Disciplining Bodies: The Social Construction of an Addict

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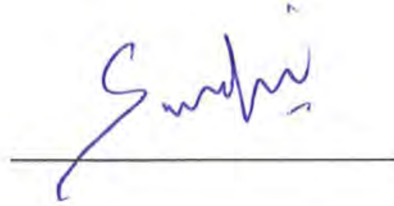

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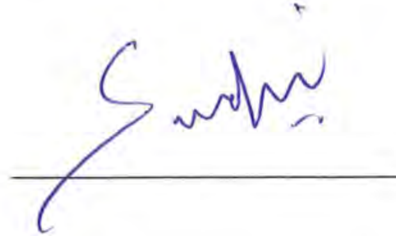

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ABSTRACT

The issue of drug addiction has always been approached by two dominant perspectives: either that of drug addiction as 'chronic brain disease' or as that of a 'moral failing'. Both of these issues utilise the language of 'harm', 'risk' and 'danger' to describe this phenomenon. Using a Foucauldian perspective this study seeks to find out how the identity of a drug addict is constructed through scientific and medical discourses and how that constructed identity is, then, used, to justify medical interventions on the body of the addict. This study also shows how the body of the addict is a site of great social anxiety and how rehabilitation is a process through which this anxiety is alleviated. Drug rehabilitation centres are institutions to create docile and disciplined bodies and to fit deviants into a standardised norm. A lot of this is based on assumptions and not empirical grounds and the science used to prop this concept up is vague and internally contradictory. Utilising the concept of biopower it shows how drug rehabilitation is a management of populations. Using in-depth interviews from the clinical staff and the recovering patients, as well as personal observations, this study shows how the key facet of the drug addict identity is constructed around a 'loss of control' and how this construction is then used to justify the process of rehabilitation. A counter-narrative to this is set-up through interviews conducted with recovering drug addicts and in which primacy is given to the role that 'pleasure' plays in the use of drugs and a partial rejection of the identity of the addict that the medical narrative seeks to establish.

Table of Contents

ABSTRACT
1 INTRODUCTION 1
1.1 Research Questions 4
1.2 Research Hypotheses 4
1.3 Research Objectives 4
1.4 Research Problem 4
1.5 Significance of the Study 8
2 RESEARCH METHODOLOGY 10
2.1 Locale 10
2.2 Rapport Building 10
2.3 Key Informant 11
2.4 Participant Observation 11
2.5 Sampling 11
2.6 Interviews 12
2.7 Respondents 12
2.8 Field Notes 12
2.9 Data Analysis 13
2.10 Ethical Considerations 13
2.11 Limitations 13
2.12 Methodological Framework 13
2.12.1 Narrative Research 14
3 LITERATURE REVIEW 15
3.1 Drugs 15
3.2 Social Construction of Drug Addiction 16
3.3 Discourse 17
3.4 Power-Knowledge 18
3.5 Identity 19
3.6 Embodiment 20
3.7 Uses of Pleasure and The Technologies of Self 21
3.8 Docile Bodies 22
3.9 Biopower 23
3.10 Drug Rehabilitation as Constructing Docility 24
3.11 Locating the Study within an Anthropological Framework 25
3.12 Theoretical Framework 26

3.12.1 Discourse Analysis: Critical or Foucauldian? 26
3.12.2 Social Constructionism 27
4 ANALYSIS 28
4.1 The Field 28
4.1.1 The Centres 28
4.1.2 The Programme 30
4.1.3 The Process 31
4.2 Data Analysis 35
4.2.1 Responses from the Clinical Staff 35
4.2.2 Defining Addiction 35
4.2.3 Treating Addictions 35
4.2.4 Identifying Addicts 36
4.2.5 Finding Addicts 37
4.2.6 Demographics 37
4.2.7 The Need to Treat Addiction 38
4.2.8 Rehabilitative Strategies 38
4.2.9 Relapse 39
4.2.10 Addiction as a Social Problem 39
4.2.11 Social Acceptance of Drugs 40
4.2.12 Rehabilitation 41
4.2.13 Analysis of Responses of the Clinical Staff 41
4.2.14 The Construction of Identity 41
4.2.15 Medical control 44
4.2.16 Self-regulating individuals 44
4.2.17 Social anxiety 46
4.2.18 Responses from the Patients 48
4.2.19 Duration and Definition of Addiction 48
4.2.20 Starting Drug Use 49
4.2.21 Reasons for Drug Use 49
4.2.22 Experience of Drug Use 50
4.2.23 Becoming an Addict 50
4.2.24 Getting Treatment 51
4.2.25 Experience of Rehabilitation 51
4.2.26 Reasons for Addiction 52
4.2.27 Drugs are bad 52
4.2.28 Plans for the Future 53

4.2.29 Analysis of the Responses from the Patients 53
4.2.30 Pleasure 53
4.2.31 Self-control 54
4.2.32 Presentation of the self 54
4.2.33 Struggling with Identity 55
4.2.34 Morality 55
4.2.35 Discipline and Control 56
4.3 The Case Study of 'K' 58
5 CONCLUSION 64
REFERENCES: 66
ANNEX1: INTERVIEW GUIDE 76

1 INTRODUCTION

Everything I shall say in this essay has been said before, and much of it seems to me to be obvious as well as unoriginal.

Robert Paul Wolff

If one could come up with a succinct image as to define the Other of a society like Pakistan's, which, for simplicities sake can be termed 'officially Puritan', one could, perhaps, do no worse than to come up with a drug[1] addict. Drug addicts, after all, neatly summarise all the dangers to the 'health' of a society. At the strictly individual level, we have the medical dangers of various kinds of cancers, AIDS, brain damage and, quaintly, loss of productivity. On the broader social level, we have dangers of crime, broken families, hygiene and of the subversion of public morality. These dangers are magnified if we imagine the addict to be a woman[2]. Regardless of how it is construed drug addiction is considered a problem.

How is this problem to be solved? Ironically, one method involves administering, even more, drugs and treatments that include detoxification, restrictions, isolation etc. The second, ostensibly the more humane, method involves removing the factors which make addiction possible and to create greater opportunities for rehabilitation. So this includes offering social amenities like meaningful jobs, housing and the inculcation of strong morals etc. Bourgois (2000) puts it as "a criminalizing morality versus a medicalizing model of addiction as-a-brain-disease" (p. 165). And believing that the road to hell is paved with good intentions one must ask the question: 'Why is it a problem to begin with?'

Both of these models neatly sidestep this question. In order to answer this question or, perhaps more humbly to ask more substantial ones, one must look at how the discourse around drugs and drug addiction is made and what are the rival discourses that exist to the discourse of 'Drugs as Problem'. A discourse, very simply, is about the systemic

[1] Throughout this study, unless otherwise specified, the word drug will be used to mean 'hard' or addictive drugs as opposed to the 'softer' variety.

[2] Drug addiction has also been compared to terrorism, another anxiety-laced bogey, and declared more lethal. See, *'Around 7 million drug addicts in Pakistan, Senate told'* (6th July, 2015) and also, more recently, *8m addicts in Pakistan, and counting'* (1st March, 2017).

construction of knowledge through language which in turn, not only, frames how certain things can be talked about but also creates the *identities* (or subjectivities) of the things being discussed (and this is key as discourse implies language and communication). More importantly, discourse analysis points out how power is expressed through language and language, then, creates social realities[3]. A discourse creates knowledge and then concrete action is taken over this very constructed knowledge. (A fuller discussion of this will be found in the next chapter). The rules constructed through discourse appear to exist independent (naturally) from the discourse. Broadly, the discourses that exist in Pakistan concerning drugs are, as mentioned, 'Drugs as Problem', and also 'Drugs as Cool' and 'Drugs as Gateways to the Spiritual'. My study focuses on the first discourse but I will, here, briefly, discuss those two other discourses to support my contention that there can be, and *are*, other ways to construe drugs usage.

There is, perhaps, no other thing more romanticised than drugs and addicts with their self-destructive aspects, perhaps, being the most attractive aspect. It is cool to do them, regardless of what anyone else would say, and they are cool precisely because they are "controlled substances" (Alvarez, 2001, p.779). A drug user lies outside of boring conformity. Countless artists from the Romantic poets of the 19th century to the rock stars of the '60s have used drugs to create an almost impenetrable aura of 'chic' around them. (*cf.* Abrams, 1971; Hayter, 2009). In certain sections consuming drugs also becomes a "political statement, a gesture of defiance" (Alvarez, 2001, p.779). While we can call the previous two as predominantly urban discourses there exists also a rival, folk (rural) discourse or what I call, 'Drugs as Gateways to the Spiritual'. Islam has a long history of tolerance towards drugs. (Anderson, 2014). Opium and hashish were used by Sufis to "arouse . . . mental excitement, enthusiasm, and divine inspiration and to endure long hours of meditation and praise" (Hamarneh, 1972, p.233). In the 60s drugs such as LSD were used, in the counterculture, to reveal the "real, authentic self, buried beneath capitalism and social convention" (Moore, 2007, p.357). More locally a *qalandar* or a wandering ascetic can very bluntly be called a spiritually sanctioned drug addict. The *Urs* celebrations of local saints, especially more prominent ones like Lal

[3] I had the dubious honour of being taught by a matronly Urdu teacher in school who called the examination room a 'theatre of war' (*maidan-e-jang*). This would make us students 'soldiers' and our stationary, literal, 'weapons' and she would, in turn, be a presiding body making sure the *jus in bello* is upheld. An examination has been turned into a ruthless contest of life and death.

Shahbaz, are celebrated with an almost anarchic, drug-fuelled, Dionysian abandon (Frembgen, 2012). The status of a *qalandar* is not achieved rather it is ascribed by God. 'Drugs and drink are things that not everyone can handle' (Personal communication, November 17, 2017) and the ability to channel these substances is a mark of special favour. This discourse, though considerably common, is not as widespread as it once was. The reason being that the tradition of *faqirs* and their practices of drug usage and begging came under attack during the 19th century when colonial officials and the rising Muslim middle class in India, using the newly socio-scientific discourses concerning morality and the 'value' of work, started undermining their traditional, religious sanctity by claiming that this was not an absorption in God but rather lazy, drug addiction[4]. (Green, 2014)

We can see that the views concerning drugs are not homogenous with drugs being treated not only just with abhorrence but also with a certain awe and as spiritual aids. What is interesting about the other two discourses is that it concerns individuals that are located on the fringes of society and the discourse of treatment seems to have acquired a certain amount of hegemony and now I think we can answer the question as to why treating drug addicts is so important. Since the addicts live with values directly opposed to bourgeois ones it is necessary for them to be reintegrated into society. Drug rehabilitation, for me, is another form of mass social control. It is an attempt to extend the authority of the postcolonial state into areas where it did not exist before. In other words, it is the use of certain discursive mechanisms to stamp out alternative uses of pleasure and create docile bodies.

This discourse works in a cycle. It creates knowledge about a subject thereby *creating* that very subject, (Drug addicts are willing to commit crimes to get their fix), using that knowledge to inform practices (They need to be rehabilitated because they are a cause of social instability) and then forming the personal identities of their subjects (Drug users start to call themselves addicts). Analysing drug rehabilitation procedures tells us about how the identity of the drug addict is constructed, how rehabilitation stems from

[4] Many cultures, like several Native American tribes in both the Americas as well as our own local ones, had been very open towards drug usage before colonialism and while the idea that 'curing' addicts could be a form of Western ideological hegemony over indigenous knowledge is a fascinating one.

a need to assuage bourgeois anxieties *embodied* in the drug addict and finally what is the normal, healthy (in both the meanings that we have already mentioned) body.

1.1 Research Questions

1. How is the identity of a drug addict constructed?
   - Why is it constructed in this particular way?
   - What are the key characteristics of this identity?
2. What are the reasons behind drug rehabilitation?
3. What are the addicts being rehabilitated into?
   - Can it be argued that they are being rehabilitated into a standardised norm?

1.2 Research Hypotheses

1. The identity of an addict is constructed to be a negation of commonly desired values.
2. Drug rehabilitation is carried out to instil discipline in unruly bodies.
   - In this regard, it is similar to many other disciplinary institutions such as schools and prisons.
3. Drug rehabilitation seeks to take deviants and bring them towards a socially approved norm.

1.3 Research Objectives

1. The study aims to provide an alternative perspective on the problem of drug addiction.
2. It seeks to show the construction of the identity of the drug addict.
3. It aims to show the disciplinary mechanisms that are employed on the bodies of the addicts.

1.4 Research Problem

In order for us to understand the phenomenon of addiction and consequently its treatment, it is necessary to know not only how this is understood by the experts in the field but also how the addicts themselves understand this and if the phenomenon is

understood differently by both of them. The construction of a 'drug addict' identity and its usage and issues concerning discipline is a gap in most research concerning addiction and its rehabilitation.

Before I elaborate on these points I must add certain caveats. This, like most topics, is an expansive one and I will, purposefully, ignore many things associated with it. For one, I am not interested in the goings-on of drug rehabilitation centres and their connection to the political economy of drugs[5]. I have been told stories of inhumane treatment but these will have to remain, sadly, in the background. Second, I am more interested in the social aspects of drug addiction and rehabilitation and not in the biochemical or 'scientific' side. This 'biomedical' approach is fairly inconsistent. Studies claim that wanting drugs is a result of human evolution (Henneberg & Saniotis, 2012) thus creating a delightful paradox. The biomedical model has proven to unsuccessful in many cases[6]. Some studies claim the relapse rate to be around ninety per cent (Yaqub, 2013). The intriguing idea that rehabilitation is an extension of colonial epistemes as adopted by postcolonial regimes will also not be pursued though it is intriguing to note that the idea has not come from local sources but rather from colonial states and neo-colonial international development agencies. The role of Big Pharma or the 'Therapeutic State': (Szasz, 1984) a collaboration between medicine and the state to 'cure' disapproved actions that range from anxiety to shyness to drug addiction to suicide in drug rehabilitation is also a corollary of political economy and will thus have to be ignored. Finally, I will not be suggesting alternative methods of treatment.

I have argued that in shaping realities discourse is a "form of social practice" (Fairclough & Wodak, 1997, p.259) and if we assume 'identity' to be a dynamic construction of the self through discourse (spoken, written, performed) then it follows that the discourses in a society provide references points for the construction of the self. The discourse of 'Drugs as Problem' also creates for itself a 'subject' which is the 'junkie identity'. This identity has some characteristics. Radcliffe & Stevens (2008)

[5] In some informal, preliminary interviews I was told that certain rehabilitation centres actually inject the patients with drugs to ensure a permanent supply of customers.

[6] Other models like the 'biopsychosocial model' presented by Buchman, Illes & Skinner (2010) or the 'disorder of choice' model (Heather, 2017) still consider it to be a disorder. For more on this see the section on Uses of Pleasure in the next chapter.

maintain that the 'junkie' identity has been constructed to mean criminality. Junkies are supposed to have come from broken families. (Seldin, 1972) Gender and gender roles play an important role in this identity not only in the case of women as addicts[7] but also of men as emasculated by their addiction. This identity has its implications. Manderson (1995) claims that the creation of the identity of the drug addict actually promotes certain behavioural tendencies in drug users. The discursive mechanism used to construct this identity is the medical gaze.

The medical or clinical gaze is a concept found in Foucault (1973). Just as the discipline of 'health' formulates the boundaries of a society, similarly, the discipline of 'medicine' draws the boundaries of what can or cannot be called a disease. The medical gaze abstracts the patient from their contexts and turns them simply into 'cases'. (Hsu & Lincoln, 2007) The medical gaze allows for the diseases to exist *outside* of the individual. So a doctor might search for the 'true' cause of a headache ignoring the patient. (Scheper-Hughes & Lock, 1987). "[T]he doctor's gaze is directed initially not towards that concrete body, that visible whole, that positive plenitude that faces him—the patient—but towards intervals in nature" (Foucault, 1973 p. 8). Under the medical gaze, the patient turns into either a functioning or a malfunctioning entity. This stems from the old Enlightenment era (some might argue Platonic) ideas of the truth existing outside of individual praxis. Thus, the medical gaze assumes treatment to simply be an act of collecting symptoms and prescribing a solution in an objective way. This objectivity masks the notion that 'illness' and 'disease' has always been a social construction[8] and behind the treatment lies power that can create identities through a taxonomy of behaviours that are called symptoms[9]. The medical gaze allows for interventions in the body of the patient. This medical discourse was shaped in the 19th century alongside the emerging scientific and empirical models. (Foucault, 1973)

[7] The UNODC Report on Drug Use in Pakistan (2013) shows that the *choice* of drug, perhaps illustrating the differences in *milieu*, is also gendered. While men are more likely to use opiates women are more likely to use tranquilizers and sedatives.
[8] In Akhil Sharma's novel, 'A Family Life' about Indian immigrants in the United States, the narrator's comatose brother is assumed to have been touched by the divine and is regularly visited by people looking to solve their problems.
[9] An interesting take on this is Greenlaugh (2001) in which she details her misdiagnosis of 'Fibromyalgia' and how medicine is a 'diagnostic-interpretive grid' (p. 87) which has corporeal, bodily and emotional implications for the patient.

