Introduction

“Mind Food”

The first time I heard psychopharmaceuticals described as “mind food” was during a psychiatric ward round in Calcutta. Dr. Roy, one of the city’s most illustrious psychiatrists, invited me to join him at the Advaitananda Seva Prathishthan, a general hospital run by a Hindu philanthropic organization. Located in a busy part of south-central Calcutta, the Advaitananda Hospital attracts patients from all over the metropolitan area. Founded in the first years after Indian Independence, the hospital caters primarily to low-income patients, but richer people also come because of the good reputation of its staff. As in most charitable hospitals in India, the spatial boundaries of the Advaitananda Hospital are minimal. Relatives are expected to feed and look after family members while they are in the hospital; hence most wards can be entered at all hours. Most psychiatric clients are seen in the general outpatient department on the ground floor of one of the hospital’s wings. In the middle of a large hall are two rows of wooden benches where patients can sit while waiting to see a doctor. Cubicles for consultation form two long rows on each side of the hall. During daytime hours, the outpatient department (OPD) is packed with hundreds of patients and their relatives, as well as nursing staff and medical representatives. Even with open windows and dozens of fans swirling overhead, the hall is always
hot and stuffy. Patients of all medical specialties share the floor, so it is impossible to tell who is waiting for what kind of doctor. Beyond the OPD, a few beds in the hospital’s upper wards are devoted to acute psychiatric cases. Patients who stay there are only admitted for a few days; the aim is to discharge them quickly because of staff and space limitations. A pool of psychiatrists gives a few hours per week of free service (seva), while maintaining for-profit chambers elsewhere in the city. To do seva not only improves the doctors’ prestige and good karma but also increases their stock of patients and the number of drug prescriptions written. In the OPD, two or three psychiatrists are available in the mornings. Each doctor’s shift lasts for about two hours. The doctors practice separately from one another and usually leave immediately after their shift ends. Senior psychiatrists like Dr. Roy also use the hospital as a venue for teaching sessions.

A plump Bengali in his late forties, Dr. Roy regularly gathered an entourage of up to fifteen psychiatrists at these teaching sessions. Most of them were recent college graduates with work experience in India, yet some also had several years’ experience in the United Kingdom or in the United States. These doctors came to see Dr. Roy practice because he had a reputation of being one of the most successful psychiatrists in West Bengal. Among his activities was the foundation of an NGO for mental illness awareness, a place where patients come together to talk about their problems in the fashion of Euro-American self-help groups. He was a favorite of pharmaceutical companies, who propped up his activities with money and drug supplies. He was respectfully addressed as “sir” even by doctors who were barely younger than he.

Dr. Roy was very skilled in establishing rapport with patients. He always touched his patients with his hands during consultations (and he often held my arm while I interviewed him). In a hierarchical society where even a handshake between a doctor and a patient is uncommon, Dr. Roy’s tactile care was strikingly different. He was also good at talking to patients and in responding to their concerns. He could simplify psychiatric concepts through earthy metaphors that tapped into popular ideas of body and health. Dr. Roy’s expression for psychopharmaceuticals was moner khabar, Bengali for “food (khabar) eaten by the mind (mon).” Mon and khabar are both common words, but the combination of “mind” and “food” in moner khabar is a neologism. Moner khabar was
coined with the intention of making psychotropic drugs acceptable to those hesitant to take them. “Mind food” is a psychiatric artifice.

Bengali *khabar* is “food” in the specific sense of a cooked edible substance for everyday human sustenance, as opposed to terms for raw food, spoiled food, or food offered to a deity. The related verb *khaoya*, “to eat,” refers primarily to the ingestion of food but also includes other forms of ingestion: “taking medications” (*osudh khaoya*) is indistinguishable from “eating medications.” *Mon* is the Bengali term for mind, heart, mood, affection, memory, desire, concentration, and subjective opinion. It is etymologically related to Sanskrit *manas* (from *matih*, “thinking”), Greek *menos*, Latin *mens*, and English “mind.” In German, the cognate word *Minne* meant “love” and “affectionate memory” in courtly love songs of the Middle Ages. Bengali *mon* is distinct from both the physical brain (*dimak*) and the head (*matha*), and does not have a precise location in the body. When people use the term, they either point to the solar plexus, point to the forehead, or move their hand between both points. *Mon*’s fluid localization between head and heart motivates the English translation “heart-mind” (Desjarlais 1992: 27; Kohrt and Harper 2008), a term coined to reflect that *mon* is not the rational, analytical counterpart to the irrationally feeling body, as in the Cartesian tradition. Although the concept of *mon* (or its equivalents) is not exclusive to Bengali language and culture, it is more commonly used in Bengali than in other Indian languages. *Moner khabar* literally means “food to be eaten by the mind,” and cannot be translated into English as “food for thought” or “intellectual stimulation.”

