Where There are only Doctors: Counselors as Psychiatrists in Indian-Administered Kashmir

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Abstract In the last decade, over half a dozen local and international humanitarian organizations have established psychosocial programs to ameliorate the suffering of victims of violence in Kashmir. Many promote nonpharmacological trauma healing, such as counseling and psychotherapy, in contrast to the pharmacological treatments preferred by state mental health services. Although anthropologists have critiqued humanitarianism for its inadequate attention to local contexts, in this article, I attempt to go beyond this critique by focusing on the locals or “nationals” who staff these organizations. Kashmiri psychosocial workers mediate between formal, international guidelines of psychosocial treatment, on the one hand, and local understandings of biomedical efficacy and care, on the other hand. I specifically show how counselors appropriate medical and psychiatric expert practices in their everyday work, not to increase their own prestige but to make their practice more legible to their patients or clients. As such, one of the unintended effects of psychosocial programs in Kashmir is the perpetuation of a medical model of care. Rather than being caused by a lack of knowledge of the local context, however, I argue that such borrowings are central to how psychosocial practices have been vernacularized in Kashmir. [trauma, psychiatry, subjectivity, practice, psychotherapy]

During one of my final days of fieldwork in Kashmir, 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 is committed to providing nonpharmacological care to victims of violence. Nonetheless, Imran’s perspective was far from unique among counselors in Kashmir.

In this article, I explore what the desire to prescribe medication reveals about the contours of psychosocial interventions in the aftermath of 13 years of armed conflict in Indian-administered Kashmir. 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 nonbiological interventions for people suffering from mental disorders (IASC 2007). As social scientists have noted, since the Bosnian war in 1995, global humanitarianism has increasingly emphasized trauma healing as a central part of relief efforts (de Jong 2002; Duffield 2001; Fassin and Rechtman 2009). Psychosocial interventions, in particular, are widely used to help conflict survivors cope with the emotional and interpersonal impact of painful wartime experiences (Locke 2009) or to
“re-engineer” selves or societies in the aftermath of devastating violence (Abramowitz 2009) or mass political upheavals (Matza 2009). In some contexts, such as Kashmir, psychosocial programs have also been adapted to supplement state mental health services, which have remained within a predominately pharmacological, biomedical psychiatric model (Young 1995:7). Some have critiqued trauma healing projects on the grounds that they psychologize embodied pain and suffering (James 2010; Summerfield 1999). Others have drawn attention to the politics of humanitarian action itself, which pivots on “lives to be risked”—those of expatriate humanitarian workers—and “lives to be saved”—those of local clients or patients (Fassin 2007).

Although such critiques are important, they do not address the ways in which local humanitarian actors—in this case, Kashmiri psychosocial workers—use, subvert, and transform humanitarian practices in their everyday work, thereby modifying the given category of psychosocial action. As Didier Fassin points out in his work on Médecins sans Frontières (MSF), many aid, developmental, and humanitarian organizations distinguish between “expatriates” and “nationals.” In the case of MSF, for example, expatriates come almost exclusively from Western countries and are volunteers of the organization, whereas nationals are local agents who are considered “mere paid employees” (Fassin 2007:515). However, within humanitarian discourse, “nationals” 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” (Abramowitz and Kleinman 2008:221). As such, I argue that local staff operate as important middle figures who shape—and are shaped by—humanitarian and medical epistemologies (Good 1994; Luhrmann 2000; Wendland 2010). Given that national or local staff are often asked to act as cultural translators within humanitarian organizations, ethnographic attention to their micropractices disrupts critiques that humanitarian actors are inattentive to “concrete situations” (Englund 2005:12) and are only concerned with universal conceptions of humanity (Malkki 1995; Pandolfi 2003).

