

**THE MEDICAL NET: PATIENTS, PSYCHIATRISTS AND PAPER TRAILS IN THE
KASHMIR VALLEY**

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ABSTRACT

The Medical Net: Patients, Psychiatrists and Paper Trails in the Kashmir valley
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This dissertation examines psychosocial interventions as specific social, political, medical, and ontological formations in the Kashmir valley. Till recently, medical humanitarianism was dominated by short-term, surgical interventions that focused on providing emergency biomedical care. In recent years, however, humanitarian organizations have increasingly focused on mental health interventions, particularly in places marked by low-intensity, long-term conflict, such as Kashmir.

This dissertation traces the indeterminacies that have arisen as the outcome and effects of humanitarian work have shifted away from questions of life and death to the terrain of psychosocial wellbeing. Specifically, it argues that while humanitarianism is constituted by new subjects and objects of knowledge—such as psychiatrists, counselors, PTSD, and trauma therapies—it is also made up by less visible moments of (mis)translation, (mis)apprehension, and doubt.

As such, I argue that medical humanitarianism takes the form of a “net” (*jal*), an object that is constituted by both its visible nodes and threads, as well as by “gaps” in between. Taking its inspiration from feminist science studies, the dissertation enacts the form of the net by moving from a focus on the visible nodes, that is, asylum and experts, to the threads that move between the clinic and the outside, namely medical cards and pills, to finally, the “gaps” in the net, that is, love stories.

The “politics of visibility” that marks humanitarian practice is also replicated within the anthropology of humanitarianism. Anthropology has traditionally approached humanitarianism as providing the gift of life—in the form of citizenship, asylum, or legal residency—for victims of violence. Yet organizations that focus on psychosocial suffering do not hold out the promise of life as much as they provide limited techniques for living with suffering. Far from universally embraced, this latter gift raises questions about the worthiness of humanitarian endeavors in places of long-term suffering. This dissertation thus goes beyond a focus on humanitarianism as a “politics of life” to an ethnographically rich account of the everyday contestations and misapprehensions that characterize humanitarianism in a zone of political stagnation.

BIOGRAPHICAL SKETCH

Saiba Varma graduated from Franklin and Marshall College with a B.A. in Anthropology and Government. She matriculated at Cornell University in 2006 and conducted fifteen months of ethnographic fieldwork in the Kashmir valley from 2009-2011. She completed her PhD in May 2013.

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I dedicate this dissertation to him and to my interlocutors in Kashmir.

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LIST OF ABBREVIATIONS

AIIMS	All-India Institute of Medical Sciences
CBT	Cognitive Behavioral Therapy
CRPF	Central Reserve Police Force
DMHP	District Mental Health Program
DSM	Diagnostics and Statistical Manual
ECT	Electro-convulsive therapy (also known as “shock therapy”)
EPE	Extrapyramidal Effects
GP	General Practitioner
GPDH	Government Psychiatric Diseases hospital
GMH	Global Mental Health
HOD	Head of Department
IAS	Indian Administrative Service
ICD	International Statistical Classification of Diseases and Related Health Problems
ICRC	International Committee for the Red Cross
JDA	Junior Doctors’ Association
MHPSS	Mental Health and Psychosocial Services
MSF	Médecins sans Frontières
NIMHANS	National Institute of Mental Health and Neurosciences (Bangalore, India)
NHRC	National Human Rights Commission
NMHP	National Mental Health Program
OCD	Obsessive Compulsive Disorder
OPD	Out Patient Department
PIL	Public Interest Litigation
WHO	World Health Organization

INTRODUCTION: ILLNESS IN THE AIR

One day in May 2011, three friends and I set out for a wedding reception in Islamabad, about ninety kilometers from Kashmir's capital, Srinagar. We left the city at noon to make it in time for the *wazwan*, a fifteen to thirty-course meal of mostly meat dishes, served on large silver platters (*traamis*) shared by four people. As we drove out of the city, I noticed the air filled with translucent pollen bubbles. They wafted through the air gently, the seemingly pure and innocuous products of nature's springtime renewal. Alif,¹ who was sitting next to me in the back seat, pointed to the bubbles and said, "In my childhood, we used to call them *retkael-sheen*. Summer snow."

Summer snow. A cheery euphemism for a seasonal epidemic – known medically as seasonal allergic rhinitis – that besieges Kashmiris every summer. During the two summers that I spent in Kashmir, all around me people developed a range of symptoms associated with summer snow: itchy and watery eyes, sneezing, sore throats, fevers, and headaches. Summer snow also brought about a general weakening of the body (*kamzori*), a loss of physical and emotional strength, making a person further susceptible to more illness. As the summer began its crescendo in May, so too did complaints about the pollen that would stick to hair and eyes and lungs. By my second summer in Kashmir, I too felt a scratching and burning sensation in my throat. When I complained to a friend, he smiled wryly and said that I was showing signs of becoming a Kashmiri, for

¹ I have changed the names of all the interlocutors with whom I worked, except for mental health experts and other professionals who requested that I use their real names. I use the term "mental health experts" as an umbrella term to refer to those engaged in biomedical or humanitarian work, including psychiatrists, clinical psychologists, social workers, and counselors.

summer snow did not affect people the first time around; it required long-term exposure.

I took the opportunity of the leisurely car ride to ask my companions more about summer snow and its associated symptoms. They told me that the pollen came from poplar trees, which had tall and skinny trunks. The poplars had been imported from Russia for timber because they are fast growing and highly profitable. “But aren’t poplars indigenous to Kashmir?” I asked. From the front passenger seat, Rashid turned around and said, “Yes, there are Kashmiri poplars, but they are smaller and don’t grow as fast, so now you don’t see them around as much as the Russian poplars.” I asked how you could distinguish between them. “The Kashmiri poplars have silvery trunks,” Alif said, pointing them out through the window. I couldn’t help but notice that the glistening trunks of the Kashmiri poplars were much more beautiful than the pale brown Russian variety. “And the Kashmiri poplars don’t produce summer snow,” Alif noted.

“Who planted these?” I asked, still astounded at how prolific the Russian poplars and their pollen were, despite being relatively recent transplants to the region. Alif responded that the Russian poplars were planted by the Department of Horticulture in the 1980s. Then he said softly, “You know, the older generation of Kashmiris never knew this problem,” while his finger traced the snowflake’s meandering path. A heavy silence took over us as unanswered questions lingered in the air: Had the Indian state planted the poplars to deliberately poison and weaken Kashmiris? Were the “increased profits” yet another ruse to bring a slow, painful death to the Kashmir valley?

A few months after the conversation about summer snow, back in Ithaca, I emailed Alif and asked him to comment on that afternoon and the silence in the car. He responded, “I think the silence means unarticulated fear. Unsubstantiated but believed.” In his email, Alif also added that in his childhood, he had heard the “old and wise” speak of the poplar plantation as not only bad for its health and environmental costs, but as part of a larger “nasty and ugly” plan to sicken the population.² Although Alif acknowledged the “unsubstantiated” basis of the claim that the poplars had been planted as part of state policy to make Kashmiris ill, he felt that it tapped into something “real.”

I suggest that the silence in the car did not have to be explained because its implications were commonsensical to Kashmiris. For instance, Alif did not need to say why it was significant that the Russian poplars were planted in the 1980s. The fact that they *were* planted in the 1980s was explanation enough, because this period represented a historical watershed. Sparked by reports of municipal elections rigged in favor of the Indian state in 1987, decades of frustration with Indian rule spilled on to the streets in the form of massive protests and demonstrations calling for Kashmiri independence (*azaadi*).³ These massive street protests eventually culminated in an armed struggle against Indian rule, which lasted till 2002. Some insurgent groups acted in order to assimilate Kashmir with Pakistan—what they believed should have been done during Partition in 1947—while others fought for an independent Kashmir.⁴

² Personal communication, Wednesday July 27, 2011.

³ Kashmiris refer to their self-determination movement as *tehrreek*, an Arabic word adopted into Urdu and Kashmiri which signifies a continuing struggle with the ultimate goal of independence (*azaadi*).

⁴ To date, approximately 70,000 Kashmiris have lost their lives in the conflict, about 10,000 are disappeared, and torture and rape have also been widely reported. There has been no definitive political resolution of Kashmir and the region continues to be mired in political instability.

In the dissertation, I use the shorthand “Kashmir” to refer to the geographical region of the Kashmir valley, approximately 135 x 32 kilometers, located between the Karakoram and Pir Panjal mountain ranges. The Kashmir valley is located within the Indian state of Jammu and Kashmir. In 1947-48, the newly independent states of India and Pakistan fought the first war—of three—for control of the territory. On January 1, 1949, a ceasefire was declared, with 65 per cent of the territory under Indian control (the state of Jammu and Kashmir) while Gilgit-Baltistan and Azad Jammu and Kashmir (AJK) went with Pakistan. While the ceasefire line was intended to be temporary, the Line of Control (LoC), as it later became known, remains the de facto border. In the summer of 1999, war again broke out between India and Pakistan in the Kargil heights, leading then US President Bill Clinton to famously call Kashmir, “the most dangerous place on earth.”⁵ As you can see in *Fig. 1*, India, Pakistan and China each make competing claims to the region.

⁵ Mishra 2008.



Figure 1
Kashmir regional map

I present this condensed history of the Kashmir conflict reluctantly. This story, of Kashmir as the site of ongoing territorial disputes between India and Pakistan, is the dominant narrative learned by Indian and Pakistani citizens alike. In recent years, this security studies narrative has been given even more urgency by a “war of terror” paradigm, which dominates scholarship on the region. As an anthropologist, this is not the story I want to tell, although it is also impossible to avoid the material and epistemological force of this narrative on Kashmiri lives. My aim is to understand the ways in which frustrations with ongoing Indian rule, militarization, and the loss of self-determination, have materialized in the form of chronic illnesses in Kashmir. To this end, I argue that while medical humanitarianism is used to make political claims, not all forms of suffering are rendered as urgent, knowable, and worthy of intervention as others.

Rather, I show how particular kinds of subjects and objects—psychiatrists, counselors, trauma, and psychotherapy—crystallize ongoing violence, whereas forms of everyday suffering are often unrecognized. I suggest that sustained ethnographic attention reveals the existence of alternative occurrences or “quasi events” within the existing catastrophe that is the “turmoil.” Following Povinelli, this dissertation accounts for those forms of suffering and enduring that are “ordinary, chronic and cruddy” rather than those that are “catastrophic, crisis-laden and sublime.”⁶ This particular politics of visibility marks both the organization of humanitarian and biomedical knowledge, as well as to the anthropology of violence. As Beth Povinelli has argued, the anthropology of violence has predominantly focused on moments of crisis and catastrophe, the “kinds of events that seem to necessitate ethical reflection and political and civic engagement.”⁷ In the case of Kashmir, this focus occurs around the category of “turmoil” [Eng.] as the conflict is known, which has become the placeholder for all kinds of social and economic problems. The conflict is a disease (*bemari*), people told me. This narrative was ubiquitous, part of a protective and collective narrative shell that Kashmiris have learned to tell in the face of heightened human rights and media attention. This is not to say that the “quasi events” I describe do not produce ethical reflection or powerful ways of narrating the self, but rather, that they are frequently occluded in the face of events that are marked as catastrophic.

In another example, one of my arguments in this dissertation is that while forms of chronic bodily distress such as weakness (*kamzori*) are being occluded

⁶ Povinelli 2011: 13.

⁷ Povinelli 2011: 13-14.

by psychological idioms of distress, this is not a straightforward replacement. To this point, I draw inspiration from Marilyn Strathern's argument that acts of revelation – in this case the production of new subjects and objects of expert humanitarian and biomedical knowledge - also invite us to consider “what is hidden and concealed” behind them.⁸ Rather than view psychiatric and psychosocial interventions as *outside of* existing healing practices, my aim is to show how they have become a part of a collective Kashmiri ‘common sense,’ which views all suffering as always having a political etiology.

A History of Violence

The Kashmiris I spoke with remembered the late 1980s as a period of impassioned and hopeful nationalist sentiment and recalled how young men bravely made the treacherous journey across the border to Pakistan for training. However, there were also darker undercurrents to the burgeoning movement, and by the mid 1990s, the mood had drastically changed from optimism to fatigue and disillusionment, as the years and death toll mounted and militarization continued, unrelenting. Many Kashmiris told me that they believed the true martyrs (*shahid*) had been killed in the early years of the conflict. Those who had survived had done so for the wrong reasons. The shiny SUVs that had appeared on the roads in Srinagar were viewed as examples of the corruption that had beset the movement for Kashmiri self-determination and evidence that ex-militants had been coopted by either India or Pakistan.

The Indian state had officially responded to the “insurgency” in 1989 by codifying a state of emergency through extrajudicial laws such as the Disturbed Areas Act (DAA) and the Armed Forces Special Powers Act (AFSPA). These

⁸ Strathern 1999: 11.

laws continue to be in place today, despite widespread criticisms that they have perpetuated widespread human rights abuses and sustained a “culture of impunity.”⁹ The state of emergency, uninterrupted since 1989, is also sustained through the mass mobilization of Indian troops, making Kashmir the most militarized region in the world.¹⁰ Yet Indian state power in Kashmir is not only sustained through extrajudicial means and militarization. As Haley Duschinski and Bruce Hoffman have argued, state power also functions through everyday means, such as a legal system that “promises but systematically denies, possibilities of accountability and redress.”¹¹ In their ethnographic work, Duschinski and Hoffman chronicle local struggles to engage with the law in Kashmir, including efforts to find alternative forums for justice.

In addition, there is also the unresolved problem of Kashmir’s minority Hindu population, which all but left the valley after members of the community were directly targeted in the first year or two of the conflict. As Suvir Kaul has argued, the exodus of Kashmir’s Hindu (Pandit) population “allowed most Indians to believe that they were dealing not with a political movement for independence, but with Islamic secessionism.”¹² The effects of this polarization were devastating on both sides: it enabled the Indian government to construct the Kashmir problem as one of “cross-border terrorism,” and following 9/11 as “Islamic terrorism,” rather than as having any indigenous basis, and for

⁹ Human Rights Watch 2006.

¹⁰ Anjum and Varma 2010.

¹¹ Duschinski and Hoffman 2011: 45.

¹² Kaul 2011: 174.

Kashmiris, the brutality of the Indian state only reminded them of previously oppressive Hindu rulers who had subjected its Muslim population.¹³

During my fieldwork, it became clear to me that the “common sense” that enabled Kashmiris to identify summer snow with a nefarious Indian government policy thus ran deeper than the years of militancy. There was an active remembering of periods of colonization that came before Indian occupation in 1947. I thus understand Kashmiri bodies as sites of accumulated suffering over time, rather than the products of a recent “epidemic of trauma” as they are imagined in humanitarian and state discourses.

Many pointed out that the Indian state was just one in a long line of successive colonizations that began with the Mughal annexation in 1586, followed by consecutive Afghan, Sikh, and Dogra rulers. The princely territories of Jammu and Kashmir – ultimately divided in the 1947-48 war – were cobbled together in 1846 from defeated Sikh ruler Ranjit Singh’s lands. Through the Treaty of Amritsar, negotiated with the East India Company in 1846, the Hindu Dogra ruler Gulab Singh was instated as the successor to the Sikh rulers rather than as an independent sovereign. As a princely state from 1858-1947 not officially part of the British Empire, Jammu and Kashmir was under indirect colonial rule. Until 1885, the British government was represented in Kashmir by an Officer-on-Special-Duty, who had limited functions. However, from 1885 on, the presence of colonial officials increased with the posting of a full-fledged Political Resident in the territories. The increased presence of colonial officials was also a much-needed boost to the fledgling enterprise of medical missionization, which had been ongoing since the 1860s, with limited support

¹³ Kaul 2011: 174.

from the colonial government. Nonetheless, as the biographies of medical missionaries who served in Kashmir attest, relations between the Dogra regime, the British government, and the Church Missionary Society, remained thorny (see Chapter Two).

As Mridu Rai has argued in her monograph on the history of the Dogra regime, although the colonial state removed the right of the Dogra rulers to wage war, the “incontestable control over the Hindu religious domain allowed the Dogras to ride roughshod over the interests and rights of the vast majority of their Kashmiri Muslim subjects.”¹⁴ It was also during the Dogra period that “religion and politics became inextricably intertwined in expressing the protest of Kashmiri Muslims against their rulers.”¹⁵ In October 1947, in the wake of the Partition, the Dogra Hindu ruler of Kashmir signed a controversial “Instrument of Annexation” to the Indian state, despite the lack of public support and the existence of a vibrant Kashmiri nationalist movement.

Many of the Kashmiris I spoke to were fluent in this history, and would remind me, “We have not been free in 400 years.” This *longue durée* of suffering was an important frame for how Kashmiris imagined the “chronically insecure environment”¹⁶ in which they live. It was also a radically different vision of the past than what was presented in the Indian school textbooks that Kashmiris on this side of the border had to learn. Thus, although a ceasefire between Kashmiri insurgent groups and the Indian state was declared in 2002, there has been no definitive resolution of the conflict and the region continues to be mired in social, political, and economic instability. For many, the words of the late Kashmiri

¹⁴ Rai 2004: 13.

¹⁵ Rai 2004: 16-17.

¹⁶ James 2010: 6.

poet Agha Shahid Ali—“they make a desolation and call it peace”¹⁷—were a testament to the present state of things and to historical patterns of oppression.

During the course of my fieldwork, in June 2010, reports of a fake “encounter”¹⁸ killing by the Indian army surfaced in the media, sparking widespread protests once again, which reminded many of 1989. This was not the first time that mass protests had broken out in the “post-ceasefire” period, but the scale and impact of these events could be described as catastrophic, in Povinelli’s sense of the term. The international and national Indian press was awash with images reminiscent of Palestine, of *kaffiya*-wearing youth hurling stones, while the Indian military responded with gunfire and tear gas. Scholars and commentators sympathetic to the movement christened it, “Kashmir’s Intifada.”¹⁹ By October 2010, when the protests gradually dissipated, 124 youth protesters had been killed and months of strikes and curfews had paralyzed life in the Kashmir valley once again.

To live and do fieldwork in Kashmir meant accommodating myself to this uneasy present and past, which was somewhat different from the optimistic phrase that Kashmir was “inching towards normalcy,”²⁰ that both the Indian media and state officials periodically proclaimed. This volatile present was also marked by the presence of two, simultaneous calendars: a state-sanctioned calendar and a “protest calendar,” issued by the Hurriyat-G, a separatist political organization, which called for a protest once a week, usually after Friday prayers. Yet even non-protest days (so-called “normal” days) could

¹⁷ Ali 1997.

¹⁸ An encounter is a euphemism used in South Asia to describe extrajudicial killings in which the victims are described as suspected gangsters or terrorists. A “fake encounter” refers to death in custody or cases where unarmed victims are framed.

¹⁹ Kak 2011.

²⁰ Habibullah 2011.

unexpectedly be interrupted by protests and violence. One of my friends told me he wanted to write a short story in which an Indian Army truck accidentally runs over some chickens that crossed the highway at the wrong moment. In the story, the farmer who owned the chickens begins protesting their death, eventually leading to massive protests all over Kashmir. The story was meant to be a humorous parable for the always-present condition for violence: “I want to show that all it takes is a match,” my friend had said.

The Rise of Humanitarianism

This dissertation describes new configurations of psychiatric and psychosocial humanitarian interventions in the post-ceasefire period (post-2002) in Kashmir. However, while these specific interventions in the terrain of mental health may be new, the kinds of suffering that they come into contact with are not necessarily new. This shows the ways in which the language of suffering in Kashmir, such as ideas of weakness (*kamzori*) and a temporality that bursts forth beyond the insurgency period, constantly exceed attempts to bound it.

In my analysis, I try to attend to these historically significant ways of marking bodies and suffering, while also understanding how “new” knowledge practices are interwoven in everyday Kashmiri social life, how they circulate within and outside the clinic, and how they are appropriated to unintended effects. The efforts I chronicle include the crystallization of developmental efforts by the Indian military through Operation *Sadbhavana* (Goodwill) since 2001; the growing presence of psychosocial organization such as Action Aid International, the International Committee for the Red Cross (ICRC), Médecins sans Frontières (MSF), among others; and an intensified commitment to mental

health care programming by the Indian government on a national level, including efforts to de-institutionalize care and promote the availability of psychiatric pharmaceuticals at the village level. These state programs are known as the National Mental Health Program (NMHP) and District Mental Health Program (DMHP) and have been shaped by experts within the movement for Global Mental Health (GMH), which I describe in detail in Chapter One.

The non-governmental organizations involved in humanitarian work in Kashmir, most notably MSF, embody what has been called the “new” or “international humanitarianism,”²¹ which has focused on alleviating suffering through providing emergency medical care.²² While this dissertation does not focus on MSF’s activities specifically—MSF has been well explored in the anthropology of humanitarianism—the organization has had a large impact in Kashmir, both in terms of its own activities and trainings, as well as in influencing the work of smaller humanitarian projects.

Within MSF, as in other medical humanitarian organizations, there is a push to increasingly incorporate mental health within the ambit of “emergency” care. According to the MSF website, “it was on the killing fields of Bosnia in the 1990s that MSF volunteers recognized that it was not enough to meet the physical needs of people caught up in conflict.”²³ From 1993-1997, MSF implemented a program to address the psychological trauma produced by the Bosnian war, and since then, has conducted mental health interventions in more than forty countries. While most of MSF’s global mental health programs exist

²¹ de Waal 1997.

²² Ticktin 2011: 16.

²³ From <http://www.doctorswithoutborders.org/news/allcontent.cfm?id=92>. Accessed October 4, 2012.

within emergency medicine, the project in Kashmir—which lasted for eleven years—was somewhat unique as a stand-alone mental health program.²⁴ As Peter Redfield has noted, despite its foray into other kinds of intervention, the ethos of MSF remains opposed to conventional practices of “development.”²⁵

For this reason, stand-alone mental health programs raise fundamental questions for humanitarian professionals, both because they challenge the concept of “emergency” as a temporal and life-threatening event, but also because they require intimate social and cultural know-how. In the case of MSF in Kashmir, for example, this know-how was provided by seventy local staff who were trained as counselors and worked in MSF’s two mental health clinics, one at the Government Psychiatric Diseases hospital in Srinagar and another in the border district of Kupwara. Expatriates, by contrast, provided training, supervision, and performed administrative duties. Although by May 2012 MSF had considerably scaled back its operations in Kashmir, their influence on mental health and humanitarian programs, particularly the emphasis on psychosocial, rather than psychiatric care (Chapter Two), is noteworthy. Further, the duration of the MSF project in Kashmir also raised fundamental questions about the program’s purpose, goals, as well as criteria for measuring success in mental health.

Not surprisingly, however, the Indian state has historically defined humanitarianism, particularly in the state of Jammu and Kashmir, quite differently than “new” humanitarianism. Scholars have argued that

²⁴ In May 2012, the *New York Times* reported that, after eleven years of operations, MSF would be considerably scaling back its operations in Kashmir, including closing down its mental health clinic in the border region of Kupwara as well as cutting its staff of 100 by nearly half (Najar 2012).

²⁵ Redfield 2012: 359.

humanitarian efforts by the postcolonial Indian state have mirrored European humanitarianism in the close dovetailing of humanitarian and military concerns.²⁶ Vazira Zamindar, for example, has shown how the management of refugees in the aftermath of the Partition was viewed as a military problem first, and a humanitarian one, second.²⁷ Within the anthropology of humanitarianism, however, there is a debate between scholars such as Didier Fassin, who has located humanitarian reason within “a Western sociodicy,”²⁸ drawn from a politics of compassion from within Christianity, and others such as Erica Bornstein, Peter Redfield and Jonathan Benthall who have argued against “attempts to monopolize the charitable sector within a historically Western frame.”²⁹ Jonathan Benthall, for example, has argued that the positive values associated with sacrifice, for example, are not specific to Christianity, but are rather foundational to Islam, as are notions of universalism and charity (*zakat*).³⁰

Similarly, as I show in this dissertation, the idea that humanitarianism was a politics of “lives to be risked” and “lives to be saved,” as Dider Fassin has described, did not ring true in the Kashmiri context. As I show, Kashmiri humanitarians did not see themselves as outside of an existing social and political milieu, thus casting into doubt both their ability and desire to “save.” In addition, the language of “saving” was not expressed through a call to a universal humanity or sense of compassion, but was rather articulated through the specific lens of Kashmiris as a political and security ‘problem’ for the Indian state. For example, as I show in Chapter Five, the argument that drug addicts in

²⁶ Fassin and Pandolfi 2010.

²⁷ Zamindar 2007.

²⁸ Fassin 2011: 248.

²⁹ Bornstein and Redfield 2011: 96.

³⁰ Benthall 2011.

Kashmir needed saving was not articulated through a language of compassion and care, but rather through a gesture of separating them from the larger body politic.

India's military-cum-humanitarian efforts have also played an important role within the global history of humanitarian intervention. As Nicholas Wheeler has argued, India's military intervention in East Pakistan in 1971 was the first case of a military intervention justified through the logic of humanitarianism. India argued to the United Nations that it could not remain passive in the face of ongoing massacres perpetrated by the Pakistani Army on the Bengali-speaking population of East Pakistan. When the Security Council chose not to act, India invaded East Pakistan on its own accord, a process which eventually led to the formation of Bangladesh in 1971. Wheeler points to this moment as the first instance of a sovereign state championing the right to intervene while the UN insisted on respect for sovereignty.³¹

This background is important in understanding how and why justifications of Indian militarism in Kashmir have also shifted over time, away from being purely about national security and Islamic terrorism, to a posture that includes humanitarian care. This seems to vindicate Foucault's assertion, in the concluding session of his 1976 lecture at the Collège de France, that the concept of biopower—that is, interventions in the social body to augment it and reshape society as a secure, life-supporting environment—was reshaping the meaning of sovereignty. As Nicolas Guilhot has argued, these technologies did not merely express the sovereign's traditional right of life and death, they "sought to secure conditions optimizing the life of populations in its most immediate biological

³¹ Wheeler 2000.

manifestation.” In this sense, “biopower does not just preserve extant life: it actively intervenes throughout the social body to augment it and reshapes society as a secure, life-supporting environment.”³² In the case of Kashmir, the exercise of biopower in the form of humanitarian and biomedical efforts have not so much replaced a more traditional form of sovereignty as supplemented it. This is because “endemic dangers,” including “threats to life, health, livelihood, personal safety and human dignity,” the stuff that biopower is meant to secure, still emanate from the Indian state itself.³³

This is largely consistent with Indian state intervention in Jammu and Kashmir historically, where humanitarianism is viewed as the work of the Indian military, rather than the civilian government, which is viewed as ineffectual and corrupt. In Indian-administered Kashmir, much like in the Northern Areas of Pakistan, the Army (Indian/Pakistani) is credited with performing what Nosheen Ali has called “participatory militarism,” whereby humanitarian work helps the military reinvent itself as a caring institution, thereby occluding the project of empire.³⁴ As Mona Bhan and Ravina Aggarwal have similarly argued, the Indian’s Army’s Operation *Sadbhavana* (Goodwill) initiated in 1998, was directed towards border communities in the Ladakh region with the explicit message to ‘Win the Hearts and Minds’ (known by its unfortunate acronym, WHAM) of the local population so as to “forestall further destabilization resulting from people’s growing alienation from the nation” as well as to prevent the rise of “incipient terrorism.”³⁵ Further, as Arpita Anant has noted, Jammu

³² Guilthot 2012: 81.

³³ Foucault 1997: 13-15.

³⁴ Ali 2010.

³⁵ Aggarwal and Bhan 2009: 534.

and Kashmir is the only state where the Indian army has extended its mandate to include not just the rooting out of terrorism, but “rebuilding the lives of people devastated by terrorism.”³⁶ These efforts have included developmental and humanitarian works including building schools and training centers, as well as publicity campaigns such as billboards and slogans. I locate the Jammu and Kashmir police efforts to combat drug and alcohol addiction within the ambit of Operation *Sadbhavana* (Chapter Five), itself one, specific instantiation of biopower, while acknowledging that the state’s powers to protect can come into direct conflict with each other.

Despite the different genealogical and historical legacies at work in these various humanitarian efforts, they share an ethics of intervention, one of the defining features of humanitarian action, according to Illana Feldman.³⁷ During my fieldwork, from September 2009-December 2010, and May-June 2011, I observed a range of such interventions within the sphere of mental health, from psychopharmacological care in the Out Patient Department at the Government Psychiatric Diseases hospital, to psychosocial care such as counseling, to drug and alcohol awareness and treatment programs, to NGO self-assessments to evaluate the worthiness of victims of violence.³⁸ While not coordinated, these interventions and the experts who staffed them intersected but also diverged in

³⁶ Anant 2010.

³⁷ Feldman 2007. I am also sympathetic to Feldman’s argument about the ways in which humanitarianism does not always have to be a radically transformative force, but in Kashmir as with Gaza, can work to maintain the status quo.

³⁸ My primary field sites consisted of the Out Patient Department (OPD) and counseling sessions in the Government Psychiatric Diseases hospital, the Drug De-Addiction Clinic run by the Jammu and Kashmir police, and visits to local and international NGOs specializing in mental health. In addition to observing this range of mental health interventions, I also analyzed documents including published academic articles, reports by human rights and humanitarian organizations, and the medical cards of patients. I also interviewed Islamic healers (*pirs*), Unani doctors, and non-psychiatric medical professionals during the course of my fieldwork, in addition to extensive interviews with the users of mental health services.

key ways. For instance, while there were significant operational differences between these programs, many experts moved between them, working part-time in multiple settings. As scholars of expert knowledge such as Timothy Mitchell have argued, these programs and interventions must be viewed not just as representative of, but as constitutive of, the field of medical humanitarianism in Kashmir.³⁹

The Politics of Visibility

The overarching argument of this dissertation is that collectively, psychiatric and psychosocial interventions have produced a politics of revelation wherein certain forms of suffering, bodily enactments, and subjectivities, such as those around trauma and post-traumatic stress disorder (PTSD), are rendered more knowable, urgent, and worthy of intervention than others. I suggest that other forms of knowledge and practice are not excluded from spaces of authoritative biomedical or humanitarian practice, but rather, they require a different kind of ethnographic attention.

In making this argument, I follow feminist scholars of science such as Donna Haraway who have argued that vision is a specific, embodied, and material practice. As Haraway argues, the point is not “partiality for its own sake, but rather, for the sake of the connections and unexpected openings situated knowledges make possible.”⁴⁰ In using the concept of a ‘net,’ I emphasize that clinical encounters are not merely instantiations of unequal power dynamics between doctors and patients, but rather, consist of alternative

³⁹ As Timothy Mitchell (2002: 4) has argued in the case of the economy, “It is not adequate to describe the economy as a social construction, or an invention of the social imagination, for such an approach always implies that the object in question is a representation, a set of meanings, a particular way of seeing the world. This kind of analysis leaves the world itself intact.”

⁴⁰ Haraway 1988: 590.

epistemologies, affects, and objects, which although less visible, are nonetheless present, making the outcomes of these encounters oftentimes surprising.

Approaching biomedical and humanitarian visions as partial also provides a counterpoint to the argument that the birth of a modern subjectivity has been associated with a particular mode of vision: a disinterested gaze, which objectifies and grasps whatever is placed before it.⁴¹ In the prison, for example, Foucault claimed that an oppressive transparency rendered everyone visible and subject to calculation.⁴² Similarly, in his work on the clinic, Foucault described how a range of investigative tools—including the stethoscope, percussion, and other chemical tests—produced truth by probing inside the body.⁴³ Building on this work, medical anthropologists and STS scholars have argued that new visual technologies, which objectify disease play a crucial role in producing a “new” regime of transparency. In Joe Dumit’s monograph on brain-imaging technologies, for instance, PET scans “become visual truths, presenting themselves as facts about people and the world such that even their own producers cannot refute them.”⁴⁴

Despite interdisciplinary efforts between psychiatrists, neurologists, physicists, chemists, and psychologists to develop brain-imaging data such as PET in the identification and treatment of psychiatric disorders, such efforts remain peripheral to humanitarian efforts to ameliorate trauma and PTSD. This is not merely because of technological disparities between the West and non-West, but is also representative of the fragmentation of the field of psychiatry in

⁴¹ Reed 1999.

⁴² Foucault 1977: 193.

⁴³ Foucault 1963; see also Berg and Harterink 2004.

⁴⁴ Dumit 2010: 17.

the contemporary moment. As Kathleen Allden has argued, for example, although the past three decades in psychiatry have been intensely focused on neurobiology, psychopharmacology and quantitative analysis, since the 1980s, medical and psychiatric experts have also been increasingly involved in human rights and humanitarian work.⁴⁵ As Allden argues, these tasks often expand the work of mental health professionals beyond caregivers—they have become political actors, criminal investigators (in the case of medical-legal investigations of torture) and scholars.⁴⁶

Humanitarian efforts, in my experience, were grounded much more in verbal and non-verbal communication between mental health professionals, patients, and kin, rather than brain-imaging technologies. This was not a space where the “fair, impartial objectivity of numbers”⁴⁷ had colonized expert subjectivity and talk; as I show in chapter 2, there was significant back and forth between various orders of knowledge. Instead, the “provisionality” of not just psychiatric diagnoses, but of the objects and subjects it calls into being, became apparent to me as I did fieldwork.⁴⁸ In this sense, rather than an objectifying, disinterested, and unidirectional gaze from doctor to patient, I found that there was a substantial “reciprocity in vision, a mutual gazing which motivate[d] and orient[ed] action.”⁴⁹ Yet I would argue that even the idea of “mutual gazing” does not capture the circulation of knowledge and affect in the clinic and the multiplicity of relations between patients, doctors, objects, and kin. In looking beyond the visible knots and nodes of humanitarianism and biomedicine—

⁴⁵ Allden 2008.

⁴⁶ Allden 2008: 398.

⁴⁷ Dumit 2010: 121.

⁴⁸ Davis 2010.

⁴⁹ Reed 2006: 950.

beyond the asylum and experts, for instance—I argue that these knowledges are not simply *at odds* with local economies of knowledge and practice, but rather, interwoven with them.

I understand these entanglements of knowledge / practice as producing a “net” of medicalization in Kashmir—a malleable and yet surprisingly durable texture. This “net” enables moments where surprising connections and relations can be made, but it also ensnares Kashmiris in a sense of political non-movement. In this dissertation, I traverse this net by focusing first on the production of expert knowledge and bodies, to an account of objects that mediate relations between experts and patients and increasingly come into focus in everyday biomedical care, and finally, to reflect on some of the unintended and eclipsed effects of medicalization, namely the proliferation of love stories. In each chapter, the authorized objects of biomedical knowledge (institutions and experts) are made to fade away as objects and affects that are initially obscured come into ethnographic focus. In so doing, this dissertation examines the indeterminate outcomes of humanitarian and biomedical practice.

The Weakening Body(politic)

I now want to return to the anecdote with which I began – that of summer snow – in order to show the politics of visibility at work as well as how seemingly opposed objects—trauma and weakness (*kamzori*) work in tandem to produce a “net” of medicalization. While medical anthropology has historically opposed the lived, active, embodied self to the passive, objective, medical body⁵⁰, here I point to an Occupied Kashmiri body that is doubly medicalized. I suggest that both summer snow and trauma are ways of metonymically linking intimate,

⁵⁰ Becker 1997; Csordas 1994; Merleau-Ponty 1964.

bodily suffering to Kashmir's larger political and social turmoil. However, there are two key differences between these epistemologies. While "summer snow" and its effect of bodily weakening (*kamzori*) are absent from authoritative accounts of suffering in Kashmir, the language of trauma and PTSD is foregrounded. In addition, while both perform this metonymic link between the individual and social, I argue that there are different ethical stakes involved in each. In moving between "summer snow" and PTSD here, I also hope to provide a taste of the kind of analytical labor I will be performing in this dissertation.

First, let me properly introduce one of the most "visible" forms of suffering in Kashmir: trauma and PTSD. Within media, humanitarian, and human rights accounts, trauma and PTSD are clearly foregrounded as the most urgent and knowable forms of suffering. This is one example from a piece on Kashmir commissioned by *Time* magazine:

In the space of 20 minutes, psychiatrist Arshad Hussain has taken a call on his cell phone from a suicidal patient and handed a box of pills to a woman who thinks her murdered brother follows her around. A former detainee, too scared to stay home alone, wants to consult with him, as does a widow who faints at the memory of her husband's shooting. Meanwhile, several men desperate to refill their tranquilizer prescriptions are trying to barge into the office.... Last year, Dr. Hussain and his small staff received 100,000 visitors, most of whom exhibited classic symptoms of post-traumatic stress disorder: panic attacks, flashbacks and nightmares.... What happens when an entire society is suffering from PTSD?⁵¹

According to the American Psychiatric Association's Diagnostics and Statistical Manual (DSM), PTSD is defined by two major criteria: an exposure to a traumatic event and a set of psychiatric symptoms that occur (or recur) after the event. The traumatic experience is defined in the DSM-IV as an event involving "actual or threatened death or serious injury or a threat to the physical integrity

⁵¹ Matloff and Nickelsberg 2009.

of self or others.”⁵² After such an experience, a person meets the criteria for the disorder if symptoms from each of three general categories are present: (i) re-experiencing the traumatic event through nightmares, flashbacks and/or intrusive thoughts or images related to the event; (ii) symptoms of hyperarousal, such as difficulty falling or staying asleep, difficulty concentrating and exaggerated startle response; (iii) symptoms of withdrawal such as avoidance of reminders of the event, emotional numbing, or feelings of detachment.⁵³ When Kashmiri mental health experts actively drew on the PTSD diagnosis, they did not use trauma in the psychoanalytical sense of an unspeakable narrative, but rather, as what humanitarian organizations refer to as “emergency-induced” problems.⁵⁴

The anthropologist Joshua Breslau has argued that PTSD is unique among mental illnesses in that its source external to the individual confers innocence on its victims, dissociating them from the taint of other psychiatric disorders.⁵⁵ In Kashmir, this was not so much a factor for patients as much as it was useful for mental health experts. I argue that the instrumentalization of PTSD served two important purposes for Kashmiri experts: it allowed them to fashion themselves as “global” experts, as drawing on a diagnosis that conferred innocence on the sufferers of trauma, without having to directly confront its underlying causes. This was particularly valuable given that most mental health experts were Indian government employees. As such, it enabled Kashmiri practitioners to reconcile their positions as pro-independence, good Kashmiri nationalists, while keeping

⁵² American Psychiatric Association 1994: 427.

⁵³ Breslau 2000: 115.

⁵⁴ These include grief, non-pathological distress, depression and anxiety disorders, including PTSD (IASC Guidelines 2007: 2).

⁵⁵ Breslau 2000: 117.

their day jobs as doctors in government-run hospitals. Nonetheless, as I will show, the instrumentalization of PTSD was also fraught in a number of ways and was not neutral in its universality. As such, I argue against Didier Fassin's contention that "the intelligibility of the conflict" and history itself is lost when one "speaks of trauma and the victim."⁵⁶ Rather, I suggest that attending to the double binds that constitute psychiatric practice in Kashmir, particularly in cases of trauma and PTSD, can itself be revelatory of an alternative history (see Chapters One and Two).

The unexpected and multiple uses of PTSD by Kashmiri mental health experts also helps explain the disparity between the overwhelming discursive representation of trauma in media, human rights and humanitarian reports and its relative absence in everyday clinical practice. During my fieldwork at the psychiatric hospital's Out Patient Department, I expected to meet scores of traumatized patients, an "entire society suffering from PTSD," as the *Time* magazine article described. When I confessed my difficulties of locating PTSD patients to Dr. Arshad Hussain, one of my closest psychiatric interlocutors, to my surprise, he agreed with me. He said that he had noted the decrease in PTSD patients to the hospital and had pointed this out to Kashmir's BBC correspondent at that time. In December 2009, the correspondent had published a story on the BBC's website entitled, "Kashmir coming out of conflict trauma." The article described a "sharp decline" in the number of PTSD patients in Kashmir, and quoted Dr. Arshad⁵⁷ as having said, "Today we see hardly one fresh case of

⁵⁶ Fassin 2011: 220.

⁵⁷ Most doctors in Kashmir, unless very senior, were referred to as "Dr. + first name" rather than their last name.

PTSD a day.”⁵⁸ Yet, Dr. Arshad felt that this story had not made a dent in the public focus on trauma and PTSD because it metonymically implied an improvement in the overall political situation in Kashmir—a position that was untenable.

I was puzzled as to how I could make sense of this discrepancy between the discursive production of PTSD and its clinical absence without falling into the problematic position of denying continued, systemic violence in Kashmir. Eventually, I began attending to not only the “practices, technologies, and narratives that glued together PTSD”⁵⁹ and the ways in which it was diagnosed, treated, and represented by various interests, but also, the experiences, practices, and narratives that were concealed by this object. To do this, it was necessary to bring *kamzori* into focus and make PTSD fuzzy.

The majority of patients I met both inside and outside the hospital spoke about somatic distress, including *kamzori* (weakness). Patients described their *kamzori* as due to tensions with husbands or wives, mothers or fathers-in-laws, money troubles, difficult children, and the absence or loss of employment or land. In other words, they pointed to some of the structural effects of long-term violence on intimate relations. Unlike the symptoms of PTSD – such as nightmares and reenactments – which were somewhat unusual in the clinic, complaints of weakness proliferated widely, both within and outside of the clinic. In fact, the vast majority of patients who came through the Out Patient Department (OPD) of the psychiatric hospital as well as the other sites of mental health care where I did fieldwork complained of an overall sense of weakness.

⁵⁸ From: http://news.bbc.co.uk/2/hi/south_asia/8320178.stm).

⁵⁹ Young 1995: 5.

While clinicians often understood *kamzori* as a symptom of depression, they generally did not understand it as a consequence of trauma. This was perhaps due to the fact that *kamzori* was not traceable to a specific, external occurrence, but existed within the continuous space of troubled familial and social relations. *Kamzori* also accompanied a number of other diseases – from cardiovascular problems to arthritis to depression. As Lawrence Cohen has noted in another north Indian context, a speaker’s fears and understandings of *kamzori* dovetailed with other local meanings of weakness.⁶⁰ In Kashmir, while *kamzori* sometimes referred to a loss of bodily strength and decay, such as in the aging bodies Cohen studied,⁶¹ it also indexed a wide range of existential, moral and psychological suffering, not limited to the physical loss of strength. For example, I frequently heard Kashmiri women, in particular, complain about the accumulated effects of years of housework on their fatigued and weakened bodies.

In addition, *kamzori* also had ambiguous moral and ethical valences. *Kamzori* could be an effect of immoral behavior, such as a mother not properly following ritual procedures after the birth of her child, resulting in the transmission of flawed bodily substance from mother to child. *Kamzori* could also signify male impotence. Long-term psychiatric patients often complained of *kamzori* as both a cause *and* effect of psychiatric illness and treatment. One woman told me how constant worry (*pareshani*) about her illness had weakened her body, making her susceptible to further illnesses. In some cases, *kamzori* was also a way for patients and kin to refer to a weak brain (*dimag*), suggesting a lack

⁶⁰ Cohen 1995: 320.

⁶¹ Cohen 1998: xv.

or loss of intellectual ability.⁶² Yet the language of *kamzori* was also a way to talk about a “weak” or overly sensitive disposition. In chapter 3, I quote Saira as complaining that her heart is *kamzor*, that she felt unable to bear emotional pain. While experienced somatically, then, *kamzori* was not reducible to individual bodily pain.

One reason why it is useful to think of trauma and *kamzori* in tandem, I think, is the fact that patients sought biomedical treatment for *kamzori*, and it was a persistent complaint in the clinic. As I show in chapter 4, even when patients saw symptomatic improvements in other aspects of their illness, they rarely reported being free of *kamzori*. Given the virulence and frequency of such complaints, doctors could not ignore them entirely, so they did the next best thing: use placebos. As standard practice, doctors doled out Vitamin B12 tonics, multivitamins, and advised their patients to read the Qur’an to combat *kamzori*. Doctors often glossed the multivitamins as “medicine” (*davai*) for their patients and told me that patients could not differentiate between multivitamins and their regular medicines. Many patients, however, could discern multivitamins from ‘real’ medicines based on the spiral packaging that was unique to multivitamins. Thus, some patients felt cheated when they received multivitamins in response to their complaints of *kamzori* and referred to these as rubbish medicines (*bakvas davai*).

Given the dismissal of *kamzori* as a legitimate ailment, it was not surprising that it was rarely written down on the medical card, and thus, not officially treated. Nonetheless, this does not mean that *kamzori* and trauma

⁶² As Lawrence Cohen points out, however, “the epistemology of weakness seldom presumes a marked distinction between the mental and the embodied life. The weakness of *dimag* (brain) is usually but one of many forms of the weakened body” (Cohen 1995: 319).

belonged to mutually exclusive epistemological domains. On the contrary, I argue that *kamzori* functioned as an analogical concept to trauma for patients in the sense that it was a means of connecting individual subjectivity with broader social and political ill health, just like PTSD was for doctors. Just like PTSD, individual patient complaints of *kamzori* were immediately linked to the social and political context of Kashmir. 45-year-old Bashir Ahmed, who I interviewed in the waiting room of a government-run Unani clinic, explained the epidemic of *kamzori* in Kashmir thus:

Even people with minor heart and kidney problems routinely go to Delhi. Don't we have an Institute [a tertiary care facility]⁶³ here? Why do they go to Delhi? Because they don't get better here. Tensions are high, so illnesses are also high. A mother whose son might be out of the house is worried that he might be caught in cross firing, so naturally she is tense. This tension makes her weak [*kamzor*]. After militancy, we have more illnesses [Personal communication, May 7, 2010].

In this narrative, Bashir pointed to existing “tensions” in Kashmir as directly responsible for producing illness. However, unlike humanitarian and psychiatric epistemologies, in which violence was directly linked to psychological suffering, in Bashir’s narrative, the “tension” experienced by Kashmiris manifested itself first in a general bodily weakening, which then facilitated the onset of more serious, somatic illnesses, such as heart and kidney problems. Even when Kashmiris sought treatment for other medical conditions, *kamzori* was usually still left over. Bashir’s narrative also showed the vernacularization of biomedical concepts in Kashmir through his use of the English-language term “tension.” However, rather than referring to a clinical

⁶³ In India, tertiary care facilities are known as Super Specialty hospitals. Since the 1990s, Super Specialty hospitals, as high-end privatized medical establishments, have been the sites of major investment and foreign monetary exchange. As Cohen (1999: 680) has described, new public-private assemblages have emerged linking medical institutions to politics and capital.

diagnosis of hypertension or to stress, Bashir used “tension” in the sense of the weight of troubles on the body and mind. In contrast, to feel happy, in Kashmiri and Urdu, means to feel “light” (*halka*), almost weightless.

As such, like PTSD, *kamzori* was also a means of collectivizing illness, of recognizing the cumulative effects of political stagnation in the bodies of individuals. While the presence of *kamzori* was not viewed as a “morally legitimate”⁶⁴ form of suffering by clinicians, it nonetheless continued to be a pressing concern for patients. In particular, I suggest that the language of *kamzori* was also a way of speaking to the fact that Kashmiri bodies had been weakened, just as the dream of a Kashmiri nation had been weakened. It indexed a loss of agency on both an individual and collective political level. In this sense, similar to what Sherine Hamdy has described in the case of poor dialysis patients in Egypt, ill bodies were revealed as effects of an ill political past, present, and future.⁶⁵ When I asked drug users in their early twenties about whether the “problem” of Kashmir would be solved in the future, many laughed and shook their heads. “This problem will never be resolved,” one said, “because neither India nor Pakistan will let it go. It will continue on like this.”

Despite their similarities as political etiologies, PTSD and *kamzori* circulated differently and also did different kinds of ethical work for the experts and patients who experienced and used them. Ultimately, as clinical diagnoses, trauma and PTSD were ways of localizing or containing violence. Not only did PTSD point to a specific external event as a cause, it also located suffering within a particular set of symptoms and determined those to be urgent and legitimate.

⁶⁴ Ticktin 2011: 19.

⁶⁵ Hamdy 2008.

Kamzori, in contrast, refused to be limited to specific diagnoses or individual bodies: it was revealed as disrupted relations, whether signifying a lack of balance within the body or the family. While consistently seeking treatment for *kamzori*, patients also situated it in the realm of chronicity. Bodily *kamzori* made visible familial *kamzori*, which, in turn, made visible the weakened dream for a Kashmiri nation. As such, unlike PTSD, the work of *kamzori* actually broadened and made diffuse the effects of violence and medicalization. It refused to heal, and in so doing, was a powerful reminder of the history of disenfranchisement that Kashmir had, and would continue to, experience.⁶⁶

In drawing attention to *kamzori* and PTSD as analogous forms of medicalization, I want to show how these dovetailed to ensnare Kashmiris within a “net” of ill health in Kashmir. To remember a time when the valley was not afflicted with disease, one had to go all the way back to when the Mughal emperor Akbar crossed the Pir Panjal mountains into Kashmir in 1586, that is, prior to any period of colonization in modern history. As I recount in chapter four, one of the psychiatrists I worked with told me a story of how, when Akbar crossed the mountains, he felt himself suffering from a severe headache. He asked some farmers who were tiling the saffron fields near Pampore if they had a cure. They responded, “What is a headache?”

Narratives such as this one produced a hegemonic sense that in Kashmir, all diseases had a political etiology. They were part of “third-person knowledge,” in C.S. Peirce’s terms, a logic that operated in the form of rationality

⁶⁶ In this sense, *kamzori* was different from the Open Mole disorder which Sharon Abramowitz has described in the Liberian context. While Open Mole is transformed from a culture-bound disorder to a gateway diagnosis of PTSD-related mental illness, I suggest that psychiatrists are unable or willing to operationalize *kamzori* in this way (Abramowitz 2010).

or common sense.⁶⁷ Within this framework, the only way to escape the corrupting, corrosive effects of violence was to physically leave Kashmir and seek health elsewhere, which those who could afford it did with greater frequency.

Theoretical Contributions

This dissertation responds to three framing questions: (i) What is humanitarianism in the context of an intractable political conflict, such as Kashmir, where questions of life and death recede to the background? (ii) How have Kashmiri mental health experts and patients translated and used the language and tools of biomedical and humanitarian knowledge and to what ends? (iii) What kinds of subjects are created at the intersection of liberal humanitarian projects which foreground psychological and psychiatric suffering?

Together, these questions acknowledge the intensive linguistic and conceptual labor required by both mental health experts and patients to make biomedical and humanitarian encounters useful. They show the ways in which biomedical tools, rather than curing suffering, have become ways of *living with* suffering. A key way of understanding what humanitarianism is in this context is by thinking about who is counted as an expert. In focusing on the work of Kashmiri mental health experts, following Peter Redfield, I argue that the image of humanitarianism as an “emergency-room ready team” of doctors does not adequately capture the everyday work that occurred within these spaces of care.⁶⁸

⁶⁷ Daniel 1984; Cohen 1995: 319.

⁶⁸ Redfield 2010.

In bringing Kashmiri experts into focus, I also challenge anthropological critiques that humanitarian practice rests on a binary between peripatetic expatriates who save and immobile victims who are saved.⁶⁹ Such critiques often minimize the role played by local staff who increasingly do the brunt of work within humanitarian organizations, including Kashmiri psychiatrists, psychologists, and social workers. Generally, local staff are underrepresented both within the public profiles of humanitarian organizations and in anthropological critiques. In the case of MSF, for example, the organization has two, distinct classes of personnel: “international volunteers” composed mainly of Euro-American expatriates and “national staff” who are hired in support roles at specific sites. However, as Redfield notes, although “national staff” outnumber expatriates in MSF about 9:1, they rarely appear in the organization’s media profile or internal governance structure.⁷⁰

When local staff do appear, they are often viewed as instruments of humanitarian knowledge, used to “manag[e] the culture *‘problem.’*”⁷¹ As Sharon Abramowitz and Arthur Kleinman have argued, for example, “through ‘local staff,’ local cultures and contexts can be learned, integrated, instrumentalized and redeployed selectively in NGO projects and activities.”⁷² As anthropologists of humanitarianism have begun to recognize, the role of local or national staff has grown more significant within humanitarian organizations, particularly as these organizations expand their repertoire to include not only medical emergencies, but also chronic conditions such as HIV / AIDS and psychological

⁶⁹ Fassin 2007.

⁷⁰ Redfield 2012: 360.

⁷¹ Abramowitz and Kleinman 2008: 221.

⁷² Abramowitz and Kleinman 2008: 221

trauma. In cases where communication and language skills were central to the performance of humanitarianism, local staff shouldered much of the work, whereas expatriate staff occupied administrative and supervisory roles.

However, there is still another factor to take into account, which has a bearing on the performance of humanitarianism: how local staff not only shape, but are themselves shaped, by NGO projects and activities, and how this process may actually impact their ability to act as “native informants.” In my experience, the more Kashmiri psychologists, social workers, and counselors encountered and were trained in global, technical, English-language discourses on mental health, the less able they were to act as conduits into the ‘local.’ Ironically, some of the expatriate staff took on roles as cultural mediators (see Chapter Two). As such, I argue that attention to the movement between universal and particular knowledge that constitutes humanitarian expertise also requires us to consider what is lost in this movement.

One of the findings of this dissertation is that humanitarian and biomedical tools—including techniques such as counseling and talk therapy, but also objects such as medical cards and pills—were plastic in the hands of Kashmiri psychiatrists, psychologists, counselors, and patients. There were consistent, everyday subversions, “vernacularizations,” and multiple ontologies at work which revealed the partiality of authoritative biomedical practices. For one, patient expectations, rather than expert intentions, clearly shaped the outcome or use of particular techniques, such as the use of medical rather than psychosocial means of care. Secondly, both experts and patients worked to make humanitarian knowledge accountable as a *political etiology* in Kashmir. Thirdly, authoritative objects of biomedical practice did not retain stable meanings or

forms across space and time; rather, they had a “sticky” quality, which enabled them to attach and detach with patient and expert relations in unexpected ways.