Dr. Roy said it was important to make patients understand and accept prescriptions. It was always possible to write drugs without explanation, but he found that a few words went a long way in increasing adherence. *Moner khabar* was a key expression that he used to link psychopharmaceuticals to food. Similar expressions were “vitamins” and “brain nutrients.” To patients, Dr. Roy said that the brain needed sufficient food to think properly, just as the stomach needed food to keep the body going. Most people had enough food for the brain, but some had too little. A starved brain made them moody, fickle, and forgetful. These people could be easily helped by extra nutrients from the outside. The pills that he prescribed worked for the mind like extra nutrition worked for the physical body.
Dr. Roy also used “diabetes” and “insulin injections” as parallels, especially toward patients who needed to be on psychopharmaceuticals for a long time. Healthy people could digest sugar without the aid of medicines, but some people needed a regular supply of insulin from the outside to do so. In the same way, some people needed to take drugs regularly to allow the mind to function. “Insulin” made sense to many patients because diabetes is now a widespread disease, especially in the cities. But even “insulin” did not have the same resonance with patients as “food.” The meaning of “insulin” was only understood by patients with some level of education. “Food,” however, made sense to everyone. As one of Dr. Roy’s followers, Dr. Bose, pointed out, “if there’s an uneducated person, he will not understand ‘insulin.’ But moner khabar is the most effective. They can very easily accept.”

On one of the visits to the inpatient ward, Dr. Roy and his entourage saw a 63-year-old monk of the Ramakrishna Mission. He had been sent to the Advaitananda Hospital by his superiors during a severe episode of “manic depression.” When the group of doctors arrived, the swami (an honorific title for Hindu monks) was clad in saffron-colored robes and sat upright in his bed reading a book. Dr. Roy had already been treating the swami for the past several years and was on familiar terms with him.

After Dr. Roy had greeted him and asked about how he was feeling at the moment, the swami said that he was feeling good and that he would prefer to leave the hospital. Asked what he was reading, the monk showed us the cover of a little book by Vivekananda (1863–1902), who founded the Ramakrishna Mission in 1897. (Vivekananda’s works are widely available in cheap paperbacks.) The monk read out a passage from “Lessons in Raja-Yoga,” where Vivekananda discusses the “force of thought” in relation to health. Sensory perception makes “the particles of the brain fall into a certain position like the mosaics of a kaleidoscope.” Conjuring memories of past perceptions means “resetting these particles.” As in perception, a state of bodily and mental health is also a constellation of particles, while disease comes from the particles in disarray. Similar to an act of remembering, powerful thought can rearrange these particles in a healthy order: “In case of illness the memory of the ideal of health may be roused and the particles re-arranged in the position into which they fell when healthy.” Once the mental work is done, the body will “follow the brain” and get well again. From this supremacy
of the mind over the body, Vivekananda extrapolates that medicines, as gross substances ingested from the outside, cannot cure the body without the support of the mind. All that drugs do is to prop up the internal healing process that is ruled by the mind. The best medicines stir up this endogenous healing force: “There is only one power to cure the body, and that is in every man. Medicine only rouses this power.”

By reading this passage, the swami wanted to challenge Dr. Roy to a disputation about the powers of the mind over the powers of medicine, but the psychiatrist only smiled politely and told his followers to note the book title and to read it in their own time. He then asked if the swami had been taking his medication as prescribed. With an oblique glance to the group of psychiatrists, Dr. Roy pointed to a line in the swami’s medical record that said that he had not been regularly taking his medication (a mixture of drugs, predominantly fluoxetine and lithium) and that this was one of the reasons for the severity of the current episode. After a few more words about the swami’s health, he said that it was now fine to leave and to return to Belur Math, the Order’s head monastery on the left bank of the Hoogly (Calcutta’s largest river, a distributary of the Ganges). Dr. Roy further reminded him that he had a regular shift at a private clinic near Belur Math and that they should keep in touch. But he also urged him to stick to the course of drugs prescribed. “What is wrong with taking drugs?” he asked. The pills were simply “nutritional supplements” for the brain. Just as anyone should take vitamins when normal food was not enough, anyone should take food supplements for the brain when nutrition was deficient. The prescribed medicines were moner khabar, and objecting to them was as unwise as objecting to taking vitamin C while having the flu.