On the contrary, I argue that psychosocial workers embody the work of “vernacularization” (Goodale and Merry 2007) in a context in which the forms of psychosocial care—such as psychotherapy and counseling—are unfamiliar to users of mental health services. Through ethnographic examples, I show how local staff manage the need to adhere to formal, international guidelines of psychosocial work, on the one hand, and the need to make their practices locally salient, on the other hand. I specifically argue that one of the unintended effects of this “vernacularization” is the promulgation of a medical model of mental health care via psychosocial practices. I show how counselors appropriate the practices of medical practitioners, particularly doctors, to make their treatments legible to patients. In this scenario, biomedicine—having already been vernacularized—acts as a more culturally familiar buffer to psychosocial knowledge, which is newer and less recognized. One of the ways in which biomedicine has been vernacularized in Kashmir has been through an emphasis on giving; the work of the doctor is to give pills (davai) just as the work of a traditional healer is to give amulets (taveez). Similarly, the borrowing of biomedical expertise by psychosocial workers also happens through the appropriation of biomedical objects, such as medical cards and highly technical treatments, which are key to vernacularization.
Field research for this article, part of my doctoral dissertation work, was conducted between October 2009 and December 2010 in the Kashmir valley and was approved by Cornell’s Institutional Review Board (IRB). My doctoral dissertation investigates the ways that psychiatric and psychological discourses and practices, particularly around trauma and post-traumatic stress disorder (PTSD), are being used and translated by the Indian state and local and international humanitarian organizations in Kashmir. Data collection consisted primarily of ethnographic methods, including observations of consultations between counselors, psychologists, psychiatrists, and their patients; unstructured and semistructured interviews with users of mental health services, psychosocial workers, Islamic healers, and biomedical doctors; and visits to community outreach programs such as mental health camps and other awareness-raising initiatives. When granted permission by patients, I also analyzed medical records. In Kashmir, the clinic is a polyglot space and includes English, Urdu, and Kashmiri. I conducted interviews in Urdu and Kashmiri. All Urdu to English translations in this work are my own, while Kashmiri to English translations were done with the assistance of a translator.

This article looks at three key practices normatively associated with medicine that are used by counselors in Kashmir: diagnosing, “(mis)reading” the medical record, and choosing technical, biomedical treatments, rather than psychosocial ones. Although these practices are deviations from the standard norms of counseling, I read each as an instantiation of “ordinary ethics,” as “relatively tacit, grounded in agreement rather than rule, in practice, rather than in knowledge or belief, and as happening without calling attention to itself” (Lambek 2010:2). In addition to using biomedical knowledge to make psychosocial care more recognizable, biomedical technologies also structure how counselors understand their own (ill) bodies. Although my title suggests that counselors act as psychiatrists, this is not to say that they are able to usurp the authority of medical experts. Rather, it is to draw attention to a particular kind of performance through which counselors attempt to approach the authority of doctors.

**A Time to Intervene**

Most Kashmiris understand themselves as living through a period of colonization and occupation by the Indian state, in place since 1947. From 1989 to 2002, Kashmiri insurgent groups waged an armed battle for self-determination (azaadi) against the Indian state and were met with brutal military and legal repression. Since 1989, a “state of emergency” continues to be in place, codified through draconian laws such as the Disturbed Areas Act (DAA) and the Armed Forces Special Powers Act (AFSPA). Human rights groups have criticized these laws for facilitating widespread human rights abuses and promoting a culture of impunity for Indian security forces in Kashmir. Meanwhile, everyday life is governed by more than half a million troops, making the region the most heavily militarized in the world (Anjum and Varma 2010). To date, approximately 70,000 Kashmiris have lost their lives in the conflict, 10,000 are disappeared, and torture and rape have been widely reported (de Jong et al. 2008). Despite the declaration of a ceasefire in 2002, there has been no definitive
political resolution of the conflict and the region continues to be mired in violence and instability, in the ambiguous zone between conflict and postconflict. In the most recent cycle of violence in 2010, over 100 youth protestors were killed in street confrontations with Indian security forces.