It is my contention that the necessity to 'cure' drug addiction is a form of biopower (Foucault, 1978) or an instrument of mass management[10]. The justification of authority in modern times does not, solely, come from coercion but also by the protection of life. Birth control, public hygiene, sexual practices etc. are all forms of biopower. Drug rehabilitation is also a manifestation of biopower because it aims to reorient people to be better human beings. What most studies on drug addiction fail to explore is that the 'addicts' are being rehabilitated into a supposed state of normalcy and health[11]. This required state is defined not by the users themselves but by governments and societies. An interesting example of this would be the contrasting forced veiling and *burqa* bans of recent times. Both are instances of biopower as they are examples of what states consider to be 'healthy' and are both based on the supposed concern of the women. The role of biopower is, ultimately, to create self-regulating, docile bodies and in this way, drug rehabilitation must be seen in the same perspective as anti-smoking campaigns or anti-obesity drives[12]. Drug rehabilitation is not only an attempt to create homogenised healthy bodies but also a restriction on alternative uses of pleasure. Understanding treatment helps us to approximate what is considered healthy in Pakistan.

The justifications for this are many. Drug addiction needs to be treated because according to Pakistan's National Anti-Narcotics Policy addicts are a challenge to "Pakistan's Law Enforcement Agencies (LEAs) and healthcare system" (National Anti-Narcotics Policy, 2010). Other answers are usually centred on supposed criminality, (For an interesting take on this see Stevens, 2007) or a lack of productivity or issues of hygiene and diseases with AIDS being the most important. The United Nations Office on Drugs and Crime (UNODC) even goes so far as to claim the solution to the problems of addiction to be part of the broad development agenda. (UNODC Annual Report, 2015). Development, crime, morality, and hygiene everything seems to be wrapped up around this.

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[10] There is a key difference between biopower and discipline. Discipline is the regulation of individuals while biopower is the regulation of populations.

[11] The parallels between drug rehabilitation and other 'diseases' is fascinating. Vrecko (2016) compares medication to prevent drug relapse to other situations like medication for cholesterol or osteoporosis and maintains that they are all remarkably similar.

[12] See, Wright (2009) in which he shows how obesity is classified a disease, specific risk factors are identified for monitoring of those who might be at risk in the name of prevention, and the assumed need for treatment of those who fall within the medically defined categories of overweight or obesity.

I have maintained that the identity of the drug addicted is constructed as a negation of the usual bourgeois values and as a threat to the health of society. I argue that the body of the addict becomes a site of bourgeois *anxiety* and it is, precisely, the need to assuage this anxiety that the need for treatment comes from. Otherwise, 'an addict only harms himself' (Personal communication, October 7, 2017). The body 'embodies' many things. It is the arena where, for example, race and gender play out. The constructed identity of the drug addict embodies an all-encompassing 'Other' to the normative order. Addiction seems to become a diffuse presence and transforms itself into crime and disease. It now exists independently of the body of the user and symbolises a dread, a danger to the continuation of society. But it is located within the body of the addict and hence it is the body that needs to be cured.

1.5 Significance of the Study

This study is important because it presents an alternative way to look at the phenomenon of addiction. This phenomenon has not been studied so far in a social scientific way and the voices of drug addicts have been muted under so much technical jargon and so much sensationalism. A social constructionist approach allows us to see how certain ideas are made and also what purpose do they serve. The concept of addiction is also a social construction. For instance, many coffee users, without their 'dose', also feel the same lethargic irritability that drug users going through withdrawal yet only one of them is actually considered dangerous and in need of 'curing'. This study shows how drug use would look like if we approach it differently. It becomes necessary to move beyond addiction as a disease if it is to be understood in totality.

This study is also significant because it aims to show how established medical and scientific models can also serve ideological work. It utilises a critical perspective in understanding this phenomenon. "The first task of the doctor is therefore political: the struggle against disease must begin with a war against bad government" (Foucault, 1973, p. 33). I seek to show how health and health-related structures are an embodiment of power. It is an attempt to understand normativity in our society and the construction of identity through discursive mechanisms. My study, which will be termed postmodern even though I do not call it that, is an attempt to go beyond observable activity and try to locate the causes of an action. To paraphrase Joan Didion I do not believe observable

activity to, exclusively, define *Anthropos*. I like to think of it as an ethnography of the present or an investigation into the historicity of contemporary times. While it has many benefits, this social constructionist approach is not without its faults. If anything it is a perspective and hence should be welcomed as such. I chose this particular topic because of a longstanding interest in discipline and treatment procedures. Partial inspiration has also been taken from Douglas Adam's satirical novel *Dirk Gently's Holistic Detective Agency* in which to solve a crime one must first 'solve' the society in which the crime took place.

2 RESEARCH METHODOLOGY

Every discipline whether it be social or scientific requires some kind of methodology or method by which data is obtained and analysed. This methodology sets limits on as to what can constitute data and its validity. Anthropology famously called the most human of the sciences also has a methodology which aims to reach the subjectivity of people.

Primary data was collected from the patients and the staff of various drug rehabilitation centres. Participant observation was also carried out wherever possible. The tool used for data collection was in-depth, semi-structured interviews with an interview guide prepared beforehand. The interviews were designed to be as open-ended as possible.

2.1 Locale

The research was carried out in Islamabad. The locale was chosen for convenience's sake and also because there is a large number of rehabilitation centres in the city. A certain amount of standardisation of practices in these centres exist throughout the country and if anything the institutes in the capital are somewhat better. These centres are mostly privately-run. The reason for choosing these is that there is only one public-sector rehabilitation centre in Islamabad: the Model Addicts Treatment & Rehabilitation Centre (MATRC) set-up by the Anti-Narcotics Force (ANF) and many public-sector hospitals only offer detoxification and that too for a short time. Secondly, these centres offer comprehensive programmes which were necessary for the analysis.

2.2 Rapport Building

Rapport building is absolutely essential to anthropological research. The first thing I did was to establish a rapport with the staff and the patients. Initially, they were very reluctant to share detail with me and this was understandable because of the nature of rehab centres and their desire to maintain strict privacy. I assured them that their details would be kept confidential. Over time the level of frankness and comfort with them increased.

2.3 Key Informant

A key informant is someone that is either extremely knowledgeable about the topic or someone that is intimately familiar with the *milieu* that one is investigating. A key informant is absolutely essential for anthropological research as it is the key informant who introduces you around and makes sure you meet with the relevant respondents. I was appointed four key informants from the relevant centres and they helped me greatly in this regard. They would inform me of any additional information that they thought was essential.

2.4 Participant Observation

Participant observation is the backbone of anthropological research. It is necessary to obtain a subjective experience of the experiences of the participants. I interacted with my respondents as much as I could give the circumstances and this gave me a deeper understanding of the phenomenon I was studying and also helped in establishing further rapport.

2.5 Sampling

The sample is composed of thirty individuals from four different rehabilitation centres with ten of them being staff members and twenty being the drug addicts. The interviews conducted were several more in number, however, the selected ones can be considered representative of common opinions and this particular number was reached to avoid repetition.

The sampling technique used was Purposive, or selective sampling as well as Convenient Sampling. In Purposive sampling, the sample is selected based on the required characteristics under study. This was done because this study only concerns the clinical staff and the patients undergoing treatment at drug rehabilitation centres. However, this is a Heterogeneous or Maximum Variation purposive sample as it seeks to utilise a wide range *within* the sample itself. This is so that maximum insight can be had into the phenomenon under study. Convenient sampling was also used.

2.6 Interviews

Interviews are the primary method of data collection and it is what separates anthropology from other disciplines. It is necessary to obtain a greater subjectivity into the minds of the respondents and for that observation is not enough and we have to also find out what is it that they, the respondents experience. I conducted in-depth, semi-structured interviews with the staff as well as the patients of my selected rehabilitation centres.

2.7 Respondents

Due to the nature of my research, as it involves confidentiality, the details of my respondents cannot be given. However to distinguish between their responses I used the terms 'Most', 'Many', 'Some' and 'Few'. These terms mean the following:

TERMS	PERCENTAGE
Most	Approximately 90 per cent of the respondents responded in this way.
Many	Approximately 70 per cent of the respondents responded in this way.
Some	Approximately 50 per cent of the respondents responded in this way.
Few	Approximately 30 per cent of the respondents responded in this way.

Any exceptions to these have been mentioned separately.

2.8 Field Notes

It is impossible to rely purely on memory alone. Some kind of field journal or field notes have always been a sort of tradition in anthropology. I took copious amounts of notes when I was in the field. I would note down anything that I considered important or worth mentioning.

2.9 Data Analysis

The data that has been obtained needs to be analysed and interpreted in order for it to make sense. There must be some kind of interpretative framework that is employed which makes this possible. Since the methodological framework, I employed was one of narrative research and hence the technique of data analysis I employed was a thematic one in which similar themes are detected within the data and then grouped together. The data was also analysed keeping in mind my theoretical framework and orientation.

2.10 Ethical Considerations

Due to the nature of my research, several things could not be reported as it would interfere with the confidentiality of the patients and their doctors. For this reason, the names of both the centres, the medical staff and the patients have been removed. Pictures or any such identifying traits were all deliberately excluded. These interviews were only possible by keeping all these things in mind.

2.11 Limitations

This study has the following limitations:

1. There is a notable absence of women. The reason for this being a lack of access and the common unavailability of women in centres such as these.
2. It does not analyse the medical aspects of rehabilitation or the various medications used. It concerns itself solely with the social aspects of this phenomenon.
3. This study also does not suggest alternatives.

2.12Methodological Framework

This research employs a qualitative framework. While there is no strict definition of what constitutes qualitative research Mason (2002) gives us the following characteristics:

1. Concerned with how the social world is interpreted, understood, experienced, produced or constituted.
2. Based on methods of data generation which are both flexible and sensitive to the social context in which data are produced
3. Based on methods of analysis, explanation and argument building which involve understandings of complexity, detail and context. (pp 3-4)

In other words, qualitative research is concerned with the 'how' and 'why' of a phenomenon and hence is appropriate for this research.

2.12.1 Narrative Research

It can be argued that all research is concerned with the construction of narratives. Moen (2006) puts it as "All human action is dialogic in nature. In its widest sense, even existence itself might be considered to be dialogic" (p. 58). Narratives are "reports on personal experience" (Paiva, 2008, p. 2). They are stories that tell "a sequence of events that are significant for the narrator or her or his audience". (Moen, 2006, p. 60). Stories reveal "the relational selves of storytellers" (Gubrium & Holstein, 2008, p. 244). We can put it as stories are the realities of the narrator. Narrative research is simply research that employs narratives as a unit of analysis. However, this analysis is assumed to be not something that is done after data collection but a process in which the researcher and the respondent actively create knowledge in a collaborative way. (Gerhart, Tarragona, & Bava, 2007). Narrative research analyses both the form and the content of a narrative. (Paiva, 2008) This research will utilise the narratives of the drug addicts themselves as well as the narratives constructed around them.

3 LITERATURE REVIEW

In this section, the literature of different writers, relevant to my theoretical assumptions is reviewed to understand the theoretical ground on which the research is based. The theoretical and conceptual understanding of the concepts employed in this research is given to develop a theoretical justification for the research.

3.1 Drugs

A drug is, very simply, anything that when ingested (either through smoking, injection, inhalation etc.) causes a temporary physiological (and/or psychological) change in the human body[13]. Drugs can be classified into three categories: Therapeutic, legal (caffeine, tobacco and in most places alcohol) and illicit drugs. (Baconi, *et al.*, 2015) Illicit drugs are a variety of drugs that are prohibited by international laws like the 1961 Single Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances. These drugs include amphetamine-type stimulants, depressants, cannabis, cocaine, heroin and other opioids, and MDMA (ecstasy). (Degenhardt *et al.*, 2004). Drug addiction is usually defined as a complex disease characterized by compulsive and uncontrollable desire to seek and consume the drug and a tendency to relapse. (Baconi, *et al*, 2015, p.18) This is considerably vague and this vagueness has been reflected in the shifting terminologies that have been associated with it. Drug addiction was initially classified as habituation, then addiction, then dependence in various WHO reports. (Baconi, *et al.* 2015, p. 19). DSM-5 (Diagnostic and Statistical Manual), published by the American Psychiatric Association, combines substance abuse and substance dependence into single "substance use disorders", specific to each substance of abuse, within a new "Addictions and related disorders" category. ICD-10 (The 10th Revision of the International Classification of Diseases and Health Problems), edited by WHO, replaced the term "physical dependence" with "neuroadaptation". Also, the term "abuse" is considered relatively ambiguous and replaced with the more specific term "hazardous use" or "harmful use". (Baconi, *et al*, 2015, p. 19). What is interesting in all this is a clear move towards a biological model for addiction as opposed to a more sociological one. Addiction, in itself, also does not have a clear definition. Sussman &

[13] Drugs are psychoactive substances and only, really, called drugs when speaking in the context of illegality.

Sussman (2011) claim that addiction has five characteristics. Engagement in the behaviour to achieve appetitive effects, a preoccupation with the behaviour, temporary satiation, loss of self-control, and finally suffering negative consequences. Intriguingly, this can also be the definition of compulsive behaviour[14]. According to the UNODC World Drug Report (2017) an estimated quarter of a billion people, or around 5 per cent of the global adult population, used drugs at least once in 2015. About 29.5 million of those drug users, or 0.6 per cent of the global adult population, suffer from drug use disorders. UNODC's report on Drug Use in Pakistan (2013) claims that approximately six per cent of the population or 6.7 million people had used any controlled substance including misuse of prescription drugs, in the last year. An estimated 860,000 or 0.8 per cent of the population are regular heroin users and 320,000 (0.3 per cent) are opium users for a combined figure of, 1.06 million people (1.0 per cent of the population aged 15-64 years) Around 4.25 million drug users in Pakistan are considered dependent on substances and require a form of structured intervention for treatment of their drug use disorder. This number is assumed to be steadily rising.

3.2 Social Construction of Drug Addiction

As I have mentioned before addiction does not have a clear, commonly understood definition. However, it is classified as a disease and often a 'disease of the mind'. May (2001) claims that explanations of addiction revolve around three ideas: 'Addiction' as a product of inherited traits (genetic explanation); addiction as a function of organic disease as shown in signs such as 'thirst' or 'craving' (disease of the endocrine system or central nervous system); or addiction as the result of interactions between persons and immoral or degenerate influences, (psychological explanation). This ignores the fact that no organ has been declared as the source of the 'core pathology' of addiction. (Reinarman, 2005) The changes in the pathways of the brain that are considered the source of addiction also occur by "acts of cooperation, maternal support, talk therapy and even looking at beautiful faces" (Reinarman, 2005, p. 309). So why is an addiction, and more specifically, drug addiction a disease? It is constructed this way because it is "useful to a wide range of social groups including the media, politicians, the anti-drugs

[14] The authors differentiate between them by the fact that compulsive behavior does not create pleasurable sensations but rather is to alleviate anxiety (e.g repeated washing of hands). (Sussman & Sussman, 2011, p. 4031).

industry, biomedical and pharmaceutical industries, the illicit drugs industry, law enforcement, and drug users and ex-users" (Hammersley, 2014, p. 4). Calling it a disease allows for addicts to explain away their actions as that motivated by pathology and it allows several industries to run smoothly.

3.3 Discourse

Critical to understanding my topic is the word 'discourse' and, ironically, it is one that has never, really, been clearly defined[15]. There are certain characteristics of discourse that can serve in place of a definition. Discourse can be considered a part of the tradition which analyses the societal construction of knowledge. Hall (1992) defines it as

A discourse is a group of statements which provide a language for talking about . . . a particular kind of knowledge about the topic. When statements about a topic are made within a particular discourse, the discourse makes possible to construct the topic in a certain way. It also limits the other ways in which the topic can be constructed. (p. 291)

In other words, discourse is an institutionalised, systemic way of talking and writing about certain things. Discourse should not be confused with text analysis. In the latter, written texts are the primary unit of analysis while in discourse they are one part of what constitutes the whole. (Titscher, 2000) Discourse is a form of social practice. (Fairclough & Wodak, 1997) In talking and writing about things people create situations (reality) which in turn lead to actions[16]. A discourse is, thus, an action. It is not all one-sided. A discourse shapes reality and, in turn, is shaped by that reality through a dialectical process. (Wodak, 1996) This leads us to an important point, namely, that discourse is contextual. An understanding of language implies an understanding of a cultural background in which they are being used. (Titscher, 2000). Any kind of declarative statement is meaningful only in a specific context which can also include previous discourses. (Wodak, 1996; Titscher, 2000) So, another difference between an analysis of text and discourse is that a discourse also includes the context in which it is operating. One of the primary precedents of the idea of discourse are the

[15] Foucault is usually assumed to be the central figure when it comes to discourse. However, that is not, strictly, true as similar ideas could also be found in figures such as Saussure, Derrida and Lacan. (Howarth, 2000)

[16] An example of this could be the use of the word 'hoodlums' for 'protestors'. In framing it in such a way the narrative shifts from one of alleviating genuine grievances to dispersing rowdy crowds.

works of Neo Marxist theorists such as Gramsci, the Frankfurt School, Althusser etc. (Fairclough & Wodak, 1996) and the idea that domination in modern societies is ideological in nature. (Althusser, 1971) Ideology, simply, is based on the assumptions that societies contain a hidden, *subconscious*, aspect (Zizek, 2009) and that interests of a certain sub-section of society are construed to be universal. This is a form of domination to continue unequal societal relations. (Larrain, 1988). A discourse also carried out ideological work as it is constructed through power. To sum up, a discourse is made up of talk and text, situated within context (van Dijk 1997) and is a way of "constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them" (Weedon, 1996, p. 108). Discourses also contain within them avenues for resistance. I have already discussed the predominant discourses concerning drugs that exist in our society. The one that is under analysis is the Drugs as Problem discourse which can be summed up by the idea that drug usage is a problem that requires expert help.