First, I argue that patients took ownership of techniques of care in unexpected ways that shaped the outcome of particular interventions. As such, they were co-participants rather than simply the victims or objects of intervention (see Chapters Three and Four). By focusing on particular biomedical technologies, such as diagnosis, I also show how these worked differently for patients and experts. For example, while experts were deeply concerned with and used biomedical diagnoses to understand their own bodily distress, patients were rarely told – and had little interest in – what their diagnosis was. This made for a drastically different clinical situation than the one described by Miriam Ticktin, for example, where diagnoses can have life or death consequences for immigrants to France.⁷³

In Kashmir, by contrast, the benefits offered to those deemed worthy “victims” of violence was limited to either “emergency support” packages, consisting of a small supply of household items, such as cooking oil, *dal*, and rice, or “livelihood support,” which at the most, consisted of providing a cow to the family in order to generate income. While I do not mean to diminish the significance of these forms of support, during household visits, I heard families complain that these benefits were not sufficient and ask the organizations for money instead. In contrast, none of the migrants who were granted legal residency in France thanks to the exceptional “illness clause” within French immigration law seemed to contest their status as the “wretched of the earth,”

⁷³ Ticktin 2011.

despite the cruel ironies produced by this legal exception.⁷⁴ While diagnosis was secondary to modes of treatment for Kashmiri patients, it was nonetheless a significant for experts in both personal and professional capacities. Experts relied on highly technical treatments to treat their own bodily distress, whereas patients were highly skeptical of these strategies and expert advice and preferred to listen to their bodily distress and widely practiced self-medication (Chapter Four). As such, I argue that experts, rather than victims, were most directly effected by certain vectors of humanitarian knowledge and practice.

Second, I show how competing illness etiologies in Kashmir worked to produce a link between ill health and violence in Kashmir; put differently, it was the ability of the etiologies to enact this link, which made them culturally resonant in the first place. The example of “summer snow” with which I began, for example, shows how ill bodies in Kashmir, even those affected by seasonal allergies, are suffused with moral and political concerns.⁷⁵ As many other examples within medical anthropology remind us – beginning with Evans-Pritchard’s classic example of Azande witchcraft – the explanation for “summer snow” is compelling for its ability to respond to the “why” question of illness. As Michael Taussig has argued, while biomedicine is remarkably good at answering the “how” question of illness, it is not particularly good at the “why” (Why me? Why now?)⁷⁶ However, separating out the “how” from the “why” between authoritative and folk discourses reifies a false distinction between these epistemologies. In Kashmir, I argue that such clear cut distinctions between the authoritative and folk, the clinical and the anecdotal, are not available since

⁷⁴ Ticktin 2011: 11-12.

⁷⁵ See also Hamdy 2008.

⁷⁶ Taussig 1980: 7.

biomedical and humanitarian knowledge is also expected to respond to the *why* question. I argue that this is one of the reasons for the traction of trauma as an idiom of distress in this region.

Similarly, Part II of the dissertation focuses on the ‘threads’ of the net – medical cards and pills – objects that move to and from the clinic in order to highlight the existence of multiple epistemologies and ontologies within the space of the clinic. Rather than view these as incommensurable, I show unexpected ways in which local idioms of distress can dovetail with an authoritative biomedical language, or alternatively, moments when there is a mutual misapprehension between different epistemologies of suffering.

In this sense, I build on the argument that the global expansion of PTSD has had more to do with its ability to connect individual subjectivity with questions of political legitimacy and social justice, and less to do with the clinical significance of the disorder.⁷⁷ Thus, rather than trauma and PTSD as forms of depoliticizing suffering, as has been shown elsewhere,⁷⁸ in Kashmir, trauma is used to link a person’s illness with external circumstances severe enough to qualify as traumatogenic.⁷⁹ I argue that dominant narratives of ill health and conflict create what I call a “net” of medicalization in Kashmir.

⁷⁷ Aretxaga 2003; Das, Kleinman, Ramphele and Reynolds 2000.

⁷⁸ Malkki 1995: 12-13; 1996; Pandolfi 2011.

⁷⁹ Young 1995: 120. Young argues against the idea that PTSD is a distinctively social diagnosis. Rather, he argues that symptoms associated with PTSD – such as insomnia or increased sleep – are also associated with other disorders, such as depression. However, as part of a PTSD diagnosis, the symptom becomes part of a clinical narrative in which it is not simply an indication of an underlying pathology but an eruption into present consciousness of the traumatic event. The narrative in which trauma moves through memory to eruption in symptoms depends, in turn, on modern Western conceptions of the self as constituted through continuities of memory. The narrative of traumatic memory, Young argues, gives an alternative meaning to observed symptoms: these are not simple symptoms of mental illness, but traces of the traumatic event that preceded them (Young 1995 Chapter 4; Breslau 2000: 116).

In addressing these nuances of vernacularization, this dissertation resists the well-worn critique that “interventions which build on the idea of universal humanity often convey contempt for concrete situations.”⁸⁰ I argue that such critiques conveniently make space for anthropology to provide the necessary ‘context’ – the cultural or historical specificity – and thereby provide an antidote to humanitarianism’s universalism.⁸¹ When the work of cultural appropriateness is already folded into interventions, as is the case in humanitarian work done by Kashmiris, what then, for the anthropologist? Following scholars of expertise who have faced similar situations of collapse between “ourselves and our objects of study, between the things studied and the frames we used to study them,”⁸² rather than provide an account of how humanitarian ideals fail in practice, this dissertation addresses the particular *form* that humanitarian interventions in Kashmir take. I attempt to go beyond a mere description of this form by demonstrating its operation through what I call a “politics of visibility.” In making the multiplicity of biomedical and humanitarian practices visible, I draw on scholars of science and medicine who have attended to the “ontological politics” at the heart of biomedical and other health interventions.⁸³ I suggest that the “ontological politics” at stake here require attention to both how problems of violence and mental health are framed by biomedicine, but also to how “overlapping and heterogeneous ways of knowing, enacting, and treating the body”⁸⁴ were available to, and used by, Kashmiris within this frame.

Outline of Chapters

⁸⁰ Englund 2005: 12.

⁸¹ Fassin 2008; James 2010; Malkki 1995.

⁸² Riles 2006a: 3. See also Choy 2011.

⁸³ Mol 2002; Langwick 2011.

⁸⁴ Pigg 2001: 483.

Each chapter of the dissertation enacts the politics of visibility at the heart of humanitarian practice in Kashmir in a different way, while moving through the net.

In Chapter One, I examine ongoing processes of deinstitutionalization in mental health care in Kashmir, particularly as they appear in the material transformation of the Government Psychiatric Diseases hospital from an asylum to a research and teaching hospital. While processes of de-institutionalization are coterminous with increasing out-patient, community-based care, short-term stays, and reliance on pharmacological treatment (in other words, an *opening* of mental illness), I suggest that, in Kashmir, processes of de-institutionalization have simultaneously resulted in processes of quarantining or attempts to *enclose* mental illness. I suggest that this politics of visibility is at the heart of de-institutionalization movements in India and also deeply marks the subjectivity of mental health experts.

I argue that this “double bind” has produced a paradoxical subjectivity for experts, who see themselves as combating “stigma” while also being deeply ensnared within a dominant logic of madness as contagion. While anthropologists have effectively used the concept of “double bind” in recent years, it is worthwhile to note that a true double bind refers to a situation that “requires a choice between two states which are equally valued and so equally insufficient that a self-perpetuating oscillation is engendered by any active choice between them... It is the result of the fact that one must choose, and moreover choose between incompatible alternatives.”⁸⁵ In this chapter, I suggest that the goals of both de-institutionalization and institutionalization represent

⁸⁵ Wilden and Wilson 1976: 276.

“incompatible alternatives” for mental health professionals in Kashmir. This chapter thus moves from an account of de-institutionalization—the visible, ethical, bureaucratic face of mental health care—to a return to the asylum and the logic of visibility that marks it.

In Chapter Two, on the production of expert psychiatric and psychosocial subjects who staff humanitarian organizations, I engage with literature on the anthropology of humanitarianism and expertise. While local or national staff have been almost invisible in both anthropological and humanitarian self-narratives, I explore the intimate ways in which Kashmiris are engaged in various humanitarian projects.

I argue that psychosocial and psychiatric interventions in Kashmir are deeply engaged in discussions about cultural appropriateness, and as such, subvert normative critiques of humanitarianism. I provide two examples of this process: discussions over the appropriateness of PTSD therapies practiced on US veterans and the spontaneous appropriation of psychiatric practices by local counselors in order to make their own practices more culturally legible. While anthropologists of expertise have shown that expert knowledge mediates between the particular and universal, I suggest that psychiatric and psychosocial experts who acquire supposedly universal knowledge – such as through the *Diagnostic and Statistical Manual* – are actually less able to engage with forms of particular, local knowledge. In other words, the mediation between the particular and universal is not a free-flowing movement, but rather, in this instance shows how universalistic knowledge is often acquired at the expense of, and often obscures, particular knowledge, and vice versa.

Chapter Three similarly examines forms of personhood that are revealed and concealed through the medical card, an object which not only mediates, but enables relations between experts and patients in Kashmir. While the card is imagined as the extension of state and bureaucratic authority, I show how its circulation enables it to be attached and detached to subjects and relations in unexpected ways. As I describe, in Kashmir, medical cards are the property and responsibility of patients, not institutions. Unlike other rationalized bureaucratic artifacts, medical cards are handwritten, circulate outside of institutional settings, and continue to bear the marks of both experts and patients in particular ways. In the case of long-term mental illness, I show how the card emerges as the proper object of biomedical intervention, and how the card is separated out from the patient. This raises questions, I suggest, about the relationship between the card and the patient (that which it is purported to represent), while also contesting medical anthropological understandings of *who* or *what* is the object of intervention in a humanitarian or biomedical space.

In Chapter Four, the materiality of biomedical practice in Kashmir is once again foregrounded with attention to pills. I suggest that, in contrast to mental health narratives which celebrate recent scientific developments in pharmaceuticals, permitting a more de-institutionalized care, from beyond the clinic's view, pills have multiple ontologies in Kashmir. In particular, I show that pills are objects towards which Kashmiri patients express deep ambivalence: they are powerful but simultaneously dangerous. I suggest that the distrust Kashmiris exhibited towards pills reflects the ways in which interpersonal relations – which are also deeply suspect - have also been remade in the context of long-term violence. I argue that in their use and appropriation of pills as a

technology of care, as well as in expert responses to this appropriation, patients shape the outcome of everyday clinical interactions and outcomes.

Lastly, in Chapter Five, I examine the production of PTSD as an object of humanitarian and biomedical intervention, including in the context of widespread drug addiction. Public health and Indian state sources establish tightly drawn links between violence, trauma, and addiction, I argue, but ethnographic attention to the narratives of drug users reveals that “everyday occupations,” such as heartbreak and romantic love, are the sites of persistent psychic wounds. Rather than read these stories as symptoms of displacement, however, I suggest that they are worthy of ethnographic attention in and of themselves. In particular, I show how “lateral” attention to love stories as ethnographic artifacts allows us to see how former drug users use the language of intoxication (*nasha*) to carve out an alternative ethics and subjectivity, that is not available through either biomedical narratives of addiction or mainstream Islamic ethics.

CHAPTER ONE: ARCHITECTS OF MENTAL HEALTH

“The people of Jammu & Kashmir have faced immense mental stress during the past 15 years of militancy and cross-border terrorism. It is, therefore, unfortunate that large parts of the State are without even basic mental health facilities. The mental hospital at Srinagar has had an unfortunate history... Training facilities for mental health personnel are deficient and urgent steps are required to augment the same. Considering the special status of this disturbed State, the case for implementing the DMHP [District Mental Health Program] in as many districts as possible needs to be supported strongly”

– National Survey of Mental Health Resources, 2008

Saiba: So, what are the most challenging aspects of practicing psychiatry?

Dr. Zaid: Psychiatry is nobody’s child. From pirs⁸⁶ to doctors, everyone is practicing psychiatry. Patients come to us after a long time, after they have visited every other expert. People don’t reach the person who is supposed to treat them – they get here a year or two later than they should.

Introduction

This chapter explores recent shifts in mental health in care in Kashmir and more broadly in India, with attention to how these transformations are expressed through, and affected by, specific embodiments of psychiatric expertise. I argue that psychiatric expertise in Kashmir is constituted through a particular “politics of visibility” where the incompleteness of de-institutionalization married with the tainted nature of asylums, a sense of biomedical crisis but lack of employment opportunities, and professional commitments to combat the “stigma” associated with mental illness while living with ongoing sense of madness as contagion.

I extend the term “double bind” to understand the conundrums faced not only by patients of severe mental disorders – as in Gregory Bateson’s original term which referred to the schizophrenic’s psychotic inability to process

⁸⁶ Islamic healers.

conventional order in the world⁸⁷ – but to experts as well. In recent years, anthropologists have used the term to describe the form of contemporary social and political movements, including humanitarianism.⁸⁸ As Peter Redfield has noted, “the double bind...is not quite the same as a structural binary, a dialectic, or even a dilemma. It lacks stability and motivates by a desire to satisfy competing injunctions, thus precipitating a problem of choice, rather than necessity.”⁸⁹

From frustrated expressions such as Dr. Z’s above to seemingly nonchalant claims that psychiatry is “like an office job,” that I also heard, individual psychiatrists offered radically different propositions for choosing psychiatry. While some cited their interest in psychiatry as based on the fact that the stakes were lower than other medical specializations—as one psychiatrist put it, “no one dies on my table”—others highlighted the challenges of intimate cultural knowledge that psychiatry required as the engine for their continued passion.⁹⁰

Psychiatrists in Kashmir, as elsewhere in the developing world, have generally enjoyed greater visibility and status in the last two decades, particularly with the growth of international medical humanitarianism. Nonetheless, they consistently expressed ambivalence towards the profession as well the reasons for what kept them motivated. There was, in fact, a paradox: while psychiatrists had gone from being largely invisible to being at the forefront of public discussions on the ongoing effects of long-term militarization and

⁸⁷ Bateson 1972.

⁸⁸ Cattelino 2010; Fortun 2001; Redfield 2012.

⁸⁹ Redfield 2012: 361.

⁹⁰ This latter position will be familiar to ethnographers of technocracy who have emphasized the ways that failures become the engines of more technocracy (Riles 2004).

violence, at the same time, they were still marginal to the help-seeking process of most Kashmiris. Almost every patient I interviewed said that they had visited one or numerous *pirs* before entering a psychiatrist's office, and many continued to visit *pirs* during their medical treatment, despite the advice of the psychiatrist to the contrary.

Further, the transactional nature of the encounter between doctors and patients in Kashmir was not merely symptomatic of unequal power dynamics between expert and non-expert, but was often a two-way process. For patients, a successful encounter was one where a transaction was successfully completed—a card signed, treatment extended, and pills acquired. This emphasis on treatment over diagnosis or explanation, which has also been described by other anthropologists of psychiatry in South Asia, often reduced psychiatrists to the status of pharmacists, a move that was not aligned with psychiatrists' own self-descriptions.⁹¹

One of the everyday “double binds” faced by Kashmiri psychiatrists, I argue, are related to the effects of de-institutionalization and humanitarian psychiatry. Kashmiri mental health experts are somewhat unique among their Indian counterparts in that they have directly participated in both these distinct transnational movements in mental health care. The Government Psychiatric Diseases hospital (GPDH) in Srinagar, where I did over six months of fieldwork, was one of the few government-run hospitals in India where humanitarian psychiatry was part of the hospital's very fabric. For over a decade, Médecins sans Frontières (MSF) counselors, not government employees, provided psychotherapy and counseling to the hospital patients. In a 2008 report by the

⁹¹ Addlakha 2008; Nunley 1998; Pinto 2012.

National Human Rights Commission (NHRC), 78 per cent of mental hospitals in India reported providing counseling services, although many had only one clinical psychologist or social worker posted to the premises.⁹² Meanwhile, psychiatrists did not receive any classes on counseling or psychoeducation in medical school, yet they described “educating the patient” as one of their primary goals in the clinic.

As one of only 37 state mental hospitals in India, the GPDH was also the site of major bureaucratic and legal interventions, including efforts to de-institutionalize mental health care via the National Mental Health Program (NMHP) and District Mental Health Program (DMHP). While humanitarian psychiatry is constructed around “emergencies” in the sense of “sudden, unpredictable events emerging against a background of ostensible normalcy,”⁹³ India’s national mental health program is also seen as responding to a crisis, but one that emerged from long-term social and economic inequalities, especially between the developed and developing world.

Despite these differences, humanitarian psychiatry and national mental health programs also share a goal: to “de-stigmatize” mental illness by de-institutionalizing mental health care and promoting care ‘in the community.’ While de-institutionalization or “community-based care” purports to make mental health care more “feasible, affordable and acceptable”⁹⁴—in other words, to make care more *open*—I argue that de-institutionalization also results in simultaneous processes of *quarantining*, which increasingly obscure continued forms of institutionalized care. In addition, while both humanitarian psychiatry

⁹² Nagaraja and Murthy 2008: 91.

⁹³ Calhoun 2010: 30.

⁹⁴ Patel 2007: 87.

and Global Mental Health produce biomedicine and medical professionals on the side of progress and modernity and patients on the side of culture and backwardness through the discourse of “stigma,” this perspective neglects the ways in which experts are themselves deeply marked by madness, a contagion.⁹⁵ In focusing on the entanglements of different orders of knowledge and experience around mental health policy, I view expert knowledge as made not only on the level of programs and policy, but also through intimate, embodied practices.

The first part of this chapter challenges the dominant logic that de-institutionalization produces a more transparent, just, and open regime of care, in favor of understanding how it also separates out what I call the ‘inside’ and the ‘outside’ of the mental hospital. The second part of the chapter focuses on tensions between the universal diagnostic categories of humanitarian psychiatry and the particular concerns of Kashmiri psychiatrists. My aim is not to show how the ideals of universalism fail in practice, but rather, to show how debates about cultural appropriateness and the applicability of humanitarian instruments to Kashmiri patients are foundational to what it means to be an expert in Kashmir. I thus point to how these tools are “vernacularized” but also show how this process of instrumentalization produces particular paradoxes for psychiatrists. Here too, there is a movement of knowledge between ‘inside’ and ‘outside,’ but this is expressed as the difference between “the ivory tower” and

⁹⁵ Daniel 1984: 8. Foundational work in the anthropology of South Asia has argued that among Indians (or Tamils, in the case of Val Daniel), all things are constituted of fluid substances, which are in perpetual flux and have the capacity to separate and mix with other substances (Marriot and Inden 1977; see also Lamb 2000). Thus it is possible, or indeed inevitable, for persons to establish inter-substantial relationships with other people and the places they live. While this work has focused on Hindu communities and is not fully transposable to the Kashmiri context, the idea of fluid or substantially interpenetrative selves is foundational in both Ayurvedic and Unani medicine (Zimmerman 1979, 1980).

the “OPD,” or between “Kashmir” and *bahar* or the world “outside.”⁹⁶ Kashmiri doctors told me that if medical experts from the outside world could see what they had to go through on a daily basis, they would be “shocked” (*hairaan*). Yet, despite the desire for more even flows of knowledge, Kashmiri psychiatrists also resisted flows from the global to the local in specific ways. In this sense, they were also engaged in a project of “remapping the possibilities” of biomedical and humanitarian geographies.⁹⁷

Part I: De-institutionalization, or the abandonment of the asylum

One of the arguments in this chapter is that the ambivalence Kashmiri psychiatrists experience in their everyday work is an expression of entanglements between past and future and between competing senses of what the hospital is in an era of de-institutionalization.

First, let me very briefly outline the history of asylums in the subcontinent. Asylums were introduced to British India in the late eighteenth century for Europeans and Indian elites, and by the early nineteenth century, there were three small institutions in the provincial capitals of Madras, Mumbai and Calcutta, with plans for further expansion.⁹⁸ Nonetheless, as Waltraud Ernst has described, British India did not have a period of institutionalization comparable to what Foucault described as ‘the great confinement of the insane’ in Europe. While the numbers of asylum inmates during this period is statistically insignificant in terms of the total population, Ernst argues that

⁹⁶ Kashmiris used the term *bahar* to differentiate spaces of knowledge and practice from each other. The term *bahar* can mean immediate outside surroundings, such as “outside the hospital,” while also referring to a more abstract sense of the world outside, to be non-Kashmiri, for example (*Bahar se aana*, “to come from outside Kashmir”).

⁹⁷ Tsing 2000.

⁹⁸ Ernst 1997. The majority of Indian asylum inmates were mendicants and beggars picked up for threatening the public peace and order (Ernst 1997: 160).

asylum policies dovetailed with larger colonial arguments for bringing civilized, humanitarian, and scientific treatment to the subcontinent. However, the operation of psychiatry as a tool of social control was restricted by the fact that institutional practices within the British empire varied significantly from parish to parish. As such, colonial medicine and psychiatry, while “carried along by the wave of humanitarianism that had become an important feature among Victorians at home and abroad,”⁹⁹ was nonetheless restricted to the level of ideological discourse.

Today, fourteen of the 37 mental hospitals in India make use of the original custodial-style architecture of the colonial period. No new stand-alone mental hospitals have been built since 1960, since mental health care was shifted away from mental hospitals to general hospital psychiatric units and later, the community.¹⁰⁰ While most hospitals were originally built on the outskirts of major cities to keep the mad out of public view, with the rapid expansion of Indian cities, many hospitals are now well incorporated into urban environments. However, despite the continued use of the asylum structure, the Indian medical establishment has shifted significantly in the postcolonial period. Post-independence, the Indian medical establishment gradually realigned itself away from a British model. In the 1950s, Indian medical colleges began using American rather than British textbooks and medical journals, such as the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM), an ubiquitous artifact in every South Asian psychiatrist’s office.¹⁰¹ Indian medical colleges, such as the All India Institute of Medical Sciences (AIIMS) in New

⁹⁹ Ernst 1997: 171.

¹⁰⁰ Dhanda 2005.

¹⁰¹ Nunley 1992: 107.

Delhi, one of the most renowned biomedical institutions in the country, was built using Johns Hopkins University as its model. However, as Michael Nunley describes, in the first three decades after independence, health care was a relatively low priority for the Indian government, which encouraged organizations such as the World Health Organization (WHO) and United Nations Children’s Fund (UNICEF) to play significant roles. At that time, the emphasis in international public health was on campaigns directed at the eradication of specific epidemic diseases, primarily through mass inoculation programs, which had varying degrees of success.¹⁰²

As such, despite its association with biomedicine—which has a powerful ideological and material apparatus in South Asia—psychiatry remained marginal within the public health system in India until the 1980s, when arguments for de-institutionalization took hold. While mental health experts were in agreement that mental institutions could not be entirely done away with, trends in Global Mental Health (GMH) particularly in what are called Low and Middle Income Countries (LAMIC), argued for a diminished role for the mental hospital as a site of care in favor of “locally available, affordable interventions in community and primary care settings.”¹⁰³ These reports often pointed to the marginalized role accorded to mental health care in the developing world; for example, while the developing world accounts for 11.1 per cent of the burden of global mental disorders, developing countries, on average, spend less than one per cent of their

¹⁰² While some of these programs (such as the ones against smallpox and cholera) were quite successful, others (against malaria and tuberculosis) were notably less so.

¹⁰³ Patel 2007: 82. In fact, Erving Goffman is often credited as being one of the first social scientists to report on the prison-like conditions of mental asylums, thereby helping to create momentum for the de-institutionalization movement. Subsequently, anthropological studies have critiqued de-institutionalization as well. See Carr 2011; Davis 2012; Floersch 2002; Goffman 1961; Jain and Jadhav 2007; Rhodes 1991.

health budget on mental health care.¹⁰⁴ Global Mental Health thus represents the intersection of discourses on human rights, social welfare, and cost effectiveness on a global scale.

Generally, the Indian and Kashmiri psychiatrists I met celebrated the knowledge being produced by Global Mental Health advocates, particularly studies that were based on research from low and middle-income countries. This research was viewed as culturally particular and appropriate, unlike studies from the resource-rich West, which were perceived as being impractical to implement in a country like India. Vikram Patel, an Indian psychiatrist at the forefront of the movement for Global Mental Health, for example, has pointed out that despite the fact that low and middle income countries account for more than 80 per cent of the world's population, less than 6 per cent of global research in mental health focuses on these countries.¹⁰⁵

One study which evaluated community-based care for chronic schizophrenics in India argued that such programs were “able to reach out to people in rural and impoverished communities, providing tangible benefits in terms of improved clinical outcomes, reduced levels of disability, and reduced family care-giving burden.”¹⁰⁶ This body of knowledge states clearly that while “care is often compromised by poor standards of care” in large psychiatric hospitals, community-care programs “improve the odds that patients who have been discharged are able to recover fully and remain in good health.”¹⁰⁷ In other

¹⁰⁴ Patel 2007: 81.

¹⁰⁵ Patel 2007: 81.

¹⁰⁶ Chatterjee et al. 2003; Murthy et al. 2005.

¹⁰⁷ Patel 2007: 91.

words, community-based treatment is also justified through a humanitarian logic.

Anthropologists have also participated in and contributed to this body of knowledge in significant ways.¹⁰⁸ For example, the landmark World Mental Health Report, which was written by medical anthropologists, argued for social factors such as poverty, social exclusion, and gender, to be taken into account as determinants of mental disorders.¹⁰⁹ In addition to addressing forms of structural violence that disproportionately affect populations in low and middle-income countries, recent reports have also argued for community-based mental health care rather than institutionalized care.

This research builds on earlier research on schizophrenia by the WHO, which argued that persons suffering from schizophrenia in the developing world had a better outcome and more benign course than those in the developed world.¹¹⁰ Scholars were quick to point out the role of the family as a key reason for this, a rationale that had been internalized by Kashmiri psychiatrists as well, but this time, in regard to PTSD, not schizophrenia.¹¹¹ As such, anthropological knowledge and the movement for de-institutionalization have been closely intertwined, both historically and in the contemporary. In pointing to these entanglements, my aim is to show that anthropologists and cultural knowledge are deeply implicated in the creation of “double binds” and predicaments for mental health experts.

¹⁰⁸ Murray and Lopez 1996; Desjarlais et al. 1995; World Mental Health Report 2001.

¹⁰⁹ Desjarlais et al. 1995.

¹¹⁰ Jablensky et al. 1992; World Health Organization 1973, 1979.

¹¹¹ Warner 1985.

As Elizabeth Davis has argued in the case of Greece, community-based treatment constitutes a “decisive new ethical development” in the history of modern psychiatry, given its demand for patient responsibility outside the hospital.¹¹² Yet despite Kashmiri psychiatrists having significant qualms about institutionalization, they did not embrace de-institutionalization in all its liberal glory. For example, as Davis argues, de-institutionalization envisions the patient as a “coherent and fully conscious subject, one endowed with legal rights and the capacity to enter and uphold agreements.”¹¹³ While concerns about individual patient rights and responsibility did emerge in the clinic, I found that they usually did not override the desires of kin.

While anthropologists have been advocates for de-institutionalized care, they have also written about the unintended effects of “community-based” care in the US and elsewhere. As Sushrut Jadhav and Sumeet Jain have shown in their work on community mental health programs in Uttar Pradesh, these programs often envision the “community” as being represented by a rural health center. Yet most rural health centers are located on the outskirts of villages, so that for those who live in the area, such buildings are always already outside the community. As such, the village itself – the site of the “community” as an anthropologist might envision it – continues to be illegible to the bureaucracy. Ironically, the “community” concept, brought in from the social sciences, seems to have slipped away from anthropology and become an altogether different object in public health policy.¹¹⁴

¹¹² Davis 2012: 12.

¹¹³ Davis 2012: 12.

¹¹⁴ As Harri Englund has similarly pointed out: “The participatory rhetoric of ‘community-based’ and ‘grass-roots’ intervention poses a dilemma to the anthropologist, whose engagement with

In India, community-based care has been the centerpiece of the National Mental Health Program (NMHP) since its inception in 1982.¹¹⁵ Many of the initiatives of the NMHP were found to be unsuccessful, however, leading to a “restrategized” program being launched in 2002. In line with the de-institutionalization thrust and community emphasis of the earlier program, the “restrategized” plan focused on improving psychiatric manpower and training in medical colleges, “modernizing” and “streamlining” psychiatric hospitals, and information and awareness- building programs to encourage “de-stigmatization.”¹¹⁶ This time, the government also committed significantly greater resources to mental health. Whereas the 9th Five Year Plan (1997-2002) budget for the NMHP had been 280 crore¹¹⁷ rupees, in the 10th Five Year Plan (2002-2007), the budget was increased to 1900 crore rupees.

The Government Psychiatric Diseases hospital in Srinagar has embodied many of the material, legal, and bureaucratic transformations entailed by the NMHP in an era of de-institutionalization. These transformations also raise several ethnographic questions: how has the hospital been reimagined during an era of “community-based” care? What is the place of the institution during a period of *de*-institutionalization? In my focus on the asylum, my aim is to point to certain obfuscations in the unequivocal commitment to the “community” as a site of care.

A “Center of Excellence”

the poor takes place within the context of a myriad of projects to improve their lot, some of which bear uncanny resemblance to the egalitarian principles of anthropology itself” (Englund 2001: 76).

¹¹⁵ Cohen 2001: 13.

¹¹⁶ Agarwal 2004: 5.

¹¹⁷ A crore is equivalent to ten million rupees.

The Government Psychiatric Diseases hospital, or GPDH, as doctors refer to it, is located next to Srinagar's famed *Badami bagh* or Almond Gardens. Once leisurely strolled by tourists and Kashmiris alike, the gardens are now the forbidding site of an Indian Army cantonment. As with other mental hospitals in India, the Psychiatric Diseases hospital has had multiple lives: it was constructed as an asylum for mentally ill prisoners in 1957 but the building was destroyed in a fire in the 1970s, rebuilt again and destroyed again in a fire in March 1996. In 2003, construction was completed for a new hospital building with assistance from MSF, and the hospital reemerged as one of the conflict's frontlines. From the early 2000s on, the hospital became one of the key sites in Kashmir for the practice of humanitarian psychiatry, as MSF and other psychosocial experts and organizations began working within, or alongside, government psychiatrists.

Despite these transformations, for ordinary Kashmiris, the hospital remained an asylum (*pagal khana*), and this was the way that people informally referred to the hospital during my fieldwork. Several male Kashmiri friends told me that when they were teenagers, they would buy candies and cigarettes from the shops outside the hospital and use them to lure patients, from inside the hospital's barred windows. They would dare each other to touch the hands of the mad, but would invariably get scared and run away. These stories usually drew nervous laughter because the hospital was still seen as a forbidding place. The asylum had tentacles, despite structural and bureaucratic efforts to clip them.



Illustration 1:
The entrance
to the
Government
Psychiatric
Diseases
hospital

In accordance with the re-strategized National Mental Health Program, since 2009, the hospital has undergone another round of comprehensive transformations. It is currently in the process of being remade into a “Center of Excellence,”¹¹⁸ a training and research institution for psychiatrists, psychologists, social workers, and psychiatric nurses. The aim is to transition away from the hospital as a site of treatment to a site where psychiatric and psychosocial manpower can be generated in order to address what are seen as chronic shortages.¹¹⁹ According to a 2005 report on mental health conducted by the WHO, for example, there are 3,500 qualified psychiatrists in India, or about 0.2 psychiatrists per 100,000 people. The report noted that this is significantly lower than the global average of 4.15 psychiatrists out of 100,000.¹²⁰

¹¹⁸ Sinha and Kaur 2011.

¹¹⁹ International public health discourse often emphasizes the lack of psychiatric manpower available in LAMIC countries. The crisis has acquired the status of “common sense” among mental health professionals in India and was affirmed by a Supreme Court decision to order that took place in the aftermath of the Erwadi disaster, a fire that took place in a private mental health clinic in 2001. 26 patients died in the fire because they were chained to their beds and unable to escape. The Supreme Court order (12 April 2002), which called for a survey of all public mental health institutions, revealed “severe manpower shortages in all categories of mental health personnel,” as well as “the uneven distribution of these scarce resources across geographical regions and rural/urban settings (Goel, Agarwal, Ichhpujani and Shrivastava 2004: 13).

¹²⁰ Kapur 2004. India has developed several national and district-level programs to address the

The Psychiatric Diseases hospital was one of eleven psychiatric hospitals in India to be selected for this transformation after a rigorous grant application process. The hospital’s administrators received a prestigious Rs. 30 crore grant to upgrade and build new facilities, including an academic block, library, hostel for postgraduate students, laboratories, and lecture halls.¹²¹ These changes also meant that the hospital was under surveillance in ways that it had not been before. For example, after the Erwadi fire in 2001 (see footnote 116), the Supreme Court ordered the National Human Rights Commission (NHRC) to conduct a survey of mental institutions once a decade.¹²² Data from the 2008 survey of mental institutions revealed the following facilities at the Government Psychiatric Diseases hospital in Srinagar. The hospital’s facilities qualified it as ranking somewhere in the middle of the 36 hospitals surveyed.

Domains	Reported status as of 2008
Infrastructure	An OPD block has been constructed with 3 rooms for consultation, EEG lab, haematology and biochemistry lab, drug counter, 5 emergency beds, a Medical Records section and 6 OPD cubicles. There has also been construction of two open wards with 10 and 20 beds each, an ECT theater, a faculty block, a recreational hall and seminar room, a counseling center, and residential quarters for doctors and employees. Medical records are being maintained manually.

mental health manpower shortage. For example, the National Mental Health Program (NMHP) and District Mental Health Program (DMHP) have both been developed to address massive shortages in mental health manpower, particularly in rural India. The vast majority of India’s 3,500 psychiatrists work at the state level, in urban settings. The DMHP provides a three-month training course in psychiatry to doctors with MBBS (Bachelor of Medicine, Bachelor of Surgery) degrees. For an ethnography of a community mental health program in India, see Jain and Jadhav 2009.

¹²¹ National Guidelines on Psycho Social Support and Mental Health Services in Disasters Released (Ministry of Health and Family Welfare 2010).

¹²² Writ Petition (Civil) No 334/2001.

Amenities and facilities	There is broadband internet connection in the library. There are facilities for toilets and drinking water and a waiting hall in OPD. Wards are well lit with attached bathrooms and dining hall. There is also a generator facility in case of power breakdown. There are 24 hours casualty and emergency services as well as telephone and ambulance services.
Diet/kitchen	Diet is free which includes two meals, dinner, breakfast and evening snack
Investigations/treatment	There is a separate dispensary for drugs. Essential drugs are available for OPD patients.
Staff and training	There are 8 qualified psychiatrists, two GMOs, two clinical psychologists, 10 general nurses, 1 lab technician, 5 administrative staff, and 15 ward attenders. There are no psychiatric social workers, trained nurses or occupational therapists. As this center is associated with a larger government medical college, consultants of all disciplines are supposed to be on call whenever needed. The Nurse Warden and Medical Superintendent stay on campus.
Recreation/Occupational Therapy/Rehabilitation	A new recreation block has been constructed. There is no rehabilitation facility.

The transformations of the hospital infrastructure, from asylum to community care to “Center of Excellence,” did not occurred in a neat or linear way, but rather, overlapped and pressed upon each other. Thus, rather than de-institutionalization leading to the closing of mental hospitals, as in the United States and elsewhere, in India, the policy reinvigorated the institution, but not as a site of care. This was justified by the argument that because of the scarcity of resources, mental health programs in low and middle -income countries like

India needed to “piggy back”¹²³ on existing institutions and programs, rather than build from scratch.

As such, under the revamped NMHP, legislation and bureaucratic interventions have focused on strengthening, expanding, and upgrading *existing* mental institutions, while simultaneously advocating for community-based care. In this sense, the transformation of the hospital to a research and training institute is far from complete—and indeed, the language of the NMHP is also ambiguous in this regard. While the focus was on building short-term wards, long-term wards are still present, where patients are often admitted for years on end. I suggest that the simultaneous revitalization of the institution but disavowal of it as a site of care has created a politics of visibility whereby the “inside” of the hospital – the closed wards where long-term patients reside – are increasingly hidden from view, whereas the hospital’s “outside” – its community outreach programs, out patient services and research and training – are increasingly under routine legal and bureaucratic scrutiny. This is a quite different configuration of the hospital than Foucault’s description of the hospital as a site of surveillance where the gaze envelopes and fixes patients. In the psychiatric hospital, certain blind spots, such as the closed wards, were not markings of the failure of the “gaze,” but rather, were constitutive of it.

The NMHP money was also used towards other beautification projects. The hospital lawn was manicured and a new board proudly stated “Lawn Development: Under NMHP” (see *Fig 3*). For much of my fieldwork, the flooring in the hallways of the faculty block was redone, and psychiatrists’ offices were repainted. New desks and swivel chairs made their way into these new

¹²³ Patel 2007: 81.

offices; cheery, printed curtains adorned the barred windows. Dr. Arshad joked that his room had been turned into a bureaucrat's office. This was an ironic statement, given that bureaucrats were increasingly divorcing themselves from mental hospitals, while some psychiatrists were busy bureaucratizing the hospital.



Illustration 3: Upgraded Library Block

The newly built library block in the background and “upgraded” lawn in the foreground at the Government Psychiatric Diseases hospital. Covered parking spaces were also constructed for doctors’ cars.

As the library block was being constructed and the lawn manicured, a small tombstone appeared at the edge of this construction. When I asked the hospital’s clinical psychologist, Dr. Huda, about the grave, she said that a patient from the closed wards had recently died and no one had claimed his body. The tombstone represented the trace of the asylum that persisted within the hospital grounds, despite the efforts at “modernization” underway at the front of the hospital. It was also a gnawing reminder of more graves to come. It marked the

inability of the hospital to transition smoothly to a “Center of Excellence,” while being unable to contend with its status as an “asylum.”

As the hospital’s ‘outside’ continued to change and emerge – the faculty and library block were the first places that a visitor to the hospital would see – I argue that there was a simultaneous process of obfuscation that took place in regards to the ‘inside.’ As Sarah Pinto has argued about closed, long-term wards elsewhere in north India, rather than a “‘zone of social abandonment,’¹²⁴ the wards were a space of “loss,” of “relation unmaking, an extension of ongoing—and very human—kin-work.”¹²⁵ While I agree with Pinto that the closed wards were not sites of “social abandonment,” I suggest that they were increasingly obscured as sites of bureaucratic, material, or ethical intervention in a moment of de-institutionalization. In many ways, my own presence in the hospital embodied these subtle shifts: while I was granted access to the closed, female ward for the first few months of my fieldwork, I was later told that the wards were “no longer open to researchers.” The closed wards, male and female, were located in a courtyard away from the hospital’s dispensary and OPD, where most patients gathered. As such, they were largely hidden from public view; aside from the hospital staff who had duties in the closed wards, other visitors seemed to stumble into this space accidentally.

Fortunately, the time I spent in the closed wards provided me with a sense of how it was increasingly separated out from the future “Center of Excellence” that hospital administrators envisioned. This was not only a matter of differential space, but also differential bodies: patients and kin who could be

¹²⁴ Biehl 2005.

¹²⁵ Pinto 2011.

treated on an out-patient basis were much more palatable within an era of de-institutionalized care than those unable to bear the burden of at-home care. Unlike the short-term wards, which were “well lit,” according to the National Human Rights Commission report I presented earlier in the chapter, the closed wards had a different ambience.

The closed wards were spaces of low visibility, with low lighting and a small television that flickered on mute at all times. The beds were arranged dormitory style, and the strong smell of urine and disinfectant mingled together. In addition to a few of the female patients, I also befriended the two female “wardens” that were in charge of the female ward. One of them, a recent divorcee, was flirtatious with the hospital’s male staff and wore shockingly bright red lipstick, which created a stark contrast with her black headscarf. I heard some of the doctors jokingly say behind her back that she was “suffering from mania” and “should be admitted to the ward as a patient.” This was a reference to one of the long-term, in-patients in the ward who had also been diagnosed as manic and who would reportedly “roam around” her village and surrounding areas without the accompaniment of kin. It was not clear to me whether doctors believed that the warden had transmitted her mania to the patient, or vice versa. What was clear, however, was that even for post-medical school psychiatrists, notions of madness as contagion were still present.

In addition to the dilemmas they faced around the democratization of expertise through programs such as the NMHP, Kashmiri psychiatrists were also deeply affected by the ways in which madness (*mot*) and politics were intertwined in Kashmir. For instance, while international public health and humanitarian accounts encouraged mental health experts to occupy a position

that is outside of specific cultural and historical understandings of madness and politics, most Kashmiri experts believed that madness was contagious and acted in ways that reinforced processes of quarantining it.¹²⁶

The days for the female in-patients were punctuated by the call for a midday meal, medication, and an evening meal, and in between these times, the wards were locked. During sunny days, sometimes the women were allowed to sit on the grass outside for a few minutes before their midday meal. The contrast between the darkened, closed wards, located in the hospital's innermost region, and the brightly lit, "bureaucratized" space of the faculty block was not a subject that many psychiatrists spoke about, yet it was a part of the increasingly disjointed structure of the hospital. Many of the senior psychiatrists avoided visiting the closed wards altogether, letting the junior residents do sporadic visits to the closed wards if and only if there was a medical emergency. Most of the junior residents expressed little hope that any of the long-term patients would show an improvement in their condition and were usually astonished when it did happen. During my fieldwork, Zeenat, a nineteen-year old, highly articulate female patient who had been diagnosed with paranoid schizophrenia, made a complete recovery and was discharged from the hospital. When her family refused to collect her from the ward, Zeenat filed and won a case for legal emancipation. The doctors who were dealing with Zeenat's case were shocked, but took her to be a miracle rather than an example of what was possible for in-patients.

¹²⁶ While the Global Mental Health movement often describes stigma as a problem common to developing countries, it is perhaps not surprising that stigma is both culturally specific and not limited to the non-West. Jean Jackson (2005), for example, has argued that the uncertain ontological status of the chronically ill can incite stigmatizing reactions in North American contexts. This is a rather different manifestation of stigma than the sense of contagion that I have identified in the South Asian context.



Illustration
4: The
closed
female
ward

While there were spirited interactions in the closed ward between female patients, the wardens and the patients, and occasionally MSF counselors and patients, doctor-patient relations were generally minimized. The lack of interaction in the wards became astonishingly clear to me when, while browsing some of the closed ward patients' medical files, I noticed pages and pages of the notation, "CST" (Continue Same Treatment), followed by quick signatures. When I asked one of the postgraduate psychiatric residents who had signed the files about this, he blushed and said that he had not felt the need to go to the wards himself—and none of his supervisors expected that of him. The assumption in "continuing same treatment" was that patients in the wards were chronically ill, with little scope for improvement. Their daily needs were taken care of by the "wardens" and medicine dispensers. While long-term residents of the hospital received infrequent visitors from kin, the Family Ward – a place of

short-term stay – bustled with the presence of kin, many who stayed by the patient’s bedsides for the duration of their stay (see chapter three).

Within the history of mental health legislation in India, closed wards have emerged as objects of intervention only in exceptional circumstances, such as the filing of Public Interest Litigations (PILs) in the Indian Supreme Court from the 1980s onwards.¹²⁷ Amita Dhanda, a legal scholar, has traced Supreme Court’s “micromanagement” of mental institutions across the country and argues that while there were “umpteenth examples of individual beneficiaries of the court’s intervention...the statutory regimes allowing for large-scale deprivations were not subjected to constitutional scrutiny.”¹²⁸ The filing of PIL is somewhat of a scandal or interruption for hospital authorities, and the Government Psychiatric Diseases hospital in Srinagar has also faced the brunt of one such inquiry.

In May 2012, the Jammu and Kashmir State Human Rights Commission (SHRC) sent a report to New Delhi over the “messy state of affairs” in the Government Psychiatric Diseases hospital. Among the critiques in the SHRC report was the negligence of patient welfare – the poor quality of food was mentioned – while “much attention [was being] paid to the office room of the Medical Superintendent and labs and lakhs of rupees were spent on it.”¹²⁹ While such reports usually shook up the hospital administrators for a short period of time, they did not address the larger structural inconsistencies that produced this problem in the first place. In addition, hospital administrators usually found ways of circumventing these periodic injunctions.

¹²⁷ Dhanda 2000.

¹²⁸ Dhanda 2000: 167.

¹²⁹ Wani 2012.

As I have argued so far, the simultaneous existence of high tech equipment and labs, on the one hand, and the relatively unchanged confinement of the in-patient wards, on the other, helps explain the persistence of cultural signs such as the asylum, in spite of efforts to mainstream mental health. I suggest that a regime of de-institutionalization does not mean the retreat of the mental hospital, but rather, a selective spotlighting of it, including the marking of certain subjects as more worthy of care than others. In this sense, the asylum was not an archaic figment of people's imagination or continued "stigma," but continued to be part of the new "Center of Excellence." In the second part of the chapter, I turn to how psychiatrists grapple with these uneven transformations in their everyday work.

Part II: Embodiments of Expertise

The processes of de-institutionalization that I described above presented certain difficulties for psychiatrists in their everyday work. First, despite the emphasis on modernizing and streamlining the institution, psychiatrists had to continue working with long-term patients, who were increasingly eclipsed in the move to community-based care.¹³⁰

In addition, the turn to "community-based" care was also potentially troubling for psychiatrists, for whom this meant a further dilution—or democratization—of expertise. This was because one of the provisions in the District Mental Health Program (DMHP), a corollary to the National Mental Health Program, called for doctors with MBBS degrees (Bachelor in Medicine, Bachelor in Surgery) to be trained in basic psychiatry over a three-month period. This was to enable the early detection and treatment of psychiatric disorders at

¹³⁰ World Mental Health Report 2001: 49-51.

the primary health care level, a move supported by NMHP provisions to supply primary health centers (PHCs) with psychotropics—one of the recommendations of the 2001 World Mental Health Report. In other words, psychiatric expertise was democratized through prescription practices, specifically through the materiality of the pill.¹³¹ As medical anthropologists of South Asia have shown, the power to prescribe is a particularly sensitive issue for Indian psychiatrists, given that most psychiatric drugs make their way to Indian consumers through *non-psychiatric* and *non-expert* channels.¹³² Pills are also significant boundary markers between psychiatrists and other mental health professionals, such as clinical psychologists and social workers, who work within a team structure but do not have the power to prescribe.

For psychiatrists, the uneven outcomes of de-institutionalization were revealed in fissures between the practice and administration of mental health care. Psychiatrists and bureaucrats each positioned themselves as committed to different prongs of the new mental health framework. While most Kashmiri psychiatrists supported the upgradation of mental hospitals under the National Mental Health Program (NMHP), others were skeptical of the project of democratizing expertise under the District Mental Health Program, which might lead to a further marginalization of their expertise.¹³³

One psychiatrist I worked with argued that rather than a form of democratization, as was intended, the DMHP trainings only exacerbated existing social inequalities, since those who were targeted for the program were doctors

¹³¹ Jain and Jadhav 2007.

¹³² Ecks and Basu 2009.

¹³³ The District Mental Health Program was implemented in the state of Jammu and Kashmir in July 2008.

with MBBS degrees, considered at the bottom of the medical hierarchy. Doctors with MBBS degrees were generally viewed as ‘village doctors’ whereas urban, middle-class doctors aspired to advanced degrees. As one of the psychiatrist residents I interviewed put it, “An MBBS degree is like a high school degree. It means nothing.” While psychiatrists expressed ambivalence about the treatment of psychiatric disorders by non-specialists at the primary care level, time and again, mental health bureaucrats argued that this was necessary for the delivery of community-based care.

Health bureaucrats, meanwhile, were far more skeptical of the “Center of Excellence” project than psychiatrists. Specifically, the bureaucrats I spoke to argued that the hospital’s past as an asylum could not be erased. The nodal officer of the NMHP in Kashmir, for example, a psychiatrist-turned-bureaucrat named Dr. Wani, pointed out that not just the Psychiatric Diseases hospital, but even “prestigious institutions like IHBAS [Institute of Human Behavior and Allied Sciences] in Delhi were still stigmatized as the *pagal khana* [asylum].” He described a past experience of being in Delhi and unsuccessfully trying to direct an auto-rickshaw driver to take him to IHBAS. “I kept saying, ‘IHBAS,’ Dr. Wani began. “But it was only when I said, ‘take me to the *pagal khana*’ that the driver understood.” Dr. Wani’s comparison to IHBAS was intended to reveal just how ossified the idea of the mental asylum was in the minds of ‘ordinary’ people and how difficult it would be to replace it with the idea of a “Center of Excellence.” His point was made even more forceful by the suggestion that this incident had occurred in Delhi, a place generally viewed by Kashmiris as representing a future modernity.

These tensions between bureaucratic and psychiatric approaches to mental health care were also evident at the higher levels of government. On a foggy morning in late January 2010, I attended the first National Consultation on the National Mental Health Program (NMHP) since it was re-strategized under India's 10th Five Year Plan (2002-2007) at the Ministry of Health and Family Welfare (MOHFW) in New Delhi.¹³⁴ This meeting, which was chaired by the then Secretary, Sujatha Rao, a Harvard-trained product of the Indian Administrative Service, brought together mental health activists, NGO representatives, academics, and bureaucrats working in the field of mental health together under a government ambit for the first time. While the meeting itself was an ethnographer's delight in terms of the dramaturgy (*tamasha*) that unfolded, there was one moment in particular which captured the ways in which psychiatrists and mental hospitals were being undermined by new policy and legislation.

One heated exchange took place between a junior-level health bureaucrat and Dr. Vikram Patel, a WHO consultant and a professor at the London School of Hygiene and Tropical Medicine, on the question of manpower shortages. In response to the bureaucrat's declaration that "we need to flood the country with psychiatric experts: psychiatrists, clinical psychologists, and psychiatric nurses," Dr. Patel made a passionate case for abandoning this plan in favor of "skilling up" grassroots health care activists (*anganwadi* workers). To my surprise, the Secretary vigorously nodded along. In fact, as the meeting progressed, I became

¹³⁴ Under this "re-strategization," the District Mental Health Program (DMHP) was expanded to over one hundred districts in India and grants were released for the "upgradation" of psychiatric wings in Government Medical Colleges (GMC) and the "modernization" of 26 mental hospitals in the country.

aware of the new alliances that were being forged between NGOs and the central government. At one point, one of the NGO representatives from Karnataka said that she had filed a Public Interest Litigation against the State Mental Health Authorities in her state since they were ineffectual, which the Secretary applauded. “Yes, you must be very aggressive with them,” she commended the NGO representative. The instrumentalization of the “community” by the WHO, as well as the condoning of legal tools to be used to hold local governments accountable, exemplified the “ironic alliances”¹³⁵ forged between social scientists, governments, and international public health institutions in India’s liberalizing economy.

At the end of Dr. Patel’s plea to skill vertically instead of laterally, the Secretary put her hands up in the air and said, “So I am going to ask a question: and perhaps the *sarkari* [government] folks won’t like it, but do we still *need* these mental institutions?” While the bureaucrats and the psychiatrists present vehemently objected to the Secretary’s suggestion, the fact that such a claim could be publicly voiced revealed the entrenchment of a ‘community-based’ model and the devaluation of psychiatric expertise. This discussion made manifest one of the “double binds” at stake in de-institutionalization: a choice between the scaling up of expert knowledge in the form of greater pharmaceuticalization and diagnosis at the local level, or the lateral development of psychiatric expertise in the form of more specialized professionals, and thus the reproduction of existing socioeconomic and geographic inequalities.

¹³⁵ Riles 2006a: 2.

While bureaucrats seemed ready to divorce themselves from the institution, the hospital was an “object multiple”¹³⁶ for the psychiatrists who worked there. For example, although the upgradation of the hospital to a “Center of Excellence” was designed to be transformational, it was focused on select material and infrastructural projects that were monopolized by senior psychiatrists. In particular, the grant specifically provided for structural developments for the hospital staff, not patients. Out of the 30 crores that the hospital received, 18 crores were earmarked for infrastructure, including building a hostel for residents and interns. Under the guidance of Dr. Mushtaq Marghoob, the Head of the Department of Psychiatry for most of my fieldwork, a new faculty block and library were constructed, along with a behavioral genetic and molecular neurobiological research laboratory, advanced Chemistry lab, and an area for psychodiagnostics. While some psychiatrists celebrated these changes, others were critical of how the money was being used. Some argued that these changes were personally beneficial to Dr. Marghoob, whose older daughter ran the psychodiagnostics lab, while the younger one, a newly-minted PhD from Jammu, was hired to run the new, plush, high-tech neurobiological research lab. Some junior psychiatrists complained to me that the money had not been dispensed in a transparent manner and that it was being wasted on superfluous changes.

Wounded Healers

Another major concern for mental health experts was related to financial constraints. Despite the increased public focus on mental health care, Kashmiri psychiatrists suffered the combined effects of low government salaries and

¹³⁶ Mol 2002.

stunted employment opportunities due to the conflict.¹³⁷ In healthcare, as with almost every other industry in Kashmir, the government was by far the largest employer, with about 20 per cent of the state's educated workforce being employed by the state government.¹³⁸ Meanwhile, the private sector has been tightly regulated by the central government. While most post-MBBS doctors supplemented their government salaries with private employment, private sector jobs were consistently thought of as secondary to the security and status of a government job (*sarkari naukri*).

Despite the low salaries, government jobs of all kinds were highly desired for the life-long stability and pension benefits they offered. As such, public sector jobs were highly competitive, given the high rates of unemployment among the educated. As Justine Hardy has pointed out, while Kashmiris are among the most well-educated in India because of the central government's attempt to "buy the love of the Kashmiri people" through state education, the state has produced "thousands of graduates full of ambition but with very little employment to temper their expectations."¹³⁹ Jammu and Kashmir is also the only state in India that has made education free to all its citizens at all levels, although literacy at 54 per cent, lacks behind the national average of 65 per cent.¹⁴⁰

On a larger scale, official budget figures show that the Jammu and Kashmir state government is deeply dependent on the central government for

¹³⁷ In the decade from 1980-1990, that is, the pre-conflict period, the state domestic product grew by only 29.5 per cent, whereas the comparable figure for India as a whole was 71.9 per cent. The Ministry of Finance gives a 2001-2002 estimate of per capita net state product at Rs. 13,320, which is 33 per cent below the all-India figure for the same year and represents a significant deterioration since 1993 (Ministry of Finance 2005).

¹³⁸ Schaffer 2005: 27.

¹³⁹ Hardy 2009: 27.

