from

large centralized treatment centers like sanatoria and mental health hospitals, and toward a community-based health approach (Petersen and Lupton 1996). Therein lies one of the fundamental transformations in terms of Foucault's analysis of public health (Foucault 2003b), the decentralization of medical authority and the move toward placing responsibility on the individual.

Typically, the clients obtaining services for alcohol or substance abuse come to the clinic at the insistence of family members (Interview, Social Worker, 08-28-2008). It is more common for family members to seek advice and help first, as clients with alcohol or substance abuse problems themselves were unlikely to seek assistance (Cubbins and Szaflarski 2001). Staff described an overall reluctance on the part of individuals to self-identify with a substance abuse problem. For example, one staff member mentioned the reluctance of people to come in because of fear regarding past Soviet practices. As mentioned in the previous chapter on narcology, it was official practice for people arrested for intoxication to have their information reported to their place of work.

Many people do not go, because they are afraid that their work will be informed that they are alcoholics, not knowing that you can do this all anonymously. That, incidentally is one of the ways for the state to help. This kind of such propaganda, even spreading of information, normal information that it is possible to go through a course of treatment. ... And not.. not fixing, then, a man, as an alcoholic. Because the Soviet system - there was a record, a certificate, etc. That's what people are afraid of. In general. Often. Although very often this is only an excuse. Well, such a reason to shield themselves from this, closed off. I would go, but ... they'll put it on record.(Interview, Social Worker, 08-28-2008).

This quote identifies the lingering stigma of Soviet narcology's disciplinary approach to alcohol abuse and alcoholism. While services are available anonymously, there is still a pervasive belief that treatment is public and dangerous. The staffer also cited a general reluctance to seek help was described as part of the stigma against alcoholism in Russian society.

Often the family will turn to the clinic only after attempting other treatment options. This includes traditional Russian narcology programs including aversion medication and coding, as well as non-traditional methods such as folk medicine and pseudo-scientific treatments such as hypnosis. In separate interviews, one subject reported having been directed toward folk medicine by his mother first, while another subject had first had gone through the coding process (Interview, 08-29-2008). A clinic staffer whose son was a drug addict also described the process of seeking out addiction cures through informal channels:

And I could not find help. I tossed about, so ... There were a lot of - now we have a lot of these healers, psychics, magicians. So, open any newspaper - there are, like, two pages - there will be the announcement that they treat "by photograph", "by mobile phone number" on whatever you want! That is ... And people devoutly believe in this, understand?! An insane amount of these charlatans have appeared here, to which people rush, just, well, that's because they do not know where else to go. And they bring their money, they give it to them. And, well, it is completely insane! So. And I too did all this (Interview, Psychologist, 08-28-2008).

In this quote we see an important example of a process common throughout Russia. The inclination for alcoholics and their families is often to first go through simple solutions, either based around folk medicine or quasi-scientific theories of treatment. Throughout

Russia there is in general a lack of information about services available beyond the typical narcology solutions of hospitalization and aversion therapy (Cockerham 1999; Elovich and Drucker 2008; Field and Twigg 2000; Raikhel 2010). The lack of information is an important indicator of the overall lack of change and lack of responsiveness in the narcology aspect of Russia's public health sphere.

Within this broader landscape of unresponsive public health practices, the staff focused on incorporating NPH methods to deal with cases of addiction and alcohol related harm. In an interview with the staff at the clinic, individuals described efforts at counseling, promoting 12-step programs, and practicing outreach within their region (Interview, Staff, 08-23-2008). In the next section, I focus on three broad areas that form specific approaches for the YZAO clinic staff to introduce NPH methods in their discourse and practice.

In offering addiction treatment services, the YZAO clinic not only departs from the typical Soviet clinic scheme, it also introduces NPH methods and geographies. As discussed previously, the introduction of NPH is associated with a variety of governmentality transformations as described by Petersen and Lupton (1996) and others (Curtis et al. 2009). Of central importance at the YZAO clinic in NPH terms are attempts to imbue a sense of health as personal responsibility to the addict or alcoholic (Larsen 2011). In doing so, the process of self-evaluation for risk potential by the patient is also a transfer of responsibility to the patient. Risk is a fundamental part of NPH practices, and

in this section I explore how the clinic staff through care, education and outreach activities constitutes risk spatially.

In terms of public health, care can be understood as a component of evaluation and treatment (Conradson 2003b; Johnsen, Cloke, and May 2005; Curtis et al. 2009; Gesler 2005). Significantly, care is also an important means of conveying risk in the health context. The emphasis on care at YZAO differs fundamentally from narcology clinics and hospitals in Russia. As I explain below, the YZAO clinic's transformation into a space for the treatment of alcoholism was one from a space of diagnosis and referral to a space of care. In this sense the staff who work at the YZAO clinic were establishing a public health site as places where people could recover from addiction illnesses.

In interviews, members of the staff highlighted how the YZAO clinic is reinforced as a place of care. For instance, in reflecting on the YZAO clinic as a place of care, one psychologist I interviewed focused on the shortcomings in Soviet-style hospitals and clinics that the staff sought to overcome. In this respect she identified that the YZAO clinic is a site where a more complete and systematic style of care is sought and provided:

...we focus on making sure the client knows how to live, not just get sober, we provide resources for the family as well. We understand that a support network is needed after someone sobers up and then struggles with life and with addiction. ...We believe that the "stop using" - is a necessary condition for recovery, but not the goal of recovery. The purpose of recovery - is to learn to live in sobriety. And not just live, but live, so to speak, meaningful life, to be self realized in this life (Interview, Psychologist, 08-28-2008).

There are several important themes to highlight in this quote. First, the interviewee places the clinic in opposition to Soviet style medicine and narcology in general by emphasizing staff efforts to help people beyond just getting them sober. Instead, the interviewee describes the clinic as a place where people are taught how to live. The emphasis on teaching people how to live raises an additional point of interest in so far as we can see directly how the staff seek to affect the behavior of individuals beyond the clinic. Furthermore, in the quote addiction is constructed as more than just a single illness that needs periodic treatment, it is a complex disease that requires management in numerous contexts. The clinic is therefore conceptualized as a source of care and information, and as a place for establishing larger networks for dealing with addiction as lifestyle. Moreover, the clinic is a place for instructing patients and family members in how to understand addiction and its risks, and how they can access available resources.

Furthermore, the psychologist's comments parallel ideas brought up by geographers concerning the production of care (Andrews and Evans 2008; Andrews 2006; Crooks and Andrews 2009). In emphasizing responsibility as a key to health, the clinic becomes a place of care that also serves to extend NPH discourse and practice. In particular it becomes a place where personal responsibility and risk are deployed as key health factors.

The extension of health practices to peoples' lives represents an aspect of NPH methods and the work done by staff at the YZAO clinic. In doing so, staff at the clinic is expanding the geography of health to the daily lives of individuals. That is, the staff have

an interest in making sure individuals are practicing healthy behavior in their daily lives. The movement of discourse into practice in this case can be best understood as geographers and others have described it (Brown and Duncan 2002), is the extension of clinic discourse and practice in general to the broader local community (Rose 2001). Such efforts entail not only the communication of risk to neighborhood residents, but increasing governmentalized behavior and self-regulation on the part of the populace in relation to their personal health. In this sense, the YZAO clinic and its staff are working to promote risk discourse into the lives of neighborhood residents. The processes of emerging self-regulation mirrors observations put forth by geographers concerning the manner in which health risk discourses and practices become incorporated in daily lives by activities of health professionals (Brown and Duncan 2002; Brown and Knopp 2010). In this way, the extension of self-regulation is a geographic concept as it describes the transfer of knowledge into practice across space, and the incorporation of health knowledge and practice into the places of peoples' lives.

In promoting such activity, staff at the YZAO clinic focused on communicating to patients the role of the individual in acknowledging the danger or illness for him/herself or a family member. People who sought help were advised with information that was designed to empower them to make healthy decisions. Such examples include pamphlets designed to inform individuals about disease risks, consultations with health professionals, and information to connect them with other help centers or recovery groups.

In this manner, the staff at YZAO were attempting to impact individual behavior outside clinic space, and attempting to transform individual health through modeling behavior. The disciplinary act of modeling behavior was further accomplished by the demonstration in counseling with individual patients that there are implicit risk factors beyond the clinic environment that must be recognized.

Furthermore, as mentioned earlier, one of the primary objectives of interviewed staff was to promote the recognition of risk and responsibility not only with those seeking treatment, but also their friends and family. That is, the object of the staff is not only the patient, but also anyone participating in the activity of care and observation. In this manner the YZAO staff can extend NPH practices to the larger community. The introduction of NPH methods and practices is therefore deployed through a wider network of individuals in the immediate community.

The YZAO staff therefore engaged in extending self-regulation by attempting to model healthy behavior. Similarly, the staff also engaged in more formal educational activities and in this sense the clinic was also a place where planning for health education and intervention could take place. I differentiate education in this sense as in particular instances the staff's activities took place in schools or with school children. Education represents a key aspect of NPH, in that it supports the effort to inform individuals with the assumption that such knowledge will help people avoid risky and unhealthy activities.

In this sense, the offices where the staff worked served as sites where they could plan presentations at local schools and invite school children to visit the clinic. Staff participated in educational outreach that stressed the dangers of drugs, alcohol, and unprotected sex. Educational outreach was also evinced by the presence of harm-reduction focused materials that the clinic staff disseminated to the wider community, such as pamphlets focusing on practicing safe-sex. Another goal of the staff was to encourage and emphasize frequent testing for Sexually Transmitted Infections. Such efforts indicate how public health workers highlight the elements of risk and lifestyle in the maintenance of health.

The educational programs evince a broader spatiality of the clinic and NPH. As previously mentioned, one staff member engaged in talks at neighborhood schools. Such talks were designed to raise awareness about risky behavior in regards to substance abuse and sexually transmitted infections. For example, in an effort to educate students about chemical dependency while they are still young, he describes his program as follows:

So we talk about how dependency can arise from any object. What is chemical dependency, non-chemical dependency. Because the development processes of dependency, they are similar in any event. How to become addicted whereby it threatens a man (Interview, psychiatrist, 08-28-2008).

The effort on his part was clearly to keep students informed, because as he mentions later, students are typically poorly apprised of the realities of substance abuse and chemical

dependency. Later in the interview, he attributes this lack of understanding to an overall failure on the part of the Russian state to educate its citizens about drugs and alcohol:

Well, the State, I think, this is my personal opinion, is losing the information war up and down because we have no social commercials about what happens to the person who took drugs the following day, how a drug addict looks in the hospital. This is not shown to us. I do not know why, but none the less. If you look around in the subway there are now flyers, that drugs are dangerous, well, it's really very surprising. First, it is difficult to see them. Well, they are this size here, an A4 sheet and compared with the beer advertisement over there, cameras, relaxation by the sea, they (health ads) are, well, I do not know, one in a hundred. They are very poorly designed and the work is of an amateur design, the information is difficult to read and of course it is not very visible. And so it is very one-sided approach to the problem. We have practically an absence of social hygiene. No one is seriously firm, the state is not engaged with education, that is, in the prevention of tobacco use, alcohol and drugs. All these lectures in schools, the seminars, it is all ... There is a saying: it is a dead poultice (useless) (Interview, Psychiatrist, 08-28-2008).

In the above quote, the psychiatrist is identifying a public health gap created by the State. That gap, which is responsible partly for the lack of 'social hygiene' as he puts it, is one of information and education. Education and awareness campaigns that do exist, are dismissed as ineffective. He later on describes seminars and lectures at school as dull and pedantic:

Usually, (the principal) says that it will be a lecture on drug abuse. And the kids really think that there will be a guy with glasses, who will sit and read something. They will sit and think, while you finish (Interview, Psychiatrist, 08-28-2008).

In his own efforts, he attempts to engage the students more directly:

students are often surprised when they see a psychologist in drug treatment clinic with an earring in his ear. So. I. .. When I talk to kids, ... Well, I do not know, but I sense they are thankful, at least for the

fact that they talked about it all. They are not read notes, they are not told how to live, instead they are asked their opinions, their arguments are listened to (Interview, Psychiatrist, 08-28-2008).

To summarize, the interviewee makes plain that the goal of his educational talks is to shape healthy behavior. However, at the same time, through his outreach he also locates the source of knowledge about risk and addiction at the clinic, and reinforces the notion that the clinic is a place to go for treatment and help.