3.4 Power-Knowledge

A common saying goes, 'Knowledge is Power'. However for Foucault, knowledge and power are, virtually, indistinguishable. Power creates knowledge which is, in turn, used by power to justify its existence in a dialectical fashion. Power-Knowledge (and sometimes Knowledge-Power) is a concept found in Discipline and Punish (1977) and the History of Sexuality (Vol. 1) (1978). Foucault would later replace this concept with the broader concept of government in the sense of limiting an area action of others'. (Foucault, 1982)

No body of knowledge can be formed without a system of communications, records, accumulation and displacement which is in itself a form of power and which is linked . . . to the other forms of power. Conversely, no power can be exercised without the extraction, appropriation, distribution or retention of knowledge. On this level, there is not knowledge on one side and society on the other, or science and the state, but only the fundamental forms of knowledge/power. (Foucault, as quoted in Sheridan 1980, p. 131)

To understand this fully we must first understand what Foucault meant by power. Foucault's ideas are radically different from how power is commonly conceived. For

him, power is diffuse and not concentrated and is not possessed but rather embodied and enacted and is not strictly coercive, and creates agents rather than, simply, being deployed by them (Gaventa, 2003). Power is not wielded by any one individual or institution but is a diffuse and multi-nodal presence. "Power is not an institution, nor a structure, nor a possession. It is the name we give to a complex strategic situation in a particular society" (Foucault, 1978, p. 93). Also, power is not necessarily negative.

We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (Foucault, 1977, p. 194)

Similarly, there are different forms of knowledge that are subordinate to the dominant modes.

'By subjugated knowledges I mean two things: on the one hand, I am referring to the historical contents that have been buried and disguised . . . On the other hand, a whole set of knowledges, that have been disqualified as inadequate or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity'. (Foucault, 1980, p.82)

It is through power that discourses (systemised knowledges) are created and challenged.

3.5 Identity

Identity is a complex thing which means different things in different disciplines. It can be defined as the state or fact of remaining the same one or ones, as under varying aspects or conditions, the condition of being oneself or itself, and not another; what a thing is (the qualities, beliefs, etc. that distinguish or identify a person or a thing) or a sense of self that provides sameness and continuity over time. Djité (2006, p.6) defines it, simply, as the "everyday word for people's sense of who they are"[17]. Identity can be

[17] Despite this breadth, our definition of identity does not simply encompass all possible characteristics that might be used to describe someone. In popular and academic discourse, the term identity is sometimes applied as a catch-all label for biological characteristics, psychological dispositions, and/or socio-demographic positions. (Luyckx, Schwartz & Vignoles, 2011, p. 2).

individual, relational or collective. (Luyckx, Schwartz & Vignoles, 2011) Individual identity includes self-definition (which includes goals, beliefs, standards etc.), relational identity incorporates roles that different identities imply towards others (e.g a 'father's *responsibility* towards his children) and collective or social identity refers to individuals' identification with larger groups (Muslim, Pakistani etc.) (Luyckx, Schwartz & Vignoles, 2011). At all levels of identity, there is a sense of 'Otherness'. "We are what we are because they are not what we are"[18] (Forgas & Tajfel, 1981, p. 124). Identity is multifaceted with different aspects of identity being deployed at different times. It should be obvious now that identity is a social construction and not only that, it is a linguistic construction (Kroskrity, 1999, p.111). The words used to describe ourselves (or someone else) and the metaphors used help shape identities. Ideologies create space for these constructions to appear natural. For example, the idea that a 'junkie' will ultimately resort to crime confuses correlation with causality (Stevens, 2007) but still is assumed to be what a junkie does. It is part of the identity and that identity is a negation or Othering of 'normal values'. Is there any identity that exists outside of discourse? Versluys (2007) argues that a problem with Foucault's notion is one of presupposition. The construction of identity is assumed to be simple attribution of value or meaning to already existing environmental elements. (Versluys, 2007,). A plausible solution to this would be that while social categories do exist outside of discourses they only become operational when used in discourse. (We have already established that discourse is action).

3.6 Embodiment

The body, it can be argued, is social. The body is both a natural, physical entity and produced through cultural, discursive practices[19]. (Pilcher & Whelehan, 2004). "The body, without ceasing to be the body, is taken in hand and transformed in social practice" (Connell, 1987, p. 83). It is *on* the body that the notions of sexual difference,

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[18] The notion of identity is not without its detractors. Geschiere & Meyer (1998) maintain that the notion of identity in social sciences is, merely, a capitalist discourse of private ownership in which every individual owns an identity.

[19] As mentioned in the previous section there is a tension in Foucault in conceptualising objects as existing outside of discourses. "Although Foucault appears to argue that the body does not exist outside the terms of its cultural inscription, it seems that the very mechanism of "inscription" implies a power that is necessarily external to the body itself" (Butler, 1989, p.603).

gender, race, and to a certain extent, class are played out[20]. The body of the drug addict embodies (in the sense of having a body or being contained within one) the values that need be removed and also a site of inscription (Butler, 1989) for new values. The body is important in the biomedical model because it is, strictly, the body of the addict that is being cured. It is assumed that their natural agency (in so far as they want to be cured) is being hampered by a body reliant on drugs. (See, Csordas, 2011). The shift is from 'addiction' to the body of the addict. However, the body is also important in a different way. The body allows for the idea that through quantification and careful qualifying bodies can be made to "testify to scientific, medical and legal truths" (Horn, 2005, p. 136). Free-floating anxiety about the health of a society can be located, grounded in the body of the addict. The body is, thus, a site for the inscription of power. Bodies become more important in the case of drug use because it is being ingested into the bodies of the addict. It is, quite literally, embodied in them.

3.7 Uses of Pleasure and The Technologies of Self

I have argued[21] that the 'Drugs as Problem' discourse constructs the agency of its subject as being hindered by an unwieldy body. There is another aspect, however, to agency that is disguised under this form and the denial of this aspect creates an interesting paradox. The 'Drugs as Problem' discourse constructs its subject as "a health-conscious citizen capable of rational decision-making, self-determination, self-regulation and risk management in order to minimise drug-related harm"[22] (Moore, 2005 p. 355). The 'Drugs as Problem' discourse is centred around the absence of pleasure and conceptualising drug use as an arena of 'excess risk' and 'harm reduction'. (Hunt *et al.*, 2007) Pleasure can also be conceptualised as "social pragmatics" (Race, 2007, p. 422). Drug users make sure of their safety through several efforts of trial and error and carefully managing their risk and their pleasure[23]. (Hunt, *et al.*, 2007) This

[20] The 'unwashed masses' is an old term used to describe the working class.
[21] This phrase, uses of pleasure, comes to us from the end of Foucault's History of Sexuality (Vol. 1) in which he posits pleasure, which is undefined and flexible, against sex which exists within discourse. 'The rallying point for the counterattack against the deployment of sexuality ought not to be sex-desire, but bodies and pleasures'. (Foucault, 1976, p. 157). Pleasure is more diffuse and is not linked to any established theory.
[22] This transforms drug use into any odd choice one can make under free market capitalism and implies that the consumers will make the 'right decision' if they make informed choices. (O'Malley & Valverde, 2004, p.36)
[23] Howard Becker's classic Becoming a Marihuana User (1953) shows that for an individual to enjoy (take pleasure from) marijuana 'he learns to smoke it in a way that will produce real effects; learns to

use of pleasure comes in conflict with the construction of the subject as rationally, harm-minimising. Since this discourse is based on rationality which implies order and restraint and pleasure in 'moderate doses' this particular use of pleasure appears compulsive and unfree. (O'Malley & Valverde, 2004). But here we find a paradox. Is not seeking out and using drugs also a rationally ordered free choice? Why then must this pleasure be proscribed? Moore (2005) argues it comes from two diverging ideas of the body. The privileged (ironically 'high') notion of the ordered, rational body of 'disciplined, civilised pleasure' and the low or 'grotesque' body whose pleasure stems *directly* from bodily functions. (p. 356) What then are the technologies of the self?

Technologies of the self, permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality. (Foucault, 1988, p. 18)

Foucault (1988) argues that the notion of 'know yourself' has been replaced by 'take care of yourself' and it is from here that the technologies developed. Pleasure is controlled and channelled through these technologies which, for instance in the case of drugs, can include abstinence, self-control, rehabilitation etc.

3.8 Docile Bodies

Foucault (1980) claims that "one must set aside the widely held thesis that power, in our bourgeois, capitalist, societies has denied the reality of the body in favour of the soul, consciousness, ideality" (p. 57). Power is still manifested in the body. The body is something that can be made. We can compare it to clay through which anything can be constructed (Foucault, 1977). It can be 'manipulated, shaped, and trained. In other words, it can be made docile or disciplined. Docility for Foucault (1977) is "the point where the analysable body meets the 'manipulable' body" (p. 136). In other words, a body that is understood is a body that can then be manipulated. A body is docile that may be subjected, used, transformed and improved through discipline. This discipline is manifested, primarily, in four ways. Cellular or spatial manipulation of the body in which bodies are arranged in ranks and places. Organic or designed, 'natural', activities

recognize the effects and connect them with drug use; and learns to enjoy the sensations he perceives'. (p. 235)

that must be carried out at specific times (e.g timetables). Genetic or graduating to denote progress and evolution (drills, homework etc.) and combinatory or tactical which implies knowledge about the discipline and the combination of many bodies into a single unit. (Foucault, 1977). "Discipline is the act of composing forces in order to obtain an efficient machine" (*ibid.* p. 164) and through discipline the individual body becomes "an element that may be placed, moved, articulated on others" (*ibid.* p. 146). While Foucault's primary example is that of soldiers this model can be used to explain docility in different disciplines. The parallels between this and schooling are obvious but one can be disciplined to obey the laws of a country, to follow the rules of different branches of academia (e.g the study of biochemistry and ethnography imposes different disciplines and different docility) and even to obey the rules of living in a home. Docility is not homogenous or standardised but exists in variations. This is also obvious in the case of drug rehabilitation as the patients are made to go through strict timetables and a rigid routine that has to be followed for the duration of their stay.

3.9 Biopower

For Foucault (1976) around the 18th century, the ancient right of the sovereign to take life was replaced by a power to create or continue life or to allow bodies to die. This power had two forms. One which he calls "an anatomo-politics of the human body" (Foucault, 1976, p.139) focused on discipline and docility of the individual body and its incorporation into established systems. The second

[F]ocused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity. Their supervision was effected through an entire series of interventions and regulatory controls: a bio-politics of the population. (Foucault, 1976, p.139)

Biopower[24] is "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (*ibid,* p.140) on a statistical level. Biopower seeks to "administer, optimize, and multiply" (*ibid,* p.137) life. Rainbow & Rose (2006) defines biopower as having three characteristics:

[24] The phrase biopower has been used differently by other authors such as Hardt and Negri and Giorgio Agamben. (See Rainbow & Rose, 2006)

1) One or more truth discourses about the 'vital' character of living human beings and an array of authorities considered competent to speak that truth.

2) Strategies for intervention upon collective existence in the name of life and health.

3) Modes of subjectification, through which individuals are brought to work on themselves, for their own life or health, that of their family or in the name of the population as a whole. (p. 197)

Dean (1999) elaborates biopower as the "processes of the optimisation of the life of the population" (p. 99) and that it is primarily concerned with the "social, cultural, environmental, economic and geographical conditions under which humans live, procreate, become ill, maintain health or become healthy, and die" (*ibid,* p. 99). Foucault did not significantly elaborate on this theme and continued to refine it throughout his life. (Kristensen, 2013) but it ties into his broader ideas on power and subjectivity.

3.10 Drug Rehabilitation as Constructing Docility

Gowan & Whetstone (2012) maintain that drug addiction is a part of a long therapeutic tradition of moral reform through modification of behaviour. Drug rehabilitation is a way to re-socialize bodies that is more effective than imprisonment and this pathological model allows for the obfuscation of systemic social issues. The goal is to cure society by carrying out interventions in the body of the addict.

Keane (2008) reviews four studies about drug rehabilitation (specifically Methadone Maintenance Therapy MMT) that all claim it to be a regulatory mechanism to create disciplined bodies from unruly ones and that this rehabilitation was an attempt to create obedient and productive subjects.

3.11 Locating the Study within an Anthropological Framework

One of the most important aspects of anthropology has always been the notion of anthropology as cultural critique and as providing emic perspectives on social phenomena. The understanding of drugs and addiction is a key part of this cultural critique considering the fact that it has increasingly become impossible to separate drugs from their moral and social meanings. Hunt & Barker (2001) term it as the moral economy of consumed substances. The study of drugs from an anthropological perspective falls into the broader multi-disciplinary domains of alcohol and drug studies and within anthropology it can be located in the field of medical anthropology. However, anthropology moves beyond a narrow socio-cultural model to incorporate diverse perspectives. Singer (2012) maintains that these perspectives are a socio-cultural perspective, the lifestyle model and the critical and experiential perspectives.

The socio-cultural perspective, and the general anthropological investigation into the phenomenon of drugs and addiction, came from the studies of drinking behaviour and alcohol that was carried out in the 1950s (Hunt & Barker, 2001). Drug consumption in this perspective is viewed through cultural contexts instead of medical ones and consumption was understood to be a social practice.

The life-style model, which first started to formulate in the 60s, analysed the phenomenon as that of a sub-culture, with its own rules, attitudes and norms, that is centred on the consumption of drugs. This model shows drug users as actively and meaningfully contributing to a lifestyle of consuming drugs (Singer, 2012).

The critical model developed in the 80s, sought to understand the role of power in the consumption of drugs and the interpretation of this act. It is concerned with macro-level issues like the use of drugs to alleviate social injustices and the political economy of drug use and its intersection with 'legal' drugs and how 'common sense' discourses are used as an interpretive framework to understand this phenomenon. (Curtis & Wendell, 2000).

The experiential perspective, gained prominence with the rise of postmodernism in the social sciences, sought to show that the *experience* of drug use is not necessarily

negative but that it provides avenues that are far more positive and that drugs, on a limited level, can be creative and even sustainable (Singer, 2012).

However, according to Hunt & Barker (2001) there have not been attempts to incorporate all these perspectives into a broad theoretical paradigm of the 'anthropology of drugs' and that these perspectives, despite intersecting on several points, nevertheless remain distinct.

My study, which is focused not on drug consumption but rather discursive mechanisms through which the addict identity is constructed belongs in the critical model as it coincides with broader societal issues.

3.12 Theoretical Framework

As has been mentioned before the study is based on the work of Foucault and his ideas on discourse, discipline and biopower. It focuses on how a subject is framed, knowledge is created about it and then practices are informed based on that knowledge by experts in the field. This study also utilises a social constructionist approach.

3.12.1 Discourse Analysis: Critical or Foucauldian?

It can be argued that Critical Discourse Analysis (CDA) and Foucauldian Discourse Analysis (FDA) are one and the same thing. However, they have some difference. For one, CDA means the "investigation of language, discourse and communication, from a socially conscious and oppositional perspective that emerged from critical linguistics and critical semiotics" (van Dijk, 1995, p. 17).

CDA is normative insofar as it understands discourse to be wielded by the powerful and the elites to perpetuate domination, discrimination, exploitation, dehumanization, naturalization, (ideologically driven) "common sense," unless its, usually, hidden effects are exposed so that awareness, resistance, emancipation, and social action can bring about social change and social justice[25]. (Waugh *et al.*, 2016, p. 72)

[25] While the ambitions are great van Dijk (1993, p.280) is quick to point out that 'facing the real issues and problems of today's world, discourse analysis, whether critical or not, may not make much difference' unless a critical perspective is stimulated in students and academia.

FDA is different, as I mentioned before because it does not assume a non-discursive realm and considers discourse to constitute the subjects of discourse. FDA endeavours to avoid the "substitution of one 'truth' for another" (Graham, 2005, p. 3) and characteristically eschews claims to objectivity and truth. FDA is not simply linguistically based but also takes into account the practices that the discourse makes possible. There is no one way of carrying out FDA or even CDA for that matter. To sum up we can say that while Foucauldian Discourse Analysis is a part of CDA not all attempts of CDA are Foucauldian. This study uses FDA.

