EXPERIENCING ADDICTION AND DEPENDENCY
AMONG YOUTH IN JAMMU, INDIA

Sugandh Gupta

A thesis submitted to the faculty at the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Art in the Department of Anthropology in the Graduate School.

Chapel Hill
2018

Approved by:
Jocelyn Lim Chua
Michele Rivkin-Fish
Townsend Middleton
ABSTRACT

Sugandh Gupta: Experiencing Addiction and Dependency among Youth in Jammu, India
(Under the direction of Jocelyn Lim Chua)

In this thesis, I advocate for an ethnographic study of addiction experiences based on 8 weeks of preliminary fieldwork during the summer of 2017 among youth residing in Jammu City, Jammu and Kashmir, India. I expand the scholarship on the anthropology of addiction to South Asia by demonstrating how addiction experience is constituted in the everyday: through kinship relations, regional and national histories, and medical and juridical regimes of state-sponsored institutions. I do so by exploring the cultural and moral practice of ‘dependency’ as a productive lens onto addiction experience, and which has long-served as an important idiom to theorize classic understandings of ‘Indian personhood’ and the ‘Indian Self’ in the South Asia literature. By locating addiction in the intimate relations of reliance and care that unfold between people, substances and institutions, my effort is to rethink ‘dependency’ at the conjuncture of regional and national histories in Jammu, India.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>ADDICTION IN JAMMU</td>
<td>4</td>
</tr>
<tr>
<td>ADDICTION</td>
<td>9</td>
</tr>
<tr>
<td>ANTHROPOLOGY OF ADDICTION</td>
<td>12</td>
</tr>
<tr>
<td>DEPENDENCY</td>
<td>17</td>
</tr>
<tr>
<td>CONCLUSION: RETHINKING “DEPENDENCY”</td>
<td>27</td>
</tr>
<tr>
<td>WORKS CITED</td>
<td>31</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1: Map of Jammu and Kashmir.................................................................2
INTRODUCTION

Every morning, approximately 600 men, aged between 14 to 45 years, gather at the large, barren courtyard of the Mira Lok Psychiatric Hospital\(^1\), an affiliate of Government Medical College and Hospital in Jammu, India. Some of these men have had to travel long distances of up to 2 hours. They come alone, in groups or with a family member. Each morning they wait for Dr. Lekha Arora. She is the in-charge for the de-addiction center. She signs each prescription and authorizes each patient’s daily dose of Opioid Substitution Therapy (OST). Because these men inject illicit drugs and are susceptible to HIV infection, they qualify for OST, according to the mandate of the National Aids Control Organization (NACO) of India. As I walk through the courtyard one summer morning at around 8 am, I see a mix of anxious faces and cheerful bantering. The security guards and patient care staff recognize several of them and engage in playful, informal conversations. Indeed, some of these men have been coming daily for as long as three years, when the de-addiction center first opened its doors. As I enter the hospital to meet the Head of the Department of Psychiatry, I feel my consciousness momentarily suspended amidst the cacophony of voices – of patients, their caregivers, the hospital staff and the doctors. A crowd begins to gather in a small corridor. The men have their arms outstretched, holding tiny pieces of paper: prescriptions for OST. In this corridor are two windows. Through one window the prescription is signed, and through the other window, the OST is administered. I see young,

\(^1\) The names of the institution, mental health practitioners and patients have been changed to ensure anonymity.
eager and nervous men determinedly shouting and stretching outwards, demanding, or perhaps, pleading, for the doctor’s attention.

Figure 1: Map of Jammu and Kashmir

My observations that morning at Mira Lok illustrate how drug de-addiction and recovery are mediated by interactions not only with family members, but also with state-employed doctors.

---

2Source: Library of Congress, United States of America, Identifier: g7653j ct001059
and medical staff who simultaneously invoke multiple relationalities: as experts, legal
authorities, state representatives, and parental-like figures. They highlight the forms and relations
of dependency\(^3\) (*nirbharta*) that frame the larger social and political worlds in which addiction is
treated and experienced in Jammu. Drawing on preliminary fieldwork conducted over 8 weeks
during the summer of 2017 in Jammu City (Figure 1), in this thesis I explore how social life and
the everyday in Jammu are orchestrated through intimate and often hierarchical social
dependencies, in ways that are magnified and mobilized by addiction.

Recognizing addiction as an integral human experience and a legitimate object of
anthropological inquiry, I expand the anthropological scholarship on addiction and personhood
by examining addiction experiences through the cultural lens of “dependency” (*nirbharta*) as
embodied and practiced in the South Asian context of India. Using the recent rise in substance
abuse in Jammu City, India as a case study, I examine how political violence and changing
socio-cultural realities in the region, set within the context of ongoing neoliberal state reforms in
India, are shaping experiences of substance addiction. While clinical studies of addiction focus
on people’s chemical and pathological reliance on substances and things, by contrast I situate
addiction in Jammu City within a broader medical, cultural, social, and political terrain of
“dependency.” I do so in order to illuminate multi-level entanglements of borders and territories,
social relationships, kinship obligations, neoliberal family forms, discourses of medical and legal

\(^3\)Dependency - I use the term dependency here for ease of language and to facilitate understanding by the reader, with an awareness of its limitations. Dependency as a term is fraught with multiple meanings. In the North American literature, it is largely perceived as pathological, however the term carries a different meaning in the South Asian context. It conveys an act of love and care woven in kinship relations and other forms of social engagement. Initiated, maintained and reciprocated in the South Asian culture, dependency destabilizes the Euro-American accepted notions of self and personhood. Hence, in its positive sense, dependency implies relationality and reciprocity but it often masks coercion and oppression. As a positive attribute dependency is valued in the South Asia context.
Addiction in Jammu

Addiction is emerging as an important social, clinical, and political concern in Jammu City. A sociological study conducted by Manzer et al. in 2013 reported that an increasing number of young people aged 14-30 years are consuming drugs, and heroin use in particular has generated moral panic in Jammu city. During my fieldwork, Dr. Vijay Gupta and Dr. Shyam Lal, psychiatrists at the Mira Lok Psychiatric Hospital, expressed concern for an alarming new trend in drug addiction. They shared that cases of petrol addiction, sedatives, analgesics such as typewriter whitener, boot polish, synthetic drugs, intravenous injections like dextropropoxphene, codeine-based cough syrups and poppy husk are becoming increasingly common. Intelligence Officers from the Narcotics Control Bureau suggested to me that Jammu and Kashmir has become a transit route for drugs. According to the statistics published by the De-addiction Centre in Jammu, both young men and women are getting addicted to narcotics. In 2010, 196 cases of substance abuse were reported. The number reduced to 184 in 2011 but increased to 194 cases in 2012. During my fieldwork, other local mental health professionals asserted that addiction is an inevitable outcome of the region’s social, cultural, geographical, historical and economic experience.

