At a drug rehabilitation clinic in Indian-occupied Kashmir, patients were subjected to a range of biomedical and penitentiary techniques. These techniques included group therapy sessions in which substance users performed narratives of their recovery—a practice that made visible their gratitude to the police, which oversaw the clinic and which, as an arm of the Indian military, many view as an illegal occupying force. While patients publicly pledged to remain sober and technically complied with the clinic’s demands, they privately demonstrated ongoing commitments to nasha (intoxication), which places substance use, romantic love, and the search for divine unity in Sufism on the same phenomenological register. Through nasha, patients defied biomedical injunctions to forget their pasts and recuperated intoxication as a worthwhile experience. [addiction, substance abuse treatment, military humanitarianism, recovery, reverie, Kashmir]
patients, particularly those who identified as Sufis, narrated reveries of romantic love in which they understood their drug use and pasts in radically different ways from the DDC’s clinicians.5

In their love reveries, patients drew on Sufi and vernacular notions of nasha (intoxication), a Kashmiri and Urdu term that locates drug use as coterminous with other intoxicating experiences, such as the search for divine or worldly love and madness. These ideas come from Sufi Islam, which has been the dominant religious tradition in Jammu and Kashmir, India’s only Muslim-majority state, since the 14th century. Through nasha, patients recuperated into intoxication as a valuable experience, maintained temporal and phenomenological links with their past selves and behaviors, and, in contrast to public recovery narratives, absolved themselves of responsibility for their addictions. Through love reveries, however, patients did not resist the DDC’s medical-penitentiary techniques; rather, they held on to unapproved desires and experiences while performing their roles as recovered and grateful subjects.

By attending to reveries and other in-between temporal states, anthropologists can engage and empathize with our interlocutors’ conscious and unconscious concerns (Borneman 2011). In the case of the DDC, patients remembered and imagined past love affairs through gotan gatshun, a Kashmiri phrase that means dipping or submerging oneself in thought, often about the past. I translate gotan gatshun as “reverie,” using Sigmund Freud’s definition of the term, rather than “fantasy,” because the latter implies flight. In contrast, Freudian reveries consist of “wandering back” into the past (Freud 1958, 48), which is closer to the Kashmiri term. In reveries, according to Freud, “one consciously imagines something while fully awake” (46), usually scenes and events in which the subject can satisfy his or her erotic wishes and egoistic needs of ambition and power (Freud 1966, 120) In his work with young, urban men in Syria, John Borneman defines reveries as “a range of psychological states, including daydreaming, distraction, self-absorption, contemplation, meditation, and sexual fantasizing” (2011, 245). This definition, in which reveries are an imaginative resource that can produce an in-between temporal state, dovetails with how romantic love in South Asia occurs “mostly in the imagination or in the interstices of ordinary life” (Orsini 2006, 37).

Reveries are, however, only partially lodged in the imagination; they are also in this case intersubjective acts, coproduced—although unequally—by the ethnographer.5 In my case, being a single, non-Kashmiri, female researcher in an all-male setting shaped both the telling and content of reveries. Further, my interlocutors and I were conscious that our contact and friendship within the DDC was limited. Many patients came for their clinical follow-ups irregularly, so I rarely saw them after their 30 days of admission. Yet this tenuous, temporary, and gendered connection—what sociologists have called a “short-term contract”—might have provided them the necessary freedom to reveal and share their reveries with me (Hey 2003). By contrast, patients did not share their love reveries with clinicians, who disapproved of the extramarital or premarital relations on which they were based, whereas my positionality opened me up to hearing reveries. At the same time, I was not privy to the more bawdy aspects of male sociality in the clinic.

Based on 20 months of ethnographic fieldwork conducted from 2009 to 2013 in Kashmir, this article contributes to three areas of anthropological concern: violence and military humanitarianism, the relation between narrative and recovery in mental health and substance abuse treatment, and the relations among emotion, ethics, and love in South Asia. The first is concerned with the way in which military-humanitarian intervention is based on a moral rather than a political principle (Aggarwal 2004; Aggarwal and Bhan 2009; Bhan 2014; Fassin and Pandolfi 2010; Lutz 2002). Less is known, however, about how such interventions are experienced and negotiated by those people who are their objects. In the case of the DDC, clinicians aim to transform unruly Kashmiri citizens into docile, grateful subjects, and this article shows how patients living in conditions of chronic violence respond to, inhabit, and quietly subvert the clinic’s structures.

The second area of concern, substance abuse and mental health treatment, has focused on how patients use or subvert narratives authorized by the medical authorities to their own ends (Carr 2010; Raikhel and Garriott 2013; Shohet 2012; Zigon 2013). For example, patients at an addiction program for homeless women in the US Midwest may “flip the script,” telling treatment staff what patients think they want to hear (Carr 2010). At the DDC, patients may flip the script but also go beyond this by drawing on alternative narratives, including reverie and nasha, to understand their drug use. Further, reverie and nasha reveal a different therapeutic function of language, one that enables patients to revisit their histories of intoxication and recast them in a positive light, rather than break with those experiences as a condition of recovery.

The third area of anthropological concern, with ethics, emotion, and love in South Asia, has focused on how romantic love and love marriages disrupt normative configurations of kinship, including gender roles, gift exchange, reciprocity, and obligation (Das 2010; de Munck 1996; Marsden 2007; Mody 2008; Orsini 2006; Pinto 2014). Work on these topics primarily examines the social and political effects of romantic love, which is often read as “aberrant love,” and mediated and pathologized in psychiatric spaces, particularly for women. By contrast, the effects of romantic love for men appear to be quite different. In particular, “mad,” romantic love and reveries had powerful and productive effects on men and operated as imaginative resources that, among other things, can take the sting out
of addiction. Reveries offered an alternative temporality of recovery, different from linear biomedical substance abuse treatment: they allowed patients to break the monotony of incarceration and purify painful memories.