In addition to being the site of ongoing violence and political unrest, in recent years, in media and human rights reports, Kashmir has also emerged as a zone of mass psychological suffering. Media reports highlight the fact that Kashmir has one of the highest rates of post-traumatic stress disorder (PTSD) in the world, with approximately one-third of the population exhibiting traumatic symptoms (Matloff and Nickelsberg 2008). Similarly, a 2006 report by Human Rights Watch entitled, “Everyone Lives in Fear,” describes an “epidemic of trauma” underway because of sustained human rights abuses. Kashmiri psychiatrists have also reported exponential increases in the number of patients visiting the only state-run psychiatric hospital in Kashmir, from 1,000 per year in 1989 to 100,000 per year in 2009.

In response to the ongoing “epidemic of trauma,” organizations such as MSF—which has been in Kashmir since 2000—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 semistructured interviews in two rural districts in Kashmir (de Jong et al. 2008). Also in 2006, Kashmiri psychiatrists conducted a survey of four districts in Indian-administered Kashmir and found a lifetime prevalence of traumatic events in 59 percent of the population (Margoob et al. 2006). These reports serve to legitimate PTSD as the recognized marker of suffering, and to produce Kashmir as a particular humanitarian “hotspot,” in need of intervention. 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 (Desjarlais 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. The Jammu and Kashmir police, for example, have established several drug and alcohol deaddiction 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 is significant ideological and personnel traffic between them. Humanitarian experts—both local and expatriate—frequently attend consultations and meetings with local, state, and national health officials, while local staff often switch employment, moving between state and nonstate organizations. Despite this frequent contact, many expatriates working for humanitarian organizations expressed “moral outrage” (Redfield 2006:5) 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 model as “de-centralized, de-stigmatized psychosocial care,” contra the institution-based, pharmacological model offered by the Indian state. This staff member described the woefully long lines at the Out Patient Department
(OPD) of the state psychiatric hospital and the fact that many psychiatrists lacked empathy for their patients, spending only a few seconds or minutes with them.

Although the need for mental health services was obvious to mental health experts, they had to make this need felt to Kashmiris. In this case, trauma and mental health had to be first created as ontological entities—different from Kashmiri concept of madness (mot) or suffering (paresbami)—before they could be intervened and acted on by these organizations. This was attempted through both awareness raising and treatment programs. In 2001, MSF began offering psychological and counseling treatments at the state psychiatric hospital, which were hitherto 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 to the counseling cell 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. In addition to offering counseling, in 2005, MSF also began production on a Kashmiri radio soap opera called “Hello, Brother Hello” (Alaw Baya Alaw) that focused on raising awareness about mental health issues in Kashmiri society. They 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.

Action Aid International, another organization specializing in psychosocial services, also attempted to strike a balance between working within and outside state institutions. Although Action Aid deputed counselors to various district hospitals around the state, they also had a cadre of 60 “paracounselors” doing door-to-door counseling and providing emergency aid relief kits in local communities. Other experts trying to fill the gap in psychosocial care delivery attempted to bypass the psychiatric establishment altogether. Justine Hardy, a British author and homeopathy therapist who established an NGO called Kashmir Life Line and Health Center, described her organization as 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 tranquilizers, sedatives, anti-psychotics, and anti-depressant drugs” (Hardy 2012). There were no psychiatrists involved in the daily functioning of Kashmir Life Line—unlike the other NGOs such as Action Aid. Further, to remove all traces of the medical, Hardy renamed the 11 counselors who worked for Kashmir Life Line as “listeners,” because she felt the counselor label was already too formal and professionalized. This article draws a great deal 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.

One of the most obvious and tangible effects of the production of a mental health crisis in Kashmir has been a newfound demand for mental health professionals, particularly individuals with psychology or social work degrees who can work as mental health counselors.
The shortage of mental health manpower in India has been a source of concern on both the national and global stage. 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 (Kapur 2004). This situation is even further exacerbated in a context of violence such as Kashmir, where mental health resources are already in crisis. Typically, the job postings for counselors require 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 the disciplines of mental health were also gaining in popularity. Although counselors staff the bulk of psychosocial organizations, when compared with psychiatry, counseling is still a new and relatively unknown profession in Kashmir. This is one of the reasons why psychosocial workers experiment with medical techniques in their everyday work and feel—like Imran in the beginning of this piece—in the hope that it may make their practice more culturally familiar.