3.12.2 Social Constructionism

Social constructionism is the idea that reality is a construction and what we assume to be reality is merely established opinions on things. It maintains that all realities have been made by humans. According to Galbin (2014), these realities comprise

'[T]he imagined worlds of human social existence and activity, gradually crystallized by habit into institutions propped up by language conventions, given ongoing legitimacy by mythology, religion and philosophy, maintained by therapies and socialization, and subjectively internalized by upbringing and education to become part of the identity of social citizens'. (p. 89)

Reality, thus, is a construct embedded in particular contexts. Social constructionism is concerned with the production of knowledge and how that knowledge is legitimised. The most obvious form of this is through language. Language constructs the world. It is a form of "social action" (Galbin, 2014, p. 90). Thus language can create different realities. Social constructionism is useful because it allows for a critique of how society has been understood and the implications of this understanding. Secondly, it allows for moving beyond a simple scientific understanding of the phenomenon and coming up with alternative ways of knowledge construction. It allows for the framing of questions in a different way and allowing for new knowledge to emerge. A social construct would be anything, an idea or value or any kind of notion that has gained widespread acceptance and is treated as common sense or something that is obvious if one were to look at it by the general population. This idea masks the constructed nature of all constructs.

4 ANALYSIS

In order for us to have a complete picture of how the identity of an addict is constructed and consequently how social discipline is instituted it is necessary to not only the narratives of the addicts themselves but also the language and the discourse that is used to describe this phenomenon. This requires an understanding of the rehabilitation centres themselves. The following is a general view of the activities and characteristics that are common to nearly all rehabilitation centres in Islamabad.

4.1 The Field

4.1.1 The Centres

Most of the centres, or 'therapeutic communities', are not only drug rehabilitation centres but are also treatment centres for all kinds of other psychological problems. In treating drug addiction there is also involved an integral psychiatric and psychological component and these centres double as centres for psychiatric health as well. Other problems that are treated here include but are not limited to treating alcoholism, stress, substance abuse, compulsive disorders which include lack of self-control and disorders of proper conduct, 'self-destructive' behaviour like self-cutting, self-harm or suicidal tendencies, anger management, anxiety, personality disorders like gender identity disorders, schizophrenia, hallucinations (which can also be brought out by drug use), bipolar disorders and lack of confidence, developmental and learning disorders, adjustment issues, and sleeping and eating disorders.

The centres are mostly led by clinical psychiatrists and psychologists and the team is composed of medical experts, psychologists, psychiatrists, at times speech therapists, counsellors, nurses and orderlies, both males and females, and administrative and security staff; all of them, ostensibly, highly trained and qualified. The job of the medical practitioners is to administer the medication and to ensure a constant state of health. The psychiatrists serve as counsellors and work on psychological rehabilitation. The job of the security staff is two-fold. They have to prevent people from running away from the centres and they have to ensure that the visitors are not sneaking in any prohibited substances. Volunteers are also encouraged in certain places. The walls are covered with anti-drug banners or inspirational posts. The staff are encouraged to be

friendly and polite and to smile more often. Therapists are encouraged to be sociable and supervisory.

Some centres have separate buildings and some are even located in densely populated residential areas with the number of in-facility patients being very small. Most of them, barring a few, are non-hospital settings. There is a great variety in size and it varies from a few rooms to 50-bed facilities. The centres are divided into several sections. Patients undergoing the detox process which is considered dangerous and in which patients can get extremely violent are kept separate. Most centres have contracts with hospitals in which the detox process is carried out while some even carry out the process residentially. There are individual rooms for sleeping in and in some cases there are halls for the patients to sleep in. All of this is dependent upon the financial position of the patient and they can opt for exclusive rooms, shared accommodations or general halls provided they pay for them. There is a hall in which the patients eat together. This hall can also double as a TV room. All these centres provide recreation of some kind. The larger ones have separate rooms in which games like table tennis can be played. Otherwise, board games of all kinds are available. Exercise equipment like treadmills and elliptical machines, dumbbells etc. are also present. Books, newspapers and magazines are also available as well as extensive literature about the organisations and issues concerning drugs. There is, in many, a place where the patients can pray together, recite the Quran and listen to sermons by a cleric. Similarly, the halls are also used for counselling sessions and lectures which are on various topics like relapse prevention, healthy life skills etc.

While the number of female patients is very little to almost non-existent most of these centres are segregated with female patients being kept completely separate from the males and having an all-female staff. Some even go so far as to maintain separate centres for the women. The presence of women, nevertheless, remains minuscule.

Most of the centres have escort services in which staff from the centre can come pick up the patients from their homes to the centres. They are all equipped with vans of some kind. These are also used for excursion trips to various sightseeing spots on the appropriate days and shopping trips. Families are also allowed to visit on selected days. The visiting of friends is restricted in certain centres and in some places, especially, in

the case of minors or young patients friends are not allowed without permission from the guardian or parent.

Some of these are run on a charitable not-for-profit basis while others have a graduated standard of service which depends upon the amount of money the patients are willing to spend. These do not come cheap. Prices can range from 1,000 to 10,000 per night. Most of them are operational 24 hours a day.

4.1.2 The Programme

All the centres provide, basically, two kinds of programmes. Residential or inpatient programmes in which the patients are kept in the facility for 10-90 days. All of this is dependent on the severity of the addiction and this time period can be extended or reduced based on the discretion of the doctors. This stay is not entirely voluntary and individuals can only leave when they go through final evaluations and when the physicians clear them. Certain exceptions can be made if the family intervenes. The treatment is cancelled if the payments are not completed and the patients are dismisse . The core idea behind this being that effective treatment does not necessarily have to be voluntary. Residential patients are then made to go through a highly regimented and structured treatment regime which involved medical treatments and physical, psychological and, at times, spiritual therapy. Physical therapy involves exercises of various kinds. This is to counter the negative effects of prolonged drug use, prevent weight gain and to counter stress.

The psychological therapy involves breaking the dependency on drugs, removing old habits that would lead to relapse and creating a 'positive' and 'healthy' outlook towards life. It can be termed as learning, 'recovery skills' which include learning alternative ways to deal with their feelings, trying to understand the underlying factors that led to addiction and resolving all such problems that arose because of it. It also requires identifying 'triggers' (which can be anything from particular scents or even roads) which can lead to relapse. Another level of this therapy is group therapy in which patients share their experiences and try to connect, identify and learn from each other. This also helps with motivation. Another level of psychological therapy is family therapy in which families are made to go through 'family recoveries'. This involves

overcoming any psychological trauma that the family may have gone through and to equip them to deal with the recovering patient and to manage any sort of contingencies.

Spiritual therapy revolves around different 12 step programmes which involve believing in a 'Higher Power' or a 'Force greater than ourselves'. This has been borrowed from international organisations like AA (Alcoholics Anonymous). It is believed that this allows for a greater focus on rehabilitation and gives a greater purpose and meaning to life. This translates practically as incorporating Islamic teachings and values into the rehabilitation process. This also applies to people who are not religious. The belief in a Higher Power, it is assumed, allows for a healthier expression of spirituality as addiction prevents them from experiencing that. A belief in a Higher Power also allows for an understanding that they have very little control over their lives and this translates into addiction as well as they might believe they are consciously consuming drugs but they are not.

The in-patient programme also has an out-patient component in which aftercare is carried out. Appointments are held with therapists to help with the transition to everyday life. For this purpose occupational counselling and vocational training is also provided in some places. These take place either in residential settings or in separate facilities. The information of the sessions is kept strictly confidential and patients are encouraged to uphold this secrecy. The therapy sessions, like other things in these centres, are also incredibly structured.

The point of all this is 'reintegration' into society and to create a sense of 'balance' within the patients and to change their 'outlook' on life towards more 'positivity'.

Some places even claim to utilise hypnotherapy though this is rare.

Other out-patient treatments are limited to curing the various mental and psychological 'disorders' that have been mentioned before. They are regular, flexible psychiatric sessions and rarely require inpatient arrangements.

4.1.3 The Process

The following is the general process of how drug rehabilitation takes place.

The patient either willingly comes to the facility or is brought there by the family. They sign consent forms and their ID card numbers and other information is noted though this is kept strictly confidential. There they undergo intensive physical and psychological tests to build a case profile. This involves using drug testing kits and interviewing the individuals and their families to get insight into their history. The drug testing kits generally use urine or blood samples to detect the concentration of drugs in the body. They are also screened for diseases such as AIDS or Hepatitis and X-Rays and other medical examinations are also carried out. Clinical interviewing seeks to establish the degree of dependency and the psychological condition of the patient. It can be both formal (using standardised tests) or informal (in which the psychologists talk informally and note down their observations). Families are also interviewed to get more insight into the behaviour of the patient. All of this is then analysed by physicians, psychologists and psychiatrists to make a unique treatment plan that is tailor-made for the individual. The person's age, gender, and physical and mental health are all taken into account to formulate this plan. Some centres have uniforms that the patients must wear; others allow a limited number of personal clothing which is searched for drugs or the like beforehand. The nails of patients are always cut regularly to prevent them from scratching themselves and to hurt others. This is known as the 'Intervention Phase' in which strategies are designed to create a change. A person is considered an addict if they meet the criteria mentioned in DSM-5. An addiction can be of illicit drugs, alcohol, painkillers, inhalants (glue, paint etc.) and tranquillizers etc.

This is usually followed by a 'Detoxification Phase' in which the drugs are flushed out of the patient's system. It is also called the phase of medical stabilisation. This can last from 5-20 days depending upon the condition of the patient and this can take place in a medical or residential setting all under careful supervision and monitoring. In this, the patient is kept on different types of medication that mimic the effects of drugs in the patient's body. Detoxification is considered highly important. However, just detoxing is not considered enough.

After this begins the 'Treatment Phase' in which the patient is brought to the facility and is subjected to several weeks of a rigorously regimented and disciplined lifestyle. A common day may include waking up early for the morning prayers, exercise and then breakfast which is followed by medication. This may be followed by the recitation of

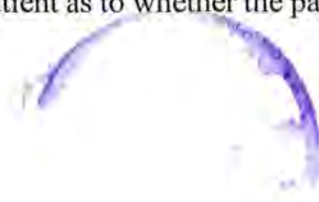
the Quran or by a visit from the social worker that keeps tabs on their history and progression. This can be followed by group lectures, lunch and prayers. Medication might be carried out three to four times throughout the day though certain centres discourage overtly relying on it. Individual therapy sessions also take place during the day and this is why most families are encouraged to call in the evenings because their caseworker or therapist could be busy during the day. Evenings are devoted to recreational activities and watching TV. Care is taken that nothing is shown that might trigger the patients. This is followed by dinner and finally the call for sleep. All of this done at the same time every day and under strict supervision. Certain days, usually the weekends, are reserved for meeting families and attending familial counselling sessions. This is also considered very important as to not create co-dependency: a phenomenon in which out of love or fear family members support the addictive behaviours of their family member going through addiction. Occasionally excursions are also planned. This process can take as long as two months and can be discontinued if funding stops.

All of this is termed Cognitive Behavioural Therapy or CBT which is, utilised by nearly all rehab centres. It is a process of making personalised strategies to break cognitive and behavioural patterns. It also involves learning new patterns of behaviour and then consolidating them. A part of this is setting goals and then trying to meet them.

While CBT is usually touted as one of the most effective forms of therapy there are several side-effects associated with it that are rarely discussed. In a study by Schermuly-Haupt *et. al.* (2018) the side-effects of CBT were discussed in which most patients reported feelings of distress, an intensification of symptoms, strains in social and family life and several other unwanted effects. This, when coupled with the equally stressful detoxification and rehabilitation procedures, leads to the entire process as being construed to be highly undesirable.

After treatment comes the 'Rehabilitation/Reintegration Phase' in which the focus is on trying to reintegrate them into society and make the transition smooth. This involves vocational training and therapy, social therapy etc.

The final phase is that of 'Discharge'. This involves a team of experts that decide, in conjunction with the families as well as the patient as to whether the patient can be sent



back home or not. Another evaluation is carried out and arrangements are made for follow-up sessions and what is termed 'aftercare' and whether treatment would be needed in another facility. Patients are encouraged to stay connected to each other and to the centres themselves to prevent the chances of relapse.

A few things must be pointed out before we can continue further:

1. As will be obvious from reading this account these centres are places where vast psychological and physical discipline is enacted on the individual body. This is done through repetitive motor patterns and intensive medication. We can see that this can be classified as biopower or the manipulation of populations in the name of the greater good.
2. These institutions resemble prisons in many ways which include, but are not limited to specialised screenings before admissions, controlling the freedom and movement of its residents, providing strict timetables and controlling who they can meet. This also ties in with the discussions of docile bodies and discipline in the previous chapter. The addict, as will be made clear in the next section, is termed as someone who lacks self-control and this unmanageable body of the addict is made docile.
3. Building up from the previous point the freedom and autonomy of the patients are taken away from them in an attempt to discipline them.
4. The families of the addicts are also incorporated into the disciplining procedure and are in fact considered a very integral part of it.
5. The patients are, ironically, kept drugged throughout their stay so that their transition is made less jarring.
6. Finally, we can see the medical gaze in operation when we study this process. A team of experts decides if someone 'qualifies' to be an addict and when that someone is considered 'healthy'. These can also diagnose other 'unhealthy' behaviours like lack of self-confidence etc. Everything can be 'cured'. The focus is on manipulating the body to ensure health. It is not addiction that is being cured but the addict.

4.2 Data Analysis

This section includes the analysis of the views of the respondents regarding addiction and rehabilitation. This section will be split into two parts: one concerning the response of the clinical staff of the rehabilitation centres composed predominantly of psychologists and psychiatrists and the second part will be the responses of the patients undergoing treatment. Different questions have been asked from both parties to try and approximate their respective narratives. The interviews from the clinical staff were conducted with both men and women and this was dependent upon their proportion in their respective rehab centres.

4.2.1 Responses from the Clinical Staff

4.2.2 Defining Addiction

Nearly everyone was of the opinion that addiction was a 'chronic disease' that effects the 'mind' that can have 'disastrous consequences' if it is not treated. It is a chronic disease because while it can be managed it cannot be 'completely cured' and it is similar to 'depression, heart diseases' etc. Addiction requires working against it 'your whole life'. It can 'come back and usually does' if care is not taken. It is a disease 'like any other and requires treatment'. Another common definition was 'compulsive behaviour that is carried out repeatedly'. Addiction is a disease which takes away 'the self-control of a person'. It changes 'regular brain functions'. It is a 'craving that effects the rewards and motivation impulses' of a person. An 'over-relying on anything' can be called an addiction. Addiction is different from 'dependence' because dependence means 'getting used to something' or developing a 'tolerance' for it. Addiction requires 'compulsive behaviour without thinking of negative consequences'. There are different 'types of addiction' and it not necessarily 'only drug-related'. 'Drug addiction is one type of addiction'. The 'compulsive use of anything' is an addiction. The 'excessive use of phones' is also an addiction. 'Gaming has recently been classified as one'.

4.2.3 Treating Addictions

The opinions were largely the same on this question as well. 'All addictions are harmful' and 'all of them need some kind of treatment' but there are some that 'have

more harmful consequences' and those 'require effective treatment'. Addictive behaviour is one of 'repetition' and constant need of 'satisfaction'. It is both 'psychological and behavioural'. There are many 'types of addictions'. Some 'women are addicted to shopping'. There are addictions such as 'video-gaming' that do not have 'as many negative consequences'. The harmful types include 'drug addiction, addiction to pornography and sex'. 'Addiction to gambling' is also a dangerous one. Some people are addicted to '*Samad Bond* and the smell of paints'. Binge eating and 'other eating disorders' are also forms of addiction and require treatment. 'Cigarette smoking' which is considered to be 'extremely common' is also a form of addiction. Women most commonly are addicted to 'painkillers and sleeping pills' and many other people are addicted to 'over-the-counter medication'. 'Treating all these problems' will lead to them living 'happier and better lives'.

4.2.4 Identifying Addicts

A drug addict is anyone that 'compulsively consumes substances' that create a 'pleasurable sensation' in the mind. Someone that can 'go to any lengths to get satisfaction'. Someone that has developed a 'high dependence on substances' and also a 'high tolerance' and needs to keep 'increasing quantity' to get the 'same feeling'. It is someone who 'if they do not get their substance' can turn 'violent and threatening'. Addiction is also 'inheritable', there might be a 'genetic tendency' towards it. A drug addict is someone who 'experiences small periods of pleasure' followed by 'feelings of guilt and paranoia'. It is not a 'stigma' to be an addict. It is a 'disease which requires treatment'. An addict is someone 'who requires immediate gratification'. An addict is someone who thinks that they have 'control over their actions but in reality do not'. An addict can be identified in many ways. They can be 'identified through clinical interviews' and 'proper medical procedures'. An addict cannot be identified 'on the basis of appearance alone'. 'They might seem very healthy and could be very educated'. Still, there are some tell-tale signs. They can be identified by 'sleeplessness and weight loss'. They can also be identified by 'red eyes which happen at the start of addiction'. They can be identified by certain behaviour such as 'being constantly irritated or annoyed', 'staying out late', 'starting to spend more than usual' or if one notices 'things going missing from the house'. They can also be identified by 'their company'. They can be identified by 'self-destructive behaviour' and by 'dishonesty and irrational

actions'. Another very common refrain was that drug addicts come from 'backgrounds of family problems' and you will always find some kind of 'pressure or trauma' in their histories.

4.2.5 Finding Addicts

Most of them were of the opinion that a very small number willingly comes to them for treatment. A lot of them are forced by their family or loved ones and are taken to these centres at times with force and with a great unwillingness on their part. The reason for this, according to them is 'the stigma that is attached to going to rehab' and the idea that 'addicts think they can control themselves but that is not true'. Addiction is a 'progressive disease' and at times it 'feels like under control'. It is important for families to 'realise that by not getting them the treatment they need' they are actually 'making the condition' worse.

