
INTRODUCTION

INDIAN PSYCHIATRIC SPACES AND 'MAD' NARRATIVES

In 2009 the *Mumbai Mirror* repeatedly reported cases of physical abuse in a huge psychiatric hospital in north Mumbai, the capital of the Indian state of Maharashtra. The article cited families that were worried about relatives who were admitted to the hospital, which I will call 'Asha'¹ in the following. Discussions in public but also among mental health professionals revolved around the bad conditions at Asha – a lack of hygiene, the poor quality of food, corruption and patients' regular corporal punishment by the hospital staff. In the same year, I accompanied two students of social work who were completing their field internship at Asha.² We met each other at the local university, the Tata Institute of Social Sciences, which I was affiliated to during my research endeavours. Mahi and Akash became my friends during the five years I carried out research in diverse mental health institutions in and around Mumbai. Both had a very critical and pessimistic view of the 'mental asylum'. Mahi and Akash told me about patients who had been there for decades, having been abandoned by their families. They spoke about roadside destitutes who neither spoke the local language Marathi nor any Hindi and were admitted against their will – some of them apparently deemed wrongly to have mental issues. They said attendants would take bribes from families who want to enter a ward to visit a relative under treatment. And they generally suspected that the staff were not really interested in taking good care of the patients but rather in the regular payment of their salary, which was guaranteed by occupying a government job. They also showed me around the hospital site. Together with

Mahi, I visited the high security cubicles in the admission ward in the female unit. Here patients who were violent or had tried to run away were locked up. In one of these cubicles, a woman lay on the floor, her breasts naked and exposed to the public. Her hair was cut ultrashort, and she seemed to have a mental disability. When Mahi asked her if something had happened, she did not respond and continued to lie on the floor motionlessly and to stare dead ahead. In the next dorm room, women were sleeping on nothing more than thin mats that were spread out on the floor. No beds were provided to the patients in this ward. The students' narratives and my impressions resonated with the media's representation of the hospital, which was rather unflattering during these years.

When I returned to Mumbai in 2011, Asha had undergone a remarkable change: the wards had been freshly painted, and plants and flowers decorated the spaces between the well-maintained pathways that connected the various hospital buildings. Garden swings and benches invited patients to take a seat and have a chat outside the wards. The hospital appeared far more inviting and welcoming than the last time I visited the place. Later I came to know that the current superintendent was the driving force behind these changes. In December 2009, the superintendent of Asha was suspended, and the new superintendent, Dr Praveen Shukla, took over. Dr Shukla promoted an image campaign that aimed at changing the grim picture Asha was associated with. I carried out extensive fieldwork at Asha between May and October 2011. During these five months, I used to spend at least three to four days in the hospital every week. I met up with Dr Shukla repeatedly during my research and discussed manifold issues concerning mental illnesses, psychiatry in India and everyday life in Asha. From November 2011 until February 2012, I continued my research in the psychiatric ward of a private hospital in southern Mumbai. However, this mental health institution is not discussed in more detail, although I draw on the material at times in order to illustrate or contextualize an issue tackled in this work. In 2013, 2014 and 2015, I travelled to Mumbai predominantly for work purposes and academic collaborations, which nevertheless enabled me to follow up on my research interests concerning mental health care in India. During my stays, I met up with friends and also several of my informants from the field.

These were predominantly mental health professionals but also two patients, Sarika and Ajay, whom I met for the first time in 2011 at Asha and whose stories I would follow up until 2014. Additionally, I discussed my material with people working in the mental health sector and other students and carried out several expert interviews that enhanced my understanding of themes that turned out to be pivotal in this ethnography: the production of psychiatric, bureaucratic, 'mad', gendered and queer narratives in the context of Indian psychiatric practice and the global mental health discourse.