In this manner, the production NPH geographies through the activities of clinic staff is similar to other geographical analyses about the production of therapeutic landscapes (Andrews 2006; Andrews and Evans 2008; Conradson 2003b). As geographers have pointed out, the work of the clinic staff is central to reinforcing NPH spaces and places at the clinic scale. The reproduction of NPH methods can be seen not only in the change of practice toward care within the clinic, rather it is also evident in the transformation of the clinic into a surveillance site for addiction diseases. However, as I point out in the next section, the clinic geography is also defined by limits to NPH methods. That is, although the clinic demonstrates many aspects of transformation along NPH lines, especially in contrast to the majority of Russia's clinics and hospitals, there are distinct limitations to such transformations, which play a central role in shaping the clinic as a public health space.

Clinical discontinuities

The primary limitation at the clinic to the further incorporation of NPH methods was material. In that sense, I am referring to a significant lack of funds to update the

equipment and supplies for the staff. For example, there were no intake forms that inquired about drug or alcohol abuse. Therefore, despite an increased amount of surveillance on the part of the individual, the clinic itself, traditionally a focal point for population monitoring, is unable to keep track of patients' drug and alcohol consumption habits. For the most part, the clinic engages in typical health surveillance, while simultaneously stressing anonymity, as is common in Western settings. However, there is no systematic way of collecting information during basic checkups in regards to a patients drug or alcohol use. This is common across Russia and the lack of systematic protocol was cited several times by respondents as a hindrance to monitoring and combating alcohol and drug abuse at the population level through public health settings. Population monitoring of health factors and trends is of central importance to NPH methodologies, as it provides a quantitative means of supporting regulatory activity. One staff member at the clinic identified their efforts at the clinic to begin documenting alcohol, drug, and sexuality information during intake sessions. She identified this as not only a necessary mission for their profession to keep up with Western standards, but also a fundamental tool for improving the public health response to alcohol and drug related issues in Russia.

The necessity of AA groups to public health efforts in Russia defines an important limit to the extent to which we can ascribe the NPH moniker to such reforms. That is, AA presents an anti-neoliberal model in that it suggests the power of individual growth is limited for alcoholics, and perhaps many others (Valverde 1998). As NPH intersects with

neo-liberalism in its stress on personal responsibility, this presents a significant paradox to any public health effort in Russia at engaging with NPH methods. That is, attempts to treat alcohol abuse and alcohol addiction (without specifically saying alcoholism) imply that personal responsibility is an illusion for those suffering from addiction. One of the central tenants of the governmentality critique of NPH is therefore called into question, as the dependency of Russian public health on AA clearly suggests limits to which individuals can be ascribed responsibility.

Conclusion

In this chapter, I examined a neighborhood Moscow narcology clinic that provides addiction treatment along NPH lines. I focused on how this clinic represents a therapeutic landscape shaped by NPH concepts. By looking at the clinic as a therapeutic landscape, I evaluated the geography of NPH transformations concerning alcohol as a Russian public health problem. I examined how practices and perspectives of the staff reflect NPH concepts. I therefore demonstrated how conflicting and overlapping geographies of public health practices in Russia regarding alcohol emerge in public health places. In doing so, I demonstrate the underlying argument of this dissertation, that therapeutic landscapes such as the clinic impact the overlying public health conceptualization of alcohol-related illness.

I began the chapter with a brief history of the group “No to Alcoholism and Drug Addiction” (NAN), a Russian health reform advocacy non-profit. NAN is the motivating force behind the reforms in the clinic network. I emphasized that through NAN, the

clinic's therapeutic landscape has been shaped by NPH concepts. I accomplish this in part by contrasting the NAN clinic with contemporary Russian clinics and the Soviet clinic model. I described the evolution of NAN from a Soviet era health promotion group to its current incarnation as an advocate for reforms that adopt NPH concepts. In particular, I demonstrated their emphasis on education and advocacy, as well as their focus on policy reform in public health matters regarding addiction. Describing the history and work of NAN reinforced the connection between the clinic where I did my field work and its links to NPH reforms.

I next focused on the clinic itself. I particularly examined the therapeutic landscape of the clinic and the practices of the clinic staff. In examining the therapeutic landscape of the clinic, I focused on its transition away from narcology methods and the Soviet clinic model described in chapter five. This transformation represents a shift in the spatialization of public health responses to alcohol abuse in Russia. In this respect, the clinic focused on informing individuals and families about risk and behavior, as opposed the narcology approaches of punishment and incarceration. In doing so, I demonstrated how NPH as a specifically bio-political rationale is a spatial process intricately connected to and produced through public health spaces and practices. The emergence of NPH concepts in the clinical setting marks a significant departure from contemporary Russian public health approaches to dealing with alcohol and addiction that are based on narcology. To reiterate, the narcology approach to dealing with alcohol and narcotics as public health

matters focuses foremost on incarceration and punishment. Instead, the clinic offered hybrid treatments, including 12-step methods, counseling, and mental health services.

I then examined the practices of the staff, and the role of such practices in constituting the therapeutic landscape of the clinic. Focusing on the attitudes and practices of the staff employed at the clinic elucidated the geography of Russia's public health in transition by demonstrating how public health spaces and places reproduce health discourse and practice. I particularly focused on the emergence of risk in the discourse and practices of the staff. I sought to show how staff practices and behavior were enmeshed in NPH and that risk discourse and practice emerge in the staff's efforts to inform patients. By looking at how clinic workers approach risk through care and education, I demonstrated how NPH practices are being reproduced and incorporated into the geography of Russian public health.

In this manner, I have argued that the clinic became a place for modeling behavior as well as a therapeutic landscape for reshaping ideas of care. The introduction of NPH practices represented a transition in how public health subjects were conceptualized and a transformed problematization of alcohol. I also demonstrated that transformations in the clinic changed how subjects recovering from alcohol related harm conceptualize themselves in relation to their illness. That is, methods of self-regulation were introduced through efforts by the staff including health education, counseling, observation and documentation, as well as portraying the clinic as a care-based environment. The NPH

transformation in the geography of this particular Russian clinic was a change not only in public health practices, but also in addiction and alcohol treatment.

I concluded the chapter by addressing the ways in which the clinic staff has not been successful with NPH-type reforms. Although substantial transformations have taken place in the clinic, Soviet narcology methods are still employed, and further transformations are hindered by lack of funding. The uneven progress of change in alcohol treatment strategies in Russia, and in Russia's public health sector in general, is emblematic of the unique geographies that emerge contextually from historical and geographic circumstance. By examining the therapeutic landscape of the clinic and the practices of its staff, this chapter demonstrated that the clinic was shifting the bio-political imagination of alcohol as a public health issue in Russia, specifically away from punishment to prevention. Such transformation represents a geographic reimagining of how public health spaces and places play a role in dealing with addiction issues.

CHAPTER VII

The Rehabilitation Center

In the following chapter, I look at the therapeutic landscape of a rehabilitation center in the suburbs of Moscow. What I refer to here as a rehabilitation center is in essence a residential treatment center, where residents stay for an extended period of time and receive extended counseling and psychological assistance. The number of private and not-for-profit treatment centers has grown in Russia since the collapse of the Soviet Union, but they still represent a small proportion of the treatment landscape. Yet as they grow in number, their therapeutic landscapes represent alternative treatments for alcoholism and addiction, and they are emerging as significant places in the understanding and negotiation of alcohol as a public health problem.

The goal of this chapter is to discuss a particular rehabilitation center as an alternative to narcology and New Public Health (NPH) methods for recovering from alcohol related-harm in Russia. I argue that places like the rehabilitation center discussed in this chapter are central in understanding how alcohol is coming to be understood as a public health problem in Russia. By looking at this center as a therapeutic landscape, I demonstrate how the discourses and practices of treatment at the center reflect and advocate a particular understanding of alcohol as a public health problem. In turn, treatment discourse and practice is embodied by the residents, whose actions are central in producing the therapeutic landscape. In describing the relationship between the residents, the therapeutic landscape, and the discourse and practice of treatment, I

identify how rehabilitation centers in general help shape the public health conceptualization of alcohol.

I focus on the discourse and practice of rehabilitation and recovery, as propagated by the Christian charitable organization running the center, *Stariy Svet* (Old World). In particular, I demonstrate how the therapeutic landscape at the rehabilitation center is structured through a complex understanding of addiction and recovery, which reflects *Stariy Svet's* organizational ideology and principles. Moreover, I focus on the experiences of the rehabilitation center residents, who embody and materialize the discourses of rehabilitation. In doing so, I demonstrate how the residents inhabit and shape the therapeutic landscape as they come to embody discourses of rehabilitation.

The conceptualization and practice of recovery from alcoholism and drug addiction at the rehabilitation center have significant implications for how alcohol is understood as a public health problem in Russia. Such centers, in general, are key components in the shaping of public health conceptualizations of alcohol (Wilton and DeVerteuil 2006; Valverde 1998). For instance, medical practices for treatment of alcohol and alcohol-related harm play a significant role in problematizing addiction, and in turn help shape conceptualizations of alcohol and its association with public health.

With respect to this research, the rehabilitation center I focused on represents a significant variation in the overall trend of health approaches to dealing with alcohol in Russia. As I address below, *Stariy Svet* employs the Minnesota Model and 12-step methods in combination with Russian Orthodoxy. In part, the practices at the center mirror NPH

transformations described at the clinic in the previous chapter. That is, the center eschews narcological approaches to addiction and attempts a more integrated approach toward rehabilitation. However, *Stariy Svet* is also strongly opposed to central aspects of NPH. For example, members are opposed to managed addiction and harm reduction as they contradict Orthodox tenets of the center's addiction philosophy. By exploring the therapeutic landscape of the rehabilitation center, this chapter demonstrates how the rehabilitation center challenges both NPH and narcology approaches. In this sense, the therapeutic landscape of the center embodies the fluctuating conceptualization of alcohol as a public health problem in Russia.

As part of my examination of the therapeutic landscape of the rehabilitation center, I consider the ways in which residents materially and discursively reproduce rehabilitation as conceived of by *Stariy Svet*. To this end, I focus particularly on the disciplinary structure of life at the center. In doing so, I draw out the connections between the governmentalizing foundations of rehabilitation and the manner in which residents embody rehabilitation as a practice and ideology. That is, the rehab center operates through governmentality as it works to discipline the residents in how to self-regulate themselves as a central aspect of recovering from addiction. In doing so, I attempt to situate *Stariy Svet's* complex definitions of addiction and recovery as an intervention in the bio-politics of Russia's overall public health system.

In order to understand more fully the conceptualization of recovery at work in the center, I begin this chapter by discussing the history of *Stariy Svet*. The ideological

foundations of *Stariy Svet*, which concern Orthodox theology and Western methods like the Minnesota Model, form the basis for the rehabilitation center's operations, and are therefore central to understanding its therapeutic landscape. I then focus on the physical layout of the center, and its relationship to the therapeutic landscape of the center. I address the built-environment of the center and how it is intentionally designed to reflect a particular conceptualization of rehabilitation. I next address the therapeutic landscape through the individuals who live and work at the rehabilitation center. I demonstrate how the residents embody discourses of rehabilitation. By focusing on the embodied experiences of the residents, I connect their struggles with recovery to the *Stariy Svet*'s overall conceptualization of addiction and rehabilitation. I conclude by situating *Stariy Svet* and the rehabilitation center within the broader landscape of Russia's public health response to alcohol related harm.

The majority of the research for this chapter is based on interviews with the staff of *Stariy Svet* and affiliated NGOs, and the residents of the rehabilitation center. I engaged in a personal interview with Evgeny Protsenko, the founder and head psychologist of *Stariy Svet*. I also interviewed several staff whom I refer to here anonymously. I refer anonymously to four residents I interviewed at the center as residents A, B, C, and D. Information about *Stariy Svet* was gathered from its website (stsv.org) and publications. Further information about the center was gathered from visits to the center and a 5th anniversary open house event held at the center and at the associated church.

The History of Stariy Svet

This section describes the history and mission of *Stariy Svet*, the NGO that operates the rehabilitation center. The history of *Stariy Svet* illustrates the impact of the organization's principles on the residents and the therapeutic landscape of the rehabilitation center. *Stariy Svet* was founded in 1992 by a group of psychologists and medical clinicians interested in approaches to dealing with addiction that differed from Russia's narcology sciences (stsv.org). Narcological methods were perceived as ineffective and harmful. Primarily, they were interested in 12-step methods as a result of contact with American AA experts. This occurred when AA members came to the Soviet Union in the late 1980s (Protsenko 2008; Keller 1987). By the time the Soviet Union collapsed in 1991, AA groups had been meeting in Moscow and St. Petersburg for several years, and their membership began to grow quickly. Furthermore, individuals like Evgeny Protsenko, the founder of *Stariy Svet*, were in a position to promote 12-step programs. In further discussing the history of *Stariy Svet*, I demonstrate how it has slowly grown in scope and scale, from an ambulatory center to a rehabilitation center, and how its further growth and conceptualization of alcohol as a public health problem is intrinsically connected with 12-step programs and the Russian Orthodox Church.