**Winning Kashmiri hearts and minds**

The DDC represents a new phase of military governance in Indian-controlled Kashmir. In 1988, after decades of frustration with Indian rule, the Kashmir valley erupted with massive protests and demonstrations calling for independence (azaadi) (Kaul 2011). There began an armed movement, which the Indian state viewed as a Pakistan-sponsored insurgency rather than an indigenous claim for self-determination; it responded aggressively, imposing a state of emergency and passing draconian laws that granted the Indian military impunity in the region (Duschinski 2009). By the early 2000s, after India and Pakistan fought their third war over Kashmir, and in light of growing concerns about widespread human rights violations committed by Indian military and paramilitary forces, the Indian military reworked its rhetoric and practices of occupation. An army general, Y. N. Bammi, emphasized that the Indian army maintained a zero tolerance policy for human rights violations, which would be strictly punished (Bammi 2007, 259). The military refrained from dismissing human rights reports as a form of “antinational” propaganda, as it had done previously, and began emphasizing care of the people as at the heart of its counterinsurgency operations (Bhan 2014).

For the Indian military, winning Kashmiris’ hearts and minds was crucial in a region where Indian rule lacks—or has entirely lost—popular legitimacy (Junaid 2013). Today, many Kashmiris have personally experienced the violence of an intrusive security state, and most of them regard the Indian state as “uncaring, even murderous” (Kaul 2011, 195). It is these strong sentiments that the hearts and minds campaign seeks to rectify. The police’s campaign has focused mainly on combating substance abuse, and it has pursued this by establishing multiple treatment centers across the state, a process that fuses military, medical, and humanitarian aims. As one DDC clinician told me, “The charasi [hashish smoker] and the sharabi [alcoholic] are outcasts in our society—no one respects them. But here, we take them in and restore their dignity.”

Clinicians also contrasted the DDC with private treatment centers in Kashmir, which could cost families up to 30,000 rupees a month, whereas the DDC charged an affordable 3,000 rupees for food, with the rest of the expenses subsidized by the police. Many family members told me that the financial incentives to seek treatment at the DDC overrode their concerns about placing their loved ones in the hands of the police. Indeed, the low cost of treatment meant that the eight beds were always occupied, with a waiting list of over 200 patients at any given time. As of December 31, 2009, 2,500 substance users had visited the center, and 175 had been treated as inpatients. Most were treated for addictions to prescription opioids and benzodiazepines (e.g., Valium and Xanax in the United States), although many also combined opioids with cannabis.

As a subject-making project, hearts and minds campaigns such as the police’s substance-abuse effort involve a “long drawn-out, sustained strategy” to ensure “a steady positive trajectory of transformation” in the population, in the words of Rahul Bhonsle (2009, 11), a former Indian military commander. Psychological initiatives like the DDC, according to Bhonsle, “play a major role” in its strategy:

The planned management of information and other measures are important to influence the opinion, emotions, attitude and behavior of hostile, neutral or friendly groups in support of current policies and aims. Themes for psychological initiatives should be chosen objectively, taking into account the perceptions of the selected target audience. (2009, 27)

In short, the DDC’s medical and penitentiary techniques were designed to psychologically transform and win the hearts and minds of substance users.

**Medical-penitentiary techniques**

The DDC is located in the heart of the Jammu and Kashmir Police headquarters, in a large, highly securitized compound known as the Police Control Room. While clinicians told me they wanted to carve out an independent, neutral biomedical space, they were undercut by the DDC’s dependence on the police for its daily functioning and by everyday clinical practices that reinforced the clinic’s links to the structures of military rule. As many patients quietly reminded me, somewhere in the control room, young protesters were being interrogated and tortured.

For visitors like myself, entering and leaving the compound required going through multiple security checkpoints, a cumbersome and intimidating process. Two uniformed policemen guarded the DDC 24 hours a day, monitoring patient behavior and providing disciplinary reinforcement. Young men at the DDC, some of whom had histories of throwing stones (pathrav) and agitating against Indian security forces, now found themselves in the custody of those whom they saw as perpetuating an illegal military occupation (Kak 2011). Though most patients did not describe themselves as political prisoners, they saw the DDC as an extension of a violent, repressive, and corrupt military and state structure.

These feelings of mistrust permeated the clinic. Although clinicians assured patients that their files were confidential, many patients believed that their medical histories were being shared with the police administration and...
that they would be arrested for past crimes or recruited as informers for the Indian state. Such fears did not result from paranoid thinking. Journalists estimate that up to 150,000 secret informers are on the payroll of different agencies of the Indian state in Kashmir, creating a “pervasive public culture of suspicion, distrust and fear” (Kaul 2011, 195). Further, many patients were aware that the Jammu and Kashmir Police is one of the most corrupt institutions in the state, which has the ignominious distinction of being the second most corrupt state in India, according to Transparency International (CMS and TII 2008). During interviews, many patients questioned the police’s efforts to combat substance abuse, since they felt the police’s own corruption and lax enforcement of existing drug laws were at least partly responsible for the region’s drug epidemic. They said this out of the clinicians’ earshot. If the clinicians heard these comments, they would likely be read as a form of resistance to treatment and result in the patients’ being either punished or forced to stay longer.9

Because the DDC focuses on psychological and politically motivated care within the hearts and minds campaign, it is a unique institution, since most biomedical substance abuse treatment in South Asia takes place in large psychiatric hospitals and consists of detoxification treatment only (Charles, Nair, and Britto 1999, 19). In contrast, patients at the DDC received a combination of biomedical care and custodial treatment designed to temporally and physically separate them from their trigger-filled external environments. They experienced time in the DDC, however, as akin to that of incarceration—there was always too much time as they waited for their treatment to end. In this context, patients had several strategies of doing what they called “timepass.” The television was helpful; it was perpetually on. Patients highly valued cigarette breaks for timepass, although many of them found it ironic that they were being weaned off drugs while being allowed or encouraged to smoke tobacco. “Even if I wasn’t a smoker before coming here,” one patient joked, “the center would have made me one.” There was also a lot of horsing around, joking, and teasing that punctuated the monotony of DDC life.