The Bureaucratic and Biomedical Management of 'Madness'

The practices and self-representation of public hospitals are moulded according to the ideal of 'modern bureaucratic organizations' (Zaman 2005: 10). Two socio-historical aspects are worth taking into consideration here: psychiatric hospitals are institutions of the state, obliged to provide care for its citizens. At the same time, they are biomedical institutions that follow certain models of disease and population management that emerged in the first half of the twentieth century in industrial countries. The classification of medical diseases and psychiatric disorders and the generation of diagnostic and statistical manuals were products of the rising domain of 'public health' (Jutel 2011: 15). Psychiatric, allopathic medicine was introduced by the British colonial regime at the beginning of the twentieth century (Mills 2001), and its wide dissemination was possible mainly through its indigenization (Mukharji 2009). The introduction of psychiatric treatment was preceded by 'the emergence and functioning of science as a form of cultural authority' (Fabrega 2009: 563) in most colonial parts of India in the second half of the nineteenth century. In this context, the modern concept of disease and the growth of biomedical theory and practice was consolidated (*ibid.*: 563). In 1835, colonial authorities implemented Western medical education that was (and still is) conducted exclusively in English (*ibid.*: 567). This was the first time in the Indian context that the treatment of 'psychiatric diseases' was spatially secluded from the treatment of other illnesses. In 1858, the first Lunacy Act was passed by the colonial regime. The es-

tablishment of so called 'lunatic asylums' at the end of the nineteenth century was determined by European ideas and concepts of 'madness'. To protect the general population from the 'mad men and women', the asylums were built outside the cities and fenced off from their surroundings by huge stone walls. Similar to mental health establishments in Europe, the focus was mainly on the management and detention of social disorder rather than the treatment and cure of individual illnesses. Initially, mental health institutions established by the British in India only admitted 'one's own' people and 'privileged' Indians – that is, those employed by or affiliated to the colonial power – before the mental asylums finally also became accessible to the common Indian population (Ernst 1991). In the following decades, again analogous to the development of the psychiatric profession in the West, 'mental hospitals' generally developed more and more into medical institutions run and supervised by medical staff (Sharma 2004: 27f.). Nevertheless, in 1946 the Bhole Committee – a delegation that carried out a study to evaluate India's mental health care system – criticized 'mental hospitals', which still rather served the purpose of detaining patients than treating psychiatric diseases (Ganju 2000: 395). Finally, in 1987, after several failed attempts, the Indian Mental Health Act was passed to improve the quality of hospitals and strengthen the rights of psychiatric patients. At the beginning of the 1980s, the National Mental Health Programme (NMHP) was launched to implement the delivery of psychiatric services at the community level via the District Mental Health Programme (DMHP) (Gandevia 1993; Kapur 2004). Despite these initiatives, only minor changes occurred regarding the conditions in governmental mental health institutions. The allopathic psychiatric system to this day is perceived as suffering from an 'acute shortage of mental health professionals' (Bayetti, Jadhav and Jain 2019: 133), with approximately four thousand psychiatrists available for the entire country (equivalent to 0.301 psychiatrists per one million patients). Additionally, allopathic psychiatry remains an urban phenomenon, with most psychiatrists operating in major cities and towns. These also host the majority of state-sponsored services and academic research facilities, which are usually integrated into general hospitals' psychiatric departments and medical schools (*ibid.*, see Wig and Awasthi 2004). The colonial

system of former mental asylums, comprising forty-two institutions (Ganju 2000: 399), is supplemented by private clinics that can only be afforded by middle and elite-class clients (Kala 2004). The restricted availability of psychiatric services, particularly in the rural regions, is one of the reasons why a major portion of the population makes use of traditional institutions for treating *pāgal* (mad) persons. Additionally, a mental illness, a psychiatric diagnosis and admission to a psychiatric hospital is more stigmatizing than, for example, being possessed by a *bhūt* (spirit) and its treatment in a temple. Therefore, the act of admitting someone to a psychiatric hospital is often seen as the last and least desirable option, after a family has already unsuccessfully tried other options like traditional healing, Yoga, Unani, Siddha, Ayurveda or Homeopathy.

Asha was established on seventy-five acres of land, which was donated by a wealthy Mumbaikar family to the British regime. Its construction was completed in 1901, and the number of beds gradually increased from two hundred to 1,850. The outpatient department started in 1983 (source: hospital report 2011). Inpatients are admitted to separate units for male and female patients (see Map 0.1). The female wards are secluded by an additional wall from the publicly accessible part of the hospital in which the male wards are also located. Everybody who wants to enter the female unit has to pass through a gate and sign into a logbook. Except for doctors, no males are allowed in the female unit. This spatial organization resembles that of a traditional Hindu house (Khare 1976). The room where visitors are received and entertained can be found at the front. The kitchen, which is commonly occupied by the women of the household in India, is located at the back of the hospital and is usually not accessible to visitors. Both units comprise the following wards: an 'admission ward', a 'sick ward', a 'TB (tuberculosis) ward', an 'epileptic ward', and several so called 'chronic wards'. In the latter, patients are admitted who suffer from a long-term mental illness or who are not accepted back by their families after treatment. In the male unit, one also finds a designated 'old age ward' (which is Ward 17 in the female unit) and a 'criminal ward'. The latter accommodates patients who either committed a crime during an acute phase of their mental illness or who fell ill during their stay in prison. Long-term patients mentioned