The *Stariy Svet* organization was set up to take a Russian Orthodox approach to the religious underpinnings of the 12-step model. Throughout the 1990s the organization ran an ambulatory center in Moscow that assisted individuals and families. They also coordinated volunteers, fund-raising, and arranged for instruction in 12-step methods for

physicians, medical professionals, and staff from other NGOs. In 1997 they started a hotline with contact information for people seeking help. In 2004, the organization opened a rehabilitation center in the village of Erino, which I discuss later in this chapter. In 2007, the organization initiated another project called “the resource center,” which is designed to provide information for those seeking help, provide training materials, coordinate policy on rehabilitation and addiction with the church, and maintain an online library of materials about addiction and treatment (Interview, *Stariy Svet* Grant Manager, 08-16-2008). In this manner, *Stariy Svet* was established in contrast to Narcological approaches to addiction and alcoholism as the organization attempted to produce a more socially and medically integrated approach to treatment.

The organization operates in three overlapping spheres. First, they run a rehabilitation center that I focus on below. Second, within Moscow the organization runs a drop-in center. The drop-in center is the longest standing element of *Stariy Svet*'s operations. It provides services free of charge for individuals and families. Third, the organization maintains a national presence by educating volunteers and public health professionals across Russia on topics of addiction, treatment, and rehabilitation. *Stariy Svet* maintains extensive contacts with groups throughout Russia. Staff members have been heavily involved in training outside volunteers and organizations in how to employ the Minnesota Model, various fundraising techniques, and information sharing.

A major component of *Stariy Svet*'s approach to rehabilitation is the Minnesota Model for addiction recovery. Much of the following information about the Minnesota

Model is adapted from William L. White's history of the American treatment movement *Slaying the Dragon* (1998), and Christopher Cook's two part critique of the model in the *British Medical Journal* (Cook 1988a; 1988b). Initially formalized in the 1950s in Minnesota at the Hazelden center, the Minnesota Model centers around the twelve-step program for addiction treatment. The conceptualization of addiction and alcoholism at the *Stariy Svet* rehabilitation center is therefore similar to the disease model propagated in Alcoholics Anonymous, as discussed in the previous chapter. However, there are several additional factors associated with the Minnesota Model that shape the therapeutic landscape of the rehabilitation center, as well as *Stariy Svet's* approach to treating alcoholism and drug addiction in general. First, a central component is the incorporation of mental health professionals and councilors into the rehabilitative process. Psychologist and councilors at the center are in frequent contact with the residents, monitoring their progress and aiding them in moving through the rehabilitation steps. According to the model, the councilors interacting with the residents should ideally have personal experience with or be recovering from chemical dependency. Some councilors at the center are recovering alcoholics or drug addicts, but the main psychologist was not. Second, the model advocates a period of continued rehabilitation after leaving the center itself. Previous center residents remained in touch with the *Stariy Svet* staff, and would regularly meet at the center for six months to a year following their stay. In this sense, the reintroduction to life outside the clinic is a managed process whereby the resident remains in contact with center staff or a specified period of time. Third, the treatment of addiction requires

psychological, physical, social, and spiritual treatment. The rehabilitation center is intended to treat multiple aspects of addiction, and treatment creates a rigid and highly structured daily landscape for the residents. It is within this structured landscape that the residents and staff materialize the discourse of rehabilitation. Additionally, a significant addition by *Stariy Svet* to the Minnesota Model is the incorporation of Russian Orthodox theology into the concept of therapy and rehabilitation.

Stariy Svet's organizational goal is to provide care and information in an Orthodox context to families and individuals seeking help for dealing with addiction related issues. Therefore, components of *Stariy Svet's* approach to rehabilitation include an emphasis on spiritual guidance to those battling addiction (stsv.org), and an emphasis on religion in representing the problems of alcohol and drugs in society. Staff argued that Orthodoxy was culturally central to the Russian people. Therefore a 12-steps program would be more effective if it was grounded in Orthodoxy rather than ambiguous non-denominationalism or non-Russian Protestantism.

As a result, the Russian Orthodox Church is a close partner of the organization. The Church oversees the incorporation of official theological doctrine regarding addiction and alcohol policy into the practices and publications of *Stariy Svet* and similar organizations. The Church and *Stariy Svet's* policy toward rehabilitation for addicts and alcoholics is one of complete abstinence. There is strident opposition to certain NPH strategies. The *Stariy Svet* staff members are opposed to harm-reduction, addiction management, and substitution therapies (Interview, Staff meeting, 08-20-2008). Staff

compared substitution therapy programs to genocide or accused them of destroying Russia's gene pool (ibid.). This viewpoint reflects the Russian Orthodox position on substitution therapy. Furthermore, it parallels the Russian Health Ministry's position. The Health Ministry, and by proxy most of the narcological establishment, has long rejected the validity of harm-reduction in general and substitution therapy in particular. The opposition is based on a belief that substituting one drug for another, or providing needle exchanges, is immoral and illegal. Therefore, while *Stariy Svet*'s position on rehabilitation is counter to the narcology in many ways, the organization mirrors narcology's conservative perspective on NPH methods.

The rehabilitation center itself is built on Church property, and the Church allows the organization limited use of nearby facilities for meetings and events (Protsenko 2008). However, as the Church strictly condemns strategies like substitution therapy, *Stariy Svet* has experienced trouble accessing international funding. Applications to the Open Society Foundation and USAID have been rejected because of funding regulations that promote strategies such as substitution therapy (Interview, *Stariy Svet* Grant Manager, 08-16-2008).

The therapeutic landscape of the rehabilitation center is heavily shaped by the principles and practices of its parent organization, *Stariy Svet*. The center's therapeutic landscape reflects an approach that is neither NPH nor Narcological. Russian psychologists and addiction specialists interested in the 12-step model founded the organization. The rehabilitation center is an outgrowth of this interest combined with the organization's exposure to the Minnesota Model for addiction recovery. The center's

practices are also grounded in the belief that the spiritual aspects of rehabilitation ought to be approached from a Russian Orthodox perspective. It is within this structured landscape that the organization's therapeutic methods attempt to rehabilitate residents.

The Rehabilitation Center's Therapeutic Landscape

In this section I concentrate on the built environment of the rehabilitation center in order to explore a central aspect of the therapeutic landscape because the built environment of the rehabilitation center is designed to impact the health and well-being of the residents. Therefore, I focus on the aspects of the therapeutic landscape that impact the lives of the residents. The rehabilitation center, shown in Figure 2, is a long-term stay facility. The goal of the center's rehabilitation activities is the reintroduction of residents back into society (stsv.org). As shown in Figure 1 below, the center is located approximately five miles south of Moscow near the city of Podol'sk in the village of Erino.



Figure 1 - Erino, the location of the Stariy Svet rehabilitation center

The Russian Orthodox Church donated the land for the building to the organization. As seen in Figure 3, a church that had been neglected under the Soviet regime and is now undergoing refurbishment is located roughly 100 yards away on the same property. As shown in Figure 4, in addition to the nearby church, fields, a small dacha community (weekend vacation cabins), and a small suburban development surround the center. However, nearby fields and pine forest shield the center from the village and housing complexes from view. Therefore, despite its proximity to two cities and nearby housing, the center has a rural setting.



Figure 2 - The *Stariy Svet* rehabilitation center



Figure 3 - The remodeled church next to the rehabilitation center



Figure 4 - the road to the rehabilitation center, the church is visible in the center left of the photograph

The emphasis on isolation and rural surroundings helps present the center as a place of care and rehabilitation. Rural settings are often associated with therapeutic landscapes, the proximity to nature being seen as beneficial to recovery and health (Gesler 2005; Bell 1999). Isolation was also seen as a benefit of rural settings for rehabilitation. Urban areas were viewed as risk-laden, as residents could easily find drugs or alcohol (Protsenko 2008). Resident A, who cited his need to be away from the influence of alcohol, narcotics, and the people who use them, highlighted the benefits of isolation.

I was looking for exactly rehabilitation centers, hospitals, like here, long-term. So that I would be, so to say, closed, indoors, in enclosed space. Because, (even though) there are groups in Tambov, I'm somewhere one hundred percent sure that they would not help me. So, anyway, I would hang out on the street, I would have freedom of movement, free time, and I would use (drugs/alcohol) anyway (Resident A, 08-28-2008).

Resident A describes a need for isolation. He described feeling that he needed to be away from the potential for substance abuse. This reflects a frequent association made by residents between rehabilitation and a need for enforced limits and boundaries that control and shape their behavior. Physically, this can be seen to represent the center itself, isolated and rural in its setting, safely beyond the urban environment. In a similar fashion, resident B discussed his desire to be under surveillance and supervision. In chapter five, on narcology, he mentions a desire to remain at the narcology hospital, where he would be under control by the staff and not go back to using.

In these quotes emerge an important relationship between the residents' understanding of alcoholism and their bodies in regards to the therapeutic landscape. Their alcoholism is constructed as a loss of control of their faculties. The goal of treatment and rehabilitation is not only the resumption of control, but learning how to maintain control over themselves. Symbolically and materially, this control returns through a therapeutic landscape of treatment ensconced in isolation and control. Furthermore, the initial reassertion of health mentally and physically comes from outside, whether from a narcologist, or from the staff at the rehabilitation center.

Isolation also forced a social framework onto the residents. This aspect of the center's design emphasizes group work to resolve addiction issues and socialization, in keeping with the Minnesota Model focus on social rehabilitation. The aim in this case is essentially to retrain residents to socially interact without the need for alcohol. Moreover, it establishes social boundaries and practices that may have been interrupted by the

residents' addiction. The social framework, which I address later in this chapter, enforces another aspect of governmentality wherein the residents are monitored for how they interact with each other.

The building housing the rehab center itself is relatively new, having been constructed in 2004 (stsv.org). Although the land for the center was donated by the Church, it was the responsibility of *Stariy Svet* and the other organizations to find funds and materials for construction of the house in which the center is located (Protsenko 2008). The building is a square two-story house with a peaked roof. On the first floor is a cloak room with a laundry machine, a communal kitchen, a large dining/living room that doubles as a meeting area, and a storage area. On the second floor are three rooms of shared living quarters with enough space for up to eight residents, a bathroom, and a small office space for the program coordinator and volunteers. The rooms were small and held some personal effects for each resident. There were two to three residents in each room. In addition, there was a garden and a green house, a small yard, and various materials for repairing or adding onto the house.

Much of the house is designed to emphasize shared responsibility and cooperation. Simultaneously, the center's design produced a lack of privacy and constant observation via the staff and other residents. On the first floor the small kitchen is open to the common room. Residents take turns preparing meals based on a formal schedule. The common room is designed for residents to eat meals together. It is also the primary location of study and prayer. Both study and prayer constitute central aspects of the

recovery process at the center and therefore the common room forms a central aspect of the house. The common room also serves as a place for lectures, where guest lectures on religion and addiction are given. Finally, it is a meeting place for NGO business. As *Stariy Svet* is part of a network of NGOs who deal with addiction related issues, the house's common room is a convenient place for volunteers to meet, and residents are encouraged to participate.

In producing a therapeutic landscape for rehabilitation from addiction, the center emphasizes a constant theme of observation through shared space. The residents share their rooms as well as their meals and study areas. There is little to no privacy. The lack of privacy is a central theme of rehabilitation communities. It has been highlighted as a communal and social aspect for recovery. However, it also demonstrates the importance of surveillance in the therapeutic landscape. Individuals understood that residents and staff observe them constantly, and that they themselves should be attentive of others as well. At the same time, surveillance is made central to the construction of community through the spatialization of shared space. Residents were actively encouraged to communicate and work together during their stay. For some, this helped create a sense of home within the center. The constant surveillance is an important aspect of discipline, but the construction of a sense of belonging is an additional governmentalizing step. By identifying rehabilitation with home and belonging, the residents arguably are emotionally disciplined to become invested in the center itself and the lives of their fellow residents. To a certain extent, the role of home and belonging mirrors what geographers

have said about the role of place in maintaining health, but it also demonstrates the varying governmentalizing influences that play a role in society.

Nonetheless, the plan of the house is a means of shaping the actions and behaviors of the residents in a manner that can be equated with Foucault's concept of anatomo-politics (Foucault 2003b). To reiterate, anatomo-politics is Foucault's conceptualization of discipline that revolves around direct physical coercion of individuals and populations. As with Brown and Knopp's (2010) observations of STD prevention programs in Seattle, or Crowley and Kitchin's (2008) discussion of Magdalene asylums, there is an emphasis on discipline in both the design of the program and the built environment of the center. As I continue below, the emphasis on discipline has important implications for how the act of rehabilitation is embodied by residents.