Jammu and Kashmir (J&K) is located within the conflicted borders of Pakistan and China and consists of three regions: the Kashmir valley with a Sunni Muslim majority, Jammu with a Hindu majority, and Ladakh, home to Tibetan Buddhists and largely Shia Muslims. Large areas of J&K are controlled by the two nations as a consequence of territorial conflict over Kashmir.
since 1947 (Sokefeld 2013). In 1947, Jammu and Kashmir had a Muslim majority population but was governed by a Hindu monarch. The region’s boundaries were contiguous to both India and Pakistan and therefore had the option to join either of the two nation-states. Pakistan claimed J&K on the basis of its Muslim majority population and its “physical contiguity” (Wirsing 1998:7-62). However, the Hindu ruler Maharaja Hari Singh remained indecisive, inclined more towards the idea of independence rather than joining any of the two domains (Punjabi 1995:39; Guha 2007:62). Accession of the state to India, however, took place under extraordinary circumstances. An invasion by the Pathan tribesmen (from the North-West of Pakistan) compelled the monarch to accede to India and seek military help (Bose 2003:33-37).

The Maharaja’s terms of accession with India initially secured a special status for the state, as laid down in Article 370 of the Indian constitution. However, the battle to gain political control over Kashmir led to wars between India and Pakistan in 1947, 1965, and 1999. The 1990s were a decade of extreme violence: from 1989 to 2002 Kashmiri insurgent groups waged an armed battle for self-determination against the Indian state, efforts that have been met with brutal military and legal repression. Many Kashmiris see themselves as living in a period of occupation and colonization by the Indian state. Since 1989, a “state of emergency” continues to be in place. The conflict has disrupted normal life to the extreme and after more than thirty years, normalcy has not returned. Thus, daily life is not only frequently interrupted by actual instances of violence but also by demonstrations, strikes and curfews.

One of the most heavily militarized regions of the world, Kashmir has attracted most scholarly and media attention, to the neglect of Jammu (Bhatia 2014). Jammu’s history is entangled in complex local, regional, and national dynamics. On a national scale, Jammu’s relationship to the nation-state of India is mediated through the discourse of Kashmir. Seen to be
second fiddle in political importance to Kashmir, the political identity of Jammu region remains disputed. Mohita Bhatia (2011:13) writes:

…despite an extensive scholarly engagement with Jammu and Kashmir, the representation of the state still remains partial and limited…first the entire state is simply equated to one of its constituents, the ‘Kashmir’ region, and the conflict is also viewed as mainly limited to this part of the state. The way in which the conflict extends to other parts of the state, and affects their society and politics is completely overlooked…Also, other parts of the state such as Jammu have not been researched independently, but rather have been described mainly in reference to Kashmir.

On a regional scale, Jammu sits uncomfortably with Kashmir and is inadvertently dependent on the latter for (in)visibility. Due to the politically dominant position of Kashmir in the power structure of the state, many in Jammu feel marginalized by the Kashmiri leadership. Rather than Hindu versus Muslim, it is the Jammu versus Kashmir rhetoric that evoked the most intense response among the people I interviewed. For instance, during the late 1980s, a Kashmiri insurgency expressing the long-accumulated discontent of Kashmiri Muslims against India, gradually spread to various parts of Jammu creating an environment in which chauvinistic ‘pro-Jammu’ and ‘anti-Kashmir’ sentiments were easily evoked. Even as militancy has subsided, the conflict continues to impact the everyday lives of people in Jammu in various ways. This includes the constant political friction between Kashmir and Jammu on various matters related to nationalism and political autonomy, pervasive feelings of political marginalization vis-à-vis Kashmir, and perpetual India-Pakistan tensions along the border areas of Jammu (Bhatia 2014:951). In addition to religious diversity, Jammu manifests immense cultural, linguistic, sub-regional, tribal, and caste plurality. But given how India-Kashmir and Kashmir-Jammu tensions have dominated regional and national politics, Jammu has largely come to matter through its relations to these tensions. There is little political space left for the expression of the concerns of Jammu residents (Bhatia 2014:945).
Living amidst these regional and national fragilities, young people in Jammu are trying to come to grips with issues including lack of employment opportunities, bleak prospects for the future, boredom, family tensions, relationship tensions, and peer pressure, of which an alarming offshoot may be increasing drug dependency (Kahlon 2014). Three years ago, Mira Lok Psychiatric Hospital received state funding after cases of opioid abuse were found to be rampant and increasing. Bordering the already afflicted and opioid-overdosed region of Punjab on one side and Pakistan on the other, Jammu has become a site of trade, transaction and consumption of illicit substances. According to a 2016 study exploring trends in drug abuse in South Asia and around the globe published by the Institute of Regional Studies in Islamabad, Pakistan, India has become a transit hub as well as the destination for heroin and hashish production. The study reports that heroin reaches India via the India-Pakistan border and is mainly traded via Gujarat, Rajasthan, Punjab, and Jammu and Kashmir. This shift is largely attributable to an intensification of the war on terrorism and war over the status of Kashmir, due to which the borders have become porous to the flow of human bodies and illicit substances. Additionally, widespread unemployment, especially among youth, may be contributing to narcotics consumption (Bourgois 2002; Garcia 2010; Manzer et al. 2017; Orlova 2009; Varma 2016). J&K is the 6th most unemployed state in India (BSE and CMIE 2017), with the highest number of unemployed youth living in Jammu district (Early Times, March 4, 2018). Despite this public knowledge, scant sustained attention has been paid to the reverberations of political violence and unrest as they impact the daily life and mental health of people in Jammu region. Studying addiction experiences is one way to engage these questions.