Most patients ranged in age from 18 to 45. The older patients were generally treated respectfully by the younger patients and often asked to take on leadership roles. At the same time, patients did not consider the center an appropriate place to make lasting friendships. They described the DDC as a space cohabited by people who were rebellious (shararat), untrustworthy (baiman), and mad (pagaal). One patient, who was very protective of his wife, who had come to visit him at the DDC, explained, “The men are not right here. They are capable of inappropriate things.” When I asked those who were friendly if they would stay in touch after being discharged, many were noncommittal or outright refused. They said associating with others from the clinic would arouse suspicion; if they were seen together in public, the secret of their addiction could be revealed. Thus friendships at the DDC were also a form of timepass, not a means to long-lasting or meaningful relationships. Cigarette breaks, quarrels, chitchats, naps, and television watching—activities that broke the monotony of the schedule—were forms of provisioning (jugar), bringing together diverse practices or technologies to cope in the meantime (Jeffrey 2010). Timepass relations were forged out of circumstance rather than choice. In many cases, patients felt frustrated and constrained by the social context of inpatient treatment because they strongly believed that addiction was a shameful condition that must be kept private.

Within the DDC, all practitioners—social workers, clinical psychologists, and psychiatrists—had their own domain of expertise, but they coordinated treatment in a single plan that focused on psychologically transforming patients.10 In most large, outpatient psychiatric clinics, in South Asia and elsewhere, the professional orientation of care is, as Renu Addlakha notes, “more or less exclusively dominated by the medical model, [reducing] other members of the team to the status of paraprofessionals” (2008, 3–4; see also Chua 2013, 345). Moreover, psychiatric practitioners emphasize pharmacological treatment over diagnosis or explanation, and patients and their families prefer biological interventions to psychological ones (Addlakha 2008; Chua 2014; Jain and Jadhav 2009; Marrow and Luhrmann 2012; Nunley 1996). In these settings, there is generally little time or inclination for “talk therapy,” and patients may struggle to find their voices or make themselves heard in psychiatric encounters (Jain and Jadhav 2009; Pinto 2014; Wilce 1995). For example, in their ethnography of a community mental health program in North India, Sumeet Jain and Sushrut Jadhav analyze how the use of English, as well as moral narratives (based on geographical, educational, and class differences), diminish patients’ authority in clinical encounters—separating “irresponsible” patients from “responsible” doctors (2009, 71). But we ought to expand our understandings of psychiatric expertise and patient-practitioner relations in settings beyond large, outpatient clinical settings, where practitioners may see hundreds of patients in a single day and where pharmacological treatments dominate.

Because the DDC was an inpatient program with only eight patients, and because of its unique positioning within a larger military-humanitarian apparatus, clinicians prioritized social and psychological interventions over pharmacological ones. This led them to focus intensively on patients’ words and narratives, as well as on establishing a new form of sociality in which former addicts were expected and encouraged to share their stories with each other in group therapy. Although DDC patients followed a heavy pharmacological regimen of antipsychotics, painkillers, and sedatives, this was only for the first week. Then the psychiatrist’s interventions tapered off, and other team members
began intensive psychosocial interventions such as individual, group, and family therapy. According to this treatment trajectory, pharmacological treatment could reduce withdrawal symptoms, such as shivering, nausea, mood swings, insomnia, and headaches, but external and internal psychological and social cues could provoke cravings and induce relapse. To prevent this, most treatment consisted of psychological counseling and therapy that reconfigured patients’ associations with their past behaviors and emotions, including external or environmental events and relationships, such as with former accomplices, and reworked how they dealt with internal states like fatigue, hunger, and moods. In addition, because clinicians believed that patients suffered from denial and used language to manipulate others in order to further their addiction, patients had to tell public recovery narratives to demonstrate that they had gained “insight” into their disease. Like the substance abuse clinicians Carr analyzes, DDC clinicians focused on the patients’ narratives to reconfigure their “relationships with language rather than simply, or even primarily, reconfiguring their relationship to drugs” (Carr 2010, 3).

Further, having patients perform recovery narratives was a key way for the police to demonstrate the efficacy of their hearts and minds campaign. In addition to properly telling their stories, patients had to demonstrate proper affect, namely gratitude to the staff and to the police establishment at large. Clinicians elicited recovery narratives during group therapy sessions, which occurred three times a week in the afternoons. During the sessions, the eight inpatients, clinicians, and visitors sat in a large circle on red plastic chairs, in the center’s main consultation room. The clinical psychologist, Dr. Ashraf, asked Feroze, a former patient, to tell his story “from the beginning.”11 Dr. Ashraf told Feroze he could speak in Kashmiri, Urdu, or English. Below is an excerpt of Feroze’s narrative, told in Kashmiri:

My name is Feroze, and I am from Shopian [a town in south Kashmir]. My parents sent me to Srinagar [the summer capital of Jammu and Kashmir] to study when I was in the fifth grade. There was a boy who was using [correction] fluid in my class. He would pour the liquid into a plastic bag and inhale it. I asked him for some, and we did it together. I enjoyed it—I had a really good time. I used fluid for a couple of years, but my family learned that I was using, and they sent me away from the city. When I went back to Shopian, I met some older guys who introduced me to alcohol and charas [cannabis]. I really enjoyed charas the first time; I laughed hysterically for an hour straight. After that, I wanted it again, and I began buying it, first 50 rupees at a time, then 100 rupees a day. Eventually, I started buying more and more, 200 to 2,000 rupees at a time. This caused a lot of fights and problems at home. I’d finish the money quickly and I would be tense thinking about how to get charas again. Sometimes I would get thoughts of murdering someone. I was totally out of control and felt like I was losing my mind.

My family put more and more pressure on me to stop using. I would try, but the next morning, I’d again feel the need and start using again. Then we learned that one of my cousins—someone I had done fluid with earlier—had been admitted here at the De-addiction Center. My kin heard that he had been cured, and they wanted to bring me here. I refused. I thought I would end up in the mental asylum, where I would be beaten up. But my family brought me here, and I stayed for 21 days.