The therapeutic landscape of the rehabilitation center constructs particular subjectivities not only through the built environment but also through the coordination and discipline of resident's lives. The rehabilitation center's program of treatment works to shape behavior of the residents as a key to furthering their sobriety. Therefore, the therapeutic landscape of the rehabilitation center is contingent upon the actions of the residents. As geographers have pointed out, a central aspect in the production of meaning in different places is the performance of the individuals taking part. Such actions materialize elements of recovery that the group stresses at the center, and residents come to embody the therapeutic landscape. This section therefore focuses on the production of the therapeutic landscape of recovery at the center through residents' lives.

Of key importance in the governmentalizing process of rehabilitation is the theme of living properly. This means that the resident is expected to learn self-government as a central control on his or her illness. Accordingly, this translates as a life of sobriety, social engagement, and communion in the Orthodox Church. The center concentrates on varied frameworks for social interaction shaping how the residents ought to understand social spaces and places. Residents were expected to work around the house and receive job training. The inhabitants engaged in a variety of daily chores and obligations designed to replace habits: house-keeping, yard work, journaling, meeting with others to discuss addiction and religion, attending religious instruction, and job training. The members also attended organizational planning meetings for *Stariy Svet* and other associated NGOs. At such meetings they could participate in planning. They also would sometimes help with other organizational duties. The center in this way was an important planning center for NGO activities.

Such activities were designed to keep residents busy and to replace habitual behaviors. Residents were expected to perform and act out socially acceptable behavior and replace negative addictive behaviors. The house rules are fairly strict, as Resident B points out in his interview, in a "dry drunk", that is acting drunk without any alcohol present in his system, he got up in class without permission (Interview, 08-28-2008). An extensive list of house rules is available online at stsv.org. They include prohibitions on outside materials, use of foul language, but also rules about maintaining respect toward the staff and maintaining personal hygiene at all times. The social framework that models

acceptable behavior and discipline for the residents is contextualized morally by the significant role played by the Orthodox Church at the center.

The location of the center on the grounds of the church emphasizes the religious connections and affiliation to the Orthodox Church. Prayer and communion in the Russian Orthodox Church is central to the therapeutic landscape of the center, and residents described explicitly seeking out the center for reasons of cultural and religious sympathy. Residents described their choice of an Orthodox associate center for cultural reasons:

Resident B: Well, yes, so. I have been here for six months. And I see this here is the best option - this center, as it is here. Here it is connected culturally with the Church, and the "12 Steps" program, and Eugene - the Consultant - he is very professional ... in his work, he's a good psychologist. Well that and God's help is most important (Interview, 08-28-2008)!

In the quote above, Resident B identifies the Church as an important aspect for his recovery and treatment. In particular, he views his cultural affinity to the Church as critical for his rehabilitation. In this manner, we can see how religion plays a significant role in the therapeutic landscape. A similar view is outlined in the following quote by

Resident A:

But - there was a Baptist Center and a short-term (center) - also for three months, all the same, no program, nothing, that's it, so, the Baptists say, at our center - there is the study of the Gospel and occupational therapy. And that's it. And then - you come home and, naturally, join a church of theirs and there you will live, and help. So. Well, I refused - I refused because of the fact it's Baptist (Interview, 08-28-2008).

In this quote, we see that not only is an affinity for the Church an important consideration in the case of Resident A, but the possibility of recovery within a Baptist/non-Orthodox setting is perceived unfavorably, as is the prospect of joining a Baptist congregation. In both cases the interviewees expressed their association with Orthodox Christianity not only as a matter of cultural affinity, but also in how they understood the process of healing, and the validity of the therapeutic landscape.

As discussed in the chapter four on AA, an understanding of a higher power is central to the discourse of the 12-steps (White 1998). Therefore, it is not unusual for religion to play a role in the therapeutic landscape of the center. However, the explicitly Orthodox orientation of the center is a departure from AA and the Minnesota Model, which are typically non-denominational (White 1998). Residents consistently engage in religious activity. Besides prayer and church services, residents are lectured on theology. Religious icons were prominently displayed along with a large poster in the common area showing the relationship of various sects of Christianity to Russian Orthodoxy.

Religion played a key role in the production of the therapeutic landscape for the residents. As respondent B says above, it's with God's help that healing and sobriety can be achieved. The role religion played in the center does not deviate from the regular AA model, but it still emphasizes a major component of the therapeutic landscape. It demonstrates that religion is foregrounded in the actions of the residents, and located centrally in their processes of healing. The integral factor here is how residents perceived Orthodoxy, in particular, as mandatory for their rehabilitation. Not only was healing

impossible without religion, it was explicitly impossible without Orthodoxy. As an aspect of governmentality, therefore, religion played a key role in shaping how residents perceived their illness and themselves. Religion was emphasized as a moral framework for the residents.

In a way, much of the center's program reflects an anatomo-political approach to discipline and health, in which the body is directly acted upon (Foucault 2003b; Brown and Knopp 2010). To reiterate, anatomo-politics emphasizes direct physical discipline as a means of influencing behavior. The residents often emphasized the physical necessity of discipline in shaping a healthy self that could deal with their underlying addiction. The following resident described the importance of such imposed boundaries on behavior in his understanding of how he would achieve rehabilitation:

Resident C: For me it is difficult to get along here with the guys. It is very difficult. I always see them here. If there is any conflict, I am used to fighting constantly... And here it is forbidden to fight. Here the decision is made. Not only for me is it a problem. I am constantly the aggressor. All that is stirred up, all the time I am here. And they cause me, here I am an emotional state. Here I write a graph. This is the goal - to achieve love, peace and joy in my soul. And here I have obstacles to achieving the goals. Inadequately, and sometimes impulsively I react to criticism in my direction, there is a desire of physical violence. (Interview, 08-28-2008)

In his statement, Resident C understands his tendency towards violence as a significant obstacle to rehabilitation, and therefore an underlying aspect of his identity as an addict. Resolving such violent tendencies is an important step for him in overcoming addiction. He simultaneously argues that the rules and structure of the center are key in his rehabilitation progress, because they not only restrict and limit his behavior but also that

of the other residents. Furthermore, within his response it is evident a process of constant self-reflection and evaluation that closely links surveillance and rehabilitation. The requirement of self-reflection is structured at the center, as residents perform the work of journaling their goals, emotions, and flaws. Recording such information is a form of disciplined activity, as in this manner the residents become visible to the center's staff and each other.

A similar sentiment can be seen the following quote from Resident B in his description of how he has changed at the rehabilitation center:

I already feel like I am starting to change here, regardless of me. I'm already not so ... rather I see myself already, as if from the side, as it were. I can see all my own - well not all, but I see many of my shortcomings. Before, I did not see this because I drank all the time. I wasn't able to come around, but now I have come around, and I have here all this, that I, how to say? Now I do not drink, but I have this energy that should be spent somewhere, and it goes either positive, or negative. And ... I don't know - it sometimes outweighs the negative. There are conflicts with the guys. But this, so, disease, it... alcoholism - this is a disease of self-will (Interview, 08-28-2008).

Here Resident B describes his recuperation as a development of will. He explicitly evokes the discourse of AA in describing his illness as a disease of self-will. Within the center he describes overcoming his illness as partly reasserting his will, while simultaneously understanding his own shortcomings. This evaluation of his weaknesses in order to develop will power is central to AA and the rehabilitation center and represents a powerful governmentalizing discourse wherein recovery can only be achieved through close analysis and rigorous self-discipline.

In evoking self-discipline, often the discourse of rehabilitation itself is spatialized and spoken of in terms of the resident's body. In this sense, a central aspect of the therapeutic landscape at the center is the residents' bodies. The following quote is from Resident B, who discussed his rehabilitation in terms of painful surgery:

Resident B: I've been writing my goals in life, my problems, and it is unpleasant. This is - like a surgical operation... It is as if I am revealing myself... I do not reveal, but God, and the guys, and X the consultant. An abscess - use a scalpel. And it's painful. Sometimes through the pain, well ... that is, in the gospel of Christ it says that we must suffer - through suffering can one enter into the kingdom of God. And I think this is the case here for me. My Cross - it is my alcoholism (Interview, 08-28-2008).

For Resident B, rehabilitation and health are achievable, but he must remove his negative characteristics he views as the roots of his addiction. However, as per 12-step discourse, he cannot remove or cure his alcoholism, rather he can manage the negative traits of his behavior (White 1998). The activity of removing the "abscess" is painful, and significantly it is a process that occurs over a long term in the center with the aid of residents and consultants. The therapeutic landscape again is constructed as an ongoing process of disciplined behavior. Resident B continues to describe dealing with his addiction:

As the Lord says: "If you want to follow me - take your cross, deny yourself and follow me" - Jesus says. That is, take up my cross - this is my ... this is my illness ... my illness; to deny myself - that is, throw my ego aside, this "I", this is my "I" - this is self-will, selfishness, arrogance - deny all this and follow Christ. That's what I want. But this is very painful, because ... you have to grab yourself by the throat. All by yourself.

In this quote Resident B reaffirms the centrality of religion to his recovery process and the therapeutic landscape. Furthermore, he addresses the need to subsume his will in order

to control his "selfishness" and "arrogance". However, his metaphoric description of accomplishing this component of recovery relies on a supreme demonstration of will power and violence, wherein he individually grabs himself by the throat to drag himself on the path to healing. In this manner the body's role in the therapeutic landscape of the rehabilitation center straddles the line between metaphor and material.

Conclusion

In this chapter, I have examined the therapeutic landscape of a rehabilitation center in the suburbs of Moscow. In doing so, I have attempted to situate the rehabilitation center within the larger context of Russian public health responses to alcohol-related harm. I focused particularly on the discourses and practices of recovery from alcoholism at the center. I also focused on understanding how recovery is spatialized in the center's therapeutic landscape. Furthermore, I explored how the organization negotiates its links to Orthodoxy to its rehabilitation program grounded in 12-steps methods and the Minnesota Model of addiction recovery. I attempt to show how such negotiations play a role in building a complex understanding of alcohol, addiction, and recovery at the center. I also demonstrate how such negotiations play a role in shaping the center's therapeutic landscape. When examining the shaping of the therapeutic landscape I focus on how the residents come to embody or resist the center's rehabilitative discourses. I argue that the actions of the residents and the construction of the therapeutic landscape demonstrate a complex combination of bio- and anatomo-political means of governmentalizing behavior.

Moreover, the center is the site of production for important public health spaces in the Russian response to alcohol related harm. The conceptualization and practice of recovery from alcoholism and addiction at the rehabilitation center has important implications for how alcohol is understood as a public health problem in Russia. With respect to this research, the rehabilitation center represents a significant variation in the overall trend of public health approaches to dealing with alcohol in Russia. As I address below, the managing organization employs the Minnesota Model and 12-step methods. In doing so, the practices of the clinic closely mirror NPH transformations described in the previous chapter on the clinic. That is, the center eschews narcology perspectives on addiction and attempts an integrated approach toward rehabilitation. However, the tenets of the organization are also strongly opposed to aspects of NPH. For example, they are opposed to harm reduction as it contradicts the Orthodox tenets of the center's addiction philosophy. By exploring the therapeutic landscape of the rehabilitation center through the discourse of recovery and the practices of its residents, I demonstrate how spaces of care in the center challenge assumptions and techniques of both NPH and narcology. The challenge to conventional public health techniques represents a means for demonstrating the uneven geography of Russia's public health response to alcohol-related harm, and also demonstrates the fluctuating conceptualization of alcohol as a public health problem.

In exploring the therapeutic landscape of the rehabilitation center, I examined the multiple scales of recovery produced through activities at the rehabilitation center. In particular, I focus on how the body as the object of care and regulation, and how bodies

affected through the close control of behavior extant at the center. Furthermore, I focus on how the act of rehabilitation constructs relationships between society, the regulated body, and behavior. In focusing on the body I examine the ways in which bodies are materially and discursively produced through the therapeutic landscape of the rehabilitation center. In doing so, I trace a line connecting the bio-politically motivated forces shaping the organization and its place in Russia's overall public health system, with the anatomo-political structure of the rehabilitation center and its impact on the idea of recovery and the bodies of the residents.

CHAPTER VIII

Conclusion

In this dissertation, I argue that therapeutic landscapes negotiate how alcohol-related illnesses are understood as public health problems in Russia. To support my argument, I address how therapeutic landscapes are central to the shaping of public health understandings of alcohol-related illnesses in Russia. In addition, I demonstrate that understanding the geography of alcohol-related illnesses in Russia hinges upon the processes and practices currently ongoing in the therapeutic landscapes where patients are treated.