When I later asked Dr. Bose, one of the younger doctors around Dr. Roy, about the meeting with the monk, he said that this was an unusually sophisticated discussion thanks to the relative familiarity between the two. That the monk disputed the efficacy of drugs, that he quoted from philosophical tracts, that he spoke about the mind rather than the body, all this was different from typical consultations. But it was typical that Dr. Roy tried to convince the patient to take the prescribed drugs. Compliance was much better if the patient agreed with the doctor’s explanation. Part of any successful psychiatric consultation was to make patients understand psychopharmaceuticals in a language that made
immediate sense to them, and nothing made more sense to Indian patients than parallels to food. To develop this language was a great skill of Dr. Roy: “What Dr. Roy does—I also follow the same trend—he says that the brain requires particular foods, nutrients.” Moner khabar was strategically coined by the psychiatrists and is not an expression used in general parlance. As Dr. Bose said, “food”—and the lack of it—nicely illustrated the causes of mental disturbances and the action of psychopharmaceuticals, overcoming patients’ stigmatizations and making them more conscientious in their required daily intake. Moner khabar was so intuitively convincing because it translated biochemical transactions between brain synapses into food transactions: as Dr. Bose put it, “There are some people who have these nutrients, which help them to speak properly, to express their affects properly. But there are some other persons who don’t have these nutrients in their brain, so they cannot do these things properly, so we have to supply them nutrients from outside. Our drugs are like these nutrients.”

Although the parallels between food and psychopharmaceuticals were strongly established in the group around Dr. Roy, not all psychiatrists were equally ready to simplify—or dissimulate—psychiatric models for their lay clients. Indeed, in the hundreds of consultations that I witnessed, psychiatrists’ explanations of disease etiologies and drug effects were either absent or kept to a bare minimum. Psychiatrists focused on how the drugs were to be taken, for example, whether before, during, or after meals, in the mornings, or in the evenings. Usually psychiatrists did not need to explain more because neither patients nor their relatives asked. Even when psychiatric patients explicitly focused on digestion themselves, the doctors tended to rely on professional authority rather than on echoing lay preconceptions (see Ecks 2010b: 157-58). While moner khabar is not an expression actually used by every psychiatrist in Calcutta, it can potentially be used by any of them if they want to talk in a language that makes sense to patients.

This ethnography explores how medications, especially mood medications, are understood and used in Calcutta. It starts from biopsychiatric treatments, traverses popular health practices, explores alternative medications prescribed in Ayurveda (the grand tradition of Indian medicine) and in homeopathy (the second most popular type of medicine in Bengal), and finally returns to psychiatry. The key argument is that
patients’ suspicions of psychopharmaceuticals are based on suspicions of biomedicine’s “magic bullet” model of drug effects. Chapter 1 discusses popular notions of health, with a focus on perceptions of how different drugs are digested and on the humoral balance between the “hot” belly and the “cool” mind. Chapter 2 analyzes Ayurvedic practices in Calcutta and shows how, in traditional Indian medicine, food is medicine and medicine is food. Chapter 3 presents Calcutta homeopaths, emphasizing their self-proclaimed ability to target patients’ “nerves.” The influential position of homeopathy in Bengal helps us to understand lay suspicions of biomedical drugs as expensive, full of toxic side effects, and capable only of superficial “suppression” of illness symptoms. Chapter 4 unfolds how Calcutta psychiatrists position themselves vis-à-vis popular “superstitions” about psychopharmaceuticals, general physicians, practitioners of nonbiomedical treatments, and the pharmaceutical industry. It reveals how psychiatrists try to manage “doctor-shopping” and overcome non-adherence to treatments. It focuses on psychiatrists’ perceptions of food, on “Bengali bowel obsession,” and on how neurochemical imbalances are likened to humoral imbalances. The concluding chapter returns to “mind food,” showing how psychiatrists are both trying to counter non-biomedical notions of drug effects and the biomedical model of short-term targeted action itself.

An Anthropology of Pharmaceuticals

Why does “mind food” resonate with Bengali notions of mind, food, belly, digestion, and plural medications? The problem explored in this book seems easily described: there are drugs that are meant to make someone feel better, happier, calmer. The doctors who prescribe them believe that they work well, whereas the patients may not be so sure and may try to refuse taking them. The doctors face a dilemma: should they explain the medications in the same medical terminology in which they themselves have learned about them and ensure patients’ “informed consent”? Or should they, as far as possible, avoid friction and describe the pills in a manner that makes intuitive sense to patients? In other words, should doctors insist on scientific purity or opt for a persuasive story? To answer this, we must investigate where patients and doctors agree or disagree; how ideas change through persuasion, dissimulation, or deception; and how new
metaphors, such as “mind food,” are attempts to overcome these divisions. “Mind food” is a form of psychiatric language that appropriates popular discourses to overcome resistance (Applbaum 2006; Kitanaka 2011).

On a primary level, this requires an ethnography of healer/patient relations. Many studies have been written on the topic, some emphasizing successful persuasion (Csordas 2002; Liebert and Gavey 2009), some emphasizing patients’ resistance and nonadherence (Pound et al. 2005; Whitmarsh 2009). The encounter between a healer and a patient can be approached as an encounter between different sets of presuppositions (Helman 2007: 122-55). These presuppositions entail, more or less explicitly articulated, what caused the illness symptoms, what would happen without medical intervention, what procedure seems most appropriate, and when an improvement of the problem can be expected. These presuppositions have been analyzed by medical anthropologists as “explanatory models” (Kleinman 1980: 104-18).