In what follows, I briefly describe addiction followed by a critical examination of the current literature on the anthropology of addiction. I illustrate how current anthropological
understandings of addiction are largely informed by knowledge produced in European and North American academies about Euroamerican experiences of addiction. Furthermore, the global templates for classification, diagnosis and treatment of addiction also emerge from Euroamerican sites of knowledge production. This trend is made apparent in a 2015 review article, “Addiction in the Making,” published in the Annual Review of Anthropology. Only three secondary sources cited in the article are based on research in locations outside the global north, suggesting the hegemony of addiction studies by scholars trained, teaching and researching in the global north. As the authors willfully acknowledge, “another characteristic of the literature on addiction science, medicine, and intervention is its overwhelming focus on North America, the United Kingdom, and other English-speaking countries” (Garriott and Raikhel 2015).

Echoing the words of Adams et al. (2015), I therefore argue for a decolonial\textsuperscript{4} anthropology of addiction that speaks not only to the lives and concerns of those who reside in Western, educated, industrialized, rich, and democratic (WEIRD) societies, but also to the lives of the global majority of the world—especially those who live in marginalized communities of the global south (Bhatia 2017:4). Shifting our gaze to the global south compels us to study how American cultural flows of media, commodities, and consumerist practices are being refashioned or reimagined in non-Western cultures, especially formerly colonized countries. It also raises questions about how specific Euro-American psychological and anthropological discourses of self and identity are now part and parcel of globalizing economies such as that of India. This includes the ways Euro-American psychological sciences and American cultural forms continue to play a crucial role in how Indian youth are reimagining their “Indianness” (Bhatia 2017:6).

\textsuperscript{4}Decolonial - The “decolonial turn” involves understanding how “coloniality” as a way of thinking continues to embody the current power relations between the Global North and the Global South, as well as the diverse relationships within the various geographies of the Global South and the Global North (Mohanty, 1991, 2003).
It is toward these efforts to de-center the anthropology of addiction that I explore “dependency” more explicitly as a central cultural and moral idiom through which we can understand South Asian addiction experiences in contemporary Jammu. By rethinking “dependency” in the context of everyday relationships and at the conjuncture of regional and national histories, this project opens doors to revisit and rethink classic understandings of “Indian personhood” and the “Indian Self” as put forth in the South Asia literature (Akhtar 2005; Aurobindo 1997, 2005; Bhatia 2017; Erikson 1969; Gergen 2009; Kakar 1981, 1989, 2003, 2007; Kitayama & Markus 1994; Misra & Mohanty 2002; Nandy 1998, 2006, 2013; Obeyesekere 1990; Pandey 2011; Roland 1988; Trawick 1992). My intent is that this discussion will enable us to see how addiction experience in Jammu is culturally and relationally constructed rather than merely an experience of individual moral failure and biological dependence, and how it is located within a wider web of affective, intimate relations of reliance, and care in the contexts of the clinic, family, community, and region (Garcia 2010).

Addiction

In their book, Addiction Trajectories, William Garriott and Eugene Raikhel (2013) inform us that both “addiction” and the notion of the “addict” in their contemporary meanings are of relatively recent origin. “Addiction” did not enter humanity’s “grammar of motives” (Burke 1969: xvi) in earnest until the late nineteenth century. The earliest use of the word “addiction” was in Roman law, where it indicated a sentence of enslavement of one person to another, usually to pay off debts. Later, the word was used to indicate a strong devotion to a habit or pursuit (Schüßl 2012). It was only during the eighteenth century that “addiction” was used in association with psychoactive drugs (Shaffer 2003).
The contemporary meaning of addiction began to take shape in the United States and the United Kingdom, during the early industrial period when heavy drinking was problematized as alcoholism. Here, the individual’s desire to consume alcohol was framed as a chronic, progressive compulsion that led eventually and inevitably to a loss of control (Garriott & Raikhel 2013). In the nineteenth century, addiction to alcohol and other substances was identified as a ‘disease of the will.” These practices were increasingly problematized for their perceived incompatibility with the behavioral strictures then valorized, particularly those of self-reliance, independence, and productivity (Ferentzy 2001; Levine 1978; Room 2003). This moral, punitive discourse pathologized addiction by locating it in the notion of individual’s choice and free will. This discourse robbed the person of a social self. By understanding a person’s addiction as a failure of personal will, the behavior was perceived as independent of the institutional structures, social organization and hierarchies of intimacies that a person inhabits. The often-denied social recognition and support from family, medical, legal and state regimes constituted the punitive element of this moral discourse.

However, by the twentieth century we begin to see a shift in how medical researchers understood the relationship between human biology, individual psychology, environment and particular psychoactive substances. Moreover, researchers’ conceptual categories and questions were deeply shaped by what states and social movements took to be significant problems of the day (Garriott and Raikhel 2015). During this time, the neurobiological model of addiction began to take prominence. Addiction was explained as a chronic relapsing disease of the brain, which leads to an incremental decline in person’s self-management and self-regulation activities. This biological dysfunction causes behavior that is considered harmful to self and others such as family and society. The neurobiological perspective expanded the concept of addiction to include
behavior such as gambling, sex, and overeating. The neurobiological model aided these notions of addiction by suggesting that certain behaviors not involving psychoactive substances nonetheless correlate with the activation and dysfunction of the same brain circuits (Block 2008; Garriott and Raikhel 2015; O’Brien et al. 2006; Petry 2006; Volkow and O’Brien 2007). Today, the meaning of addiction continues to be revised and contested in light of new scientific knowledge, medical treatments, and subjective experience (Garriott and Raikhel 2013).

It is important to note that both the moral and the neurobiological discourses of addiction emerged within the European and North American addiction paradigms. Even the treatment programs, namely, the globally pervasive and theologically-based Twelve-Step recovery model of Alcoholic Anonymous, Detoxification and Opioid Substitution Therapy emerged in these cultural contexts. The two-discourses on addiction and the treatment approaches inform the globally-employed diagnostic and classificatory manuals of psychiatric illness: the International Classification of Disease (ICD) administered by the World Health Organization (WHO) and the Diagnostic and Statistical Manual (DSM) administered by the American Psychological Association (APA). This information is pertinent to understanding how the literature on addiction science, medicine, and intervention is overwhelmingly focused on North America, the United Kingdom, and other English-speaking countries (Garriott and Raikhel 2015). Moreover, diagnostic categories also standardize the terms used for research in, for example, efficacy of various treatments for substance abuse and dependence (Glasser 2012).