4.2.6 Demographics

There is 'no one class that addicts can come from'. 'Addiction can happen to anyone and at any time'. Addicts have come from 'working class families' and from 'the elites' as well. There is a 'great use of drugs such as cigarettes and *charas* among the low class'. Kids 'see this behaviour' and 'internalise it'. So there is a 'greater acceptance' there. Among 'the elites since there is a lot more money' the access to the drugs 'is very easy'. Some claimed to have patients from 'between 14-45 years of age' and though I personally did not see children there I do not think it is entirely implausible. Most of the patients are 'young men' and the proportion of 'women is relatively smaller' but this number 'is increasing'. Women are 'usually addicted to sleeping pills and painkillers' especially after 'having children'. They 'prefer to go to psychiatric institutes instead of rehabilitation centres'. Young girls 'are also increasing in number'. 'The number of girls' that are addicts 'is rapidly increasing' especially 'among urban areas'. There is also 'a significant amount of middle-aged and older men'. Another group that is 'very common' is that of 'college and university students'. The 'access to drugs' has become very easy 'in our educational institutes'. Also, another rapidly rising form of 'urban addiction' is the use of 'painkillers and over-the-counter medication'.

4.2.7 The Need to Treat Addiction

Many were surprised that I had felt the need to ask this question. They thought the answer was obvious. 'It is a social as well as medical problem'. 'Addiction can lead to death'. 'It destroys families'. 'It is a *laanat* (a curse)'. 'Addicts can resort to committing crimes if their needs are not met'. 'It eats away at a person until there is nothing left'. One respondent told me a story of a boy 'from the elite' who was also an only son and he became a 'heroin addict'. He was a 'handsome young man' and soon because of calcium deficiency 'his teeth started to fall' and his 'parents were oblivious to this fact and he 'finally died' because of his addiction. One of them pointed out how their motto was, 'Say no to drugs and say yes to life'. 'Addicts can lose control'. Our 'youth is being destroyed' by this 'cancer'. For girls 'addiction can even lead to prostitution'. 'Addicts, especially heroin addicts, are at a greater risk of contracting AIDS'. 'Addiction prevents people from living a normal life'. It is often the case that 'addicts are also suffering from other mental illnesses' as well. 'Addiction is a threat to the well-being of people'. One respondent while insisting that it is still a medical problem and should not be stigmatised however believed that 'addiction is a moral failing' and those individuals have 'lost guidance' and show a 'weakness in character'. Addiction can 'ruin society'. Addiction 'prevents people from living productive lives'. Addiction 'destroys dreams and lives'. It is 'near impossible' to live with an addict and it is a 'nerve-wracking' experience. Addicts become 'rebellious'. Centres such as these are 'necessary so that the best care can be provided', so that 'lives can be saved '. One respondent believed it was because their centre was 'state-of-the-art and could effectively cure addiction'. Rehabilitation centres are necessary 'to prevent the spread of drug usage and to counter the stigma of going through rehabilitation' and provide people with a 'fresh start to life' and a new 'perspective about themselves'.

4.2.8 Rehabilitative Strategies

The rehabilitative strategies that are used are, with slight variations, common throughout all these centres. All of them give structure and discipline to the patient's life because 'an addict is disorderly and mismanaged', they go through counselling which is vocational, familial, social, personal and spiritual. Spiritual counselling is necessary because 'if you have a strong relationship with God you will be careful about

yourself and the rights of others'. Many utilise 'art therapy' in which patients are encouraged to 'paint or draw' as a means of 'expressing their feelings'. They are encouraged to 'write journals and identify their cravings'. A focus is on 'setting goals and then trying to achieve them' and focusing on gaining 'independence' and a 'desire to work with others'. The focus is that they 'come back as healthier and productive members of society'. Vocational training is also provided, 'so that they do not fall back into that trap'. Attempts are made to improve the physical health as well. An important rehabilitative strategy is to 'empower individuals' and help them achieve 'psychological and physical strength'.

4.2.9 Relapse

Nearly all of them agree that the chances of relapse are 'incredibly high' and that too 'immediately following the months after rehabilitation'. Addiction is a 'chronic disease and it can start again after months of inactivity'. However, a 'relapse does not mean that the treatment' has failed but rather that 'it needs to be continued for a longer period of time'. 'The longer someone spends in getting treated the better it will be for them'. 'Rehabilitation works absolutely' but it is 'possible that they slip back into the disease'. Relapses, however, are not strictly 'the responsibility of the centres' themselves. It is dependent on a whole host of other factors. To counter relapse patients are encouraged to 'stay in contact with the centres' and their 'counsellors' and to inculcate a belief in 'the Higher Power'. I was told of a person who 'had relapsed twice' but now he 'wants to get married' and is 'living a healthy life'. They do acknowledge that 'relapses are a significant problem' in 'treating addiction' and the government should work 'to prevent this easy access towards drugs'. Many complained that the 'government does not do enough for rehabilitation or mental health'. They claimed this was why 'effective aftercare programmes' and 'family counselling' was so important.

4.2.10 Addiction as a Social Problem

Many were confused as to what I meant with this question. 'Of course, it is a social problem. It actively destroys the lives of many'. 'As many as 700 people die daily as a result of heroin'. I explained as to whether they thought addiction was purely a medical problem or did its roots lie in our societies. My respondents disagreed with this contention. 'Addiction is a medical problem. Addicts attempt to flood their mind with

dopamine' which is the 'happy feeling hormone'. While the 'beginnings' of addiction are social and 'voluntary' as people try them 'to either counter some anxiety' or 'out of curiosity' or 'peer pressure' it soon turns into a medical issue. 'There are other ways to deal with stress' and this is exactly 'what we try to inculcate' among our patients. 'Only effective treatment' can help stop the addiction. 'Preventive measures' should be taken to ensure that 'drugs are not spread' and more people get addicted. Addiction can happen also because 'of what people see on TV'. It is presented as a very 'attractive thing' and this creates a 'curiosity' to try it out for themselves. It is 'widespread' and is found in the 'poorest and the most educated and well-off sections' of society. 'Poverty itself is not a cause'. 'It is a medical problem and requires medical solutions'. If that were not so 'addicts would be able to quit any time they wanted'. It is a social problem insofar as 'it affects people socially'. Addiction is 'a disease' but this 'disease is complimented' by many things. Society is a mere 'a causal' factor.

4.2.11 Social Acceptance of Drugs

They disagreed that there is a great social acceptance of drugs in our society. However, 'this is steadily increasing' and that this was happening at an 'alarming rate'. People have 'and probably will never accept drugs' but their 'usage is becoming more and more common'. There are 'certain cultural practices' that 'encourage' drug use but 'it should be brought to everyone's attention' that these are 'harmful acts' and can have 'grave consequences in the future'. 'Drugs are not something we should want to have a great acceptance in society'. One respondent considered the use of drugs at shrines to be 'disrespectful' and that the 'sacred nature of those places' was being 'polluted' by drug use. Many agreed that 'poor people' have a 'greater opportunity' to use drugs and that there might be a 'greater acceptance' towards this in that sub-section of society. This 'minimal' or 'marginal' acceptance should be countered by 'effective outreach programmes'. The police should 'do their jobs more efficiently'. This social acceptance could also be explained by the fact that 'people see them on TV and the Internet'. The 'hero' appears 'very cool' while doing it. 'They should also show the devastating effects' of the drugs themselves. The cultural acceptance 'is a mostly rural phenomenon' and you will not find it among 'urban settings'. Though amongst 'the youth' it is slowly 'gaining traction'.

4.2.12 Rehabilitation

All of my respondents maintained that they wanted to 'give the patients a normal life'. They have 'deviated' from the norm and it was their job to 'reintegrate them back into society'. All rehab centres can be called 're-socialisation' institutes. Patients are 'slowly and carefully' made to 're-enter' a 'regular life'. Addiction 'greatly disrupts life' and creates other 'ills inside a personality' like 'lying, losing control over themselves, ignoring their social responsibilities' and all this is removed via the rehabilitation process and they are made 'responsible individuals once again'. 'Rehabilitation brings people from certain death to life'. It 'equips people' with a 'new attitude' towards their lives. This brings a 'balance back to life'. It creates a 'community of people' that are 'disciplined in their lives' and 'encourage others to do so'. Addicts have 'regulated their lives' around drugs and they learn to 're-focus their energy' towards their families and themselves.

4.2.13 Analysis of Responses of the Clinical Staff

The responses of the staff will, in this section, be grouped together thematically and analysed.

The first thing that needs to be pointed out is how there is a remarkable congruence between the responses of the psychiatrists and the medical practitioners. They both seem to be saying the same things.

4.2.14 The Construction of Identity

We can see a clear narrative being formed when we go through these responses and we can start to see how a 'junkie identity' is formed by these elaborate discursive procedures. The narrative is that addiction is only a medical problem, and this is ostensibly done to remove the stigma associated with it, and can only be cured through the help of professionals. Thus the phenomenon of addiction becomes a justification for the presence of a class of professionals who could not exist without this phenomenon, to begin with. What is even more interesting is that it is this very class of professionals that decides what is and is not an addiction, how it is to be cured and has the curative process been successful or not. This narrative works in a circular way. This narrative also ignores the question as to why addiction exists. They explain it as

addiction might happen because of 'trauma' of some kind but this evades the question of why is the only recourse towards dealing with this trauma drugs. This is a political question and its answer lies probably in the fact that our society is alienating and wracked with inequalities. This also makes invisible the role of pleasure in the use of drugs. The pleasure itself is either dismissed as inauthentic or worse, dangerous. This is achieved by repeating the fact that an addict has very little self-control. Ironically, this control over the self is also taken away from the addicts during the process of treatment. Experts decide everything for them. They cannot do anything they like unless they are deemed cured by these experts.

The salient features of the junkie identity that we can derive from this are:

1. Lack of self-control.
2. Criminality.
3. Social and moral deficiencies.
4. An inauthentic relationship to the spiritual
5. Lack of balance.

We can see that these are values that are frowned upon in society. This identity is a negation of what a healthy person should be. By constructing the identity in this particular way it justifies the attempts to bring them back to a supposed normalcy. Drug rehabilitation is an attempt to normalise people. To bring deviants back into a monotonous whole. The identity is constructed in this particular way because it allows for further medical interventions in the life of the individual. It is repeatedly stressed that rehabilitation is a lifelong process. The narrative and the constructed identity work together in complementary ways. An identity created by a class of professionals is then used as a justification by the very same class to carry out curative processes.

The most important characteristic of them all is the first one. Drug addicts are repeatedly told to have no control over their actions. They are powerless in the face of their addiction. In order to satisfy their cravings, they can go to any lengths. Their own willpower is not enough and that is consumed by this disease. They need a proper way and a structured intervention for them to be able to regain this self-control. All of the other facets of this identity are derived from the first one. Since they lack complete self-control they will be willing to do anything to get what they want. They can commit

crimes, endure homelessness and the pressure of being constantly vigilant for the law-enforcement agencies. Many of them beg, steal and borrow to satisfy their cravings and have all kinds of social and moral deficiencies. They are, or rather become because of the disease, liars, irresponsible, manipulative, self-centred and recognise no limits. Their social circles are composed of people that are exactly similar. All they do recognise is their craving and the means to get them. They do not care how their actions are affecting others. The patients also cannot truly have access to the spiritual because their pleasure is derived from consuming substances and it is derived from their bodies. They cannot experience any true spirituality because they lack the self-control and the discipline to recognise it and to accept that what they are doing is wrong. Anyone who is in the pursuit of pleasure cannot experience the divine and whatever experience they do have is the result of the 'reward centres' of their brain being flooded with dopamine 'the feel-good hormone'.

I think point number four is especially intriguing. By forcing a standardised and ritualised belief in a Higher Power this identity not only creates religious individuals but also counters the idea that drugs can ever be gateways to the spiritual. The heightened spiritual fervour can be easily dismissed as a loss of self-control and authentic spiritual experiences can be considered those which have been 'consciously' done. Also, it is assumed that prayer gives *sukoon* (satisfaction) to the heart which is a true satisfaction and not dependent on consuming substances. Building a connection, it is assumed, with the divine will focus their energies more towards rehabilitation. People who are conscious of their responsibility towards the divine will always be careful of their responsibilities to themselves and to others. Ostensibly, this is done to keep them occupied and busy. However, we can see a contradiction within this identity. If it is true that addicts have no control over their actions could it also not be a possibility that they can do some good no matter how unwillingly? After all, an addict can do *anything* or for that matter absolutely nothing then why must all this negativity be associated with it. This achieves two things: One, it allows for the presence of rehabilitation centres and experts as I have already mentioned (An addict, who is a patient suffering from a disease, can do X things and hence needs to be cured) and two it justifies their presence (Because addicts can do X things they need to be cured). It is a circular narrative and employs a circular logic that revolves around and in itself.

4.2.15 Medical control

The discursive mechanism used in the construction of this identity is the Medical Gaze. The doctors and the physicians focus not on the phenomenon of addiction but on the body of the patient because it is assumed to be the place where addiction lies. The body is abstracted from the patients themselves. It is treated as something that has abused its regular functions. The social nature of addiction insofar as it is a reaction to social realities is either ignored or given a slight nod as being causal factors but not essential ones. Addiction for them is a medical occurrence and social conditions play a very little part in it. This is also reinforced by the fact that it is stressed that addiction does not have a particular demographic but that any and everyone can suffer from it. The assumption behind all of this is that if the body is cured and made strong and normal the social conditions will not matter. Despite the various reasons that have been given for starting on drugs the prognosis is the same: with a slight variation the patient needs to undergo a physical and psychiatric restructuring. This allows for the maintenance of a social status quo and rehabilitation centres makes themselves appear indispensable by the claim of restoring individuals back to a state of normalcy.

This medical gaze is also a highly generalised one. Several assumptions are already implicit in the idea of drug use. This point will be made clearer in the following paragraphs.

4.2.16 Self-regulating individuals

Biopower, as I have discussed previously, is the manipulation of populations using scientific discourses seemingly for their own benefit. Biopower not only includes external interventions but also requires the production of self-regulating individuals. This is achieved by instilling social discipline and inculcating values. The entire point of drug rehabilitation is to produce these very self-regulating citizens. Patients are repeatedly encouraged to 'confess' their problems to either themselves (in the form of journals for instance) or to medical experts in order that this self-regulation can continue. Patients are encouraged to develop 'monitoring skills' which they can use to detect the presence of relapses. A therapy that is used throughout these treatments is CBT or Cognitive Behavioural Therapy which can be simplified as to mean that if persons are made to recognise behaviours that are considered unhealthy and harmful

for themselves and are also equipped with the means to deal with those behaviours in different situations then that person will ultimately stop continuing with those behaviours. This can be used to cure almost anything. However, if we can rephrase it CBT boils down to learning self-control and learning to control yourself in situations where you otherwise or usually did not. It is mastery of the self. Ironically, this mastery is achieved by depriving people of their autonomy and freedom albeit for a limited amount of time. We encounter yet another contradiction. If addiction is a chronic, near-lifelong disease and if one of the major effects that this disease has on people is that they lose control over themselves then how can learning self-control help these individuals when it is precisely this what they lack and can, quite possibly, never gain? Drug rehabilitation should be viewed for what it is and that is an attempt to produce homogenised, standardised bodies. They clinical staff themselves agree to this. They want to 're-introduce' people to society and turn them into healthy, functioning, productive, happy people. The process involves relearning all the values that are considered good in society. Biopower is the learning of discipline and the creation of docile bodies and this is precisely what these facilities are hoping to achieve.

The families of the addicts are also made to go through these disciplinary mechanisms and, basically, fulfil the role of external surveillance. They are taught to recognise signs that an addict might relapse and also to modify their behaviour as to not 'trigger' anything. They even offer counselling, separate from the rehab process, to families who might be going through stress.

Attention, I think should be brought how all undesirable behaviours can be 'cured' by medical interventions. Social media, phones, screens, internet all can be classified as addictions and according to this narrative addictions are only curable via medical professionals. The construction of the identity of the drug addict is done through a scientific-medical discourse that claims that it is the only authentic and appropriate way of understanding addiction. This knowledge is privileged over other forms of knowledge and given a hegemonic status precisely because it is assumed it is backed by science and statistics. This identity, however, is necessary for the existence of these very professionals. By repeatedly stressing the fact that 'addiction is a disease' they allow room for themselves as if it were not a disease there would be no need for the presence of a class of experts in the first place. It is termed a 'chronic disease' because

it cannot ever be thought to completely go away and is in need of constant medical intervention and expert oversight. Thus, this model allows for the presence of a lifelong disease in the body of the addict that can flare up at any time or at least even after a long time of treatment. The addiction is a disease model is utilised also because it is the least stigmatic. Just like no one should look down on you for having a fever similarly no one should be maligned for going through addiction. This 'disease' model also allows addicts room to explain away their actions as that of a diseased and unhealthy person. This identity is constructed through a highly systemised use of language that classifies and explains the entire phenomenon. The use of this language gives it the privileged position of truth.