Studies of explanatory models usually assume that healer/patient encounters are temporal sequences. First, people perceive illness symptoms; then they try to make sense of the symptoms; then they seek medical help; then a doctor gives a diagnosis; then, on the basis of that diagnosis, treatment is prescribed. However, this temporality risks obscuring what precedes both the illness episode and the clinical encounter. New illness classifications have been disseminated that are reshaping people’s symptom recognition, and new drugs are available that promise a cure for ills where there had been none before. Ian Hacking (2007) argues that medical classifications are interacting with what they are classifying. This makes it impossible to determine what comes first: the disease label, the people being labeled as having that disease, the institutions designed to deal with this disease, the body of knowledge that supports the disease label, or the experts in charge. Analyzing the networks formed by humans and nonhumans, Bruno Latour (1987, 1993, 2005) shows that humans do not precede things, either temporally or hierarchically. Medical encounters are not encounters between two human beings only, but also crossings between disparate networks of objects and people. Work on medicalization processes (Conrad 2007; Busfield 2010; Clarke et al. 2010; Metzl and Kirkland 2010) has shown that changing medical classifications and novel therapeutic promises can turn previously “healthy” people into “patients.”
The social importance of material things has long been studied by anthropologists (Appadurai 1986; Miller 2005; Henare, Holbraad, and Wastell 2007). Applying a notion of “social biographies of things” to an anthropology of pharmaceuticals, Van der Geest, Whyte, and Hardon (1996: 153) observe the same power of concreteness in medicines: “By applying a ‘thing,’ we transform the state of dysphoria into something concrete, into some thing to which the patient and others can address their efforts.” The materiality of medicines is particularly important in the domain of psychopharmacology, where drugs are a more stable reference point than disease labels (Healy 1997: 56; Lakoff 2002, 2005). This ethnography takes the presence of psychopharmaceuticals as a driving force in medical encounters, in psychiatry, and beyond. Starting with drugs reverses the temporality of explanatory models and reorders the questions to be asked: What are the available drugs for treatment? How does the presence of drugs influence the perceived causes of illness? How does the availability of drugs transform perceptions of illness? A focus on drugs, and the alternative temporality of healer/patient relations that it triggers, is a constitutive move of an anthropology of pharmaceuticals (Whyte, van der Geest, and Hardon 2002; Petryna, Lakoff, and Kleinman 2006; Biehl 2007; Ecks 2008; Jenkins 2010).

At stake in this book are different models of drug effects and how they come into play with one another. These models are often more tacit and amorphous than explicit and clearly defined. They also always rely on comparisons and metaphors. There is no objective and metaphor-free way of describing drug effects: Ayurvedic medicines are said to “balance” bodily humors. Homeopathic remedies are presumed to “stir up” the “vital force.” And biomedical drugs ideally work like “magic bullets” that cure a specific disease with specific active ingredients. Understandings of drug effects are not contained within the boundaries of discrete medical systems. Instead, ideas about remedies can shade into one another, with sometimes paradoxical results. As I will argue, the plausibility of calling psychopharmaceuticals “mind food” relies less on patients’ ideas about biomedical psychopharmaceuticals as magic bullets than on a deeply layered combination of biomedical, Ayurvedic, homeopathic, and popular notions. The persuasive power of the metaphor springs from the illusion that “mind food” transcends all contradictions and inconsistencies. My task is to explore why “mind
food” makes both immediate sense and, looked at closely, not much sense at all.

Like healer/patient encounters, medical pluralism is another central concern in social health studies, in India and beyond (Leslie 1976, 1992; Cant and Sharma 1999; Sujatha and Abraham 2009; Broom, Doron, and Tovey 2009). Pluralism can be found in various forms across the world, but it is particularly pronounced in India, where biomedicine always had to compete with long-established traditions, such as Ayurveda. Since the 1970s, the Indian government has officially promoted non-biomedical practices, including Ayurveda, Unani, Siddha, Yoga, naturopathy, and homeopathy. Beyond these recognized “Indian Systems of Medicine,” many other local and marginal forms of healing are also practiced (Hardiman and Mukharji 2012).

What drives medical pluralism in India is neither state provision of medical services nor even official recognition, but an almost unregulated private market. Practitioners with training from official institutions are working in parallel to many who do not have any certified education (Cross and MacGregor 2010). Public spending on health—including biomedicine and the Indian Systems—has been rising over the past decades but remains extremely low compared to almost all other countries in the world. There is a chronic shortage of facilities provided by the state and a palpable public dissatisfaction with the quality of care. All this further fuels the predominance of the private health market (Jain and Jadhav 2008; Pinto 2011). About 70 percent of all health expenditures in India go to the private market. Private facilities account for around 60 percent of all in-patient and for 80 percent of all out-patient care. Only a fraction of these expenditures is covered by insurance or other forms of reimbursement; the majority is out of pocket (Organization for Economic Cooperation and Development 2011: 37-38). This ethnography of pluralism in Calcutta focuses on what is happening in private doctors’ chambers. The fact that the doctors described here are paid directly by the patients adds pressure on doctors to make sense—lest they lose the patients to the competition.