that in former times patients who behaved violently, had suicidal tendencies, or misbehaved in any way were brought to the criminal ward and put into isolation cells. There is no equivalent to a criminal ward in the female unit; during my time at Asha a female patient who killed her daughter during a psychotic phase was admitted to the admission ward, guarded by three female police officers.

In May 2011 when I started my research, there were 700 male and 693 female inpatients at Asha (total: 1,393).³ Overall, 633 male patients were admitted to the hospital between January and May 2011. This was almost double the number of female patients (349) who were admitted during this period. Nunley (1992: 96) points out that while in American psychiatric institutions women are numerically over-represented, there are two times more men than women under psychiatric treatment in Indian medical institutions. Vindhya et al. (2012: 168) observe that while these numerical differences prevail in public psychiatric institutions, they become smaller in private hospitals. They conclude from these observations that women, especially from rural and poor economic backgrounds, have limited access to psychiatric treatment (Davar 1999: 154ff.).

While fewer women are admitted to the hospital, they tend to stay for a longer time, if they are brought in for psychiatric treatment (see Table 0.1). Indeed, it is more likely for a woman not to leave Asha ever again and to die there than for a male patient. The percentage of patients, male as well as female, admitted by

Table 0.1. Length of stay in correlation to patients' sex.

Length of stay	Male	Female	Total
Up to 3 months	290	172	462
Up to 6 months	79	46	125
6 to 12 months	82	46	128
1 to 2 years	63	69	132
2 to 5 years	48	94	142
5 to 10 years	48	94	142
10 to 20 years	41	98	139
Above 20 years	49	74	123
Total	700	693	1,393

a 'reception order' (RO) was around 40 per cent. The majority of patients, though, were admitted by a 'detention order' (DO), picked up by the police because they were wandering the streets or acting violently towards others. Only a minority (between 1–2 per cent) of patients were 'voluntary boarders' (VB), which formally denotes that they agreed to be admitted and treated in the psychiatric hospital and signed the admission papers themselves in addition to one of their relatives.

In the outpatient department (OPD), people collect medications, let a family member be re-examined or extend the 'leave of absence' (LOA) card of a formerly admitted patient. It is also the first stop in the hospital if a family seeks to admit a patient. Information boards on the walls outline every step of the admission and discharge procedure. Yet another board in the OPD waiting area informs that giving and taking bribes is considered a crime. The text on the board states that at Asha all charges comply with government regulations and in any case of reported corruption – for example, hospital staff who demand amounts exceeding the regular fees – the anti-corruption department bureau should be contacted immediately. In 2008–9, a total of 29,836 patients with their relatives visited the outpatient department.

When Asha was evaluated as part of the National Human Rights Commission Project Report on Quality Assurance in Mental Health, published in 1999 (Nagaraja and Murthy 2008), its overall rating was perceived as 'poor'. The report criticized the condition of some of the buildings and the overcrowding of wards, which led to many patients having to sleep on the floor, and that short stay and open wards were missing. Additionally, hygiene standards were found to be low. The report mentioned further that 'staff burnout' was common and that staff, particularly in the lower ranks, were transferred to the psychiatric hospital as a kind of 'punishment'. There were also vacant posts for clinical psychologists, and staff urgently needed to be sensitized to the needs and rights of people with mental health issues. The number of involuntary admissions was found to be too high. Finally, the report mentioned that psychosocial intervention and rehab services would have to be improved, which included psycho-education, individual counselling of the family and vocational rehab. In 2008, almost ten years after the first review, governmental psychiatric hospitals were evaluated again.