¹⁴⁰ Schaffer 2005: 10.

funds. 68 per cent of the state government's revenue receipts in 2003-2004 were granted through aid from the central government, a figure that is in line with other insurgency-affected states in India. The controller and auditor general's report estimates the state's financial liabilities at Rs. 130,380 million in 2004—over 150 per cent of total annual state expenditures and 63 per cent of gross state domestic product.¹⁴¹ In addition to financing state government expenditures, the central government has also committed substantial federal funds to revive 'normal' economic activities.¹⁴² In outlining these statistics, I want to note, however inadequately, the ways in which the Kashmiri economy is deeply dependent on the central government of India, a move that is clearly intended to delegitimize claims for self-determination.

Government jobs also required long periods of waiting: waiting for examinations, waiting for results, and waiting for job openings that may or may not be posted. This process was exacerbated during the conflict years. During the 1990s, for example, during the darkest days of the insurgency, no state medical school examinations were held for seven years consecutively. As Craig Jeffrey has argued in the case of rural unemployed youth in the north Indian city of Meerut, waiting required an amount of cultural capital: "the ability to wait patiently before cashing in on a social connection or to wait for sons to acquire urban jobs depended on people's knowledge of how fields operated."¹⁴³ As Jeffrey also points out, however, these tenuous waiting strategies were not

¹⁴¹ Comptroller and Auditor General of India 2003.

¹⁴² The Rs. 85,190 million package (\$1.76 billion) announced in 2002, for example, included funding for railways, roads, support for traditional handicrafts, support payments to military and police families, raising two additional reserve battalions, support for Hindu Pandit families who were displaced during the early years of the conflict, and economic development in the border areas (Schaffer 2005: 13).

¹⁴³ Jeffrey 2010: 33-4.

always successful. Many Kashmiri doctors I spoke with complained that the gaining government employment was not based on merit, but on personal networks and connections. Dr. Surrayah Qadeem, a female doctor I met who worked with the Central Reserve Police Force (CRPF) on a contractual basis, told me that she had not been confirmed by the Public Service Commission for a government job, even though she had “topped” her interviews because her father had refused to pay a bribe.

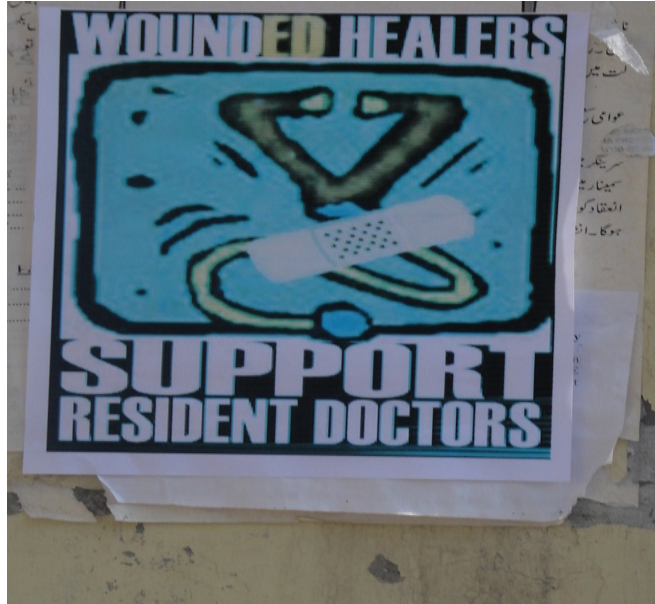
Doctors, including psychiatrists, were also confronted with the sense that, while illnesses were everywhere, their employment opportunities were severely curtailed. This was a moment of “biomedicine’s inability to address the very crises that constitute it.”¹⁴⁴ One doctor told me, “Look at the situation we have here. On the one hand, we have qualified doctors who are sitting unemployed, and on the other hand, we have posts just lying vacant.” This was taken as one example of the kind of structural madness that had been unleashed in Kashmir since 1989. In one of the district hospitals I visited, for example, there were over forty posts that had not been filled because they had not been publicly advertised. The hospital’s only surgeon told me that he worked 48-hour shifts and that he had once conducted two operations simultaneously, moving back and forth between two etherized bodies. There was no cleaning staff either, and the hospital’s toilets were entirely dysfunctional. When I asked the superintendent of the hospital why the vacant posts had not been advertised, he shrugged his shoulders and gave the same explanation that is provided for everything that doesn’t work in Kashmir: “Political reasons. I don’t know why.”

¹⁴⁴ Langwick 2008: 429.

Some of these grievances came to public attention in October 2009, when 700 junior doctors in Kashmir, members of the Junior Doctors' Association (JDA), decided to strike. One of their arguments was that while junior doctors in other states received a salary of 60,000 rupees, doctors in Kashmir only received 16,000 rupees a month. Dr. Anand Singh, a psychiatrist in his early 30s and member of the JDA, explained that the JDA had been given written assurance by the state's Chief Minister, Omar Abdullah, that the problem would be redressed. That was back in 2005. Yet no one was surprised when nothing was done.

The doctors had gone on a "warning strike" two months earlier, but to no avail. This time, the JDA board's decision to strike indefinitely was unanimous. The strike both tapped into – and made visible – a sense of doctors as a victimized community. In this sense, the strike and its pre-existing conditions countered humanitarian and Global Mental Health (GMH) assumptions that experts were somehow outside of, and apart from, constraints that kept communities from developing more 'modern' attitudes towards mental health. Those narratives did not take into account the ways in which experts were deeply affected by the sociopolitical realities unfolding around them.

The JDA strike galvanized under the slogan of 'wounded healers.' Although the phrase was intended to describe the plight of doctors during the strike, it was notable for capturing the state of doctors in general, as working within an ongoing – and potentially unending – political crisis.



*Illustration 4:
Wounded Healers*
A poster stuck
on the wall of the
Government
Medical College,
Srinagar

These sentiments were given shape through the speeches given by members of the JDA board during the strike:

“Doctors are not demi-gods. We are crippled by our workload”--

“We’re giving patients the best healthcare, but we cannot continue to give it unless the welfare of doctors is also taken care of”--

“We sacrifice our health for their health”--

“During the 2005 earthquake, people were running for their lives in other parts of the state, but we did not run. We stayed with our patients.”

“Let any politician or bureaucrat sit with us for just one night in Lal Ded hospital!”¹⁴⁵

“We have reduced the number of graves in Kashmir.”

“Although we are doctors first, we didn’t do an MBBS degree to work for peanuts [lit. to sell chickpeas] outside the houses of bureaucrats”--

¹⁴⁵ Kashmir’s only government-run maternity hospital.

In contrast to the media coverage of the strike as primarily about equal pay, the doctors I met insisted that their intention was not simply to gain compensation, but rather, to redress structural concerns. Dr. Heena, an anesthesiologist, told me bluntly: “This is a corrupt state – from the CM [Chief Minister] to the MS [Medical Superintendent].” Heena was also referring to a recent study, widely publicized in the Kashmiri media, by Transparency International India and the Centre for Media Studies, which ranked Jammu and Kashmir as the second most corrupt state in India.¹⁴⁶

Nonetheless, her statement was immediately tempered by another colleague, Dr. Ambar, who stated, “But, if we ask ourselves, what would we do if we were in those positions [of authority]? Would we also be corrupt? I mean, we’re not alone either, right? We have families too. So I don’t think we would fight or try to change the system.” She said all this with an outright frankness that made us laugh. Nonetheless, I think that Ambar and Heena’s position captured another “double bind” for doctors in Kashmir: an acute sense of injustice married with a sense of commitment to existing structures of hierarchy. In other words, it was the sense of being caught in between two unappealing choices.

A few days into the strike, Dr. Anand, one of the junior psychiatrists I knew from the hospital, drove me to Srinagar’s Government Medical College (GMC), which was being used as the headquarters of the strike. The strike was covered on the front pages of all the major Kashmiri newspapers.¹⁴⁷ Doctors milled about on the lawns of the medical college, listened to speeches, chatted,

¹⁴⁶ Schaffer 2005: 27.

¹⁴⁷ See for ex. Bhat 2009.

and made posters. I asked Dr. Anand how he and other doctors were coping with the ethical dilemma of striking, given that medical emergencies never stopped. “Of course it is a dilemma,” he said, “Unfortunately, patients suffer the most...” Then he added, “But emergency services are still on,” perhaps reassuring himself as well as me that doctors had not entirely abandoned their patients.

Dr. Anand suggested that we go to the college canteen for a cup of coffee and the interview. The canteen was a bustling, large hall, with sea foam green walls and red upholstery and curtains, a classically Kashmiri color combination. We sat on a table in the corner, where the remnants of an earlier meal were still present: crumbs and splotches of spilt *chai*. I asked Dr. Anand more about his background. Unlike most of the other psychiatrists, he was a Hindu – not a Kashmiri Muslim – from the city of Jammu. He was not a native Kashmiri speaker and said that he had learned it while in the OPD. He described his comprehension at “about 70 per cent.” He had moved to Srinagar about three years ago, after successfully qualifying to specialize in psychiatry.¹⁴⁸ He was one of only six psychiatry postgraduates selected in the state that year. I asked Dr. Anand how medical specializations were allocated, and he said that they were offered according to merit, and individuals were ranked in state and national medical exams.

¹⁴⁸ Students choose their specializations based on their scores in an all-India medical exam, conducted by the Central Board of Secondary Education (CBSE), or in state-level entrance exams, conducted by individual state administrations. As such, specializations are decided on scores, not necessarily personal preference. The CBSE exam, which takes place in April/May, is extremely competitive and takes only 2,500 applicants out of approximately 200,000 who compete every year.

Radiology was the most popular specialization, Anand said, because, “It is very easy. All you have to do is look at an x-ray and say, ‘Yes, his leg is fractured.’ And the machine does everything else.” Pediatrics and psychiatry were also relatively popular, he said, because they were perceived to be like office jobs, from “10 am – 4 pm.” When I asked Anand if this was the reason why psychiatry had appealed to him as well, he agreed, “To tell you *very* frankly, I am satisfied with my work because no one dies from a psychiatric illness. They might die from a medical illness, but we can sleep well because we know that none of our patients faces mortality.”

While Anand described psychiatry as a “10 am – 4 pm” job, this was not a description that all psychiatrists agreed with. Others often emphasized what happened between 10 am and 4 pm as far more stressful than other medical professions. In particular, while most medical professionals in Kashmir described themselves as working within a context of triage in the sense of diminished resources, large numbers of patients, and bodily ailments that biomedicine could not completely cure, psychiatrists had the additional burden of working in a profession that was still marked by “stigma.” In Kashmir, as elsewhere in South Asia, psychiatrists were sometimes called *pagalwalé* doctors, meaning doctors who are “associated with madness.” This deliberately ambiguous term meant that the doctor treated patients who were mad and that the doctor him/herself was mad.¹⁴⁹

Medical anthropologists have described medical school as an immersive, totalizing process of subjective transformation,¹⁵⁰ and many Kashmiri

¹⁴⁹ Nunley 1992: 206.

¹⁵⁰ Good 1994.

psychiatrists described a similar process whereby their earlier prejudices about madness melted away. When I asked a 27-year old postgraduate, Mohammed Farooq, about his first impressions of psychiatry, he responded:

I had mixed feelings about it. I think I was carrying some stigmas associated with it. I remember seeing a schizophrenic patient for the first time and feeling afraid of his disease. I wanted to protect myself from it. As a doctor, these fears gradually went away and I began to understand psychiatry as a very important branch of medicine. Society is full of psychiatric problems, but we see only the tip of the iceberg...

For Mohammed, the initial apprehensions towards madness that he carried with him could only be overcome by understanding mental illness through the biomedical model of disease. For Mohammad, as for the psychiatric residents Tanya Luhrmann worked with, psychiatry provided both a glimpse of, and relief from, “exhilarating, terrifying ecstasy and strange irrationality.”¹⁵¹

Nonetheless, the continuing “stigma” that psychiatrists experienced as an outcome of their work became visible in intimate matters, such as marriage talk. Their narratives of seeking appropriate marriage partners were contrary to the rosy language of progress and modernization that marked the bureaucratic future of Indian mental health. For example, when I asked why there were no female psychiatrists in Kashmir, I was told that this was because of “stigma” and that a female psychiatrist would have difficulty getting married. Similarly, several male psychiatrists also told me that when they had chosen psychiatry as their specialization, members of their family had discouraged them from doing so, for the same reason. As such, stigma was not only located in the lives of

¹⁵¹ Luhrmann 2000: 4.

patients, to be beaten out by progressive doctors, but rather, also intimately affected the personal lives of doctors.

As Michael Nunlely and other anthropologists of South Asia have described, this sense of contagion and madness-by-association that psychiatrists and patients both experienced emerges from a sense of self that is permeable to the moral qualities of others.¹⁵² Some of the former drug users with whom I worked at the De-Addiction Clinic in chapter five I knew had been forcibly admitted to the Government Psychiatric Diseases hospital as patients and described how they resented being clubbed together with “mad people” (*pagal log*). They described feeling that rather than getting better, the madness of others would “rub off on them” (*hum bhi pagal ho jayenge*). Psychiatric work, whether as doctor, patient, or even observer, was polluting. The lady who ran the guest house in Srinagar where I stayed told me, gently but repeatedly, “not to spend too much time at the mental hospital.” As one female doctor who had interned at the psychiatric hospital (she eventually chose not to do psychiatry as her specialization) told me, “People think it’s contagious. *Pagal log* [crazy people] and all that.” Similarly, the vivid memories that my Kashmiri interlocutors told about the mental hospital as teenagers, along with the continued presence of long-term patients in the psychiatric hospital, suggested that madness needed to be continually quarantined. The mental hospital could be opened, but only selectively so.

Conclusion: The Human Touch

¹⁵² Daniel 1984.

By way of conclusion, I want to reflect on one final “double bind” for psychiatrists in Kashmir: the sense that while they had a special role to play in mitigating the effects of violence, that they were not exceptional, or apart from, other healers, such as *pirs*. In other words, psychiatrists had to navigate a complex landscape where, despite coming to the fore in public debates about conflict and trauma, they were marginalized by both bureaucratic regimes of de-institutionalization and by the help-seeking behavior of their patients.

Many of the psychiatrists I interviewed drew strength from the growing legibility of mental illness in Kashmir and the opportunities that this offered. “There has been such a surge in these kinds of problems in our society,” one said; and “my interest in this grew because of the current turmoil and the high numbers of depressed patients and those suffering with PTSD,” said another.

Most spoke of violence in the abstract, but Dr. Majid, a 39 year-old MD, was one of the few doctors to describe his intellectual journey as a deeply personal one. He told me how, in 1998, four of his neighbors in Bandipora were killed one night. One of the survivors was a three year old girl who lost her father, grandfather, and two other relatives. “Her name was Khushboo,” he told me quietly. Khushboo in Hindustani means fragrant. “And she went into mania,” he said and told me that the family was still suffering. Witnessing this tragedy up close had encouraged Dr. Majid to specialize in psychiatry. I asked Dr. Majid what qualities a good psychiatrist needed. He said that they needed the “human touch.” They needed to, “see the patient as his brother, sister, father.” This knowledge did not come from psychiatric textbooks, he noted, but from a person’s own disposition and experiences. “My parents separated when I was three months old,” he said. “I never saw them together. My *Mamaji*

[maternal uncle], I owe him everything. I use my experience as a tool; I am an example of someone without a mother or father who has come so far.”

Nonetheless, Dr. Majid also acknowledged that his approach did not happen overnight. He recalled his days as an intern at the psychiatric hospital with a mix of shame and amusement: “ We [the other interns and I] would crack jokes and laugh about the patients because we could not understand their suffering. Initially, we had a sense of humor about their problems.” But later, he said, “the issue would trouble us: why are they here?” Similarly, Dr. Arshad also described his days as an intern as puzzling, thereby piquing his interest:

An an intern, after the initial period of training, I began seeing a lot patients with my mentor, Dr. Zaffar. We saw a lot of patients who would come with complaints of headaches. We would do neurological exams, CT scans, you name it. But the results of these tests wouldn't show anything. It would have been very easy to say to the patient, 'You're fine. You don't have anything.' But somehow, I was never satisfied with that answer. How was it that a man came all the way from Gurez [a valley about four hours by road from Srinagar] to this hospital and he has nothing?

While other medical specializations could rely on medical tests or technology to figure out what was wrong, psychiatrists described their work as much more challenging given their reliance on the subjectivity of patients and their kin (see chapter three). Many described history writing as an “art” and said that this was the main distinguishing feature between psychiatry and other specializations.

In addition, psychiatrists also emphasized that they were in the unique position, as doctors, of having to practice a “culturally-approved” medicine. In this sense, psychiatrists recognized themselves as competing with other practitioners who dealt with the intersection of bodily and mental distress. While they were winning this contest from the perspective of science, the

behavior of their patients suggested otherwise. This was, again, an incommensurable position with the idea that mental health needed to exist above, or outside of, specific cultural and political contexts. Like madness itself, psychiatric expertise could not be quarantined within the realm of science, it was drawn into comparisons with other healing techniques.

When I asked psychiatrists about the role of other practitioners in mental health – particularly *pirs* – I received the same answer again and again. Psychiatrists regaled me with stories of “quack” *pirs*, those who had allegedly claimed that they could cure HIV or cancer with a single touch. In general, psychiatrists agreed that, “*pirs* do more harm than good,” that they encourage patients to stop taking medication, particularly anti-psychotics, which have dire consequences. Nonetheless, patients continued to visit *pirs* with aplomb; they merely refrained from speaking to their doctor about such visits. In this sense, as much as psychiatrists tried to distance themselves from their patients, they were pulled into the same web of contagion, entangled by the same practices they sought to eliminate. Somehow, they were forced into a subject position that argued for their indispensability and marginality at the same time.

As I described earlier in the chapter, Kashmiri psychiatry is unique in its location at the intersection of two, transnational movements in mental health: de-institutionalization/Global Mental Health and humanitarian psychiatry. I have hopefully made clear what is at stake in the move to de-institutionalize and democratize psychiatric expertise in contemporary India. In the next chapter, I foreground some further paradoxes of expert subjectivity brought on by the introduction of humanitarian psychiatry in Kashmir.

CHAPTER 2: LOSS IN MOVEMENT: NEGOTIATING KASHMIR AND THE 'OUTSIDE'

Introduction: Beyond "Unshaven, Cigarette-Smoking Frenchmen"

The image with which I begin this chapter—that of “unshaven, cigarette-smoking Frenchmen”—comes from an a moment in Peter Redfield’s ethnography, in which an Asian-American MSF volunteer expresses her frustration toward the distorted image of the humanitarian ideal.¹⁵³ In this chapter, I too provide a counterpoint to the image of the exemplary humanitarian as a white, European male who is performing emergency medical relief in an “out-of-the-way place.”¹⁵⁴

As anthropologists have noted, in recent years, the constitution of medical humanitarianism has shifted significantly to focus increasingly on trauma and chronic conditions such as HIV / AIDS. For example, Didier Fassin and Richard Rechtman have described how discourses and practices around trauma dovetailed with a rights-based regime in Euro-America, particularly for veterans and victims of gender-based violence. They argued that such convergences, in turn, led to the development and globalization of post-traumatic stress disorder as a taken-for-granted dimension of humanitarian assistance on a global level.¹⁵⁵ While medical humanitarianism continues to justify its *raison d’être* as the mitigation of political crisis, natural disasters, and other emergencies, what are deemed as necessary within these contexts increasingly includes “psychosocial,” not just emergency medical care.¹⁵⁶ Thus, psychosocial care, while increasingly

¹⁵³ One of Peter Redfield’s interlocutors, an Asian American former volunteer with MSF, describes her frustration toward the distorted image of MSF as a collectivity of (French and male) doctors (Redfield 2012).

¹⁵⁴ Tsing 1993.

¹⁵⁵ Fassin and Rechtman 2009.

¹⁵⁶ As Didier Fassin and Richard Rechtman have shown, the growth of humanitarian psychiatry has been triggered by three major events: (i) the development of psychiatric victimology and

identified as part of “emergency” relief, nonetheless requires new rubrics and guidelines, both in terms of the length of intervention and measurements of success. In other words, as the gifts of humanitarianism diversify to include technologies such as psychosocial care, I suggest that this has radical implications for how we understand encounters between experts and victims of violence.

This new modality of humanitarianism in the form of non-emergency care thus presents challenges for an anthropology of humanitarianism, which has thus far hinged on questions of biopolitics, life, and death.¹⁵⁷ This work draws on Giorgio Agamben and Carl Schmitt in understanding humanitarianism a space of exception in which sovereign power is played out. In this understanding, sovereign power is manifest as the power to give life social and political definition, while abandoning other forms of life outside the law as ‘bare’ and unqualified.¹⁵⁸ While anthropologists have questioned whether people are actually reduced to ‘bare life,’ they have documented the ways in which medical humanitarian interventions strip people of their political, social, and cultural particularities in various contexts.¹⁵⁹

In this sense, the anthropology of humanitarianism is one subfield where ethnographic knowledge clearly lags behind humanitarianism in its ability to

intervention on the scene of assaults and accidents, hostage-taking incidents and natural disasters, and the establishment of emergency medical and psychological units in France; (ii) the work of *Médecins sans Frontières* (MSF) and *Médecins du Monde* (MDM) in the aftermath of earthquakes and wars; (iii) NGO operations in the psycho-traumatology of exile, particularly among asylum seekers and victims of torture (Fassin and Rechtman 2009: 7-10).

¹⁵⁷ Although questions of life and death have been central to classic topics within anthropology—including politics, ethics, kinship and religion—in recent years, secular domains of inquiry such as ecology, human rights, and humanitarianism have also emerged as key sites for the investigation of the construction of valued life.

¹⁵⁸ Agamben 1998; Schmitt 1985. See also Ticktin 2005.

¹⁵⁹ Malkki 1995; James 2010.

conceptualize new formations of intervention and care. As Nicolas Guilhot similarly asks: “the question is...whether the temptation to accuse humanitarianism of, alternatively, imperialism or depoliticization simply means that we have not yet developed the proper conceptual tools for analyzing politics once it is translated into biopower.”¹⁶⁰ It is somewhat ironic that the turn to humanitarianism by anthropologists may itself be an effect of “a more general anxiety regarding the incongruity between the temporal orientation of [anthropological] knowledge and that of the changed or changing world.”¹⁶¹ One way through this quandary seems to be to transform the temporality of anthropological knowledge from a ‘vertical’ to a ‘lateral’ engagement, as Miyazaki does in his work. I attempt to perform a similar analysis in this chapter by examining the ways in which humanitarianism is knitted together through its more visible (unshaven, cigarette-smoking Frenchmen, emergency care, universal knowledge) and less visible (Kashmiri psychosocial workers, psychosocial care, particular knowledge) constituent parts.

While the forms of psychosocial care I describe in this chapter may be new to Kashmir, medical humanitarianism is not. As such, I think it is helpful to identify some of its historical precedents. What I am interested in is thinking about how psychosocial humanitarianism is “new” and in what ways it resonates with older interventions in the valley? In responding to this question, I want to present the Kashmiri body(politic), as a site of accumulated suffering, in the manner that Kashmiris themselves understand their political situation.

¹⁶⁰ Guilhot 2012: 99.

¹⁶¹ Miyazaki 2003: 255. As Hiro Miyazaki has argued, the quest for novelty on the part of anthropologists, whether “through new research objects” or as a move to “put knowledge in perpetual motion through open-ended modes of inquiry,” emerges from “an anxiety about being behind (Miyazaki 2003: 255).

Despite the many differences between humanitarianism as a handmaiden to colonialism and its current transnational form, I suggest that a foray into the nineteenth century also helps us better understand how medical humanitarianism constructs its object of intervention.

The Adventures of Medical Missionaries

“Nor does nature, who presents so fair and smiling a face to the summer visitor, always treat the inhabitants kindly. From time to time, disastrous fires have swept the city, which, with its wood-built houses and narrow alley-ways, presents similar opportunities for the easy spreading of an outbreak of fire to that afforded by the London of the seventeenth century. Earthquakes occasionally occur, floods, with famine in their train, have caused serious havoc and much loss of life more than once, while cholera and smallpox have decimated the people upon several occasions. These visitations, together with the grandeur of the scenery in which they live, have kept the might of natural forces before the eyes of Kashmiris and have fostered their apathetic and fatalistic attitude of mind.”

-Dermot Norris, *Kashmir: the Switzerland of India: A Descriptive Guide with Chapters on Ski-ing and Mountaineering, Large and Small Game Shooting, Fishing, etc.* Newman and co, Limited: Calcutta, pp. 7.

“With all this light there is a deep shadow. And why should I stop and hesitate to mention and to repeat that which comes up first into my mind—the disgraceful oppression of the people [of Kashmir]. Yes, disgraceful to *us* English, for we sold, literally sold, the country into the hands of its present possessors; and selling it; sold with it the flesh and blood of thousands of our fellow creatures, --sold them into a perpetual slavery”

-- An anonymous article written in the *Christian Intelligencer*, March 1871¹⁶²

While the British refrained from official intervention into the princely state of Jammu and Kashmir, the beauty of Kashmir first entered the European imagination through the publication of *Lalla Rookh*, Thomas Moore’s ‘Oriental

¹⁶² Elmslie and Thomson 1876: 76.

Romance,' in 1817.¹⁶³ However, as Ananya Kabir has argued, it was the development of photography and its intertwining with colonial imperatives of commerce, nostalgia, and control, that transformed the valley from “landscape to fantasy” in the middle of the nineteenth century.¹⁶⁴

In 1866, Samuel Bourne, a photographer-adventurer traveled to Kashmir and took hundreds of photographs, many motivated by a sense of nostalgia for England that the Himalayan landscape inspired. “The freshness, fertility, verdure, and sylvan beauty of Kashmir is very great, and seems to remind one very forcibly of the hills, and valleys, and green fields, parks and pastures of England,” he wrote in one of his weekly Himalayan journal entries.¹⁶⁵ Bourne’s photographs, which were highly fêted in Europe, are credited with creating a taste for Kashmir in the colonial imagination. Yet Bourne was not the first photographer of Kashmir; the British government had used the camera in the region earlier for pragmatic purposes, in order to seek alternative routes to Chinese Turkestan, which was the source of the highly coveted *pashm* wool, from which Kashmiri weavers then made pashmina shawls.¹⁶⁶ These missions had limited success, however, since Maharaja Ranbir Singh (1857-1885) jealously guarded the trade routes. As such, colonial interest in Kashmir in the mid nineteenth century was marked by a growing interest in high altitude landscape photography and adventure tourism combined with excitement over the Great Game—competing British and Russian interests over Afghanistan and Central Asia in the nineteenth century.

¹⁶³ Rai 2004.

¹⁶⁴ Kabir 2004: 71.

¹⁶⁵ Bourne 1866.

¹⁶⁶ Kabir 2009: 66.

It was into this milieu that the first British missionaries entered Kashmir. Several of the early missionaries to Kashmir are remembered as brave adventurers; Robert Clark, for example, who is credited with planning the “Kashmir Mission,” was reportedly one of the first Europeans to explore the entire region, including Ladak and Baltistan, in 1854. Clark was also the first missionary to the Afghans and had worked for many years in Peshawar.¹⁶⁷

While the Church Missionary Society in Amritsar did not receive official government funds for their Kashmir Mission, several governors, including Montgomery (1859-1865) and McLeod (1865-1870), privately funded the establishment of a dispensary. At the time, globally, the medical auxiliary of the Church Missionary Society was still a fledgling enterprise, with only half a dozen hospitals in different parts of the world, most of them manned by a single doctor. The Kashmir Mission Dispensary, which Rev. Clark established in 1862, faced not only financial difficulties, but also significant opposition from the Maharaja, who was highly suspicious of the presence of foreigners in Kashmir, not entirely without reason. For example, until 1872, the Maharaja decreed that all Europeans had to leave the Kashmir valley from October to April. As such, the dispensary had to be dismantled after every season and the medicos had to make the treacherous journey through the Pir Panjal mountains from Kashmir to Punjab biannually. In addition, the missionaries had to renegotiate a new place for their dispensary every year and then had to spread the word about their new location to patients.

Dr. William Jackson Elmslie, who worked as a medical missionary in Kashmir as Rev. Clark’s successor, from 1864-1872, described how other

¹⁶⁷ Neve 1911: 4-5.

limitations were also placed on patients who visited the dispensary: “Sepoys were placed at the entrances of all the avenues leading from the city to the European quarters... Some [patients] were allowed to pass on, after giving the sepoys some money; others who were caught coming to me were rough handled and beaten, some were fined and others were imprisoned.”¹⁶⁸ At other times, Dr. Elmslie found himself the victim of rumors intended to curtail patient visitations, including that his medicines were made of “swine’s flesh and blood.”¹⁶⁹ Elmslie, on his part, was also critical of the Dogra regime’s policies towards its Muslim subjects—and of British tacit tolerance of this policy—in his diary; as he noted: “the Maharaja keeps up an army so utterly disproportionate to the size of his country. He must grind the faces of the poor to sustain such a large permanent force.”¹⁷⁰

Despite these rather severe restrictions, Dr. Elmslie’s biography indicates that while the missionizing end of things was not particularly successful, a large number of Kashmiris received biomedical care during this period. As he describes at the end of the season in 1868, for example, “a period of five months and four days, 4161 individual patients have received medical and surgical aid at the Mission Dispensary.”¹⁷¹

From 1872 on, official Dogra policy permitted non-government Europeans to remain in the valley for the winter months. This move helped the Kashmir Mission gain credibility and permanence than they had earlier. While Dr. Elmslie’s dispensary had been rather basic, with no facilities for in-patients for

¹⁶⁸ Elmslie and Thomson 1876: 194.

¹⁶⁹ Elmslie and Thomson 1876: 212.

¹⁷⁰ Elmslie and Thomson 1876: 76.

¹⁷¹ Elmslie and Thomson 1876: 221.

example, by the time his successor, Dr. Arthur Neve, arrived in Kashmir, there had been significant improvements to the establishment. A permanent hospital structure had been built and had already “made a great reputation” and “spread into many channels.”¹⁷² Neve was also impressed with the hospital’s location, “perched on an outjutting spur of the Takht-i-Suliman...[it] commands a view of the vale of purple glens and snow-cold streams.”¹⁷³



Illustration 5:
Temple of
Shankaracharya
(ca. 220 BC)
on the Takht-i-
Suliman Hill,
near Srinagar.

Photo credit:
John Burke.
1886.
Courtesy of
the British
Library

Nonetheless, despite the hospital’s location, Neve found the infrastructure wanting. The hospital buildings were “quite unsuitable for big surgical work,” the few “string *charpoy*s were hopelessly unsanitary and most patients lay in their own garments upon mats on the floor,” and “the assistants were untrained.”¹⁷⁴ Nonetheless, relations between the Dogra regime and British government also improved by 1885, when Ranbir Singh’s son, Pratap Singh, acceded to the throne. In 1889, the British dispossessed Pratap Singh of his right to rule over Jammu

¹⁷² Neve 1911 [1984]: 29.

¹⁷³ Neve 1911 [1984]: 28.

¹⁷⁴ Neve 1911 [1984]: 32.

and Kashmir and established the State Council to administer the State under the direction of the British Residency. Although British involvement in Kashmir was far from altruistic, extensive reports about the mistreatment of Kashmiri Muslims at the hands of their Hindu rulers had made their way into the British-Indian press, enabling the British government to justify this move as a humanitarian one.¹⁷⁵ In addition, as Chitrlekha Zutshi has argued, due to subsequent reforms of the land revenue system, including the granting of occupancy rights to Kashmiri cultivators, the Residency's intervention was read by many as being on behalf of Kashmiri Muslims.¹⁷⁶

This period of increased British influence in Kashmir coincided with Neve's tenure, a significant portion of which consisted of upgrading the hospital, including rebuilding the entire structure in the aftermath of a devastating earthquake in 1885. However, Neve also had to contend with the devastating effects of the Great Famine of 1887-89, which ravaged much of the subcontinent. In his memoir, *Thirty Years in Kashmir*, Neve recalled that the scars of the famine were still visible on his arrival in Kashmir: "Those who had been through it had terrible stories to tell of the suffering, and sinister rumors as to the malignant influences at work, intensifying the trouble."¹⁷⁷ Neve's memoir reveals the ways in which the famine and its effect were not understood through the lens of contingency, but rather, as part of nefarious government policy to deliberately weaken the population and then hide the evidence from public view. Neve recalls one particularly horrifying rumor that did the rounds:

¹⁷⁵ Zutshi 2000: 114.

¹⁷⁶ Zutshi 2000: 114.

¹⁷⁷ Neve 1911 [1984]: 30.

There was...a rumor that some hundreds of starving people had been purposely drowned in the Wular Lake, to which colour was lent by the sudden death of an eye-witness and informer within a few hours of making the report. Though I subsequently met those who believed it, the story always appeared to me incredible: but it pointed to an alienation of sympathy, and to an intensity of sinister suspicion which boded ill for the relation of the poor Mohammedan cultivators and weavers with their rulers.¹⁷⁸

The account refers to subsequent protests against the Dogra regime which, by 1911—the year Neve published his memoir—had come to the political forefront in Kashmir. In addition to the “sinister rumors,” Neve also reported on the grim aftermath of the famine, evident in the “very scanty ragged garments” worn by weavers, the “emaciated bodies of many of the poorer classes,” and the “half-naked corpses that...[were] lying by the roadside even in the European quarter.”¹⁷⁹

In the narratives of both Dr. Elmslie and Dr. Neve, then, the suffering and weakened bodies of Kashmiris were on full display, stark in the face of inadequate biomedical provisions. The sense of “urgency” in these accounts—Elmslie also wrote extensively about the outbreak of a cholera epidemic in the 1860s—is palpable, and made even more acute by the fact that missionaries felt that they were one of the only sources of relief for the ill masses. Yet, at least during Elmslie’s term, their work in Kashmir was constantly curtailed. During the 1876 cholera outbreak, for example, Elmslie recalls visiting “the city almost daily, and [doing] what I could to alleviate the suffering of the miserable inhabitants, many of whom are daily carried off with cholera.” Yet when Elmslie reaches out to the Maharaja’s representative (Diwan), in the form of “a most polite letter, in Persian...expressing my sorrow at the heavy calamity that had

¹⁷⁸ Neve 1911 [1984]: 11.

¹⁷⁹ Neve 1911 [1984]: 31.

fallen on his people, and offering him my professional advice, and personal assistance, in this trying emergency," he never receives a response to his offer.¹⁸⁰ As such, despite seeing medical emergencies unfold before them, missionaries had to learn how to navigate a tenuous political situation. Their own mission was consistently undermined by the relative success of biomedicine and the lack of success of their missionizing endeavors, as well as by ongoing tensions with both the British government and Dogra regime.

In Neve's memoir, the post-famine years were focused on rebuilding the Kashmir Mission hospital, which took another twelve years and eventually included a 140-bed facility, an out-patient building with three operating rooms, a bacteriological laboratory, and two consulting room. Demand for biomedical services steadily grew, according to Neve, who described visitations to the hospital as a form of "pilgrimage," comparable to the "great days to which the people...look keenly forward" of visiting the Hazratbal shrine, a holy site in Srinagar where a hair of the Prophet Mohammed is displayed.¹⁸¹ Neve also enjoyed a certain lavishness of detail in his account of the hospital, which reminded me of contemporary media descriptions of the Government Psychiatric Diseases hospital:

There is a second pilgrimage center with a special attraction for the many who have sore eyes or various surgical complaints, namely the Mission Hospital, and the waves of the rising tides begin to lap at the gates. It is scarcely the busiest season, but already 135 beds are occupied, and all these in-patients have been personally seen before 10 am... By 12:45 pm, everything is once more in full swing; and in one room some private paying patients, including a high state official, are being attended to, while operations are being performed simultaneously in two other rooms... By 230 pm, most of the out-patients have been treated...and the European members

¹⁸⁰ Elmslie and Thomson 1876: 196.

¹⁸¹ Neve 1911 [1984]: 301.

of the staff take a hurried lunch... Then again we plunge into operating: so far six major and forty minor operations have been done... A bad smash is brought in after ten days' journey, from a town where there is a doctor. "Why did you come?" "Oh, *sahib!* The doctor wanted to cut off my boy's leg, and we heard that you save legs." An antiseptic leg-bath was ordered, splints were applied after removing some bone, and the leg was kept on (He was able to walk in two months). And so the hours passed. By 4 pm over 350 patients had been seen; but it was getting on for seven o'clock before our last operations were finished... Well, it had been a good day's work."¹⁸²

By 1905, another hospital called Elizabeth Newman hospital for women was also built, in addition to the Mission Hospital. The missionary imprint is still evident in contemporary Kashmir, as elsewhere in India, through the establishment of schools, which are still considered the most elite educational institutions in the valley. However, while missionaries clearly identified the traction of biomedicine in Kashmir as an effect of the efficacy they provided, a retired octogenarian doctor I interviewed in Srinagar, Dr. Naseer, provided a somewhat different explanation. For Dr. Naseer, the ability of Kashmiris to embrace biomedicine was linked to a culturalist explanation related to the flexibility of religious practices that had historically developed in this region.¹⁸³ The same cultural flexibility which had allowed Kashmiri Muslims to worship "in both shrines and temples" until early in the twentieth century had also made them amenable to new healing techniques, he argued.

¹⁸² Neve 1911 [1984]: 302-303.

¹⁸³ The majority of Kashmir's population converted to Islam from Hinduism in the fourteenth century, and Sayyid Adbur Rahman, who is said to have introduced Islam to Kashmir, belonged to the Hanafi order, a school of Islamic jurisprudence that follows the legalist interpretations of Imam Abu Hanifa (699-766 AD), who was considered a champion of leniency. Most Kashmiri Sunni Muslims are of the Hanafi persuasion. However, as Chitralkha Zutshi (2000) has argued, schisms between the 'Hanafi' and 'Wahabbi' first appeared in the 1880s and continued on well into the twentieth century.

Despite the different interpretations for the traction of biomedicine in Kashmir, my aim in presenting these narratives is to suggest the ways in which the logic of intertwined bodily and political fate is evident in two, distinct historical moments. However, these two moments also stand in contrast for what they reveal about the ability of biomedicine to ultimately save lives. While the missionaries' attempts to save lives were thwarted by nefarious political games and not due to any failure of biomedical technology, in the turn to psychosocial care, biomedicine no longer saves lives, but only suggests ways to endure suffering. The language of suffering in Neve's account of the famine is quite different—the emphasis on “emaciated bodies,” for instance—from contemporary accounts of trauma in Kashmir—yet there is a sense that chronicity is located in the landscape. In this sense, I want to propose that this particular illness-politics etiology might thus be read as the accumulation of suffering over time, rather than the sole product of the recent insurgency.

Psychosocial Healing

As with medical missionaries who operated in a highly competitive market—in which Muslim and Hindu communities each had their own healers (*hakims* and *vaids*, respectively)—humanitarian organizations offering psychosocial care in contemporary Kashmir also have to contend with the popularity of other forms of healing.

The first psychosocial organizations entered Kashmir in 2001-2002, and since then, the discourse and techniques of psychosocial care have proliferated widely. Several local NGOs have incorporated a psychosocial agenda into their work, whether their focus is on rehabilitating widows or educational and funding opportunities for orphans. The forms of psychosocial care being

practiced in Kashmir include psycho-education or awareness-raising programs such as public health initiatives and camps, counseling and psychotherapy, psycho-diagnostics, such as IQ testing, and more technical psychological treatments such as cognitive behavioral therapy (CBT).

These efforts are expressly *non-medical* technologies of the self. According to the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings, the terms *psychosocial rehabilitation* or *psychosocial treatment* generally describe non-biological interventions for people suffering from mental disorders.¹⁸⁴ Globally, these treatments have been used to help individuals cope with the emotional and interpersonal impact of painful wartime experiences¹⁸⁵ or to “re-engineer” selves or societies in the aftermath of devastating violence¹⁸⁶ or mass political upheavals.¹⁸⁷ In Kashmir, psychosocial programs have also been adapted to supplement state mental health services, which have remained within a predominately pharmacological, biomedical psychiatric model.¹⁸⁸

In highlighting psychosocial and psychiatric care as emergent humanitarian forms in Kashmir and elsewhere, I am careful to mark them as distinct from what Miriam Ticktin calls “regimes of care.” In Ticktin’s account, the “regimes of care” that come into focus are humanitarian exceptions in French immigration laws, which give legal residency papers to immigrants who have pathologies of life-threatening consequence, if they are unable to receive proper

¹⁸⁴ IASC 2007.

¹⁸⁵ Locke 2009.

¹⁸⁶ Abramowitz 2009.

¹⁸⁷ Matza 2009.

¹⁸⁸ Young 1995: 7.

treatment in their home countries.¹⁸⁹ The texture of Ticktin’s account is different from what I present here, partly because the effects of medical humanitarian practices such as diagnosing vary significantly across contexts. In addition, following Sarah Willen, I prefer the language of “deservingness” over care to understand relations between Kashmiri experts and their patients, particularly since “care” is located within a legal regime, whereas deservingness claims are articulated in a “vernacular *moral* register that is situationally specific and often context-dependent.”¹⁹⁰

For example, while diagnoses are matters of life and death for the immigrants Ticktin worked with, in Kashmir, patients or clients of humanitarian organizations were rarely told their diagnoses and the benefits that these diagnoses accrued were also relatively limited. As I will show, forms of psychosocial humanitarianism were not particularly effective as “modes of subjectification” or technologies of the self.¹⁹¹ Rather, in practice, both experts and recipients of aid curtailed these effects in key ways.

In April 2010, I accompanied a survey team that had been hired by Action Aid, an international psychosocial organization, to evaluate the impact of their work on their “beneficiaries.” One of the houses we visited was in a village near the town of Traal, about forty kilometers away from Srinagar. It was a rainy, cold afternoon, and I remember being grateful for the local knowledge of the “para counselors” who worked in the area, as we trudged through muddy paddy fields and narrow alleyways. On this day, the team consisted of five male consultants, two Action Aid counselors who were from the area, and me.

¹⁸⁹ Ticktin 2010: 2.

¹⁹⁰ Willen 2012: 814.

¹⁹¹ Rabinow and Rose 2006: 197.

The house we visited looked well built. The “beneficiary,” a middle-aged woman with sharp features named Saleema, led us to a small shed at the back of the house used for grain storage. We all crammed inside the shed, which was already occupied by bags of rice. Only once we were inside did I notice that the walls were riddled with bullet holes. Saleema told us that this was the place where her husband had been killed in an “encounter” killing a few months earlier. Sajad, the head of the survey team, began asking Saleema the standard survey questions, which first began with details of her family, and then moved on to questions about what kinds of violence Saleema had witnessed while living in the village.

Although Sajad was looking for specific signs that would suggest Saleema was traumatized—he probed for symptoms such as disturbed sleep, nightmares, headaches, and anxiety—I was surprised by how Saleema managed to maneuver the conversation away from the narrow survey guidelines to her own matters of concern. For instance, after Sajad began questioning Saleema about the status of her daughters’ education, Saleema interjected: “Actually, we would like to receive some thing.” A little taken aback, Sajad responded, “We are not a government agency or anything like that.”

When Sajad moved on to specific questions about Action Aid’s role in the aftermath of her husband’s death, Saleema responded that the organization had given the family rice, *dal*, and blankets. She did not mention any of the counseling that the family had received, even though the counselors had previously visited the family were present during this interview. When Sajad finally explained what we were all doing there—that the team was here to survey “the damage done”—Saleema pointed to the wall behind her. “See, this

wall, it is like a sieve," she said. "The question is, do we fix this wall or do we take care of our children?" To this, Sajad replied, "Thank Allah you are alright." This again seemed like a diversion from Saleema's direct inquiry about financial assistance to help repair the wall.

Saleema, dissatisfied with Sajad's response, continued: "There is no door, there are no windows, nothing is intact." After the interview was over, when we were back in the car, Sajad confessed that he did not think that Saleema was a "worthy victim" because "she was not needy enough." His judgment was based on the size and the good condition of her house, he said.

This encounter was striking for a number of reasons. Both Sajad and Saleema were using non-psychological signs to assess claims for the worthiness of their cause. Neither Saleema nor Sajad followed the script of humanitarian testimony in the sense of a "subjectivity without a subject" (Saleema) or a neutral, impartial witness (Sajad).¹⁹² In other words, Saleema refused to be the figure of the witness inspiring pity, and instead, insisted on an account of what she had suffered on her own terms. (Unlike Fassin, I do not necessarily think that this is an "objective truth of the event" as much as an alternative one).¹⁹³ Rather than an incommensurability between recipient and giver, they misapprehended each other over the same criteria: the issue of the gift, expressed through material benefit. Saleema deemed the organization "unworthy" in terms of what they had offered her; Sajad deemed Saleema unworthy due to her relative economic well being. In leading us into the shed—the very site of violence and loss—Saleema challenged the organization to confront her legacy,

¹⁹² Cf. Fassin 2011.

¹⁹³ Fassin 2011: 208.

her definition of what had been lost—something that the team was unable to do. In pointing to the bullet holes in the wall and her graying hair, Saleema also indicated that for her, trauma was located in the “visible” materiality of house and body, not the domain of psychological suffering.

Saleema was not alone in deeming the gifts of humanitarianism inadequate. During visits to the homes of other Action Aid beneficiaries, this was a common refrain: the sense that while the organization had provided *something*, much more was needed. Rather than the survey team dictate these encounters, I witnessed benefactors find ways to ask for further assistance, particularly monetary and livelihood support. During these visits, what also became apparent to me were the ways in which the organization’s primary goal—of providing psychosocial care—was consistently viewed as secondary or almost inconsequential in the minds of benefactors. Thus, in contrast to the gift of citizenship that legal exceptions in Europe offered, the most common forms of humanitarian assistance given to those diagnosed with PTSD or traumatic symptoms in Kashmir were free counseling and medication, emergency relief packages, and livelihood support. None of the immigrants in Ticktin’s account, for example, questioned the gift of legal residency, even though this gift demanded that they remain debilitated. In contrast, benefactors like Saleema actually refused these gifts.

Perhaps because psychosocial humanitarianism offers victims of violence limited gifts in Kashmir, for those who are performing this work, it requires intensive intellectual, linguistic, and pragmatic skill. Psychosocial care is distinguished from other kinds of medical humanitarianism (i.e. emergency relief) by the fact that it is much more difficult to measure than a tally of lives

saved. Survey rubrics such as identifying sleep disturbances on a scale of 1-10 did not translate well in the sessions I observed. Psychosocial care is also mostly performed by national or local staff. Not only do local or national staff work as translators within medical humanitarian organization, but they increasingly work as counselors and psychosocial workers—the very doers of humanitarianism.¹⁹⁴ In an organization such as MSF, for example, national or local staff now account for 90 per cent of the total workforce. In addition to disrupting the smoking Frenchman cliché, this development also disrupts the assumptions that humanitarian action pivots on “lives to be risked”—expatriate humanitarian workers—and “lives to be saved”—local clients or patients.¹⁹⁵

As Didier Fassin and Peter Redfield have both noted, many aid, developmental, and humanitarian organizations distinguish between “expatriates” and “nationals.”¹⁹⁶ In the case of MSF, for example, expatriates come almost exclusively from Western countries as volunteers of the organization, whereas nationals are local agents who are often considered “mere paid employees.”¹⁹⁷ While “expatriates” enjoy the freedom of mobility and international travel and thus embody the “*sans frontières*” of the organization’s name, “national” employees generally remain immobile, attached to the specific context in which they work and live.¹⁹⁸ Further, Redfield writes that, “locals remained relatively invisible in the group’s public profile, in contrast to the international participants who enjoyed ample media attention.”¹⁹⁹

¹⁹⁴ Redfield 2012.

¹⁹⁵ Fassin 2007.

¹⁹⁶ Fassin 2007; Redfield 2012.

¹⁹⁷ Fassin 2007: 515.

¹⁹⁸ Redfield 2012.

¹⁹⁹ Redfield 2012: 364.

Unfortunately, anthropology has largely mirrored this politics of visibility. When local or national staff do appear in anthropological accounts, they are often described as the conduits through which “local cultures and contexts can be learned, integrated, instrumentalized and redeployed selectively in NGO projects and activities.”²⁰⁰ In this chapter, I argue that local staff are more than instruments through which local cultures can be accessed for humanitarian organizations. Rather, they play crucial roles as middle figures in shaping humanitarian and medical epistemologies and ontologies on the ground.²⁰¹ Further, ethnographic attention to their micro-practices also disrupts critiques that humanitarian actors are inattentive to “concrete situations”²⁰² and only show concern for universal conceptions of humanity.²⁰³

I argue that the engagement of local and national staff in psychosocial care has fundamentally altered the texture of humanitarian practice and expertise. Rather than view local or national staff as somehow corrupted versions of the expatriate ideal, I am interested in how they make psychosocial humanitarianism “land.” I borrow the metaphor of “landing” from Tim Choy’s ethnography of environmental expertise in Hong Kong, as I understand it as capturing the idea that expert knowledge is marked by its ability to both travel and somehow remain intact.²⁰⁴ In this sense, I am interested in the intellectual, affective, and physical labor required to transport knowledge and practices such as “talk therapy” across contexts and professions without assuming that they are intact

²⁰⁰ Abramowitz and Kleinman 2008: 221.

²⁰¹ Good 1994; Luhrmann 2000; Wendland 2010.

²⁰² Englund 2005: 12.

²⁰³ Malkki 1995; Pandolfi 2003.

²⁰⁴ Choy 2011.

or pure anywhere. Following my interlocutors, I read this labor through the difference between ‘Kashmir’ and the world ‘outside’ (*bahar*).²⁰⁵

As with the government officials with whom Tim Choy worked, Kashmiri psychiatrists were also acutely aware that, to be credible, their expertise needed to “bear universalizing and particularizing marks simultaneously.”²⁰⁶ For government officials in Hong Kong, knowledge or statistics about air pollution produced in Western metropolitan cities did not sufficiently explain or account for Hong Kong’s poor air quality or how to measure it. As Choy shows, to convince the Hong Kong government, international environmental consultants needed to embody a truth that “[scaled] down—particularize[d]—at the same time as it scale[d] up—universalize[d].”²⁰⁷ As such, it was not enough to have mastery over technical discourse. Expertise also needed to “land” in order to be recognized as legitimate.

I find the lens of Kashmir and the ‘outside’ useful in thinking about the negotiations of scale and the translations required to make humanitarian knowledge locally salient. However, where I depart from Choy is in my understanding of the effects of this movement, particularly on experts themselves. Specifically, I argue that what is at stake in the formation of psychosocial expertise is not merely a movement between the particular and the ‘outside,’ but rather, the loss that happens in this movement. In this sense, I see the movement between Kashmir and the ‘outside’ as asymptotic. In other words, in the reach for worldly knowledge, I show how the particular is eclipsed, and at times, lost. Rather than science and medicine be viewed as value neutral or

²⁰⁵ Choy 2011.

²⁰⁶ Choy 2011: 81.

²⁰⁷ Choy 2011: 87.

objective tools, their use raised questions about personal integrity and existing commitments to the particular conditions of Kashmiri psychiatry.

I note this loss-in-movement in both the practices of psychiatric experts, who questioned the use of PTSD therapies on the basis of their cultural appropriateness, and in the labor of psychosocial workers, who aspired to highly technical, medical forms of care. In so doing, I point to two constitutive paradoxes of psychosocial humanitarianism: first, that the inclusion of national or local staff as the doers of humanitarianism depends on their estrangement from the particularities of local knowledge—the very reason why they are brought in; and second, that the “landing” of the psychosocial actually depends on a loss of its *form* or intactness. Among the psychosocial workers with whom I did fieldwork, for example, I found that while their growing familiarity with diagnostic categories and technical, English-language terms enabled counselors to perform an expertise that their peers would recognize, it also made it increasingly difficult for them to communicate and empathize with their patients.

However, before I reflect on what was lost in the movement of expert knowledge from the ‘outside’ to Kashmir and vice versa, I want to foreground how psychosocial and psychiatric knowledge are made to “land” in Kashmir. I want to highlight one of the paradoxes I pointed to earlier, namely the ways in which using local or national staff for psychosocial work ends up inhibiting their ability to act as cultural mediators.

During one of my final days of fieldwork, I interviewed Imran, a counselor at a local humanitarian organization that specializes in providing

psychosocial treatment to victims of violence. I asked Imran how he would improve his practice as a counselor. He responded, “I would like to prescribe medication.” Imran’s statement was surprising because he worked for an organization that was committed to providing non-pharmacological care to victims of violence. While Imran’s perspective was fairly common among counselors in Kashmir, it was far removed from the Inter-Agency Standing Committee guidelines on psychosocial treatment.

One of the enduring challenges for psychosocial workers in Kashmir was the fact that their tools – counseling, psychotherapy, and talk – were not recognized as legitimate or efficacious modes of care.²⁰⁸ As such, I argue that one of the ways in which psychosocial workers succeeded in making this technology “land” in Kashmir was through the promulgation of a medical model of care, in other words, through an eschewing of psychosocial practices. In other words, counselors appropriated the practices of medical practitioners, not to enhance their own prestige, but to make their treatments legible to patients. In this scenario, biomedicine—having already been vernacularized—acted as a more culturally familiar buffer to psychosocial knowledge, which was newer and less recognized.²⁰⁹

Specifically, I argue that psychosocial workers spontaneously appropriated key practices normatively associated with medicine: diagnosing, “(mis)reading” the medical card, and choosing technical, biomedical treatments over psychosocial ones. While these practices were deviations from the standard

²⁰⁸ This problem is by no means unique to Kashmir or South Asia. Vinh-Kim Nguyen (2010) has described a similar aversion to talk therapy in the context of AIDS intervention in West Africa.

²⁰⁹ Biomedical objects and practices have also undergone practices of vernacularization, which I discuss in chapters 3 and 4.

norms of counseling, they were an instantiation of “ordinary ethics...relatively tacit, grounded in agreement rather than rule, in practice, rather than in knowledge or belief, and as happening without calling attention to itself.”²¹⁰ Further, counselors chose not to use psychosocial tools on themselves, but consistently and actively elicited biomedical technologies to understand and treat their own (ill) bodies. In this way, biomedicine cast a long shadow over psychosocial humanitarianism, obscuring its potentialities.