4.2.17 Social anxiety

A drug addict, and specifically, the body of an addict is a site where fear and anxieties about the health, hygiene and general well-being of a society can be displaced and consequently fixed. Health and hygiene both demarcate boundaries and are classificatory systems. The body of the addict falls outside both of them. There are other bodies in which these anxieties also exist like for instance the 'criminal' or the sex worker etc. but the body of the drug addict is considered as a conduit for both these acts. You can become, or rather there is a high probability of you becoming, a criminal or a sex worker if you are an addict. By curing the body of the addict you can start curing society of its 'ills' and 'diseases'. It is an attempt to reform society without actually reforming society. So what are the anxieties that are displaced on the body of the addict? Broken families, crimes, homelessness, diseases, moral failings, weak characters, lack of productivity, aimlessness, mental instability to name just a few. Addicts destroy themselves and the lives of others. They cannot lead normal lives. They lack balance and self-control. Addiction is a curse, cancer that is swallowing the youth of this country. Here another question can be asked. If addiction is a disease and addicts have no self-control how can it destroy lives and ruin families etc.? No one, to the best of my knowledge, has ever blamed cancer for creating a non-productive individual. This is not to say that cancer and drug addictions are one and the same thing but the argument can still stand. Drug addicts have enough agency to commit crimes and enough mental clarity to lie, cheat and steal but they still have no self-control? It is the same contradiction that we found in the previous section. A lot of the vocabulary around

the process of addiction and rehabilitation revolves around concepts of danger and risk. This is obvious in the language that is used to describe it.

The very name, 'rehabilitation', implies a restoration to a previously lost state. All these centres claim to bring people back to the light and give them a new life and a brighter tomorrow and a better future etc. However, the treatment process also involves inculcating in them certain values which are considered 'good' in society. Thus we have here, at the very beginning, not a scientific discovery but rather an *a priori* assumption. I have already shown how rehabilitation works on many such assumptions. So while the teaching of having a positive outlook, gaining some kind of vocational training and overcoming psychological barriers to becoming a fuller person might be good but what are the other things that are assumed? The most important thing is the element of spirituality that is introduced. One can encounter many references to 'Quranic wisdom' in these rehab centres and the patients are forced to pray even if they do not necessarily want to or believe in that sort of thing. They consider it as helpful in the recovery process and claim that it is often successful but why cannot it be something else? There are many such 'religion-based' rehabilitation centres in the world but they have not proven to be any more successful than more secular ones. The rehab centres admit to their own failures when they acknowledge that relapse is so common but as they say, and to an extent rightly so, that that is out of their control. The assumption behind all relapse centres is to take deviants and bring them back to normalcy. They, the addicts, lack balance in their lives. They cannot evenly give importance to all the aspects of life. They have shifted to the extremes and need to be, at time forcefully, brought back towards a centre of balance and wellness and they cannot do that themselves because. Once again, they do not have the self-control necessary to make positive changes in their lives.

The values of the society are never challenged or investigated but are rather enforced. It is the presence of a 'norm' that makes abnormality possible. The addicts must go through a period of normalisation precisely because they are uncomfortable truths for society and not for any qualities of their own.

4.2.18 Responses from the Patients

The narrative can be fully understood if we contrast it with the narratives of the patients themselves. A few things should be kept in mind before continuing. One, these interviews were conducted in the presence of the staff and after most of them had started going through the Treatment Phase so the authenticity of these responses should be taken with a grain of salt. Second, I could not interview any women and so these responses will be considerably one-sided. Most of the men were young, between 20-35 years of age approximately. Some were older. They were all Muslims but this was probably because these were Muslim majority areas. Most of them were addicts of heroin, cocaine and ICE or Crystal Meth. Some would also burn painkillers. Another thing is that these were all privately run rehab centres so the people mostly had occupations or their families could bear the financial burden of the treatment. They were mostly, ethnically, Potoharis or Punjabis and there was a smattering of Pashtuns as well.

4.2.19 Duration and Definition of Addiction

Many of my respondents found it hard to define addiction. For them, it was less a question of addiction and more a question of drug use itself. They would start to repeat certain clinical terms. But on further prodding they would define it as 'excessive use of drugs' is addiction. Addiction is when you 'feel a craving to do an act'. When you 'try and control yourself but fail'. 'An irresistible urge'. 'Struggling with the urge to do something'. When you 'cannot control yourself from doing something'. Something that 'you enjoy doing but cannot control yourself'. 'When you do something again and again'. The inability to 'stop using drugs' was an addiction. A lot of them did classify it as a 'disease of the mind'. Most of them had been addicts for some time now with nearly all of them using some kind of drug for over two years. Some had been addicts for 5 years. Some had started when they were children sometimes at even 12-13 years of age. However, they would still not say I have been addicted for all this time but rather I have been using drugs for this duration.

4.2.20 Starting Drug Use

Many respondents considered drug use something that they had 'seen all their lives'. Others had 'friends that introduced drugs' to them. One of my respondents claimed to have started using drugs 'to increase sexual pleasure'. He did not feel 'stimulated enough'. A lot of them maintained that the first 'drug' that they ever used was 'cigarettes' although the ages at which they started was different. Some people had even experimented with more exotic drugs like LSD and Ecstasy. One of them responded that he was under 'severe stress' because of his 'ACCA exam' and he decided to 'do cocaine' to get 'some energy'. Another one had been 'doing it off and on' for some time but it was recently that the 'amount' of it had increased. He did not 'remember how he started'. One of them had started because 'a girl had rejected him' and he took to smoking *charas* to get over his feelings of rejection. The reasons for starting using drugs were many and there was found a great deal of variety in the responses of the respondents.

4.2.21 Reasons for Drug Use

Nearly all of them agreed that they first started using because their friends used drugs. Some of them were coerced into peer-pressure to try it out but most of them had simply been curious as to 'how it feels'. One person claimed that he had, initially, thought 'cigarettes were like *qehwa* (Green Tea)' and would 'help in digestion'. Some of my respondents from the lower class said that 'some kind of drug use' had been common in his life and he had seen his father smoke '*charas* when he came back from his job as a daily labourer'. Another maintained that he would 'get extremely tired' at his job which was at a 'brick kiln' and he would use them to 'relax'. Another respondent claimed that his 'ACCA exams' were 'stressing him out' and 'his friends' used to hang out in a park where they could 'do cocaine' and would 'rub it on his gums' so that the smell wouldn't come from his clothes and his 'parents wouldn't find out'. Another respondent claimed his friends had told him that it would 'make sex more enjoyable' and that this was 'true'. If he smoked *charas* while doing it he would 'cool down'. Almost everyone had a different reason for starting drugs.

4.2.22 Experience of Drug Use

Everybody felt differently when describing their experience. However, nearly all of the experience was intensely pleasurable. They described feelings of intense euphoria. The respondents claimed to have felt 'happy', 'relaxed' and 'at ease'. One respondent claimed he would 'lay down' and would feel as if 'the sky was about to fall' on him. Some of them felt an incredible need to 'talk' while others would fall completely 'silent'. Another respondent maintained that he felt 'incredibly warm' and would feel as if he could 'run a mile'. Some would get incredibly 'hungry' and for some, the hunger would cease completely and the drugs would help them 'go to sleep'. The drugs would help them if they felt 'physical pain'. Another respondent claimed that he would start 'feeling happy' while he was only preparing his drugs and that they gave him 'all kinds of new ideas'. One respondent said that he would 'call all his friends' at '3 in the night' and tell them to 'open the gate' because he was standing outside. However, there were other experiences as well. Some would get 'angry' and their 'eyesight' would 'start to blur'. Some respondents' 'eyes would start to burn'. Another respondent claimed that life was 'boring' without the drugs and he would 'scratch his arms' to try and get the same feeling. Some would feel as if 'something was biting' their insides. Some would feel 'nauseated' and others would 'get very sad'. If they didn't get them they would 'lay down all day in severe pain'. Drugs 'felt very good at the start' but that wears off 'very quickly' and was replaced by feelings of 'drowsiness' and 'laziness'.

4.2.23 Becoming an Addict

None of my respondents claimed that they ever felt they were addicts before coming to the centres. They only realised that afterwards when they started listening to the lectures and the therapists and the doctors. One of my respondents told me how he would 'smoke 5-6 cigarettes of *charas* at a time' and then he would 'eat a whole lot and go to sleep'. If he woke up in the night 'to drink water or anything' he would roll himself another one and go back to sleep. Sometimes he would 'get feverish' and his 'head would hurt' but he did not think he was an addict. Many of the respondents maintained they could 'regulate their cravings'. Another respondent claimed that he had not had 'his injection' for a few days because he had been 'saving money' to buy it. He went to a 'park where a man was selling'. Then he realised he was short 'a hundred rupees'. He

'begged for a few hours' and then got his 'injection' and that it was a very difficult experience for him to go through. Many respondents claimed that they were only doing it 'to feel good'. The respondent who had to hide from his parents claimed that he felt he was 'always in control' and had to make a 'lot of preparations' before he went home. Now they admit that they are addicts and it is only because this aspect of their drug use was brought to their attention through rehab.

4.2.24 Getting Treatment

Only one of my respondents had come to the centre on his own and this was the second time he was undergoing treatment. The rest had all been sent there by their families. I was told this was a very common occurrence because addicts always feel they can stop at any time. Many maintained that if they had not been forced to come to a rehab centre they probably would never have come on their own. One respondent had 'started selling' the stuff from his house and 'his wife had been constantly forcing him' to go to a rehab centre when one day 'she called her relatives and brothers' and they forced him to come here. Most of their families had become weary of living with them and sent them to the centres. Many of them felt 'great embarrassment' at having to go through this but they thought it was 'ultimately good for them' as they did not want to 'waste their lives anymore'. One of my respondents claimed that his parents started to 'suspect something' when he started using more and more of his pocket-money.

4.2.25 Experience of Rehabilitation

Most of them claimed that their experience of going through rehabilitation was very good. They singled out the detox process as being the worse. Many of them claimed to have felt 'slow' and 'lethargic' when going through it. They all felt 'tired' and went through severe withdrawal symptoms. Most of them felt 'severe headaches' and 'migraines'. Some of them even complained of 'diarrhoea'. They would complain of 'body aches'. Still, they felt the rehabilitation centre had been a good experience. Their 'families' were 'happy' and they 'felt better'. I was told that many of the people they knew had been 'kicked out of their homes' and were now 'living on the roads' and so they felt 'lucky'. All of them had known people that 'had died'. They felt that a huge section of their income had been spent on drugs and this way that was 'controlled'. I was told however that many people had also tried escaping. I was also told stories about

other rehab centres in which 'patients are handcuffed to beds' and there are 'lice' everywhere. These centres were much better. A few of them claimed that they felt good that they had started 'praying five times a day'.

4.2.26 Reasons for Addiction

The reasons for addiction that they gave were that this is a 'pleasurable experience' and your body 'gets used to it'. 'You want to do it again and again'. Many claimed that this 'disease' grabs a 'hold of you' and 'you want to quit but you cannot'. It happens 'suddenly' because it is 'so enjoyable'. It becomes a 'habit'. One respondent got very agitated and claimed that the 'police were responsible'. 'They know everything that is going on and still, they do not do anything to stop it. They might beat up the person buying it but they do not stop the person selling it'. Some were of the opinion that it is because of the 'easy access to drugs'. 'In Islamabad, you can call and they will drop it off at your home'. Some even claimed to have bought theirs from outside the city from places as far as 'Sangjani'. Another respondent claimed that you become an addict because of 'environment'. 'Your friends introduce you to things like these'. It is 'very easy' to become addicted.

4.2.27 Drugs are bad

All of them agreed that drugs were bad. 'It is enjoyable' when you are doing them 'but even you soon realise that they are bad for you'. One of them claimed that I did not think 'anything could happen' to him. One of my respondents claimed that he used to 'collapse unconscious while he was walking'. Another claimed that his '*gosht* (flesh) started to rot' and that it started from his 'arms and legs' and spread to 'his chest'. Another claimed that he had to 'allocate 1000 Rs. everyday' so he could fund his addiction. Yet another told me that he had once 'sold the water motor of his house' and used the money to buy Powder. One of them had started selling drugs to 'university students' but he had stopped that after a while. Many of them felt incredibly 'embarrassed and ashamed' to be addicts and maintained that they had given 'great grief and shame' to their 'families' and felt that they had behaved 'irresponsibly'. They had 'destroyed and wasted' their lives in pursuit of this. Some were even ashamed that their families now had to 'pay for their treatment' as well but it was necessary. None of them had committed serious crimes, however.

4.2.28 Plans for the Future

Almost all of them, except a few claimed that now they were completely cured and they would not even touch a *khaali* (regular) cigarette in their lives. They did admit that it would be 'very difficult' to go back to their 'regular lives' and some were worried that they might 'start using again'. One of them wanted to volunteer at other institutions so he could help others 'going through the same thing' that he did. They wanted to stay as far away from drugs and advise others to do the same. They wanted to be 'positive and helpful' people from now on. Some of them had gone through rehab before as well and they claimed that this time they felt better and had developed a 'greater resolve' to fight it. They had stopped using for a 'couple of months' but then got back to doing them.

4.2.29 Analysis of the Responses from the Patients

4.2.30 Pleasure

The narrative of the drug users themselves is a different one from the one that we had obtained from the medical experts. For one, pleasure is at the forefront of this narrative. The entire point of drug use, and it might be motivated by anxiety or peer pressure, is pleasure and the pleasurable feelings that the drug use brought on. This pleasure is completely absent from the narratives of the clinical staff. Drugs bring within them feelings of happiness and safety. One of the biggest differences that I found between the narratives of the experts and the narratives of the patients was that of the complete absence of pleasure in the medical narratives. The experts will claim that an addict will want to use drugs again and again to release dopamine which makes them feel good but the visceral experience of pleasure, which is the whole point of using drugs is made invisible. The patients told me accounts of how amazing the drugs made them feel and how their lives seemed boring in comparison. Some even went so far as to say it was indescribable and that it can only be experienced. We can discover a few reasons for this absence in the official accounts. One, addiction is supposed to be a disease and one of its effects is this brief pleasure. Two, if pleasure is allowed into the narrative it has the potential to disrupt the entire structure because the introduction of pleasure brings with it issues of choice and rational decision making and the idea of 'loss of self-control' is put in danger. Finally, we can assume that it is absent because it is an extreme pleasure. It upsets the delicate balance that is necessary, according to them, for a healthy

life. It is not considered normal in society. So we can see that rehabilitation is based upon many assumptions that are taken to be truths.

4.2.31 Self-control

The second important that we must notice in this narrative is that of considerable self-control and planning. Despite the claims of the experts that addicts have no self-control here, we see that they could regulate their cravings. The idea that they 'cannot control' themselves needs to be investigated. Drug users are aware of the negative consequences but they still choose to do it. Not only that they form like-minded communities, must be on a constant guard from the police and must maintain a steady stream of revenue. Furthermore a very small amount of addicts actually wilfully commit themselves to treatment. This is not because of a lack of self-control but rather the opposite. They are consciously do all of these actions. If they do it they are rewarded with feelings of intense pleasure. If not they are irritable and suffer from all kinds of pain. There is an element of free-will in all of this[26].

The insistence on addicts lacking 'self-control' serves to bolster the idea that this can only be dealt with by professionals. This facet of the 'junkie identity' is a justification for the discipline of rehabilitation.

4.2.32 Presentation of the self

We can see them constantly struggling with trying to express their own ideas and experiences and repeating what had been taught to them and the answers that they were supposed to give. They can present that they have been suffering because this is what is expected of them to believe. If they do not repeat what is told to them they can never fully be classified as 'cured'. They need to present themselves as 'suffering' or fighting with a disease even though this might contradict their experience. So like in most everyday life that aspect of the self is presented that will most fit their audience and not necessarily their complete experience.

[26] For a remarkable take on this *cf.* Heyman (2017) in which he shows through statistical data that dependence voluntarily ceases after a certain amount of time.

4.2.33 Struggling with Identity

None of them actually, explicitly, call themselves addicts. They classify themselves as 'people who use drugs' and not only that but they specify which drugs they do use. The identity of the addict does not cover their entire selves. Many of them have jobs and families. Some of them are highly educated. They start to call themselves that after undergoing or during their treatment. Addicts are thus navigating the different aspects of their personal and ascribed identities. They will in front of interviewers, such as myself, and their medical staff claim to be suffering from a disease and being sick but when asked slightly different questions or in a different audience they would focus more on the thrill of doing drugs and the enjoyment it caused. The patients themselves rarely call themselves addicts and instead use the term drug users. They only ever start calling themselves that when they have undergone treatment for a long time. The reason for this is because they can only be considered cured if they repeat the terms and opinions that have been said about them and on a higher level learn to accept them. None of the patients want to call themselves addicts because the term brings with it many assumptions about what an addict is supposed to be like and about the supposed behaviour of an addict. It is a stereotype all in itself. They might accept that they are suffering from a disease and that they do not have any control over themselves but they will not admit that the phenomenon of addiction is a moral failing which the identity seems to imply. A point that needs to be understood is that the addicts bring different aspects of this identity to the forefront depending on their audience and the context. They might parrot what they are taught when asked about such things because this allows them a way to shift blame on to the disease. A common line is not that I stole for instance but that I stole under the influence of drugs. However, other aspects of their own personalities can also shine through for instance when they are talking about the pleasures of using.