Regarding the follow-up report, Asha had improved in regard to certain aspects, such as new utensils for the kitchen and the addition of trollies to transport cooking pots to the wards. The hospital had also marginally reduced its official bed numbers from 1,880 to 1,850 and had 'significantly' reduced its (formerly exceeded) occupancy (from 2,000 to 1,253). A separate ward for 'the criminally mentally ill' had been established, and outpatient geriatric mental health services were offered (at that time, no outpatient service or old age ward existed). Regarding the other shortcomings previously mentioned, though, no significant change was recorded. The majority of admissions still occurred through courts and were therefore deemed as 'involuntary'. Again, staff numbers were noted as inadequate, even if the hospital was ranked at the upper end regarding the educational status of its professional staff compared to other state-run mental health hospitals. At least three psychiatric social workers were employed at Asha in 2008, while in twelve out of thirty-two evaluated hospitals not even one psychiatric social worker was present. The report further mentioned that nineteen of the hospitals had not employed a single psychiatric nurse during the last decade. However, the overall situation in hospitals located in Maharashtra was declared as better, with many nurses having received psychiatric training at the National Institute of Mental Health and Neurosciences (NIMHANS). In general, though, even if some improvements had occurred during the previous decade, the conditions in the four government-run hospitals in Maharashtra were still described as 'horrible' and 'shocking', according to the Bombay High Court. An article in the *Times of India* from 17 October 2007 described 'governmental mental hospitals' as places 'worse than jails'.

At the time I spoke to the superintendent, Dr Shukla, during an official interview in September 2011, he had been in charge of Asha for over a year and a half. His efforts in networking to make the hospital appear more open to outsiders and to establish partnerships with NGOs meant the tone of media reports about Asha had changed remarkably. Articles in the local newspapers reported that Dr Shukla had proposed changing the hospital's name from 'Asha Mental Hospital' to a more clinical-sounding one like 'Institute of Behavioural Science' or 'Institute of Psychiatry' in order to change the perception of public mental hospitals

and decrease the stigma attached to them. The press also reported the superintendent's endeavour to train and educate the hospital staff on the particular needs of psychiatric patients. Another planned measure was the construction of a 'family ward' in which families could stay and accompany a family member for the length of their psychiatric treatment. The superintendent shared his vision of the inclusion of families not just as a moral support but to help train them in regard to handling 'a patient's emotions and behaviour later at home'. The education of families and so called 'lay counsellors' is a recent strategy adopted by NGOs, mental health professionals and activists to address the pressing shortage of qualified staff in the mental health sector (H. Basu 2018: 127f.). Another newspaper article reported plans to establish an additional hospital wing and rehabilitation centre that would include a college for the training of doctors and nursing staff. Dr Shukla imagined the project as a public-private partnership in offering potential investors a plot of land for the construction of their private hospitals or medical centres. Yet another article published during my time at Asha announced that the hospital planned to set up particular vocational training as part of occupational therapy and to train patients in making incense sticks and eco-friendly Ganesha statues⁴ in order to sell these products under their brand name. The superintendent and the Maharashtra health minister were mentioned as being the driving force behind these innovations and improvements in the hospital.

All these developments and initiatives took place in the context of the so called global mental health movement and the endeavour to 'modernize' Indian psychiatry (H. Basu 2009, 2010a; Davar 2014). In August 2001, in Tamil Nadu, twenty-five people who stayed near a *dargāh*, a Sufi healing shrine, where they sought treatment, were killed during a fire (the so called 'Erwadi tragedy'). The 'incident set off widespread alarm among some citizens' groups and professional sectors about modernizing mental health care and complying with international human rights standards' (Davar 2014: 266). The developments at Asha furthermore stood in the context of the emergence of the expanding private (mental) health sector from the early 1990s. Public-private collaborations, as put forward by Dr Shukla, are supported by a national health policy that sees such partner-

ships as a viable option to enhance health service delivery to underserved populations (Barua 2005; Davar 2012).

In this work, I understand public psychiatric institutions and their tendency to classify and treat people according to certain administrative and medical categories as typical 'bureaucratic organizations'. Don Handelman (1978: 16) argues that the idea of bureaucracy constitutes a 'mode of framing experiences' that particularly underlies Western and scientific thought. Bureaucracy as an administrative framework and by its systemic taxonomy produces social categories and things that constitute a certain social reality or domain to interact within. Discussing bureaucracy in relation to the modern state, Handelman understands bureaucracy as an instrument of modelling that works in a foreseen, controlled way. He understands the life in modern states as 'put together by organizations that are quite aware of their own systemic premises' (1998: 79) and constitute what he calls 'hegemony over transformational work': modern states engage in 'predictive modelling', which transforms the values of information they process.