Like psychosocial workers, Kashmiri psychiatrists also developed new techniques and debated issues of cultural particularity, especially those therapeutic tools that were seen as coming from ‘outside’ Kashmir. In so doing, they were also engaged in making knowledge around trauma and PTSD “land” in Kashmir. Nonetheless, rather than humanitarian knowledge being understood as “antipolitics” or as a neutral or universal good, it was questioned precisely for its ability to mesh with local systems of patronage and politics. In this sense, those who were seen as overly driven by such ‘outside’ knowledge were cast as circumspect in terms of their motivations and as no longer qualified to speak of the particular. Here too a crucial occlusion occurred.

A Space to Intervene

As I described in the Introduction, in recent years, in media and human rights reports, Kashmir has emerged as a zone of mass psychological suffering. Media reports highlight the fact that Kashmir has one of the highest rates of PTSD in the world, with approximately one-third of the population exhibiting traumatic symptoms.²¹¹ Kashmiri psychiatrists have reported exponential

²¹⁰ Lambek 2010:2.

²¹¹ Matloff and Nickelsberg 2008.

increases in the numbers of patients visiting the psychiatric hospital in Kashmir, from 1,000 per year in 1989 to 100,000 per year in 2009. Similarly, a 2006 report by Human Rights Watch entitled, “Everyone Lives in Fear,” described an “epidemic of trauma” underway because of sustained human rights abuses. Local human rights NGOs have also emerged as important actors in this space, both for producing knowledge about ongoing suffering and victimization and linking this to Kashmir’s quest for self-determination.²¹²

In response to the ongoing “epidemic of trauma,” organizations such as MSF—which worked in Kashmir from 2001-2012—and Kashmiri psychiatrists alike have conducted epidemiological studies on PTSD and developed psychosocial programs to identify and treat Kashmir’s traumatized population. In 2006, to identify “needs and support project planning,” MSF conducted a survey consisting of 510 semi-structured interviews in two rural districts in Kashmir.²¹³ Also in 2006, Kashmiri psychiatrists conducted a survey of four districts in Jammu and Kashmir and found a lifetime prevalence of traumatic events in 59 percent of the population.²¹⁴ These reports legitimated PTSD as the recognized marker of suffering, and produced Kashmir as a particular humanitarian “hotspot,” in need of intervention.²¹⁵ In other words, in Kashmir, as elsewhere, the accumulation of scientifically validated data allowed the transformation of trauma from a subjective experience to a “public health crisis” worthy of intervention.²¹⁶

²¹² Cf. Allen 2009.

²¹³ De Jong et al. 2008.

²¹⁴ Margoob et al. 2006.

²¹⁵ For a similar argument in other contexts, see Fassin 2008 (for the case of Palestinian refugees) and see Crescenzi and colleagues 2002 (for the case of Tibetan refugees in exile).

²¹⁶ Desjarlais et al. 1995.

In addition to prominent international humanitarian organizations, including MSF, the International Committee of the Red Cross (ICRC), and Action Aid International, local Kashmiri organizations and the Indian state have also developed psychosocial programs for traumatized populations. As I describe in Chapter Five, for example, the Jammu and Kashmir police has established several drug and alcohol de-addiction centers across the Kashmir valley, as well as a stress management telephone hotline. Rather than governmental and nongovernmental trauma healing efforts occupying completely distinct spheres of action, there was significant ideological and personnel traffic between them. Humanitarian experts—both local and expatriate—frequently attended consultations and meetings with local, state, and national health officials, and national staff often switched employment, moving between state and non-state organizations. Given the overwhelming preference for government employment, however, most Kashmiris recognized NGO employment as unstable and temporary, a fact that was compounded by the fact that most humanitarian organizations had a limited mandate, though the contours of this mandate were not always clear. Nonetheless, I heard MSF staff consistently affirm their public commitment to not “create a parallel system of government.” This was nonetheless sometimes a jarring argument to sustain given the significant institutional presence of MSF in Kashmir, the fact that they had employed and trained over one hundred local staff, and the amount of time they had been in Kashmir (more than a decade).

Despite the frequent contact between state and non-state officials, many administrators of humanitarian organizations—both expatriates and Kashmiris—

expressed “moral outrage”²¹⁷ at the state model of mental health care and defined their model of “psychosocial” care in explicit contrast to the state model. A senior staff of Action Aid, for example, described their approach as “de-centralized, de-stigmatized psychosocial care,” contra the institution-based, pharmacological model offered at the Psychiatric Diseases hospital. This Action Aid staff member described the woefully long lines at the OPD of the state hospital and the fact that many psychiatrists lacked empathy for their patients, spending only a few seconds or minutes with them.

In addition to quantifying and evaluating the extent of psychological trauma in Kashmir, psychosocial organizations and experts also had the added task of “awareness raising,” that is, introducing concepts such as trauma, depression, and talk therapy, to the Kashmiri public. In this case, trauma and mental health had to be first created as ontological entities—different from Kashmiri concept of madness (*mot*) or suffering (*pareshani*)—before they could be intervened and acted on by these organizations.²¹⁸ To this end, in 2005, MSF began producing a Kashmiri radio soap opera called “Hello, Brother Hello” (*Alaw Baya Alaw*) that focused on raising awareness about mental health issues in Kashmiri society, which ran until 2012. MSF also held annual camps in public parks on World Mental Health Day (October 10), which included a staged performance and poetry and drawing exhibits by school children.

In terms of treatment, in 2001, MSF also began offering psychological and counseling treatments at the state psychiatric hospital, which were hitherto

²¹⁷ Redfield 2006: 5.

²¹⁸ Stacey Pigg (2001) describes a similar process in the case of developmental efforts around HIV/AIDS awareness in Nepal.

nonexistent. The hospital authorities provided MSF with a counseling cell, but counselors continued to be dependent on psychiatrists for referrals. Many of the hospital psychiatrists were skeptical of the efficacy of psychotherapy, and, thus, referred patients only occasionally. The enduring tensions between the medically dominated “outside” of the hospital and the counseling-dominated “inside” of the counseling cell led MSF to ultimately abandon its mission at the hospital in July 2011. However, they continued to do counseling in their own standalone clinic in the district of Kupwara until May 2012. In an interview with a Kashmiri journalist, the project coordinator of MSF provided a somewhat cryptic explanation for MSF’s departure from Kashmir: “We do see there are still needs to be met. It’s not that we’re saying that everything’s perfect in Kupwara district. But sometimes we have to make difficult decisions.”²¹⁹ As with MSF, Action Aid also attempted to strike a balance between working within and outside state institutions. Although Action Aid deputed counselors to various district hospitals, they also had a cadre of 60 “paracounselors” doing door-to-door counseling and providing emergency aid relief kits in local communities, such as the ones who had worked with Saleema.

Other experts trying to fill the gap in psychosocial care delivery attempted to bypass the psychiatric establishment altogether. Justine Hardy, a psychotherapist specializing in conflict trauma, who has a deep personal attachment to Kashmir, established an NGO called Kashmir Life Line and Health Center in 2009. She located the organization explicitly “outside” the medical domain. Her organization’s website states that psychiatrists were simply “medicating” the problem of trauma, “literally, with very high doses of

²¹⁹ Najjar 2012.

tranquilizers, sedatives, anti-psychotics, and anti-depressant drugs.”²²⁰ In addition to face-to-face counseling, Kashmir Life Line also began offering telephonic counseling. There were no psychiatrists involved in the daily functioning of Kashmir Life Line—unlike the other NGOs such as Action Aid and MSF. The two staff supervisors, who I will introduce later in this chapter, were a Unani doctor and a Swiss psychotherapist.

Further, to remove all traces of the medical, Hardy renamed the eleven counselors who worked for Kashmir Life Line “listeners,” because she felt the counselor label was already too formal and professionalized. This chapter draws on fieldwork conducted with the listeners of Kashmir Life Line, because this organization was explicitly envisioned as being outside of the psychiatric domain, yet it shows the ways that the medical model asserts itself in psychosocial care, even in cases in which psychiatrists are not directly involved.



Figure 2:
The
Kashmir
Life Line
website

One of the most obvious and tangible effects of the production of a mental health crisis in Kashmir was a newfound demand for individuals with

²²⁰ From http://www.justinehardy.com/pages/aid_projects/healing_kashmir/the-idea.asp.

psychology or social work degrees who could be employed as psychosocial workers in humanitarian organizations. Typically, the job postings for psychosocial workers in humanitarian organizations required an MA in Psychology or a Masters in Social Work (MSW). Administrators of psychosocial programs often lamented the difficulty of filling these positions with qualified persons, although it appeared that disciplines such as psychology and social work were gaining in popularity. This also represents a major shift in humanitarian practice, away from a cadre of volunteers to a professional workforce. Although counselors staffed the bulk of psychosocial organizations, when compared with psychiatry, counseling was still a new and relatively unknown profession in Kashmir. This was one of the reasons why psychosocial workers experimented with medical techniques in their everyday work and felt that it may make their practice more culturally familiar.

The Heavy Diagnosis

One of the medical or psychiatric practices most borrowed by psychosocial workers was the act of making diagnoses. In this context, psychiatric diagnoses were objects of concern not only for psychiatrists, but for other mental health experts as well. However, for counselors, the diagnosis cut both ways—it could be empowering or disempowering, an avenue for agentive action or the curtailing of it. The diagnosis was a heavy presence, sitting like a stone on the front of a person’s medical card.

Dr. Arshad, an M.D. in Psychiatry who I introduced earlier in the dissertation, has trained Action Aid’s counselors in Kashmir since 2002. He told me that he had trained Action Aid’s counselors to become “barefoot psychiatrists.” He told me proudly that one of the senior psychiatrists from the

hospital had gone to visit Action Aid's PTSD clients, but the doctor had been unable to change a single diagnosis. "All 23 PTSD cases were correctly diagnosed by the counselors," Dr. Arshad said triumphantly. He described the senior psychiatrist's chagrin when he found that he did not need to change a single diagnosis. For Dr. Arshad, diagnosing was the accomplishment of a complicated hermeneutic process, usually acquired after years of medical training.²²¹ That the counselors had gained this skill without formal medical training suggested that they were "really something," as Dr. Arshad put it.

I had the opportunity to witness one of Dr. Arshad's training sessions, in which he attempted to impart the art of diagnosing to Action Aid's counselors. "I know what the DSM [Diagnostic and Statistical Manual of Mental Disorders] says about depression," he began, "But what do people say?" The counselors had offered some responses—heart palpitations, aches and pains, headaches, which Dr. Arshad had written on the whiteboard. Looking at the list, Dr. Arshad had said, sounding very much like a medical anthropologist:

So, it is clear that no one comes to you with depression as it is defined in the DSM-IV. No one comes to you and says, "Doctor, I've had depression for two months." No. People will talk about somatic complaints; they will describe themselves as physically ill ... Then, the question for us really is, how do we explain this somatization of mental health? Why do people talk in somatic symptoms? [Long, silent pause] You see, to explain oneself psychologically, you have to have an in-depth understanding of the psyche, which is absent in Kashmiri society ... and secondly, the language of distress in our culture is somatic.²²²

In this explanation, Dr. Arshad called for counselors to put aside their careful study of the DSM, that is, textbook knowledge, in favor of attending to what would be present in the clinic: the language of the body. Imparting this "clinical

²²¹ Luhrmann 2000.

²²² Fieldnotes, December 8, 2009.

intuition”²²³ to counselors—and thus potentially rendering psychiatrists redundant—did not make Dr. Arshad particularly popular among his peers. As such, Dr. Arshad viewed himself as a Promethean figure, wresting psychiatric knowledge away from psychiatrists and potentially paying a high price for it.

This was a case in which a particular psychiatric skill—diagnosing—was deliberately passed on to counselors to enhance their practice. However, there were other cases in which the diagnosis did not play such an empowering role in the lives of counselors. At other times, the diagnosis was deliberately kept in view, even if it meant that counselors had to curtail their own interventions.

One such incident occurred at the Stress Management Helpline, which was inaugurated in March 2011 as an extension of psychosocial services offered by the Jammu and Kashmir Police. As I describe in chapter 5, since 2008, the Jammu and Kashmir Police have been running a Drug De-Addiction Clinic as a public outreach initiative. Although the clinic was located within the auspices of the police headquarters, the clinic’s staff attempted to maintain a sense of independence from the police through methods such as guaranteeing patient confidentiality. Both the staff and senior police administration believed that the telephone helpline, as opposed to an in-patient treatment center, could provide greater anonymity for those suffering from mental illnesses, and that the helpline could reach a broader base of people, not just those struggling with substance abuse problems. Maintaining anonymity was of great concern to those suffering from mental illnesses, given persistent stigma attached to certain forms of madness. This was made more difficult by the fact that caring for a sick person was usually a relational matter, involving both immediate and extended kin

²²³ Luhrmann 2000: 34.

networks. For example, it was extremely rare that a person would come to a mental health center alone.

The Stress Management team—those running the telephone hotline—was comprised of a number of counselors and was managed by a clinical psychologist, Dr. Muzzafar Khan. The counselors had M.A. degrees in Psychology and had each received a short course in telephonic counseling. Although the emphasis was on building empathetic listening skills, the counselors would often draw on medical or psychiatric knowledge. For example, during one of the weekly review meetings, one of the counselors, Mudasir, described an hour-long phone call he had had the previous week. The caller, a young woman, had detailed a nine year long and troubled history of mental health problems. Over the years, she had received a number of different diagnoses, including depression, generalized anxiety disorder (GAD), and obsessive-compulsive disorder (OCD). She had been treated by the most famous mental health experts in Kashmir, including the current Head of the Department of Psychiatry at Kashmir's Medical College, and even by Mudasir's supervisor, Dr. Muzzafar Khan. She had also had nine rounds of electroconvulsive therapy (ECT). Yet she felt no improvement in her condition. As he was relaying this information to the other staff members, Mudasir's voice dropped. "I told her I could not do anything for her," he said. At this point, the caller hung up.

The discussion following Mudasir's narration was led by a visiting expert from Mumbai, a female counselor with over ten years of experience with telephonic counseling. She thanked Mudasir for sharing his case, and told him that he had ended the call long before the caller had actually hung up. "You checked out of the conversation as soon as this woman told you her diagnoses,"

she said. Using Mudasir as an example, the visiting expert encouraged all the counselors to treat each phone call as “a fresh case,” because by “focusing on past treatments and diagnoses, they were blocking their own capabilities as counselors.” Yet while the visiting expert saw Mudasir’s gesture as a mistake, Mudasir argued that his refusal had been a deliberate calculation.

For Mudasir, this young woman’s psychiatric history was insurmountable. In a later interview with me, he explained: if these other experts—people he admired—had failed to help this woman, what could he possibly do? In this act, Mudasir operationalized a particular schema of the mental health field, in which psychiatry and clinical psychology occupied higher positions than counseling and social work. This hierarchy of knowledge was reinforced by the fact that psychiatrists and clinical psychologists tend to have greater educational qualifications than counselors and social workers and also earn significantly higher salaries. In this sense, while the telephone helpline may have shaped the subjectivity of Mudasir and the caller, it did not produce a new set of skills or capabilities as Vinh-Kim Nguyen has described in West Africa, but made counselors more attune to their own limits.²²⁴

As Renu Addlakha has shown, although mental health professionals in South Asia privilege the multidisciplinary model of mental health care in theory, in practice, this model is often subverted and debated.²²⁵ However, while Addlakha argues that it is often psychiatrists themselves who “cut into the collaborative work culture of the clinic,”²²⁶ the example of Mudasir is useful in showing how those on the “lower” rungs also hold up the hierarchy. In this

²²⁴ Nguyen 2010: 47.

²²⁵ Addlakha 2008.

²²⁶ Addlakha 2008: 3.

sense, given that both psychiatric and psychological knowledge had failed to help this young woman, Mudasir chose to avoid what he felt would inevitably be another disappointment in a long history of failed treatment. Rather than read Mudasir's decision as simply checking out or a refusal to treat, then, I would argue that, in *not acting*, Mudasir understood himself to be behaving in an ethical manner. This example also complicates the category of "lives to be saved"²²⁷ in the sense that not all lives are worthy of being saved. Mudasir did not refuse to save a life; rather, he saw himself as helpless to act.

The Art of "(Mis)Reading"

A second medical practice that was actively emulated by counselors in Kashmir was the act of "(mis)reading" patients' medical cards.²²⁸ I call this process "(mis)reading" to highlight the fact that there was something missing for counselors in the act of reading: comprehension. Although counselors themselves were unable to read or comment on patients' medical cards, they mimicked the reading practices of doctors because they recognized that this was a significant yardstick of biomedical care for patients. As a result, this performance of psychiatric expertise was an attempt to make non-biological, psychosocial interventions more legible to those they were treating by incorporating aspects of the medical model within them.

²²⁷ Fassin 2007.

²²⁸ As I describe in chapter 3, each hospital produces its own medical cards, which are slightly different from each other. Medical cards have to be bought by patients for a small sum, usually between two and five Indian rupees. The cards are generally blank, except for the name, age, and place of residence of the patient written on top by an administrator. Generally, doctors will write patient complaints ("c/o") on the card, diagnoses (tentative or established), and the prescriptions and ongoing treatments. Patients are expected to carry these cards with them for follow-up visits as doctors encourage patients to maintain a paper trail.

During the course of my fieldwork, I accompanied the listeners of Kashmir Life Line to a district hospital, about an hour's drive from the capital, Srinagar, where they had been provided with a small, dingy room to do counseling. There were two counselors who shared this room at any given time, and they were dependent on doctors in the OPD for patient referrals. The slow trickle of patients led one of the listeners to comment, "I bet even the doctors don't know what counseling is." The other counselor described how, a few days earlier, a fellow passenger in the communal SUV-taxi to the hospital had asked her what she did. When she had said that she was a counselor, the man had just "looked at her blankly."

Both these statements reveal counselors' self-perceptions about their work and its illegibility in the Kashmiri context. According to the first counselor, many doctors themselves were ignorant of what counseling is, making it all the more frustrating that psychosocial workers depended on doctors for referrals. This illegibility and lack of trust between psychiatrists and psychosocial workers also came to light within the space of the psychiatric diseases hospital, where humanitarian psychiatry – in the form of MSF's counseling cell – was a troubling presence.

For example, Kashmir Life Line, the psychosocial organization started by Justine Hardy, had its roots at the psychiatric hospital, where she began a trauma healing project in the winter of 2009. She brought two Reiki healers from the UK, and in collaboration with the psychosocial organization Action Aid, worked with patients who had been diagnosed with PTSD.



Illustration 6: Hardy giving Reiki healing to a patient at the hospital, December 2009.

However, when I asked hospital psychiatrists what they thought of Hardy's project, they were mostly cynical. One described it as "placebo effect." When I cited the fact that some patients had experienced a significant improvement in their symptoms, another said, "Well, who wouldn't want to be treated by a white lady doctor?" Eventually, Hardy parted ways with the psychiatrists of the psychiatric diseases hospital, and decided to establish her NGO without the collaboration of any psychiatrists, a decision that no doubt made her work in Kashmir significantly more difficult. Given the historical and contemporary meddling of outsiders in the affairs of Kashmiris, all non-Kashmiris, particularly Indians and foreigners, were automatically suspicious in this context.

The refusal of patients to recognize non-pharmacological treatments as legitimate forms of care compounded the difficulties that psychosocial workers faced. Counselors routinely complained that in addition to the difficulties of working with trauma survivors, they also had to deal with everyday, persistent communicative difficulties generated by the fact that most patients were unfamiliar with counseling techniques or the English language. In particular, the

high level of client participation expected in psychotherapy was in sharp contrast to the much more culturally familiar mode of passively receiving biomedical or religious treatments or cures. Further, in addition to the struggles of translating somatic distress into psychiatric symptoms, counselors also struggled to translate technical, English-language concepts like “cognition” or “emotion” into Kashmiri or Urdu.²²⁹

As Stacey Pigg has described in the case of HIV / AIDS awareness programs in Nepal, activists and NGO workers expressed a preference for English-language terms over their Nepali equivalents because English was considered the appropriate and transparent medium to explicate a theory of disease. Further, when English terms were translated into Nepali, Sanskrit-based neologisms were used rather than colloquial Nepali, thus creating a third, entirely new idiom to communicate (although most did not understand this highly technical Nepali) HIV / AIDS to a Nepali audience. In Kashmir, while there was not the creation of a “third” language, nonetheless, I noticed how English language terms such as “stress” and “tension” made their way into everyday Kashmiri parlance, sometimes with quite different meanings than what counselors meant by them.²³⁰

In many of the sessions I witnessed, counselors gave up trying to find vernacular equivalents of these words and continued to say them in English, even though patients did not understand. Several also verbalized a preference for working with English-speaking clients, for whom they did not have to engage in such elaborate translation. With first-time clients, the situation was

²²⁹ For a similar struggle over translating terms associated with HIV / AIDS in Nepal, see Pigg 2001.

²³⁰ Cf. Halliburton 2002.

particularly difficult. One counselor described the experience like this: “Even after spending a precious half an hour or hour explaining counseling to a patient and doing a session with them, they turn around and say, ‘Okay, we can do all that. But can I have my medicine now, Doctor *Sahab* (Sir)?’” In calling all mental health professionals by this name, “Doctor *Sahab*,” patients situated doctors and counselors within the same category of medical professional and, thus, probably expected similar outcomes. Rather than contest this categorization, most counselors allowed themselves to be called “Doctor *Sahab*” or “Doctor *Memsahib*” and tried to incorporate more doctor-like practices (*daktari kam*) into their counseling. As Amar Dhand has pointed out in his study of NGO interventions around heroin addiction in New Delhi, the English word ‘doctor’ has a range of meanings, spanning from medical professionals in government and non-governmental settings to intravenous drug users (IDUs) who are particularly skilled with needles.²³¹

For these reasons and more, counseling at district hospitals was an extremely challenging task. Because counselors were dependent on doctors in the OPD for referrals, they spent a long time waiting. When patients did wander in, many of them did so accidentally, looking for the OPD or dispensary. When psychosocial workers received a patient referral, they were often not told why or were given incomplete information. During one of my visits, for example, the hospital’s pharmacist brought in a distraught fifteen year-old girl from an ethnic minority (Gujjar) community and said, “She has ingested poison,” and left. Initially, the Kashmir Life Line counselors panicked, thinking that she needed immediate medical attention. It was only after questioning her for a few minutes

²³¹ Dhand 2006; Pinto 2004.

that they learned she had consumed rat poison three days earlier. This radical uncertainty further encouraged counselors to rely on what was tangible and written: the medical card.

While the interaction between psychiatrists and patients was usually focused on the medical card (see Chapter Three), in the training sessions I observed, psychosocial workers were actively encouraged to literally, put aside the medical card. They were taught to take the first few minutes of the session to greet the patient, make eye contact, and embody an empathetic listening posture. Although such guidance was rigorously reinforced in training sessions, which often included role play, the reality of counseling sessions was quite different. As they were accustomed to doing with doctors, patients would usually hand over their medical cards to counselors first, while expecting little or no verbal communication. Rather than putting the card aside as they had been instructed, however, counselors would attempt to read the card, thereby replicating the familiar encounter between doctor and patient. Listeners “(mis)read” the card, as they could not follow the messy, shorthand scribbles of doctors. As elsewhere, in Kashmir as well, doctors’ handwriting veered toward the illegible.

In a group discussion with listeners from Kashmir Life Line, I asked them what would happen if they did not read the card. One of the counselors piped up: “We can’t do that!” he said, shaking his head vehemently. “But you can’t understand what the card says?” I asked again. The counselor spoke again, this time more slowly. “No, we must show them [the patients] that we are reading it. They want us to read it. Otherwise they’ll think that we don’t care.” The counselor equated the practice of “(mis)reading” the medical card as a practice of care, directed not toward enhancing his own knowledge of the patient’s history

but toward improving the patient's perception of the encounter by changing its aesthetic form. In other words, listeners diluted their own counseling techniques in favor of a biomedical performance they felt patients would prefer. This move resonates with Michael Nunley's insight that mental health experts in India feel a greater need than experts elsewhere to satisfy client expectations, particularly because of the general lack of recognition of mental health care vis-à-vis more established biomedical practices.²³² At the same time, my research also updates some of Nunley's findings, particularly in showing how the dovetailing of client expectations and practitioner practices have cemented a particular form of biomedicine in South Asia: one that is deeply material, enacted through receiving biomedical treatments, rather than through Cognitive Behavioral Therapy (CBT), for example, which stresses a person's ability to modify his or her own behavior.

In the counseling sessions I observed with the clinical psychologist, Dr. Huda, at the hospital, for example, she would often draw out what she called the "logic of CBT" for her patients, particularly those who were less educated. While the drawing was meant as a communicative aid, it exemplifies some of the communicative difficulties experienced by professionals such as Huda in navigating between English and Urdu/Kashmiri concepts:

²³² Nunley 1996.

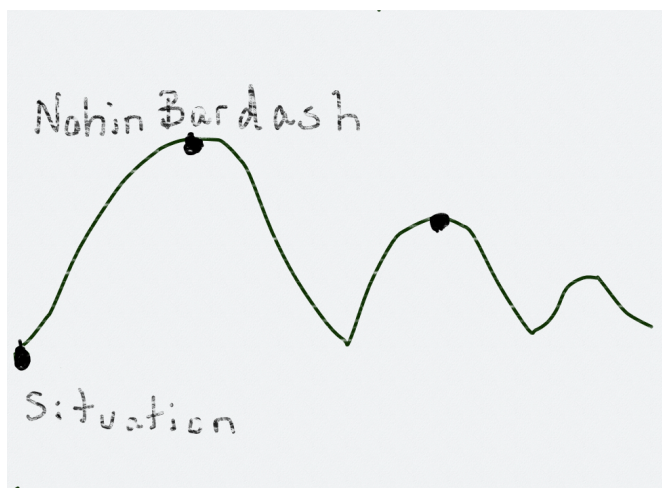


Figure 3: *Nahin bardash*

Huda's drawing of the CBT model to a patient suffering from OCD.

Nahin bardash is an Urdu phrase which means unable to tolerate.

In the drawing, the upward curves represent the “irrational” [Eng.] urges felt by a patient suffering from OCD, for instance, the desire to wash hands repeatedly. The desire, Huda explained, keeps rising until it reaches a point of intolerability (*nahin bardash*). However, through practicing restraint—that is, if the person did not give into the “irrational” desire to wash—the urge would gradually dissipate. The curves in the drawing get smaller to represent the fact that every time a person is able to withhold the urge to wash, the strength of the desire is itself reduced. While I could not assess the efficacy of the drawing as a teaching tool in Huda's sessions with patients, the language used, particularly the combination of English and Urdu (“situation” and “*nahin bardash*”) suggested that it was best suited for middle-class patients, who were familiar with both teaching aids such as graphs and charts, as well as the seamless combination of English and Urdu.

Treatment Potentialities

How did psychosocial workers come to produce a form of psychosocial care that was paradoxically medicalized? This process was neither entirely spontaneous nor planned, based on my observations of the group sessions I

observed. Nonetheless, there was an undeniable tug towards technical, biomedical practices that the listeners seemed drawn to, despite receiving advice to the contrary.

To better illustrate the dramaturgical aspects of this meeting, I provide an excerpt from my field notes. The two supervisors of Kashmir Life Line mentioned are Dr. Arif Khan, a doctor of Unani medicine, and Christine Huettinger, a Swiss psychotherapist who has been living in Kashmir for the past eight years.

The Kashmir Life Line and Health Center is located in an upper-middle class, residential neighborhood in Srinagar. The doors of the house are painted red and the walls are powder blue. I can still smell the paint, the whiff of newness. Dr. Arif, one of the supervisors of Kashmir Life Line, receives me at the door and we go upstairs to a room where I find Christine and the listeners sitting in red plastic chairs arranged in a circle. Dr. Arif tells me that the listeners are in the process of making their case presentations of patients they saw the previous week. All the presentations are in English.

The first speaker, Nafisa, begins her presentation in a loud and clear voice. She says that she will discuss “MDD” [major depressive disorder]. She lists a range of symptoms associated with MDD—decreased motor activity, lack of modulation in voice, suicidal thoughts, and decreased appetite. These she divides into two categories, the “affective” and “physical.” In the “affective,” she lists pessimism, self criticism, and worthlessness, amongst other examples. In “physical” symptoms, she lists loss of pleasure, crying, and indecisiveness. She ends the presentation by saying that for severe depression, the appropriate intervention consists of medication and CBT. The next presentation, which is about drug addiction, follows a similar format. The listener uses “affective” and “physical” symptoms to structure her presentation. She also ends by offering CBT as the appropriate intervention. Both presentations sound like they are straight out of a psychology textbook.

After the presentations, everyone claps. Dr. Arif opens the floor up for questions. Christine, the other supervisor and a trained psychotherapist, begins. “Both of you mentioned CBT in your presentations. What is CBT?” she asks the whole group. One of the male listeners answers, “Cognitive Behavioral therapy?” “Yes, that’s right,” Christine says. “And how do you use CBT?”

The listeners are silent and some of them respectfully lower their gazes,

blushing. No one responds. Christine continues, making her tone more gentle, "Both of you said CBT. We don't have to just say CBT. There are lots of other therapies and methods we can use. Remember the woman who we saw at the hospital [the woman with the MDD diagnosis]? Remember the expression on her face when we spoke about her deceased husband? She smiled and remembered him fondly. We can use that memory positively to get her out of this state. We don't always have to go for the most technical treatment."

At this point, Dr. Arif interjects. "So, no one knows the different steps of CBT?" he asks. "Go and read up on it tonight." He turns to Christine and me with a look that says, "Problem solved." ²³³

This somewhat uncomfortable friction of knowledges was striking for several reasons. For one, it demonstrated the ways in which psychosocial workers in Kashmir navigated psychosocial and medical knowledge in ways that were quite different from someone like Christine, who embodied aspects of Kashmiri-ness that the counselors were themselves unfamiliar with. Since her marriage to a Kashmiri eight years earlier, Christine had been living in a remote village in Kashmir. She had gained fluency in Kashmiri, learned how to work in the fields and take care of a rural household, and had also mastered the nuances of a feminine Kashmiri *habitus*, such as tucking her scarf over her forehead and behind her ears. Given her mastery of these subtle feminine manners, the first time I had seen her, I had thought that she was Kashmiri—since her light skin tone and eyes did not necessarily disqualify her. It was only once she began speaking English that her German-tinged accent gave her away.

Christine felt more Kashmiri than the counselors, the majority of whom were from urban, middle class backgrounds and had been educated in English-medium schools. She joked that they could not understand her Kashmiri because it was "too colloquial" and "rustic." In private conversations, Christine

²³³ Field notes, June 6, 2011.

also expressed her worry that the counselors were being drawn into medical idioms, despite her best efforts to point them to simple, psychosocial techniques, such as empathetic listening. She was protective of the Kashmiri life that she knew and experienced, while also being aware of the class and geographic gulf between her and the counselors. In other words, her imagination of the particular was fundamentally different from how the counselors understood 'Kashmiri culture.'

Meanwhile, the counselors and Dr. Arif seemed surprised by Christine's contestation of CBT as an appropriate therapy for cases of depression. What was more recognizable and appealing to them was to acquire—rather than avoid—specialized biomedical and psychological knowledge. As Pigg has similarly described in the case of Nepalese HIV / AIDS workers who seemed to cling on to arcane scientific facts about the virus, scientific knowledge is the “magnetic north toward which all compasses are now compelled to point, no matter which forests of meaning people may be dwelling in.”²³⁴ There was pleasure to be had in the pursuit of esoteric, scientific knowledge; for listeners this came in the form of CBT.

At the time of my fieldwork, there were only two clinical psychologists in Kashmir trained to administer CBT, one of whom was Dr. Huda. CBT had cache power, and the listeners expressed their desire to possess it. Although this desire was in line with global trends in psychosocial care, in which CBT has emerged as the “therapy of choice” for a number of mental illnesses, including depression, eating disorders, and OCD,²³⁵ I argue that this was also in line with “local”

²³⁴ Pigg 2001: 510.

²³⁵ Holmes 2002: 288. However, some practitioners have argued that the popularity of CBT

demands for technical, biomedical treatment. In this sense, in encouraging the counselors to “go read up” on CBT, Dr. Arif was arguing that psychological or psychiatric knowledge should not be confined to particular individuals but, rather, should be shared. From this perspective, learning CBT would make them better counselors, just as learning symptomatology from their U.S. psychology textbook would help them understand the workings of Major Depressive Disorder (MDD).

Nonetheless, my observations of counselors in the clinic did not necessarily suggest that the familiarization with technical terms or therapies made listeners more patient or empathetic. Rather, it seemed to have the opposite effect. As counselors became more conversant in the technical, English-language of their textbooks, the desire and ability to translate those concepts into Kashmiri or Urdu were less appealing. In other words, as they continued to perform biomedical authority in a way that their clients would recognize, the more they desired biomedical languages and techniques, not psychosocial ones.

Counselors were not alone in their negotiations of intimate and ‘outside’ knowledge. In describing the epistemological transformations necessary to make psychosocial care land in Kashmir, I also tried to show how national staff play an increasingly important role in the making of humanitarian and biomedical knowledge. However, entry into this technical language not only structured relations with clients, but also the ways in which psychosocial workers understood their own ailments. For Kashmiri counselors, exposure to the psychiatric or psychological models of disease and treatment were just as

should not be mistaken for its higher effectiveness vis-à-vis other therapies but, rather, because of its more successful “manualization” as compared to other psychotherapies (Holmes 2002:288).

transformative as an anatomy class is for medical students.²³⁶ In Kashmir, the biomedical model is the language through which counselors not only understand their clients, but the way that they relate to their own bodies and ill health. I take an example from my field notes:

One of the listeners, Noor and I shared a ride to Kangan [District Hospital] in a "Sumo," a communal SUV-taxi service. We arrived at the hospital at 9:30 am, and I am surprised when Noor stopped at a corner shop near the bus station to buy a large packet of Lays Sour Cream and Onion potato chips. During the first two hours, no one came to the counseling room—so we had an opportunity to chat.

Sensing a slow morning, at 10 am, Noor rolled her eyes, which she had artfully painted with thick black eyeliner and tore open the packet of chips. "I'm so hungry," she said. "I shouldn't be eating these" Thinking that she was referring to junk food, I agreed, "These chips are really addictive." Noor shook her head and said that she has "stomach problems." She described her long history of stomach ailments and said she has seen many doctors. Finally, she visited the most famous gastroenterologist in Kashmir, who told her that her problems were related to acidity caused by junk food. He encouraged her to change her diet.

"I used to be a lot worse," Noor continued, "I would eat oily samosas off the roadside. But now I only eat one packet of chips per week when I come to the hospital." (From Noor's mischievous smile, it seemed that this was a slight understatement.)

Although she had visited the best specialist, Noor wasn't totally convinced by the gastroenterologist's explanation that her stomach problems were simply reducible to acidity. She said that although she has been taking the medication he's prescribed her—and somewhat altered her diet—she doesn't feel healthy. "I still don't feel totally okay." I asked her what would convince her that she was okay, and she said, her eyes brightening, "What I really want is an endoscopy. Not just any endoscopy, but a digital endoscopy. Then I will really know if I am sick or not." As our conversation continued, Noor laughed and said, "I don't know what's wrong with me. I have this feeling like I'm dying or something—that there is a cancer growing inside me—or that I am really, really sick for some reason. I don't know why!"²³⁷

²³⁶ Good 1994.

²³⁷ Field notes, July 24, 2011.

Like Imran, with whom I began this chapter, Noor expressed her desire for health and wellbeing through the language and technology of biomedicine. A digital endoscopy, which she believed would reveal the truth of her illness, was a technology not yet available in Kashmir; she would have to travel to New Delhi to avail herself of it. I read Noor's appeal to an expensive, out of reach technology—rather than the gastroenterologist's suggestion to change her dietary habits—as part of a local medical ontology, which both psychosocial workers and patients draw on. In particular, this ontology was defined by the sense that medical science was not “outside” of the environment in which it was practiced but, rather, deeply influenced by it. For Noor, for example, a digital endoscopy was appealing precisely because it existed outside of Kashmir, and thus was not likely to be contaminated by the ongoing climate of sociopolitical uncertainty and violence.²³⁸

Those Kashmiris with the financial wherewithal increasingly travel to New Delhi or other metropolitan areas to achieve a purer context for care—and by extension, a better—treatment. Many use tertiary care centers (called Super Specialty Hospitals) for even routine check-ups, despite the fact that the cost of treatment is prohibitively high in these private centers. Although this pattern of behavior is likely to be found in other parts of the global South, my interlocutors always reminded me that the need to seek treatment elsewhere was because of immediate concerns that it was impossible to be healthy in Kashmir. I understand this logic as a “net” of medicalization that encloses Kashmir in illness.

²³⁸ Hamdy 2008.

In the following section, I describe how questions of Kashmir and the ‘outside’ were also central to negotiations between psychiatrists.

Making PTSD

While some Kashmiri psychiatrists—as Kashmiris in general—held outsiders in a gaze of suspicion, many had also gained a degree of celebrity in an era of medical humanitarianism. Organizations including Save the Children, Action Aid, the ICRC, and MSF, frequently called upon local psychiatrists to work as consultants on projects and train psychosocial workers. In 2010, Dr. Arshad traveled to international psychiatric conferences in Lisbon and Kobe, where he had won a prestigious award for his research on PTSD in Kashmir. While such travel was not unusual for Kashmiri businessmen, it also impressive for someone like Dr. Arshad, who would have been subject to a cumbersome regime of bureaucratic passport control.

However, while psychiatrists publicly instrumentalized trauma and PTSD, behind closed doors, the concept remained controversial. One of the critiques presented to me by psychiatrists themselves was that the diagnosis of PTSD said more about the person wielding the tool than for those for whom it was supposedly being wielded. This was remarkably similar to critiques that anthropologists have made about humanitarianism, that it “indicates more about the moral sentiment of the witness than about the experience of the victim.”²³⁹ Put another way, while the global mobility and celebrity that the diagnosis of PTSD offered to psychiatrists was undeniable—“PTSD is our bread and butter, “Dr. Arshad once said to me—its deployment was not viewed as apolitical. As

²³⁹ Fassin 2011: 204. Nicolas Guillhot (2012: 94) also questions whether this problem may well be common to all historical interpretation.

such, I argue that attention to the micro-politics of PTSD and its attending therapies, and not just its deployment as a clinical diagnosis, reveal deep ethical, intellectual, and generational differences between psychiatrists. It also reveals the ways in which a humanitarian sensibility has become a necessary component of the self-presentation of Kashmiri psychiatrists.

While anthropologists of trauma and humanitarianism have provided rich literature on the effects of the deployment of a diagnostic category like PTSD, we know less about the intricate micro-politics involved between experts as, or before, the clinical definition becomes a tool. One of the questions that motivates me here is: what is at stake in the transformation of PTSD as a tool of practice?

Some scholars have pointed to the fact that the globalization of PTSD depends upon its successful appropriation into local political agendas,²⁴⁰ however, I am interested in how Kashmir and its 'outside' are implicated in these discussions. Finally, these debates center on questions of cultural appropriateness, and so doing, challenge conventional anthropological critiques of humanitarian knowledge. For example, questions of what to adopt from *bahar* or "outside" Kashmir appeared frequently in discussions about knowledge and therapies around trauma, as well as in the everyday frictions between the hospital psychiatrists and MSF staff. As such, like the environmental consultants that Tim Choy worked with, questions of local appropriateness of particular technologies were often already folded into discussions around the politics of expertise.

²⁴⁰ Breslau 2000.

One chilly morning in December 2009, I arrived at the Government Psychiatric Diseases hospital to attend a lecture that was to be given by a visiting psychiatrist, Dr. Zaffar Ali. Dr. Zaffar, a Kashmiri psychiatrist, had been trained at the Psychiatric Diseases hospital in the 1990s, but had immigrated to the US where he now worked as the Director of Inpatient Psychiatry at the Department of Veterans Affairs in the Bronx. All the hospital's psychiatrists were present and had arranged themselves appropriate to their rank in the office of the current Head of the Department (HOD), Dr. Mushtaq Margoob. The post-graduate students sat shoulder-to-shoulder on couches near the far wall, the female staff sat at the front of the room and giggled on cue when Dr. Margoob made a joke, and the senior-most staff sat closest to the gas heaters. I made my way through the crowded room and sat next to Dr. Huda, the clinical psychologist who also happened to be Dr. Margoob's daughter.

Dr. Zaffar was clean shaven and wore an olive green North Face fleece. His lecture was on the uses of exposure therapy in cases of PTSD, which he delivered in perfect English, with a slight American accent. He explained that exposure therapy was the opposite of cognitive behavioral therapy (CBT), the latter's aim being to "*prevent a response [to a stressor].*" In contrast, in exposure therapy, the patient was exposed to the traumatic stressor over and over again, in order to change their response to the stimuli. The aim was to address one of the main symptoms of PTSD: an increased arousal to (and avoidance of) stimuli recalling the traumatic event. "You have to continually train the brain to accept this memory as normal," Dr. Zaffar explained. "The aim is to prevent a response that is maladaptive to one that is more normal... in other words, to reintegrate the act into memory." Dr. Zaffar cautioned that exposure therapy was extremely

risky and that it may only be appropriate for thirty to forty per cent of PTSD patients. However, he said that he had successfully used exposure therapy to treat US war veterans who experienced an intense fear of subway trains in New York by encouraging them to ride the trains during the day, when the cars were less crowded.

After Dr. Zaffar's lecture, some of the senior psychiatrists spoke. To my surprise – since I had not heard many psychiatrists question the authority of those more senior to them – their tone was questioning. Dr. Wani, a consultant-level psychiatrist interjected first: "You have to consider the particular context of Kashmir, and in the case of chronic traumas, exposure therapy can be contra-indicative." Another asked: "If we have a PTSD patient, can we take them to a family member's grave for exposure therapy?" Before Dr. Zaffar could respond, another snorted, "This is what the faith healers are already doing!" Given the derogatory ways that psychiatrists spoke of faith healers – many said openly that they thought faith healers perpetuated, rather than abetted people's mental distress – this was a particularly harsh comment.

The general consensus among the senior psychiatrists seemed to be that exposure therapy could not be adopted in Kashmir. The younger psychiatrists sat quietly, imbibing the knowledge of the elders. Dr. Margoob, who had convened the lecture, interrupted and said that, on the other hand, they could not afford to reject all knowledge that came from outside. Rather, the question was, as he put it, "how to translate between the ivory tower and the OPD." This juxtaposition was striking: the "ivory tower" was the place where cutting-edge therapies and theories originated, whereas the "OPD" was marked as the ground where these theories were enacted, the gritty and more real 'local.' On a broader

level, the “ivory tower” also marked that which was “outside” Kashmir, whereas the “OPD” became a shorthand for Kashmir. The discussion had moved away from being Dr. Zaffar’s lecture about a specific therapy for PTSD to a generalized debate about the circulation of biomedical and psychiatric knowledge and whether or not this circulation needed to be controlled in particular ways.

Later, over cups of hot, milky tea in the hospital canteen, Dr. Arshad, Dr. Zaffar and I sat together in a booth, and continued the conversation about the politics of knowledge around PTSD. I knew that Dr. Arshad and Dr. Zaffar were close, as Dr. Arshad had told me how Dr. Zaffar had mentored him in his early days as an intern at the hospital. I asked Dr. Zaffar about the reported epidemic of PTSD in Kashmir. He began outlining a history of PTSD as it related to Vietnam War veterans in the US and said that the recognition of psychological suffering in the form of PTSD was an important step forward for “humanity.” However, he also pointed out that important differences had emerged in the literature between civilian and combat PTSD: “Combat PTSD has been shown to be a severe illness, producing high levels of irritability amongst sufferers. In the US military, we have seen that the biggest risk takers are usually those most prone to developing PTSD. This has come to be known as a ‘trauma personality,’” he explained. However, in civilians, PTSD was being looked at quite differently. “With civilians, what is often emphasized is the role of culture. Earlier in Kashmir, people said that there would not be PTSD because of the intense religiosity of the population. But several standardized assessments have shown that PTSD is an epidemic here,” he said, confirming the epidemiological studies that Kashmiri psychiatrists and organizations such as MSF had conducted.

At this point, Dr. Arshad corrected him: “But Kashmiris who develop PTSD tend to do better than those who develop PTSD elsewhere.” When I asked why, Dr. Arshad said that there were probably three reasons. “One reason is social and family support – which is tremendous. Second, those who develop mild PTSD will probably never seek treatment. Thirdly, people are able to give meaning to the trauma,” he said. “Give meaning?” I asked. “What do you mean by that?” Dr. Arshad answered, “The sufferer thinks of him or herself as belonging to a larger society. There is a sense of identification with others who have been traumatized. There is solidarity among victims.” This solidarity came from the intertwining of a biomedical and political narrative in Kashmir, which largely absolved victims of both responsibility and agency and instead situated them as being caught within a confluence of malignant forces.

Dr. Arshad then turned to Dr. Zaffar and said that he would like to use the families of disappeared persons²⁴¹ as a sample group of those suffering from “complicated grief.”²⁴² He said he wanted to develop a psychopathology scale to assess symptoms that might be particular to this population in Kashmir. His intervention was striking because it went substantially beyond the interventions of the psychiatrists earlier. Rather than simply trying to particularize Dr. Zaffar’s supposedly universal knowledge (from the “ivory tower”), Dr. Arshad wanted to use a particular phenomenon – Kashmir’s families of disappeared persons – to

²⁴¹ According to the Association of Parents of Disappeared Persons (APDP), a Kashmiri NGO, approximately 7000 persons are thought disappeared from Indian-controlled Kashmir.

²⁴² As per psychiatric knowledge, “complicated grief” is a condition in which the symptoms of grief and loss may linger or become debilitating with time. Unresolved, protracted, complicated, or traumatic grief as it is called, includes features of both depression and PTSD. The most characteristic symptoms are intrusive thoughts and images of the deceased person and a painful yearning for his or her presence. Other complications are denial of the death, imagining that the dead person is alive, desperate loneliness and helplessness, anger and bitterness, and wanting to die.

generate a new, universal diagnostic category. This move is familiar to medical anthropologists, who have similarly attempted to empirically test the boundaries of “culture-bound” syndromes, for example.²⁴³

Put together, these moments also suggest that psychiatrists in Kashmir have crafted their practice to be distinct from the normative, American neuropsychiatric model of disorders found in their DSM manuals. Although they do not use the term “ethnopsychiatry” themselves, in the debate following Dr. Zaffar’s lecture, their words suggest an awareness of “psychiatry as a historical product, a culturally shaped *savoir-faire* among others.”²⁴⁴ However, given that Kashmiri psychiatrists were not explicitly drawing upon a tradition of ethnopsychiatry, it would be unfair to characterize them as practicing a variation or derivation of, a more normative, American psychiatry, simply because they invoked “culture” in their discussions. I do not want to imply that. Rather, drawing on the work of Cristiana Giordano, I suggest that, just as the ethnopsychiatric project in Italy is haunted by an ambivalence and based on an instrumentalization of ‘culture,’ this is also a characteristic of Kashmiri psychiatry. However, unlike the ethnopsychiatrists that Giordano worked with, I suggest that Dr. Arshad was able to glimpse the limits of processes of translation and instrumentalization of the culture of the ‘Other’ that are at the heart of the psychiatric endeavor.

While the psychiatrists’ rebuttal to Dr. Zaffar’s lecture was based on a sense of cultural appropriateness, in this instance, the ‘Other’ who was being implicated was not the patient, but the *pir* (“This is what faith healers are already

²⁴³ Sushrut Jadhav, a psychiatrist and medical anthropologist has undertaken a similar project using the *dhat* syndrome, an established South Asian culture specific neurosis. See Jadhav 2007.

²⁴⁴ Coppo 2005 in Giordano 2011: 236.

doing!”). In other words, the objection was not that exposure therapy was too foreign to Kashmir, but rather, that it did not offer psychiatrists *enough* of a distance from the practices of healers, with whom they were in competition. In other words, the problem was not so much about how to make exposure therapy more relevant or culturally grounded for Kashmiri patients, but rather, how to better distinguish psychiatrists from *pirs*.

As such, there were different stakes involved for psychiatrists in comparison to the counselors I discussed earlier in the chapter. While both counselors and psychiatrists were occupied with questions of legibility and cultural appropriateness, their response to this puzzle depended on their relation to biomedical knowledge. Counselors were keen to borrow biomedical practices in order to make their psychosocial work more familiar and recognizable, whereas for psychiatrists, there was a need to maintain a clear demarcation of boundaries between religious healers and psychiatrists. At least some of the ambivalence that psychiatrists experienced towards knowledge from the “ivory tower” was produced by the uneasy balance between Kashmir and the outside that had to be maintained. To fully embrace “cultural practices,” such as encouraging patients to visit the graves of deceased family members, would strip psychiatrist of their particular expertise. At the same time, theories that were too rooted in the “ivory tower” were also not useful either; the way that Kashmiri psychiatrists had to make use of these tools was fundamentally different from the way American psychiatrists like Dr. Zaffar were using them. Interestingly, while psychosocial workers evaluated knowledge on the basis of how their clients would receive it, psychiatrists evaluated knowledge based on how effectively they could instrumentalize it.

In fact, Dr. Zaffar's own career trajectory embodied some of the tensions between Kashmir and the outside that psychiatrists grappled with. Like the counselors I described earlier, whose relationship to technical, biomedical knowledge was incomplete, I suggest that for psychiatrists, a similar process was at work. Although Dr. Zaffar had clearly "made it" as a psychiatrist – he lived in the United States and worked for the US government, no less – that success had also distanced him from what psychiatrists interpreted as "the OPD," or Kashmir. For example, while Dr. Zaffar expected there to be an epidemic of PTSD in Kashmir because "several standardized assessments" had shown it to be so, Dr. Arshad qualified this assertion with a more ethnographic account of how Kashmiris were coping with their PTSD symptoms, emphasizing the role of the family and community and the fact that most Kashmiris who exhibited traumatic symptoms went undiagnosed. These qualifications prevented Dr. Zaffar's knowledge of US veterans from "landing" in Kashmir in a straightforward way.

Thus, while Kashmiri psychiatrists described PTSD as their "bread and butter," its deployment was much more controversial than what this mundane analogy implied. In addition to the circumspection around particular PTSD treatments, the local production of expertise around PTSD could also be viewed as an act of self promotion. One senior psychiatrist – who I will call Dr. X - was describing as having an "over-healthy ego" in regard to his work on PTSD. On several occasions, particularly when there was a foreign expert visiting the hospital, I, along with all the hospital's psychiatrists, was called on to witness Dr. X's work on PTSD. Deeply influenced by a humanitarian ethos, the video closely resembled the visual material and podcasts that organizations such as MSF

routinely produced to document and promote their work.²⁴⁵ Nonetheless, MSF's videos promoted their work through a "neutral," informative tone and tended to focus less on the acts of any individual doctor or practitioner and more on the activities of the team as a whole. What was surprising about Dr. X's video – aside from the fact that it was the handiwork of one particular psychiatrist – was its much more bombastic note.

The video began with text informing the audience that, in the winter of 2005, a village called Wartego in northwestern Kashmir had been devastated by an earthquake and severe snowstorms. The text faded to a summer scene, a few months after the disaster. Amid tall, green grasses and imposing mountains, images of children in tattered clothing, wrinkled and tanned men and women entered the frame. This juxtaposition of suffering Kashmiris against a beautiful landscape has become a stock image used in media and humanitarian publicity tools, the latest in a long history of symbolic appropriation that Ananya Kabir has documented.²⁴⁶

Suddenly, a white SUV appears and a narrator tells us that, "hope comes in the form of psychiatrists." Four or five psychiatrists get out of the SUV and make their way down a slope with big, confident strides. The narrator continues, "The human touch makes its presence felt in the shape of Dr. X." Next, we see Dr. X sitting on the grass in his pristine white coat, surrounded by a group of village children. "A heart-to-heart talk, a laugh – provides the inspiration to move on," the narrator continues. Next, the camera pans to wide-angled shots of the entire village. Notebooks and medication surround the two other

²⁴⁵ See for ex. http://www.youtube.com/watch?v=pb97_Tar--4.

²⁴⁶ Kabir 2009: 5.

psychiatrists, who are also wearing crisp white coats. This scene of humanitarian healing then fades to a flashback of a desolate winter scene of the same village in the immediate aftermath of the snowstorm. The psychiatrists are here again, but this time, more warmly clad. One of the psychiatrists promises a small child that he will bring him socks and warm undershirts the next time. Doctors distribute blankets and food to the villagers. The narrator chimes in: “Just a little satisfaction, but the journey continues...”

During the times I watched this video, Dr. X usually followed it with another, which took on the question of PTSD more explicitly. The second video, which employed the same narrator, began with a question: “Are the psychological experiences of disaster universal?” After a brief pause, the narrator responded: “PTSD is one of the most common aftermaths of experiencing trauma or disaster.” The video briefly showed the toll of recent disasters in South Asia, including the 2004 Indian Ocean tsunami and earthquake, as well as the 2001 Gujarat earthquake in which approximately 20,000 people lost their lives. Then it focused on Kashmir, which “has suffered fifteen years of conflict” as well as a devastating earthquake and snowstorms in 2005.

The next part was more difficult to watch. The image showed the Psychiatric Diseases hospital, which was presented as an epicenter of treatment on PTSD. First, we see a young girl – perhaps nine years old – who, we are told, has lost her entire family in the earthquake. She is quiet, withdrawn, her head bowed down. In the background, we hear a doctor’s voice – Dr. X – gently addressing her as “*beti*” (daughter), coaxing her to answer questions about her age, where she is from. She does not respond. After this scene, we are shown

another patient, a man in his twenties, with dark under-eye circles and eyes red from crying. Again, the practitioner is not visible, only the patient, who begs the doctor to give him *some* medication – sleeping pills or something. He pleads continuously to be given something. The scene continues for some time, with the young man openly expressing his anger towards the doctors for not alleviating his pain. We are lead to question his sanity, as well as his innocence as he veers towards a violent outburst. His outburst is cut short by the narrator who informs us that, “PTSD is not a culture-bound syndrome of the West. It affects us all.”