4.2.34 Morality

Despite the claims of immorality a lot of them do feel intense feelings of guilt and shame. These feelings are geared towards themselves but also towards their families. The moral centres of a lot of these people remain intact. They do feel bad while stealing things or carrying on with their habits. Not a lot of them had committed any serious

crimes apart from petty theft. The supposed criminality of addicts is also an assumption and perhaps conflates co-occurrence with causality. However, all this must be quantified with the idea that perhaps they did not want to tell me this or that these feelings of guilt and shame only came after going through the rehabilitative process.

One more interesting difference is that while the patients seem optimistic about the future the experts rarely are.

4.2.35 Discipline and Control

Rehabilitation centres attempt to create disciplined and docile bodies out of unwieldy and unruly ones. They are centres for instilling general physical and psychological discipline as they 'cure' everything from addiction to shyness. Our focus has been on drug rehabilitation and the situation there is no different. Drug rehabilitation involves a process of forcing the body into a strict schedule of activities that need to be repeated, at the same time, every day and it is expected that this discipline carries over into their lives outside of the centres. Stress is laid on maintaining this discipline afterwards as well. This is done because addiction is considered an arena of 'harm and risk' and it is precisely through this perspective that the entire process takes place. Drug rehabilitation can be called 'harm reduction'. The body which is a site of 'anxiety' but also a site of 'harm' must be made manageable. The chaos must be brought to order and the body is made manageable through these processes. We have seen that a typical day involved all kinds of activities that range from exercise to meditation and compulsory lectures. The parallels between this and prisons are obvious. While rehab centres are considered voluntary and technically the patients can opt-out anytime they want it is assumed that they will stay there for the complete 3-4 month period. Some rehab centres go further and make it compulsory to stay.

A lot of an individuals' freedom or the ability to make decisions is taken away from them because, again, they cannot do that because of the overriding state of addiction that they are in. Rather, they are taught to make autonomous and conscious decisions which they could not do before and it is assumed that they will now make healthier decisions.

Another parallel can be made with schools. Strict timetables, processes of learning, breaks and recreational activities etc. Rehabilitation centres are like any other disciplinary institutions in society.

4.3 The Case Study of 'K'

It was by a happy accident that I came across K. He used to work for a friend of mine and upon hearing the topic of my research mentioned him to me. My friend mentioned that K had approached him because K wanted to be admitted to a drug rehab facility and was hoping for some kind of financial assistance in this regard. I immediately wanted to meet this man and my friend arranged for a meeting.

K was a middle-aged man around 45 years of age though he looks considerably older. He was dressed in a khaki-coloured *shalwar kameez* which had not been ironed and a faint odour of sweat exuded from them. His face, wrinkled and furrowed, always had an expression of extreme appeasement as if he was scared of offending anyone and he would smile often showing a broad set of teeth many of which were missing and several of which were decaying. He was incredibly thin. He lived in Rawalpindi and worked as a sweeper and cleaner and mostly worked for the many stores in the Jeweller's Market on Murree Road. He did not have a strict salary but a more informal working arrangement in which different storeowners gave him different amounts of money. He was married but did not have any children. His wife also worked as a maid in several houses. He had been doing this kind of work for several years now. During our conversation, he smoked incessantly. He had a warm and friendly demeanour.

He had also been an addict for most of his life.

'I've tried them all *sirji*', he said. 'Powder, *charas*, heroin, you name it!' 'Heroin I have smoked it, rolled it in a cigarette, injected it, inhaled it: everything. I used to inhale it at the start. That is how I started heroin. By inhaling it'.

When I asked him how long had he been an addict for he seemed to be confused. He had forgotten how long ago he had started. He squinted his eyes for a long time before saying that he had started smoking cigarettes at the age of 12 but it seemed like he had been doing this his entire life. He came from a working-class background and his father smoked copiously. 'He could finish a couple of *dabbis* (packs of cigarettes) in an hour'. He was introduced to cigarettes by some older boys and he would smoke on his way to school. He was careful to not let his father know. 'If he found out he would have probably beaten me with the rubber pipe'. Slowly, through this process, he was

introduced to *charas*. '*Charas* is the start of all other drugs, *sirji*. If you've started that I can guarantee it that you will move on to other things. I say this because you want that feeling to become more intense. You cannot stop at that'. His eyes would widen when he was describing these things and sometimes he would clench his fists. His father turned a blind eye towards his *charas* smoking. 'He knew. My father did. I used to come home from school with no idea where I was. I would stay out late at night and smoke as much as I could. But this was so common. Everybody was doing it. My father himself'.

It was when he was around 15 years old that he was introduced to heroin. A friend of his had brought some heroin one day saying this was a new thing and much better than *charas*. All the group started to use it but he didn't. 'When I smelt it I knew it would get stuck to my clothes and my father would immediately figure out that this was something else'. So he abstained from doing it and smoked his regular *charas* cigarette. 'When I saw their faces they seemed to be glowing and they seemed to be transported to another world'. He raised his hands and spread his fingers. 'I wanted to try it. When I saw that I wanted to try it'. The next time he decided to inhale it and he felt feelings of intense pleasure and euphoria. 'I cannot explain it *sirji* but it feels like you can take on anything. You feel warm. Think of something that you enjoy the most and it is still much more than that'.

This continued for a time before he started injecting heroin. He showed me his forearms and there were tiny scars and blisters all over them. 'The problem with heroin *sirji* is that you can do it for months and feel no intense *talab* (craving) but then one day you are suddenly hooked and you do not realise it'. He had first started injecting himself in his toe so that the marks could not be seen. His schooling had suffered all this time and he had started doing odd jobs. His father soon figured it out and the first thing he did was to get him married. 'He thought that if I had a wife I would be much more responsible'. It worked for a while. He stayed clean for a couple of months but then he started using again. 'I controlled myself for as long as I could. I worked as a taxi driver and I avoided those friends of mine'. 'You're not married *sirji*. Wives nag you all the time. There is no escaping it. Mine still does to this very day'. He started using again and since he could not meet those friends of his again he decided to make his own contacts.

'The first time that I went to a *heroini* centre was at that time. And it wasn't really a proper centre. My family and my wife's family forced me to go there. They chained you to a bed and kept you there for a few weeks. I ran away from that place the first chance I got'. After that, he went through a period of self-control again and things for him got considerably better. Soon, however, he returned to his old habits and this has been going on, on and off, ever since. He looked for different veins through which he could inject himself with. I asked him which places could one inject themselves and he replied everywhere. It can be done on the hands, on the arms, on the feet, in the neck, in the armpits, in the groin etc.

I asked him what his family thought about this. 'My father has been dead for several years now but the wife is still around and she is as irritating as ever'. His wife used to scold him every day because of his drug habit. 'I have never stolen anything' he said with a faint hint of pride. 'Nobody can call me a thief. I have always paid for it one way or another'. I asked him how he managed his expenses. He said that he always tried to earn enough money in a day so he could buy his heroin. On days he could not do that he would ask his employers for a little extra money. 'A hundred, two hundred. Most of them probably know what I use this money for. Once there was this Madam and I asked her for some money and she refused. I said okay Madam as you see fit. And she got so scared that she kept staring at me!' He started laughing in a loud voice. 'She would go in every room that I was cleaning. She was probably worried that I was either going to kill her or steal something'.

Though he told me another way of earning a little extra money. Jeweller's Market, as is obvious from the name, has many stores that sell jewellery and gold. What he used to do is that he would take a fine carpet brush and clean the floors with them making sure to take all the dust outside. There he would carefully collect all of it and keep cleaning the entrance of the stores. When all the dust is collected he takes it home and strains it for tiny particles of gold. 'Every day I earn around 200, 250 worth of gold. But now the office boys of those store owners have figured out what I do and they do not let me clean the floor. I can still pick up stuff from the outside'. Armed with this money he goes and buys his drugs. 'I remember when it used to be for 250 at *Pirwadhai*. Now it has gotten more expensive. I am extremely tired when I get home but the minute

I do it I am not tired anymore'. He has never tried selling it. 'Occasionally, I have sold some stuff to friends but that's about it'.

'Once you get it another challenge starts. You need to find out a safe place to do it. I now do it at home but before that, I had to go find places where other addicts were and which I knew were safe. I once remember I went to a boulder behind some fields and as soon as I was about to inject two boys, chasing each other, appeared from out of nowhere. I had to leave'.

I asked him how it felt if he did not get it every day. He replied that even though he did want it every day it was very hard for him to get it. 'You feel as if you are freezing and then you start sweating. You have no idea what is going to happen and your hands and feet hurt like anything. The only way to fix that is to get your fix'. Sometimes he would still have to work despite going through severe withdrawal. He said that he only takes days off because of two things. Either he has gotten his fix or he has not and he cannot carry on. 'You want to do it again and again. You have no control over this desire to do it'.

I asked him why he wanted to go to a rehab centre. 'For one, my wife is always going on about how I need to get myself fixed. Her family members come to me and try and threaten me. I want to go to a rehab centre because it has become too hard for me to do this at my age. I have been lucky. I know several people who have died. I know several people who have started to grow blisters on their bodies. Some have even contracted diseases but he has mostly been clear of it. I want to do it because it has become too expensive for me. I want to quit doing drugs finally. This is why I asked *sirji* to help me'. On asking had he ever gone to a proper rehab centre before he said yes. This would be the fourth one. I was shocked. I asked him what had happened the first three times. He replied that some centres would take you in for a couple of months and then say that you were cured and then they would let you go and every time he actually believed that he was completely cured but it turned out to be no different from the times when he would voluntarily quit taking drugs. I asked him what would be so different this time around and he answered that he was willing to try it just in case. According to him, the treatments had not worked because his life was the same. 'I meet the same people, I do the same jobs. All of this leads me back to drugs'. He did feel that if he had a child he

would perhaps be more motivated to quit because he would not want his child to be like him.

I asked him if he felt that he was sick. 'I have never felt that I was sick but I know that I am. I have tried, honestly, but this something that I have been doing all my life'. I asked him why he did it. 'For relaxation, for enjoyment, for pleasure. If it were not enjoyable why would anyone risk their health for this? It is something that needs to be done again and again'. This time he wanted to go to a proper institute so that he could finally be rid of this habit of his. 'I do not want to do it anymore'.

He told me about the experience of going through rehabilitation. 'I want to go to a proper one this time. There was one I went to and the guards would sometimes inject the patients with heroin so that they could stay their longer. It is a business after all *sirji*. In another one, the system was so lax that my friends could sneak in drugs to me and I kept doing it inside the centres! Some of the guards used to treat us very badly. They would say you are all *charsis* (*charas* addicts) and do nothing but snort your drugs every day. You want to keep the guards friendly when you're in there'.

He believed that while things have become more expensive they have become easier to access. 'You can now go to the stores and buy those tablets and you can keep buying them and nobody cares. There are so many ways of getting high (*nasha*) that you would be surprised'. 'A drug user only harms himself and no one else'. He had come up with a solution to the problem of drug addiction and he thought it was a very great idea. 'I don't know if I have come up with this myself or someone told me or I heard it somewhere but I think it is the best idea if you want to get rid of all these *nashais* (drug addicts). The idea was that the government should round up all the addicts in an area, take them to an enclosed space and then under careful government supervision and regulation allow them to take drugs. 'You can give fresh syringe so that they do not get diseases and you can regulate the amount that everyone can take in a day'. His plan was to slowly, over a long stretch of time, reduce the amount and frequency of drug intake until they get used to living without them. 'It will be very hard because your body gets used to big amounts of drugs and they will complain and go through withdrawal but they will still be getting their drugs and they will be safe and they will be given food so they will not want to leave the place and then slowly they will be completely fixed'.

He also mentioned what he thought was a problem with most drug rehab facilities. 'They make you do all those things *sirji* even though you do not want to. You are forced to do these things. It is like with children. They will walk in lines in schools all day but at *chutti time* (when school's off) they start running around and screaming'.

I will make a few remarks concerning this particular testimony as I believe it can stand on its own.

1. Once again we see that the notions of pleasure are at the forefront of the narratives of drug users themselves. They might admit that they want to stop doing it but they never deny that it is a highly pleasurable experience.
2. This narrative shows how much control and planning is required to live with addiction. It also shows how the 'loss of control' is not as simple as the official or medical narrative would have you believe.
3. The process of rehab is considered to be infantilizing in which control is taken away from the patients and handed to experts. This once again is because of the idea that addicts have no control over their selves and need external forms of control.
4. Addiction for 'K' is more of a lifestyle than a disease and a lifestyle which he can no longer support. This, however, cannot be generalised. His motivations for getting treatment show the same ambivalence of identity that we have seen in other cases.
5. There has been little to no criminal activity in this narrative though how much of that has been not told or edited remains a question.

5 CONCLUSION

There is nothing either good or bad but thinking makes it so.

Hamlet (Act 2, Scene 2)

This study began with asking the question why is addiction and specifically drug addiction a problem and evolved into an entirely different thing altogether. I have maintained that drug rehabilitation is an extension of the many disciplinary institutions and its purpose is to create docile and productive bodies and like most disciplinary institutions it predominantly fails but this failure in itself becomes a justification for its existence. It does this by creating an identity whose basis is, apparently, scientific knowledge but whose constitutive parts are a lack of self-control and a lack of balance to name just two and which classifies addiction as a brain disease. It is created by employing a medical discourse called the medical gaze in which the body of the addict is given a central focus. The narratives of the addicts themselves revolve around pleasure and an inability to identify, completely with the 'addict identity'. Two, different but mutually intersecting narratives were discovered and this brought forward a different dimension to understanding. A lot of social anxieties are also associated with the addict. While addiction itself cannot be located within the body of the addict this anxiety can. It is, thus, an embodied anxiety. This identity requires instilling social, psychological, bodily and religious discipline.

The entire process of rehabilitation can be called as the deposition of an identity over another individual. The construction of this identity requires a considerable amount of labelling and assumptions that are, apparently, backed by statistics and psychology however even within the medical model this is a highly unsubstantiated argument. What is most intriguing is that a medication that replicates the feelings of drugs is given throughout in a sanitised reproduction of their addiction. This process is highly restrictive, involves labelling and to a certain extent stereotyping and also inculcating religiosity to a certain extent.

I discussed how a discourse creates reality and then uses that reality as a means for its own justification. Similarly, drug rehabilitation centres are their own reasons and justifications. The language used to describe addiction is deliberately kept vague and

loose so much so that many everyday behaviours can be classified as addictions and they, according to this narrative, always require external interventions. Addiction, like criminality or anything for that matter, is a social construction and what we call addiction tells us more about ourselves than anything else.

This study in no way claims that addiction or at least the physiological phenomena associated with addiction do not exist or are ideological creations but rather it claims we have not fully engaged with the phenomenon of addiction and if we narrow-mindedly focus on it through a medical perspective the full range of this phenomenon and also how it is understood by the people going through it would be lost on us. This is an attempt to offer an alternative understanding of this phenomenon.

I believe that we have to move beyond simple medical models if we are to effectively understand it. An alternative perspective on drug addiction would help in creating much more effective solutions. For many addiction is a pleasurable experience, it is an unhealthy and possibly dangerous one but a pleasurable experience nevertheless and simple medical interventions or insisting on a medical interpretation of this will not lead to any different results than the ones we are getting now with massive relapse rates. A different conceptualisation of this phenomenon is needed which allows for greater autonomy and self-determination on the part of the addicts themselves and allows for a greater choice of treatment and rehabilitation.

This study does not claim to be exhaustive and further work is absolutely necessary for this fascinating topic which has implications for many disciplines and even for philosophical investigations as to the existence of free will.

REFERENCES:

Abrams, M. H. (1971). *The Milk of Paradise*. New York: Octagon Books.

Althusser, L. (1971). Ideology and Ideological State Apparatuses. In L. Althusser (Ed.), *Lenin and Philosophy and other Essays*. 85-127. New York: Monthly Review Press.

Alvarez, A. (2001). Drugs and Inspiration. *Social Research*, *68(3)*, 779-793. Retrieved November 28, 2017 from http://www.jstor.org/stable/40971911?seq=1#page_scan_tab_contents

Anderson, K. (2014, December 22). Islamic World Takes Same Drugs We Do: It Just Has Different Rules About Them. Retrieved September 12, 2017, from http://www.alternet.org/drugs/drugs-islamic-world-same-substances-different-rules

Around 7 million drug addicts in Pakistan, Senate told. (2015, July 06). Retrieved November 28, 2017, from https://www.dawn.com/news/1192715

Baconi, D. L, Bălălău, C., Ciobanu, Anne-Marie, Cobani, O. D., Negrei, C. &. Vlăsceanu, A. M. (2015) Current Concepts on Drug Abuse and Dependence. *Journal of Mind and Medical Sciences*. *(2)1*, 18- 33. Retrieved November 28, 2017, from http://scholar.valpo.edu/cgi/viewcontent.cgi?article=1008&context=jmms

Becker, H. (1953). Becoming a Marihuana User. *American Journal of Sociology, 59*(3), 235-242. Retrieved from http://www.jstor.org/stable/2771989

Bourgois, P. (2000). Disciplining Addictions: The Bio-politics of Methadone and Heroin in the United States. *Culture, Medicine and Psychiatry, 24,* 165-195. Retrieved September 12, 2017, from http://philippebourgois.net/Culture%20Medicine%20Psychiatry%20Methadone%202000.pdf

Bourgois, P., & Hart, L. K. (2010). Science, Religion and the Challenges of Substance Abuse Treatment. *Substance Use and Misuse, 45(14),* 2357-2410. doi:10.3109/10826081003747611

Buchman, D. Z., Illes, J., & Skinner, W. (2010). Negotiating the Relationship Between Addiction, Ethics, and Brain Science. *AJOB Neuroscience*, *1*(1), 36–45. Retrieved, September 14, 2017, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2910924/

Butler, J. (1989). Foucault and the Paradox of Bodily Inscriptions. *The Journal of Philosophy, 86*(11), 601-607. Retrieved from http://www.jstor.org/stable/2027036

Connell, R. (1987). The Body and Social Practice. In *Gender and Power: Society, the Person and Sexual Politics* (1st ed., pp. 66-90). Cambridge: Polity.