Indeed, numerous scholars have drawn attention to the different intellectual and institutional conceptualizations around addiction, their roots in distinct national and political histories, and how these continue to hold sway in settings such as France (Lovell 2006) and Russia (Raikhel 2010; Zigon 2010). Others have examined the translation of Twelve Step groups
and other interventions to Japan (Borovoy 2005; Christensen 2014), Mexico (Brandes 2002), China (Hyde 2011), and Native American communities (Prussing 2011; Spicer 2001). Yet, much work remains to be done to understand how “embedded rationalities and embodied experiences of the West [are] shaping and limiting our anthropological understanding of addiction” (Knight 2015b:178). This thesis joins the efforts of other scholars to bring South Asia into focus in the anthropology of addiction. By engaging the narratives of youth from India, the nation with the world’s largest youth population (United Nations Population Fund, 2014), my intent is to push the stories and narratives of the margin into visibility and re-draw the elusive hierarchy of the anthropological literature on addiction.

To this end, in the next section I present a brief overview of the anthropological literature on addiction. By highlighting the forms and relations of dependency that shape addiction experience in Jammu, I will also pose new questions to problematize and expand the literature on the anthropology of addiction.

**Anthropology of Addiction**

Anthropologists have demonstrated that, as a complex ontological category, addiction is a site of entanglement: biological, social, and neoliberal processes of the globalizing world coincide to redefine bodies, borders, relationalities, and personhood. Addiction is more than a clinical diagnosis, and a failure of the will. It is multi-modal. Anthropologists have demonstrated how addiction is experienced as a way of living (Bourgois 1996; Schüll 2012); a cultural manifestation of political dispossession (Garcia 2010); a reverie with the Self (Varma 2016); and an opportunity to escape the changing socio-cultural realities and economic precariousness of daily life (Lovell 2006).
Medical anthropologists have highlighted the relationships between addiction and forms of structural violence and inequality. Philippe Bourgois’s *In Search of Respect – Selling Crack in El Barrio* (1996) explores substance abuse and addiction among minority ethnic groups as being symptomatic of deeper disparities embedded in the United States’ cultural, political and economic systems. Befriending users, peddlers and local residents inhabiting the inhospitable streets of East Harlem, New York, Bourgois demonstrates that addiction is not an individual or community’s failure in their effort to strive for the virtues of the American Dream but is rather a harsh consequence of pursuing that dream. At the same time, addicts are perceived as partial state subjects, and a threat to social and public institutions.

In studying addiction, anthropologists have also highlighted themes of care, relationality, and dependency, focusing on addiction in contexts of economic and social precarity – an unfortunate outcome of neoliberal forms of living. Anna Lowenhaupt Tsing (2015: 20) observes:

> Precarity is the condition of our time. Precarity is the condition of being vulnerable to others. Unable to rely on a stable structure of community, we are thrown into shifting assemblages, which remake us as well as our others. We can’t rely on the status quo; everything is in flux, including our ability to survive. A precarious world is a world without teleology…but thinking through precarity makes it evident that indeterminacy also makes life possible.

The relationship between precarity and addiction is evident in Clara Han’s (2011) ethnographic work in La Pincoya, a low-income neighborhood in the northern zone of Santiago, Chile. While working with the women caregivers of addicts, Han explains the economic precariousness of their daily life at the intersection of poverty and the Chilean credit system. Care, kinship and perpetual indebtedness define the lives of these women. Han shows us how addiction’s life-support system is embedded in relationalities. To care for their kin with addiction, women rely on “a wider network of dependencies – from neighbors to lending institutions–that provide temporal and material resources (Han 2011:9).”
Relationality and dependency are further exemplified in Natasha Dow Schüll’s ethnography of gambling addiction in Las Vegas. Schüll (2012) suggests that addiction is a relationship that emerges from repeated interactions between a subject and object. The lives of gambling addicts in Las Vegas illustrates a broader need to escape the existential insecurities and uncertainties fueled by the neoliberal directives of the world. Most of these addicts live alone, without the support of extended social networks and kinship relationships. By losing themselves in “the solitary, absorptive gambling activity that can suspend time, space, monetary value, social roles and sometimes even one’s very sense of existence (Schüll 2012:12)”, the addicts engage in an act of disconnecting from Self and disconnecting the Self from the world. By relying on technology, their addiction relationship opens possibilities for newer forms of personhood. Addiction, then, is a culturally mediated, technological affliction continuously reproduced with the help of state agents and private players for political-economic benefits.

Anthropologists studying addiction have also explored the critical role of institutions in shaping addiction experience. Challenging the Anglo-American addiction paradigm, Anne Lovell (2013), for example, demonstrates how distinct national and political histories define the institutional, social and cultural discourse on understanding addiction and its treatment. Taking us physically across borders from Russia to France, she illustrates the “transnational assemblage of drugs, drug users, drug workers, police and other officials becoming entangled in two drug-management regimes: a medical, legal, and social regime based on Soviet narcology and a solidarity-based hybrid of harm reduction and biomedical treatment particular to France” (Lovell 2013:128). Angela Garcia (2010) also enlightens us to the tension between the efforts of public health and the legal system in managing addiction against the collective power of history, memory, mourning and loss in maintaining addiction. Through ethnography in a state-run clinic
in the Española Valley of New Mexico, Garcia introduces heroin addiction as a phenomenon and an analytic. Caught amidst the entanglement of culture, politics and history, Española Valley is a site experiencing a collective mourning of dispossession, loss of land, intergenerational struggle for survival, and an overarching feeling of being abandoned by the state. As Garcia interacts with addicts who are often sentenced to the punitive action of detoxification, she pays close attention to the personal and collective histories: of addicts; institutional bodies such as the deaddiction center and the legal apparatus; and the Hispanic community at large. Spaces and relationships of care such as home-family and treatment centers become the sites of re-inscribing addiction due to economic precariousness and institutional neglect. Addiction then becomes a dangerously ordinary site with its paraphernalia of people, peddlers and partnerships of private-public therapeutic regimes scattered around the streets.