The Heavy Diagnosis

One of the medical or psychiatric practices most borrowed by psychosocial counselors in Kashmir was the act of making diagnoses. In this context, psychiatric diagnoses were not just “matters of concern” for psychiatrists (Latour 2004), but for other mental health experts as well. However, for counselors, the diagnosis cut both ways—it could be empowering or disempowering, promoting action or suspending it. The diagnosis was a heavy presence, sitting like a stone on the front of a person’s medical card.

Dr. Arshad Hussain, who holds an M.D. in Psychiatry and works at the Government Psychiatric Diseases hospital (GPDH), Kashmir’s state-run psychiatric hospital, has trained Action Aid’s counselors in Kashmir for the last eight years. He said that he had trained Action Aid’s counselors to be “barefoot psychiatrists.” He told me proudly that one of the senior psychiatrists from the state hospital had gone to visit Action Aid’s PTSD clients, but that the doctor had been unable to change a single diagnosis. “All 23 PTSD cases were correctly diagnosed by the counselors,” Dr. Hussain said triumphantly. He described the senior psychiatrist’s chagrin when he found that he did not need to change a single diagnosis.

For Dr. Hussain, diagnosing was the accomplishment of a complicated hermeneutic process, usually acquired after years of medical training (Luhrmann 2000). That the counselors had gained this skill without formal medical training suggested that they were “really something,” as Dr. Hussain put it. I had the opportunity to witness one of Dr. Hussain’s training sessions, in which he attempted to impart the art of diagnosis 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. Hussain had written on the whiteboard. Looking at the list, Dr. Hussain 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. [field notes, December 8, 2009]

In this explanation, Dr. Hussain was calling 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 intuition” (Luhrmann 2000:34) to counselors—and thus potentially rendering psychiatrists redundant—did not make Dr. Hussain particularly popular among his peers. As such, Dr. Hussain viewed himself as a Promethean figure, wrestling 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 life of counselors. At times, the diagnosis was deliberately kept in view, even if it meant that counselors had to curtail their own interventions. One particular 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. Since 2008, the Jammu and Kashmir Police have been running a Drug De-Addiction Clinic as a public outreach initiative, which has been immensely successful. Although the clinic is 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. Such efforts by the staff were only partially successful, and most in-patients described feeling surveyed or imprisoned at some point during their 30-day stay.

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. 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 networks. For example, it was extremely rare that a person would come to a mental health center alone. As a result, hospital OPDs and waiting rooms were quasipublic spaces.

The Stress Management team—those running the telephone hotline—comprised 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 fall back 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. As Renu Addlakha (2008) has shown in another South Asian context, although practically all mental health professionals privilege the multidisciplinary model of mental health care in theory, in practice, this model is often subverted and debated. However, while Addlakha (2008:3) argues that it is often psychiatrists themselves who “cut into the collaborative work culture of the clinic,” the example of Mudasir is useful in showing how those on the “lower” rungs also hold up the hierarchy of mental health care. In this 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” (Fassin 2007) in the sense that not all victims are seen as potentially savable within humanitarian work. 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. 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 nonbiological, psychosocial interventions more legible to those they were treating by incorporating aspects of the medical model within them.

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 are worthy of attention for revealing counselors’ self-perceptions about their work and its illegibility in the Kashmiri context. According to the first counselor, many doctors themselves are ignorant of what counseling is, making it all the more frustrating that psychosocial workers depend on doctors for referrals. 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 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 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 (cf. Pigg 2001). In many of the sessions I observed, it was clear that counselors had given up trying to find vernacular equivalents of these words and continued to say them in English, even though patients did not fully understand. Many counselors also verbalized a preference for working with English-speaking clients, as these were cases in which their linguistic labor was greatly reduced. With first-time clients, 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, however, most counselors allowed themselves to be called “Doctor Sahab” and tried to incorporate more doctor-like practices (daktari kam) into counseling (cf. Pinto 2004).