Despite my feelings about discomfort about the videos, I chose not to bring the subject up with any of the other psychiatrists, unsure of how they would react since Dr. X was, by now, very senior in the hospital hierarchy. The cracks appeared only months later. Out of the blue, chatting after an OPD session, one of the consultant level psychiatrists asked me whether I had seen Dr. X’s videos and what I thought of them. I responded with trepidation that I had been quite surprised by them. The doctor nodded solemnly and said that he found them to be a joke. At another time, one of the psychologists I worked with spoke at length about Dr. X: “Some people have become very rich thanks to this PTSD thing. How is it that Dr. X drives a car worth seven lakh rupees, while the rest of us are driving cars worth two or three lakhs?”

How do we make sense of the intense debates surrounding the applicability of exposure therapy and the knowledge of an American-based psychiatrist, on the one hand, and the blatant promotion of Kashmiri psychiatry around a shared concern with PTSD, on the other? I argue that both these processes constitute the uneven ways PTSD is approached as an object of intervention in Kashmiri psychiatry. In the first debate after Dr. Zaffar’s lecture,

the attempt was to keep psychiatry removed from other practices of healing, while the latter case, the example of Dr. X's videos, were attempts to claim humanitarian psychiatry *as* a Kashmiri practice. As such, these efforts were attempts to keep "Kashmiri psychiatry" at the right proximity from both "Kashmir" and the "outside." They revealed the precariousness of the boundaries between "western science" (the ivory tower) and the "OPD," given that these boundaries had to be continuously negotiated and renegotiated on an everyday basis. The use of videos as a technique borrowed from international humanitarianism was thus an instance of psychiatric expertise instrumentalizing knowledge in a way that emphasized the universality of Kashmir. At the same time, they also reveal the ways in which expertise required a parsing out of the ways in which these tools were being instrumentalized: to what extent they served a particular individual and to what extent were they beneficial to Kashmiri psychiatry as a whole (i.e. its need to separate itself out from other healing practices).

Conclusion: Beyond a critique of expertise

While experts, from canoe makers to scientists, have been the backbone of anthropological knowledge production, anthropologists have generally been critical, or at least ambivalent, towards experts and the effects of their work.²⁴⁷ In his study of pandemic planning, for example, Andrew Lakoff argues that the historical switch from population security to "vitals systems security" – a transformation of an object of expertise, in other words – had dramatic effects in

²⁴⁷ Carr 2011; Espeland and Vannebo 2007; Lakoff 2008; Mitchell 2002.

how catastrophes are defined and understood.²⁴⁸ Similarly, Tim Mitchell has argued that the expertise of modern engineering, technology and economics produced gaps between the ‘modern’ and the ‘traditional,’ the ‘scientists’ and the ‘peasant,’ in which experts could then intervene.²⁴⁹ Though recent anthropological work on expertise has attempted to go beyond such critiques, a deep ambivalence towards experts and technocrats is still embedded within this “new” anthropology. This seems evident in the disproportionate attention given to “illicit” discourses and “tacit” knowledges *within* contexts of bureaucratic or modern expertise, re-producing the anthropologist in the role of archaeologist, excavating hidden knowledge.²⁵⁰ Similarly, within medical anthropology, Byron Good has argued that the “soteriological” is present in medical practice as an “irruption into awareness” or when it “cause[s] a *breakdown* in routinized practice [my emphasis].”²⁵¹ As he describes, moments of soteriological irruption become illicit in the life of medical residents, given that their performance of expertise requires a “take charge, deep voice” attitude.²⁵²

While these are important steps towards refiguring an account of expertise, I seek to push this literature further by attending to the ways in which expert ambivalence towards their own tools is constitutive of their subject positions.²⁵³ More specifically, I suggest that questions over the

²⁴⁸ Lakoff 2008: 422.

²⁴⁹ Mitchell 2002: 15.

²⁵⁰ For Doug Holmes and George Marcus, for example, “illicit discourses” consist of those practices – such as anecdotes, hype, and intuition – which are “repressed, subordinated, and considered slightly illicit” in the work of European central bankers (Holmes and Marcus 2005: 237).

²⁵¹ Good 1994: 80.

²⁵² Good 1994: 85.

²⁵³ Cf. Miyazaki 2007. Miyazaki argues that the ambivalence exhibited by Japanese arbitrageurs towards the category of arbitrage is a marker of their particular epistemological stance, identity, and ethical commitment.

instrumentalization of the tools of psychiatry and psychology, as they produce Kashmir and the 'outside,' are critical to the project of humanitarianism in Kashmir.

This ambivalence is hidden from view when anthropology focuses on the ends, and not the means, of expert knowledge, for instance, on the diagnosing of PTSD rather than the debates the lead up to its ontological production beyond a clinical use. As Akhil Gupta has argued in the case of development camps in India, "one should not confuse the spectacle of disciplinary power with its operation."²⁵⁴ As Gupta notes, the camp may be a model of disciplinary rationality, but its production is highly contingent on uncertain procedures of planning and implementation, communication or lack thereof across hierarchies, and the rule-following behavior of particular officials. I draw inspiration from his analysis and bring into focus those negotiations of knowledge and place not normally elaborated in either anthropological or humanitarian accounts.

While both humanitarian and anthropological knowledge often reduces psychosocial workers as the "conduits" through which local cultures are accessed, this perspective obscures the ways in which this knowledge acts upon and transforms psychosocial workers. This is significant because many anthropological critiques of humanitarianism rest on an assumption that "victims" of violence or the putative "benefactors" of such interventions are primarily affected, while experts are already fully made. My research suggests that humanitarian knowledge and practices, particularly psychosocial care, undergoes dramatic transformations from its articulation in the manuals of

²⁵⁴ Gupta 2012: 13.

humanitarian practice to its operationalization in everyday clinical work. As I have shown, the very fundamentals of psychosocial work – such as avoiding diagnosis and empathizing through eye contact and verbal cues – are upended in the Kashmiri context. Nonetheless, this is not to say that psychosocial workers willingly take on these compromises. I suggest that there is an enduring cost of encountering biomedical and humanitarian knowledge for Kashmiri psychosocial workers: it distances them from those they purport to treat.

On my last visit to the hospital, in June 2011, I went to say goodbye to Dr. Arshad. As usual, he greeted me warmly and we chatted about a possible future collaboration. During our earlier visits, we had brainstormed the idea of co-authoring a piece on “local idioms of distress” and how ghost stories in Kashmir had been replaced by stories of real fear once the Indian army had penetrated Kashmiri villages. Unlike the vast majority of psychiatrists in Kashmir and India, Dr. Arshad had grown up in a village in Anantnag district, and thus was familiar with the ghost stories that used to be told in his childhood, but which had now largely disappeared. Here, ghost stories appeared as distinct from videos in terms of the way in which psychiatric expertise was instrumentalized to understand this phenomenon: it was another instance where Dr. Arshad was keen to raise the status of ‘Kashmiri’ knowledge.

He told me how he was particularly concerned that many of the Kashmiri postgraduate psychiatry students did not have enough of a grasp of Kashmiri culture or village life to understand the nuances in the language used by patients, most of whom were from rural backgrounds. During our final conversation, Dr. Arshad was more candid than ever. He expressed his growing ambivalence

towards his discipline, an ambivalence which I felt was partly an outgrowth of joint ethnographic and psychiatric labor of forced self reflection. Although I had heard him offer an optimistic future scenario for psychiatry in Kashmir to younger staff and interns, he described a much bleaker picture to me, where the possibility of communicating with patients would no longer be possible: “As doctors, you can ignore the pain someone experiences in their heart, but not the pain in their soul. We’re so obsessed with objective science, with doing EEGs and other tests, that we’ve forgotten that this is not the patient’s perspective. We don’t look at distress from the patient’s angle.”

He told me that he felt that cultural approaches had been sidelined in psychiatry. Even postgraduates were alienated from Kashmiri culture and had to be “taught what to look at.” It was not obvious to them. At the end of our conversation, Dr. Arshad said, “I have been involved in the mainstreaming and the normalizing of psychiatry in Kashmir, but now I wonder, is it doing any good? *Am I doing any good?*” While earlier Dr. Arshad had emphasized a *better* instrumentalization of Kashmiri culture, here was a moment where he questioned his discipline as a whole. Familiar to the anthropologist, it was a moment of disciplinary crisis and perhaps, an engine for growth in a new direction.

While conducting fieldwork, it was difficult to gain a perspective on biomedicine since it seemed to operate as a “net” to ensnare Kashmiris. Both mental health practitioners and patients were deeply invested in biomedical techniques and cures, and these notions made their way clearly into everyday

psychosocial practices. As I have argued, the effect of such “vernacularization” was paradoxical: although it helped psychosocial interventions “land” in Kashmir—to be somewhat recognized as legitimate—the vernacularization also diluted the mission of many of these organizations, which was to provide a viable alternative to pharmacological, state models of mental health care. As such, psychosocial counselors struggled to gain recognition for psychotherapy and counseling in a context where pharmaceutical pills (*davai*) rather than talk was the desired treatment.

I eventually found a small section of people in Kashmir who had recently turned away from biomedicine to Unani.⁹ Many described having “maximized” their relationship with biomedical practitioners and had experienced serious side effects from pharmaceuticals. I asked one user of Unani medicine—45-year-old Bashir Ahmed—to explain why many Kashmiris felt that they could not get well in Kashmir. He responded:

Even people with minor heart and kidney problems routinely go to Delhi. Don't we have an Institute [a Super Specialty Hospital] here? Why do they go to Delhi? Because they don't get better here. Tensions are high, so illnesses are also high. A mother whose son might be out of the house is worried that he might be caught in cross firing, so naturally she is tense and then becomes weak [*kamzor*]. After militancy, we have more illnesses.²⁵⁵

In their statements, both Noor, the psychosocial worker I described earlier in the chapter and Bashir pointed to a sense that it was impossible to be healthy in Kashmir. As Noor stated, “I have this feeling like I'm dying or something—that there is a cancer growing inside me—or that I am really, really sick for some reason. I don't know why!” Noor's humorous tone indicated that she identified the problem as partially in her mind—“I have this feeling” and, thus, following

²⁵⁵ Field notes, May 7, 2010.

the logic of cognitive behavioral therapy, as something she could rectify. Yet both these statements also clearly posited links between Kashmir's violence and chronic or intractable illnesses.

This chapter has attempted to chart key ways in which counselors in Kashmir take up, borrow, or emulate, the practices and language of medicine, specifically psychiatry. Rather than see medicalization or humanitarianism as a top-down processes, I argue that, in Kashmir, counselors play crucial roles as “gatekeepers”²⁵⁶ in mediating between psychosocial discourses and practices, on the one hand, and Kashmiri patients, on the other hand. Patients and psychosocial counselors share an understanding of biomedical treatments as superior to talk therapy, and find forms of medical expertise more credible than psychosocial ones. Although this subverts normative critiques of humanitarianism—that it is not locally grounded or specific—it raises new questions for the future of psychosocial or humanitarian action in Kashmir and elsewhere. In particular, to what extent should psychosocial organizations adapt themselves to local contexts? What are the long-term effects of such entanglements between psychosocial and medical models of care?

In Kashmir, doctors frequently complained that pharmaceuticals have too much power in this context, such that even doctors are at their mercy. Given this influence, rather than impose an unrecognizable form of care on patients in Kashmir—such as counseling—counselors take on the practices of psychiatrists as a form of “ethical action.” Although psychosocial programs are increasingly designed to be locally and culturally sensitive,²⁵⁷ in places like Kashmir, they

²⁵⁶ Ticktin 2006.

²⁵⁷ IASC 2007.

must be medicalized to be rendered legitimate in the eyes of the public. However, in Kashmir, the blending of the medical and psychosocial models of care is neither entirely accidental nor entirely designed; it is borne of individual practices and acts that attempt to respond to a powerful local ontology of medical care and illness. As a result, the medical model of care is sometimes gifted, other times smuggled in, and at still other times, downright demanded.

In the next chapter, I begin Part II of the dissertation, which focuses on objects that mediate between the space of the clinic and the world outside: medical cards and pills. I focus on medical cards and the ways in which they relate to both patient and expert subjectivities. As objects, medical cards are highly visible in the psychiatric domain, yet here I try to show how they both reveal and conceal aspects of relations between doctors and patients in unexpected ways. Since they move in and out of bureaucratic settings, I suggest that medical cards offer unique orderings of relations that are otherwise not possible with documents that remain within official contexts.

CHAPTER 3: UNRULY RELATIONS, PAPER TRAILS

Prelude

A clinical scene: Patients and their kin mill about in clusters; male doctors, distinguished by their Western clothing and white coats, sit side by side on a long table. The soundtrack of the OPD includes the din of multiple conversations, the door periodically creaking open and being slammed shut by an alert gatekeeper as new patients poured in and those already seen trudged out; and occasional spillovers of tension, an angry, loud voice, usually a patient. From the outside, patients and kin peer in from the crack in the door, waiting their turn. From 10 am – 3 pm, on what Kashmiris called a “normal” day, that is, a day marked by the absence of strikes of curfews, between eighty and 150 patients go through this routine. For the doctors inside, the minutes fly by; for many of the patients outside, the hospital visit is an expedition that can cost an entire day’s house or agricultural labor.

Papers are everywhere in the OPD. A stack of medical cards determines the order of patients inside. Doctors try to honor the order of the stack, but sometimes cards get moved around, creating confusion. Underneath all these papers are more paper: pamphlets, cardboard cutouts, and calendars gifted by pharmaceutical representatives. In addition to the medical cards, there are prescription slips, known as receipts (*parchis*)²⁵⁸ strewn about, waiting to be filled and then carried to the hospital’s pharmacy. To write a prescription is called “cutting a receipt” (*parchi katna*). Here, writing is a form of cutting. Cutting, like writing, is an action, not a substitute for action.²⁵⁹ The language of cutting is

²⁵⁸ Perhaps from the Sanskrit word, *paricaya*, which also means to acknowledge.

²⁵⁹ Gupta 2012: 36.

useful here in thinking about the ways in which patients are separated out from his or her medical card, to the point where the card and patient are ontologically distinct entities, not necessarily in a referential relation.

When a patient's name is called by the doctor, s/he steps forward with kin, while the doctor picks up the card and reads through its contents. The time taken to read the card is sometimes the longest part of the doctor-patient interaction and may proceed without any verbal exchange, particularly when a patient is "known" (many patients came on the same day of the week so that the same doctor was on OPD duty). A prescription for medication is either written within the card or, if medicines are to be collected from the hospital's pharmacy, the prescription is written on a separate slip of paper. In the case of new patients, doctors filled up the biographical details of the medical card first, then wait, with their pens poised, as the patient or kin respond to the question: "*Tuh¹ kai chu takleef* (What seems to be the difficulty)?" For doctors, the most desirable transactions were the ones where familiarity with the patient enabled the card to be treated handily.

Introduction

So far, this dissertation has focused on the making of mental health through the production of expert knowledges and bodies, including psychiatrists (chapter 1) and psychosocial workers (chapter 2). This chapter serves as a pivot between part I of the dissertation, on the making of expert subjects and part III, on everyday experiences of medicalization, psychiatric care, and violence. As medical cards are objects carried to and from the clinic to the world outside, they represent the 'threads' of the net, between the visible institutional nodes and less visible experiences. Chapters Three and Four are both concerned with the

materiality of biomedical and humanitarian care in Kashmir and build on recent work in medical anthropology which has shown the “manyfoldedness”²⁶⁰ of singular forms, such as medical cards. I suggest that the concept of “manyfoldedness” allows us to see the ways in which technologies of medicine diversely used, producing medicalization as a process that happens both within the clinic and outside it.

Rather than understand medical cards as emblems of the reach and authority of biomedicine,²⁶¹ however, I am interested in how medical documents rework relations between patients, kin, and experts. While a significant part of the anthropology of bureaucracy and medical anthropology has focused on how these technologies substitute or stand in for the agency of particular persons²⁶², I diverge from this literature in two ways. First, I show how medical cards circulate or multiply in ways that are different from other objects of bureaucratic authority, which are stored and often “stagnate”²⁶³ in offices, cupboards, or archives. Bureaucratic documents, including medical records, generally move within or between bureaucracies, but rarely have a life outside of their official contexts.

In most South Asian medical contexts, however, patients and kin possess their own medical cards, which are carried to and from clinics, homes, and laboratories. During my visits to patient’s homes, medical documents would usually be kept in a plastic bag, hung on a doorknob or from a nail on the wall in the sitting room. While doctors sometimes bemoaned the lack of a centralized

²⁶⁰ Mol 2002: 84.

²⁶¹ For an argument about documents as an emblem of statecraft, see cf. Navaro-Yashin 2007.

²⁶² Cf. Dumit 2004.

²⁶³ Hoag 2011; Hull 2012. While there was a Medical Records section in the psychiatric hospital where the files of discharged patients were kept, any patient who was currently being treated had possession of their own records.

recordkeeping system, treatment was streamlined not by any bureaucratic procedure, but, ironically, by the fact that patients kept their own records. As such, unlike what Ramah McKay found in the case of medical records in Mozambique, doctors rarely denied treatment on the basis of lost or misplaced records since most patients cared for their own records.²⁶⁴ There were, however, other consequences of the patient ownership of documents.

In particular, I found that the possession of medical cards by patients and their “therapy management group”²⁶⁵ enabled the card to circulate in unexpected ways, complicating a straightforward referential relationship between the patient and his or her medical document. In other words, to build upon Annemarie Mol’s question about ontological choreography, I ask: what practices of coordination and uncoordination draw the card and person—both experts and patients—into relations? What does the co-presence of the patient and card enable and what are the effects of divergence between the card and person?²⁶⁶

I suggest that the card has an ability to both converge and diverge from relations with patients and experts in particular ways. For example, the handwritten nature of medical cards and the fact that they circulated freely from expert to expert meant that they were read as forms of personalized knowledge, rather than the de-personalized conception of bureaucracy in Weberian analyses.²⁶⁷ In this sense, in Kashmir, bureaucratic innovations and interventions were read and evaluated as emblematic of individual capabilities and creativity.

As I will show, while the materiality of the card was associated with the patient’s

²⁶⁴ McKay 2012.

²⁶⁵ Janzen 1978.

²⁶⁶ Mol 2002.

²⁶⁷ Weber argued that as “bureaucracy develops more perfectly, the more it is ‘dehumanized,’ the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, irrational, and emotional elements” (Weber 1978: 975).

character in particular ways, there were also key moments of divergence between the patient and the card, when the card became an object that was treated independently, not in a relation of likeness with the patient. In this case, I show how the card and patient developed independent trajectories; however, the co-presence of the card and kin were able to substitute for the patient in the clinic.

These dynamic relations between the card, patient, expert, and kin could also be read as one of the unintended effects of de-institutionalization, in that efforts to quickly empty beds force a transformation between objects and persons from a relation of likeness (convergence) to one of unlikeness (divergence). In both these moments of partial relationality—convergence and divergence—I argue that the ability of the card to reference a bodily truth is secondary; what is important is that the card produces its own truth, pointing to itself.²⁶⁸

Documents in Anthropology

Recent social scientific approaches to documents have been deeply influenced by Michel Foucault's analysis of their constitutive effects.²⁶⁹ For example, in describing the widespread use of the examination across disciplines, Foucault writes: "the examination...places individuals in a field of surveillance [while] also situating them in a network of writing: it engages them in a whole mass of documents that capture and fix them."²⁷⁰ Historians and anthropologists of South Asia have drawn on this work to show how documents, as

²⁶⁸ Riles 2006c.

²⁶⁹ For Foucault, the political function of writing is to constitute individuals as an "effect and object of power, as [an] effect and object of knowledge" (Foucault 1977: 192). For an elegant critique of this approach, see Reed 2006.

²⁷⁰ Foucault 1977: 189.

governmental technologies, have produced the objectification and reification of particular sociological categories, such as caste.²⁷¹

In her study of colonial bureaucratic practices, Bhavani Raman has shown how the East India Company introduced “a government of writing” in the late eighteenth century to check the abuse of power and facilitate the spread of the market under colonial rule.²⁷² The idea that writing could ensure political accountability by making actions transparent and legible has been termed “papereality.”²⁷³ Yet as Raman argues, arguments for “papereality” leave unexamined the self-evidence with which writing is associated with legibility and longevity.²⁷⁴ Unfortunately, when compared to the rich literature on colonial bureaucratic and writing practices, the history of the medical card in South Asia remains somewhat oblique. South Asian twentieth century medical cards have not been examined by historians of medicine, while the more culturally ‘thick’ domain of Indian psychoanalysis has received significantly greater attention.²⁷⁵

Building on Weberian and Foucauldian approaches to documents, anthropologists of humanitarianism have focused on the affective quality of documents, particularly on those who are undocumented, such as *les sans papiers* in France.²⁷⁶ In the case of asylum seekers in France, Didier Fassin and Estelle d’Halluin have argued that the medical certificate – increasingly called upon by French authorities to corroborate the narratives of asylum seekers – leads to the

²⁷¹ Cohn 1987; Dirks 2001; Raheja 1996. Recent work in South Asian studies has argued that rather than its purported aim of producing transparency, official writing often produces opacity instead (Hull 2008; Sharma 2012).

²⁷² Raman 2012.

²⁷³ Dery 1998.

²⁷⁴ Raman 2012: 3.

²⁷⁵ Nandi 1995; Kakar 1996.

²⁷⁶ Fassin and d’Halluin 2005; Ticktin 2011.

reification of the asylum seeker's body.²⁷⁷ Implicit in this understanding is the sense that medical cards are significant to the extent that they refer or denote the body.²⁷⁸ In much medical sociology literature, similarly, scholars have shown how both paper-based and electronic records restrict the patient's voice and individuality, diminishing the patient to a "minor supporting role."²⁷⁹

There have been several critiques to approaching documents in this way. Anthropologists have argued that this line of scholarship treats documents as "cultural texts," as "receptacles of (politically or culturally) meaningful knowledge to be 'read' by the theorist/observer."²⁸⁰ They argue that in foregrounding the textual meaning and content of documents, documents get narrowly defined as texts to be interpreted. In response, scholars have called for greater attention to the materiality of bureaucratic practices, arguing that such texts are not abstractable from their material forms, whether they be, files, forms, reports, or graphs.²⁸¹ An important insight that has emerged from this body of literature has been that documents can be more than representations of, or evidence for, things other than themselves.

²⁷⁷ Fassin and d'Halluin 2005: 598. While the relationship between bodily truth and textual representation is the focus of Fassin and d'Halluin's work, they also briefly note that not just asylum seekers, but doctors also feel reified in this process of legitimation. Many of the doctors they interviewed described feeling like instruments and felt that their medical expertise was reduced to the act of writing of medical certificates (Fassin and d'Halluin 2005). This feeling of instrumentalization was a similar affective response that I encountered with counselors and psychiatrists who felt subordinated to the authority of objects, such as medical cards and pills. As you will recall, counselors reported feeling frustrated and dismayed when their labor was negated by patients through their desire for pills, rather than talk (Chapter 2).

²⁷⁸ For more on denotation and reference as forms of representation, see Hull 2012.

²⁷⁹ Rhodes et al. 2006: 374. See also Darbyshire 2004; Lee 2006; Rodriguez 2001.

²⁸⁰ Riles 2006a: 12.

²⁸¹ Hull 2012: 253. Scholars drawing on S&TS, for example, have followed artifacts as they circulate within and beyond institutional settings and how their form is used to derive multiple meanings for users of these artifacts (Brodwin 2010; Cabot 2012; Heimer 2006; Latour 1992; Reed 2006; Riles 2001).

Annelise Riles has argued for the primacy that Fijian government workers and activists gave to the aesthetics of document production.²⁸² In her analysis, Riles draws an analogy between documents and the self-evident geometric patterns of Fijian mats; she argues that what mattered was less the content of documents, and more of what was “all on the surface, dictated, and known from the start.”²⁸³ As with the mats, documents were not valued for their creative or innovative potential, but rather, for how successfully they could be replicated to form a pattern.²⁸⁴ Similarly, in her study of patient consent forms in Israeli hospitals, Marie-Andrée Jacob found that these documents were often faded, Xeroxed, and of poor quality. As such, she argues that rather than represent a person’s agency – since these forms were often not legible and usually not read – they created an alternative form of personhood.²⁸⁵

Drawing on these insights, this chapter attempts to think through both the referential content and formal meaning of medical cards, and how the card entangles or diverges with patients and experts. In so doing, I attend to the material form of documents, while also reflecting on their affective quality, following scholars of documents who have emphasized the interplay of form and content and cautioned against reifying this distinction.²⁸⁶ Nonetheless, while bureaucratic documents are important to “think with” alongside medical cards, I

²⁸² Riles 2001, 2006b.

²⁸³ Riles 2001: 79.

²⁸⁴ Riles 2001: 79.

²⁸⁵ Jacob 2012. For more work on the aesthetics of document production, see Brenneis 2006; Elyachar 2006; Li 2009.

²⁸⁶ Brenneis 2006. This relationship is also important in the case of other medical technologies, such as pills (see Chapter 4). As such, I politely disagree with Yael Navaro-Yashin’s argument that we treat documents either as “sensual, excessive and affective” objects *or* by their “form, pattern, and designers,” as Riles does (Navaro-Yashin 2000: 21). Navaro-Yashin’s critique of Riles argues that the search for aesthetics and form in the document may involve a sterilization and neutralization which distracts the analysis from the excessive potentialities of political objects of this genre.

attend to the ways in which medical cards are different from other bureaucratic artifacts. The emergence of medical cards coincides with the growth of evidence-based medicine in the early twentieth century. As historians of science have argued, the patient-centered record replaced the casebook—which had hitherto been kept privately by doctors as a diary or journal—and thus symbolized medicine’s organization around the patient, rather than around the doctor or ward.²⁸⁷ Medical documents have also been viewed as essential to the ontological production of disease.²⁸⁸ Within the South Asian context, asylum reports and casebooks are the forbearers to the personalized medical record. As Waltraud Ernst has shown, asylum reports from the early nineteenth century revealed a concern for the humane and enlightened treatment of inmates, which was gradually replaced by “a more pragmatic, narrowly managerial focus on the specifics of medical treatment and statistical analysis of institutions’ patient populations.”²⁸⁹

The relative openness of the medical card as compared to other bureaucratic technologies lends it a “sticky” quality, whereby it attaches to both psychiatrist and patient in unexpected ways not taught in medical school. While reading the card for signs of a patient’s subjectivity might have an administrative purpose, following Matthew Hull, I suggest that these techniques “do not converge in a unified set of representations. They generate ensembles of artifacts of limited and differing perspectives.”²⁹⁰ For example, while patient desires to have their medical cards written on dovetail with expert psychiatric practices

²⁸⁷ Berg and Harterink 2004: 19.

²⁸⁸ Bowker and Star 1999; Mol 2002.

²⁸⁹ Ernst 2011: 541.

²⁹⁰ Hull 2008: 509.

that emphasize writing, but this in itself is not evidence of a unified biomedical authority.

In the second part of the chapter, I argue that medical cards do not always operate—and are not always valued for—their ability to refer back to a patient’s body. In this sense, I respond to the critique of the bureaucratization of medical practice, which often assumes that the card and person are coterminous. Rather, cards can develop their own independent trajectories, which can ultimately lead to a separation between the patient and the card, which I call “divergence.”

Practitioners care for the textual trajectory of the medical card and cultivate it over time, until a steady rhythm of intervention is achieved and the card emerges as a locus of action, separate from the patient. This also says something about the temporality of treatment: the longer a patient remains a patient, the more likely it is that the patient and card will diverge.

One of the ways in which medical cards circulated outside of medical contexts was when patients visited Sufi elders or *pirs*, often before or after visits to the hospital. In contemporary Kashmir, *pirs* were often the connective tissue between spaces of medical and religious treatment, both of which are known as sites of treatment (*ilaj*). Patients who visited *pirs* also experienced treatments where writing was also a central component of healing.²⁹¹ Flueckiger found that the charisma, strength, and authority of *pirs* derives, in part, from their association with the written word:

The centrality of the written word is striking in the healing room. Amma’s primary method of diagnosis is based on the written word, as are most of her prescriptions and treatments.... Amma writes all day long, opening the ‘mystery of numbers’ (*abjad ka phal kholna*) to diagnose the troubles of a patient and writing out

²⁹¹ Messick 1993; Flueckiger 2006; Metcalf 1996; Schimmel 1970; Qureshi 1996.

prescriptions... Amma's fingers are ink-stained, and her desk is covered with slips of paper on which mathematical calculations have been made, stacks of amulets upon which magical squares and Arabic letters and numbers have been written, a clipboard, and an inkpot.²⁹²

This description suggests that despite the best efforts of psychiatrists to mark their space as apart from, and outside of, spaces of religious healing, the continuities between the healing room and psychiatric OPD were made apparent by the circulation patterns of patients.

Anthropological work on Islamic religious and legal traditions has shown how the semantic content of Arabic words can be may be subordinated to their power and auspiciousness (*barkat*) in specific legal and religious contexts.²⁹³ In the case of cassette sermons in Egypt, for example, Charles Hirschkind argues that apart from their referential content, sermons were also valued as techniques for "training the body's gestures and affects, its physiological textures and colorations, its rhythms and styles of expression."²⁹⁴

Similarly, as Joyce Flueckiger has noted, patients who visited *pirs* routinely wear, drink, burn, or bury the written word of God and the various representations of his name on various kinds of amulets (*taviz*). The words written on amulets are often manipulated, scrambled or written in such haste as to be illegible. As such, "patients [who visit *pirs*] do not know specifically what is written on the paper, and I never heard anyone ask."²⁹⁵ The same was true in

²⁹² Flueckiger 2006: 65.

²⁹³ As Messick puts it in the context of Yemen: "it would be difficult to overstate the high regard ordinary Yemenis have for legal documents. People care for and protect their own papers as the most vital of personal effects. Held in private hands, documents are folded or rolled into narrow scrolls, placed in individual protective tubes or tied together in bunches, and then stored in cloth bundles or in wooden chests" (Messick 1993: 217). See also Hirschkind 2001.

²⁹⁴ Hirschkind 2001: 637.

²⁹⁵ Flueckiger 2006: 68-69.

the case of medical cards; I never heard patients ask what was written on their medical card: what mattered was that the card was activated through inscription. The amulets received from *pirs* and the medical cards given by doctors were also treated in similar ways by patients. In addition to circulating in the same treatment context, these objects were the property of the patient and were usually treated with extreme care.

Contrary to practices in the West where the pharmacist retains the doctor's prescription, in India, prescriptions are returned to customers after medicines have been purchased so that they can be reused. This gives prescriptions a "floating" quality to them.²⁹⁶ In their ethnographic study of chemist shops in Mumbai, Kamat and Nichter describe how customers reused prescriptions freely without any objection from chemists; in one case, a prescription over five years old was reused unproblematically.²⁹⁷ For patients, the actual content of the card was less important than its ability to be exchanged for treatments. As I argue in Chapter Two, this emphasis on treatment through writing was one of the reasons for the lack of success of psychosocial interventions in Kashmir, which were focused on talk. Much like the patients at the psychiatric hospital, visitors to Amma's healing room were reluctant to leave the healer's table without tangible prescriptions.²⁹⁸ Similarly, just as amulets were imbued with power no matter the length of time or degree of separation from the healer, so prescriptions too retained the mark of authority well beyond the moment of the transaction.

Part I: Convergences

²⁹⁶ Ecks and Basu 2009.

²⁹⁷ Kamat and Nichter 1998.

²⁹⁸ Flueckiger 2006: 105.

Patient Extensions

In this section, I argue that medical cards were not only significant for their contents about a patient's diagnosis, treatment, and symptoms, but that cards were also read on and for their surface (or "formal meaning").

In Kashmir, the medical cards of each hospital were slightly different, but most of the cards I saw were made of a thick, cardboard-like paper, with large white spaces to be filled up by the doctor on the patient's first visit. Medical cards were artifacts of hospital bureaucracies; in private clinics, doctors usually tore out a single sheet from a prescription pad, hence "cutting" was also literal. Cards were solely the responsibility of patients and kin, and patients usually carried their entire written medical history with them to every hospital visit, which could include an assortment of different objects, including prescription papers from private clinics, multiple medical cards, test results from different hospitals or labs, and sometimes, old samples of medicines (a used strip or bottle) to show the doctor what they had been consuming or to confirm dosages. *Fig. 10* shows the medical card (also called an OPD Ticket) of a first-time patient to the psychiatric hospital in Srinagar.

GOVT. PSYCHIATRIC DISEASES HOSPITAL, SRINAGAR
 (Associated Hospital of Govt. Medical College, Srinagar)

No. **4352** **O.P.D. Ticket** Unit **11**
 Cost Rs. 5/- Date of Issue **17 NOV 2019**

Name **[REDACTED]** Age/Sex **28/P**
 S/o, D/o, W/o **[REDACTED]** R/o **[REDACTED]**

Provisional Diagnosis :

Date	Investigation/Treatment

Illustration 7:
A blank
medical card

→ Symptoms
Usually written
as: "(C/o -
Complaints of)"

→ Diagnosis
A "A" indicates
the diagnosis is
provisional
written in the
ICD-10 code

↓
Pharmacological treatments

Medical cards thus contained a significant amount of information beyond the patient's diagnosis. As Risse and Warner have noted, while the basic structure of the case history has remained largely stable over the past two centuries, both the content and the language used in composing case histories have changed dramatically.²⁹⁹ However, Waltraud Ernst has argued that both the structure and the content of reports has changed dramatically since the nineteenth century. Drawing on the case reports of Baron Georg von Liebig, a young German nobleman who worked in the East India Company's medical service in the 1850s, she argues that rather than the "conclusive summary

²⁹⁹ For example, in the nineteenth century, methods of physical diagnosis and 'objective' signs of disease superseded the patient's subjective accounts of their bodies. In addition, later in the nineteenth century, there was also a shift from words towards numbers and visual representations of bodily disorders (Risse and Warner 1992: 191-92).

statements” of today’s case histories, physicians such as Liebig typically supplied “a picture of the various stages in the diagnostic process, reflecting the often inchoate development of the diagnostician’s hypothesis in exactly the crude way in which they occurred, rather than pruning preceding observations *post festum* so they fitted the conclusion subsequently gained.”³⁰⁰ In the seventeenth and eighteenth centuries, professionals would also write letters to a newspaper or to the Royal Society in which they presented a variety of personal impressions and observations as evidence for a general statement, such as those pertaining to an inferior racial or national character.³⁰¹

The medical cards I saw revealed the trace of: the first encounter between psychiatrist and patient in the form of symptoms recorded; the process of establishing a diagnosis; a train of psychopharmacological or psychotherapeutic procedures that the patient had undergone, with brief notes about his or her changing condition, as per the expert on call; which expert had treated this particular patient, as these records were handwritten; and, the number of visits and duration of treatment that a patient had undergone.

While doing fieldwork in the OPD, I was struck by the fact that, rather than tell me to listen carefully to what a patient was saying, psychiatrists would affectively respond to a particular case by passing me a person’s medical card or documents: “Take a look at this,” they would say, not, “did you hear that?” For doctors, turning to documents was a means of recognizing a patient’s long and

³⁰⁰ Ernst 1990: 214-215.

³⁰¹ One example given is Montesquieu’s argument that after he had ‘observed the outermost part of a sheep’s tongue,’ he was able to come to certain generalizations about the physical and psychological effects of temperature, and he then used this to make an argument about differences in national culture (Glacken 1967: 569).

unfulfilled institutional journey, itself evidence for a patient worthy of care, rather than the specific condition for which they were seeking treatment. In this sense, papers were self-generative: medical documents were deserving of more documents. Psychiatrists tended to be more compassionate towards those patients who had a large quantity of well-kept cards and prescriptions. Medical cards were thus valuable for things other than revealing the “truth” about a person’s illness: the card was an important means of eliciting a patient’s character and disposition. Similarly, psychiatrists tended to be more critical of patients whose cards were perceived to be in shoddy condition or if any of their documentation was missing (unless the lack of documentation was evidence for the poor state of an institution). “To be without documents is to not exist,” explained one psychiatrist, when I asked why medical documents were important.

Patients also recognized the importance of the medical card as an institutional record because they knew the record was related to – and could even substitute for – their own agency.³⁰² Nargis, a female patient I met outside the OPD of the psychiatric hospital, said she was worried that the attending psychiatrist would criticize the state of her card. She showed me that the front of her card was smudged. “He will say, ‘*What is wrong with you? Why is your medical card in this condition?*’” she said in a mock deep voice. She made a gesture of flinging the card toward me with her hand. In this sense, Nargis’ nervous humor captured her worry that she would be held accountable—and judged for—the material condition of the card, rather than her bodily condition.

³⁰² cf. Reed 2006; Langwick 2011: 168.

At other times, the surface of documents were significant not for how they indexed a particular patient's character, but for what they revealed about the medical institution from which they came. Inscriptions were sometimes analyzed for their adherence to proper procedure, for instance. One day at the psychiatric hospital, Dr. Zaid, one of the Consultant level psychiatrists, directed me to a female patient who had been admitted to the Family Ward, which was used for short-term stays. Rimjhim, who was in her mid-30s, was a highly atypical patient in the psychiatric hospital: she was not Kashmiri, but from the northeastern Indian state of Assam and from an upper-middle class background. Although her hair was disheveled, she was well dressed. The latest diagnosis in her file read "bipolar affective disorder," which had been changed from an earlier diagnosis of manic depression. In English, she told me that her husband was South African and worked as a computer engineer in Mysore and that they had a three-year old son. She said that because he was a foreigner, he was not given permission to travel to Kashmir to see her.³⁰³ Based on her narrative, neither I nor the other doctors understood how or why she had ended up in Kashmir, where she knew no one.

To the doctors, what was more appealing than Rimjhim's attractive appearance was her thick stack of medical records. Her file showed that she had first been institutionalized in NIMHANS – the top-ranking mental health institute in India - in Bangalore, where she had been admitted for a period of two weeks. Following this, she had been admitted to the All-India Institute of Medical Sciences (AIIMS) in Delhi, again, one of the most renowned medical

³⁰³ Foreign nationals require a special permit from the central government in order to visit Kashmir.

hospitals and research institutes in the country. Then, somehow, she had ended up at the psychiatric hospital in Srinagar.

“This is a very interesting case,” Dr. Zaid told me, as we walked towards the ward to meet her, “usually patients go the other way around.” Dr. Zaid was referring to the reversal of the usual trajectory that most middle class patients underwent: the movement from state-run hospitals like the psychiatric hospital in Kashmir to more specialized, tertiary care hospitals in India’s metropolitan centers, such as AIIMS and NIMHANS. What was interesting to Dr. Zaid was not Rimjhim’s diagnosis or condition, but her movement through some of India’s most reputable medical establishments. The doctors were eager to examine her letters, referrals, and documents from NIMHANS and AIIMS and compare those documentary practices with their own. They pored over her files and commented how thorough her records were, how each transfer from one department and one hospital to the next had been written and signed by *both* a resident and a consulting psychiatrist. In this sense, they marveled at the bureaucratic processes recorded in Rimjhim’s files, rather than the medical procedures or treatments that were done.

Similarly, some months later, one of the Kashmiri residents I knew from the hospital, Dr. Zeeshan, returned from an internship at AIIMS; he was the first Kashmiri psychiatrist to have gotten this prestigious position. When I saw Dr. Zeeshan again, I asked about his experiences and what he found to be difference between the psychiatric hospital in Kashmir and AIIMS. He said that he didn’t find too much of a difference, except that the documentary practices of hospitals like AIIMS were much better. Dr. Zeeshan and other doctors did not make an explicit link between documentary practices and patient care, however. This

seemed to be another instance where documentation was valued as ethical practice in and of itself, where expert efforts were concentrated on the index rather than the outcome.³⁰⁴ However, what was also significant here was that the documents were not valued for their depersonalized quality, but rather, for how they retained the traces of the prestigious institutions from where they came. There was a different epistemology at work here than what Joe Dumit has described in the case of PET scans, for example, where the fair, impartial objectivity of numbers is seen as ‘harder’ and more persuasive than the expert who produced those numbers. In the case I describe, by contrast, the “expert craft at the base of scientific practice” was not papered over, but rather, foregrounded.³⁰⁵

On the flipside, the lack of a proper paper trail was viewed as a crisis within the psychiatric context. In addition to reflecting poorly on the patient, a lack of documents also reflected poorly on the doctors and institutions that had treated the individual. In one instance, a young man of Ladakhi³⁰⁶ origin was referred to the De-Addiction Center (DDC) after having spent thirty days in the closed ward of the psychiatric hospital. When he arrived at the DDC with his family, Bilal Ahmed Bhatt’s cumulative medical records consisted of a skeletal discharge sheet and a single piece of prescription paper. On the discharge sheet, someone had written: “F₂₀ with cannabis abuse.” F₂₀ was the International Statistical Classification of Diseases and Related Health Problems (ICD)-10 code for schizophrenia. The sheet was not signed, and further, it was dated one full

³⁰⁴ Dumit 2010: 245.

³⁰⁵ Dumit 2010: 123.

³⁰⁶ Ladakh is a Buddhist-majority region with a population of Tibetan origin in the state of Jammu and Kashmir.

day after Bilal's discharge, which, according to his family had been February 17, 2010. Dr. Wiqar Bashir, the attending psychiatrist at the DDC, was visibly upset. He passed the charge sheet to me, dismayed. "This is the shortest description I have ever seen," he said, "I wouldn't even call this a document."

The fact that the discharge sheet contained no history of Bilal's treatment which had been a substantial 30 days – the medications he had received, his condition over the course of his treatment, or the medications he was given upon discharge – was bad enough, Dr. Wiqar explained, but even worse was the fact that the sheet had not even been signed. In addition to the discharge sheet, Bilal's family also had a year-old prescription from the private clinic of a well-known psychiatrist. However, the prescription was illegible. Dr. Wiqar called it "cryptographic." "Even I, a psychiatrist, can't read this," he said helplessly. For doctors, Bilal's flimsy paper trail indexed the poor quality of care he had received at the hands of the hospital and the private psychiatrist. Unlike the case of Nargis who I described earlier, this time, the patient was not held culpable for the poor state of his medical records.

The DDC staff would reinforce this indexical relationship between the card and institution by asking Bilal repeatedly about his time at the psychiatric hospital: "They kept us like animals there, we felt like we were cows and goats," Bilal would respond. Dr. Wiqar would suck in his breath sharply, to create a whistling sound, a combination of empathy, shock, but also, it seemed to me, satisfaction. The staff consistently promised Bilal's parents that his treatment at the DDC would be significantly better, and importantly, that they would keep good records. Eventually, Bilal spent another five weeks in treatment at the DDC and was finally released on March 29, 2010 with a diagnosis of "undifferentiated

psychosis,” that is, psychosis linked to substance abuse, not a preexisting condition. In a rare gesture, the schizophrenia diagnosis was overturned. This moment of diagnostic change suggested that although Bilal’s non-existence as a medical subject was a “problem” for the clinical staff, it enabled them to craft a new subject – a paper subject – from scratch.

Paperwork Ethics

In this section, I examine convergences between the card and expert. For psychiatrists, writing signified work done, and work done was the expression of an ethical, professional self who is able to write documents in a particular way. Dr. Wiqar Bashir, the consultant psychiatrist at the police De-Addiction Center, told me that one of the most important maxims he learned in medical school was, “What you have not written, you have not done.” I found it interesting that the maxim was expressed in the negative, as an absence. “So, does it work the other way around too?” I asked. “Yes,” he replied, “what you have written, you have done.” Given that psychiatrists equated work done with what was written on the file, in instances where clinicians disagreed with each other over diagnoses and lines of treatment, they were careful to conduct these arguments verbally and not textually. As I witnessed, and as with the government bureaucrats with whom Anu Sharma worked, to textually criticize another expert’s work or to point to gaps in work done could permanently damage interpersonal relations, whereas verbal disagreements were seen as less serious.³⁰⁷ The primacy of writing for psychiatrists was also a source of conflict with professionals from other disciplines, such as clinical psychology or counseling, for whom writing did not have the same status.

³⁰⁷ Sharma 2012.

Just as poorly kept and poorly written medical cards were to be critiqued and even derided based on the institution or doctor who was seen as attached to them, doctors often applauded what they considered skillfully written medical cards. This was an example of how medical cards revealed, in the sense of making clear a doctor's expertise. This was a particularly sensitive issue for Dr. Wiqar, who took a great deal of pride in his system of writing a patient's medical history. Acts of writing the medical card also revealed the ways in which psychiatric knowledge was deeply performative: it was about recording work done and indicative of the skill level of a particular practitioner.

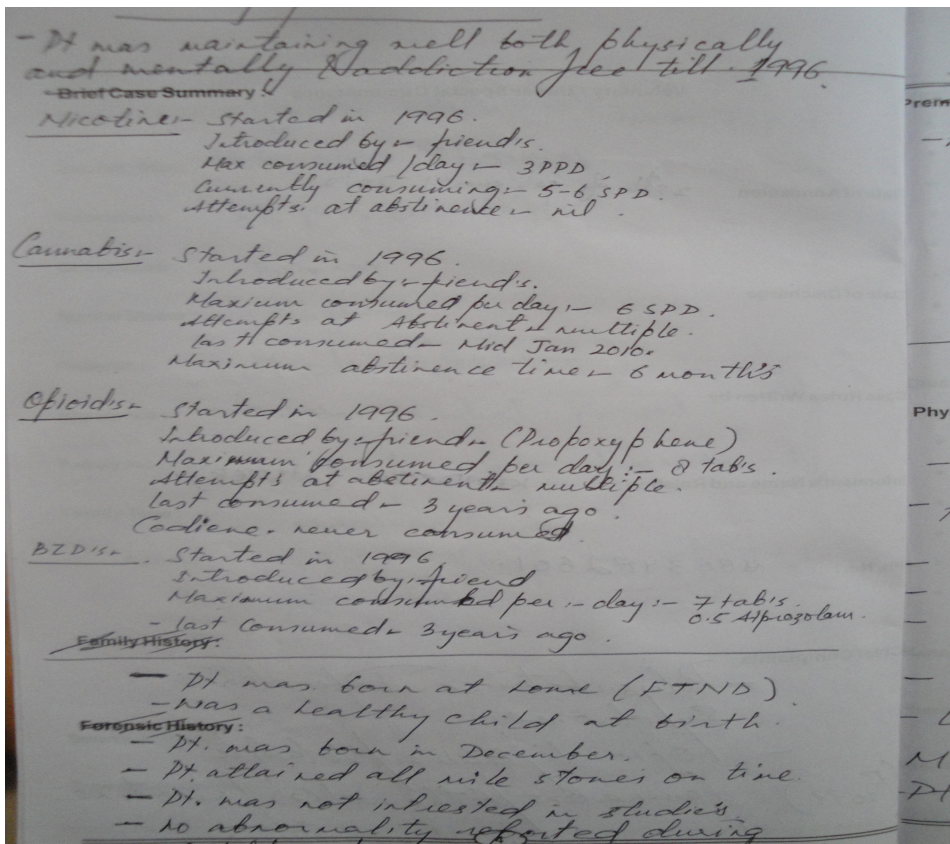


Illustration 8: A patient's history of drug use written by Dr. Wiqar

In his writing, Dr. Wiqar organized a patient's history according to the drugs they had consumed: nicotine, cannabis, opioids, and benzodiazepines (BZDs), in this case. He wrote details such as the duration of consumption, how

they began using, and amounts consumed, in bullet-point form. According to Dr. Wiqar, this bullet-point form was what he described as a “logical” way of organizing relevant information about a patient’s prior drug use and was preferable to a narrative; it was a kind of “paperwork ethics.”³⁰⁸ As he put it:

“For me, this approach [of] trying to construct a story out of it [drug abuse]...like, one day, he wasn’t feeling well, and then the next day, he smoked *charas* [hashish], etc. as if writing a story... For me, that’s not scientific. If I was in the US, I would have patented this [bullet point] approach, it is something that is entirely mine.”

In Dr. Wiqar’s statement, in which he compared his bullet-point system to patenting new drugs, he expressed a commitment to bureaucratic innovation, but claimed the innovation as a personal achievement. Under his guiding hand, the messiness of patient’s past drug histories were transformed into bullet points with a steady, repetitive rhythm. This particular aesthetic of textual regularity is something I will return to in part II of this chapter.

Dr. Wiqar was also meticulous about recording a patient’s condition, including their blood pressure and the symptoms reported, after their morning medical exams. He wanted all the DDC files to be updated everyday by both the social worker and clinical psychologist, so that they could record “what had been done.” Since the social worker and clinical psychologist considered their work primarily to be counseling family members and patients, they found it cumbersome to record the nitty-gritty of these interactions on paper. While Dr. Wiqar made notes in the file while he spoke to patients (writing as work done), the clinical psychologist and social worker usually did this after the fact. In fact, for them, writing took away from other kinds of work: it was an obstruction

³⁰⁸ Hull 2012: 257.

rather than a revelation as Dr. Wiqar imagined it. Dr. Wiqar had frequent arguments with Dr. Muzzafar, the clinical psychologist at the DDC, not about the treatments pursued, but about whether and how such treatments had been recorded in a patient's medical card.

Learning how to write effectively and succinctly, particularly when a patient's history had to be taken, was a test of skill. For psychiatrists, these first etchings – of relevant symptoms and a potential diagnosis – were usually the most significant part of a patient's card. The deceptively brief diagnosis – further condensed in the form of an ICD-10 code – represented the culmination of an extensive verbal process of history taking. Generally, younger residents were given the responsibility of taking a patient's history in a room separate from the OPD. This process usually took between fifteen and thirty minutes and when completed, the file was brought back to the consulting psychiatrist on duty for review. Although residents were responsible for writing down a patient's relevant symptoms, they usually withheld writing a diagnosis until it had been orally discussed with the consultant. As Sarah Pinto has described, the process of diagnosis making was “part of the way doctors in training achieve[d] a specific mode of perceiving by extracting a named ailment from tangles of language and behavior.”³⁰⁹ Pinto also noted the particular affective register to reporting a patient's history in Indian clinics: “When reporting [to the more senior psychiatrist], residents' voices dropped. They (and I) adopted the masklike gaze of the low ranked, silent until spoken to.”³¹⁰

³⁰⁹ Pinto 2011: 123.

³¹⁰ Pinto 2012: 133.

I witnessed many a nervous junior resident quizzed and berated for their failure to attend to the consequential symptoms or their missteps in arriving at a diagnosis. However, the act of “history taking” – of recording a person’s medical history, their symptoms and complaints – was not always a smooth or easy process, and in many ways, was “para-ethnographic.”³¹¹ Like anthropologists, psychiatrists had to distill multiple voices and narratives and construct a coherent, linear narrative. Yet while ethnographers have the luxury of, and are even encouraged to, record all kinds of details to add “thickness” to their accounts, the writing of psychiatrists was evaluated, in part, on its thinness.

Given the complexity of assembling patient and kin narratives, many psychiatrists recognized that what was at stake in history taking was an act of not just linguistic translation, but also cultural translation. One psychiatrist described the act of history taking as “part art, part science.” Many also emphasized the importance of cultural knowledge in the process of history taking. For example, during the session, patients and their kin rarely reported physical or psychological symptoms of distress to the psychiatrist. Instead, as Jocelyn Chua found in the case of Kerala, and what was true of Kashmir as well, was that “complaints” consisted of “a wider catchment for the grievances and morally weighted accusations that circulated among patient, kin and clinicians.”³¹² As such, most clinicians were well aware of how their English-

³¹¹ Holmes and Marcus 2005.

³¹² Chua 2012: 222. Chua notes this in the case of Kerala, but I found this to resonate in the Kashmiri context as well. However, while Chua’s work on “complaints” has focused on the ways that accusations were transformed into an illness, I am more interested in how clinicians produced a final, written product given that patient and kin narratives were often contradictory, “irrelevant,” or difficult to decipher.³¹²

language writing on the card required a double translation: from one language to another, as well as from ontological state to another.³¹³

In history taking and reporting, the performativity of psychiatric knowledge was clearly on display.³¹⁴ The process of diagnosing revealed a chain of command, with first-year residents deferring to second years, and second years to third years, and finally, to the consulting psychiatrist on duty. This hierarchy was crucial for residents because diagnoses, once written, were rarely changed. While psychiatrists of the same seniority would often disagree with each other about a diagnosis, younger doctors would almost always be rejected in their attempts to change a more senior person's diagnosis, even if others agreed that the diagnosis was incorrect. One postgraduate psychiatry student who I interviewed said that he had attempted to overturn a more senior psychiatrist's diagnosis twice in his three years at the psychiatric hospital, but that he would "never make that mistake again." He described feeling "burned" at the public way in which his opinion was shot down by senior doctors both times.

For psychiatrists, then, the written words on a medical card represented the distillation of intense verbal argumentation and conflict that characterized everyday relations between patients, kin, and clinicians. The reliance on words also marked psychiatry as unique from other branches of medicine (see Chapter One). "As you know, all we have is subjectivity," one psychiatrist told me, referring to the fact that other medical specializations had machines and tests to

³¹³ Giordano 2008: 589.

³¹⁴ Pinto 2012: 134.

rely on. As such, psychiatrists were keenly aware that diagnosing is, as Bryon Good described it, a “dialogic process,”³¹⁵ not unlike ethnography.