Keeping the above points in mind, this dissertation therefore serves as a response to existing health geography literature on the concept of the therapeutic landscape landscapes (Williams 1999a; Conradson 2003a; Gesler 2005). To this end, I argue that therapeutic landscapes need to be more rigorously applied as an analytical approach. In my analysis of the Russian therapeutic landscapes of alcohol-related illness, I put forth one example for how geographers can build on the concept of the therapeutic landscape. I illustrate that therapeutic landscapes are integral to the process of framing alcohol as a public health problem. I show that therapeutic landscapes are not only places with significant health importance and unique healing qualities. Rather, such spaces and places are productive of health geographies and public health discourses (Brown 2000a; 2003; Andrews and Evans 2008; Conradson 2005).

I base my argument and intervention in therapeutic landscape analysis on an examination of contrasting treatments for alcohol related illnesses in Russia: narcology, the 12 steps, and New Public Health (NPH). In my consideration of each of these approaches, I demonstrate how rehabilitation and illness are materially and discursively constructed in each therapeutic landscape. I also link the practices that take place in each landscape to the broader public health conceptualizations of alcohol-related illness in Russia.

As a way of considering each of these distinct ways of treating alcohol-related illness in Russia, I focus on three locations: narcological spaces, a clinic undergoing reform based on Western public health principles, and a 12-step and a Russian Orthodox Church-based rehabilitation center. These locations capture the prevailing tensions surrounding how alcohol is understood as a public health problem in Russia (White 1996; Raikhel 2010; Levintova 2007; Khalturina and Korotaev 2008; Bobrova et al. 2006; The Lancet 2009). I examine the landscapes of each of these locations, with an eye towards their constitutive institutions and processes. At the same time, my research has centered on interviews that I carried out with public health professionals. Interviews were done namely with counselors, social workers, nurses, and doctors. I also conducted interviews with individuals undergoing treatment for alcohol-related illness. These diverse interviews are my primary sources, communicating how therapeutic landscapes shape conceptualizations of alcohol-related illnesses. I bolstered my research by collecting and

examining textual evidence from participating organizations and their publications, including websites. I also gathered materials from public health archives.

To reiterate, the central contention of my dissertation is that therapeutic landscapes are productive of public health processes, transformations, and outcomes. Keeping this last point in mind, I maintain that therapeutic landscapes are therefore not merely repositories for health experiences or just reflective of dominant public health discourses and practices (Williams 1999a; Conradson 2005; Deverteuil and Andrews 2007; English, Wilson, and Keller-Olaman 2008; Gesler 2005; Laws 2009; Lea 2008). My intervention into health geography, and in the area of therapeutic landscapes, is therefore based on bringing therapeutic landscape analysis into dialogue with more critical health geography analyses.

In this respect, I put therapeutic landscape literature in dialogue with work carried out by geographers critical of NPH (Petersen and Lupton 1996; Brown 2000b). The central critique of NPH by geographers and other social scientists is that larger public health transformations do not only encompass institutional changes. Instead, these public health transformations are a reflection of changes in the fundamental understandings of health and healthy subjects (Brown and Burges Watson 2009; Moon, Kearns, and Joseph 2006; Brown 2003). I draw from these critiques as I address how therapeutic landscapes are linked with broader public health transformations. I also consider these critiques in my analysis of how therapeutic landscapes discursively and materially produce rehabilitating subjects to align with Russian public health transformations.

Moreover, this dissertation and my research specifically extend work of health geographers, who use the idea of therapeutic landscape to describe diverse places of care and recovery (Williams 1999a; Conradson 2005; DeVerteuil and Andrews 2007; English, Wilson, and Keller-Olaman 2008; Gesler 2005; Laws 2009; Lea 2008; Burges-Watson et al. 2007; Conradson 2003b; Curtis et al. 2007; Evans, Crooks, and Kingsbury 2009; Wilton and DeVerteuil 2006). As I have described in this dissertation, therapeutic landscape approaches rely on both ethnographic and textual methods to better the health aspects of a landscape (Gesler 1992; Williams 1999a). To this end, therapeutic landscape literature has successfully positioned the geographic concept of place within broader issues of health and medicine. At the same time, using therapeutic landscape as a framework, has allowed health geographers to trace the relationships between health, place, identity/subjectivity, and care (DeVerteuil and Andrews 2007; Conradson 2005; English, Wilson, and Keller-Olaman 2008). This dissertation both builds on and extends these contributions. I have done so by employing therapeutic landscape methods to document the process of care, recovery, and rehabilitation through an emphasis on place and individual experience.

Despite the important insights of health geographers using the concept of the therapeutic landscape, I argue that the concept and its application have proven to be limited. I maintain that much of the literature does not analyze or critique the relationship between therapeutic landscapes and broader public health processes and transformations. As I describe in my case studies, by focusing primarily on place and the phenomenology

of health and care experience, authors ignore the ways in which therapeutic landscapes are embedded within public health discourses and institutions. As a response to the existing literature, I argue that therapeutic landscapes should be recognized for the role they play in how particular illnesses and the process of recovery may be conceptualized in public health contexts. In addition, I identify that practices within therapeutic landscapes help shape discourses about illness and disease, just as those landscapes are in turn shaped by public health discourse. Following this line of argument, I demonstrate how therapeutic landscapes that treat alcohol-related illness can influence public health discourse on alcohol-related illness. My contribution to the discussion on therapeutic landscapes is premised on the assertion that analyzing therapeutic landscapes in Russia is critical to understanding how alcohol-related illnesses have become a public health problem. I demonstrate that therapeutic landscapes are productive spaces that shape and are shaped by public health discourses and subjectivities.

The above stated contributions are laid out in chapter two, in which I address my theoretical contributions. I extend the therapeutic landscape concept by interpreting the relationship to public health processes through ideas from health geography literature critical of NPH (Brown 2000b; Moon and Brown 2000). NPH describes recent reforms in the sphere of public health and subsequent critiques concerning the moral and ethical foundations of health in society (Lupton 1995). As I explain, critiques of NPH from within health geography have commented on how public health discourse is critical in shaping subjects in health geography (Parr 2006; Philo, Parr, and Burns 2005). Geographers who

critically interrogate NPH draw extensively from the works of Michel Foucault. In particular, these scholars demonstrate the ways in which Foucault's theories on discourse, governmentality, and biopower elucidate the social implications of contemporary public health transformations (Philo 2005b; Brown and Knopp 2010; Legg 2005). As Russian public health and the therapeutic landscapes for treating alcohol-related illnesses are currently undergoing transformations, Foucault's ideas and critiques of NPH provide a means of interpreting and understanding the outcomes of these emergent landscapes.

By working with Foucault's theories, geographers have attempted to show how state policies and practices, like those in public health, operate along lines of power. To this end, power is dispersed outwards, shaping both subjects and geographies. Geographers show that such lines of power also operate at various scales, including at the scale of the everyday life of the subject. Moreover, as I show through my research, both health care providers and individuals reproduce and negotiate policies of public health and alcohol regulation. In identifying the role of these subjects, I broaden the application of therapeutic landscape as a methodological approach in geography. I do so by focusing on how therapeutic landscapes are constituted of such subjects, processes, and discourses.

By engaging with therapeutic landscapes within the context of NPH criticism, I demonstrate that therapeutic landscapes are the product of health discourses. Furthermore, I show the ways in which therapeutic landscapes constitute productive spaces. That is, the processes and practices within the therapeutic landscape broadly

influence public health concepts and geographies. I demonstrate this idea in my consideration of the conceptualization in public health of alcohol-related illnesses.

I contend that NPH critiques are well positioned to show how therapeutic landscapes are not only informed by larger health processes and health geographies (Crampton and Elden 2006). These critiques also serve to demonstrate how therapeutic landscapes are productive of those same processes and geographies. In addition, I emphasize how NPH critiques stress the role of discourse. The important role of discourse comes forth in my analysis of therapeutic landscapes. I focus on how discourse is central to the idea of recovery, and how the processes and practices within the therapeutic landscape affect larger public health processes. In this manner, I demonstrate the recursive relationship between NPH and therapeutic landscapes.

In chapter three, I outline my argument regarding the relationship of therapeutic landscapes to Russian public health responses toward alcohol-related illnesses. I do so as a means of contextualizing the framework I used to collect data and conceptualize my dissertation research. I then discuss how therapeutic landscape analysis informs my approach to research and field methods, including the approaches I used for interviewing study participants. I next review the empirical foci of my research and explain how such foci fit within my overall dissertation argument. In addition, I outline the organization of my research and discuss the methods, techniques, and instruments I employed to gather data.

As part of my discussion in chapter three, I also describe the progress of my research after I arrived in the field. I explain the goals of my fieldwork and how these goals changed during my field research. In addition, I address the extent to which my research answered my original research question. I also consider in what ways my research was not successful, and address how it could have been improved. Finally, I address the various challenges I met in the field, and how they affected my research in general. In particular, I focus on barriers to access that I faced in interviewing participants that presented themselves during my fieldwork. In providing this overview of my research, fieldwork, and analysis, my goal is to show the underlying methodological framework and related methods I used to consider the role of therapeutic landscapes in Russia's public health treatment of alcohol-related illnesses. In this respect, I demonstrate that therapeutic landscape approaches are a significant positive methodological approach for understanding linkages between place, experience and broader public health processes.

Following my methods discussion, I present the findings of my research. In chapter four, I look at the therapeutic landscape of Alcoholics Anonymous (AA) in Russia and its role in the production of alcoholic identities and concepts of rehabilitation. Here, I argue that AA plays a significant role in how alcohol is problematized as a public health issue in Russia. Moreover, I describe how this problematization of alcoholism through AA presents a significant alternative to Russia's mainstream narcology approach (Raikhel 2011). As part of this discussion, I also demonstrate that the therapeutic landscape of AA

relies on a specific set of governmentalizing practices. Specifically, AA uses disciplinary practices to shape conceptualizations of alcoholism for its members (Valverde and White-Mair 1999). However, AA also plays a critical role for its production of therapeutic landscapes within Russian public health geographies. In this respect, AA groups and members work together to reproduce and reinforce AA discourses and practices within hospitals, clinics, and other areas throughout Russia (The Lancet 2009). By way of these conduits, AA systematically works towards the production of therapeutic landscapes. The production of AA therapeutic landscapes leads to the formation of distinct public health geographies where AA methods and practices are key components of the recovery process. In this manner, I explain how AA therapeutic landscapes affect contemporary Russian public health by shaping conceptualizations of alcohol-related illnesses and treatment.

In structuring my argument concerning AA, I begin with an overview of AA's history and the 12-step program. I lay out the underlying pastoral elements of AA as a technique of governmentality (Valverde 1998). As part of my argument, I maintain that the governmentality aspects of AA can be traced back to its foundations. The organization's goals emphasize the important role of the self and identity in maintaining sobriety (White 1998). I therefore incorporate this institutional history as I address the relevance of Foucault's concept of governmentality to understanding the therapeutic landscape of AA.

As part of my discussion on governmentality and the therapeutic landscape of AA, I focus on group meetings. At meetings, members affirm their alcoholism and discuss their efforts at working through the 12-steps. I describe how the therapeutic landscape of the meeting works towards reinforcing disciplinary practices for members, as well as their conceptualizations of alcoholism. At the same time, I also demonstrate how AA spatializes members' daily lives outside the group, as they define their lives through their recovery. Moreover, in the context of both meetings and their daily lives, members also perform an alcoholic identity in which they come to embody AA discourses of healing and recovery. Consequently, I show that the therapeutic landscape of AA presents a heavily governmentalized space, where members are in a constant state of self-regulation and self-surveillance. In my consideration of the governmentalizing aspects of the AA meetings and members' daily lives, I also present an initial disciplinary therapeutic landscape of AA, which is critical for understanding the operation of AA in Russia.

To address AA, I provide a history of AA within Russia. As I explain, the slow and sometimes troubled introduction of AA into Russia is central in understanding how AA is viewed and critiqued in Russia (Green, Holloway, and Fleming 2001; Green and Holloway 2002). Moreover, the history of AA in Russia reveals how alcoholics are popularly and clinically stigmatized in Russian society (White 1996). I argue that understanding how AA is perceived in Russia explains the difficult and slow growth of the group in Russia. Additionally, reviewing the troubled history of AA in Russia serves as a way of highlighting the influence of narcology on public health in Russia. In this

sense, many of the obstacles to AA expansion in Russia are outgrowths of narcological conceptualizations of alcohol-related illness and their predominance in Russian public health.

Lastly, I focus on the different spaces through which AA produces self-governing subjects. In this respect, I examine the experiences of Russians who are AA members. I also analyze the geographic aspects of AA through which surveillance, regulation, and discipline take place, particularly at the AA meeting. Through examining both participants and the geographies of surveillance, I demonstrated how the discourse of AA shapes participants' views of their own alcohol-related experiences. I simultaneously illustrate the connections of power and discipline that give structure to Russia's geography of public health and alcohol. I argue that understanding the geography of AA is central to understanding the geographies of Russia's public health response to alcohol abuse in general. Specifically, I put forth that an analysis of AA establishes a distinct therapeutic landscape for treating alcohol abuse in places such as the addiction clinic and rehabilitation center.