I’m sorted now. I’m absolutely fine. I’d rather be here at the De-addiction Center than at home with my family—that’s how much I love this place. I owe so much to the doctors. I’m grateful to them for becoming well [unki mehrbani se mai theek hoon]. If they hadn’t helped me, I would have died or gone crazy.

Feroze’s narrative exemplifies the typical structure of recovery narratives, which usually began with the patient introducing himself, describing which drugs he used and how much (often with a focus on how much it cost), and referring to specific triggers (in Feroze’s case, his peers). In addition to verbal expressions of gratitude, clinicians judged patients for giving nonverbal cues of respect, such as speaking with tones of deference, lowering or averting their eyes when addressing doctors, and other bodily postures of dependence common throughout South Asia (Appadurai 1985, 237). When patients deviated from this form, the clinical psychologist or social worker would prompt them to return to it.

Feroze’s narrative served a dual purpose: it showed other patients what they needed to do to be discharged, and it indexed Feroze’s own psychological and physiological transformation as complete. In other words, by listening to one another’s recovery narratives, patients learned to perform the clinical roles assigned to them (Dyson 2010, 494). After Feroze finished his narrative, Dr. Ashraf asked him several questions about his present behaviors, including his sleeping and eating habits, as well as his plans for employment. These questions gauged whether Feroze had recovered from the physiological effects of addiction and demonstrated that he had fully transformed himself. Feroze described how he had successfully cut himself off from relapse-inducing triggers, including past behaviors and friends. The narrative suggested that he was no longer his past self: instead of recklessly spending money on drugs and fighting with his family, he had become a productive member of the family’s orchard business; instead of resisting treatment, he advocated for the DDC.

Feroze concluded his narrative by expressing gratitude and indebtedness to the DDC and its clinicians, including the (hyperbolic) statement that he felt more at home at the DDC than with his own family. Feroze used the Kashmiri
and Urdu term mehrbani to thank the staff, a term that suggests indebtedness and ongoing relationality and placed Feroze, as the indebted one, in a position of inferiority vis-à-vis the clinicians and structure of the DDC. We should, however, read Feroze’s gratitude not as a transparent outpouring of his inner feelings but as a public act that he performed to meet clinicians’ expectations. This is suggested in the work of medical anthropologists on South Asia, who have found that rather than the model of the autonomous patient, patient-doctor encounters in the region are better understood through the guru-chela (teacher-disciple) model, since these encounters foster dependency and well-being in line with dominant cultural values (Addlakha 2008; Nunley 1996; von Schmädel and Hochkirchen 2001). This relation of indebtedness and gratitude has particular political significance in the context of the hearts and mind campaign, given that producing gratitude was also visible in other public spaces in militarized Kashmir. For example, the paramilitary Central Reserve Police Force publicized its humanitarian mission with billboards along the Jammu-Srinagar highway, the main link from the Kashmir valley to the Indian plains. One billboard showed an elderly Kashmiri man bowing and cupping his hands to accept water from the flask of a young Indian soldier. The image strikingly reversed age hierarchies in South Asia, as the elderly Kashmiri man is shown in a posture of dependence, while the young soldier is positioned as the benefactor. Such images—along with expressions of gratitude in the clinic—reinscribed the idea of a robust, benevolent Indian nation-state saving an enfeebled Kashmiri body politic. Thus, patients’ performances of recovery narratives at the DDC dovetailed with politics outside the clinic, where the Indian military was remaking how the Indian state and Kashmiri subject-citizens related to each other, changing an idiom of national security to one of humanitarianism. Both idioms reinforce Kashmir’s dependence on the Indian state for survival, a dependence that grates against political agitation for independence in the region (Bhan 2014, 12; Ferguson 2013). At the same time, Feroze and the other patients were acutely aware—and skeptical—of the larger military-humanitarian context of which the DDC was a part. In this sense, Feroze’s performance might be productively thought of as a moment of “flipping the script” (Carr 2010, 191). Although it is methodologically difficult, if not impossible, to determine to what extent Feroze’s recovery narrative expressed his inner thoughts and feelings, we do know that patients used more than one script in the clinic. In more private moments, they expressed ambivalence toward the police’s “social mission” and clinical mandates of abstinence from drugs and alcohol. As we will see, in contrast to public recovery narrative performances, they engaged in love reveries through which they reclaimed—and purified—experiences of intoxication.

Reclaiming intoxication

Patients and clinicians had radically different understandings of intoxication. According to clinicians, all forms of nasha were harmful and needed to be avoided for patients to live “straight” or “proper” (seedhi) lives. They were particularly critical of Sufi and vernacular understandings of nasha and spoke derisively of cultural and historical links between Sufism and cannabis use. During my fieldwork, I heard many doctors argue that, in addition to the conflict in Kashmir, traditional healers (pirs) were responsible for the ongoing drug epidemic because they lured devotees with cannabis. At the DDC, I heard the clinical psychologist, Dr. Ashraf, explain the drug epidemic in Kashmir through the following vignette:

I knew a boy once who used to hang out in a 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. 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 had become an addict.