Psychiatry resembles this systematic understanding in its approach to illness and its treatment. Biomedicine relies on a systemic classification of diseases and a causal-mechanistic interpretation of the human body. It treats 'disorders', whose identification in the diagnostic process implies the existence of an 'order' or status quo concerning a perceived healthy mind or social behaviour that has to be re-established to effect a cure. Psychiatric institutions that are embedded in a bureaucratic state apparatus and the public mental health system are therefore associated with a 'predictive modelling' function. Their approach stands in stark contrast to a 'transformative healing' process, which is often identified by medical anthropologists as the central mechanism of ritual healing approaches (see e.g. Hinton and Kirmayer 2017). Ironically, their stress on order, regulations and a systemic approach did not prevent bureaucratic institutions from being associated with 'madness' or sending people 'mad'. Think, for example, of the eighth task that Asterix has to master in the film *Les douze travaux d'Astérix* (1976), written and directed by René Goscinny and Albert Uderzo: 'Find permit A-38 in the place that sends you mad', a mind-numbing multistorey building founded on bureaucracy and staffed by unhelpful

people who direct all their clients to other similarly unhelpful people elsewhere in the building.

Social anthropologists, among other social scientists, try to understand the inhuman and indifferent social spheres that bureaucratic organizations so often seem to produce and govern. Michael Herzfeld (1993) in his analysis of Greek and Western bureaucracy in general asks: 'How and why can political entities that celebrate the rights of individuals and small groups so often seem cruelly selective in applying those rights? Indifference to the plight of individuals and groups often coexists with democratic and egalitarian ideals' (ibid.: 1). Herzfeld draws a grim picture of bureaucracy and associates it with ineptitude and callous oppression by the nation-state against its citizens. According to Herzfeld, the bureaucrats' religion is nationalism, and he outlines how bureaucratic responses to disorder are ways of dealing with symbolic pollution. Similarly to Herzfeld, we can ask in the case of public psychiatric hospitals in India how it is possible that in medical institutions, which are supposed to help and serve people as public services, people are often not cared for but neglected, maltreated or even killed? When it comes to understanding individual behaviour, social practices, interaction and encounters, approaches like Herzfeld's that equate bureaucracy with nationalism and focus on the analysis of symbols and language necessarily remain on a rather superficial level. The political scientist Michael Lipsky (1980) argues that 'to understand how and why these [bureaucratic] organizations often perform contrary to their own rules and goals, we need to know how the rules are experienced by workers in the organization and to what other pressures they are subject' (ibid.: xi). Additionally, Akhil Gupta (2012) criticizes that 'most analyses of the state reinforce its unitary and purposive qualities, even when its power is criticized' (ibid.: 44). In contrast to these approaches, he refrains from treating the state as a unitary organization acting with a singular intention but sees it as characterized 'by various levels that pull in different directions' (ibid.: 47) and unintended outcomes that 'are systematically produced by the friction between agendas, bureaus, levels, and spaces that make up the state' (ibid.: 47). Dr Shukla faced this kind of friction when he tried to realize his visions and imaginations concerning Asha. The much-requested staff training, which was authorized by the

state public health department at the beginning of 2011, could not be implemented because the government demanded it be conducted by 'experts' from outside the hospital. The superintendent struggled with these regulations, feeling that his own skills and expertise in the field were questioned, but he asked the government functionaries to hire anybody they thought would be appropriate to carry out the task. When I talked to Dr Shukla nine months later, there was still no progress or decision taken on this matter, and therefore the staff training was still pending. Another pending issue concerned the family ward and planned health care centre, the conceptualization of which he had initiated when he was appointed as Asha's medical superintendent the first time in 2004/5. Around this time, he took care of the basic planning in calling an architect and sending the architectural plan to the respective government office for approval. The approbation of the project took another five years. At the time of our conversation, the superintendent hoped the ward would be almost finished in another nine months. However, almost four years later, in 2015, I came across an article announcing that the family ward was soon to be established on the hospital premises. Meanwhile, the superintendent had changed again. Dr Shukla had obviously left his project unfinished once again and entrusted his follower with its completion.