One effect of doctors having to reckon with medical pluralism is that this makes it more likely that they tell colorful stories. Indian doctors find themselves in a highly competitive market. Ideologists of free market capitalism assume that maximum competition leads to maximum
transparency (of prices, quality, and so on). The evidence presented in the following suggests, however, that the relationship between therapeutic competition and therapeutic transparency is inversely related. Doctors’ fear of losing patients to competitors—both biomedical and nonbiomedical—creates a permanent goal conflict with being truthful, if being truthful risks confrontation with patients, and if confrontation leads to a potential loss of business (see Ariely 2012: 67-96). In the absence of effective regulation of the way doctors must explain diagnoses and treatments to patients, they tend to prefer obfuscation to transparency. Obfuscation takes many forms, and explaining one’s drugs in terms of other substances to “make the medicine go down” is one of them. Perhaps a general principle can be inferred from this: whenever medical pluralism and market competition increases, deceptive behaviors by doctors also increase.

Definitions of medical pluralism are contested, including the supposition—as suggested by “pluralism”—that different systems are existing happily alongside one another. But professional biomedicine occupies a hegemonic position that no other stream of healing can ignore. In India, a “doctor” is first of all a biomedical doctor, commonly called “allopath” (see chapter 3). Any other healer would need to be specified, for example as a “homeopathic” doctor. Biomedicine sets the standard for the way doctors look and for how drugs look. The chapters take the boundaries between different medical streams as a starting point, but each of them shows where the boundaries get blurry. I try to refrain from making claims about how medical “systems” in their entirety are related to one another: attempts in this direction usually lead to wrong generalizations. What I try to do, however, is to show where there is friction between different sets of assumptions about drugs and how a metaphor such as “mind food” is able to gloss over crucial differences.

This is a study in the anthropology of pharmaceuticals, but at many moments in the discussion, food comes to the fore: for example, when Ayurvedic “drugs” shade into “food,” when medical diagnostics begin with food tastes, and when ritual concepts of subtle nourishment inform popular ideas of drug efficacy. There is a burgeoning anthropology of food and the sensuality of eating (e.g., Sutton 2010). This scholarship shows the many connections between food and other domains, such as power (e.g., Mintz 1996; Bray 1997; Farquhar 2002), religion (e.g., Khare 1992), kinship (Carsten 1997), or memory (Holtzman
The cosmo-political centrality of food in India has long been studied (e.g., Appadurai 1981; Roy 2010), and excellent ethnographic work has been carried out on Bengali cooking in particular (e.g., Donner 2008; Janeja 2010). Psychiatrists who speak of “mind food” establish an explicit connection between food and psychopharmaceuticals. Yet the links between meals and medications discussed in this book are almost all one-sided: while food is used to make sense of drugs, drugs are not used to make sense of food. Metabolic metaphors such as moner khabar take features of food and transpose them to the domain of medications, but they seem to have little, if any, influence on what is meant by food. It would, however, be extremely interesting to incorporate pharmaceuticals in anthropologies of food and to see how eating medications might change the way meals are eaten.

Social studies of both patient/healer relations and medical pluralism avoid the question of drug efficacy. Whether a remedy “works” or not is left to medical research. In this book I also stay clear of my own opinions of efficacy. But this does not mean that efficacy gets bracketed. Instead, I represent how drug efficacy is evaluated from a diversity of viewpoints. The chapter on lay perceptions of health explores how allopathic, homeopathic, and Ayurvedic remedies are seen to work. In turn, the chapters on professional healers look at how they try to make patients understand prescriptions. “Drug effects” are treated in the broadest possible way, including how notions of bodily constitution, diagnostic procedures, and different ways of producing and dispensing drugs impinge on perceptions of how they work. Drug effects also raise critical questions of postcolonial modernity, individual autonomy, and ethical authenticity. They also raise fundamental ontological questions about materiality and the relation between matter and the mind.