This apocryphal narrative mocked the journey to divine love—often analogized to nasha in poetry and literature—that is central to Sufi thought. Unlike Dr. Ashraf’s narrative, in which a Sufi spiritual journey turns into addiction, patient reveries did not entirely dismiss nasha as a negative experience. Rather, for patients, intoxication was a valuable, valid experience, and it was possible precisely because it is seen in Sufism as the pathway to divine or worldly love. In the Sufi ideology of love, a hierarchy extends upward from the interpersonal love of the phenomenal world to the transpersonal connection with the Divine (Behl 2012, 66, 68–70). In this scheme, human love can mirror divine love. Since many patients’ histories of drug use were intimately tied to romantic love and heartbeat, the concept of nasha imbued their own experiences of intoxication with spiritual significance. The love reveries that patients engaged in drew on cultural expressions of love and madness that are prevalent in Hindi and Urdu literature, cinema, and everyday life, expressions that have roots in premodern Sufi poetry (Anjaria and Anjaria 2008; Marsden 2007, 98; Orsini 2006). For example, the masnawi, a romantic narrative genre that flourished in Persian courtly circles from the 11th century onward, often explicitly addressed the theme of mad love. One of the most famous masnavis of all time, still well known today,
tells the story of Layla and Majnun. Because of his excessive love for Layla, Majnun (the “crazed”) forgets all his religious and social obligations, including his promise of secrecy to his beloved, leading to the lovers’ destruction. The parable of Layla and Majnun is about how excessive, uncontrollable love can lead to the “loss of self-awareness” (fanaa). A 2006 Bollywood blockbuster called Fanaa similarly focuses on “mad” or doomed love leading to the lovers’ destruction. As Magnus Marsden (2007) has argued, young men and women in Muslim societies in South Asia are inspired by long-standing Persianate Sufic literary and poetic genres, but they also draw on modern forms of romantic love, such as those in Hindi-language cinema. Thus, contemporary Kashmiri ideas of romantic love synthesize “older and newer conceptions” (2007, 104).

From clinicians’ perspectives, love affairs were potential “triggers” for relapse and disrupted normative kin relations. In contrast, Patients were encouraged to end love affairs as part of the recovery process, yet romantic love occupied an ambiguous place within the DDC because clinicians could not enforce this recommendation as part of the therapeutic regimen, which focused on patients’ maintaining sobriety and telling recovery narratives. Yet since patients knew clinicians disapproved of these love affairs, they tried to be discreet about them. This was a strategic choice, which enabled them to move through the DDC quickly, relatively unencumbered, without facing accusations or the censure of noncompliance or disobedience. Thus, though patients viewed love as a form of nasha, they continued performing their public roles as recovered, grateful addicts. As an emotion, love-as-intoxication was both nonconformist and socially acceptable: it allowed patients to remain intoxicated and drug free at the same time.

Two reveries

The following love reveries use vernacular understandings of love-as-intoxication, drug use, madness, and a spiritual journey, and in doing so offer alternative explanations of how a person succumbs to—and recovers from—aaddiction. Not all patients I interviewed identified love as their main trigger of addiction; some were victims of state violence, for example. Both romantic love and the specter of violence figured significantly in most of their reveries. Yet clinicians did not see love as a legitimate cause of addiction, nor did they note the resources that patients could marshal through reverie and nasha.

I. Arif

When Arif was admitted to the DDC, he was 35 years old but looked much older. His frame was skeletal, many of his teeth had fallen out, and he had lost most of his hair. He was married, had one daughter, and was the oldest of the center’s eight patients, often taking on the role of spokesman. In one of our interviews, Arif 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.” Arif, like other patients who identified as Sufi, loved listening to devotional music (qawwali) and avidly read Urdu poetry. Arif came from an illustrious and well-respected family. His father had served as a member of the state Legislative Assembly and had spearheaded the revival of kani, an indigenous practice of weaving shawls. In 2001, Arif’s father died, which gave him a very big “jolt.” He felt unprepared to handle the responsibilities thrust on his shoulders. But it was not his father’s death that Arif blamed for his codeine and cannabis use. Rather, he started using in 1992–93, he said, after “a train ride changed my life.”

One afternoon, after all the patients had eaten lunch, I asked Arif if I could interview him. We sat alone in the DDC’s front room, where guests and kin were received. One of the other patients drew a curtain to give us privacy. Arif narrated his reverie to me in English with sprinklings of Urdu and Hindi phrases. This was clearly a deliberate choice, to keep his reverie obscure to the other patients, who were not fluent in English, and private between us; in other words, it kept both his past love affair and the telling of the reverie out of clinical and public view. I asked Arif how he had started using codeine and cannabis. He responded:

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 [washermen] 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 Hanuman [Hindu deity] statue for protection.

Anjali spoke no Hindi, so we would exchange letters in English. Our relationship blossomed, and I was completely intoxicated by her [main nasha mein thay]. I went to Mysore regularly to meet her for the next two to three years. The last time I saw her, she said 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 me [to have a relationship] 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.

Arif’s reverie contains certain themes that can be read within a frame of postcolonial desire, yet his reverie also exceeds this frame. Arif is enticed by Anjali because of, not in spite of, her difference from him: she is Hindu, half-American, from a southern corner of India, while Arif is Muslim, Kashmiri, from the northern corner. This structure of opposites—Hindu/Muslim and north/south—and a love affair that culminates in tragedy (or a miraculous overcoming) is a dominant theme in Hindi-language cinema.

Arif’s reverie captures his desire to momentarily escape the strictures and expectations of bourgeois masculinity thrust on him, namely the expectations that he will expand his father’s business and carry on the family name as the eldest son. The tryst with Anjali, the “fantasy sequence,” if you will, is a digression from his assumed life trajectory. Significantly, Arif does not embark on the affair as a form of teenage rebellion but rather receives his father’s consent to pursue Anjali. In describing his father’s tolerant attitude toward his premarital love affair, Arif demonstrates his family’s status as modern and forward thinking (Najmabadi 2005). Through the reverie, Arif reworks and reimagines his past, particularly his relations with his father, which were strained by Arif’s drug use. From what I knew of Arif’s family, many of them were deeply disappointed that Arif failed to carry out his familial responsibilities. Yet in his reverie, this burden is lifted from him as he seeks out “true” maddening love with his father’s blessing.