Gupta replaces the notion of a bureaucracy as the rationalization of power in a disciplinary society with the idea that it is 'shot through with contingency and barely controlled chaos' (ibid.: 14). He does not perceive 'the production of arbitrariness' as peculiar to Indian bureaucracy, though, but denotes it as a feature of any complex bureaucratic organization. Additionally, not all outcomes of the administrative system are arbitrary, but some forms of discrimination are consistent, systematic and institutionalized. And, therefore, cultural capital tremendously helps in navigating bureaucratic structures in public hospitals (ibid.: 25). Bureaucratic procedures like the admission process can be accelerated remarkably if one has a contact at the hospital. An equally effective alternative is to pay an agent, of whom plenty wait for customers near the hospital gate, for their assistance in completing the necessary paperwork. Furthermore, giving *bakshīs* (a tip) to attendants or helpers to look after a patient is common practice at Asha (see Zaman 2005: 126). To be

familiar with a bureaucratic habitus and its routines equips one with negotiating power within the institution. This encompasses language (Marathi, Hindi and/or English), reading and writing, navigating bureaucratic hierarchies and possessing or at least knowing how to get hold of relevant documents. Eventually, the mere familiarity with bureaucratic categories – that is, knowing one's age and birth date⁵ – constitutes important cultural capital (Shamgar-Handelman and Handelman 1991).

The survivors of the Erwadi tragedy were admitted to the government mental health hospital in Chennai. Unfortunately, they did not enjoy much better conditions or receive better treatment than in the Muslim shrine. Indian media, which just shortly before had harshly criticized the 'cruelty' of traditional healing methods, now also discussed the problem of the outdated and obsolete institution of the 'mental asylum' (H. Basu 2009: 32f.). As a consequence of these events, the Indian Supreme Court passed several regulations that aimed at the reformation of Indian mental health services that many mental health professionals had so long called for. At the same time, religious healing sites became a contested and controversial topic, with the Supreme Court ordering 'a comprehensive awareness campaign' that was supposed to educate particularly the population in rural regions about the fact 'that mental patients should be sent to doctors and not to religious places such as Temples or Dargahs' (Agarwal 2004: 512). Since Indian Independence, a number of nongovernmental organizations (NGOs) have emerged that are also active in the mental health sector (Patel and Thara 2003; Patel and Varghese 2004). By their practices, the NGOs construct both religious healing and mental asylums as relics of the past, the latter of which are perceived as less complex but nevertheless outdated and something that should be abolished (H. Basu 2018: 120). These archaic practices have to be put aside in order for India to become a 'modern' and secular society that is built on the clear demarcation between religious salvation and psychiatric treatment that operates according to up-to-date scientific and psychological knowledge (ibid. 2010). Nevertheless, some activists bring up the question of whether modern biomedical practice too – and particularly private psychiatric services – needs to be controlled by the state more fiercely in order to protect its users. The topic was also taken up by the media

on, for example, the popular talk show *Satyamev Jayate* (Truth Prevails), which was directed and presented by the famous Bollywood actor and director Aamir Khan. In one episode, he discussed biomedical malpractices in India's health system such as the administering of unnecessary or risky treatments and surgery (Satyamev Jayate 2012). During my own research, I was repeatedly confronted with the families' and patients' fear that private psychiatrists predominantly practise in accordance with their own (financial) interests and not for the well-being of their clients. This leads to a contrastive public image of mental health services. The huge and asylum-like public psychiatric hospitals are known for their scarce resources and lack of manpower but are nevertheless considered more reliable and less prone to exploiting clients financially. They have the reputation of being spaces of slow-working bureaucracy, leisure and corruption. In contrast, private institutions are often suspected of engaging in money-making practices and therefore of prescribing treatment that is unnecessary or even harmful to their patients.

Finally, a notable characteristic of Indian psychiatry is its heavy reliance on psychotropic drugs, with psychosocial interventions and therapies less developed, practised and even absent in many institutions (Nunley 1996; Jain and Jadhav 2009; Ecks and Basu 2009, 2014; Ecks 2014: 149). One reason may be the lay conception of biomedicine as a powerful, fast-acting and effective medicine, which a patient thus expects to receive (Nichter 1980). Psychiatrists bolster these conceptions and even stress the unique characteristics of biomedicine during interactions with their patients, something which is additionally fuelled by an experienced rivalry with other doctors and non-allopathic approaches like Ayurveda or ritual healing (Nunley 1996). Indian mental health professionals orient themselves towards the needs and expectations of the community, patients and their families in the context of markets and policies and make recourse to the conceptual tools and strategies that are part of national and global mental health discourses (Weiss et al. 2001). Earlier Indian mental health policies emphasized 'access to services and community participation with a focus on serious mental disorders' (Jain and Jadhav 2009: 63). More recent policies, though, advocate the provision and distribution of psychotropic medication while remaining unclear about the