Since psychopharmaceuticals frame this ethnographic investigation, some remarks on how they are currently evaluated are in order. The efficacy of psychopharmaceuticals, especially of antidepressants, has long been the subject of controversy (Healy 2004; Breggin 2008). There was a time when new medications seemed to herald a new era of treating mental ills through drugs. The drugs not only were easing illness but also were capable of making people “better than well” (Kramer 1992; Elliott 2003). This position now seems untenable. Over the years, evidence against antidepressants has been mounting, and even
psychiatrists have announced “the end of the psychopharmaceutical revolution” (Tyrer 2012). As many critics point out, the theory of “neurochemical imbalance,” which undergirds and explains the efficacy of the drugs, has never been proven (Moncrieff 2008; Kirsch 2009; Whitaker 2010). Meta-analyses of clinical trial data, including findings that had been withheld by pharmaceutical companies, conclude that antidepressants are no better than placebos for mild and moderate depression (Kirsch 2009). Even more alarming is the allegation that rising prescription rates of antidepressants and other psychopharmaceuticals is the cause for the current epidemic of mental illnesses and chronic disability (Whitaker 2010). Psychiatric drugs do have an effect on brain chemistry, but the beneficial effects seem to occur only—if they occur at all—in the early treatment phase. Over longer months and years, the drugs appear to deepen and to prolong suffering. Statistics show that those who never got treated with psychopharmaceuticals have a better chance of full recovery than those who did. Assessments of efficacy had systematically neglected the outcomes of long-term exposure (Whitaker 2010: 65). At the very least, there is no reason to believe that biopsychiatric drugs are unquestionably superior to other forms of treatment or even superior to no treatment. This book is written from a position of doubt about psychopharmaceuticals.

Doubting pharmaceuticals is difficult when the mandate to treat everyone who suffers is taken as the highest goal. All major international health organizations support the widened uses of psychopharmaceuticals, even though the imperative to use drugs is not as clear-cut as in other areas, such as infectious diseases. The basic position of the World Health Organization (WHO) is that there is a worldwide “treatment gap” for mental illnesses, with developing countries staying far behind the developed countries in providing effective treatments to everyone in need. “Scaling up” psychiatric provisions across the globe is the only answer to the rising rates of disease. The latest global treatment algorithms (World Health Organization 2010) recommend “considering” antidepressants for moderate-severe depression together with nonpharmacological interventions such as psychoeducation. Mild depression and unexplained somatic symptoms should no longer be treated with antidepressants. This is a more cautious guideline than those of a few years ago, when SSRIs were recommended as the best first-line
treatment (Dawson and Tylee 2001). Given that drug prescriptions are much cheaper and much easier to organize than other services, they clearly remain the default mode of treatment for mood disorders. Being doubtful is difficult in a biopolitical regime that makes health an unquestioned priority. “Biopolitics” is a concept coined by Michel Foucault to describe a particular regime of power that emerged in the seventeenth century and fully unfolded in the nineteenth century. Biopolitics are engaged with birth, life, death, health, and illness. Foucault (1978) introduced biopolitics under the heading “biopower” (bio-pouvoir). Biopower has two basic forms. The first is “anatomo-politics,” which is centered on the individual body that is being disciplined, optimized in its capabilities. The other basic form of biopower is biopolitics, which tries to optimize life and longevity through interventions and regulatory controls (Foucault 1978: 139). Biopolitics is always an intervention focused on optimization, with “health” as a moving target on an infinite horizon. These optimizing inventions provide, in turn, legitimacy to political and bureaucratic regimes. Even if states do not always have the right or the obligation to intervene and optimize, and even if the responsibility for health has, in many ways, shifted from states to individuals (Rose 2007), biopolitics remain a pervasive force as a generalized form of governing (Fassin 2009; Raman and Tutton 2010).

A concern with biopolitics raises many questions (Lemke 2011: 117-24): what makes diseases unacceptable and populations “in urgent need of therapy”? Who profits from the promised optimization of health? How are individuals called upon to improve their physical and mental health? If “health” has become the ultimate justification for any intervention, can one even think and act “against health” without sounding deviant (Metzl and Kirkland 2010)? This ethnography of plural medications in India addresses these questions of biopolitics in diverse ways, showing that “health” has many meanings. Its goal is to describe alternatives to a monoculture of happiness encapsulated in biopsychiatric medications (Kirmayer 2002; Ecks 2005; Lock and Nguyen 2010).

Notes on Method

Calcutta is the capital of the Indian state of West Bengal and the cultural and economic center of northeastern India. The spelling of the
city’s name was officially changed to “Kolkata” in 2001 to emphasize its Bengali pronunciation, yet “Calcutta” remains widely used in English-language publications in India and abroad. More than fifteen million people live in the Calcutta metropolitan area, making it one of the world’s most densely populated urban agglomerations. Calcutta is famous for its artistic and intellectual aspirations, as well as for decades of communist and trade union dominance. For thirty-four years, from 1977 until 2011, the Communist Party of India (Marxist) ruled, making it the longest-running democratically elected communist government in history. Once one of the richest and most globally connected cities in the world, Calcutta experienced economic decline throughout the second half of the twentieth century. In the first decade of the twenty-first century, the moderately “pro-capitalist” policies of Chief Minister Buddhadeb Bhattacharya brought an economic upturn. But violent protests against industrial megaprojects, such as a chemical plant in Nandigram (2007) or the proposed Tata Nano car factory in Singur (2006-2008), showed that “pro-people” politics remain a decisive force in West Bengal. This book is based on research conducted in Calcutta during this decade of accelerated yet contested economic liberalization.