For these reasons and more, counseling at district hospitals was an extremely challenging task. Counselors were dependent on doctors in the OPD for referrals, and spent a lot of time waiting. When patients did wander in, many of them did so accidentally, looking for the OPD or dispensary. When the psychosocial workers received a patient referral, in many cases, they were not told why or were given incomplete information. During one of my visits, for example, the hospital’s pharmacist brought in a distraught 15-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 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.

In Kashmir, patients in institutional settings generally carry their medical cards with them at all times because there are no electronic medical records. Both patients and doctors were aware of the fact that these medical cards were their only proof of their medical history and existence as medicobureaucratic subjects. Yet these cards were made of paper and were flimsy and required a great deal of maintenance. During my fieldwork, I saw cards that were smudged, tattered, with liquid spilled on them, but also those that were kept in mint condition, in carefully marked plastic folders. Generally, from my visits to patients’ homes, I knew that most patients tried to keep their medical cards carefully. This was both because they recognized the importance of the paper as an institutional record, but also because they knew the record was an extension of—and could substitute for—their own agency (cf. Langwick 2011:168; Reed 2006). Nargis, a female patient I met outside the OPD of the psychiatric hospital, confessed her worry 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 concise rendering, Nargis related the idea that the documented form constitutes the person even more than it retains her traces (Derrida 1995; Jacob 2007). Further, the respect Nargis granted to the material form of her medical card suggested that, for her, the text was significant in and of itself. As such, Nargis’s gesture was also consistent within the framework of Islamic reading practices in which material objects have a force of their own, apart from their content (Messick 1993).

Harold Garfinkel, in his famous essay on clinical records, argued that there were “ties between records and the social system that service and are serviced by these records” (1967:192). Social scientists drawing on this body of work have shown how medical records structure relations between mental health experts, including social workers and their clients or patients (Epstein 1995). Although the interaction between psychiatrists and patients was usually focused on the medical card, in the training sessions I observed, psychosocial workers were
actively encouraged to literally, put aside the medical card. Instead, 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 well and good in training sessions, the reality of counseling sessions was quite different. As stated earlier, all of the patients who visited counselors referred to the listeners as “Doctor Sahab (Sir) or Doctor Memsahab (Madam),” a title that counselors did not refuse. Second, as they were accustomed to doing with doctors, patients would hand over their medical card to counselors right away, before any 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 pretended to read the card, as they could not follow the messy, sometimes 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 (1996) insight that mental health experts in India feel a greater need than experts elsewhere to satisfy client expectations; in this case, the effort is to establish mental health care as a legitimate kind of biomedical practice. Rather than these psychosocial workers being unaware of their patients’ expectations or desires, then, this example reveals to what extent such experts will go to perform what patients demand.

**Treatment Potentialities**

My third example of a “technique of the body” (Mauss 1973) appropriated by counselors concerns the kinds of treatments they considered the best or most efficacious—not just for their clients but also for themselves. In particular, by appealing to psychiatric or highly technical biomedical regimens in their own personal lives as well, counselors situated themselves as part of, rather than apart from, the individuals and communities who sought their help.

In this section, I present an excerpt from my field notes, because the social drama embedded in the text is emblematic of the tensions and contradictions within psychosocial organizations (cf. Fassin 2007). 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 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 things like pessimism, self criticism, and worthlessness. 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 (Cognitive Behavioral Therapy). 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 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.”

At this point, Dr. Arif interjects. “So, no one can tell me the different steps of CBT?” he asks.