Finally, anthropologists have also explored how therapies and treatments for addiction emerge out of particular historical, social, and political conditions. Nancy D. Campbell (2013) conducts what she terms “an ethnography of pharmacological optimism,” by which she examines public contributions of neuroscientists as they influence policy changes and shift in public imagination about the meaning of addiction in the twenty-first century United States. Campbell (2013:244) asserts that, “neuroscience is essentially offering a new morality, through an expert discourse in which a new set of pharmaceutical and imaging technologies testifies to the inadequacy of the old one.” This discourse is adopted by legal apparatus and increasingly dominates public narratives thus lending credibility to neuroscientists. In recognizing how cultural, political, and historical conditions shape the meanings and experiences of addiction, Eugene Raikhel (2016) argues for understanding addiction in contexts outside the non-West by exploring addiction medicine prescribed at the clinical institutions in Russia. Narcology was
developed as a distinct subspecialty during the 1970s. Narcologists, as specialists in addiction medicine are known in Russia, represent this therapy to patients as *khimzashchita*, which translates literally as ‘chemical protection’—a potent pharmacological treatment that renders their bodies unable to process alcohol (Raikhel 2013). Specialists in North America and Western Europe criticize Russian narcology and condemn it as paternalistic, and manipulative as it disregards patient autonomy but Raikhel informs us that patients and caregivers in Russia uphold its therapeutic value. Such dynamics unfold in the context of the Russian political and social order under Putin, in which responsibility, initiative, and personal sovereignty are affirmed as necessary traits within certain spheres, even as relationships of beneficence and obligations are valorized in others (Bernstein 2013; Rivkin-Fish 2005; Matza 2009, 2012).

Medical anthropologist Saiba Varma has written about de-addiction in Kashmir. Through an ethnography of police-run de-addiction center (DDC) in Kashmir, Varma (2016) shows us the state’s employment of medical-penitentiary technique to treat addiction. Offering subsidized treatment to men, the doctors at DDC employed the technique of recovery narrative in which the addicts “chronologically describe their history of substance abuse, affirm a commitment to sobriety, and expresses gratitude toward the DDC staff” (Varma 2016:50). Also known as “the talking cure,” the rituals of speaking recovery narratives characterize mainstream American addiction treatment (cf. Carr 2011). It is important to note that speech in the de-addiction center at Kashmir is being moderated by the state. The DDC is not an independently-run institution but is established in collaboration with the police. It is noteworthy to note the dubious role of the state as the treatment process fuses “medical, military and humanitarian aims” (Varma 2016:52).
While Varma’s work in Kashmir has been important to efforts to de-center the Euroamerican focus in the anthropology of addiction literature, little is known about addiction experience in neighboring Jammu and how it is shaped by Jammu’s distinct placement in regional and national political histories. Studying addiction in Jammu also requires an understanding of the role of the state, historical trauma and ongoing political volatility in maintaining addiction. In the next section, I draw on ethnographic examples to explore relations of dependency in addiction experiences in Jammu city, and to forward the utility of “dependency” as analytic in the anthropology of addiction in South Asia.

**Dependency**

I reach Mira Lok Psychiatric Hospital at 09.45 am on a Thursday morning. I have an appointment with the Head of the Department of Psychiatry, Dr. Vijay Gupta. He was on “vacation” for the past two weeks. A holiday out of force rather than choice, as he jokingly mentioned to me. I had heard the word “vacation” on the first day of my arrival at Jammu, in the exceedingly hot summer month of June. Immediately on arriving in Jammu, I learned about the annual summer vacation at state-sponsored institutions. The summer vacation policy applied to universities, hospitals, schools and state-administered public offices. Every year, the government would release two sets of summer vacation dates. Each state employee had to apply for one-month vacation. The leave was mandatory and could not be canceled or cashed.

Sitting in Dr. Gupta's room, we began the interview by discussing the history of the psychiatric institution at Jammu. As we were discussing the current state of mental health affairs at Jammu, the door opened, and with a gentle and joyful demeanor, a woman dressed smartly in business formals walked in. She sat across Dr. Gupta and greeted him kindly. Introducing us, Dr.
Gupta said, "Dr. Lekha, meet Sugandh. She is interested in the issues that the youth in Jammu is grappling with." He continued, "Sugandh, Dr. Lekha here is the in-charge of the De-Addiction Centre. She daily interacts with 600 young men. Single-handedly she set up the de-addiction clinic. You must speak to her. She will tell you all there is to know."

Dr. Lekha Arora is in her mid-30s. Living in an upper-class locality of Jammu, she is married with two daughters. Trained as a pathologist, she took up the role of running the De-Addiction Centre about three years ago when the state sanctioned and released funds for its establishment. Although I could not garner what prompted her to take up this role, Dr. Gupta, the Head of the Department of Psychiatry, satisfactorily recounted her perseverance at successfully setting up a team and running the center smoothly. A few minutes after my conversation with Dr. Gupta, I was invited by Dr. Arora for a conversation in a separate room.

As we walked out of Dr. Gupta’s chamber, passing through several rooms, we entered a busy corridor. I saw men flocking the windows and walking hurriedly one way or the other. There was chaos as if people didn't know what to do or whom to ask. Like me, there were other onlookers too. These were family members of patients institutionalized or those visiting the psychiatrist for consultation.

All at once, I was flung into multiple conversations. Dr. Arora, approached by a staff member, was attending an administrative matter. Other onlookers were talking loudly amongst themselves, openly discussing the psychiatric diagnosis of their kin, describing symptoms and daily challenges while the patient stood next to them. Occasionally they exchanged sheepish

---

5Chamber – Psychiatrists at the Mira Lok Psychiatric Hospital frequently called the rooms in which they saw patient as chambers. The legal undertone of the word is striking. The notion of authority and policing are embedded in the phrase chamber. I often heard them say, “I am meeting patients and their family in chamber.” “Why don’t we talk in my chamber?” This is not to say that they did not use the word room or office but chamber was often articulated.
glances and commented how loud the screams of one particular woman were. The woman was in a psychiatric cell. About 20 meters away, at the far end of the corridor, one could see a woman dressed in salwar-kameez\textsuperscript{6}, without a dupatta\textsuperscript{7}, her hair open, unkempt, loudly screaming and hurling abuses in Hindi as she banged her bangles and head along the metal bars that separated her and us. No doors, no soundproof mirror, but metal bars. Her pain was transparent to us and the misery of onlookers who winced at her screams was visible to her. A security guard dressed in khaki\textsuperscript{8} stood outside the metal bars. He occasionally slammed his rod and screamed at her to stop. But the woman was unstoppable. The metal bars and the guard reminded me of a prison cell.