The chapters on Ayurvedic, homeopathic, and allopathic doctors are based on interviews and observations of clinical practice. I chose to look at Ayurveda and homeopathy because they are the most established nonallopathic medical streams in Calcutta. Different healing streams are variously present across the regions of India, and for West Bengal and many other parts of northern India, homeopathy is far more popular than Ayurveda or any other nonallopathic system.

All of the doctors discussed here were trained in medical colleges; worked predominantly in private practice; and have had several years of work experience. Nearly sixty doctors from homeopathy, Ayurveda, and psychiatry were interviewed, as well as more than thirty doctors from other branches of biomedicine. Most of the doctors I met were men, which reflects the strong gender bias found in these professions. Almost all interviews were recorded and transcribed. Personal names were altered to ensure anonymity.

The doctors were generally very cooperative. From among the different healers, homeopaths were by far the easiest to approach. It certainly helped that I am originally from Germany, the motherland of homeopathy; and
it was not unusual for doctors to point to a portrait of Samuel Hahnemann in their chamber and exclaim something like, “Hahnemann, our God!” Psychiatrists were slightly less receptive, but still very welcoming. The greatest problem with psychiatrists was that they were short of time and rarely willing to sacrifice more than one hour. In turn, Ayurvedic doctors were the most difficult to deal with. It often felt as if I was stumbling into an ongoing turf war among rival lineages of doctors, without me fully understanding where they each positioned themselves. Many of the Ayurvedic kavirajś were unwilling to introduce me to other colleagues under the pretext that that they did “not know anyone else.”

Research on popular ideas and practices was mostly conducted in southwest Calcutta, a mixed residential and commercial area. The majority of residents in this part of the city are Bengali-speaking Hindus. Some tracts of southwest Calcutta had been settled since before the eighteenth century, but it was only with the arrival, in enormous numbers, of Hindu refugees from East Bengal (now Bangladesh) between the 1950s and the 1970s, that the area received its current architectural form (Kundu and Nag 1990). Most people who live in southwest Calcutta are lower-middle- and middle-class people who partly work in local businesses, partly in the offices of central Calcutta. There are a number of bustees (slums) throughout the area, most of them Hindu, some of them Muslim. The male residents of the bustees engage in various types of informal wage labor. Many of the bustee women work as domestic servants in local middle-class households.

Nevertheless, this is an ethnography of Calcuttans more generally, rather than an ethnography of people in a specific neighborhood (De Neve and Donner 2006). No doubt, convenient access to a physician is a factor in people’s health-seeking behavior. But in a metropolis like Calcutta, mass transportation tends to decouple access to physicians from place of residence. Patients often travel all over the city to see a doctor whom they trust, and many doctors practice in up to three different locations across Calcutta. One of my longest conversations with a psychiatrist took place over several hours, when we were sitting in his car and driving to one of his charitable clinics in a district outside of Calcutta. During participant observation in different clinics, I usually saw patients from different areas of Calcutta, as well as patients from other parts of Bengal, from neighboring states, and even medical tourists from Bangladesh. The “bigger” the doctor, the further the distance a
patient is willing to travel. For psychiatry, which is still stigmatized, the need to travel outside one's own neighborhood was an advantage.

I found that getting Calcuttans to talk to me was not difficult. People were curious about what I was doing and always open to talk. “Health” was seen as an obvious and worthy field of research for someone from Europe. Moreover, Bengalis hold academic research in high esteem. I never had any problems in getting people to spend time answering my questions, even people who were busy with their working lives. Calcuttans are proud to say that their city is not as “mechanical” and hurried as Delhi or Mumbai, and that people still take time to sit and chat whenever they feel like it.

For research among Calcuttans, I combined long-term participant observation with interviews. Participant observation was mostly unstructured. Day-to-day observations and serendipitous conversations were recorded in a diary. Besides everyday encounters, I conducted unstructured and semistructured interviews. Overall, I followed the rules of “nonprobability sampling” (Bernard 2002: 180-202), which is better suited for cultural interpretations of how things are done than methods that emphasize how often they are done.

The data include a set of ninety-five interviews. From among these, seventy-nine were with Bengali informants and sixteen with people from other ethnic groups. Seventy-eight interviews were with Hindus, fourteen with Muslims, and three with Christians. Fifty-six interviews were conducted with men, twenty-nine with men and women together (e.g., husband and wife), and ten with women only. Bengali language was most common in these interviews, but several were also recorded in English and in Hindi. For translations from Bengali and Hindi, I worked with an assistant, Jokesh Francis. As with the doctors, I have anonymized all personal names.