role of community participation, integration of mental health with primary care and psychosocial interventions (ibid.: 65). Furthermore, the government's neoliberal approach to the pharmaceutical industry in a highly competitive marketplace together with a poor regulation of drug companies' practices and marketing techniques allow pharmaceutical representatives to develop close 'working relationships' with medical professionals and students across all medical specialities (Bayetti, Jadhav and Jain 2019: 157). Consequently, Indian psychiatric culture relies heavily on pharmaceutical treatments, maybe more than in most other parts of the world, and this has become 'an essential part of being a psychiatrist' (ibid.: 138). Bayetti, Jadhav and Jain (2019) suggest that under the current lack of resources in the Indian mental health system a heavy reliance on biomedical psychiatry and psychotropics 'allows for the best possible compromise between *time-efficiency* and *treatment-efficacy*' (ibid.: 155) and enables professionals in OPDs to see and treat what is a vast number of patients. At Asha around 150 patients are seen every day during the OPD opening hours from 9.00 AM until 3.00 PM, which amounts to around thirty thousand each year.

Social Anthropology and Psychiatry: Cultural Allies and Alienated Opponents

Social anthropology and the psy-sciences have much in common when it comes to their historical origin and epistemological approach. Early anthropological and psychiatric authors shared many ideas and attitudes concerning the 'psychology of primitive man' (Skultans 2007: 101; see Freud 1960; Levy-Bruhl 1966). Both sciences actively construct and reproduce the other by translating people's behaviour, words and suffering into symbolic categories (Van Dongen 2000: 124). This gives rise to an asymmetrical relationship between psychiatrist/social anthropologist and the other: while the latter's behaviour and mental health is questioned, the moral order of the former is rarely under scrutiny (ibid.: 132). In the medical sciences as well as in social anthropology, the potential misuse of power was met with similar methodological measures. Ethical codes were supposed to prevent anything similar to the abhorrent medical ex-

periments in Nazi Germany during the Second World War from happening again (Bell 2014) and evolved out of confronting its colonial past in social anthropology.

Both disciplines, psychiatry as well as social anthropology, assume that it is possible to understand the other by empathy and to a certain extent also by reflecting on and interpreting its limits (Van Dongen 2000: 124; Skultans 2007: 107; Kirmayer 2008). Medical anthropology's fascination for narratives, which reach 'out to reality' and in the process create 'a new social and personal reality which obscures it' (Skultans 2000: 96), is shared by psychoanalysis and talking therapies. Both disciplines draw on the rich meanings that are carried by the narrative form in their analytical writings and professional practices. Finally, the preoccupation with the 'abnormal' in a cultural comparative perspective once provided a fruitful basis for interdisciplinary collaboration between psychiatry, social anthropology and psychoanalysis (Jenkins 2015: 7; Hollan 2016).

In the following decades, though, a fundamental reorientation in the disciplines and therewith a diverging understanding and complication of the term 'culture' caused a disciplinary alienation prevalent to this today. Vieda Skultans traces one reason for the mistrust social anthropologists developed concerning psychology and psychiatry to Émile Durkheim's analysis of the origin of religious thought, which led to a 'reappraisal of concepts of mental health and illness as culturally grounded categories whose intelligibility depends upon a proper identification of their social roots rather than the identification of the behaviour to which they refer' (Skultans 2007: 103). Suddenly psychiatry itself became 'the other'. Psychiatry's own 'culture', its historical origins, the politics of its nosologies, its clinical engagement with its subjects and its understanding of 'culture' became the subject of social anthropological studies (Littlewood 2000: 67). The anthropological gaze excavated diverse facets of early psychiatry's ethnocentrism and shed light on the racist assumptions some psychoanalytic and psychiatric concepts were built on (Skultans 2007: 98). Under particular scrutiny was a psychiatric category that came into being in the 1950s, the so called 'culture-bound syndromes' (Littlewood 2000: 77; see Jadhav 2004). In contrast to the contemporary psychiatric perspective, social anthropologists propose that all illnesses and human responses to them are

socioculturally determined and that human action is constitutive of biology as well (Littlewood 2000: 85). Janis Jenkins (2015: 4ff.) criticizes psychiatry for its tendency to reduce the locus of disorder to a biochemical 'substrate' rather than trying to grasp it in terms of a person's lived experience. Overall, it seems that the once 'cultural allies' have become 'alienated opponents' (Skultans 2007: 110).