In this South Asian ideology of romantic love, as scholars have argued, love “just happens to people” and, “like other types of emotions, ‘befalls’ or ‘is felt’ by people” (Ahearn 2003, 110). This is not only how people experience love but also how men like Arif want to, or imagine, experiencing it. As Laura Ahearn points out, the abdication of agency involved in “falling” in love links to “a sense of agency in other realms” (2003, 113). In Arif’s reverie, surrendering to love, rather than being in control, is in a sense an act of rebellious agency, representing a break from his life as a highly educated, upper-class Kashmiri man expected to secure his family. Instead, in Arif’s reverie, he is shaped and transformed by Anjali rather than having to act on her. Anjali both initiates the affair and ends it. As the recipient of her desire, Arif structurally occupies the role of a female in the reverie, while Anjali occupies the male role of the Beloved or God. This structure mirrors Sufi descriptions of union with God as a “marriage” between a devotee (structurally female) and God (structurally male) (Ewing 1984, 362).

Arif’s reverie enables him to recast painful memories—intoxication in the form of excessive love and drug use, among them. Through the reverie, Arif remembers the pleasures of intoxication without confronting the negative affects and effects of his past drug use. In contrast to the model of taking responsibility that the clinic and public recovery narratives advocated, Arif absolved himself of both agency and responsibility for his intoxication through his reverie. This was crucial for enabling him to reinhabit the structures of normative kinship to which he would return after treatment. In other words, reverie not only expunged Arif’s painful past but also helped him imagine a more pleasant domestic future with his wife and daughter.

II. Rouf

Rouf, 21, was fashionable, shuffling around the DDC in skinny jeans, Converse sneakers, and printed T-shirts. He used to drive a commercial minibus in the city and enjoyed telling stories about his reckless driving and the road accidents he caused while high on cannabis and opiates. Like Arif, Rouf drew on Sufi tropes of intoxication to describe both his drug use and his tumultuous relationships with women. Unlike Arif, whose reverie flowed chronologically and had a clear beginning and end, Rouf told me his reveries in fragments, and they were full of contradictions. The first time he mentioned his love affair, we had been casually talking about something else.

“I have replaced drugs with tears. Now I just cry for her,” Rouf said abruptly.

“Who is she?” I asked him.

“Her family is poor and my family is rich. My father is completely against the marriage.” I noted, but did not comment on, his description of his family as “rich,” even though he drove a minibus for a living.

“Does she know about your treatment here?” I asked.

“She knows that I am getting some kind of treatment [eila], but she thinks it is for stomach problems and back pain.”

On another day, Rouf told me how, once when he had been intoxicated (nash mein tha), he told her to stop studying after she completed her 10th-grade exams. 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 and he bowed his head in shame. He described his jealousy and feelings of possessiveness as madness (pagalpan), aggravated by his love and substance use. In his mind, Rouf was ready to battle both his own family and his girlfriend’s to win their approval for marriage.

Rouf also told me that he used to sneak into his girlfriend’s room at night, stay until the morning call to prayer (azaan), then duck out of her window. They almost got caught once; they heard a knock on the door, but she quickly said a cat had jumped in through the window.
sexual undertones of this reverie were scandalous in Kashmir and also very different from Arif's more modest reverie. "She is my Khuda [God]," Rouf said. Like Arif, Rouf too understood himself as structurally female in his love relations and his girlfriend as structurally male (Allah/Khuda). Despite this proclamation, Rouf, unlike Arif, was not exclusive with his ladylove. He often spoke about other women with whom he had affairs. Also unlike Arif, whose love was in the past, Rouf experienced nasha during his treatment. Because of the affair's turbulence, Rouf's moods would change quickly. In a single day, he could be exhilarated, exhausted, and morose. Clinicians chalked up his emotional turmoil to withdrawal—the absence of intoxication. I argue, however, that these moods were actually the effects of Rouf's continued nasha.

One day when I found Rouf in a melancholic mood, I asked him what was wrong. He said, "All I ask of her is that she speak to her mother [about their 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." Rouf said his girlfriend had also threatened to kill herself if Rouf got engaged to someone else. Evoking the Sufi idea of losing self-awareness (fanaa), she told him that she would rather die than let another man touch her. While at the DDC, Rouf was frequently on the phone, either talking to his family members about his girlfriend or trying to appease her. By going to great lengths to attain true love, even alienating his family in the process, Rouf tried to demonstrate that he was a "proper lover" (sahi asheqan), not someone who was just stringing his girlfriend along (de Munck 1996, 706; Marsden 2007). At the same time, his statements of devotion—"she is my Khuda [God]"—were undercut by Rouf's promiscuity. During one of our conversations, Rouf began asking me leading, flirtatious questions, and I quickly ended our conversation. The next time we met, he had seemingly forgotten his transgression, and we went on as before. This was, however, one of the difficulties in sharing love reveries, particularly with younger patients like Rouf, who struggled to manage their (multiple) love intoxications.16

Whereas Arif's love affair with Anjali was not an object of clinical intervention or knowledge, clinicians pressed Rouf to end his affair. They insisted that marriage was not a viable option, given his youth and lack of steady employment. Rouf, however, told me he was unable to forget his girlfriend. There was something that was preventing him from moving on. "I cannot live without her [main junoon main hoon]," he told me. In using the word junoon, Rouf described the feeling of being addicted to his girlfriend. But before he was discharged, Rouf performed his recovery narrative, saying he had broken from a toxic past and from unhealthy relationships. He did not, however, adhere to the clinicians' recommendations to end his love affair. Instead, Rouf's telling statement that he had replaced "drugs with tears" suggested that, rather than abstain from intoxicants, he had switched from one to another.

Both Arif and Rouf's reveries contain references to fanaa: Rouf's girlfriend threatened to kill herself if he married someone else, while Arif described the loss of his romantic union as coming down from the sky to the earth. As Carl Ernst and Bruce Lawrence write, attaining fanaa "requires … an overpowering love. It is a love that leads to annihilation. It leads to what is described as 'destruction of the soul’" (2002, 15). Within this frame, annihilating the self (i.e., losing self-awareness) is necessary to unite with the Beloved or God. Fanaa thus radically upends biomedical ideas of death as failure and pathologized notions of codependency. Within a Sufi epistemology, the loss of the self required for union with the Beloved is turbulent but highly rewarding.