Dr. Arora called my name, and distractedly I began following her. We started to walk through the busy corridor towards an empty room. As Dr. Arora and I walked, several men and women acknowledged her presence by a brief greeting of Namaste, bowed their heads or nodded in recognition. Dr. Arora responded to some and continued walking. The room was empty. Not quiet, but empty. Outside conversations were filling the insides of the room already. Bare walls had been painted a shade of clear sky's blue color. One table, a doctor's chair, and three more chairs were all the furniture in the room. Dr. Arora occupied her chair. And across the table, I seated myself on a corner seat, next to a glassless window. I felt uneasy. I was curious to ask

\textsuperscript{6}Salwar-Kameez - a long tunic (kameez) worn over pajama-like trousers (salwar). Traditionally, the salwar trousers are tailored to be long and loose-fitting with narrow hems above the ankles that are stitched to look like cuffs. The traditional kameez top is a loose-fitting, knee-length tunic with long sleeves. The tunic is worn by pulling it over the head through a round neckline that has a front slit.

\textsuperscript{7}Dupatta - The salwar kameez is usually paired with a long, sheer fabric scarf or shawl known as a dupatta, which is either draped across the neck or over the head. The dupatta is traditionally seen as a symbol of modesty as its main purpose is as a veil.

\textsuperscript{8}The word khaki comes from a Hindi word meaning ‘dusty’ or ‘dust.’ It is rumored that khakis became popular in the 1840s when British Indian soldiers would dye their cotton pants in tea, curry powder, and mud to blend in with landscapes. Since then, Khaki is the color of the police dress in few states of India and certain government institutions (such as the Indian Postal Service).
who these men were? Why was there so much noise, such chaos outside the room? Why were the men carrying bits of paper and hastily moving between windows? Some men looked haggard, while some didn't. The air smelled different. There was a foul odor, but of what? Sweat? Medicines? Exhausted bodies and their sighs?

Dr. Arora finished her chores and turned her attention to me. I re-introduced myself. On enquiring, I learned that we were sitting in the de-addiction ward. She is the only doctor-in-charge of the clinic and daily signs approximately 600 prescriptions for opioid substitution therapy (OST). The men outside were carrying prescriptions for the OST. They come here every day. The women accompanying them are wives, mothers, sisters, and sometimes daughters. Before I could begin asking her more questions, there was a knock at her door and a couple walked-in along with their young son. Dr. Arora greeted Manoj, the man, and his wife, Rita. Manoj has been coming to the center daily for two years to receive his dose of OST. Manoj walks into the room and stands along the door frame while Rita sits on an empty chair next to me, with their son in her lap.

They both exchange glances and then begin to look at the doctor. Dr. Arora senses their desire to talk. She sits back in her chair and enquires the purpose of Manoj's visits to the center with his wife. She remarks that it has been a while since she last met Rita, since Manoj typically comes to the hospital alone. Manoj murmurs something and hesitantly begins to speak. He informs her in a slightly unsteady tone that his sister is getting married in the neighboring village. Soon, he and his wife will have to leave town for a week to fulfill the marriage rituals. He pauses then. Dr. Arora congratulates him and then in an off-hand way enquires that what could she do and why was he here. He speaks again, keeping his eyes lowered, his body stooping along the door. Rita is sitting silently attending to the child. Manoj speaks, requesting Dr. Arora
to write him an advanced prescription granting him six days of dosage that he could carry with him. Since his village is far, he confesses that he will be unable to travel daily for OST and without consuming his daily dose, he experiences withdrawal symptoms.

Dr. Arora immediately refuses him, appearing to be shocked by his appeal. She says in a matter-of-fact tone that the rules of the OST are apparent. The institutional body has mandated that no more than three days of dosage will be provided at one time and that, too, under “special circumstances.” She admits that if the village had a running OST program, she would write him a letter of admission but since that isn’t the case, she is bound to the rules. In her words, *her hands were tied.* If she were to break the rule, she would risk losing her job. Moreover, she states that bending the rules for one person would invite similar requests from several other patients, and she did not intend to start a trend. Her belief in her training and the governing laws of OST were steadfast. Nobody speaks for several seconds, until Dr. Arora begins reminding Manoj and his wife how difficult his early days of recovery had been. Speaking in a caring tone, she states that her concern towards them is that of an experienced, caring elder and not just a doctor. She reminds them how upset Rita used to be when Manoj was an “ineffective” husband.

For the longest time, the wife's demeanor is slightly disengaged. She had been attending to the child, playing with his hair, rocking him in her lap while witnessing the exchange between the doctor and her husband. But when Dr. Arora refuses the dosage, Rita begins speaking. Brushing her child's hair, she tries to interject a few times. Agreeing with Dr. Arora, Rita thanks her for the magical treatment of OST. She admits that Manoj was an improved person for he had become a good husband by providing for her and their son. She shares how he now spends leisure time at home now rather than with his friends, as in the past. She offers several examples to affirm Manoj's transformation and simultaneously expresses gratitude to the de-addiction
center, the doctor, and the wonder drug of OST. At the same time, she is trying to persuade the
doctor to agree to their request for the 6-day dose prescription. The doctor hears her and
expresses appreciation for Manoj's commitment towards recovery, but then affectionately
reprimands him for his childish and impossible request. Eventually, Manoj tries one more time.
In a pleading tone, he reminds Dr. Arora that his request is genuine, and that this is the first time
in two-years that he has ever asked for an extra dose. Citing Indian marriage customs, he
explains that as the brother of the bride-to-be, he has essential family roles to fulfill. His presence
at his sister's wedding is crucial. Without OST, his functionality would be diminished.

Dr. Arora refuses.

Manoj’s story is not an anomaly but rather the story of several young men who visit Mira
Lok daily for OST. In some ways, the interaction between Dr. Arora and Manoj was over even
before it began. The doctor’s decision was pre-fixed and declared at the beginning of the
interaction. Manoj’s plea and his wife’s persuasion were met with refusal. But this encounter is
critical to understand how addiction is cradled in a world of intimate and hierarchical social
dependencies that characterize everyday life in Jammu and South Asia at large. Addiction then
becomes one node in a more substantial network of dependencies between people, things, and
institutions. These dependencies frame the broader social and political worlds in which addiction
is treated and experienced. These network of dependencies in turn inform notions of self and
personhood in Jammu.