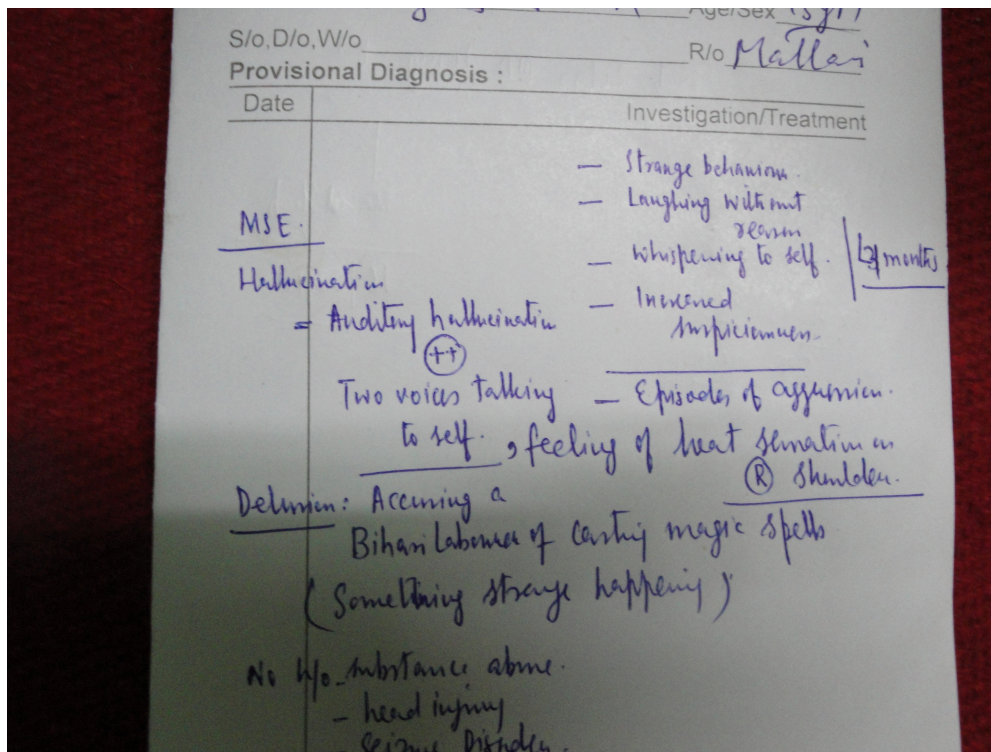


Illustration 9: History taking: narrative style

Most history taking was done in the “narrative style” shown above; Dr. Wiqar’s bullet point style was thus quite a departure from this form. In addition to the ways in which cards were personalized based on the style of history taking, the personalization also extended to actual writing, since these cards were written by hand.

All the psychiatrists I observed engaged in practices of graphology to determine the identity and level of expertise of those before them in the paper trail. In fact, the identity of other doctors on the card was crucial in determining or circumscribing their intervention. Thus, while some psychiatrists longed for bureaucratic consistency – such as referrals having signatures from both the

³¹⁵ Good 1994.

consulting psychiatrist and the junior resident on call – they also relied on a bureaucratic practice that was thoroughly individuated. For example, if a well-respected psychiatrist was identified by his handwriting, it was likely that the next doctor would pursue the same pharmacological trail, rather than try to change course.

As such, clarity of handwriting also represented clarity of purpose, as Dr. Wiqar's dismissal of Bilal's illegible prescription showed. Dr. Mohammed Yousuf, a retired cardiologist who I interviewed, also described to me how practices of writing a prescription revealed a doctor's character and intention. He said that he had carefully kept a few old prescriptions written by Dr. Ali Jaan, known as "the father of medicine" in Kashmir. He was inspired by how each of Dr. Jaan's prescriptions meticulously noted the patient's full name (most medical cards I saw only noted the patient's first name), diagnoses, investigations, and prophylaxis for attendants. In addition, Dr. Jaan prescriptions also included an emergency home contact number, where the doctor could be reached. Dr. Yousuf said that such practices reflected Dr. Jaan's integrity and the respect he offered his patients, and Dr. Yousuf continued to model his own prescription writing after him.

The expertise of a psychiatrist was thus revealed through the representational form of the pharmacological trail they produced, not necessarily for the effects that trail produced in a patient. For example, Dr. Arshad said that he recognized a "weak" or "insecure" psychiatrist if he saw a prescription for multiple antipsychotics in small doses, rather than one in a more substantial amount. According to him, this showed the character of the psychiatrist as not

experienced enough to prescribe one drug in a relatively high dose, and instead, took a weaker route, risking the interaction of multiple substances.

These examples suggest that our understandings of the medical card as an object that is read for meaning are limited. Rather, the card entangles with patients and experts in different ways, such as an index of a patient or professional's character and expertise or as an extension of an institution. For experts, in particular, medical cards are sites where medical authority is performed in predictable (as in acts of diagnosing and history taking) and unpredictable ways (reading a doctor's handwriting). While we might expect the expert's agency to be displaced by increased bureaucratization of knowledge, as other studies of bureaucratic organizations have shown, in the case of medical cards in Kashmir, the artifact continues to bear the mark of those whom it encounters.

Part II: Divergence

In part II, through a close reading of a medical file, I examine how, in the case of an extended, unresolved psychiatric illness where cure was not possible, the medical card emerges as an object of clinical intervention and care independent from its relation to the patient. I describe this separation of the card and patient as a form of divergence. By divergence, I mean the production of two, distinct ontological entities – the person and the “file self” – rather than one substituting or replacing the other. However, this was not a smooth or gradual process; rather, the establishment of a steady rhythm was only achieved after significant back and forth, unsteady, and uneven movements. The flatter and more steady the rhythm of the card, the more separated out the patient and the card.

To develop this argument, I turn to the case of Saira Irshad, a case which Dr. Arshad had described to me as a “failure,” as one of those cases where, “no matter what you do, you are essentially helpless.” In my decision to focus on Saira’s case, I follow a long line of medical anthropological work on troubled or troubling subjects who raise paradigmatic questions about psychiatric and anthropological narratives, knowledge practices, evidence, and ethics. One of the narrative solutions to these “knotty” cases, to borrow Stefania Pandolfo’s metaphor,³¹⁶ has been to tell the stories of subjects in multiple ways. In their accounts of such cases, scholars have emphasized how knowing was simultaneously a process of unknowing. For example, Ian Hacking writes: “The more I know what really happened, the more I wonder if there is a ‘what really happened.’”³¹⁷

Similarly, in her work on a female patient named Lata in a case of a suspected forced marriage in north India, Sarah Pinto argues that a “hermeneutics of discord,” that is, forming an account out of several contradictory stories, offers insight into how kinship relations are refashioned in the space of the family, law, and clinic.³¹⁸ Pinto describes the inadequacy of different explanatory frameworks, including medicine, law, social reform, feminist critique, and anthropology, in understanding Lata’s condition. Pinto’s ethnographic response is to tell Lata’s story, “three ways, emphasizing their points of divergence.”³¹⁹ Rather than see love, arranged marriage, and, I would add, the clinic, as sites of exclusion, drawing on Marilyn Strathern’s work on

³¹⁶ Pandolfo 2008.

³¹⁷ Hacking 1991: 839.

³¹⁸ Pinto 2012.

³¹⁹ Pinto 2012: 121.

science and kinship, Pinto suggests that they may be sites of accumulation and “recombinance” instead, in the sense that both “science and kinship build knowledge from relations at points of remaking.”³²⁰

I draw on these insights in my partial retelling of Saira’s journey to and from the clinic to emphasize how processes of knowing Saira also entailed simultaneous forms of unknowing or unraveling. In particular, Saira’s embodied self was gradually detached from her “file self.” In the early days of her treatment, Saira’s bodily presence was felt in the card in the form of what I describe as a “back and forth,” frequent, oftentimes aggrieved interruptions that obstructed the paper trail’s proper path. Yet, as her treatment progressed, the flatter and more regular the rhythm of the medical card became, despite Saira’s continued emotional and behavioral trouble. This suggests that the card emerged as a locus of action independent of its referent. This divergence is one of the markings of de-institutionalization; it “empties beds” without the promise of a finalized cure.

Saira was a twenty-year old female patient who I met in the Family Ward of the psychiatric hospital in the spring of 2010, and whose family I continued to know and visit with until the end of my fieldwork in June 2011. In following Saira’s case, her own and her kin’s experiences, it became clear to me that as her illness progressed, her relationship to the medical file – that “veritable carrier of truth”³²¹ – was increasingly loosened. In this instance, then, Saira’s file was not reducible to a technology of biopower in the sense that it was a form of “letting

³²⁰ Pinto 2011: 377.

³²¹ Hacking 1991: 839.

die”;³²² on the contrary, as the medical file attempted to reknit an authoritative biomedical discourse, it increasingly separated itself out from Saira’s experience. Meanwhile, Saira’s bodily discomforts were displaced from the site of the clinic and card to the home. I tell her story in four, overlapping parts, in order to emphasize points of divergence.

I. *Psychotherapeutic interventions*

I first heard about Saira in April 2010 from Dr. Huda Mushtaq, the hospital’s clinical psychologist. Saira had been a regular patient at the psychiatric OPD, under treatment for obsessive-compulsive disorder (OCD); however, recently her illness had taken a turn for the worse. Saira had been referred to Huda by psychiatrists at the hospital, who hoped that the “softer” science of clinical psychology might bear fruit where psychotropic medication had been unsuccessful. Over our usual lunch of buttered toast and tea, Huda told me how, in their first session together, Saira had spoken incessantly about fire. Whenever Saira would see a flame, she would put her hand over it and burn herself. For her next session of counseling with Huda, Saira had shown up with a burned nose.

Huda was the hospital’s only qualified clinical psychologist and female doctor, having recently completed her M. Phil from a university in Delhi. She only saw patients on a referral basis; most required either IQ testing or counseling. Psychiatrists also passed on patients to her who were suffering from chronic illnesses and were unresponsive to medication. These tended to be female patients suffering from illnesses that were known as “women’s distress,” such as depression, dissociative disorders, and OCD.

³²² Biehl 2007: 404.

Huda, for her part, had felt that she was more equipped than the psychiatrists to treat Saira's distress. Despite the fact that her father, Dr. Mushtaq Margoob, was the Head of the Department of Psychiatry, privately, Huda critiqued the practices of some of the younger psychiatrists, arguing that they were too focused on symptomatic treatment. For example, she told me that the psychiatrists in the OPD had attributed Saira's burned nose to "suicidal ideation," whereas Huda felt that the burned nose was related to Saira's ongoing delusions. Huda explained to me that Saira she saw herself as a "sinner" and she deserved to be punished for sins that were "unforgivable" (these were Huda's words). After these conversations with Saira, Huda had managed to convince the psychiatrists that Saira's burned nose was not a form of "suicidal ideation," but was part of OCD, which was treatment resistant or unresponsive to medication.

Huda had begun treating Saira for what she described as her "delusions," drawing on the methodology of cognitive behavioral therapy (CBT) to get Saira to view her obsession with flames as "irrational," and then to reform her behavior. However, the CBT was interrupted when Saira stopped showing up for her appointments. About three weeks after Saira's absence at the hospital, Huda bumped into Saira's mother on the street. On seeing her, Saira's mother had burst into tears and told her that her daughter had not eaten anything for the last two weeks. Huda had urged Saira's mother to have her admitted to the hospital's Family Ward. Saira's mother agreed.

II. *Biomedical Inscriptions*

Upon her admission, Saira's refusal to eat was read by the psychiatrists as a confirmation of her suicidal tendencies, and they once again moved away from

the OCD diagnosis.³²³ Psychotherapeutic interventions – Huda’s role – was considered irrelevant in this crisis situation, since doctors assumed that there was a threat to life.

From this time to the day that I met Saira, 27 days had passed since her admission to the hospital. This was a significant period of time, as admissions in the Family Ward rarely exceeded thirty days. The first time I met her, Saira was sitting outside the Family Ward, licking the remnants of rice and kidney bean curry from her fingers, as her parents looked on. While the scene seemed happy—Saira and her parents finishing lunch in the warm April sun; she, much different from the medical reports of a few days prior—a gloom quickly set in.

Saira’s parents reported that she had undergone extensive shock (electroconvulsive) therapy since her admission at the hospital. At this point, Saira’s future was radically uncertain. She was finally eating, but she and her family were now suffering in new ways. To respond to these uncertain conditions, I wondered what had happened in the 25 days prior to her stay. What could the trajectory of her illness, as experienced by her, her kin, as well as on her medical file, tell us about the relationship between medical institutions, biomedical inscriptions, and suffering patients?

I began the process of reading through Saira’s file to fill in the blanks of the last 26 days. In this section, I use italics to capture all direct quotes from Saira’s file. I want to draw attention to the rhythm of the writing, specifically focusing on how certain types of rhythms indicate the relative entanglement or

³²³ Psychiatrists struggled to define Saira’s diagnosis throughout her admission in the hospital, and her diagnosis was changed as different symptoms appeared. While practices of diagnosing are not the focus of my discussion here, I want to note that Saira’s diagnosis was shifted from OCD to schizophrenia to psychotic depression with suicidal tendencies to bipolar affective disorder (BPAD) at different points in her admission.

divergence from Saira as she experienced herself and what I am calling her “file self,” following Roma Chatterji.

At the time of her admission, the postgraduate in charge of Saira’s admission noted her refusal to eat as a “*threat to life.*” This move established the immediacy of the crisis at hand, away from Huda’s preferred diagnosis as OCD. Gradually but surely, Huda’s interventions into the case were also wiped out of the file in favor of progressively stronger psychiatric techniques (The psychologist was also disappeared in this process of psychiatric treatment).

Saira’s history of mental distress was noted in relation to the crisis thus: “*Since 2003—complaints of restlessness, loss of interest in work, feelings of impending doom, excessive washing. History of suicidal thoughts and five suicidal attempts. Patient withdrawn medication on her own since February 10th.*” Saira’s physical condition on her date of admission was described as: “*emaciated, conscious, non-cooperative, depressed. No involuntary movements. Dressed appropriately.*”

The initial writings in Saira’s file were marked by what I describe as a “back and forth”: an attempt by psychiatrists to move the treatment forward in the direction of improvement, but such attempts were frequently undercut by Saira’s responses to treatment and her continued suffering, which impinged on this thrust towards improvement. In the Family Ward, psychiatrists did rounds at least twice a day, since the aim was to discharge patients as quickly as possible. Yet, at the beginning of Saira’s treatment, the writing in the file would swing from a neutral, in-control tone of reportage (of steadily moving forward), to backpedaling.

For example, on Day 3, a large and bold + sign was made in the file, signaling improvement. Later that same day, however, a note written in larger

letters and underlined read: *Pt. not improving*. The ICD-10 symbol for schizophrenia (F₂₀) was written, followed by a question mark. The *pt. not improving* was further undercut by written comments that Saira was refusing to eat or orally take her medication.

On day 8, a nasogastric tube was put in for feeding and a + sign was made. On day 10, the writing noted that Saira had removed the tube and was refusing her oral medication. The file noted: *Pt. continuing to refuse to take orally*. The urgency of this biological crisis revealed itself in the fact that new handwritings in the file appeared, suggesting more consultations as psychiatrist tried to respond. “F₂₀?” a new hand asked, almost insisting now (In the OPD, too, I had seen a similar gesture of pulling towards a schizophrenia diagnosis).³²⁴ The F₂₀ diagnosis was an attempt to make sense of Saira’s continued resistance towards her treatment, yet it did not address the underlying *threat to life*, which had been noted earlier.

The hospital’s psychiatrists, apparently under increasing pressure, reached out to another department for help. This letter came next in Saira’s file:

To: The Registrar, Department of Anesthesia, SMHS Hospital, Srinagar

Respected Sir,

Kindly examine and advise us about the pt. admitted with our department for the last 10 days, a c/o [case of] schizo-obsessive disorder with suicidal ideation with five previous attempts of suicide. Pt. is most of the time agitated and not cooperative. Presently, she is not accepting anything orally in order to harm

³²⁴ During my fieldwork, I noticed that patients with complex and contradictory symptomatology were often labeled as “F₂₀.” I would suggest that schizophrenia has emerged as a sort of catchall for particularly intractable, chronic illnesses in Kashmir and possibly elsewhere in South Asia as well. When I asked about the frequency of F₂₀ diagnoses in the psychiatric hospital’s OPD, Dr. Arshad agreed and described this as the “F₂₀ization of psychiatry.”

herself for the past five days. Pt. needs ECT therapy but ECT machine is out of order and we have to maintain her on medication till ECT machine starts working. So, kindly help us to start her oral feeding by putting in a Ryle's tube [a stomach tube].

Thank you in advance,

Registrar – Department of Psychiatry

The letter clearly laid out Saira's precarious situation, emphasizing her refusal to eat as a form of self-harm (reinforced by "five previous suicide attempts"). At the same time, the letter assumed that Saira's problem of not eating would be resolved once she was given ECT. Saira was to be kept alive till she could be given ECT.

On day 13 of her admission, the ECT machine started working again. ECT, rather than medication and talk, quickly became the primary intervention and also gradually transformed the virulent back and forth that characterized the early days of treatment.³²⁵ On day 16, Saira was given her first round of ECT. The event was noted with a frank, "ECT given." This was followed by quick, positive results: "Pt. accepting [medication] orally." However, the next day, there was backpedaling again, as Saira was "irritable, verbally arguing." A second ECT was scheduled for four days later, "Third ECT given: Continue same treatment." However, it was interrupted again with a note: "pt. complaints of psychotic depression."

However, by day 21, that is, after Saira's third bout of ECT, there seemed to be less back and forth.

³²⁵ However, Saira also continued to be prescribed a heady mix of medications: voxamine, lopez, migrabeta.

On day 21, a brief note: *Pt. doing well.*

Day 22, 4th ECT done. *Pt. doing well.*

Day 25, 5th ECT done. *No complications.* This was underlined in the file, as if anticipating this as a potential endpoint. But then, a trace of Saira's continued troubles reappeared in the file: "*Attendants complaining that she doesn't sleep at night and keeps on talking to us and laughs...but is not inappropriate.*"

From day 26 onwards, there was an even steadier rhythm to the notes, and fewer interruptions by Saira in the file. A new subject was born:

Day 27, *Pt. doing well; ECT done; symptomatically improved.*

Day 29, 7th ECT done. *Pt. doing well. Continue same treatment (Rx – CST)*

Day 32, *Improvement ++ (Rx – CST)*

Day 36, 8th ECT done. *Pt. improving +*

Day 42, *To be discharged on Friday [A diagnosis of psychotic depression with suicidal ideation is also proposed]*

Day 46, *Doing well. Continue same treatment.*

A week before Saira was to be discharged (her discharge was delayed twice), her diagnosis was changed again: *BPAD [Bipolar affective disorder]: current episode psychotic depression with OCD.*

Day 50, *Pt. to be discharged tomorrow.*

END

At the beginning of her illness, Saira was a persistent and troubling presence in the file. Her long history of mental illness and her current complaints, her physical appearance ("*emaciated, conscious, non-cooperative, depressed. No involuntary movements. Dressed appropriately*") were all meticulously recorded at the beginning of her admission. For Saira's parents, these

characteristics resembled their daughter in some way. Yet as the treatment progressed, I suggest that the writing on the card shows the ways in which Saira, as a fleshy, bodily presence, was separated out from the file, in favor of a subject who was *improving* and eventually *doing well*. Although Saira was in the hospital for a total of 46 days, her last appearance in the form of a “back and forth” appears on day 25. After day 26, the card develops its own rhythm, steadier and more even than before, yet also increasingly divergent from the reality of Saira as experienced by herself and kin.

II. *Saira's Story*

While the rhythm of her file steadied and gradually reduced over time, Saira's lifeworld continued to be turbulent. On the day that Saira was to be discharged from the hospital, I saw her father pacing nervously outside the Nurse's station, waiting for the postgraduate resident to write her discharge slip, which had been delayed several times. I followed him back to the Family Ward, where Saira was alert and dressed in a pink and purple *salwar kameez*, wearing her glasses for the first time since her admission. At first, she looked almost healthy: still skinny, but her large, round eyes seemed ready to take in the world. She resembled the *pt. doing well. To be discharged* of her file. But just for a moment.

When she saw me, Saira breathlessly asked if I would teach her how to swim. “Will you teach me how to swim? This fear, this fear of water, it is holding me back in life,” she told me, almost singing. It seemed that Saira's fear of fire had also undergone a substitution in this period of intensive intervention. Somehow her fear of fire had transmuted into a fear of water. Saira's parents looked at me helplessly, and asked her to stop talking this way. Saira had

expressed her regret to them: “I feel bad that my heart is weak (*dil kamzor*) and that I can’t bear this pain (*dard*),” she said.

It was significant that she used the word *dil* (heart) to describe her pain. As Magnus Marsden has argued in the case of Muslims living in the North-West Frontier of Pakistan, and what was true of Kashmir as well, was that the locus of a person’s genuine thought was the heart, and not the mind (*zahn*) or brain (*dimagh*). While a person’s brain could be cunning (*chalak*), a person’s heart was the source of truth; the only way to understand somebody was to know their heart (*dil ki baat*). In this sense, the heart was not simply the source of spontaneous emotions or passions, but rather, the coalescence of complex forms of thought.³²⁶ For Saira, it was thus significant that she located the source of her suffering in her heart, rather than in her brain, the region targeted by the shock therapy. After being discharged from the hospital, Saira also began seeing a *pir*, but she told me she stopped when he told her that her parents had spoiled her and that she was “wasting away at home.”

Over the next few months that I spent with Saira and her family, she would ask me often about her own perceived weakness, which was both physical and ethical. She did not tell me when or how weakness had originated, but she repeatedly spoke of her attraction to fire and water. Why these basic elements of life? I asked myself over and over. Was it their cleansing qualities, their significance in marking life and death? Saira told me that she could not explain this, and following Ellen Corin’s argument about the lifeworlds of

³²⁶ Marsden 2007: 88.

schizophrenics, this made me aware of just how complex and nontransparent this reality was, for her as well as for her interlocutors.³²⁷

After she came home from the hospital, Saira would lie in bed all day and watch the Discovery Channel. She was particularly fascinated by shows about deformities and disfigurements like elephantitis. I think she believed that her own illness was such a disfigurement. Meanwhile, she continued to ask about swimming and would practice holding her breath in her bed for long periods of time. One day, Saira left the house and tried to jump into the Jhelum river that flowed nearby. Luckily someone at the bridge had prevented her from jumping in. The last time I saw her, the day before I left Kashmir, she told me that she still felt restless.

IV. *Home Life and Kin Work*

The sight of Saira wolfing down her lunch that April day—the first day I had met the family—had brought tears to her mother’s eyes. She had told me that this was the first time that Saira was willingly eating since her admission. Her father, however, had been less optimistic. He had taken me aside and told me that Saira’s memory was ruined and that she had difficulty remembering even simple details. Later, I found out that he was referring to the effects of Saira’s extensive electroconvulsive therapy (ECT) treatment.

Furthermore, the long hospital stay had taken its toll on Saira’s parents, who were elderly. For 25 continuous days, they had both slept on the floor, on either side of Saira’s hospital bed. Saira’s mother had lifted up her gray overcoat (*pheran*) and said that she had not bathed or even had a chance to change her clothes since Saira’s admission into the hospital. Saira’s father, the sole

³²⁷ Corin 1998.

breadwinner of the family, had closed down his corner store for the duration of Saira's admission, so the family had been deprived of an income for almost an entire month. When I asked why he didn't open his shop now, Saira's father explained that Saira would not let him go; she insisted that both her parents stay with her. Her parents had obliged because they recognized a certain stubbornness in their daughter. *She won't let us leave her, even for a second, they told me.* Here I understand Saira as not just a victim of her illness, but rather, as an agent—unwavering and at times, demanding—in her desires on her parents. Saira was their only child, and that too, a daughter. This further heightened the pressure they felt to singlehandedly care for her, given the difficulty of asking extended kin to care for a person recognized as mad (*mot*).

Her parents also told me that before leaving the hospital, the psychiatrists had explained to them that Saira's original diagnosis had been changed. While they did not know the specific diagnoses, I learned from her file that her diagnosis had been changed, on the final days of her admission, from schizophrenia to bipolar affective disorder (BPAD) with depressive psychosis. One of the doctors treating Saira had told her father that, "earlier we could not tell what the illness really was. But now what we expected to appear has appeared [i.e. mania]."

The doctors also told Saira's parents to be "encouraging," which her father said he understood to mean giving in to her wishes and demands. Meanwhile, the implications of being "encouraging" meant that while the hospital resolved the problem of illness by performing a cut between the card and patient, Saira's family grappled with her desires and demands. The day they had left the hospital, I had asked Saira what she would do once she got home. She said that

she would do some housework, wash clothes, help her mother with the cooking, and then, her eyes brightened—maybe watch some TV.

Over the next few months, I visited Saira and her parents regularly in their home near one of Srinagar's most famous mosques, the austere Jama Masjid. On these visits, it became apparent to me how Saira's "file self" had graduated to the status of routinized entries, whereas Saira's home life was substantively different. For her parents, the first moment of rupture occurred with the psychiatrists' decision that Saira had to undergo ECT. While Saira's parents had been adamantly against ECT for their daughter, they had been persuaded over a period of days by psychiatrists who insisted that it was the only way for Saira to get better. They consented to the treatment under a great deal of pressure, but were never comfortable with it and were affirmed in their doubts by the lack of change in Saira's emotional state. In particular, while they expected that the ECT would allow Saira a certain protective numbing from her emotional pain, what they found was that she continued to be in pain, but that the numbing had dulled other capacities in her. Saira's mother told me that she thought the ECT had taken out the light in her daughter's eyes.

Saira, on her part, had only a vague recollection of the ECT sessions, and also felt that she had lost her sense of time and history. "How many shocks did I have?" she asked me several times. She was a student of English literature in college but confessed that she had "forgotten everything."³²⁸ This was not just a case where the stigma of shock therapy had left a mark on the family, but rather, where Saira's parents were convinced that the treatment had actually altered

³²⁸ This was not actually the case. After telling me that she liked Ernest Hemingway, I bought Saira a copy of *The Old Man and the Sea*, which she read easily and remembered key passages from class notes.

Saira's subjectivity in fundamental ways. Aside from the fact that Saira had resumed eating, the ECT had no positive effects on other aspects of her behavior which her parents were concerned about. Despite Saira's best efforts, her relentless talk about fire (and now, water) continued, as did her physical weakness (she would spend days in bed), and she was unable to help her mother with even basic household chores. Perhaps, then, there was a double divergence at work: a self separated from Saira, and a Saira whose brain was "treated" (although what this meant was also questionable) but whose heart remained troubled (*tang*). Far from the stability that doctors desired, or the restoration of her former self that Saira's parents desired, or to be free of emotional pain as Saira wanted, the hospital stay produced a new subjectivity for Saira, an agentive self who was difficult to manage for her parents.

After months of caring for Saira at home, her parents decided that an outing might do them good and the family traveled together to Saira's cousin's engagement party in Batwara. There, amongst her extended family, Saira described feeling "strange" (*ajeeb*). At one point, she thought one of her cousins said, in English, referring to Saira, "*She's empty, that's why she makes so much noise.*" The phrase repeated itself in Saira's mind and by evening she felt incapacitated, unable to even drink tea with her relatives. At night, thoroughly uncomfortable around so many people, Saira begged her parents to return home, and they hired a taxi to drive them back, arriving in Srinagar at one am. I could only imagine the embarrassment that her parents faced in front of their extended kin, not to mention the extra expenditure of hiring a taxi in the middle of the night. Were there associations made between the childless marriage of her parents and Saira's illness? Such late-night travel was highly unusual in

Kashmir, reserved only for medical and other emergencies, and in the imagination, for stories of boisterous celebrations in the pre-militancy period. Later, when she told me about the events that had transpired, Saira said that she realized that the voice she thought was her cousin's had not been real, that it had probably emanated from her own mind.

Meanwhile, despite this event and Saira's continued bouts of ill health, including her attempt to jump into the river, her parents refused to take her back to the hospital. Her treatment would only continue through a "proxy": her parents and her medical card could go to the OPD instead of her. In the psychiatric hospital, it was not uncommon to see kin of patients bring in medical cards on their behalf and have the doctor write on the card without consultation with the patient. Both doctors and kin usually offered financial justifications for this practice: the family was poor and could not afford two bus tickets, or the family could not afford to lose the patient's labor in the home on that particular day. While "treatment by proxy" raised questions about medical ethics for some practitioners, I suggest that they were able to continue this practice because they understood that the card was a site of care and intervention that existed in a relationship of likeness to the patient. Both doctors and patients understood that the card had a life of its own.

Yet "proxy" was also enabled by kin work. The card would continue to be treated, to be kept in play through the labor of kin who would make the trek to the hospital to collect medicines. The patient, meanwhile, continued a trajectory separate from the card in the form of home life, however disruptive and turbulent it may be.

Conclusion: Anthropological Convergences

While significant work in medical anthropology has shown that medical, particularly psychiatric, institutions help form collusive relationships between the state and family,³²⁹ Saira's case illustrates that there is a more nuanced relationship at work between these forces. Specifically, while psychiatric clinics in Kashmir (and more generally in north India) grapple with "the gendered fallouts of kinship,"³³⁰ they also produce new schisms within the family. The medical card, I suggest, has a significant role to play in this process.

I have argued that the fragile maintenance of a hospital-kin alliance, in part, rests on the kind of relation that is maintained between a patient and his or her "file self."³³¹ In other words, Saira's kin patiently bore the pain of her extended hospital stay, partly because they believed the action on Saira's medical card would correspond to an improvement in her bodily suffering. In the case of Saira, I showed how this relation of similarity between the file and patient broke down. In the failure of the hospital to take responsibility for Saira's lifeworld beyond hospitalization, however, a new relation was made: that of a "proxy."

Anthropologists and sociologists have described record keeping as a tool of social control in its ability to obfuscate social relations, produce uniformity in action, and make actors interchangeable. In the case of medical cards in Kashmir, I have tried to show that, despite attention to them as bureaucratic artifacts, they are not necessarily valued for their depersonalized, rationalized quality. Rather, I have shown how cards continue to bear the marks of both experts and patients who come into contact with them, a process I describe as *entanglement*. Instead of the idea that record keeping simply obfuscates social

³²⁹ Addlakha 2008: 29; Donzelot 1980; De Swaan 1988, 1990.

³³⁰ Pinto 2011.

³³¹ Harre 1984.

relations, then, I suggest that ethnographic attention to the card reveals the selective visualizations that the card enables: how certain aspects of a person are foregrounded – such as the character of the patient and doctor – while others – such as bodily suffering – are diverged.

By way of conclusion, I want to also reflect on what biomedical knowledge might tell us about ethnographic knowledge. I think documents have something important to offer in this regard. Far from being dry and mundane, anthropologists of documents and documentary practice have also shown that documents are valuable for the ways that they illuminate the process of ethnographic knowledge production itself.³³²

While in the psychiatric diseases hospital, I pored over medical records in the cool, dark, and generally quiet environs of the Nurse's Station, away from the clamor of the OPD. Since there were no photocopying facilities in the hospital, I was forced to record the content of patient files by hand, a process that was both time consuming and meditative in its effects. Thinking back on the movement between the relative silence of the Nurse's station and the cacophonous Family Ward, I have come to see that process similarly mirror the process of writing up and fieldwork, in the sense that each was an order of engagement that "partly inhabits or touches upon but does not encompass the other."³³³ As I discovered, to understand the relationship between files, patients, and experts, an alternation between immersion and movement was required.

³³² As Annelise Riles puts it, as artifacts, documents are ways for ethnographers to reflect on our own knowledge practices. As the joint labor between the anthropologist and her interlocutors, the document can become at once an "ethnographic object, an analytical category, and a methodological orientation" (Riles 2006: 7).

³³³ Strathern 1999: 2.

This switching of perspectives between revealing and concealing is also at the heart of the ethnographic process.³³⁴ The more I came to know Saira as a “file self,” the more she unraveled for me as a person that was still assertive, yet suffering. The more time I spent with her and her family in their home, the less visible the “*pt. doing well*” was to me. The movement between these perspectives did not make a complete picture, by any means; they only reinforced how partial each of those pictures – just like our writing work and field work – were in the first place. Yet, if these were the similarities between ethnographic and biomedical knowledge, what was different about them? I came to understand that while ethnographic knowledge was forged in the convergences between immersion and writing, biomedical knowledge, particularly in difficult cases, was actually thwarted by such movement. Divergence was necessary to achieve a rhythmic trajectory for the card, one that could be treated independently from the patient. While anthropological knowledge craves convergence, biomedicine requires divergence.

In the next chapter, I turn my attention to another material form—pills—which are revelatory of the multiple ways in which Kashmiri patients interact with and use biomedical technologies. While humanitarian workers have critiqued the use of medication to alleviate trauma in the Kashmiri context, there has been little attention paid to how pills are circulated, used, and experienced by Kashmiris. Pills are a key node in the “net” of medicalization, not only because of their status as boundary objects, but also because their appropriation usually exceeds the intent of the biomedical practitioner. As with the medical card, I suggest that pills also make clear the multiplicity of relations between

³³⁴ Strathern 1999: 6.

doctors and patients, complicating biomedical narratives about patient “non compliance.”

Chapter 4: “English Medicine” and the Multiplicity of *Davai*

Prelude: Amidst Pills

“Kashmiris are not health conscious; they are disease conscious,” said a pharmaceutical distributor to me, leaning back in his swivel chair. I was interviewing him in his house in a middle-class neighborhood of Srinagar, which he had converted into a stock room. He distributed pharmaceuticals from a number of Euro-American and Indian companies, such as GlaxoSmithKline and Ranbaxy. Around him, large notebook ledgers lay open, the inventory interrupted, tall shelves burst full of medicines, bottles, and cardboard sachets of tablets stacked full of “vibrant matter.”³³⁵ The room smelled bitter and was stuffy, like a school chemistry lab. Distracted and a little confused, I asked him to explain. “We Kashmiris, we only remember our bodies when we are sick. And now, because of the conflict, we want immediate results...so that [explains] the success of English medicine in Kashmir. Because of the conflict, our attention has been diverted: we don’t think about our bodies anymore. No one is healthy in Kashmir.”

This pharmaceutical distributor presented moral and political – rather than commercial, scientific, or historical – arguments for the “success” of biomedicine, called “English medicine,” in Kashmir and elsewhere in South Asia. Rather than point to aggressive marketing by the pharmaceutical juggernauts, for him, the success of pills was due to a lack of concern for the body and a low

³³⁵ Jane Bennett describes “vitality” as “the capacity of things—edibles, commodities, storms, metals—not only to impede or block the will and designs of humans but also to act as quasi agents or forces with trajectories, propensities, or tendencies of their own (Bennett 2010: viii).

tolerance for pain in light of longstanding trauma and suffering.³³⁶ In this chapter, I examine how pills provoke such heated, and at times, moralizing responses on the parts of medical professionals and consumers. This chapter examines the ways that the materiality of pills—their multiple, unstable, and mysterious forms—affect the ways in which people experience their effects.

For many Kashmiris, pills are the first line of defense against forms of bodily weakness (*kamzori*), as well as other bodily ailments related to longstanding trauma. In this context, pills are used as objects of anonymity, such as in cases of self-medication or intoxication, while at other times, they are markers of the body's ailments and of knots of familiarity. In other words, I argue that the pill is a commodity form of self-alienation, while also being a way to return the individual to his or her body in an intimate way. In this sense, the pill is an important node in the “net” of medicalization in Kashmir. It shows the ways in which medicalization is produced both through the prescription practices of experts, as well as through the everyday choices and negotiations of patients.

Introduction

In Kashmir and throughout South Asia, the Urdu word *dawai* refers to medicine in general as well as connotes the pill's material form. In Kashmir, psychopharmaceuticals continue to be a significant part of mental health treatment, despite the efforts of humanitarian organizations to move away from medical or pharmaceutical treatments towards counseling and other techniques. However, while humanitarian organizations, psychologists, and counselors often characterized the relationship Kashmiris have with biomedicine as a form of

³³⁶ As psychiatrists frequently pointed out to me, unattended trauma reduces a person's ability to withstand even ordinary pain and suffering.

“dependence,” I argue that the relationship between pills and bodies is actually a much more complex one, underpinned by a hermeneutics of suspicion that also characterizes interpersonal relations. For instance, I contest the narrative of “non compliance” that practitioners frequently used to critique patient practices by taking seriously uncertainties, ambivalence, and doubt toward pills as powerful motivating forces for the particular consumption practices that patients developed.³³⁷

Within psychiatry, psychopharmaceuticals have emerged as the cornerstone of the de-institutionalization movement. As Paul Brodwin has argued, the wide range of out-patient services available to psychiatric patients nonetheless all endorse psychopharmaceuticals as a key part of long-term treatment.³³⁸ Pills have increasingly come into focus as objects of concern in the medical anthropology of South Asia as well, particularly with the new National Mental Health Program (NMHP) focus on the provision and distribution of psychotropic medication at the Primary Health Center (PHC) levels.³³⁹ Sushrut Jadhav and Sumeet Jain, for example, use the journey of ‘the pill’ as a metaphor to “illuminate the social, cultural, and political processes that shape and actualize policy.”³⁴⁰ While this work is an important starting point for understanding the workings of macro-policy initiatives such as the National Mental Health Program, it leaves questions about the pill’s ontological form unexamined. In this chapter, my aim is not to critique pharmaceuticalization as the antithesis of patient participation and access to care. Rather, I am interested in the multiple

³³⁷ Cf. Leibing 2009.

³³⁸ Brodwin 2010.

³³⁹ Ecks and Basu 2009; Jain and Jadhav 2009; Kamat and Nichter 1998.

³⁴⁰ Jain and Jadhav 2009: 61.

ways in which pills produce uneven, partial participation within biomedical regimes.

Unlike the English word, *medicine*, *davai* does not foreground a body of expert knowledge, but rather understands medicine through its material aesthetic.³⁴¹ This chapter attempts to take seriously the semiotic, material, and experiential dimensions of biomedical pills in Kashmir as they cut across diverse spaces, somatic experiences, and therapeutic functions. In so doing, this chapter maps a “multiple ontology” of *davai*, in which not just the meanings, but the material form of pills are transformed as they move between terrains such as the marketplace, where they are sold by local “chemists” (pharmacists), the clinic, where they are a highly recognizable form of biomedical care, and in private spaces, where they are consumed as modes of self-care or intoxication. For example, how do these “common, sociomaterial practices”³⁴² produce pills as multiple objects?

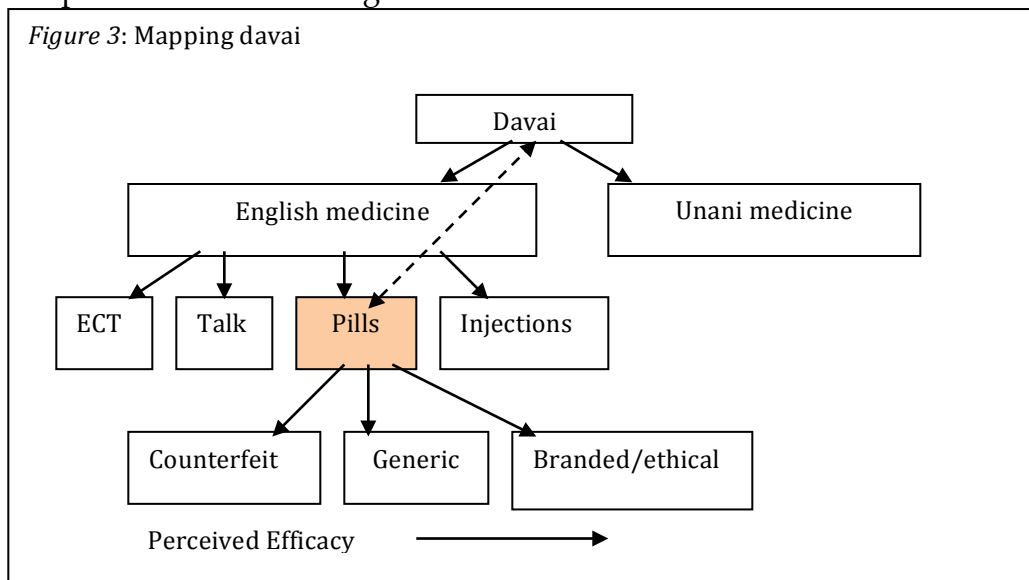
In foregrounding the relationship between people’s experiences of pills and their material forms, this chapter draws on recent work in science studies and medical anthropology which focuses on the production and performance of objects, bodies, and entities, sometimes across diverse sites of knowledge and practice.³⁴³ This work has disrupted the philosophical notion of ontology as “a property of things” in favor of showing “how ontologies are distributed through

³⁴¹ The Urdu word *daktari* or *daktari-kaam* (from the English word “doctor”) is usually used to refer to the study and practice of medicine (medicine as a body of knowledge).

³⁴² Mol 2002: 8.

³⁴³ Langwick 2011: 8. A concern for ontology has spilled into medical anthropology from science studies and has inspired a number of important works, including Annette Leibing’s work on gerontology and geriatrics (2009), Annemarie Mol and John Law’s work on hypoglycemia (2004), Allan Young’s history of post-traumatic stress disorder (1995), Lawrence Cohen’s examination of Alzheimer’s and its lack in India (1998), Stacey Pigg’s work on the production of AIDS as an object of developmental intervention (2001), and Margaret Lock’s notion of “local biologies” (1993), to name just a few.

practices of knowing and intervening.”³⁴⁴ Building on Annemarie Mol’s work on the “body multiple” – that is, how bodies or organisms hang together across different sites of medical expertise and bureaucracy – I want to explore the “pharmaceutical multiple” – how the pill becomes different things at different moments, and how it is produced as a form through affective experiences ranging from deliberate self-intoxication to doubt. In using the term, “multiplicity” thus, I refer to the ambivalent, contradictory, and uncertain effects that pills or *davai* are thought to have on Kashmiri bodies.



This chapter aims to disrupt the notion that medicine silences the objects of its knowledge³⁴⁵ and shows instead how pills and bodies produce each other in unexpected ways. Further, in drawing attention the multiplicity of pills, I provide an alternative discourse to the clinical language of “non compliance,” which is seen as a form of ignorance on the part of patients or their inability or unwillingness to follow a pharmaceutical regimen.

³⁴⁴ Langwick 2011: 8.

³⁴⁵ Sullivan 1986.

I asked one senior psychologist about high levels of pharmaceuticalization in Kashmir, for example, and she suggested, citing Peter Levine's *Waking the Tiger*, that Kashmiris' overdependence on pharmaceuticals could be a form of "abdicating responsibility" for social, political, or psychological problems. Counselors and psychologists who were trained in forms of psychotherapy also complained that patients preferred to "passively" receive their medication rather than take an active part in the therapeutic process. As a result, they reported low efficacy around therapies like Cognitive Behavioral Therapy (CBT), which were identified as shifting the locus of responsibility for behavioral improvement from the clinician to the patient (see chapter 2).

In drawing attention to the uncertainties and ambivalences in practices of consumption, I suggest that there is something more at stake than pills as simply the abdication of personal or social responsibility. The argument for the abdication of responsibility did not seem to ring true, since most people I encountered felt that this kind of freewheeling agency was not possible in Kashmir—and it had not been possible for four hundred years. While I read desires to consume pills as agentive acts, then, I suggest that Kashmiris are well aware of the temporary and circumscribed nature of the relief they offer.

This chapter outlines two kinds of "multiplicities" around pills. First, I argue that there is multiplicity around the aesthetic or *form* of pills. The singularity of the pill is destabilized by the fact that medicines are used as intoxicants, which then have to be retransformed into drugs in the clinic. I argue that anxieties about the aesthetic of pills stems from a) the uneven movement of global capital, particularly as it relates to the Indian pharmaceutical market and the production of branded, generic, and counterfeit drugs; b) historical and

political arguments about the ways in which corruption, mistrust, and suspicion have pervaded relations between persons in the period of insurgency (1989-2002) and its uncertain aftermath. As such pills are also markers used to compare Kashmir's political and social environs to other places, while also asserting Kashmir's particular traumatic history.

Second, I argue that there is multiplicity around the *effects* of pills, which are considered to be unknown, difficult to narrate, and which require somatic attention. This latter multiplicity relates to the fact that biomedical pills are thought to be potent or powerful objects, yet this understanding of potency also contains an aspect of danger within it. Rather than such multiplicities being excluded from the clinic – the idea that pills are simply prescribed from practitioner to patient, or that they exist simply as medicines in the space of the clinic - I show how both patients and clinicians are active participants in the everyday negotiations around the circulation, use, and consumption of pills.

As I will show, anxieties around the form and the content of pills cannot be easily separated, but rather, mutually inform each other. For instance, the circulation of branded, generic, and counterfeit drugs in Indian markets contributes to the sense that the efficacy or content of pills is not stable. Approximately 25 per cent of all biomedicines in India are thought to be counterfeit, fake, or of “substandard” quality, although there are not clear guidelines as to what constitutes “counterfeit” drugs in the Indian market.³⁴⁶ While concerns around generic and counterfeit drugs abound in other contexts

³⁴⁶ Lakshmi 2010. In some instances, counterfeit drugs are those that have been manufactured without appropriate licenses. In other cases, the content of these substances may have been compromised when compared to branded or generics. Further, expired drugs may also be labeled “counterfeit” in certain cases.

as well, there is something particular about the ways that these concerns congeal around pills and not other commodity forms, and that there is a specific history at stake here.

The Marketplace

In Kashmir, as elsewhere in India, most biomedical pills, including psychopharmaceuticals, are obtained over-the-counter from local pharmacy (called “chemist”) shops. Chemist shops are ubiquitous in both rural and urban marketplaces, although they are more visible in urban settings. According to a 2011 study of consumers in India’s four largest metropolitan areas, 88 per cent of respondents said that they had a chemist shop in their neighborhood, while 39 per cent said that they had more than one.³⁴⁷ In addition to their stockpile of drugs, chemist shops also often sell everyday household goods – milk, eggs, one-rupee sachets of shampoo and laundry detergent, diapers, biscuits, Maggi instant noodles, and cooking oil. The shops are easily identifiable, even to non-English speakers, due to the green “+” signs used on their banners (see *Figs 15 and 16*). In Kashmir, chemist shops also occupy an exceptional position as the only vendors who are allowed to stay open on strike or curfew days.

³⁴⁷ Narayana et al. 2011.



Illustration 11 and 12: Chemist shops in downtown Srinagar

Photos courtesy of Aditi Saraf



Although chemist shops sell drugs at more expensive rates than the pharmacies located in government hospitals, they tend to have a more stable supply of goods. As medical anthropologists working in India have shown, most pharmaceuticals make their way to Indian consumers not through specialized practitioners such as psychiatrists, but through “unlicensed” practitioners, such

as chemists, general practitioners (GPs) or rural medical practitioners (RMPs).³⁴⁸ While chemist shops are usually licensed by the Department of Health, it is commonplace to find the everyday running of the chemist shop without the presence of a licensed pharmacist. In addition, many chemist shops are family-run businesses, where expertise is gained on the job and shared between kin.³⁴⁹

I gained first-hand experience of the chemist shop as a vital node in the circulation of *davai* when, in the spring of 2010, I developed a kidney infection. I think the infection was caused by the long day-trips I was taking with Action Aid's survey team and the absence of public restrooms for women (an unfortunate feature of both rural and urban South Asian landscapes). Most days we would leave Srinagar at nine am and return at six pm or later. During these trips, I would ration my water carefully; perhaps too carefully, I thought later. After my symptoms did not improve, one of my psychologist friends took me to a GP in a private hospital who smoothly wrote out a prescription for 10 days of injectible antibiotics. I was told that any local chemist could provide me with the antibiotics or that I could come back to the private hospital.

I decided to go the chemist shop route, partly to avoid the unnecessary fuss of the hospital and partly to experience the sociality of a chemist's shop. In addition to their impressive stockpile of drugs and other everyday commodities, the chemist shop I visited also had a separate chamber used for things other than collecting medications. Staff used this space to check customers' blood pressure,

³⁴⁸ Ecks and Basu 2009.

³⁴⁹ In India, the Department of Health and Family Welfare issues two types of licenses for operating chemist shops. One is a Retail Drug License (RDL), which is only supposed to be issued to a person who possesses a degree or diploma in pharmacy from a recognized institution. The second license, the Wholesale Drug License (WDL) does not have this stipulation. In practice, the pharmacist in whose name the RDL license has been issued might not have any connection with the actual running of the shop.

administer injections – everything from antibiotics to insulin to calcium – or change bandages or gauzes. Since these shops are often located within neighborhoods, many of the customers are known by name or face and have been coming to the same shop for years. In these more informal spaces, patients could articulate their preference for injections over other forms of biomedical treatment without being questioned. In her fieldwork in rural north India, Sarah Pinto has similarly described how marginalized populations, such as Dalits and Muslims, frequently expressed a preference for medical techniques such as abortions and injections administered outside of state institutions as entailing less risk than those in official spaces. For such historically disenfranchised groups, the fear that hospital needles might contain poison or that they might receive inadequate care or forced sterilization while in hospital was a very real one.³⁵⁰ As we shall see, patients in Kashmir also expressed similar fears.

In the chemist shop, the air was usually calm, as people waited around unrushed. Despite the presence of gauzes, syringes, tubes and pills, the atmosphere resembled the homely drawing rooms used by *pirs*³⁵¹ – in which rounds of tea and bread are served as families wait to be seen – rather than the bureaucratized space of a doctor’s waiting room. In addition to this paramedic work, in the main part of the shop, chemists acted as full-fledged albeit “ersatz” doctors, doing much more than just filling prescriptions.³⁵² They exercised their own diagnostic capabilities every day since many customers came without prescriptions or with outdated ones. As a result, chemists created their own

³⁵⁰ Pinto 2004: 343. See also Tarlo 2003.

³⁵¹ Most Sufi healers in Kashmir practice from their homes.

³⁵² Pinto 2004.

chains of treatment after asking questions about symptoms, past ailments, and side effects.

Nonetheless, while the chemist shops appeared to be immune from some of the formal bureaucratization of hospitals, they were not outside of the logics of mistrust and corruption that characterized interpersonal relations in Kashmir, particularly those mediated by commercial interests. Chemists themselves acknowledged their in-between role between pharmaceutical companies and consumers and told me how pharmaceutical representatives would periodically come to quiz the staff about what kinds of drugs they prescribed, in order to designate them “A” (high) or “B” (low) prescribers.³⁵³ In addition to being guided by profit motives, ordinary Kashmiris also questioned the authenticity of chemists and the medicines they provided.

Part of this mistrust was generated by the fact that almost all pharmaceuticals and psychopharmaceuticals are found in three, almost identical forms in the marketplace: as “branded/ethical,” “generic” and “counterfeit” drugs. Most patients do not know whether they are being prescribed a generic or branded drugs, and prescriptions are difficult to read, even for those conversant in English. Although branded and generics are meant to be identical in content, generic medications cost significantly less than their branded counterparts. For example, whereas ten capsules of fluoxetine (the active ingredient in Prozac) 20mg sold for less than \$1 in India in 2008, the same amount sold for \$40 in the US by the pharmaceutical company, Eli Lilly.

³⁵³ Ecks and Basu 2009.

Whereas only one company (Eli Lilly) produces Prozac, there are over sixty companies that produce fluoxetine in the Indian market.³⁵⁴

The vast production of generic drugs like fluoxetine in India was enabled by a national patent regime (in place from 1972-2005) that protected the *process* of drug manufacturing, not the active ingredients. In practice, this meant that any molecule, even if produced in other countries, could be reverse-engineered and generically produced in India. Over the past decades, this patent regime has allowed the Indian pharmaceutical industry to become the world's leading producer and exporter of generic medications.³⁵⁵ Meanwhile, the Indian pharmaceutical market is a crowded space, with thousands of small, medium, and large pharmaceutical companies competing with practically identical "generic" medications.³⁵⁶ Some scholars, like Stefan Ecks and Soumita Basu (2009) have argued that the proliferation of generic drugs in the Indian market contradicts World Health Organization (WHO) assumptions about "treatment gaps" in mental health care between developed and developing countries.

While it is certainly true that psychopharmaceuticals are widely available in Indian markets, such arguments flatten the multiplicity of pills, which produce differentiations between generics and branded drugs, even though these are alleged to contain the same active ingredients and presumably, efficacy. In other words, while it may be true that Indian consumers financially benefit from the wide availability and relatively low cost of generic medications, there is an

³⁵⁴ In a landmark 2004 case, the Indian pharmaceutical company Ranbaxy won FDA approval to sell generic fluoxetine 40 mg in the US.

³⁵⁵ Ecks and Basu 2009. This particular regime is set to change in 2015, when India becomes a signatory to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) takes effect, as part of its WTO membership requirements.

³⁵⁶ According to a 2005 Ernst and Young study, only about 250 of the estimated 3000-20,000 pharmaceutical companies in India today generated annual sales of more than US \$2 million (Ecks and Basu 2009: 96).

“ecology of comparison”³⁵⁷ at work. By “ecology of comparison,” I refer to the process by which pills produce Kashmir as a substandard, potentially poisoned landscape in contrast to an imagined ‘outside,’ which is less corrupt, wealthier, and more modern. Such comparisons also manifest themselves in the personal preferences of younger drug users, for whom intoxicants that can be purchased from the market or stationary shop are more valuable than those that are found naturally grown.

It is not accidental, for example, that while most generics are produced by Indian pharmaceutical companies, most branded drugs are produced by Euro-American companies. As one pharmaceutical representative told me, “It is not clear where generic drugs are manufactured and under what conditions. There could be a scrimping on ingredients or the exclusion of basic salts.” In this account, there is an unstable relationship between the pill’s form and content, based on whether or not a drug is labeled generic or branded. This was also captured by the fact that Kashmiris referred to branded drugs using the English word, “ethical.”

Ethical, generic, and counterfeit drugs are difficult to tell apart because of the aesthetics at work in the production of these commodities. Like other non-branded commodities in the Indian market – such as music CDs, DVDs, or clothes – the ‘real’ and ‘not-real’ closely resemble each other. As Constantine Nakassis has shown in the case of counterfeit and branded clothes sold for domestic consumption in South India, for example:

local producers increasingly altered the logos and names of their brand ‘models’ [such as turning the outdoor sporting goods company *Columbia* into *Columbian*] in order to make them different

³⁵⁷ Choy 2011.

enough so as to not count as counterfeiting. To their mind, only an *exact* replica would count as breaking the law. But to treat such brand designs as aesthetic objects, freely able to be borrowed the same way one might use a color palette or geometrical shape, would be unproblematic.”³⁵⁸

Unlike the production of counterfeit clothing, generic medications in India are legal. However, recent news reports have also pointed to the vast market in counterfeit drugs as a byproduct of generic production. As one New Delhi-based private investigator put it, “They look real, but these are all fakes,” pointing to confiscated counterfeits in the packaging of GlaxoSmithKline, Novartis and Pfizer.³⁵⁹ In this sense, a similar logic governs the aesthetics of domestic pharmaceutical packaging, whereby the branded packages serve as “aesthetic objects, freely able to be borrowed” in the way that Nakassis describes branded clothing companies like Columbia and Adidas. Brands such as Prozac (Fig 17) serve as “models” for the ways that fluoxetine generics, such as Fludac by the Indian pharmaceutical company, Cadila (Fig 18) look.

Illustration 12:
The packaging
of Prozac



³⁵⁸ Nakassis 2012.