In terms of socioeconomic class, roughly thirty-one of the interviews were conducted with lower-class informants, forty-eight with lower-middle-/middle-class informants, and sixteen with upper-middle-/ upper-class informants. When Calcuttans speak about “class,” they mostly make blanket distinctions between “the rich” (bara lok, “big people”) on one side and “the poor” (garib lok, “poor people”) on the other. Depending on the speaker and the context of the conversation, the lines between these two groups can shift strongly. For example, a lower-ranking white-collar government employee appears as a bara lok
to a slum dweller but as a *garib lok* to a member of the upper classes. The distinctions that are drawn here between lower-, lower-middle-, upper-middle-, and upper-class are fluid. As an approximation, “low” means that people can hardly scrape a living, are staying in rickety houses, and have enjoyed no or only rudimentary education. “Middle-class” people live in decent brick-built houses, have completed formal education, and have a reasonable amount of disposable income. “Middle-class” includes the *bhadralok* (“respectable people”), an ideal type of a cultivated white-collar employee that emerged in the nineteenth century (Donner 2008; Janeja 2010: 27-36). Difference between “lower-middle” and “upper-middle” is only one of degrees. In terms of economic standing, for example, lower-class people have no or only a few luxury goods such as washing machines or cars, whereas upper-middle-class people have several of these items. Lastly, “upper-class” people have been through many years of English-language education and enjoy the same living standards as people in Western Europe or North America.

Capturing popular perceptions of mind, body, and different medications is challenging. Summarizing decades of research on folk medicine, George Foster (1994) underlines its methodological difficulties: “To attempt to formulate the principles underlying health beliefs and practices is somewhat akin to fitting together the pieces of a gigantic jigsaw puzzle” (1994: 21). Other aspects of culture, such as religious rituals or daily work, tend to be routinized and observable as discrete events. Yet illness episodes can only be observed in a fraction of the population, hardly ever from beginning to end, and their episodic character tends not to be molded into routines. To shift one’s attention to the (relatively) public and routine behaviors in doctor-patient encounters does not, of course, solve the problem of studying understandings held outside clinical settings. Hence ethnographic research on popular perceptions must rely on what people say, and what they say takes more often the form of passing remarks than of coherent illness narratives. Moreover, anything that relates to health and “the body” is often only tacit know-*how*, instead of explicit know-*that* (see Bloch 1998; Dreyfus 1991; Taylor 1995; Thompson, Ritenbaugh, and Nichter 2009).

To analyze data that are largely linguistic, fragmentary, and about tacit know-*how*, I relied on analysis methods developed by cognitive linguists, who showed that metaphors pervade not only everyday
language but also everyday thought and action (Lakoff 1987; Lakoff and
Johnson 1980). The body is the existential ground of culture (Csordas
1994), and metaphors are “the body in the mind” (Johnson 1987), con-
densing elementary bodily experiences of spatial orientation, shape,
taste, and physical texture. Sensory experiences of the body motivate
systematic “image schemata,” or gestalt structures, with which the
world is described. Both popular and scientific thought can be analyzed
as a compound cluster of metaphors (see Blumenberg 1999; Bachelard
1967). Metaphors are “good to think with” because they make abstract
ideas concrete and create consensus through sensual simplicity. Given
that metaphors change more slowly than actual practice (e.g., we still
speak of someone who is overcommitted as having “too many fires
burning”), a close study of metaphors also enables us to detect the
traces of half-forgotten traditions. For local speakers, metaphors can be
grasped easily and appear to make thinking effortless (Danesi and Per-
ron 1999: 183). To systematically collect and analyze metaphors in this
way has been done by many cultural and medical anthropologists over
the past decades (e.g., Desjarlais 1992; Kirmayer 1993; Parry 1985, 1991;
Nichter 1989; Mukharji 2009).

Metaphor analysis is also akin to current thinking in transcultural
psychiatry. In a literature review on the cultural emergence of somatic
syndromes and their place in the new edition of the American Psychi-
atric Association’s Diagnostic and Statistical Manual of Mental Disor-
ders (DSM-5), Kirmayer and Sartorius (2007: 835) argue that notions
of “culture-bound syndromes” are outdated and should be replaced by
“cultural idioms of distress.” Also drawing on cognitive linguistics (e.g.,
Kövecses 2000), Kirmayer and Sartorius point out that bodily experi-
ence, language, and culturally shared illness narratives co-constitute
each other. What have, so far, been described as “syndromes” are not
discrete disorders but “culturally prescribed modes of understanding
and narrating health problems and broader personal and social con-
cerns” (2007: 835). To speak of idioms of distress emphasizes the com-
municative dimension of suffering: what seems like an exotic complaint
might simply be “a way to express dissatisfaction with living conditions,
legitimate difficulties in performing social roles, and allow the indi-
vidual to seek outside help” (2007: 835). Metaphors are one of the best
entry points into these expressions.