At the beginning of the anecdote, we gain an introduction to the practice of psychiatry in
Jammu. We see how in India, a patient’s examination, treatment planning, counseling, and
institutionalization are shaped by the presence and decisions of immediate and extended family
(Addlakha 2005, 2008; Das 2001, 2015; Kakar 2007; Nandy 2013; Nunley 1996; Pinto 2014; Roland 1998; Singh 2017; Varma 2016a, 2016b). Discussing family members’ diagnoses and symptoms with strangers met on hospital wards or in outpatient units are familiar sights in Indian psychiatric institutions. This is not viewed as a breach of confidentiality. The critical role of a patient’s family in seeking treatment is also evidenced in Michael Nunley’s (1996) ethnography of state-sponsored psychiatric hospital at Uttar Pradesh, India. It is the family members who first bring the patient to the psychiatrist, they engage in consultation on behalf of the patient and also take part in deciding both, the appropriate treatment and the continuation of treatment. If family members do not perceive a marked improvement in the patient then they may stop the treatment.

Building support, gaining a collective understanding of illness, befriending other caregivers, reciprocating treatment advisories, and sharing reviews about the doctor, a pharmacist, and even the hospital, all form a part of the informal agreement of everyday care. Often, not sharing information is perceived contrary to social relationships: the party from whom information is withheld may experience a sense of decline in social capital. Care is believed to be collective. Partly motivated by a lack of adequate information about psychiatric services and by notions of socially-dispersed personhood, these practices are a common sight. As rising addiction impacts public and intimate spaces of relationalities, care as a collective effort therefore lays the groundwork for how social and intimate dependencies are invoked in relation to managing addiction when one is living along the margin as shadowed and invisible.

We also learn that Mira Lok is a state-sponsored institution. Every summer, for two-months the hospital is understaffed due to state’s mandatory vacation policy. Although one can appreciate the concern for work-life balance, it is hard to ignore the costs and by-products of it. A patient’s follow-up visit is compromised because the supervising doctor is on vacation. But on
the other hand, a doctor’s hours of private practice increases. All the psychiatrists in Jammu practice privately at their homes or in rented spaces. The consultation fee at private practice is marginally higher than the charge at the hospital, and during the summer patients are compelled to visit the doctor privately. Additionally, a doctor may live off the city limits, making it difficult for the patient to travel via public transport. In such instances, the patients either delay their visit, rely on an extended family member to drive them or shell several rupees of money to rent a vehicle for few hours. Since Mira Lok is a state-run institution, it serves people from all classes especially low socioeconomic rung that seeks subsidized treatment. These advantages are compromised when the patient has to visit the doctor at a private practice.

In Manoj’s case, we witness a complex interplay of several other forms and relations of dependency. Manoj’s de-addiction experience is tied to the socio-political history of the state, most expressly through Manoj’s dependence on the state. Dr. Lekha Arora recognizes the state’s failure in setting up OST centers in other districts. Had there been another OST center in the village, Manoj would not have been at the mercy of Dr. Arora’s decision. However, this was not the case. India has rich clinical experience in OST and expertise in carrying out large-scale OST programs. Different OST models, such as stand-alone NGO centers, stand-alone government centers, and the NGO-government hospital collaborative model have been tried and found to be feasible and useful (Ambedkar et al. 2015). But these models are not functional in Jammu. Due to conflict in Kashmir and Kashmir’s unstable relationship with India, non-governmental organizations are few in Jammu. Only the stand-alone government hospital is authorized to dispense OST, unlike in other states. It is here that de-addiction as mediated through relations of “dependency” on the state become apparent. The region’s own stability depends on the stability
of neighboring Kashmir, and on the developmental and humanitarian largesse of the Indian state and its recognition of Jammu as the “peaceful” and victimized sibling.

We also observe how the patient has to navigate precarious realms of a biopolitical state to be recognized as a legitimate subject. The relation between “law” as an expression of sovereign power and “discipline” as an expression of biopower have both played a crucial role in the emergence of the biopolitical state (Das 2015). Manoj is also a subject of this biopolitical state. By the intervention of the judicial logic (as suggested by Dr. Arora saying “my hands are tied”), Manoj is reminded of the state’s perception of him as being reckless and unruly subject. A precursor of being deviant is already attached to his personhood thereby reifying the possibility of a relapse. But Manoj contests this label. He is aware that his request qualifies as a ‘special circumstance’ as per the guidelines published by National AIDS Control Organization, Ministry of Health and Family Welfare, India. The clause states: “take home doses for OST medicines can be given for 1-2 days but inquiry should be made and the client’s claim should be verified from his/ her family members. In addition, the past record (adherence to medicines, any documented history of diversion/ attempted diversion/ non- compliance with the rules and regulations, etc.) should be checked.” To prove his qualification for the ‘special circumstance,’ he comes along with his wife and child. Manoj’s wife defends and supports her husband’s request by appealing to the doctor’s authority. She articulates a narrative of care and positive affect. The wife’s approval of the effectiveness of his various kinship roles such as father, husband, and son in the presence of the doctor reveal to us an ensemble of relationships in which Indian personhood is imagined, espoused and practiced.

As this encounter at Mira Lok illustrates, dependency is also apparent in how addicts, kin, and healthcare providers negotiate de-addiction. Medical anthropologists have illustrated
how psychiatric care unfolds through complex interactions between patients, family members, and clinicians in India (Addlakha 2005, 2008; Das 2001, 2015; Kakar 2007; Nandy 2013; Nunley 1996; Pinto 2014; Roland 1998; Singh 2017; Varma 2016a, 2016b). In clinical contexts where family members participate actively in clinical care, addiction experiences unfold at the intersection of clinical authority, personhood, and kinship relations. Social life and the everyday in Jammu are orchestrated through intimate and often hierarchical social dependencies, in ways that are magnified and mobilized by addiction. For instance, an addict’s recovery may require the support of extended family and community in ways shaped by moral and gendered economies of kinship and care.

Consider how gender mediated relationships of dependency in this encounter. At Mira Lok, I only saw two-female doctors. One was Dr. Arora⁹ and the other was Dr. Rigzin Kilam, the only psychologist practicing in the entire Jammu region. Dr. Arora single-handedly manages the de-addiction center and interacts with 600 men on day-to-day basis. Manoj’s literal dependency on Dr. Arora to write his prescription, as well as to his wife to provide convincing testimony to his character, is therefore a potent moment in the clinic, one shaped by gender as much as by class. Despite being the breadwinner in the family, his addiction caused a change in the status of his personhood. At least for the moment of this clinical encounter, Manoj is subordinated to the authority of women.