In chapter five, I then turn to the therapeutic landscapes of Russian narcology (Elovich and Drucker 2008). Here, I explain how narcological approaches to dealing with alcohol-related illnesses are based upon a particular understanding of alcoholism and addiction, and treat addiction through a combination of detoxification, chemical aversion therapy, and hypnotic suggestion (Raikhel 2010). By examining narcology's therapeutic

landscapes, I demonstrate that narcological treatments materially and discursively shape the public health response to alcohol-related illness in Russia.

In addition, chapter five elaborates on how narcological therapeutic landscapes are physically restricted to clinical settings (Babayan, Gaevskii, and Bardin 2000; Mendelevich 2004c; 2007a). These settings include the narcological hospital and the narcological dispensary. However, I also show that such strictly bounded treatment settings, combined with narcology's underlying focus on individual treatment, have affected society and public health related issues in particular (Fleming, Meyroyan, and Klimova 1994). Of particular importance to my argument, is how narcological approaches restrict public health responses to alcoholism in Russia. As I explain, narcology critically shapes perceptions in Russian society of alcohol-related illnesses. In particular, narcology has complicated the contemporary development of Russia's public health response to alcohol-related illness through particular flawed conceptualizations of alcoholism and addiction as the central components of alcohol-related illnesses (Elovich and Drucker 2008; Raikhel 2010; 2011). That is, the discourses and practices of narcology limit the extent to which alcohol-related illnesses can be conceptualized as a public health problem. Such limitations are the product of a bio-politics of addiction and alcoholism in narcology that emphasizes individual responsibility in alcohol-related illnesses, while simultaneously silencing the role of social and environmental factors. Such emphasis on the individual has had the effect of justifying punitive treatment methods for dealing with alcohol-related illness. Indeed, the narcological therapeutic landscape has had a long history of

focusing on the individual and combining treatment with punishment. Just as important, however, is that the impact of narcological science in shaping alcohol-related illnesses through a stigmatized conceptualization of alcoholism that has been discursively and materially influential.

In evaluating narcology's therapeutic landscape, I focus first on its origins as a branch of Soviet psychiatry. By describing the origins of narcology and its therapeutic landscapes, I establish the underlying bio-politics of Russia's contemporary public health response to alcohol-related illness (Brown and Knopp 2010). As I explain, the narcological emphasis on personal responsibility, which was fomented in the political context of Soviet society, shapes alcohol-related illness as a moral hazard (White 1996). The perceived immorality of alcohol related-illness validates the construction of therapeutic landscapes that stressed punitive approaches toward treatment subjects. Punitive approaches to alcohol-related illnesses are further emphasized within therapeutic landscapes via the narcological perspective of addiction in general (Gilinskiy and Zobnev 1998). The implementation of the narcology service, combined with Soviet policing strategies, work towards further shaping perspectives on substance abuse as a criminal behavior and mental illness. Furthermore, I demonstrate the manner in which narcology establishes the discursive and material boundaries around concepts of alcohol-related illness. These concepts are crucial in the contemporary public health sphere.

To demonstrate specifically how narcological therapeutic landscapes have shaped contemporary public health perceptions, I examine the experiences of individuals who

have either received or provided narcological treatment for alcohol-related illnesses. I focus on the experiences of subjects and practitioners in order to elucidate the practices and discourses of the contemporary therapeutic landscape of narcology. I also examine narcological approaches used in private clinics to deal with alcohol and addiction, such as *kodirivanie* (coding - a form of hypnotic suggestion) (Raikhel 2011; cip.nsk.su 2009). I then discuss how the narcology system continues to emphasize individual approaches to dealing with addiction. In doing so, I demonstrate how discourses and practices of treatment in narcology's therapeutic landscapes are central to the conceptualization of alcohol-related illnesses in Russia. Furthermore, I examine how narcology's discourses and practices have produced limitations on Russia's public health response to alcohol-related illnesses.

In the final part of my examination of narcology, I address recent changes regarding treatment for alcohol-related illness that have occurred in the therapeutic landscape of narcology. In particular, the emergence of AA in hospitals and narcology dispensaries signals that narcology is undergoing a reevaluation, albeit limited, of the concepts of addiction and alcoholism. I examine how narcological perspectives on addiction have changed incrementally and how some narcologists are adopting new treatment methods, which incorporate social and environmental determinants of alcohol-related illness (Mendelevich 2007a; 2007b). I demonstrate that the boundaries narcology places on public health approaches to dealing with alcohol-related illness are neither static

nor inflexible. Instead, these boundaries are slowly changing to incorporate social and environmental perspectives regarding alcohol-related illness.

In chapter six, I examine a neighborhood clinic in Moscow that provides addiction treatment and family mental health services. I focus on how this clinic represents a therapeutic landscape shaped in part by NPH concepts (Lupton 1995; Petersen and Lupton 1996). I also address the extent and limitation of NPH transformations regarding the construction of alcohol as a Russian public health problem. In particular, I focus on how practices and perspectives of the clinic staff were shaped by NPH concepts (Williams 1999b; Andrews and Evans 2008; 2009). I demonstrate how the therapeutic landscape of the clinic and the activities of the clinic staff are bio-political focal points in the negotiation of alcohol as a Russian public health matter.

I then discuss how the emergence of NPH concepts in the clinical setting marks a significant departure from contemporary Russian public health approaches to dealing with alcohol and addiction that are based on narcology. Unlike narcology's overall punitive approach to alcohol and addiction, NPH concepts emphasize risk, education, and prevention (Petersen and Lupton 1996). The clinic I focus on offers a hybrid of treatments that include 12-step methods along with counseling and mental health services. The clinic's efforts represent an important shift in the bio-political imagination of alcohol as a public health issue in Russia, as emphasis shifts from punishment to prevention.

Moreover, the clinic provides additional services designed to provide mental health services, space for 12-step meetings, and engagements with educational outreach. I discuss how the emergence of NPH through the clinic is not only a departure from narcology and the introduction of new ideas about alcohol as a public health concern; it also represents a geographic reimagining of how public health spaces and places play an important role with addiction issues in Russia.

Additionally, I show that the transition away from narcology and earlier Soviet clinic models, to a NPH clinic model represents a shift in the spatialization of public health responses to alcohol abuse in Russia (Rechel et al. 2011a). In this respect, staff efforts are reframing space and place in order to inform individuals and families about risk and behavior. Their efforts contrast with the traditional clinic model of primary care, direct treatment, and referral. Their efforts also contrast with narcology methods of punishment and incarceration. In this sense, I demonstrate how NPH as a bio-political rationale is a spatial process intricately connected to and produced through public health spaces and practices (Legg 2006; Philo 2005c; Brown and Knopp 2010).

In chapter six, I particularly focus on the emergence of risk in the discourse and practices of the clinic staff. To this end, I examine the reframing of the clinic as a place for modeling behavior and as a therapeutic landscape (Foucault 1973; Philo 2000b). It is here that individuals and families reshape their ideas of care. At the same time, I argue that the introduction of NPH represents a transition in how public health subjects are conceptualized and how alcohol is problematized as a public health problem in Russia.

Furthermore, NPH also represents a transformation in how public health subjects recovering from alcohol-related harm conceptualize themselves. Methods of self-regulation include increasing efforts by the staff at health education, counseling, observation and documentation, as well as portraying the clinic as a care-based environment. Thus, the emergence of NPH geographies and governmentality in the Russian clinic represents a change not only in public health practices, but also in addiction and alcohol treatment.

I initially begin chapter six with a brief history of the group “No to Alcoholism and Drug Addiction” (NAN). NAN is a Russian non-profit that motivated the reform of the clinic network also discussed in the same chapter. NAN represents a focal point for the introduction of NPH reforms into Russia's public health sphere. Understanding how NPH has been introduced into Russian public health is central in demonstrating the uneven process of public health transformation in Russia.

I then focus on the attitudes and practices of the staff employed at the YZAO clinic affiliate of the larger YZAO health network. I look at how they approach and rationalize treatment. In particular, I examine how they incorporate NPH themes of prevention and risk into their work. The reproduction of NPH practices helped shape the clinic and governmentalize spaces beyond the clinic, as people transfer knowledge of healthy behavior and risk into practice (Andrews and Evans 2008; Andrews et al. 2012). In addition, I focus on how the practices of the clinic staff frame risk: specifically in the form of education and care. Finally, I describe how the staff works to construct the clinic as a

place to confront addiction. In this respect, the staff helps to transform the clinic space into a place of care. By looking at how clinic workers approach risk through care and education, I demonstrate that NPH practices are also being reproduced and incorporated into the geography of Russian public health. Consequently, the clinic represents a biopolitical shift in how alcohol is constructed as a public health issue in Russia (Brown and Knopp 2010; Evans 2012; Legg 2005; Ong 1995; Rutherford and Rutherford 2013).

I conclude chapter six by addressing the ways in which the clinic staff has not been able to operate in a manner consistent with NPH practices. The clinic has been the site of an uneven transformation of health geography. This situation exemplifies Foucault's arguments about uneven transformations manifest in governmentality. To this end, the uneven progress of change in alcohol treatment strategies in Russia, and in Russia's public health sector in general, is emblematic of the unique geographies that emerge contextually from historical and geographic circumstance.

In chapter seven, my final empirical chapter, I look at the therapeutic landscape of a rehabilitation center in the suburbs of Moscow. In essence chapter seven is a discussion of rehabilitation centers as alternative therapeutic landscapes to narcology and NPH methods. By looking at this center as a therapeutic landscape, I demonstrate how the discourses and practices of treatment at the center reflect and advocate a particular understanding of alcohol as a public health problem. In turn, I demonstrate that the residents embodied treatment discourses and practices. In particular, their actions were

central in producing the therapeutic landscape. Moreover, I describe how rehabilitation centers in general help shape the public health conceptualization of alcohol in Russia.

I begin chapter seven by discussing the history of the organization running the center, *Stariy Svet*. I then focus on the physical layout of the center, and its relationship to the therapeutic landscape. In this sense, I address the built-environment and how it is intentionally designed to reflect a particular conceptualization of rehabilitation. I next address the therapeutic landscape through the individuals who live and work at the rehabilitation center (Wilton and DeVerteuil 2006; Wilton and Moreno 2012). I demonstrate that the residents embody discourses of rehabilitation. By focusing on the embodied experiences of the residents, I connect their struggles with recovery to *Stariy Svet's* overall conceptualization of addiction and rehabilitation. I conclude by situating *Stariy Svet* and the rehabilitation center within the broader landscape of Russia's public health response to alcohol-related harm.

My analysis in chapter seven also focuses on the discourse and practice of rehabilitation and recovery, as propagated by *Stariy Svet* (Old World). I demonstrate that the therapeutic landscape at the rehabilitation center was structured through a complex understanding of addiction and recovery, which reflects *Stariy Svet's* organizational ideology and principles. Likewise, I focus on the experiences of the rehabilitation center residents, who embody and materialize the discourses of rehabilitation. In doing so, I demonstrate how the residents inhabit and shape the therapeutic landscape as they come to embody discourses of rehabilitation.

The conceptualization and practice of recovery from alcoholism and drug addiction at the rehabilitation center have significant implications for how alcohol is understood as a public health problem in Russia (Balabanova et al. 2004; Bobrova et al. 2006; Fleming, Meyroyan, and Klimova 1994; Khalturina and Korotaev 2008; Levintova 2007; Raikhel 2010; *The Lancet* 2009). Such centers, in general, are key components in the shaping of public health conceptualizations of alcohol. The *Stariy Svet* rehabilitation center represents a significant variation in the overall trend of health approaches to dealing with alcohol in Russia. By exploring the therapeutic landscape of the rehabilitation center, this chapter demonstrated that both NPH and narcology approaches and landscapes can be challenged by variations in geographies of care. In this sense, the therapeutic landscape of the center embodies the fluctuating conceptualization of alcohol as a public health problem in Russia.

I consider the ways in which residents materially and discursively reproduce rehabilitation as conceived of by *Stariy Svet*. I focus particularly on the disciplinary structure of life at the center. I draw out the connections between the governmentalizing foundations of rehabilitation and the manner in which residents embody rehabilitation as a practice and ideology. I demonstrate that the rehab center operates through governmentality as it works to discipline the residents in self-regulating themselves as a central aspect of recovering from addiction (Wilton and DeVerteuil 2006; Crowley and Kitchen 2008; Brown and Knopp 2010). I situate *Stariy Svet's* complex definitions of

addiction and recovery as an intervention in the bio-politics of Russia's overall public health system.