³⁵⁹ Lakshmi 2010.

Illustration 13: The packaging of Fludac (fluoxetine) by the Indian pharmaceutical company, Cadila



Many patients articulated the unstable relationship between ethical, generic, and counterfeits in economic terms: if the same medicine can cost ten rupees or forty rupees, how can it be the same thing? A patient I met at a hospital of Unani medicine, Bashir Iqbal also described generics with a sense of distrust. Bashir told me that recently, his wife had gotten a rash and she had used a tube of generic medicine, but her symptoms had not improved. “Here the chemists make so much money,” Bashir told me, “And I have no faith even if I go to the doctor, because he might prescribe a generic medicine [rather than a branded one]. It would be different if he were to write a proper medicine. But how would I even know if he wrote a poison or if he wrote a medicine?”

In his narrative, Bashir located the agency of the thing firmly with branded rather than generic drugs by describing branded drugs as “proper medicines.” Yet, as a person without the medical expertise to distinguish

between generics and branded drugs, Bashir also pointed to how this pharmaceutical regime promoted a culture of mistrust between doctors and patients, in which doctors might just prescribe poison. The questioning of generics was not restricted to patients. One of the psychiatrists I worked with described the subsidized psychopharmaceuticals available at the Government Psychiatric Diseases hospital as “sawdust.” I found that this deep sense of mistrust and inconsistency about the content of pills has led patients to develop modes of self-medication or self-care, which are more in line with their own bodily sensations, responses, and experiences of medication, rather than clinical prescriptions.

For Bashir, the efficacy of pills was also dependent upon the ethical orientation of the biomedical practitioner or the person giving the medication. As such, practitioners could also be ranked in terms of their efficacy. For Bashir, pills and practitioners were deeply intertwined; as he put it, “English medicine is alright as long as the practitioner is alright.” Within global psychiatric practice, pills are powerful precisely because they are detachable from practitioners and institutions, fostering de-institutionalized care. For patients, however, the detachability of pills was also a source of anxiety: “We buy medicines from the market, we don’t even *know* what is inside of them,” one patient said, contrasting this with an economy of the past, in which you procured raw ingredients, such as medicinal plants or herbs directly from healers themselves. (Today, of course, Ayurveda, Unani, and biomedical concoctions all jostle for space on the same crowded shelves of chemist shops). “And if we did know what was inside of them, but still ate them, then that would be an even greater sin,” he said,

referring to the possibility pork fat being used, which would be *haram* (forbidden) within Islam.³⁶⁰

Others like Bashir also felt that doctors had become corrupted and now only worked for money. Bashir compared the contemporary situation to a past where biomedical treatment was untainted by the nefarious forces of violence and corruption. He told me that, years ago, there used to be an English doctor in SMHS, Kashmir's largest public hospital, who had put his hand on his mother's stomach and knew that she had a gall bladder problem. This particular doctor had also saved Bashir's father from having an unnecessary surgery, while a different doctor had told him that surgery was essential.

Medical practitioners who I interviewed also echoed a sense that 'branded' or good doctors were ones who had a x-ray clinical vision and could unlock powerful ailments simply by touching or listening to a pulse.³⁶¹ According to Bashir, the entire discipline of medicine had become corrupted; rather than rely on touch, "now they have ultrasounds and God knows what else; they even strip the person naked," he told me, horrified. Bashir's aversion to these biomedical practices invoked doctor-patient relations that were not just corrupted by the onset of commercial interests (although this was also important), but also by the compromise of social ethics and responsibilities, such as norms of modesty.

In his narrative, Bashir pointed to the possibility of being poisoned either by the drug itself or by the practitioner. This suggests a level of mistrust that is

³⁶⁰ As I recounted in Chapter Two, medical missionaries also faced similar rumors about pork fat being used in biomedical treatment.

³⁶¹ Listening to the pulse is one of the diagnostic techniques used in Ayurvedic and Unani medicine.

deeper than the idea that medicine has been sullied by commercial interests. In particular, I argue that such worries about misrecognition marked daily interactions between Kashmiris, as it was commonly said that, “You never know who anyone is in Kashmir.” Given the long duration of the conflict and the ongoing participation of multiple shadowy forces – Indian and Pakistani paramilitary groups and intelligence organizations and local political factions (some of whom were funded by either side) – it was difficult to know who worked for who. Many times I would return from an interview and a friend would tell me that I had actually interviewed a mole of the Indian or Pakistani intelligence or sometimes even the CIA. I would suggest that the unpredictable movement of rumors about persons also extended to rumors about objects of care, including pills. While violence had exacerbated people’s dependency on *davai*, many felt that this dependency was not without consequence.

The Clinic

Medical professionals tried to establish a singular ontology of pills in the clinic, based around notions of compliance and the definition of mental illness as a chronic problem, requiring the consumption of psychopharmaceuticals, even without the presence of existing symptoms. However, given the multiplicities around pills, such norms of “compliance” were rarely accomplished. As such, rather than being a one-way process of prescription, the clinic was a space of negotiation, where relationships between patients and biomedical pills could not be reduced to a singular, clinical ontology.

In this section, I explore the ways in which complex relations between persons and pills emerged in the clinic to unexpected ends. These multiplicities once again related to the effect and forms of biomedical pills, including a

troubled history of kinship expressed through relations with pills; class-based preference for pills as intoxicants or medicine as drugs; and the sense that pills act on the body in ways that are difficult to discern but ultimately detrimental. In presenting a case of patient non-compliance from the Drug De-Addiction Clinic (DDC), I show how a clinical ontology of pills interacts with, and misses, the complexities of one particular patient's complicated history with biomedicine.

Tuesday, June 15, 2010 [From my field notes]

Today is the third day of a statewide strike. Three days ago, a teenager, Tufail Ahmed Mattoo, was killed by a teargas shell on his way home from an after-school tutorial. The shell came from security forces or the police; we are not sure. On the street, they found his notebooks, half-filled with practice exercises. Syed Ali Shah Geelani, the head of one of Kashmir's largest pro-independence political parties, the Hurriyat-G, lies on a hospital bed in Delhi and issues a call for more strikes. The marketplaces are eerily quiet in protest of Tufail's death; all the shop shutters down—or almost down. By now we've learned to read the in-between signs, those shopkeepers who crack their shutters open a few inches are willing to sell surreptitiously. Long, green summer gourds and money are exchanged quickly and quietly. Nothing more is revealed than a tanned and wrinkled hand from the other side. Some mumble that they have been threatened by young boys on motorcycles who demand that their shutters stay all the way down. The dogs own the streets—they stretch themselves out in the middle of the road, yawning lazily.

There are no auto rickshaws today, so I walk to the De-Addiction Center, from the street confrontations into the confrontations of the clinic. Hilal, one of the admitted patients, is standing in the middle of the ward in disheveled clothes. He announces to the other patients that they should not swallow their medicines. He has been faking his own medication intake for days, it turns out.

When the staff tells Hilal to “come down, talk to us, at least talk to us first,” Hilal responds, “I am absolutely fine, I am absolutely fine.” He is mimicking the psychiatrist, Dr. Wiqar, who tells him those same words every morning (“You are absolutely fine now”) while taking his blood pressure and tapering his medication. But now the staff tell him: No, Hilal, this time you are not fine.

The clinical psychologist, Dr. Muzzafar, and the social worker, Yasir, exchange glances at this irony. Dr. Muzzafar has been in arguments with Dr. Wiqar for weeks over the fact that he tells patients that they are

“absolutely fine” during their medical check-ups every morning. “Well, then they think, if I’m absolutely fine, why can’t I go home?” Dr. Muzzafar told me earlier, shaking his head. “Then it becomes a problem for us to keep them here. We have to motivate them all over again.” Of course, what Dr. Wiqar means is that they are “absolutely fine” from a purely medical standpoint, not in terms of the psychological or social component of their treatment, which is not his “domain.”

In the middle of this standoff, I ask Hilal why he doesn’t want his medicine. He says that he’s not suffering any side effects. “I don’t have diarrhea or pain in my legs or body, so why should I take these medicines?” he asks. Dr. Muzzafar tells Hilal that it’s not his choice; it’s not up to him when to decide to stop taking the pills. Now Dr. Muzzafar tries to appeal to Hilal in a more gentle way: he is older than the other boys, he is married, he is from a pirzada (high caste) family and he should be behaving in a manner more befitting of his position and status. Finally, after much persuasion, Hilal reluctantly agrees to start taking his pills again. As we file out of the ward, Dr. Muzzafar tells one of the security guards that he has his permission to beat up any patient who refuses to take his medication. Dr. Wiqar tells me that in the US, patients who refuse to take their meds are called “cheekers,” because they store the pills in their cheeks. “In psychiatry, we call these people malingerers,” he tells me.

Although it was a crisis, Hilal’s outburst was not a total surprise. A day earlier, Hilal’s refusal to take medication had been anxiously noted in his file by Dr. Wiqar. Dr. Wiqar marked this event as a crisis by noting not just the date of its occurrence, but also the specific time, 4:20 pm.

From the file of Pirzada Hilal Ahmed:

<p>June 14, 2010 – 4:20 pm. Pt. does not want medicine. STOP Gabapentin³⁶² STOP Inj. Neurobion forte STOP Librium³⁶³ STOP Dolo³⁶⁴ Pt. refuses to consume syp. Practin [sic] on inquiry of allegation. Plan: Pt. to be kept in DDC only if motivation is enhanced (Pt. creating problems in DDC, trying to get Codeine by various means).</p>

³⁶² Used in the treatment of seizures or epilepsy.

³⁶³ Chlordiazepoxide, used to relieve anxiety and to control agitation caused by alcohol withdrawal.

³⁶⁴ Paracetamol.

Here pills and the dispute around them became the markers of ongoing tensions between the different disciplines in the clinic – the clinical psychologists and social worker, on the one side, and the psychiatrist on the other. “Pt. to be kept in DDC only if motivation is enhanced” indicated that since motivation was the realm of the psychosocial, as the psychiatrist, Dr. Wiqar was absolved of all responsibility. He reduced his role to purely pharmacological functions and the repeated “STOPs” in the file were a note limiting his own interventions since the psychosocial interventions had failed.

The day of Hilal’s outburst, Dr. Wiqar also avoided responsibility for what happened. In the file, he described Hilal’s outburst as: “Misbehavior in ward reported. Pt. has not taken medicine and reports no medical complaint.” Although he was present in the ward for the unfolding of this scene, Dr. Wiqar again chose to write himself out of it. “Misbehavior” was simply reported; it just happened. This signaled his careful attempt to delineate a field of intervention for himself that was separate from the realm of the psychosocial, but nonetheless one that was also marked by it (see Chapter One).

For the DDC staff, Hilal presented a risk in a number of ways. He was “creating problems” in the center and he lacked motivation to stay. As Dr. Wiqar frustratingly described to me the day before the incident in the ward: “Yesterday he bluntly refused medicine. I discussed it with him for a long time, but he bluntly refused. Medicine cannot be forced, but *this is where the skill of the practitioner comes in...* he will have to be motivated again.” In referring to the “skill of the practitioner,” Dr. Wiqar felt that the brewing crisis was due to ongoing failures by Dr. Muzzafar and Yasir. Meanwhile, Dr. Muzzafar and Yasir

used Hilal's outburst to express their frustrations towards Dr. Wiqar. They were secretly relishing the fact that, in his psychotic outburst, Hilal had turned Dr. Wiqar's medical phrase – "you are absolutely fine" – upside down.

The incident with Hilal left a trace on the De-Addiction Clinic in terms of tensions between the staff being foregrounded, but it was not a particularly significant event in Hilal's own self narrative. Within the clinic's logic, Hilal's refusal to take medication was an effect of his opioid dependency, or possibly, an indicator of Bipolar Affective Disorder or "F19" (mental and behavioral disorders due to multiple drug use and use of other psychoactive substances),³⁶⁵ both of which were "queried" in his file as potential diagnoses. In a subsequent interview with Hilal, however, it came to light that his dependency on medicinal opiates was tied to a much more complicated relationship with biomedicine in general and pills in particular. Pills, for Hilal, were a material force connecting him to his father, who had also suffered from a severe mental illness.

Hilal told me that his father was treated for many years by Dr. Mohammed Beg, a famous (he described him using the English phrase "brand name") psychiatrist in Kashmir who was widely known as the 'father of psychiatry.' Hilal's father ran a chemist shop in Shopian, a town in north Kashmir. According to Hilal, his father had such a sharp temperament (*tez*) that he would "scare customers away." During Hilal's childhood, he remembers his father yelling at him and his siblings, "If even two rupees were missing." In contrast, Hilal's mother was a very "decent and loving" (*shareef*) woman, he says. His mother's relatives used to tell her that it was because she had "*too* much

³⁶⁵ The ICD-10 Classification of Mental and Behavioral Disorders: Clinical descriptions and diagnostic guidelines (F10-F19).

patience (*sabr*)” that all her children turned out badly. Hilal told me that ever since he could remember, his father used to beat his mother, and she would lie to people, telling them that she fell down the stairs. “My father,” began Hilal,

would take medicines for his illness. Dr. Beg would give him medicines for tension³⁶⁶ [Eng.] He would give him Librium and Diazepam. Then he would fall asleep and I would take control of the shop. But after Dr. Beg’s death, about 20 or 25 years ago, my father stopped taking the medicines. He started misbehaving with us all over again, but people would tell me, ‘Leave it. He’s your father.’

Nonetheless, the problems between Hilal and his father continued and eventually led Hilal to seek treatment from a psychiatrist as well. The doctor Hilal visited, whom he remembered by name – Dr. Ghulam Rasool Sheikh – also prescribed Hilal with Diazepam as well and some other pills he called “81.” The problematic kin knot was tightened through the generational transmission of illness.

After taking these medications, Hilal said that his “mouth would shut down. I wouldn’t be able to speak at all.” He went to see another doctor who told him to drink “a couple of capfuls of Corex [Codeine phosphate].”³⁶⁷ Hilal says that he slowly got into the habit of taking Codeine because it would make him feel relaxed and peaceful [*sakoon milta tha*]. Gradually, he began increasing the amount he took and eventually he felt that “he couldn’t do anything without it.” Despite his escalating medicinal use, it was important for Hilal to keep it a

³⁶⁶ As Murphy Halliburton has astutely pointed out, although English language words such as tension, stress, and depression have made their way into vernacular South Asian languages, these words are used distinctively from their association with psychological distress or embodied experience in English. Specifically, he argues that these terms are used as kinetic metaphors in Malayalam (and I would argue, Kashmiri as well) and denote a physical torsion – “they convey a feeling of pressure or weight on the body in order to represent conditions of mind and emotion” (Halliburton 2002: 1131).

³⁶⁷ An opioid painkiller.

secret. He got engaged about two years after he started using Codeine, and since his fiancée's family lived nearby, he didn't want word about his drug use getting around. He used to only drink Codeine alone, he said. "I felt that others who took drugs were dirty (*ganda*), and I didn't want to be associated with them. I still drank, but just alone."

For Hilal, it was important that Codeine was medicine or *davai*. "Yes, its true that it intoxicates," he told me, "but it is a medicine." According to Hilal, this made Codeine distinct from other intoxicants like alcohol (*sharaab*). Because Codeine was a medicine, it also had positive properties. While other intoxicants like alcohol, "depressed the mind" (*dimag dal jaata hai*), with Codeine, Hilal felt that he could be more productive, that it enhanced his ability to work well. As a result, he felt that he would not have taken another substance in place of Codeine.

Nonetheless, Hilal's drug use precipitated the sense that he was becoming like his father. "Slowly, I became like him," he told me. Before his wedding, Hilal decided to quit Codeine because he was worried that it might affect the relationship with his fiancée. He said that he managed to stay clean, despite the fact that he was in a lot of pain. Although Hilal worked hard to maintain cordial relations with his wife and in-laws, his father made it extremely difficult for him. The day of the *nikah* ceremony (the signing of the marriage contract), there were 32 relatives from Hilal's family who were set to go to his wife's home. A few hours before the ceremony, Hilal's father called his wife's family and mysteriously told them that only four people would be coming. His wife's family became upset and said that they had made arrangements for forty people to come, and why had Hilal's family "ruined [lit. thrown water on] everything?"

They thought that the entire marriage was going to be called off. Eventually the issue was straightened out and the marriage proceeded. No one knew why Hilal's father had taken this bizarre step and almost jeopardized the entire arrangement. When Hilal spoke to me about this particular incident, his voice quivered with anger.

Hilal articulated his knotty relationship with his father through the language of biomedicine, specifically *davai*; in other words, the dependencies produced through mental illness and drugs such as Diazepam became "part of the relational mix that is kinship."³⁶⁸ For Hilal, the relationship with his father was cemented through the fact that they shared a history of "tension," as well as with medication - both father and son were prescribed Diazepam. However, unlike the heroin addicts that Angela Garcia worked with in New Mexico, for whom shooting up heroin together was a form of care, here, Diazepam was not a shared practice. Rather, like heroin, it was the unfortunate groove through which painful kin relations circulated.

Hilal structured the time spent with his father as drifting between times when his father was "on medication" and therefore his behavior was somewhat subdued ("he would fall asleep") so that Hilal could properly "take control" of the shop. However, times when his father was not on medication are marked by anxiety and interpersonal turmoil for Hilal, including the violent behavior he expressed towards his mother and the fact that he almost jeopardized Hilal's marriage plans as well. This complicated history with medicine – including an ambivalent relationship to his father's own treatment and problems with mental illness (although Hilal never named it such, only as "*tension*") – was somehow

³⁶⁸ Garcia 2010: 128.

crystallized in the ward incident. Yet it also extended to experiences outside of his troubled relationship with his father. In this sense, pills, even when used in the clinic, articulated with a range of interpersonal relations that were outside of the staff's control. Further, despite the clinic's best efforts to demarcate drugs within the clinic as being different from intoxicants used outside the clinic, such distinctions were constantly blurred by patient doubts about the sanctity of the form/content relation of pills.

Medicine as Drugs, Drugs as Medicine

Other patients in the De-Addiction Clinic also expressed complex, ambivalent relations towards pills. Most patients had abused some form of medicinal opiates in the form of pills and described these as *davai* or medicine. As I will show in this section, there were many reasons why former drug users found pills to be desirable intoxicants, including, significantly, a metonymic relation between substance and person.³⁶⁹ These classifications were strikingly different from the medico-legal classifications used by clinicians, which categorized drugs as opiates, stimulants, depressants, hallucinogens, cannabis and volatile solvents. Whereas clinicians also used character "typologies" to relate to particular substances (ex. alcoholics tend to be gregarious, jovial and have rosy cheeks), patients described an alternate ontology based on whether drugs were "natural" or "man made." Further, given their prior entanglements with and dependence on biomedicine, most patients found it difficult to continue to trust medicines as a form of de-addiction treatment within the clinic.

Whether a patient chose to do "natural" drugs or "man made" drugs said a lot about his personality, class background, and ethics. While those who

³⁶⁹ Daniel 1984.

smoked hashish were generally derided as being “low class,” they were also described as being more “spiritually inclined,” “artistic,” or “Sufi” compared to those who chose other substances. As a precocious seventeen-year old patient named Junaid made clear, differences between drugs indexed differences in personhood. Junaid was a user of what the clinic called “volatile” substances – namely glue (known by its brand name, Fevicol) and whitener fluid (known as “flud” or *mushka*). Junaid felt that substances like medicine or glue – those that could be purchased at a chemist or stationary shop – were more respectable than “natural” drugs like cannabis. According to Junaid, substances like fluid or glue were “the drugs of choice for Westerners” (*yeh angrez ka nasha hai*); they also happened to be the drugs of choice for young men under the age of 21. While substances like whitener fluid and Fevicol came from other parts of India, “natural” drugs were produced locally. For Junaid, cannabis and other “natural drugs” were what “low class people, like drivers,” consume. On the other hand, those who chose to do “fluid” and other substances styled themselves as middle or upper-middle class and were desirous of a fast-paced, exciting life (*mazaa*).

In contrast to “natural” drug users who self-identified as Sufis and were more “spiritually inclined” (see chapter 5), those who used medicines also felt that there were certain advantages to the materiality of pills. In addition to the advantages of class, “man made” intoxicants such as pills were preferable in that they were more difficult to detect - they did not have a distinct smell, like alcohol or hashish. As everyday commodity or therapeutic objects, they were also easier to conceal than bottles of alcohol or cigarettes. Since hashish was mostly smoked mixed with tobacco, in rolled cigarettes, cigarettes could arouse suspicion. In addition, according to many drug users that I interviewed, the red eyes that

sometimes accompanied cannabis use were a giveaway. While medicines blurred your perception, sense of time, and balance, many said that these were easier to disguise than the telltale signs of “natural” intoxicants.

In this sense, “man made” vs. “natural” substances were seen as producing fundamentally different ethical subjectivities, which were in turn, deeply influenced by class distinctions. Despite the fact that using medicines was a form of mitigating the shame associated with drug use, however, all intoxicants were labeled as shameful in some way. While many patients in detox described experimenting with drugs for the first time in social settings, many described getting high alone because they were too ashamed or embarrassed that their habit might bring ruin to their entire family. A former alcoholic told me that his decision to get clean was catalyzed by a time when he heard his neighbor call out to her children not to play with his daughter, because she was the “daughter of an alcoholic” (*sharaabi ki beti*).³⁷⁰ He said that he flashed forward to a time in the future when he and his wife would struggle to find a marriage partner for his daughter because of his behavior. It was in this moment that he realized the effect of his behavior on his family, and it was then that he decided to seek help. For Hilal, similarly, the fact that he was using a medicine and not a “drug like cannabis” somewhat mitigated the label that he was an addict. Yet, he was well aware of the habit-forming potential of Codeine, which he described as making him feel “dirty” (*ganda*). Despite the fact that he was using medicine, Hilal was not immune to the logic of contamination or impurity with which he

³⁷⁰ Alcohol (*sharaab*) occupies a different status in Kashmir because of its explicit prohibition in the Qu’ran. In everyday discourse, I found that there was much more social stigma around alcohol than other intoxicants.

associated the act of being high (*nasha karna*). This meant that he had to keep his drug use a secret and that he only drank Codeine alone.³⁷¹

Many former drug users at the Drug De-Addiction Center also expressed skepticism about the role of medication in the process of detoxification or getting clean. As Veena Das has argued, skepticism has the ability to “unsettle social relations and produce the conditions of possibility for suffering and violence.”³⁷² I add to this an ethnographic account of how not just social relations, but relations with objects, are also disrupted in a highly skeptical environment, producing the sense of being caught or suspended.

This skepticism was produced through patients’ emphasis on willpower as the key to staying clean rather than anything the clinic could offer them, as well as the experience of having already been habituated to medicines. Rafiq, a 28 year-old handicrafts salesman and former heroin user, often complained to me about the medicines that he was being given at the De-Addiction Center. He said that the medicines gave him headaches, made his mouth dry, and were “unreliable.” He also acknowledged that medicines were not all that important in the process of staying clean, and on a previous occasion, he had quit “brown” (heroin) entirely on his own, by locking himself up in his room for a month. Many other patients also had similar experiences of detoxing on their own and being able to stay clean for a few months or years, without their relatives or friends ever knowing about their habit. For many, this was preferable to being incarcerated and potentially outed.

³⁷¹ There was a pervasive sense that both drug use and treatment needed to be kept a secret. Drug users were anxious about the group setting of the De-Addiction Clinic, for instance, and how it might betray their association to intoxicants. For more on this, see Chapter Five.

³⁷² Das 2007 in Khan 2012: 13.

Others, like Hilal, also doubted medicines because their addiction had been iatrogenic. One patient I interviewed, Hidayatullah, was 45 years old, married, with four children. He worked as a senior pharmacist in the Health Department of the Jammu and Kashmir government and had also been appointed as First Respondent for the Indian Army in Uri, an area close to the battlefield of the Kargil war, which was fought between India and Pakistan in 1999. When I asked him about the years of insurgency in Kashmir, he sounded rattled. He said that “militancy” (the insurgency) has wrecked havoc on Kashmiri society; “the panorama of death has depressed me, despaired me, handicapped me,” he said. “There was a time I thought—which bullet will kill me? Or which might rescue me? I experienced it all: despondency, grief, despair, helplessness.” Hidayatullah said that soon after the war, he decided to see a doctor for what he described as “persistent shivering.” The doctor prescribed a sleeping aid, Alparax³⁷³ (known in the US as Xanax), which is known to have addictive properties. As a pharmacist, Hidayatullah knew this, but said that he continued to take it, sometimes mixing it with another alprazolam called Anxit. Hidayatullah told me that he knew that the doctor had made a mistake prescribing Alparax, but he kept using.

Then, in 2007, Hidayatullah became ill with pneumonia and began taking Codeine phosphate, a medicine that is one of the most widely used pharmaceutical intoxicants in Kashmir. He said that when he tried to quit Codeine, he couldn’t, because by then his drug use “had already become a chain.” Hidayatullah said that he had taken pills to “escape his original life.” However, unlike Rafiq, Hidayatullah said that although he had tried to stop

³⁷³ A short acting anxiolytic of the benzodiazepine class of psychoactive drugs.

several times at home, he had not been successful. As a result, he felt that the in-patient treatment he was receiving at the De-Addiction Clinic was necessary for him to quit drugs entirely.

For drug users, as well as for other users of pharmaceuticals, *davai* are thus known to have potent, and potentially dangerous, properties and effects. While I have shown how former drug users negotiated their intoxication through substances that were befitting to their personalities and class considerations, in the following section, I focus on how notions of potency make their way into the clinic through means other than the phenomenology of intoxication.

Negotiations

Unlike the English word potency, the Hindu / Urdu term *shakti*³⁷⁴ has an ambivalent quality – the potential to harm as well as heal. While doctors often characterized their patients as hungry or desirous for pills, I found that pills were located within a continuum of biomedical objects of efficacy and care, which included more reliable objects such as injections and less reliable objects like talk therapy. As I have shown, pills were laden with anxieties related to their form (generic, ethical, and counterfeit) as well as their content or uncertain effects. As such, rather than think of pills flowing in one direction, from doctors to patients, I have tried to describe a more complex map, where pills circulate beyond authorized domains and where they frequently exceed their intended function. As such, I argue that diverse patient experiences of these objects produce them as unstable material objects.

Within the psychiatric hospital, the role of pills in treatment had to be carefully negotiated through an account of bodily effects. However, as I will

³⁷⁴ The English term, “potent” comes from the Latin *potens* or able, from the verb *posse*, to be able.

show, in order for a negotiation to be successful for the patient, the language of the body needed to fortuitously dovetail with the language of “extrapyramidal” symptoms or side effects. Psychiatrists in Kashmir were well versed in the intense debates around side effects for different psychopharmaceuticals. Debates around traditional antipsychotics, for example, have been particularly intense, where “extrapyramidal symptoms” (EPS) or side effects include tremors, involuntary movements, rigidity, bodily restlessness, muscle contractions and changes in heart rate, and in some cases can be fatal.³⁷⁵ As I will show, debates about “extrapyramidal symptoms” served as important guidelines in everyday clinical practice, when many patients expressed symptoms and bodily affects that did not fit into the existing scientific literature. Thus, although advances in neurochemistry and pharmacology have been essential to global de-institutionalization movements, psychiatrists and mental health practitioners were also often cognizant of the fact that pills can have unexpected, detrimental effects on the body. Yet the burden of proof always lay with the patient.

As I have shown, patients frequently expressed concern whether or not they had been prescribed the correct medication – whether they had gone to a doctor or a chemist, what these medicines actually contained, and what unknown effects they had on the body. Unlike many consumers of psychopharmaceuticals in the United States, who expressed side effects that were in line with clinical conceptions (such as weight gain or drowsiness),³⁷⁶ many consumers in Kashmir spoke in idioms – such as notions of pressure or temperature – that were not recognized by doctors as legitimate. Even the

³⁷⁵ Leibing 2009: 182.

³⁷⁶ Jenkins and Carpenter-Song 2005.

English-language word, “tension,” which has been vernacularized, does not connote the clinical definition of hypertension so much as the notion of heaviness or weight, as in, literally, ‘Don’t take more weight on yourself’ [Tension *mat le*].³⁷⁷ As such, many of the effects described by Kashmiri patients did not fit into the clinical matrix of “acceptable” or “authorized” side effects.

A clinical encounter that I witnessed between a woman in her twenties called Ruksana and one of the psychiatrists at the government psychiatric hospital, exemplified the ways multiple ontologies can rub up against each other. Much like the complex negotiations that mark relations between healers (*pirs*), djinns, and persons, the clinic is also a space where the effects of drugs are negotiated, rather than fixed.

Ruksana came to the Out Patient Department (OPD) of the psychiatric hospital on a cold Saturday morning in November 2009. Despite the damp, gray day, patients and their families huddled outside the OPD in their long overcoats (*pherans*), waiting for their name to be called to enter the doctor’s chamber, as they did almost every day. This particular morning, I found Dr. Zaid Wani, the psychiatrist on duty, in a bad mood. When I entered the consulting room, Dr. Zaid told me that he was suffering from a bad backache, due to the fact that his car had broken down the previous day, and while changing the tire, he had experienced a spasm in his back. In addition, he explained, none of the postgraduate (PG) psychiatry students or other psychiatrists who were supposed to be in attendance for the OPD were present, leaving Dr. Zaid to handle the large volume of patients single handedly. When I entered the OPD, I overheard him telling someone on the other end of the phone, “No one is here. No one is

³⁷⁷ Halliburton 2002.

here.” Nonetheless, as he had done so many times before, Dr. Zaid decided to get on with it. The steady stream of patients began at ten am and ended at two pm, at which time Dr. Zaid would usually wearily retreat to his office, where I had seen him chain smoke cigarettes, play Farmville on Facebook, and maybe work on his PTSD article.



Illustration 14:
Outside the Out
Patient
Department
(OPD) of the
Government
Psychiatric
Diseases
hospital

At about 10:30 am, when I had been sitting with Dr. Zaid for about half an hour, Ruksana entered. From their familiar mode of greeting each other, I learned that Ruksana had been Dr. Zaid’s patient for the duration of her illness. Here, I reproduce an excerpt of their exchange to underscore the ways in which pills and their effects on the body are negotiated between doctor and patient:

Dr. Zaid: How are you? Tell me your news. You look “set” [good] today.

Ruksana: Yes, today I feel like I’ve improved. *But overall I have become much weaker [kamzor].*

Dr. Zaid: You have been weak for a long time...

Ruksana: But today I feel weaker.

Dr. Zaid [to me]: You should have seen her before – she was almost dead.

Ruksana: When I went to JVC [another hospital], I improved. They gave me some medicines and I got a lot of strength [*taaqaat*] from them. They also gave me calcium.

Dr. Zaid: Don't worry. You can have another calcium injection.

Ruksana: Yes, calcium gives me strength.

Dr. Zaid [to me]: She was diagnosed with a major depressive disorder and she has gradually improved. Presently she's in remission [symptom free for two months].

[To Ruksana] Last time you came, I had given you a syrup. What happened to that?

Ruskana: It helped with my hunger [*mel*]. But I can't walk because of this tiredness [*thakavat*].

[One of the postgraduates who has just showed up for duty interrupts the conversation to ask Dr. Zaid a question, then leaves].

Dr. Zaid [to Ruksana]: So, should I prescribe you an injection or something else?

Ruksana: Do I have to put the injection in my arm?

Dr. Zaid: No, on your thigh.

[Another patient who Dr. Zaid has already seen comes into the consulting room and asks again about when he should be taking his medication. Dr. Zaid repeats it: ½ a tablet twice a day, after morning tea and after dinner. Then after six days, the ½ tablet is increased to 1. The patient leaves the room mumbling that his memory is weak.]

Ruksana: Oh, I thought you had to put the injection in your arm.

Dr. Zaid: No, you shouldn't put an injection into your arm because your arm is already weak. You'll have to take the injection every alternate day. In any case, where do you live?

Ruksana: Khejan.

Dr. Zaid: Also, you'll have to keep eating the medicine I gave you. How many children do you have?

Ruksana: I already told you last time that I'm not married yet. I got engaged recently.

Dr. Zaid: So when is the wedding?

Ruskana: Well, right now, I'm dying. I feel like I'm in a grave. The medicine I ate, that red medicine, from that *something happened to me...*

Dr. Zaid: But tell me, how much are you improving?

Ruksana: I still have pain in my arms and legs.

Dr. Zaid: You have to keep taking that red medicine. That will help you.

Otherwise you will have to buy a medicine from the market. What do you say?

What does your husband do?

Ruksana: He's a carpenter.

Dr. Zaid: OK, there is a tablet that you can buy from the market. From that you will see quick improvement. Do you have acidity in your stomach?

Ruksana: No just this: my heart gets troubled [*tang*] and I feel pain in my legs and arms. Then I have to ask someone to massage my legs for me.

Dr. Zaid: You will be all right.

Ruksana: These last few days, I thought I would kill myself. I was feeling horrible.

Dr. Zaid: Do you urinate OK?

Ruksana: Yes, twice a day.³⁷⁸

Dr. Zaid: Since you started taking this red medicine, did you have any problems urinating? Did it lessen?

Ruksana: No – from that medicine, I felt happy. But I felt a weight over my eyelids.

Dr. Zaid: Yes, it happens with this medicine.

Ruksana: The rest of my body is weighed down. I feel like I really can't move.

Dr. Zaid: So I will stop it then. Take one medicine from the market and take it once per day.

Ruksana: We're from the village and we have a lot of work, which we have to do ourselves.

Dr. Zaid: Don't worry. [After writing the new prescription, he hands the medical card back to Ruksana, who says salaam and leaves].

There are several micro-negotiations that take place in this encounter between Dr. Zaid and Ruksana, and the encounter is imbued with sexual tension, particularly Dr. Zaid's comments on Ruksana's physique ("You look set today"). It seemed that Dr. Zaid was not actually listening to Ruksana; his repeated injunctions to "not worry" seem dismissive. In fact, "don't worry" and "you will be fine" were two of the most oft repeated phrases in the clinic. Nonetheless, Ruksana persisted in her requests.

Pills are supplemented with injections as per Ruksana's request ("calcium gives me strength), and eventually and accidentally, Ruksana is able to convince Dr. Zaid that the "red medicine" is too unstable to continue. On his part, Dr.

³⁷⁸ Female patients from rural Kashmir often said they would urinate only twice a day – once in the morning before sunrise and once at night after sunset.

Zaid presses Ruksana for signs of improvement but only receives negative responses (“I am much weaker now,” “I felt like killing myself,” “I have pain in my arms and legs”). Nonetheless, once he checks whether or not Ruksana can afford to get off the red medicine (he asks what her future husband does to gauge their economic status) and once she describes “legitimate” side effects, such as drowsiness, Dr. Zaid is willing to change her regimen.

At the beginning of this encounter, Ruksana describes her experience with psychopharmaceuticals through a language of ambivalence and uncertainty. While Dr. Zaid locates her improvement in her physical comportment, Ruksana immediately contradicts this by pointing to the longer trajectory of her illness: “Yes, *today* I have improved,” she responds, “but *overall* I have become much weaker.” As I described in the Introduction, the language of “weakness” (*kamzori*) here that Ruksana draws upon indexes not just physical weakness, but also a spiritual, moral, and political affliction. This form of weakness is not easily treated by pills, as Ruksana indicates, but rather is better treated through injections, which are seen as “giving strength.” The experience of weakness and strength suggests that the body Ruksana knows through her experience of the “red medicine” is a radically different one from that which Dr. Zaid seeks to produce. Yet that body demands to be heard; it is insistent. In this exchange, I argue that Ruksana hails her body as a different kind of materialized presence than what Dr. Zaid is willing to acknowledge. I use the term “materialization” here, following Judith Butler, to extend Althusser’s notion of interpellation to embodiment.³⁷⁹ Ruksana’s insistence on the primacy of her experience suggest

³⁷⁹ Butler 1993.

that the interpellation by Dr. Zaid – and by extension, the state and medical establishment – do not fully capture her. However, both Dr. Zaid and Ruksana direct the process of medicalizing weakness (*kamzori*), though for different reasons, producing multiple materializations of suffering.

However, Ruksana's weakness is not equated with helplessness, in that she clearly indicates that when she took a calcium injection at another hospital, she felt much better. Yet, for her, better necessary implies *stronger*, whereas for Dr. Zaid, better would mean the subsiding of somatic symptoms. Whereas pills are seen as potentially dangerous, unknowable, and unstable, many patients express a preference for injections. In addition, many doctors and psychiatrists told me that they would use injections as a carrot in order to treat ambiguous symptoms such as weakness, because they felt that patients preferred injections, *even though they did not have a rational basis for doing so*. In the Kashmiri clinics where I did fieldwork, calcium, vitamin and even saline injections were common. Doctors would accede to these requests cheekily, treating these as placebos. Rather than dismiss injections at the level of perception, however, I would suggest that in examining their relation to pills, we see a fundamentally different body brought into being – one that can be made commensurable with a biomedical body only in a moment of contingency.

Injections have had a long history in South Asia and have been a highly visible marker of biomedicine in the region. As David Arnold has argued, colonial vaccination and immunization campaigns became emblematic of the colonial regime's "self-declared humanity and benevolence toward the people of

India.”³⁸⁰ Arnold argues that mass vaccination campaigns were the counterpoint to the East India Company’s ‘rule by force’ strategy, which became starkly evident in their ongoing disputes with the Maratha kingdom. Immunization programs continue to be an important cornerstone of the Ministry of Health and Family Welfare’s child and reproductive health strategies and are under close World Health Organization (WHO) monitoring and assessment. For instance, in 1985, India instituted the Universal Immunization Program (UIP), targeted towards vaccine preventable diseases including diphtheria, pertussis, tetanus, poliomyelitis, measles and childhood tuberculosis. Injections, central to vaccination and immunization programs, are thus one of the first and most visible vehicles for the transmission of biomedical knowledge and practice in India.

Far from being a mute or inarticulate recipient of biomedical treatment, Ruksana provided Dr. Zaid with a rich vocabulary for understanding how she saw the phenomenological core of her condition – including fatigue [*thakavat*], weakness [*kamzori*], and restlessness [*tang*] – which the pills were unable to dissolve. In contrast, Dr. Zaid asked pointed questions about the effects of the pills according to the “extrapyramidal effects” that have been authoritatively established, such as whether or not the medicine has affected urination. Towards the end of the encounter, there was a moment of accidental convergence between the language Ruksana provides and what Dr. Zaid was willing to recognize: that is, Ruksana’s description of “a weight over my eyelids... I feel like I really can’t move” which Dr. Zaid quickly translated into

³⁸⁰ Arnold 1993: 136.

feelings of sedation, which he finally acknowledged, can “happen with that medicine.”³⁸¹

The “actant”³⁸² that mediated this encounter is the “red medicine.” Ruksana takes seriously the fact that this medicine has dangerous, potentially unknown effects (“I don’t know what happens to me,” she said) and as a result, she keeps it at arm’s length. I argue that Ruksana’s deliberately vague description of the “red medicine” is a strategic distancing of this object from her body. While doctors would describe this lack of referentiality as an example of Ruksana’s ignorance about pills, there is something particular about the way in which this medicine does *not* get named here. The “red medicine” is a mysterious object; this open field of meaning suggests that its effects are also not fully known.

This encounter between Ruksana and Dr. Zaid exemplifies how both patients and doctors in Kashmir operate within competing, although not entirely distinct, ontologies of medicine. Nonetheless, while Ruksana chose to curtail her engagement with pills, other patients suffering from severe depression actively chose to continue taking pills in cases when the alternative was electroconvulsive therapy (ECT).³⁸³ In one case, I witnessed a male patient who lobbied his consulting psychiatrist to stay on his medication rather than begin sessions of

³⁸¹ As Judith Butler has argued, subjects appear agentive when they do something more than simply be iterative. As she puts it, a performance succeeds “not because an intention successfully governs the action of speech, but only because the action echoes prior actions and accumulates the force of authority through the repetition...of a prior and authoritative set of practices (Butler 1997: 51).

³⁸² Following science studies scholars, I use the term “actant” to refer to anything or anybody that shapes, influences, or modifies another entity through interacting with it. Actant covers the agency of both humans and nonhumans.

³⁸³ Much controversy surrounds the use of electroconvulsive therapy in severe mental illness, particularly in the developing world where it is often administered without anesthesia. While psychiatrists at the hospital were very aware of the debates surrounding “modified,” that is, with anesthesia, and “unmodified” ECT, the psychiatric hospital in Kashmir continued to administer “unmodified” ECT.

ECT. He described feelings of “chronic phobia” towards ECT. Although the psychiatrist continued to push for ECT, arguing that the patient was already on a high dose of medication and ECT had shown to be effective in cases of severe depression, the patient pleaded to stay on the medication. In the middle of this exchange, the ECT technician entered the psychiatrist’s chamber and complained that the machine was not working properly and that they were not being able to generate convulsions. The psychiatrist ordered the technician to stop doing any more ECTs until the machine was fixed. After this interruption, he conceded to the patient, telling him warily that, “it is your right to choose your own treatment.” Once again, this seemed to be a particularly fortuitous coming together of different interests in a moment of contingency, rather than the careful working out of a strategy. As with Ruksana, here too, the ability of a patient to negotiate in the clinic—while possible—was dependent on how it knitted together with authoritative biomedical epistemologies, such as established extrapyramidal symptoms or the smooth functioning of technology.

Conclusion

This chapter has attempted to map out the multiple materialities of pills – as medicines, forms of intoxication, unstable commodities, and as objects in a biomedical toolkit. I have tried to show how the uncertainty around the form and content of pills is produced by, and further exacerbates, a profound uncertainty about the ontological foundations of the social in Kashmir, situated in a long history of violence and occupation. As such, the circulation, use and misuse of pills, are a way of seeing the effects of violence, and they make visible the limited ways in which Kashmiris are able to navigate a net of medicalization. As such, pill negotiations are “not just examples of agency; they are agency’s

critical ground.”³⁸⁴ As a “critical ground,” however, such negotiations are uneven. For Ruksana, a gendered subject who is otherwise all too easily flattened under the gaze of Dr. Zaid, an intimate, bodily experience with pills is a means of asserting knowledge. Significantly for my larger argument, this knowledge does not consist of overturning the medical net, but of finding a way to maneuver within it.

In delineating the multiplicity of pills, I also seek to provide a counter narrative to the argument that Kashmiris are excessively dependent on pills because they are either a) looking for “fast relief” because they have a lower threshold for pain due to the corrosive effects of violence or b) due to culturalist arguments about a love of all things “new” or “Western.” As one doctor put it, “now patients want treatment (*eilaj*) for all kinds of aches and pains. The nail on my pinky finger hurts, so give me something for that, they’ll say.”

In this sense, pills were called upon to make a culturalist argument of decay, of a general weakening of the body, and the sapping of the Kashmiri body politic by violence and colonization. While patients longed for a more intuitive medicine – where doctors could “feel” or “touch” disease – many doctors and pharmaceutical distributors moralized and fantasized about a time where they did not exist, at least not in such demand. Dr. Wiqar, the psychiatrist at the De-Addiction Clinic, told me the following story when I asked him about the prevalence of biomedicine in Kashmir:

When the Mughal Emperor Akbar came through the Pir Panjal mountains [the mountain range that separates north India from Kashmir] in the 16th century, he found that he had a headache. He thought that it might be because of the saffron being cultivated in

³⁸⁴ Cohen 1999: 667.

the fields. He asked those working in the fields: how come you don't get headaches? They responded, 'What is a headache?'

This fantasy, told to me in the quiet of an empty afternoon consulting room, suggested that at least some biomedical practitioners longed for their own erasure. It also echoed the sentiments of the pharmaceutical distributor at the beginning of this chapter. At least part of this fantasy comes from the sense that the biomedical toolkit is unable to grapple with the forms of illness with which it is confronted, such as patients like Ruksana who insist that today she is better, *but overall she is much weaker*. In one ontology, calcium injections work better than the psychopharmaceuticals developed in high-end labs. In another, *davai* is more desirable as intoxicants than opium or cannabis, blurring the inside and the outside of the clinic. Pills are slippery, producing disjunctions between aims and ends, becoming markers of things and bodies larger and other than themselves.

In Chapter 5, I examine the ways in which an "epidemic" of drug addiction is produced in Kashmir by human rights, humanitarian, and media reports, as an artifact of trauma. In producing this tightly drawn link between violence, trauma and addiction, I argue that biomedical and humanitarian discourses obscured a view of everyday sufferings that were also present in the De-Addiction Clinic. In the final chapter, I seek to make visible some of these obfuscations, and in so doing, I point to a particular politics of visibility as opposed to exclusionary practices that I see at work in humanitarianism.

CHAPTER 5: LOVE IN THE TIME OF PTSD: LOSS, LONGING, AND ADDICTION

Introduction: Making an Epidemic

On a crisp April morning in 2010, to much media fanfare, the Jammu and Kashmir police hosted inauguration of a Stress Management Telephone Helpline. Since early that morning, the helpline's newly minted staff—clinical psychologists and social workers—had been nervously dusting their desks and chairs, adjusting and readjusting the optimistic posters they had made, and setting up trays of flowers and sweets for the dignitaries, including high level bureaucrats from the police, paramilitary organizations, and civilian government. The chief guest for the occasion, the Minister of State for Home Affairs, was taken on a tour of the DDC, flanked by dozens of junior police officers. The Minister peered into the ward, the large, dormitory-style room where the eight in-patients resided. The patients, all of them bathed and neatly dressed for the occasion, sat on plastic chairs in a semi-circle: a menagerie for the Minister to behold. Then, one of the junior bureaucrats blurted out, "Sir! They are even sniffing shoe polish!" The Minister paused for a moment, as if sensing that this was a perfect opportunity for a quote: "We have lost one generation to guns, and we are going to lose another generation to drugs!" he declared.

The Minister's statement was part of a well-rehearsed narrative about an "epidemic" of drug addiction as an effect of conflict-generated trauma that was told by the media, human rights and humanitarian organizations, and clinicians. As I have tried to show in this dissertation, this moment of revelation—designed to spotlight the "epidemic"—also concealed more than it revealed. For one, moment amplified the issue of drug addiction through the perversity of inhaling shoe polish. While this account fit the biomedical narrative of addiction as

pathology, it was particularly striking in a context where feet—associated with shoes and shoe polish—are considered the most impure part of the body. Through shoe polish, then, drug users were identified with a particularly perverse pathological act; they were not the “sympathy-deserving suffering humans”³⁸⁵ that have been mobilized in human rights and humanitarian claims in Palestine, for example.

This incident captured for me some of the paradoxes and “double binds” that constitute biomedical and humanitarian work in Kashmir. Rather than victims as the exemplification of “bare life,” which is so often seen in anthropological critiques of humanitarianism, here victims emerged through the lens of Kashmir’s particular political history. The traces of the dangerous insurgent or terrorist, which have marked, and continue to mark, male Kashmiris are still present within the humanitarian embrace.

The Minister was not alone in his belief that an entire generation of Kashmiris was in danger of *being “lost”* to drug addiction as a direct effect of violence, however; *drugs* had replaced *guns*, as he put it. In public accounts, medical professionals often identified drug addiction primarily as a product of conflict-generated trauma. In private, over hushed tones, medical professionals often present another explanation for addiction, namely that it was one of the lingering effects of Sufi influences in Kashmiri society. Despite the different political implications of both explanations, there was a consensus around the fact that drug addiction *was* at epidemic levels in contemporary Kashmir.

A recent news report claimed that approximately forty per cent of school and college students in Kashmir have used drugs in order to cope with ongoing

³⁸⁵ Allen 2009.

socio-political violence.³⁸⁶ Another feature on drug addiction in a local, English-language magazine, developed a tight causal relationship between torture, trauma, and addiction thus:

Inam Rashid (name changed) was among the many unfortunate ones who was picked up and interrogated by state agencies on the pretext of having links with militancy. For five days he was put under severe interrogation and was subsequently released without being charged. The mental scars of this ordeal refused to heal. As if this was not enough, this 35 year old lost 12 members of his family to the massive earthquake of 2005 in Uri. This was more than Rashid could bear. He sought a grim refuge in multiple addictive substances 'to erase the memories of his extended sufferings.' He turned to cannabis, nicotine, opium, ethanol, and benzodiazepine in search of relief.³⁸⁷

In this narrative, drug addiction and PTSD were inextricably linked, and drug addiction brought into the fold of other conflict-related psychiatric and psychological forms of distress, which, the argument went, were practically non-existent prior to 1989.

It was not only medical professionals who claimed that drug addiction was part of the PTSD phenomenon. The Indian military establishment was also making similar arguments. Anthropologists of PTSD and humanitarianism have powerfully shown how the diagnosis, recognition, and treatment of trauma have been rapidly globalized.³⁸⁸ A number of rich ethnographies have also shown that the globalization of PTSD has depended upon, and in some cases, been limited by, its appropriation into local political agendas.³⁸⁹ In the case of Kashmir, I have argued that the tools of medical humanitarianism, specifically PTSD, have been readily instrumentalized by the Indian state as well.

³⁸⁶ Bukhari 2010.

³⁸⁷ Boga 2010.

³⁸⁸ Fassin and Rechtman 2009; Fischer 1999.

³⁸⁹ Breslau 2000.

The Telephone Helpline was the latest such effort, located adjacent to a Drug De-Addiction Clinic, which was set up in the heart of the police headquarters, open to both civilians and police personnel. In addition, the police had also sponsored a number of de-addiction camps in both rural and urban areas. As with other “social services” in this zone of emergency, the redressal of drug addiction by the military establishment produced a belated response by the civilian government, leading to the establishment of a number of new de-addiction centers in both rural and urban areas as appendages to existing Primary Healthcare Centers (PHCs).³⁹⁰

The Jammu and Kashmir police’s involvement in drug and alcohol awareness and treatment was described to me as a curious accident of history; however, the police’s involvement in drug and alcohol awareness and treatment fits into a larger trend of Indian military efforts to use developmental and humanitarian instruments as justifications for continued Indian rule of the region. As Ravina Aggarwal and Mona Bhan have shown in the case of Ladakh, the impetus of the Indian military to do development or humanitarian work in the state was given a robust framework by Lt. General Arjun Ray, who laid out an initiative for the Indian army called Operation *Sadbhavana* (Operation Goodwill) in 2001.³⁹¹ *Sadbhavana* was implemented in 190 villages and towns in the Ladakh border region, not in the Kashmir valley. However, my ethnographic material suggests that *Sadbhavana* has been influential in Kashmir as well,

³⁹⁰ See for ex. <http://greaterkashmir.com/news/2011/Jun/13/drug-de-addiction-centre-in-sopore-60.asp>.

³⁹¹ While the intervention of the military in developmental efforts as a subsidiary organization and as an ‘aid to the civil government’ was not a new phenomenon for India, *Sadbhavana* marked the crystallization of hitherto isolated developmental and welfare efforts by the military into a comprehensive program especially geared towards border communities (Aggarwal and Bhan 2009: 520).

including as part of the military's self narrative. For instance, in recent years, the Central Reserve Police Force (CRPF) has rolled out billboards in Srinagar city, as well as on the Jammu-Srinagar highway, explicitly extolling its own civic virtues. One shows an elderly Kashmiri man, cupping his hands to accept water from the flask of a young Indian soldier. The proliferation of such humanitarian images, slogans, and programs in Kashmir, though not necessarily explicit at the policy level, nonetheless show how influential *Sadbhavana* as a slogan and a policy directive has been among bureaucrats and police personnel.

The police-run De-Addiction Center was another instantiation of *Sadbhavana*, in that it was part of an effort by the Indian government to recalibrate the means of counterinsurgency work by examining how terrorist "Others" could be transformed into helpless victims. In this sense, the DDC was part of a broader effort to rearticulate the means of counterinsurgency itself, including recalibrating how enemies could be transformed into victims through the language of medical humanitarianism.

In this chapter, I argue that, in the process of both Indian state and biomedical accounts of drug addiction as an effect of PTSD in Kashmir, everyday forms of suffering located in the link between love, madness, and intoxication, were increasingly obscured from clinical view. For example, it was through the idiom of intoxication, rather than the biomedical language of addiction, that drug users described their habit, as in, "I used to intoxicate myself (*Main nasha karta tha*)." In this sense, I suggest that narratives of love and drug intoxication can

reveal how drug users construct an alternative or “adjacent”³⁹² ethics outside of dominant clinical and religious discourses.

Recent anthropological work on ordinary ethics has argued for understanding of ethical and moral life beyond the capacity of individuals to make moral judgments and follow rules of conduct.³⁹³ In her work on Hindu-Muslim marriages in Delhi, for example, Veena Das has argued that “love [can] provide an opportunity to realize our ‘virtual being,’ which is not the idealized infantile self but rather...an adjacent self that is allowed to come into being.”³⁹⁴ Drawing on Stanley Cavell’s work, she defines an “adjacent self” as not a self that strives “to some higher level,” but points to a “striving in which the eventual everyday emerges in a relation of nextness to the actual everyday.”³⁹⁵ While this chapter is indebted to Das’ call to attend to the “everyday” as a place of “achievement”³⁹⁶ as she puts it, in Kashmir, I suggest that the language of intoxication favored by drug users includes an idea of transcending the vicissitudes of daily life. While this ascendancy is not for the “idealized infantile self,” nonetheless, I argue that the import of Sufi idioms in love stories is due to their ability to dovetail with, and thereby elevate, the status of worldly love to the divine.

Located in the heart of the J&K police headquarters or Police Control Room, the DDC was established in 2008. The police compound, a heavily fortified and guarded area, was located in one of the neighborhoods most affected by ‘militancy’ in Srinagar, Batmaloo. The neighborhood still had the

³⁹² Das 2010.

³⁹³ Lambek 2010.

³⁹⁴ Das 2010: 397.

³⁹⁵ Das 2010: 377.

³⁹⁶ Das 2007.

scars of urban insurgency: bunkers, some abandoned, some still occupied by soldiers scattered amidst shops and homes; ominous searchlights still turned on in the evenings and followed people's nervous shadows as they scuttled home. Some of my interlocutors told me how, in the 1990s, it had been impossible to walk the streets outside the police compound after four pm.