Through their reveries, both Rouf and Arif remained committed to the loss of self that nasha offered. For Arif, this commitment was mainly expressed through reverie; for Rouf, it continued through his unfolding romantic entanglements, which were phenomenologically similar to intoxication by drugs. In this sense, reveries were radically different from recovery narratives, which attempted to restructure patients' lives by creating a break between past and present and by moving patients linearly from addiction to abstinence. By contrast, reveries provided a recursive, rather than linear movement of recovery and elevated intoxication as something worthwhile.

**Toward an anthropology of reverie**

As an element of the Indian state's new constellation of military-humanitarian efforts, the DDC aims to transform both the inner and outer lives of Kashmiri men using pharmacological, psychotherapeutic, and psychiatric tools. Its emphasis on psychologically transforming addicts is politically motivated, producing the DDC as a key site where fraught relations between the Indian state and military and Kashmiri citizens are being negotiated and remade (cf. Aggarwal 2004; Bhan 2014; Kaul 2011). Despite the growing salience of medical humanitarism in Kashmir, however, the underlying conditions of militarization and uninterrupted “state of emergency” that Kashmiris have been living in since 1989 have not changed. In this sense, humanitarism in Kashmir is not a tool of postconflict reconstruction, as it has been elsewhere, but a means of reshaping an ongoing military occupation (Abramowitz 2014; James 2009).

But the Indian state is not unique in its use of medical and psychological techniques in counterinsurgency programs. In 2015, the central role played by psychologists in US counterinsurgency efforts was publicized and debated (Huffington Post, July 24, 2015), with the publication of the US Senate Select Intelligence Committee's report on torture
and the American Psychology Association’s subsequent response (Hoffman et al. 2015). The Senate committee report raised troubling questions about the place of medicine and psychology within structures of military humanitarianism, suggesting the need for more scholarly work on this subject (Johnson, Grasso, and Maslowski 2010). In particular, ethnography can make visible the microprocesses through which military humanitarianism operates as a mode of governance, albeit an incomplete one. At least in Kashmir, we see how people survive and struggle within structures of military humanitarianism in surprising ways—for example, by finding moments to think and talk about love.

Love reveries reveal how Kashmiris—and perhaps others in conditions of chronic violence—inhabit structures of military occupation. Kashmiri substance users discreetly mobilized languages that allowed them to conform to the expectations of clinicians without absorbing the clinic’s agenda. Rather than resisting in any straightforward sense the medical-penitentiary techniques they were subjected to, patients, for the most part, performed and adhered to the clinic’s rules so that they could complete treatment quickly and with minimal friction. In this sense, reveries allowed patients to fulfill their obligations as grateful citizen-subjects while holding on to unapproved desires and liaisons. At stake here, then, is a model of resistance that does not involve direct confrontation but which offered patients a culturally salient language with which to reinterpret their pasts while avoiding additional discipline, violence, or time in treatment. To this end, it was important that telling reveries hinged on the temporary, limited friendships between me and my interlocutors. My being other in this setting—as a non-Kashmiri, woman, and nonrelative—enabled patients to tell me their reveries freely, because they knew I did not belong to their milieu.

Nasha offered patients a discursive and experiential capsule through which to express and recast illicit experiences of drug use, love, madness, and jealousy that are thick with emotion, deeply painful, and otherwise intangible. Its presence—along with the durability of love reveries—shows how patients have alternative therapeutic and narrative resources than those that the clinic authorized. While not all patients marshaled nasha as the cause of their addiction, the contrast between public recovery narratives and reveries suggests the multiplicity of narrative possibilities that exist in a single clinical space, and that rather than being in conflict, these genres might exist side by side. Nasha also troubles biomedical models of substance abuse treatment, which produce a linear trajectory from addiction to abstinence, demand that addicts take full responsibility for their past mistakes, and require them to separate their past and present selves. In contrast to the therapeutic function of recovery narratives, nasha did not force patients to forget or completely separate themselves from their histories of intoxication. Rather, the Sufi language of nasha absorbed the negative attributions of drug use into a more encompassing, positive frame, allowing patients to revisit their pasts while avoiding the shame and stigma associated with uncontrolled drug use. In contrast to clinical injunctions that all intoxications are harmful and that the past should be forgotten, patients used reverie to recuperate intoxication as something pleasurable, dangerous, and worth remembering. In other words, reveries allowed patients to dip back into their pasts, rework and reinterpret their intoxication as an outcome of mad, excessive—but socially legible—love, and thus reaccess intoxication without the taint of shame or stigma.

Unlike dreams, daydreaming has received very little anthropological attention (cf. Borneman 2011). Yet there are good reasons for anthropologists to attend to these in-between temporal states in our fieldwork and writing. For both anthropologists and their interlocutors, daydreams and reveries break the monotony of routine time in fieldwork or inpatient treatment; they are a mode of traveling while standing still. For men of a certain age, such as Arif, they can transport a person to a time before military occupation, when Kashmiris could easily crisscross the subcontinent if they had the means; for others, like Rouf, they are a way of journeying into illicit spaces—such as his girlfriend’s room—and engage in risky behaviors. Such free and pleasurable movement across time and space, like acts of ethnographic writing, create a “to and fro” temporality between the past and present: they connect the here and now with the then and there. For substance users, reveries allow histories of intoxication to seep into the present, without the sense of shame or the weight of responsibility that usually accompanies addiction. What appear at first glance to be tenuous and fleeting half-thoughts thus offer clues as to how people reconstruct themselves in the aftermath of serious emotional and existential upheavals, such as addiction, as well as how they survive in the midst of political stagnation.

Notes

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1. For ease of reading, I will refer to the Kashmir valley in the Indian-controlled state of Jammu and Kashmir henceforth simply as “Kashmir.”
2. The Jammu and Kashmir Police is the primary law enforcement agency in the state. The police work closely with the Indian Army, Central Reserve Police Force, and other paramilitary organizations in the state on counterinsurgency and other covert operations. The police in India are two tiered: senior ranks, from assistant superintendent and higher, are occupied by an elite cadre called the Indian Police Services (IPS). The IPS is one of three All-India Services established under Article 312 of the Indian Constitution. Personnel drawn from the secondary, state (provincial) cadre occupy lower ranks of constable up to the deputy superintendent level. Police personnel from the state cadre—such as those who staff the DDC and do street-level work—are locals from the state of Jammu and Kashmir, whereas the higher echelons of the police (those from the IPS) may come from anywhere in India.