“Go and read up on it tonight.” He turns to Christine and me and says, “Problem solved.” [field notes, June 6, 2011]

Nafisa and the other listeners were surprised by Christine’s interruption. What was more recognizable and appealing to them was to acquire—rather than avoid—the specialized knowledge offered by, in this case, CBT. At the time of my fieldwork, there were only two clinical psychologists in Kashmir trained to administer CBT. 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 (Holmes 2002:288), I would argue that this was also in line with “local” demands for technical, biomedical
treatment. Nonetheless, the place of technical, biomedical knowledge within psychosocial organizations such as Kashmir Life Line was highly contested and is here embodied in the tension between Christine and Dr. Arif. In Dr. Arif’s suggestion that the counselors should “go read up” on CBT, he was echoing the “barefoot psychiatrist” perspective espoused by Dr. Hussain earlier. In other words, he was making an argument 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 a Kashmiri woman suffering from a major depressive disorder.

In the earlier section, I showed how counselors enacted medical practices, particularly (mis)reading, to satisfy client or patient expectations. However, this explanation does not fully get at the ways in which counselors’ own approaches to biomedicine structured their everyday lives. In particular, I argue that, for Kashmiri counselors, exposure to the psychiatric or psychological models of disease and treatment are just as transformative as an anatomy class is for medical students (Good 1994). 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. To illustrate this, I will provide a final ethnographic fragment.

One of the listeners, Nazima 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 a.m., and I am surprised when Nazima 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 10:00 a.m., Nazima 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.” Nazima 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,” Nazima 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 Nazima’s mischievous smile, it seemed that this was a slight understatement.)

Although she had visited the best specialist, Nazima 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, Nazima 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!” [field notes, June 24, 2011]
Like Imran, with whom I began this piece, Nazima expressed her desire for health and well-being 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 Nazima’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 Nazima, 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 (cf. Hamdy 2008). 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.

**Conclusion: Medicalization from Below**

While conducting fieldwork, it was difficult to gain a perspective on biomedicine from the “outside,” as it often seemed there was nothing outside of medicalization. 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. The effect of such “vernacularization” was somewhat 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. 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. After militancy, we have more illnesses. [May 7, 2010]

In their statements, both Nazima and Bashir pointed to a sense that it was impossible to be healthy in Kashmir. As Nazima 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!” Nazima’s humorous tone indicated that she identified the problem as partially
in her mind—“I have this feeling” and, thus, following 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 article has attempted to chart three 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” (Ticktin 2006) 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 complain 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 (IASC 2007), in
places like Kashmir, they 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.

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1. China, India, and Pakistan all make competing claims to parts of Kashmir. The region of Kashmir is currently
bifurcated along a “Line of Control” (LoC), a ceasefire line established in 1949. On one side lies Pakistan-
occupied Kashmir or Azad (Free) Kashmir, while on the other side of the border is Indian administered or Indian
occupied Kashmir. Fieldwork was entirely conducted in the Kashmir valley, an area administered by the Indian state.

2. Kashmiris refer to their movement for the right to self determination as *tehreek*, an Arabic word adopted into Urdu and Kashmiri languages that signifies the total idea of a continuing struggle with the ultimate goal of freedom and independence, or azaadi (Duschinski 2009).

3. 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).


5. India has developed several national and district-level programs to address the 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.

6. Staff at the De-Addiction Clinic claim that the clinic has achieved rates lower than the global average. As one of the only drug deaddiction centers in Indian-administered Kashmir, the center consists of an eight-bedded, in-patient facility for men, which was always full and had a prohibitively long waiting list. A 2008 study commissioned by the UN Drug Control Program (UNDCP) estimated that there were 60,000 substance abusers in Indian-administered Kashmir, including 4,000 female addicts, for whom there are no treatment centers (Bukhari 2010).

7. 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.

8. However, some practitioners have argued that the popularity of CBT 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).

9. Unani (Greek) medicine is a form of traditional healing widely practiced in South Asia, which draws on Greek, Arabic, and Iranian medicine. Like Ayurveda, Unani is also based on the balance of four humors.

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