In this dissertation, I have argued that therapeutic landscapes for treating alcohol-related illnesses in Russia are key locations for the negotiation of alcohol-related illnesses as public health problems. As I have shown, therapeutic landscapes are centrally important in shaping public health understandings of alcohol-related illnesses in Russia.

Throughout this dissertation I have sought to draw out the significant contrasts that exist in how alcoholism, addiction, and rehabilitation are understood and constructed as health issues in Russia. I have demonstrated that the contemporary landscape of public health in Russia is populated by practices and ideas for treating alcohol-related illnesses that contrast sharply. The practices and ideas contrast not only in terms of what it means to be addicted to alcohol, or being alcoholic, but also what it means to be treated, rehabilitated, and healthy.

In examining therapeutic landscapes, I have argued for extending the literature in geography that focuses upon places of care and rehabilitation. Specifically, I have contended that therapeutic landscapes are intrinsically connected to broader public health processes and institutions. As such, in examining the therapeutic landscapes for treating alcohol-related illnesses in Russia, I have argued that not only do the landscapes reflect conceptualizations of illness and recovery, therapeutic landscapes are also productive of public health ideas about alcohol and alcohol-related illnesses as public health problems.

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APPENDIX A - Scripts and forms of consent

Appendix A-1: Initial Contact Script for Phase I

Initial contact conversation (over the telephone)

** To be conversed in Russian and to be edited by local professors/research assistants, as needed.

Hello (and local greetings)

My name is Ian Duncan and I obtained your name from _____. _____ told me that he/she spoke with you and that you gave your permission for me to contact you. Is that correct? (if yes) I am an American doctoral student at the University of Washington and I am here doing research on health care and alcohol in Russia. I am contacting you as a potential informant in this study. Are you interested in hearing more about this study? (if yes) Is this a good time to talk?

I am conducting a research study on health care workers and professionals in Russia. I am interested in speaking with you about your experiences and perspectives. I am also interested in asking you some general questions about how approaches to raising awareness about the dangers of alcohol, or the role of health care workers may have changed in recent years. If you agree to participate, I will interview you for this project for approximately one hour at a date and time of your preference. I will also ask your permission to audiotape the interview. You can refuse to be audio taped and still take part in the study. You can also ask me to stop or destroy the audiotape anytime during or after the interview.

If you think that you might be interested in participating in this study, I would like to schedule an appointment with you either at work or at some other more appropriate location of your preference. At the beginning of our meeting we will talk in detail about the study and any questions you might have. After we discuss the study and you have a chance to ask questions about the project, you can decide if you would like to participate or not. Also, you may decide at any time during the interview or afterwards that you do not want to participate in the project. Participation is voluntary and this request and your response will remain confidential.

Thank you for your time. Here is my phone number in case you need to reach me (local number).

Sign off.

Appendix A-2: Written Consent for Phase I

UNIVERSITY OF WASHINGTON WRITTEN CONSENT FORM FOR INDIVIDUAL INTERVIEWS

Title: *Alcohol and Public Health in Russia*

Investigators: Ian Duncan, Department of Geography, Craig ZumBrunnen, Professor, Department of Geography; Box 353550, University of Washington, Seattle, WA 98195. Tel.206-819-9703

**To be edited by local professors and translated into Russian

Introduction

I am asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be in the study. Please read the form carefully. You may ask questions about the purpose of the research, what I would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When all your questions have been answered, you can decide if you want to take part in the study or not. This process is called "informed consent."

Purpose of the Study

This research project concerns health care in Russia and the role of health workers and providers concerning alcohol abuse. This research will also help us understand different perceptions among health care professionals, workers, and advocates concerning alcohol as a public health issue. This study aims to understand how individuals in Russia's public health sector play a role in mitigating the consumption of alcohol because of its adverse physical and social effects. This study is part of the research for my dissertation in human geography at the University of Washington.

Procedures

If you choose to participate in this study, I would like to interview for approximately one hour. You will not be asked any personal questions that do not directly relate to your professional experiences. The questions I will ask will focus on Russia's health care institutions, the role of alcohol in Russian society, Russian public health programs regarding alcohol abuse. You do not have to answer every question. You will be interviewed only once.

I would like to tape-record the interview with your permission. You may choose not to have your interview audio taped. You may also ask me to turn off the tape recorder

at any time. Only members of the research team will have access to the audiotapes. I will replace names with codes when I transcribe recordings and notes. Tapes will be kept in a secure location separate from your name or any identifying information. The tapes will be transcribed and translated within one year of your interview. Once the tapes are transcribed and translated, they will be destroyed. You may listen to the audiotapes or read your interview transcripts anytime. You can also change your answers anytime. You may also edit or tell me not to use some of your answers. If you decide to withdraw from the study at anytime, I will immediately destroy the audiotape and any transcripts of your interview.

Risk, Stress or Discomfort

Some people feel that providing information for a research study is an invasion of privacy, or feel nervous or uncomfortable when they are tape-recorded. You do not have to answer all the questions and you may request that the tape-recorder be turned off at any time. You may also end the interview at any time.

Benefits of the Study

You may not directly benefit from taking part in this study. However, we hope that the results of this study will help us the role of Russia's public health sector in raising awareness about the dangers of alcohol abuse.

Other Information

Taking part in this study is voluntary. You can stop at any time. Information about you is confidential. I will code the study information. I will keep the link between your name and the code in a separate, secured location until May 2009. Then I will destroy the link. If the results of this study are published or presented, I will not use your name. Because I am a U.S. researcher I need to tell you that government or university staff sometimes review studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

I may want to re-contact you to clarify information from your interview. In that case, I will telephone you and ask you for a convenient time to ask you additional questions closely related to your interview. Please indicate below whether or not you give your permission for me to re-contact you for that purpose. Giving your permission for me to re-contact you does not obligate you in any way.

I may want to quote you using your name. In that case, I will ask you to review the quote and edit it before giving your written permission to publish the quote with your name.

If you are interested, I will send you a copy of the written research for your review. If you have questions about the study at any time, you can call me at _____

(local number) or reach me via e-mail at rid@u.washington.edu. Please note that I cannot ensure the confidentiality of information sent via e-mail.

Signature of investigator Printed Name Date

Subjects Statement

This study has been explained to me, and I voluntarily consent to participate. I have had an opportunity to ask questions. I understand that future questions I may have about the research will be answered by one of the investigators listed above. If I have questions about my rights as a subject, I may call or e-mail the University of Washington Human Subject's Division at 011-1-206-543-0098 (international call) or hsd@u.washington.edu.

____ I give my permission for the researcher to audiotape my interview.

____ I do NOT give my permission for the researcher to audiotape my interview.

____ I give my permission for the researcher to re-contact me to clarify my interview.

____ I do NOT give my permission for the researcher to re-contact me to clarify information.

Signature of subject Printed Name Date

Copies to: Investigator's file
Subject

Appendix A-3: Sample Interview Questions for Phase I

1. What is the nature of your position?
2. How would you describe the role of the public health sector in Russian society?
3. What do you believe informs health approaches regarding alcohol related illnesses?
4. Do people commonly seek treatment for alcohol related problems?
5. Where do they seek treatment?

6. How do organizations or government offices ensure that people receive such services?
7. How would you describe the relationship between the various actors in the health care community in Belgorod? In Russia?
8. Has the demand for health care changed in recent years? What factors have informed these changes?
9. Have demands on public health services changed in recent years? How so?
10. Have recent changes in law resulted in a change public health approaches to alcohol related problems?
11. What do you think about debates on the role of alcohol in Russia in relation to the country's broader societal health?
12. What do you think about government involvement in informing people about the dangers of excessive alcohol consumption?
13. What are the strengths and weaknesses of the current health care system?
14. If you were able to change one thing in the current system, what would you change?

Appendix A-4: Initial Contact Script for Phase II

Initial contact conversation (over the telephone)

** To be conversed in Russian and to be edited by local professors/research assistants, as needed.

Hello (and local greetings)

My name is Ian Duncan and I got your name from _____. _____ told me that he/she spoke with you and that you gave your permission for me to contact you. Is that correct? (if yes) I am an American doctoral student at the University of Washington and I am here doing research on health care and alcohol in Russia. I am contacting you as a potential informant in this study. Are you interested in hearing more about this study? (if yes) Is this a good time to talk?

First, I wanted to find out a bit about your background. How long have you been involved in the health care sector? What are your main duties at your position?

(if participant is not working in the Russian health sector).

Thank you for your time, but for this study I am only interviewing people who are engaged in, or have been engaged in, health care provision.

(if participant works in the Russian health sector)

I would like to interview about sixty health workers in the Belgorod region. I am interested in talking with you about your experiences in health care provision, your thoughts on alcohol abuse in Russian society, and your perception concerning the role health services plays in mitigating the consumption of alcohol among Russians. If you decide to participate I will interview you for 30-45 minutes. You will only be interviewed once. I will also ask your permission to audiotape the interview. You can refuse to be audio taped and still take part in the study. You can also ask me to stop or destroy the audiotape anytime during or after the interview.

If you think that you might be interested in participating in this study, I would like to speak with you in more detail about the project. Is now a good time?

(if yes, then continue with conversation and begin consent process).

(if no)

Can we meet and schedule an appointment for some other time?

At our meeting we will talk in detail about the study and any questions you might have. After we discuss the study and you have a chance to ask questions about the project, you can decide if you would like to participate or not. Also, you may decide at any time during the interview or afterwards that you do not want to participate in the project. Participation is voluntary and this request and your response will remain confidential.

Thank you for your time. Here is my phone number in case you need to reach me.

End conversation.

Appendix A-5: Written Consent for Phase II

UNIVERSITY OF WASHINGTON
WRITTEN CONSENT FORM
FOR INDIVIDUAL INTERVIEWS

Title: *Alcohol and Public Health in Russia*

Investigators: Ian Duncan, Department of Geography, Craig ZumBrunnen, Professor, Department of Geography; Box 353550, University of Washington, Seattle, WA 98195. Tel.206-819-9703

**To be edited by local professors and translated into Russian

Introduction

I am asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be in the study. Please read the form carefully. You may ask questions about the purpose of the research, what I would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When all your questions have been answered, you can decide if you want to take part in the study or not. This process is called "informed consent."

Purpose of the Study

This research project concerns health care in Russia and the role of health workers and providers concerning alcohol abuse. This research will also help us understand different perceptions among health care professionals, workers, and advocates concerning alcohol as a public health issue. This study aims to understand how individuals in Russia's public health sector play a role in mitigating the consumption of alcohol because of its adverse physical and social effects. This study is part of the research for my dissertation in human geography at the University of Washington.

Procedures

If you choose to participate in this study, I would like to interview for approximately one hour. You will not be asked any personal questions that do not directly relate to your professional experiences. The questions I will ask will focus on Russia's health care institutions, the role of alcohol in Russian society, Russian health care programs regarding alcohol abuse. You do not have to answer every question. You will be interviewed only once.

I would like to tape-record the interview with your permission. You may choose not to have your interview audio taped. You may also ask me to turn off the tape recorder at any time. Only members of the research team will have access to the audiotapes. Tapes will be kept in a secure location separate from your name or any identifying information. The tapes will be transcribed and translated within one year of your interview. Once the tapes are transcribed and translated, they will be destroyed. You may listen to the audiotapes or read your interview transcripts anytime. You can also change your answers anytime. You may also edit or tell me not to use some of your answers. If you decide to

withdraw from the study at anytime, I will immediately destroy the audiotape and any transcripts of your interview.

Risk, Stress or Discomfort

Some people feel that providing information for a research study is an invasion of privacy, or feel nervous or uncomfortable when they are tape-recorded. You do not have to answer all the questions and you may request that the tape-recorder be turned off at any time. You may also end the interview at any time. The decision is up to you whether you feel comfortable interviewing in this setting.

Benefits of the Study

You may not directly benefit from taking part in this study. However, we hope that the results of this study will help us the role of Russia's health sector in raising awareness about the dangers of alcohol abuse.

Other Information

Taking part in this study is voluntary. You can stop at any time. Information about you is confidential. I will code the study information. I will keep the link between your name and the code in a separate, secured location until May 2009. Then I will destroy the link. If the results of this study are published or presented, I will not use your name. Because I am a U.S. researcher I need to tell you that government or university staff sometimes reviews studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

I may want to re-contact you to clarify information from your interview, or to invite you to participate in future parts of this research. In that case, I will telephone you and ask you for a convenient time to ask you additional questions closely related to your interview. Please indicate below whether or not you give your permission for me to re-contact you for that purpose. Giving your permission for me to re-contact you does not obligate you in any way.