At the time of my fieldwork, the DDC had a total of eight beds. These beds were always occupied, with a waiting list of over 200 patients at any given time. This was despite the fact that the DDC was not publicized in any way, and all of the patients who visited the center came through discreet, interpersonal networks – through doctor referrals, ex-patients, or relatives in the police. Almost all of the patients I interviewed were trying to keep their treatment a secret from *someone* in their lives – girlfriends, extended family members, friends, or neighbors. For staff, patients, ex-patients, family members, and anyone else who wanted to visit the center, there were three security checkpoints to cross. The DDC's staff also included two policemen who provided 24-hour surveillance and were responsible for frisking all male visitors. The security was cumbersome, to say the least.

Clinical staff consisted of a psychiatrist, a clinical psychologist and administrator, a social worker, and a pharmacist.³⁹⁷ This was an all-male staff complementing an all-male ward. Aside from the occasional visits by female family members – who conducted their conversations behind the privacy of a curtain in the waiting area – I was usually the only woman present. When I asked one middle-aged patient why he was so protective of his wife who had

³⁹⁷ In early 2011, in addition to the Stress Management Helpline staff (four full-time counselors), another medical officer was also hired for the de-addiction clinic.

come to visit him, he said, “The men are not right here. They are capable of inappropriate things.” On my first day at the center, the clinical psychologist, Dr. Muzzafar, asked me not to divulge too many personal details when interviewing patients and to never give out my phone number. Although I was hyperaware of my gendered existence within this space, thanks largely to the staff’s generosity, I was able to establish a good rapport with most of the patients I interviewed and with many of their female relatives who visited. Nonetheless, there were jokes and asides that I was not privy to, so I could only observe the more bawdy aspects of male sociality from a distance. Although, through the reveries I will present, I was able to glimpse another dimension of male subjectivity that, to the best of my knowledge, was not accessed by the other staff at the DDC.

At any given time, there was usually only one patient out of eight whose drug use was directly related to a violent experience, in the way that the news report I cited earlier described. So, while I continued to collect narratives of trauma, I also began to opportunistically collect the narratives of ‘non-PTSD’ patients. These stories surprised me. Unlike the ‘PTSD’ patient narratives where the conflict was center stage, in the ‘non-PTSD’ patient population, the conflict was almost entirely absent. I asked my interlocutors direct questions about the possible links between the conflict and addiction, but none of the patients I spoke to described this as a reason for their drug use. Far from suffering from conflict-related wounds, those who I interviewed privileged love wounds as sites of their psychic trouble. Rather than read these love wounds as a sign of displaced war trauma, I argue that they are worthy of ethnographic attention in and of themselves. Methodologically, I attempt to treat the love stories here as

ethnographic artifacts, in that an artifact is the product of the ethnographic effort of working through one's theoretical concerns not by deductive analysis but as Annelise Riles puts it, "laterally, through the ethnographic apprehension of, or empathy for, others' analytical concerns."³⁹⁸

When I asked DDC staff about the prevalence of love trouble in narratives of addiction, they acknowledged their frequency, but dismissed them as youthful meanderings. Only one of my psychiatrist interlocutors found the love stories worthy of analysis, but for him, they were symptomatic of a larger pathology that had beset Kashmiri culture: globalization. He was pointing, in part, to the dramatic effect of modern technologies in facilitating love affairs. At the DDC, for example, patients carried out their businesses, love affairs, and familial obligations through cell phones. Cell phones also worked as boom boxes, providing a mode of sharing and singing along to the latest Hindi hits, and thus of broadcasting, although obliquely, one's particular mood. In this sense, as devices that selectively straddle both the public and private, mobile phones disrupt scholarly accounts of love in South Asia as happening mainly, "in the imagination, in the interstices of ordinary life, when no one else is looking, or in the interval between dreams and expectations."³⁹⁹

While acknowledging the significance of modern technologies in sustaining love affairs in Kashmir, I do not want to argue that such stories are the effects of such technologies. Unlike Laura Ahearn's ethnographic study of youth in rural Nepal, falling in love in Kashmir was not only about being modern,

³⁹⁸ Riles 2006a: 17.

³⁹⁹ Orsini 2006: 37.

successful, developed and independent.⁴⁰⁰ Rather, the reveries I present here are interesting precisely because they resist being fully subsumed within any of the available narrative frames: the history of the conflict, the narrative of PTSD, the onslaught of global modernity, or the handiwork of Sufi charlatans. Specifically, I argue that these reveries provide temporary literary flights out of the daily drudgery of the De-Addiction Center and Kashmir's present political *ennui* more generally. At the same time, these stories are not *only* "abstract lines of escape"⁴⁰¹ from the rigid confines of violence and trauma. Rather, these narratives also contain justifications for the present state of suspension or liminality that their speakers find themselves in. In Freud's terms, in "wandering back" to the past, they are modes of reflecting on "current impressions."⁴⁰²

In the case of love stories, I explore how such reveries enact links between madness, love, and intoxication, which cannot be easily folded into clinical discourses about addiction, violence or PTSD. For example, these stories drew on diverse yet highly conventional South Asian love repertoires – from Perso-Arabic stories focusing on *ishq* (a Sufi term that means love for the divine) and *muhabbat* (usually glossed as romantic love), to Hindi film plots highlighting structures of impossibility, to Sufi poetry and devotional songs (*qawwalis*), blurring the language of divine and worldly love.⁴⁰³

To situate these narratives in a more concrete time and place, let me first describe in some detail the temporality of everyday life at the DDC.

Timepass

⁴⁰⁰ Ahearn 2001.

⁴⁰¹ Deleuze 2006: 13.

⁴⁰² Freud 1958: 48.

⁴⁰³ Orsini 2006.

The DDC's policies were explicit attempts to distract patients from the state of suspension that they found themselves in after years of sustained drug use. One of the major challenges for patients and staff alike was motivating – or feeling motivated – to stay for the duration of treatment, typically 30 days. After all, no one willingly admitted themselves for in-patient treatment. In most cases, they were coerced, cajoled, or tricked into doing so by their family members.

During the first week of admission, patients were usually in an agitated state and eager to leave. Clinicians were able to convince family members that the desire to leave was simply a manifestation of “cravings” related to withdrawal. During this period, patients were usually heavily medicated while psychological interventions were kept to a minimum. It was usually after the first week, when the period of intense biomedical intervention was over, that patients would experience mood swings – moments of euphoria, but also feelings of anxiety, boredom, listlessness and depression. On their part, staff tried to combat their “lack of motivation” by analogizing the clinic to a “hotel.” “You have every comfort here,” staff members would tell patients, citing the fact that family members could visit them, that there was a TV in the ward, and that there was non-vegetarian food at least three times per week. These small ‘luxuries’ did mark the DDC as different from other in-patient treatment options in Kashmir, but patients could not shake the feeling that they were imprisoned.

To punctuate time and to facilitate motivation, the staff had also created what they considered to be a full and varied schedule, which included a “gym” and “outdoor game” period, in addition to a medicine review with the psychiatrist, an educative session with the social worker, and group sessions

with the clinical psychologist. This schedule was optimistically displayed in a glass display case at the center's entrance. In practice, however, the schedule operated more as a "fantasy document"⁴⁰⁴ rather than a strict template for daily activity, and certain parts of the schedule were more fixed than others. While patients often appreciated the daily "medicine review" every morning as other drug treatment facilities did not have doctors on site or check-ups on a daily basis, these morning routines also quickly became monotonous. For patients, responding to the same questions about mood, appetite, quality of sleep, cravings, and somatic complaints became redundant. By the end of thirty days, many would respond simply by rote, describing the encounter with doctors as a mandatory performance of progress.

For patients, the everyday of in-patient treatment seemed to have a problematic, doubly oppressive quality to it. They were frustrated by the fact that the outside could impinge upon their activities within the clinic, but that they could not effect the outside, either in times of strikes (*hartals*) or curfews or during important family occasions, such as weddings. Strikes (*hartals*) were always a particularly tense time in the city, with the heightened possibility of stone pelting (*pathrav*) or curfews imposed at a moment's notice.

Despite the staff's optimistic promises that the center was like a "hotel," for patients, the more obvious analogy was with jail.⁴⁰⁵ Time was marked by the discomforts of communal living. All eight in-patients slept on hospital beds in a single, large ward. For the bulk of my fieldwork, patients did not have lockers to

⁴⁰⁴ Clarke 2001.

⁴⁰⁵ Robert Desjarlais similarly notes that while staff of the homeless shelter in Boston where he conducted fieldwork described their shelter as the "Rolls Royce" of shelters, guests "do not hold the same level of enthusiasm" (Desjarlais 1994: 898).

place their personal belongings. There were regular complaints about the “lack of privacy.” There was only one bathroom, which had frequent hot water shortages and plumbing problems. Although there was the theoretical promise of non-vegetarian food, there were frequent fights between the patients and the police canteen staff over the low quality of the food. These daily confrontations orbited precisely around the same facilities that the staff had declared as making the center “hotel”-like.

In addition to these daily frictions, patients had several strategies to do *timepass* (pass the time) in the clinic. The television was helpful; it was perpetually on. Cigarette breaks were highly valued for their ability to pass time as well as important constituents of sociality;⁴⁰⁶ nonetheless many patients found it ironic that they were being weaned off drugs while being allowed or encouraged to smoke tobacco. One patient joked that, “even if I wasn’t a smoker before coming here, the center would have made me one.”⁴⁰⁷ There was also a lot of horsing around, joking, and teasing that punctuated the monotony of DDC life. Nonetheless, patients did not consider the center an appropriate place to make lasting friendships. When I would ask those who were friendly with one another if they would stay in touch after their admission, many were noncommittal or downright refused. At least part of this refusal had to do with the compact of secrecy shared by many admitted patients. If they were seen hanging out around town together, there was the likelihood that the secret of

⁴⁰⁶ In his analysis of the prison of Bomana gaol in Papua New Guinea, Adam Reed foregrounds the agency of tobacco or *smuk* in everyday prison life. For the inmates of Bomana gaol, *smuk* “is the dominant actor in prison.” More than something to do while passing time, tobacco smoking is held to alter one’s state of mind in ways that Reed finds are not reducible to its chemical effects. See Reed 2006.

⁴⁰⁷ While patients acknowledged the ontological status of tobacco as a drug, I did not find the same kind of transformative power of tobacco that Adam Reed found in Bomana gaol.

their addiction would be revealed. Thus, friendships at the DDC were also a form of *timepass*.

In this sense, cigarette breaks, quarrels, chitchats, naps, and television watching - those activities that broke the monotony of the schedule – were forms of provisioning (*jugar*), improvisations of bringing together diverse practices or technologies to cope in the meantime. In his work on unemployed, educated young men in north India, Craig Jeffrey found large numbers of youth engaged in forms of *timepass* characterized by “aimlessness and ennui.”⁴⁰⁸ Nonetheless, while *timepass* was productive for the unemployed youth Jeffrey worked with, at the DDC, there was the sense the *timepass* was an endpoint in itself.

In particular, at the DDC, *timepass* did not produce the rich forms of sociality that Jeffrey has described. DDC patients were doubly constrained in their relations with others by conditions of incarceration and the feeling that addiction was a shameful act that needed to be kept private because of its ability to reflect poorly not only on themselves, but on their entire family.⁴⁰⁹ In this sense, the stigma of drug addiction was similar to the stigma of dementia that Lawrence Cohen was written about since both were understood as forms of madness; the ‘old’ or ‘mad’ body “[was] not stigmatized as ‘itself’ but as the body of the family.”⁴¹⁰ The methods of *timepass* inside the DDC were not so different from the kinds of *timepass* outside the clinic, given the high rates of unemployment. As such, in many ways the DDC only heightened further the sense that “living in Kashmir is like living in a big jail,” a phrase I heard many times.

⁴⁰⁸ Jeffrey 2010: 4.

⁴⁰⁹ Cohen 1998.

⁴¹⁰ Cohen 1998: 177.

Reveries

The telling of love stories was another kind of *timepass* that was important in the life of the DDC. These stories walked the line between the fantastical and real. While they had a dreamlike quality to them, they were not, strictly speaking, acts of dreaming. They were somewhere in-between stories, daydreams, contemplations, sexual fantasies, and musings. As John Borneman has pointed out, while anthropological interest in the activity of dreaming has been sustained through the discipline's history⁴¹¹, anthropologists have left lateral activities – such as daydreaming and reverie - relatively untouched. As Borneman points out, reveries are akin to the psychoanalytic notion of fantasy, which describes processes that are accessible to the conscious subjects (unlike phantasy). While I do not take up Borneman's concern with how conscious reveries reemerge in unconscious dream-states, I find the concept of reverie useful in thinking about these stories as a narrative genre that is particular to South Asia. The temporality of reverie also captures the sense of suspension that I think is particular to the telling of these stories during a period of exile from society.

In this sense, while the telling of love reveries was a form of *timepass*, I suggest it was more than absent-minded television watching. Rather, it was closer to the idea of "experience" that Robert Desjarlais explores in his ethnography of a homeless shelter in Boston.⁴¹² Desjarlais argues that anthropological notions of "experience" are not particularly well defined and suggests that the term often stands in for a "fundamental, authentic, and

⁴¹¹ See for example, Fabian 1966. More recent work on dreaming includes Borneman 2011; Mittermaier 2010.

⁴¹² Desjarlais 1994.

unchanging constant in human life.”⁴¹³ For the tenuously mobile inhabitants of the homeless shelter who were his informants, Desjarlais argues that “struggling along” rather than “experiencing,” is a more appropriate category for the quality of time and reflection that was possible in that precarious place.⁴¹⁴ As he beautifully describes, the majority of shelter residents spent their time “between nervousness and staying calm,” making an effort to keep “shocks to a minimum and to hold oneself together.”⁴¹⁵

While many of Desjarlais’ descriptions resonated with the temporality of life in the DDC, particularly the residents’ preoccupation with time, I would argue that the telling of reveries provided patients with the possibility of narrative that was beyond simply “holding oneself together.” This might be because many of the patients came from relatively stable, middle-class homes and did not face the same existential threats of life on the streets as Desjarlais’ informants. The reveries I describe are one example of how patient experiences at the DDC transcended “struggling along.” These love reveries created an aesthetic, which included integration, coherence, renewal, and tying things together through time – some of the facets of ‘experience.’⁴¹⁶

Let me now turn to the storytellers.

Sajad

Sajad was 35 years old at the time of his admission, but looked much older. Years of sustained Codeine use had made his frame skeletal, many of his teeth had fallen out, and he had lost most of his hair. Out of the eight patients at

⁴¹³ Desjarlais 1994: 887.

⁴¹⁴ Desjarlais 1994: 887.

⁴¹⁵ Desjarlais 1994: 891.

⁴¹⁶ Desjarlais 1994: 896-7.

the center, he was the oldest and often took on the role of spokesman. In one of our interviews, Sajad said, “These boys are young. They go into drugs but they don’t have real problems – they do it for fun, on a whim (*shawk*). I feel like I have lived for 100 years.”

Sajad came from an illustrious and well-respected family. His father had served as a MLA under the Bakshi government and had spearheaded the revival of *kani* shawls in Kashmir.⁴¹⁷ Sajad’s father died in 2001, at which time he describes feeling a very big “jolt.” He felt unprepared to handle the host of responsibilities thrust on his shoulders. However, it was not his father’s death that Sajad blamed for his Codeine use. He told me that he started using in 1992-93. He turned to drugs after “a train ride changed his life.” Sajad’s narrative went like this:

I was traveling with my father by train. There was a girl sitting across from us, in the same compartment. She wrote a note and threw it to me. The note read, ‘My name is Anjali. I’m from Mysore [a city in the southern Indian state of Karnataka]. What’s your name and where are you from?’ I responded to the note. My father and I were supposed to get off the train at Bangalore, but when my father saw what was happening between us, he told me to continue on to Mysore with Anjali. My father had had a love marriage, and so he had never limited anyone’s marriage choice. I asked Anjali where she lived since I knew Mysore quite well. She gave me an address. It was a place where a lot of *dhobis* [washer men] lived. At that time, I thought to myself, even if she’s the daughter of a *dhobi*, I’ll marry her. It turned out that her father was not a *dhobi*, but an industrialist. I later learned that her mother was American and that her parents had also had a love marriage. When I got back to Kashmir after meeting her in Mysore, my mother had a letter from Anjali already waiting for me. She had also sent me a little Hanuman⁴¹⁸ statue for protection. Anjali spoke no Hindi, so we would exchange letters in English. Our relationship blossomed. I went to Mysore regularly to meet her for the next 2-3 years. The last time I saw her, she said

⁴¹⁷ *Kani* is a historically significant practice of shawl weaving using numerous eyeless wooden spokes (*tujis* or *kanis*) in the place of a shuttle. *Kani* literally means eyeless in Kashmiri.

⁴¹⁸ Hanuman is a Hindu deity and one of Rama’s most devoted companions in the Ramayana epic.

something that scared me. I told her I was coming to Mysore. She came to meet me on her Kinetic Honda scooter and we went to a park. Then she told me, 'I don't want to waste my time. I can't marry you.' I asked her why she had proposed [to have a relationship] to me in the first place. I told her, 'You should have told me straight.'

I caught the train back to Bangalore and cried profusely. I came down to earth from the sky.

Sajad's story contains many motifs that are familiar to South Asian literary and cinematic genres. Two that interest me here are the train journey and love letters, both of which are highly significant in Partition narratives, which Sajad grew up hearing. During the Partition, trains were transformed from being the grand instruments of colonial rule to silent funeral carriers. In the short story, "Her Body Beyond Pain" (*Khol Do*), for example, the Kashmiri writer Saadat Hasan Manto juxtaposed the timetable-like certainty of train journeys with the radical uncertainty of the Partition violence unfolding outside them. *Khol Do* begins thus: "The special train left Amritsar at two in the afternoon and reached Mughalpura eight hours later [a thirty mile journey]. Many people were killed en route, many injured; some went astray."⁴¹⁹ In Khushwant Singh's more optimistic 1956 novel, *Train to Pakistan*, the horrors of Partition violence are transcended by cross-cultural love between a Sikh boy and a Muslim girl.

Like Khushwant Singh's novel, Sajad's narrative recuperated the train as a site of utopian possibility. The train compartment is a space where difference is visible (caste/class/ethnicity/religion/region), but does not exist as a structure of impossibility. Rather, Sajad is enticed by Anjali precisely because of her difference from him: she is Hindu, half-American, from a southern corner of

⁴¹⁹ Manto 2011. In 2002, trains were once again the sites of intense communal violence. Riots that claimed the lives of thousands of Muslims in Gujarat were triggered by the burning of a train carriage carrying Hindu pilgrims, allegedly by a Muslim mob.

India, while Sajad is Muslim, Kashmiri, from the northern corner. This structure of opposites – particularly Hindu/Muslim and rich/poor – has been replicated countless times in contemporary Hindi cinema lovescapes. Although Anjali turns out to be rich like Sajad, he fantasizes about her as the daughter of a washerman, preparing himself to cross boundaries of class in addition to his willingness to traverse boundaries of religion, race, and geography.⁴²⁰

Sajad's narrative exemplifies this traversing of boundaries, but also of linguistic registers. He told the story to me in English with sprinklings of Urdu and Hindi phrases. As Rachel Dwyer has argued, love in Hindi films is polyglot; it is "made out of a whole set of visual codes (landscape, setting, physical appearance, costume, symbols, and so on) as well as those of language itself, a blend of registers of Hindi, Urdu and English."⁴²¹ The fact that Anjali and Sajad's romance blossoms through the writing of letters in English is also significant. As scholars have shown, in Hindi cinema, the expression or affirmation of love is often expressed through the English phrase, 'I love you,' rather than through any of the numerous words or phrases in Hindi/Urdu. Suvir Kaul also points out that Hindi-language film came to the motif of letters partly because of Partition separations, and partly because men and women did not have venues in which to meet, so "glances from afar and letters/notes stood in for real contact."⁴²² In this story, Anjali initiates the process of letter writing, suggesting that Sajad is a somewhat passive recipient of Anjali's desire. It is Anjali who makes the first move by throwing him a note; Sajad merely responds. This is an arena of life where Sajad does not have to take charge, unlike say, in the continuation of his

⁴²⁰ Das 2010.

⁴²¹ Dwyer 2000.

⁴²² Personal communication, December 11, 2011.

father's business. This abdication of agency is important in a context where love and intoxication are semiotically linked – a point which I will return to.

In his 1908 essay, "The Relation of the Poet to Day-Dreaming," Freud cautions against stereotyping fantasies or viewing them as static. Rather, he argues that the relation between fantasy and time is of utmost importance. According to Freud, fantasies "fit themselves into the changing impressions of life, alter with the vicissitudes of life."⁴²³ For Freud, day-dreams and reveries contain within them three periods of time or ideation: some current impression, occasioned by an event in the present, which has the power to arouse desire; a wandering back to the memory of an earlier experience in which this wish was fulfilled; and the creation of a situation of emergence in the future, representing the fulfillment of the wish.⁴²⁴

Following Freud, attending to the temporal structure of Sajad's reverie is instructive here: a "current impression" – an interview with a younger, unmarried, female, non-Kashmiri researcher - makes space for a "wandering back" into the past, which in turn paves the way for the future fulfillment of a wish. While I find Freud's intersecting temporalities useful, there is a need to complicate what we mean by "wandering back" and "wish fulfillment" in Sajad's narrative. For example, Freud's "wandering back" refers quite specifically to an early experience, generally belonging to infancy.⁴²⁵ While there may be the latent desire for a future wish fulfillment, I suggest that the temporality of importance here is between the past and the "current impression,"

⁴²³ Freud 1958: 48.

⁴²⁴ Freud 1958: 48.

⁴²⁵ Freud 1958: 48-49.

the moment of the interview, the location within the de-addiction center, and more broadly, within Kashmir's stagnant political present.

Sajad ends his story with the phrase: "I came down to the earth from the sky." At first listen, this appears to be a unidirectional fall from grace. Yet I suggest that the telling of this reverie, its ability to transport both speaker and listener to a different temporal and experiential plane, can itself be thought of as a re-ascension. In this sense, while Sajad projects himself in a state of fall, he also recognizes the need to move beyond this moment. This is a different engagement with the past than that of the "melancholic subject," who is trapped in affect and incapable of sublimating the pain of past loss so that he may live meaningfully in the present. Sajad is clearly marked by the past, but not entirely inhibited by it. In this sense, Sajad is different from the heroin addicts with whom Angela Garcia worked in the Rio Grande; he is not a "prisoner to the past" whose destiny is to "live a life as a partially realized subject."⁴²⁶ Rather, what Freud opens up for us nicely in his description of daydreaming is the possibility of performance in the present – the "current impression" – and the sense that the visit to the past is a "wandering," although perhaps a culturally familiar "wandering." For Sajad, wandering back to the past is also full of pleasurable moments – the tacit consent of his father, the writing of love letters between two cosmopolitans, the electric connection between two strangers.

Sajad's love story took another turn when I became acquainted with his wife, who would come to visit him every other day at the De-Addiction Center. Sajad and his wife had an arranged marriage in 2000, a year before his father's passing. It was clear why she had been an appropriate match for him: she was

⁴²⁶ Garcia 2010: 209.

elegant, well educated, and from a well-to-do family. Although she felt betrayed by Sajad's drug use – which had been a constant part of their marriage – she was determined to help restore his health. While Sajad's relationship with Anjali had been marked by passion and impossibility, his relationship with his wife was marked by understanding and possibility. Anjali and Sajad's relationship, as with many narratives I collected in this genre, did not culminate in marriage. In Sajad's life, they played diametrically opposed roles: his lover drove him to addiction, while his wife patiently shepherded him out of it.

One day, Sajad's wife brought a photo of him for me to see, from his "unspoiled" days, as she called them. Although Sajad had taken drugs since the early 1990s, his physical deterioration was evident only in the last few years. He was completely unrecognizable in the photo. He was holding his daughter in his arms, smiling widely with all his teeth in place, had a full head of hair, and a healthy frame. His wife told me that they had scheduled an appointment with a famous dentist in Delhi so that Sajad could have his teeth fixed. At the time, holding the photograph, I felt a sense of sadness in which her love was unrequited to the warmth that Sajad had bestowed on Anjali, and still did, so many years later. Reflecting on that moment now, however, it is clear that Sajad's past was more complex and contradictory than that of his reverie. There were forces and people who were pulling him out of his dreamlike state. By the end of his admission, Sajad had put on a bit of weight. There was a sense, however tenuous, that his new life – starting with a new set of teeth – was beginning.

Rouf

Rouf was 21 years old when I interviewed him. He embodied the quintessentially cool Kashmiri teenager, blasted the latest Bollywood hits on his cell phone, and shuffled around in dark, skinny jeans, Converse sneakers, and printed T-shirts. Rouf used to drive a commercial minibus in the city and enjoyed telling stories about his reckless driving and the roadside accidents he had gotten into, or almost gotten into, because he had been high on cannabis and painkillers.

In private, my conversations with Rouf turned to the romantic. Unlike Sajad, whose narrative flowed chronologically and had a clear beginning and end, Rouf's story meandered and was full of contradictions. It was difficult to draw out a clear trajectory of events, as Rouf spoke in fragments. The first time he told me about his love affairs, it was in the middle of a casual conversation about something else:

"I have replaced drugs with tears. Now I just cry for her," Rouf said.

"Who is she?" I asked him.

"Her family is poor and my family is rich. My father is completely against the wedding."

"Does she know about your treatment here?" I asked.

"She knows that I am getting some kind of treatment (*eilaj*), but that she thinks it is for stomach problems and back pain."

On another day, Rouf told me how, once when he had been intoxicated, he told her to stop studying after she had passed her tenth grade exams (i.e. matriculated). When I asked him why, he said, "Well, I was scared that she would go to college, and then other boys might see her...." His voice trailed off. He admitted that it was an irrational, even mad, thought.

“Her brothers are very dangerous, and are also dead against the relationship. They are even more dangerous than Hindus,” he told me, without a trace of sarcasm. Later, he said that although they were dangerous, that “he could handle them.”

Rouf said that he used to sneak into her room at night and stay until the morning call to prayer (*azaan*) and then duck out of the window. They almost got caught once; they heard a knock on the door but she had quickly said that a cat had jumped in through the window.

“She is my *Khuda* (God),” said Rouf.

Unlike Sajad, however, Rouf was not exclusive with his ladylove. He often spoke about other women he had affairs with. In one of our interviews, he openly tried to flirt with me. Uncomfortable, I casually ended the conversation. His flirtation did not seem to be premeditated or serious. The next time we met, it seemed that he had forgotten his forwardness.

For Rouf, managing an unsanctioned love affair from the DDC was difficult. He was frequently on the phone, either talking to his family members about his girlfriend or trying to appease her. This intense back-and-forth left him quite tired and often in a bad mood. On one of those days when he was upset, I asked Rouf what was wrong. He said: “All I ask of her is that she speak to her mother [about our relationship]. But she faints at the smallest sign of stress. For hours, she just lies there unconscious. She has become a heart patient because of me,” he said, his head bowed. Rouf said that she had also threatened to kill herself if Rouf got engaged to someone else. She told him that *she would rather die than let another man touch her*, echoing many a Hindi film. Towards the end of his time at the DDC, Rouf revealed that although he was promiscuous, he was

unable to forget her. There was something that was preventing him from ungluing himself from her: “I saw another girl that looked like her, but she didn’t talk like her. That’s what I missed: the way she talks,” he said.

Rouf’s love story provides an important contrast to Sajad’s, and, in many ways, is emblematic of what has transpired between a generation of Kashmiri men. Sajad, having already come of age when the insurgency began in 1989, had opportunities to travel beyond Kashmir with his father, and his narrative clearly reflects cosmopolitan desires for a united, postcolonial India that is achieved through transcending difference. Like Sajad, Rouf’s narrative was also marked by certain structures of impossibility, but I would argue that these were of a critically different scale than those of Sajad’s. In particular, Rouf’s narrative centered on issues around class, ‘my family is rich, her family is poor,’ rather than the geographical, religious, ethnic, and regional boundaries that Sajad was able to imagine.

Further, unlike Sajad’s narrative, in which romance was clearly contained within the material forms of the letters and train, Rouf’s narrative was both highly sexualized and tinged with violence, both in his telling of spending the night in his girlfriend’s room, as well as her promise that “she will not let another man touch her.” In addition, Rouf’s desire to trample his girlfriend’s dreams of a higher education because of his jealousy (understood as a form of madness in this context), her threat of suicide if they did not marry, and Rouf’s willingness to take on her “dangerous” brothers, were examples of the intermingling of violence and love. While Rouf was too young to have participated in Kashmir’s armed movement for self-determination, his narrative reveals the ways in which long-standing violence and suffering and the intense

militarization of everyday life, are experienced and reformulated in seemingly mundane stories of love and loss.

Of love, drugs, and madness

Despite their differences, for Sajad and Rouf, the reveries and the Sufi poetic language deployed in them, specifically the language of intoxication, provided a way to voice transgressive desires, longings for intimacy and unions in a way that was culturally recognizable, while still being elusive.⁴²⁷ In particular, I argue that the language of intoxication or *nasha*, drawn from Sufism, enabled both Sajad and Rouf, but also others who I interviewed, to draw upon phenomenological and semiotic links between love and madness. Unlike the young women who Sarah Pinto worked with in a north Indian clinic whose romantic lives were the objects of biomedical intervention,⁴²⁸ for male drug users in Kashmir, stories of romantic love operated as *alternatives* to biomedical and dominant religious discourses on addiction. As such, they were not the objects of biomedical intervention as much as responses to it.

While patients like Sajad and Rouf drew on a Sufi linguistic and phenomenological repertoire, clinicians often critiqued Sufism based on the perceived association between Sufis and intoxicating substances, particularly cannabis.⁴²⁹ The argument, which I heard many times over, was that prevalent drug use in Kashmir was the handiwork of *pirs* who relied on cannabis to lure

⁴²⁷ Green 2010: 308. Intoxication, love and poetry have been long intertwined in the South Asian Islamic context. See also Jaisi 2004.

⁴²⁸ Pinto 2011.

⁴²⁹ Historically, one sect of Sufism has been associated with practices of asceticism (*qalandar*) including smoking cannabis.

unassuming devotees. Dr. Muzzafar, the clinical psychologist at the De-Addiction Center, told a version of this story numbers times:

I knew a boy once who used to hang out in the park with his friends. One day, they met a *pir* in the park who promised them heaven (*jannat*). The *pir* took them on a long trek through the mountains until they reached a cave. For three days straight, the *pir* provided the boys with cannabis and they smoked continuously. They smoked so much that they believed they had actually seen heaven [usually laughter at this point]. They returned to the city, the *pir*'s promise fulfilled. But the boy was not satisfied: he wanted to experience heaven again. He began looking for the *pir* all over the city. Finally, he found him. When the *pir* saw the boy, he laughed knowingly. The boy became an addict.

This story was fascinating – although certainly not new. Nonetheless the story's mythic overtones also suggested that it was not meant to represent reality in a straightforward way, but rather, showed the ways in which a biomedical problem – addiction – has been instrumentalized to make a sectarian argument about proper Islamic practice.

The narrative satirizes the journey of divine love central to Sufism, clearly situating Sufis on the wrong path, and in so doing, exemplified the ways in which sectarian debates between Sufis and non-Sufis were alive and were heated everyday topics of conversation. During my fieldwork, I heard friends and colleagues argue vociferously over whether or not certain Sufi practices were proper to Islam. While some lamented the “demise” of Sufism – which they saw as an indigenous movement and thus tied to Kashmiri nationalism – in the face of reformist movements such as Salafism, others echoed familiar colonial and modernist arguments that the “superstition” of Sufism had persisted largely due to the backwardness of Kashmiri women, who continued to visit *pirs* and shrines. Most doctors I met, however, agreed with Dr. Muzzafar, that *pirs* did more harm than good. As Ernst and Lawrence have astutely pointed out, both sides of the

debate on the place of Sufism within Islam rest on a narrative of “decline,” a narrative, which has historically appealed to everyone from Orientalists, secular modernists, and fundamentalists, albeit for different reasons.⁴³⁰

Despite the public controversy surrounding Sufi devotional practices, many of the patients who told me stories about love quietly identified as Sufis. This practice was similar to what Katherine Ewing has described in the case of Pakistan, where men, in particular, were “drawn to Sufism and yet avoid [openly] identifying themselves as Sufis.”⁴³¹ For many, including Sajad, listening to Sufi devotional music (*qawwalis*) was a favorite pastime, although they knew that the place of music in devotional practice was highly contentious in contemporary public discourse.⁴³² However, Sufism provided a language through which to link the loss of self entailed by love – divine or worldly – with the loss of self entailed by intoxication. Urdu language poets, for example, Mir Taqi Mir, have also elaborated links between intoxication, love, and religious transgression, where intoxication is directly linked to the idea of losing oneself in divine love (*haqiqi*).

In making this argument, I want to note that I am not arguing that the language of Sufism is somehow more literal, truer to the subject, than the language of addiction or trauma. Rather, Rouf’s narrative drew on both Sufi and biomedical idioms—his invocation of *tension* and his reference to her as a “heart

⁴³⁰ Ernst and Lawrence 2002: 12.

⁴³¹ Ewing 1997: 163.

⁴³² The twentieth-century missionary movement of the Tablighi Jama’at, for example and the Sabiri Chishtis – who founded the Deoband seminary – rejected Sufi practices of tomb pilgrimage and listening to music altogether. Within certain strands of Sufism, particularly Chishti Sufism, the remembrance of God is achieved in two ways: through reciting the divine name (*zikr*) or evoking God’s presence through song (*sama*). As Ernst and Lawrence (2002: 107) along with other scholars have pointed out, the concept of *sama* has been particularly contentious the history of Islamic thought, between different sects of Sufis as well as between Sufi and more scriptural forms of Islam.

patient” are just two examples—in a seamless fashion to craft a narrative that hinged on a journey of *being lost* in intoxication. This is significant in my argument about the interweaving of biomedical and local idioms of suffering in Kashmir. However, it is also notable that the language of intoxication, rather than addiction, captures the sensual pleasures and turbulence of both love and drug highs. Here both Sufism and biomedicine are instruments through which Rouf and other drug users expressed their devotion—to God and their lovers—as ecstasy and madness.

Within Sufism, the path to divine love is achieved through *fanaʿ* or annihilation of the self. As Ernst and Lawrence eloquently put it, the attainment of *fanaʿ* “requires divine love, love inspired by God, satisfied by nothing less than God. It is an overpowering love. It is a love that leads to annihilation. It leads to what is described as ‘destruction of the soul.’”⁴³³ This destruction is not an endpoint, but rather an entryway into divine restoration or permanence (*baqaʿ*). As such, this sense of annihilation as productive is also radically different from a biomedical understanding of death or annihilation, which is read as a failure.

Within Urdu poetry, this permanence is imagined as a form of restlessness or agitation (*iztirab*). As the poet Mir writes, “Again and again I am caught in fear [of her?]/Now I’m restless, agitated in my being”⁴³⁴ The ambiguity of divine and worldly love so central to Mir’s poetry are echoed in Rouf’s words and in Sajad’s loss of Anjali: the loss of unity with the divine and the fall from the sky to the earth is analogized to the return to the self after ecstasy or *fanaʿ*. Similarly, the call to experience the immediacy of God through acts such as

⁴³³ Ernst and Lawrence 2002: 15.

⁴³⁴ *Bar bar us ke dar pah jata hun/ Halat ab iztirab ki si hai* (From: Hasti Apni Habab Ki Si Hai).

spiritual intoxication, I would argue, also informed the ways in which patients at the DDC described their journey through worldly love (*majazi*). These were phenomenologically linked, as in Rouf's succinct phrase, "She is my *Khuda* (God)."

I argue that the language of intoxication (*nasha*) thus provides a way to move between discourses of devotion and addiction. *Nasha* has polysemic moral and religious valences which go beyond clinical understandings of addiction; *nasha* is not only intoxication from illicit substances, but can also be a form of ecstasy, borne of unity with the divine. There is also a direct linguistic association between "madness" and "love" in Urdu, through the concept of *junoon*, a word etymologically derived from classical Arabic love story of Layla and Majnun or "The Madman and Layla." Today, "Majnun" continues to refer to a person who is in *junoon* (madly in love). *Junoon*, a word which sometimes substitutes for "addiction," literally means something you cannot live without.

Conclusion: An Alternate Self?

To conclude, I also want to suggest that the language of intoxication (*nasha*) also opens up an alternative ontology of drugs at work in Kashmir. In this ontology, drugs are not lumped into a single category, but rather are distinguishable based on the ethical subjectivities they produce. This was a very different ontology from the language of clinicians, for whom addiction was an artifact of misguided Sufi practices *or* conflict-generated trauma. These reveries also called for a sense of being lost that was radically different from the Minister of State's proclamation that a generation of Kashmiris had been "lost" to drugs. To *lose oneself* rather than *to be lost*, however, does not simply suggest an inversion of agency, although the implications for agency are important. After

all, the path to divine love, to lose oneself in intoxication or ecstasy, can be riddled with turmoil and dizzying uncertainty. Yet, losing oneself in love or *fana*, also means that there is an Other to whom we speak; losing oneself can be a means to reanimate the subject in a dialogical relation.

Similarly, for many patients, a connection with a Sufi *pir* constituted an important part of their healing process, and in spite of the advice of mental health professionals to the contrary, many continued to visit *pirs* for the duration and beyond the course of their medical treatment. They cited several reasons for doing so, but one patient I met, Sohail, articulated his reasons well. Sohail, a seventeen-year old auto rickshaw driver that I met at the DDC was firmly committed to the idea that a *pir*, not the DDC, would cure his dependency on drugs.

Sohail described to me his experience with a *pir* named Yusuf Sahab from his hometown. He said that meeting him had been a transformative experience. As I scribbled furiously in my notebook, Sohail said, “You see, as you’re writing now, I don’t feel anything. But when he used to write, I would feel that he was writing words in my heart.” Sohail wore a ring that Yusuf Sahab had blessed in 2001. He said that this object, not any medical treatment, would get him out of this spiral. When I asked him why, Sohail responded that the medical establishment did not fully understand the complexity of substances like cannabis, but they simply labeled them as ‘bad.’ When I asked Sohail what was positive about cannabis, he said that it enabled the contemplation of certain unknowns. “Such as?” I asked him. Sohail engaged in a rare moment of eye contact with me and responded, “What comes before birth and after death.”

In other interviews, some patients had also confessed to me that rather than being un-Islamic, cannabis actually produced a more ethical subjectivity than they would otherwise have. An eighteen-year old patient, Umar Farooq, who I met at the DDC, who described himself as an “excellent” student before his drug use (a combination of whitener fluid and cannabis), was particularly eloquent on this subject. One day, as I was interviewing another patient, Sameer, in the ward, Umar was sitting near by, within earshot, but with his attention turned to the TV blaring Hindi film songs. During the course of my interview, I asked Sameer why someone might prefer one form of intoxication (*nasha*) over another. Umar turned his head around and interrupted us, “*Nasha*, what do we even call *nasha*?”

Sameer and I were both stumped, and Umar happily took over the conversation. According to Umar, while some drugs “stopped your mind from working, other drugs, like *charas* (cannabis), helped you to start thinking. *Charas* has a different effect on you.” I asked Umar to give an example. Umar said that when he was high on cannabis, he was able to remember God. He also said that cannabis allowed him to properly practice respect towards elders and women, such as *nazar* (lowering the gaze). As he explained to me, when he used whitener fluid, “I used to speak to my father with my nose in the air (lit. boldly; *sir uttha ke*).” But when he used cannabis, he was able to “lower his gaze.” Echoing Sohail, Umar also said that cannabis enabled a certain solitary (*tanhayee*) contemplation; it brought about a more humble self in relation to God.

Thus, in addition to the alternative language of *nasha*, drug users in Kashmir also described a different ontology of drugs at work than those used by the clinic. While clinical staff typically distinguished between different types of

drugs (benzodiazepines, cannabis, nicotine, alcohol, and volatile substances), the experiences of Umar, Sohail, and others suggested that they deployed a different system of classification, one that enabled a parsing out of drugs based on the kinds of ethics and phenomenological states they enabled. As such, drugs were distinguishable for the kinds of ethical horizons they opened up, and cannabis, in particular, was valued for its ability to move the user closer to god.

In this chapter, I have argued that the language of intoxication enables the enfolding of narratives of worldly love and loss into notions of divine love. I have also tried to show how biomedical understandings of PTSD, violence, and addiction in Kashmir obscure a view of alternative ontologies of drugs and experiences of intoxication present within the space of the clinic. However, humanitarian knowledge and Sufism are not fundamentally opposed, but as part of the same “net” which subjects find themselves caught in: one that makes visible certain nodes and connections while concealing others. For example, while Sufi idioms offered drug users a way out of the drudgery of *timepass* and constricting biomedical and religious discourses on addiction, they presented a path to love that was dizzying and unsteady. Nonetheless, I contend that these love stories provided a way, however fleeting, for drug users to carve a coherent narrative self in a world lacking in such coherence.

CONCLUSION: MEDITATION ON A NET

In this dissertation, I have proposed the net as an appropriate form through which to understand relations between bodily experience, medical and humanitarian knowledge, and profound social, political, and historical upheavals in Kashmir.

Several key works in the anthropology of humanitarianism have focused on how social life is recalibrated within a new moral economy of humanitarianism. In these analyses, suffering is shown as replacing social and economic inequalities; social and political problems are individualized; political violence is re-read as psychosomatic “trauma”; and politics itself is replaced with an emotional response directed at depoliticized victims.⁴³⁵ I have argued that some of these critiques obscure more than they reveal about the frictions that characterize everyday life in the clinic and the ways in which biomedical and humanitarian tools are appropriated outside of their intended functions. Rather than view humanitarian and biomedical forms as characterized by totalizing ontological and epistemological shifts, I have argued instead, that it is forged by a politics of visibility marked by co-presence rather than substitution or exclusion.

In evoking *the net* as both visual metaphor and performative device, my aim has not been to imply the existence of an object and its corresponding image. Instead, I understand the net as constituted by both interwoven lines and by gaps in between. This includes the co-presence of alternative epistemologies—such as around madness (Chapter One), medical cards (Chapter Three), pills

⁴³⁵ Fassin 2011; James 2010; Malkki 1995; Pandolfi 2011; Summerfield 1999; Ticktin 2011. For other accounts of co-presence see Pandolfo 2007; Povinelli 2002.

(Chapter Four), and addiction (Chapter 5), as well as around less visible subjects, such as local or national staff, victims, and patients (Chapter Two)—within the biomedical and humanitarian aesthetic. In this sense, I do not see humanitarianism as a politics of movement between “lives to be risked” and “lives to be saved.”⁴³⁶ Rather, I insist that it is forged through practices that are about *living with* chronic illness, broken politics, and epistemological doubt in Kashmir.

I use the idea of the net to also capture the fact that, despite their purported aim of being ‘outside’ existing cultural or social practices, humanitarian and biomedical knowledge are constituted by specific knots or *convergences*. For example, I focused on local and national staff, as well as ongoing debates over trauma therapies in Kashmir (Chapters One and Two) in order to contest humanitarian self-narratives which position themselves as outside of “backward” Kashmiri beliefs and “superstition” about mental illness. For humanitarian organizations, the *outside* tends to be an impingement to the work of the *inside*, particularly since the humanitarian space is conceived as neutral, excluded from the surrounding conflict, thus rendering it neutral and impartial.⁴³⁷ Instead, I have tried to show how psychiatric and psychosocial expertise were forged through debates about what constituted ‘Kashmir’ and the ‘outside’ (*behar*), categories that had to be constantly remade.

The convergences I describe also have to do with the circulation and the co-existence of medical and psychological vocabularies within and beyond the clinic. Rather than see the clinic as the site of diagnostic language and the world

⁴³⁶ Fassin 2008.

⁴³⁷ As Peter Redfield has argued, however, the relationship between witnessing and neutrality has always been unstable (2011: 63).

outside as the site of somatic distress, I have tried to show how the language of ‘tension,’ PTSD, pills, weakness (*kamzori*), and stress, to name just a few, were related to each other and re-appropriated by patients and experts in unlikely ways. As such, while the language and technologies of biomedicine were widely used in Kashmir, there were significant re-routings and re-orientations of knowledge and practice. For example, while the movement to de-institutionalize mental health care in Kashmir made visible certain aspects of the institution (such as the OPD), it also concealed others (the closed wards). In other words, de-institutionalization and de-stigmatization efforts were themselves constituted by simultaneous practices of quarantining madness.

This dissertation has attempted to go beyond the language of trauma and PTSD by focusing on patients, experts, and encounters that are often written out of humanitarian self-narratives. In particular, I have tried to show how feelings of weakness (*kamzori*), the overwhelming presence of ‘local’ or national staff, the quiet scribbling and personalized medical cards, pills, and love stories, present threads of movement between the clinic and the world outside. In so doing, this dissertation has argued that states of emergency such as Kashmir are not only zones of endless suffering, violence, and occupation, but rather, of many moments in-between: of cigarette sociality, waiting for pills or patients, *timepass*, and drinking endless cups of *chai*. These moments not only constitute emergencies, as Veena Das’ work has powerfully illustrated, they also make visible anthropological entanglements.

Co-presence, rather than substitution or exclusion, is also the eventual aim of ethnographic knowledge. As I argued in Chapter Three, ethnographic knowledge is enacted in the movement from immersement to writing, which also

hinges on a politics of movement between 'here' and 'there.' However, a compelling ethnography, as a final product, requires a hybrid '(t)here' to be created through writing: it must transport us. Biomedical knowledge, in contrast, insists on divergence rather than entanglement. In creating a (t)here, I suggest that ethnographic knowledge has the ability to draw together and reflect on disparate entities, subjects, and practices in ways that the net cannot.

Medical humanitarianism, I suggest, merely *catches* these disparate entities in its net while insisting on their separation. For example, as Annemarie Mol and John Law have argued, epidemiology is "incapable of articulating links and tensions between [different variables]." ⁴³⁸ The "jagged story-lines" ⁴³⁹ and at times cacophonous voices that I have presented in my ethnography are thus attempts to capture these tensions of life in Kashmir and in the clinic and the flows in between. In this sense, ethnography is itself constituted by the interwoven lines and shapes of the net.

By way of conclusion, I also want to reflect on how my net is different from some analogous forms within anthropology and science and technology studies. First, I want to distinguish my net from Roy Wagner's use of the net in *An Anthropology of the Subject*. As Wagner writes:

the net is an image of what holography *may* be from the standpoint of one who cannot grasp the absolute identity of part and whole. It is only a "net," an iconic snare or entangler, if its parts are perceived as *holes*, interstices. From the viewpoint of the god on the insight, or *darsan*, of his divine encompassment, the image of the net and its contagious qualification of things does not exist. What may seem to others to be holes in a net are priceless and perfect jewels, gems that reflect one another so perfectly that 'they do not know whether they are one or many.' ⁴⁴⁰

⁴³⁸ Mol and Law 2004: 17.

⁴³⁹ Mol and Law 2004: 17.

⁴⁴⁰ Wagner 2001: 13.

Wagner uses the example of Indra—the chief of the ancient Vedic pantheon of India and “pragmatic ‘imager’ of world and divinity through the net of *maya* (illusion)”⁴⁴¹—to explicate the holographic worldview. In Wagner’s analysis, the “holes” or points in Indra’s net (the “gems that reflect one another so perfectly”) illustrate the symmetry or “absolute identity” of part and whole. The net I describe is not holographic, in that the holes (parts) are mirrors of the whole. Rather, what I have tried to show are the ways the net is composed of both individual “holes”—nodes/connections/links—but also by what is in between different nodes and connections. In this sense, this dissertation presents shapes created by individual lines and points on the net or by its “gaps.” The holes that I describe are thus distinct from Wagner’s idea of the (w)hole. However, I will return to an aspect of Wagner’s net which I find useful.

A closer concept to my idea of the net is meshwork in anthropology and science and technology studies.⁴⁴² Tim Ingold has described meshworks as forms in which nodes/egos/subjects/agents are made by the combination of the ties in which they are enmeshed.⁴⁴³ In his formulation of meshwork, Ingold challenges the idea that networks are composed of discrete, interconnected entities by arguing that humans and nonhumans are constituted by the network fabric in which they are embedded.⁴⁴⁴ Unlike the network, which is determined by a particular aesthetic in which connections are valuable for their own sake,

⁴⁴¹ Wagner 2001: 13.

⁴⁴² Escobar 2008; Ingold 2001; Murillo et al. 2012; Pollard 2010.

⁴⁴³ Ingold 2001. For Ingold, this is also a powerful argument against the idea of two, ontologically distinct domains of nature and culture. Ingold’s definition of meshwork is distinct from Escobar’s, for whom meshworks are lateral, informal and decentralized and in contrast to fixed structures of participation, such as labor unions, political parties and social movements which have hierarchical network forms (Escobar 2008).

⁴⁴⁴ Ingold 2001: 379.

meshwork and the “net” I propose allow for uncertain, improvised and unfinished outcomes. The concept of meshwork also takes us away from thinking about “interconnected points” to an understanding of “interwoven lines,” each of which is a relation along which “materials flow, mix, and mutate.”⁴⁴⁵

Ingold’s focus on materials is instructive in that what is at stake in the Kashmiri clinic are not just different epistemologies and subjectivities, but also different material expressions of madness and understandings of the body. For Kashmiri experts and patients, bodies were made permeable through encounters with potentially polluting substances, including illness.⁴⁴⁶ For example, the tools of psychosocial work, such as group therapy, were blunted in the face of the gnawing possibility that one was permeable to the dirty (*ganda*) habits of someone else. I recall one afternoon in the DDC when a young patient stormed into the consulting room, where Dr. Wiqar, the psychiatrist, Yasir, the social worker, and I were sitting and chatting. When Yasir asked him what was wrong, he said, “There is something wrong with Imtiaz... He is completely crazy [*pagal*]. When we smoke outside, I’ve seen him pick up our tossed cigarettes from the ground and smoke the entire filter. You need to tell him that it is disgusting.” The patient was visibly shaken; this seemed his first face-to-face encounter with what he understood to be madness. What disturbed him, it seemed, was the sense that madness was not contained within Imtiaz, but rather, it flowed through material forms, such as saliva, cigarettes, and shared living spaces such as the DDC.

⁴⁴⁵ Ingold 2001: 35.

⁴⁴⁶ Daniel 1984.

Similarly, as I described in Chapter Two, psychosocial workers who were constantly confronted with chronic illnesses that may or may not be treatable, found their own bodies to be sites of ill health and weakness (*kamzori*). This was not merely a side effect of the difficult labor of counseling, but rather, was an instance where bodies were viewed as permeable to the substances (illnesses) of others. I used these moments to illustrate how psychological idioms and technologies coexisted with engagements with multiple materialities, including radically different understandings of substances such as pills or intoxicants (Chapters Four and Five).

However, while meshwork is helpful, there is some conceptual work that the net does that is different. In particular, the net's constitution means that humanitarian and biomedical practices in Kashmir are made by both visible relations (the interwoven lines), but also of the less visible aspects of humanitarian and biomedical knowledge, such as the ways in which medicalization is produced from 'below.' Further, unlike the mesh, which is composed of strings or lines, the net provides a grid-like structure, in which individual parts are replicable.⁴⁴⁷ I have tried to describe this self-scaling capacity of the net in my ethnography, in moments such as when doubts about interpersonal relations are transposed on to the realm of biomedical objects, such as pills (see Chapter Four), as well as in terms of the medical card's self-referential capacity (Chapter Three). Similarly, as in the example of the patient smoking cigarette butts above, despite the regime of de-institutionalization and de-stigmatization, there was always the danger that madness (*mot*) would spill over into the bodies of others and be replicated. This was also the anxiety of the

⁴⁴⁷ Wagner 2001.

genealogical knot that Hilal shared with his father through a shared diagnosis of *tension* and the consumption of Diazepam (Chapter Four).

I want to provide a final anecdote that illustrates the replicability of the net, while also opening up the analytical possibility that violence itself might be a net.

“Kashmir jannat hai (Kashmir is heaven),” I often heard Kashmiris remark. The statement echoed the iconic statement of the Mughal Emperor Akbar, who was reportedly the first to proclaim this, ca. 1586.

The statement was, however, usually accompanied by a long sigh. Indeed, during my fieldwork – the long car rides to and from neighboring districts of Srinagar or walking along the banks of the Jhelum river on my way home to Rajbagh after a day at the hospital – despite my wariness of the clichés, the beauty of the Kashmir valley took my breath away. From afar, the landscape seemed to have it all: jagged, imposing mountains, florescent green paddy fields, glassy lakes, and bubbling streams flowing with crisp glacial water.

Yet the landscape had also been through a war, decades of conflict and neglect, which showed in a big way. The banks of the Jhelum were littered with plastic bags, trash, and the remnants of a once-booming tourist industry, including decayed, out of use houseboats. The famous Dal Lake, the postcard and travel brochure staple, was dense with weeds and slushy water.

The debates that raged around Kashmir’s ecology were similar to those raised in mental health circles. Should efforts be spent on an issue that was a side effect, not the root cause, of the conflict? How could the issue of environmental degradation (or trauma) be addressed when the occupation was

still in place? For some, the quest for self-determination and freedom (*azaadi*) eclipsed other, immediate concerns. Others argued that these problems would be there regardless of Kashmir's political situation. These were also struggles over the ontological and epistemological meaning of Kashmir as place: was it *jannat* (heaven) or was it jail?

Despite these two rather distinct issues—trauma and environmental degradation—they were both caught within a net of illness and broken politics. The net ensnared forms of social and political life unlikely to be connected to each other otherwise. In its capacity to encompass unlikely domains, the net was both suffocating and comforting. There was no further explanation required for the unseemly, highly charged events that seemed to occur on a daily basis.

This dissertation has attempted to describe, perform, and finally, to go beyond the suffocating potentiality of the net by focusing on what is less visible. I have tried to capture the kinds of agentic action that are possible when the experiential starting point is *being caught*. Rather than the lofty goals of “saving lives,” I have tried to show how psychosocial workers refuse certain lives as worthy of care (Chapter Two), how Kashmiris suffering from long-term weakness and tiredness cope by consuming pills, but not without transforming them into permeable objects (Chapter Four), and how narratives of desire and love underpin accounts of biomedical addiction (Chapter Five). In so doing, this dissertation has been an account of what kinds of actions are possible when non-movement is the given condition of life.

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