Correspondent, T. N. (2017, March 01). 8m addicts in Pakistan, and counting. Retrieved November 28, 2017, from https://www.dawn.com/news/1317663

Csordas, T. (2011). Cultural Phenomenology: Embodiment: Agency, Sexual Difference, and Illness. In F. E. Mascia-Lees (Ed.), *A Companion to the Anthropology of the Body and Embodiment* (1st ed., pp. 137-156). Malden: Wiley-Blackwell.

Curtis R., Wendel T. (2000) Toward the development of a typology of illegal drug markets. In M. Hough & M. Natarajan, (Eds.) *Illegal Drug Markets: From Research to Policy.* 121–52. Monsey, NJ: Criminal Justice Press

Dean, M. (1999). *Governmentality: Power and Rule in Modern Society*. Los Angeles: SAGE.

Degenhardt, L. Hall, Lynskey, & M. Warner-Smith. (2004) Illicit Drug Use. In M. Ezzati, A. D. Lopez, A. Rodgers & C. J.L. Murray (Eds.) *Comparative Quantification of Health Risks Global and Regional Burden of Disease Attributable to Selected Major Risk Factors. Volume 1.* 1109-1176. Geneva: World Health Organisation (WHO). Retrieved Septemeber 12, 2017 from http://www.who.int/publications/cra/chapters/volume1/1109-1176.pdf

Dijk, T. A. (1993). Principles of Critical Discourse Analysis. *Discourse & Society, 4*(2), 249-283. doi:10.1177/0957926593004002006

_________ (1995). Aims of Critical Discourse Analysis. *Japanese Discourse, 1*, 17-27. Retrieved December 10, 2017, from http://discourses.org/OldArticles/Aims%20of%20Critical%20Discourse%20Analysis.pdf

_________ (1997) Discourse as Interaction in Society. In T. A. van Dijk (Ed.) *Discourse as Social Interaction. Discourse Studies: A Multidisciplinary Introduction, Volume 2,* (pp. 1-37). London: Sage.

Djite, P. G. (2006). Shifts in Linguistic Identities in a Global World. *Language Problems and Language Planning,30*(1), 1-20. doi:10.1075/lplp.30.1.02dji

Drug Use in Pakistan (Rep.). (2013). Retrieved November 28, 2017, from https://www.unodc.org/documents/pakistan/Survey_Report_Final_2013.pdf

drug. (n.d.). *Dictionary.com Unabridged.* Retrieved December 5, 2017, from Dictionary.com website http://www.dictionary.com/browse/drug

Fairclough, N. & Wodak, R., (1997). Critical Discourse Analysis. In T. A. van Dijk (Ed.), *Discourse as Social Interaction. A Multidisciplinary Introduction. Volume 2*, (pp. 258 284). London: Sage.

Forgas, J. P. & Tajfel, H. (1981). Social Categorization: Cognitions, Values, and Groups. In J.P. Forgas (Ed.), *Social Cognition: Perspectives on Everyday Understanding,* Academic Press, New York, pp. 113–140.

Foucault, M. (1973). *Birth of the Clinic: An Archaeology of Medical Perception* (A. S. Smith, Trans.) (Original work published 1963)

__________ (1977). *Discipline and Punish: The Birth of the Prison.* (A. S. Smith, Trans.) (Original work published 1975)

_________ (1978). *The History of Sexuality: The Will to Knowledge (Vol. 1).* (Robert Hurley, Trans.) (Original work published 1976)

__________ (1980). *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (C. Gordon, Ed.). Harvester Books.

__________ (1982) The Subject and Power. In H. L. Dreyfus & P. Rainbow (Eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics*. 2nd edition. Chicago: University of Chicago Press.

__________ (1988). Technologies of the Self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the Self: A Seminar with Michel Foucault* (pp. 16-49). Univ. of Massachusetts Press.

Frembgen, J. W. (2012). *At the Shrine of the Red Sufi: Five Days and Nights on Pilgrimage in Pakistan.* Karachi: Oxford University Press.

Galbin, A. (2014). An Introduction to Social Constructionism. *Social Research Reports,26*, 82-92. Retrieved August 8, 2018, from https://www.researchgate.net/publication/283547838_AN_INTRODUCTION_TO_SOCIAL_CONSTRUCTIONISM.

Gaventa, J. (2003). *Power after Lukes: An Overview of Theories of Power since Lukes and Their Application to Development.* Brighton: Participation Group, Institute of Development Studies. https://www.powercube.net/wp-content/uploads/2009/11/power_after_lukes.pdf

Gerhart, D., Tarragona, M., & Bava, S. (2007) A collaborative approach to research and inquiry. In H. Anderson & D. Gehart (Eds.), *Collaborative therapy: Relationships and conversations that make a difference* (pp. 367-390). London, UK: Routledge.

Geschiere, P. & Meyer, B. (1998). Globalization and Identity: Dialectics of Flow and Closure. Introduction. *Development and Change 29.* 601-615. doi:10.1111/1467-7660.00092

Gowan, T., & Whetstone, S. (2012). Making the criminal addict: Subjectivity and social control in a strong-arm rehab. *Punishment & Society, 14(1), 69-93.* doi:10.1177/1462474511424684

Graham, L. J. (2005, November 21). Discourse Analysis and the Critical Use of Foucault. In *The Australian Association of Research in Education Annual Conference.* Retrieved December 10, 2017, from https://eprints.qut.edu.au/2689/1/2689.pdf

Green, N. (2014). Breaking the Begging Bowl: Morals, Drugs, and Madness in the Fate of the Muslim Faqīr. *South Asian History and Culture, 5(2)*, 226-245. doi:10.1080/19472498.2014.883761

Greenhalgh, S. (2001). *Under the Medical Gaze: Facts and Fictions of Chronic Pain.* Berkeley: Univ. of California Press.

Gubrium, J. F., & Holstein, J. A. (2008). Narrative Ethnography. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of Emergent Methods* (pp. 241-264). New York, NY: Guilford Press.

Hall, S. (1992) The West and the Rest: Discourse and Power. In: H. Stuart & G., Bram (Eds.): *Formations of Modernity*, 275-332. Oxford.

Hamarneh, S. (1972). Pharmacy in Medieval Islam and the History of Drug Addiction. *Medical History, 16(03),* 226-237. doi:10.1017/s0025727300017725

Hayter, A. (2009). *Opium and the Romantic Imagination.* London: Faber and Faber.

Hammersley, R. (2017). How and Why Addiction is Socially Constructed. 1-18. doi:10.13140/RG.2.2.17828.48008

Heather, N. (2017). Q: Is Addiction a Brain Disease or a Moral Failing? A: Neither. *Neuroethics, 10*(1), 115–124. http://doi.org/10.1007/s12152-016-9289-0

Heyman, G. M. (2017). Do addicts have freewill? An empirical approach to a vexing question. *Addictive Behaviors Reports, 1-9.* doi:10.1016/j.abrep.2017.02.001

Horn, D. G. (2005). *Anthropologies of Modernity: Foucault, Governmentality, and Life Politics* (pp. 135-158) (J. X. Inda, Ed.). Malden, MA: Blackwell Pub.

Howarth, D. R. (2000). Saussure, Structuralism and Symbolic Systems. In *Discourse* (pp. 16-35). Buckingham: Open University Press.

Hsu, H. L. & Lincoln, M. (2007). Biopower, Bodies . . . the Exhibition, and the Spectacle of Public Health. *Discourse 29(1)*, 15-34. Wayne State University Press. Retrieved November 28, 2017, from https://muse.jhu.edu/article/252905/pdf

Hunt, G., & Barker, J. C. (2001). Socio-cultural anthropology and alcohol and drug research. *Social Science & Medicine, 53(2), 165-188.* doi:10.1016/s0277-9536(00)00329-4

Hunt, G. P., Evans, K., & Kares, F. (2007). Drug Use and Meanings of Risk and Pleasure. *Journal of Youth Studies, 10*(1), 73-96. doi:10.1080/13676260600983668

Identity. (n.d.). Retrieved December 05, 2017, from http://www.dictionary.com/browse/identity

Keane, H. (2008). Foucault on Methadone: Beyond Biopower. *International Journal of Drug Policy, 20*(5), 450-452. doi:10.1016/j.drugpo.2008.10.005

Kristensen, K. S. (April 2013). *Michel Foucault on Bio-power and Biopolitics* (Unpublished master's thesis). University of Helsinki. Retrieved December 9, 2017, from https://helda.helsinki.fi/bitstream/handle/10138/39514/Kristensen%20Masters%20Thesis.pdf?sequence=3

Kroskrity, P. V. (1999), Identity. *Journal of Linguistic Anthropology 9.* 111–114. doi:10.1525/jlin.1999.9.1-2.111

Larrain, J. (1988). Lukács' Concept of Ideology. *Lukács Today Sovietica, 51*, 52-69. doi:10.1007/978-94-009-2897-8_5

Luyckx, K., Schwartz, S. J., & Vignoles, V. L. (2011). Introduction: Toward an Integrative View of Identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of Identity Theory and Research* (1st ed., Vol. 1, pp. 1-30). New York: Springer-Verlag. doi:10.1007/978-1-4419-7988-9

Manderson, D. (1995). Metamorphoses: Clashing Symbols in the Social Construction of Drugs. *Journal of Drug Issues, 25(4)*, 799-816. doi:10.1177/002204269502500410

Mason, J. (2002). *Qualitative Researching* (2nd ed.). London: SAGE.

May, C. (2001). Pathology, Identity and the Social Construction of Alcohol Dependence. *Sociology,35*(2), 385-401. doi:10.1017/s0038038501000189

Moen, T. (2006). Reflections on the Narrative Research Approach. *International Journal of Qualitative Methods*, 5(4), 56-69. Retrieved May 7, 2018, from http://journals.sagepub.com/doi/pdf/10.1177/160940690600500405

Moore, D. (2008). Erasing Pleasure from Public Discourse on Illicit drugs: On the Creation and Reproduction of an Absence. *International Journal of Drug Policy, 19*(5), 353-358. doi:10.1016/j.drugpo.2007.07.004

National Anti-Narcotics Policy (Rep.). (2010). Retrieved September 12, 2017, from http://www.narcon.gov.pk/narconweb/userfiles1/file/Policies/National%20AntiNarcotics%20Policies/Policy%20Revised.pdf

O'Malley, P., & Valverde, M. (2004). Pleasure, Freedom and Drugs: The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption. *Sociology, 38*(1), 25-42. doi:10.1177/0038038504039359

Paiva, V. L. (2008). Narrative research: An introduction. *Revista Brasileira De Lingüística Aplicada (RBLA)*, 1-5. Retrieved May 7, 2018, from http://www.scielo.br/pdf/rbla/v8n2/en_01.pdf

Pilcher, J., & Whelehan, I. (2004). Body. In *Fifty Key Concepts in Gender Studies* (pp. 6-10). SAGE.

Rainbow, P., & Rose, N. (2006). Biopower Today. *BioSocieties, 1*(2), 195-217. doi:10.1017/s1745855206040014

Race, K. (2008). The Use of Pleasure in Harm Reduction: Perspectives from the History of Sexuality. *International Journal of Drug Policy, 19*(5), 417-423. doi:10.1016/j.drugpo.2007.08.008

Radcliffe, P., & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. *Social Science & Medicine, 67(7)*, 1065-1073. doi:10.1016/j.socscimed.2008.06.004

Reinarman, C. (2005). Addiction as accomplishment: The discursive construction of disease. *Addiction Research & Theory, 13*(4), *307-320.* doi:10.1080/16066350500077728

Saniotis, A., & Henneberg, M. (2012). Craving for Drugs Is a Consequence of Evolution. *Anthropos, 107(2)*, 571-578. Retrieved from http://www.jstor.org/stable/23510061

Scheper-Hughes, N., & Lock, M. (1987). The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly, 1(1), new series,* 6-41. Retrieved from http://www.jstor.org/stable/648769

Schermuly-Haupt, M., Linden, M., & Rush, A. J. (2018). Unwanted Events and Side Effects in Cognitive Behavior Therapy. *Cognitive Therapy and Research, 42(3), 219-229.* doi:10.1007/s10608-018-9904-y

Seldin, N. E. (1972). The Family of the Addict: A Review of the Literature. International Journal of the Addictions,7(1), 97-107. doi:10.3109/10826087209026764

Sheridan, A. (1980). *Michel Foucault: The Will to Truth.* Routledge.

Singer, M. (2012). Anthropology and addiction: An historical review. *Addiction, 107(10), 1747-1755.* doi:10.1111/j.1360-0443.2012.03879.x

Stevens, A. (2007). When two dark figures collide: Evidence and discourse on drug-related crime. *Critical Social Policy, 27(1),* 77-99. doi:10.1177/0261018307072208

Sussman, S., & Sussman, A. N. (2011). Considering the Definition of Addiction. *International Journal of Environmental Research and Public Health, 8(12)*, 4025-4038. doi:10.3390/ijerph8104025

Szasz, T. S. (1984). *The Therapeutic State: Psychiatry in the Mirror of Current Events*. Buffalo, NY: Prometheus Books.

Titscher, S. (2000) *Methods of Text and Discourse Analysis. In Search of Meaning.* Sage Publications.

UNODC Annual Report (Rep.). (2015). Retrieved September 12, 2017, from https://www.unodc.org/documents/AnnualReport2015/Annual_Report_2016_WEB.pdf

Versluys, E. (2007). The Notion of Identity in Discourse Analysis: Some 'discourse analytical' remarks. *RASK: internationalt tidsskrift for sprog og kommunikation, 26*, 89-99. Retrieved December 5, 2017, from https://static.sdu.dk/mediafiles/1/6/4/%7B164DE69B-9E30-499B-B5F9-C6264E6293ED%7DEline%20Versluys,%2089-99.pdf.

Vrecko, S. (2016). Risky Bodies, Drugs and Biopolitics. *Body & Society, 22(3)*, 54-76. doi:10.1177/1357034x16644509

Waugh L., Catalano T., Masaeed K., Hong Do T., Renigar P. (2016) Critical Discourse Analysis: Definition, Approaches, Relation to Pragmatics, Critique, and Trends. In Capone A., Mey J. (Eds.) *Interdisciplinary Studies in Pragmatics, Culture and Society. Perspectives in Pragmatics, Philosophy & Psychology, Vol. 4*. Springer, Cham.

Weedon, C. (1996). Discourse, Power and Resistance. In *Feminist Practice and Poststructuralist Theory* (2nd ed., pp. 104-132). Wiley-Blackwell.

Wodak, R. (1996) *Disorders in Discourse*, New York.

World Drug Report 2017 (Rep.) (2017, May). Retrieved December 5, 2017, from United Nations Office on Drugs and Crime website: https://www.unodc.org/wdr2017/field/Booklet_1_EXSUM.pdf

Wright, J. (2009). Biopower, Biopedagogies and the obesity epidemic. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'Obesity Epidemic': Governing Bodies* (pp. 1-14). New York: Routledge.

Yaqub, F. (2013). Pakistan's Drug Problem. *The Lancet, 381(9884)*, 2153-2154. doi:10.1016/s0140-6736(13)61426-9

Zizek, S. (2009). *The Sublime Object of Ideology*. London: Verso.

ANNEX1: INTERVIEW GUIDE

FOR THE STAFF:

1. How would you define addiction?
2. Do all forms of addiction need be treated?
3. What is a drug addict? Can addicts be identified?
4. How do addicts usually reach you?
5. Do the majority of them come from a particular demographic?
6. Why does drug addiction need to be treated? Why do we need centres such as these?
7. What are the rehabilitative strategies you employ to treat addiction?
8. How do you deal with relapse?
9. Is addiction a social problem? Why does addiction happen?
10. What are your opinions on the great social acceptance of drugs?
11. What are addicts rehabilitated into in your institution?

FOR THE PATIENTS:

1. How long have you been an addict? How would you define addiction?
2. How did you first start using drugs?
3. Why did you start using drugs?
4. How was the experience of using drugs?
5. How did you first realise you were an addict?
6. How did you first decide to get treatment?
7. How has your experience been so far?
8. Why does addiction happen in the first place?
9. Would you consider drugs as bad things?
10. What do you think will happen after you leave this institution?