3. While many organizations and substance abuse centers globally have dropped the term addiction in favor of the psychological language of dependence or the more holistic rehabilitation, biomedical practitioners in the DDC and across Kashmir preferred addiction and de-addiction. As Eugene Raikhel and William Garriott note, “The [global] proliferation of models of substance abuse treatment means that different models of addiction are the product of different, highly contingent epistemic trajectories” (2013, 18). While the term de-addiction prioritizes detoxification, the DDC uniquely emphasized psychological and psychosocial intervention.

4. Sufism is a mystical tradition in Islam that begins with the soul’s conversion, or turning toward God. Although “Sufism” is the modern, English translation of the Arabic tasawwuf, it is not, as Carl Ernst has pointed out, an “ism” or a theory, but rather a lived experience and quest for perfection that comes with union with God (Ernst 1985). The first Sufi order to be introduced in Kashmir was the Suhrawardi, in the 14th century.

5. Borneman argues that reveries can produce “an alternative sense of reality, in which the anthropologist, at least momentarily, also takes part” (2011, 245). In a session of psychoanalysis, both analyst and analysand participate (though asymmetrically) in this process, known as the intersubjective analytic third (Ogden 1997, 109).

6. The former princely state of Kashmir is bifurcated along the Line of Control (LoC), a de facto international border. Sixty-five percent of the territory is under Indian control, while Gilgit-Baltistan and Azad Jammu and Kashmir are currently under Pakistani control. China controls the northeastern portion known as Aksai Chin and the Trans-Karakoram Tract.

7. Some 60,000 Kashmiris died in the armed struggle, over 200,000 Kashmiri Hindus (Pandits) were displaced, and about 8,000 men were forcibly disappeared.

8. Many in Kashmir speculate that the military’s strategy from the mid-1990s on of using state-sponsored counterinsurgency paramilitary groups—which operated as a secret, illegal army composed of former or “reformed” militants—was an attempt to restore the Indian army’s tarnished image. In other words, the army increasingly outsourced abuses and human rights violations to unaccountable forces, which in due time themselves became the targets of public anger.

9. The very desire to leave before treatment concluded was also read as a sign of “withdrawal” symptoms—an ongoing mark of the disease of addiction. Clinicians “motivated” patients to stay by coercing them emotionally and physically. I witnessed clinicians sometimes ordering security guards to beat patients who violated the clinic’s rules, but they more commonly enlisted kin and other patients to persuade recalcitrant patients to continue treatment.

10. In addition to biomedical treatment, the staff also informally encouraged patients to read the Koran and pray (namaz) and frequently invited imams to give lectures on the status of intoxicants as prohibited (haram) under Islamic law. While clinicians drew on these resources, cultural or religious practices were not formally part of the therapeutic regime. In other words, patients were not held accountable or considered “noncompliant” if they did not use them.

11. I use pseudonyms for all the people I spoke with. Although all the clinicians were Kashmiri Muslims, the patients were more diverse. Most were Muslim, but there were patients of other ethnic and religious backgrounds present, including Hindus and Sikhs, though always as a minority. As I point out, however, there were important differences among Kashmiri Muslims; for example, some identified as Sufi and others did not.

12. As Mona Bhan (2014) has argued, the experience of the Kargil conflict, fought between India and Pakistan in 1999, spurred the central government—headed by the nationalist Bharatiya Janata Party (BJP)—to “humanize” its Kashmir strategy. In Kashmir, the People’s Democratic Party (PDP) came to power in 2002 on a “healing touch” policy based on human rights. In March 2003, the PDP-led government opened investigations into alleged disappearances and custodial deaths, arguing that healing “moral and historical wounds” was urgently required to promote a culture of goodwill and reconciliation in the region and rebuild civil society (Bhan 2014, 12).

13. Historically, practices of intoxication have been associated with Sufi orders such as the Malangs/Malangis or Qalandars, who smoke hashish to eliminate the lower soul (nafs) and bring the spirit (ruh) in union with God (Ewing 1984). Using cannabis, along with other practices associated with Sufism, was heatedly debated in Kashmir. While some argued that Sufism was indigenous to Kashmir in a way that some Islamic reformist movements were not, others questioned Sufi practices of venerating saints and visiting shrines (dargah) as being “proper” to Islam.

14. ‘Umar ibn ‘Alí ibn al-Frírd (1181–1235), a Sufi poet, distinguishes three modes of experience: normal, abnormal, and supernormal. Normal experience, or sobriety (sahwu), is the multiple, shifting consciousness of ordinary men; abnormal or ecstatic experience is the loss of that consciousness in ecstasy (sukr); and supernormal experience is the higher, mystical, unified consciousness which may result from ecstasy, known as “the sobriety of union” (sahwu ‘l-jam’) or the “second sobriety.” This last phenomenological state is necessarily preceded by intoxication but does not necessarily follow it. In most cases, the mystic returns to normal consciousness after his or her state of ecstasy is over. On the other hand, the intoxication can be succeeded by a state of “sobriety” in which the seer regards himself as united with God. According to Ibn al-Farid, this is the supreme degree of oneness (ittihad).

15. It was unclear what the causes of his physical deterioration were, given that these symptoms are not generally associated with opiate use.

16. Borneman writes that anthropologists, psychoanalysts, and others who engage in what he calls “interlocution-based fieldwork” often experience highly charged countertransference. In these encounters, they are often asked to serve as “containers” for the desires, anxieties, and fantasies that their interlocutors disclose (2011, 235; see also Bion 2013).

References
Reveries, longing, and intoxication in Kashmir


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