Another form of dependency evident in this encounter is how doctors simultaneously invoke multiple relationalities as medical experts, legal authorities, and parental-like figures. We

⁹Dr. Arora’s challenges dominant social narratives in Jammu which require women to be politically apathetic, conformist, reproductive beings and custodians of Hindu faith (Bhatia 2009) and educated mothers and housewives to provide Hindu samskaras to their families (Katju 2005; Sethi 2002). In Jammu, women are largely defined in the context of men, family, kin, and caste. This situation is not specific to Jammu but reflects a broader Indian reality (Bhatia 2009).
see this in the ways that Dr. Arora simultaneously positions herself as legal authority, physician, sisterly figure, and parent, all in a single clinical interaction. Mental health professionals in India command a very high social capital such that they can valorize and pathologize dimensions of social life (Chua 2014). Dr. Arora asserted her medical expertise to Manoj and his wife by highlighting the benefits of OST in enabling him to manage his behavior and re-access his social self. Inevitably, she passed a moral assessment of his past, present, and future self. Manoj’s aspiration for renewed subjectivity is contextualized “as threatening, rendering desire a problem for selfhood” (Pinto 2014). As a parental-like figure, she tried to reason with his “childish” request by disciplining him and dismissing his appeal at the outset. Instead of extending care and understanding by being an authority figure, she abandons Manoj.

**Conclusion: Rethinking “Dependency”**

By locating addiction in intimate relations of reliance and care in the contexts of family and the cultural milieu as illustrated through the ethnographic encounter with Manoj, my effort is to rethink “dependency” in the context of everyday relationships between people, things, and institutions at the conjuncture of regional and national histories in Jammu, India. Importantly, dependency has long-served as an important idiom through which classic understandings of “Indian personhood” and the “Indian Self” have been theorized in the South Asia literature. Cultural ideas of Indian personhood and selfhood have been theorized from the perspective of psychoanalysis (Akhtar 2005; Erikson 1969; Kakar 1981, 1989, 2003, 2007; Nandy 1998, 2006, 2013; Obeyesekere 1990; Roland 1988) and Indian psychology (Aurobindo 1997, 2005; Bhatia 2017; Gergen 2009; Kitayama and Markus 1994; Misra and Mohanty 2002; Pandey 2011; Trawick 1992).
Many scholars contrast the Indian self to the Western self by suggesting that the Indian self is relational and un-individuated. Sometimes referred as the ‘familial self’ (Roland 1988) or ‘we-self’ (Collins and Desai 1986), the Indian self’s psychological functioning and growth is profoundly entwined with the domestic, social and cultural milieu. In much of this literature, the Indian self is theorized as lacking a differentiation between self and non-self (Kakar 1997) valuing reciprocity, emotionally intimate relationships, and embodying interdependence with permeable ‘ego’ boundaries (Roland 1988). A Self dependent on others such as family and other groups predominantly characterizes Indian self. By exploring dependency in the context of addiction as a constant, affective, cultural, and moral practice embedded in the everyday sphere of: home, community, region and nation, I expand the work of scholars seeking to bridge psychoanalytic and psychological insights with social science work, including the work of post-colonial scholars (Das 2015; Gooptu 2013; Lukose 2009; Sen 2005). Thus, to speak of dependency in Jammu accomplishes two interventions: it expands our lens onto addiction experiences, while enabling us to revisit and potentially retheorize approaches to the Indian self.

My intent is also to decenter the diagnostic categories and classification systems that is, the International Classification of Diseases and the Diagnostic and Statistical Manual that dominate global mental health care and Indian psychiatry. The mental health practitioners in Jammu and India are trained in Western psychiatry and often fall trap to, what Arthur Kleinman (1988) describes as “category fallacy.” Critiquing the classificatory systems, Kleinman argues that “they fail to adequately account for cultural influences on universal syndromes; fail to present local idioms of distress and illness experience as real diseases; and insist on using data from Euro-American populations, which make up less than 20 percent of the global populations, as its evidence base (Akyeampong:35).” Such a practice affected by globalization and
accelerated in neoliberal times has led to the pathologization of social problems and moral experience (Canguilhem 1991; Horwitz and Wakefield 2007; Foucault 2003), which has led to the pharmaceuticalization of populations (Dumit 2012); and the normalization of experiences of the body and the self. Through studying addiction experiences, I will document detailed local phenomenological descriptions, rich in local idioms that open up forms of selfhood and personhood describing local worlds, and core moral and cultural practices.

In this thesis, I have argued that the literature within anthropology concerning addiction has largely been dominated by scholarship produced in North America and Europe about Euroamerican experiences of addiction (Bourgois 2010; Campbell 2013; Carr 2011; Garcia, 2010; Garriott and Raikhel 2013, 2015; Glasser 2012; Han 2011, Lovell 2013; Schüll 2013). These mainstream-Western frameworks have been circulated widely. Occupying a normative position, they inform the global understanding of the concept of addiction and its therapeutic trajectories. One can observe a scholarly lacuna regarding addiction studies of the South Asia. Proposing a vision of ‘decolonial anthropology’ and to bring South Asia more squarely into the focus of addiction studies I have suggested an ethnographic study of drug-dependent youth, residing in Jammu City. By exploring the cultural and moral idiom of dependency (nirbharta), I show how addiction experience is reconstituted in the everyday: through kinship relations, regional and national histories, and medical and juridical regimes of state-sponsored institutions.

Since India’s independence in 1947, J&K has been a site of conflict and violence. Large parts of the region are occupied by Pakistan and China. A territorial conflict over Kashmir has resulted in the disruption of everyday life. Over the last three decades, a ‘state of emergency’ has been operative in the region. Daily life is marred with protests, strikes and indefinite curfews. Although, Kashmir is the epicenter of the conflict, the reverberations of this unrest are
experienced in Jammu, too. Significant scholarly and media attention is devoted to Kashmir but scarce attention is paid to Jammu. A feeling of being marginalized and shadowed by the discourse on Kashmir was often expressed by my participants. Through a study of addiction experiences of Jammu youth, my research intends to open the area to scholarly investigation, expand the scholarship on the anthropology of addiction to South Asia, and illustrate the entanglements of class, caste, history, culture, politics, and social processes in shaping addiction experiences.