I may want to quote you using your name. In that case, I will ask you to review the quote and edit it before giving your written permission to publish the quote with your name.

If you are interested, I will send you a copy of the written research for your review. If you have questions about the study at any time, you can call me at _____ (local number) or reach me via e-mail at rid@u.washington.edu. Please note that I cannot ensure the confidentiality of information sent via e-mail.

Signature of investigator Printed Name Date

Subjects Statement

This study has been explained to me, and I voluntarily consent to participate. I have had an opportunity to ask questions. I understand that future questions I may have about the research will be answered by one of the investigators listed above. If I have questions about my rights as a subject, I may call or e-mail the University of Washington Human Subject's Division at 011-1-206-543-0098 (international call) or hsd@u.washington.edu. I will receive a copy of this consent form.

___ I give my permission for the researcher to audiotape my interview.

___ I do NOT give my permission for the researcher to audiotape my interview.

___ I give my permission for the researcher to re-contact me to clarify my interview.

___ I do NOT give my permission for the researcher to re-contact me to clarify information.

___ I give my permission for the researcher to re-contact me about taking part in future research.

___ I do NOT give my permission for the research to re-contact me about future research.

Signature of subject Printed Name Date

Copies to: Investigator's file

Subject

Appendix A-6: Sample Interview Questions for Phase II

1. How long have you worked in the public health sector?
2. How has your work changed over the past 10 years? 20 years?
3. Do you treat individuals for alcohol related illnesses or problems? How often do you treat individuals for alcohol related illnesses or health problems?
4. Is there a limit to the services you can provide individuals at this location?
5. What is the approximate proportion of people who seek services for alcohol related illnesses?
6. Does the demand for services differ among alcohol related cases?
7. What do you believe informs the decisions of those individuals who seek services for alcohol related illnesses or problems?

8. What reasons may an individual give for not accessing public health services?
9. Do public health workers or professionals attempt to overcome such reasoning? How so (why not)?
10. What do you believe informs public health approaches and practices regarding alcohol related illnesses or problems?
11. How do organizations or government offices inform people that such services are available?
12. Have the demands on public health services changed in recent years? What factors have informed these changes?
13. What do you think about debates on the role of alcohol in Russia in relation to the country's broader societal health?
14. Does the government attempt to inform people about the dangers of excessive alcohol consumption?
15. What are the strengths and weaknesses of the current health system?
16. If you were able to change one thing in the current system, what would you change?

Appendix A-7: Initial Contact Script for Phase III

Initial contact conversation (over the telephone)

** To be conversed in Russian and to be edited by local professors/research assistants, as needed.

Hello (and local greetings)

I spoke with you previously and you gave your permission for me to contact you again. Is that correct? (if yes) As you know, I am an American doctoral student at the University of Washington and I am here doing research on health care and alcohol in Russia. I am contacting you again to find out more about your experiences and perspectives. Are you interested in finding out more about the types of questions I may ask? (if yes) Is this a good time to talk?

(if participant is involved in the administration of health related programs in Russia).

I would like to interview about 20 individuals who are involved in the administration of health care programs in Russia. I am interested in talking more in depth with you about your experiences as an administrator, your perceptions concerning the abuse of alcohol in Russia, and your views on the role the health sector plays in mitigating consumption and raising awareness about the dangers of alcohol abuse. If you decide to participate I will interview you for 90-120 minutes. You will be interviewed at least once, however, I may ask your permission to meet with you another time if I have additional questions. In addition, you may opt to interview for 90-120 minutes in several meetings. I will also ask your permission to audiotape the interview. You can refuse to be audio taped and still take part in the study. You can also ask me to destroy the audiotape anytime during or after the interview.

If you think that you might be interested in participating in this study, I would like to speak with you in more detail about the project. Is now a good time?

(if yes, then continue with conversation and begin consent process).

(if no)

Can we meet and schedule an appointment for some other time?

At our meeting we will talk in detail about the study and any questions you might have. After we discuss the study and you have a chance to ask questions about the project, you can decide if you would like to participate or not. Also, you may decide at any time during the interview or afterwards that you do not want to participate in the project. Participation is voluntary and this request and your response will remain confidential.

Thank you for your time. Here is my phone number in case you need to reach me.

End conversation.

Appendix A-8: Written Consent for Phase III

UNIVERSITY OF WASHINGTON
WRITTEN CONSENT FORM
FOR INDIVIDUAL INTERVIEWS

Title: *Alcohol and Public Health in Russia*

Investigators: Ian Duncan, Department of Geography, Craig ZumBrunnen, Professor, Department of Geography; Box 353550, University of Washington, Seattle, WA 98195. Tel.206-819-9703

**To be edited by local professors and translated into Russian

Introduction

I am asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be in the study. Please read the form carefully. You may ask questions about the purpose of the research, what I would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When all your questions have been answered, you can decide if you want to take part in the study or not. This process is called "informed consent."

Purpose of the Study

This research project concerns health care in Russia and the role of health workers and providers concerning alcohol abuse. This research will also help us understand different perceptions among health care professionals, workers, and advocates concerning alcohol as a public health issue. This study aims to understand how individuals in Russia's public health sector play a role in mitigating the consumption of alcohol because of its adverse physical and social effects. This study is part of the research for my dissertation in human geography at the University of Washington.

Procedures

If you choose to participate in this study, I would like to interview for approximately one hour. You will not be asked any personal questions that do not directly relate to your professional experiences. The questions I will ask will focus on Russia's health care institutions, the role of alcohol in Russian society, Russian health care programs regarding alcohol abuse. You do not have to answer every question. You will be interviewed only once.

I would like to tape-record the interview with your permission. You may choose not to have your interview audio taped. You may also ask me to turn off the tape recorder at any time. Only members of the research team will have access to the audiotapes. Tapes will be kept in a secure location separate from your name or any identifying information. The tapes will be transcribed and translated within one year of your interview. Once the tapes are transcribed and translated, they will be destroyed. You may listen to the audiotapes or read your interview transcripts anytime. You can also change your answers anytime. You may also edit or tell me not to use some of your answers. If you decide to withdraw from the study at anytime, I will immediately destroy the audiotape and any transcripts of your interview.

Risk, Stress or Discomfort

Some people feel that providing information for a research study is an invasion of privacy, or feel nervous or uncomfortable when they are tape-recorded. You do not have to answer all the questions and you may request that the tape-recorder be turned off at any time. You may also end the interview at any time.

Benefits of the Study

You may not directly benefit from taking part in this study. However, we hope that the results of this study will help us the role of Russia's health care sector in raising awareness about the dangers of alcohol abuse.

Other Information

Taking part in this study is voluntary. You can stop at any time. Information about you is confidential. I will code the study information. I will keep the link between your name and the code in a separate, secured location until May 2009. Then I will destroy the link. If the results of this study are published or presented, I will not use your name. Because I am a U.S. researcher I need to tell you that government or university staff sometimes reviews studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

I may want to re-contact you to clarify information from your interview. In that case, I will telephone you and ask you for a convenient time to ask you additional questions closely related to your interview. Please indicate below whether or not you give your permission for me to re-contact you for that purpose. Giving your permission for me to re-contact you does not obligate you in any way.

I may want to quote you using your name. In that case, I will ask you to review the quote and edit it before giving your written permission to publish the quote with your name.

If you are interested, I will send you a copy of the written research for your review. If you have questions about the study at any time, you can call me at _____ (local number) or reach me via e-mail at rid@u.washington.edu. Please note that I cannot ensure the confidentiality of information sent via e-mail.

Signature of investigator Printed Name Date

Subjects Statement

This study has been explained to me, and I voluntarily consent to participate. I have had an opportunity to ask questions. I understand that future questions I may have about the research will be answered by one of the investigators listed above. If I have

questions about my rights as a subject, I may call or e-mail the University of Washington Human Subject's Division at 011-1-206-543-0098 (international call) or hsd@u.washington.edu. I will receive a copy of this consent form.

___ I give my permission for the researcher to audiotape my interviews.

___ I do NOT give my permission for the researcher to audiotape my interviews.

___ I give my permission for the researcher to re-contact me to clarify my interviews.

___ I do NOT give my permission for the researcher to re-contact me to clarify information.

Signature of subject	Printed Name	Date
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Copies to: Investigator's file
Subject

Appendix A-9: Sample Interview Questions for Phase III

1. How has your work changed in the past twenty years?
2. What are the biggest concerns for those who work in the public health sector? Are these concerns different than ten years ago? Twenty years ago?
3. Do the concerns of public health professionals or workers differ regarding their role in public health?
4. How would you describe the issue of alcohol abuse as a public health care problem?
5. Has the problem of alcohol abuse increased or decreased in the past twenty years?
6. Do public health workers play a role in education regarding public health issues? What about alcohol abuse?
7. What do you think are the best ways to deal with alcohol abuse at an individual level? What about at a societal level?
8. What role is there for state regulation of alcohol?
9. Do you foresee any changes in the patterns of how Russia deals with alcohol and alcohol abuse?

APPENDIX B : Curriculum Vitae

R. IAN DUNCAN

Ianduncan100@gmail.com / 1954 E 27th St #2 Oakland, CA 94606

EDUCATION

Current **University of Washington**, Seattle

PhC, Geography; Alcohol policy and Public Health in Russia

March 2004 **University of Washington**, Seattle

GPA: 3.86 MA in Geography; Urban and Russian Geography

Thesis focus: Post-Soviet Transitions, Urban Geography, Public Transportation

May 1999 **Macalester College**, St. Paul, MN

GPA: 3.4 BA in Geography, concentration in GIS and cartography

BA in Russian Language and Literature

DISSERTATION

"Therapeutic Landscapes and the Public Health Conceptualization of Alcohol-Related Illness in Moscow, Russia"

Chair: Craig ZumBrunnen

Reading Committee: Michael P. Brown, Kathleen Braden

LEADERSHIP AND TEACHING EXPERIENCE

Instructor

- Lecturer for Geographic Information Systems, San Francisco State University (2011-present)
- Lecturer for Physical Geography, San Francisco State University (2009-present); City College of San Francisco (2011-present)
- Lecturer for Geographic Techniques, San Francisco State University (2010-present)

Teaching Asst.

- University of Washington, Seattle "Introduction to Human Geography"; "Drugs and Society"; "GIS Workshop"; "Research Methods in Human Geography" (2001-2007)

RESEARCH AND RELATED EXPERIENCE

Research Fellow, American Councils for International Education

- Conducted research on public health responses to alcohol-related harm in Moscow, Russia; designed surveys, interviewed public health officials, health care providers, and individuals recovering from alcohol-related illnesses, translated public health materials and interviews. (06/2008-10/2008)

Foreign Language Area Studies fellow

- Conducted research on Russian urban politics and planning; designed original research and methods; field work in St. Petersburg (07/02-09/02).

ACADEMIC AWARDS

2008	American Councils for International Education ACTR/ACCELS: Combined Research and Language Training Award
2007-08	Fulbright Alternate: Russia
2007	Dean's Commendation for Teaching Excellence in the Social Sciences
2002	Summer (St. Petersburg State U.) Foreign Language Area Studies Fellow
2002-04	Foreign Language Area Studies Fellow

PUBLICATIONS AND WORKS IN PROGRESS

2010 "Situating Politics in Health/Medical Geography" (co-author with C. Donovan) in *The Companion to Health and Medical Geography*. eds. Tim Brown, McLafferty, S., and Moon, G. Wiley-Blackwell: Malden, MA.

CONFERENCE PARTICIPATION AND PAPERS PRESENTED

2008 "Russia, Geography, Gender and Sexuality" (organizer & presenter) American Association for the Advancement of Slavic Studies Annual Meeting, Philadelphia

2008 Author meets critics: Rebecca Kay's "Men in Contemporary Russia: The Fallen Heroes of Post-soviet Change?" (panelist) American Association of Geographers Annual Meeting, Boston

2008 "How to study post-Soviet space II: issues of transition across regions and states" (chair) American Association of Geographers Annual Meeting, Boston

2007 "Alcohol, Public Health, and the Demographic Crisis in Russia" (presenter) Association of Pacific Coast Geographers Annual Meeting, Long Beach

2007 "Alcohol, Public Health Policy, and Globalization" (presenter) International Symposium of Medical Geography, Bonn

SKILLS

- Public Health researcher

- Interview experience, Focus group leading, methods training
- Qualitative analysis skills: Survey design and execution, Methodology, Interviews, Textual analysis
- Quantitative analysis skills: Database management, statistical analysis, metadata analysis, data mining
- Word, Excel, Access, PowerPoint, SPSS, SAS
- Advanced Russian skills and Intermediate French skills
- GIS: Advanced Arc GIS skills, experienced with ArcView, Info, and Spatial Analyst.

REFERENCES

References available upon request