By embracing the analytic concept of 'psychiatric culture', I attempt to develop an approach to the understanding of psychiatric practice that refrains from framing biomedicine, the psychosciences or 'Western culture' as an immoral opponent in this work. The term 'culture' I understand as 'an orientation to being-in-the-world that is dynamically created and re-created in the process of social interaction and historical context' (Jenkins 2015: 9). This 'orientation to being-in-the-world' is constitutive for subjectivities, experiences and social realities. Several authors who influenced and shaped the field of medical anthropology have shown how culture informs body techniques (Mauss 1973), postures, styles and tastes (Bourdieu 2002), the expression and communication of distress (Nichter 1981), the performance of suffering and healing (Csordas 1990; Wilce 1995) and the creation of scientific knowledge (Latour and Woolgar 1986; Berger and Luckmann 1990 [1966]). Further, socioculturally created entities react to and act upon (Latour 2010) and can even make up people (Hacking 2007). Nevertheless, 'culture' always remains an abstract and analytical term that denotes a process or potential of meaning-making rather than a concrete, material or social object. Culture cannot be observed, measured or quantified as a materialized entity. Nor are people, things or symbols carriers of cultural meanings. Culture's meaning-making effects, created by certain 'causal powers' that enfold through an interplay between social and material entities, can be recognized as patterns and structures in social institutions, discourses, bodies, behaviour, language, perception and practices (Elder-Vass 2012). Medical anthropologists understand culture as a 'meaning-generating context' (Van Dongen 2000: 135; see Van Dijk 1998) that fundamentally shapes everything from risk/vulnerability factors to course and outcome of an illness but also serves as an important 'therapeutic tool' (Van Dongen 2000: 135) in itself. In this work, I draw on Laurence J. Kirmayer's (2006) understanding of

culture as a dynamic system in which stories reshape people's perception of the world, drive individual action, imbue every action with meaning and at the same time act self-reflexively and change the frames of interpretation and understanding. This understanding of culture emphasizes 'the dynamically constructed and contested nature of lived experience and the social world' (ibid.: 133), builds on a conceptualization of the self as a narrative construction and frames a human's psychology as 'competing and conflicting stories of the self' (ibid.: 132).

As a critical scientific approach, social anthropology, and medical anthropology in particular, has the potential to problematize psychiatries as cultural organizations with diverse sociocultural and political practices. 'Local psychiatric cultures' are constituted by embodied institutional roles, social interactions, relationships and practices that shape the organizational everyday life (Caudill 1958; Fengler and Fengler 1984; Nunley 1992). Psychiatric institutions rely on certain ideologies that structure relationships within them and direct the behaviour of people towards certain organizational goals (Rhodes 1991; Young 1993; Strauss 2011). Talal Asad (1979) suggests understanding dominant ideologies structuring interactions in organizations as essential meanings that became authoritative under specific historical circumstances. Hospital cultures evolve in sociocultural and political contexts; they are not static but a product of a daily ongoing process of negotiation (Strauss et al. 1963; Long, Hunter and Van der Geest 2008).

Nevertheless, not all voices and perspectives within an organizational structure have an equal value and weight and therefore the same possibility to be heard or have the imaginations uttered by them realized (Graeber 2015: 45). Particularly in psychiatric organizations the voices of patients tend to be muted and their 'mad' speech and bodies are fiercely controlled by institutional practices (H. Basu 2009). What psychiatric patients speak about is often perceived as bizarre, unintelligible or nonsense and therefore is excluded from the discourse of sanity (Van Dongen 2004). Patients' bodies, movements and their speech are controlled or cut off in order to 'treat' and reshape them in a socially acceptable manner. The meaning of the term 'patient' is – not coincidentally one would suppose – twofold here. The term 'patient' denotes somebody who receives treatment from any kind

of health care provider. Etymologically it is derived from the meaning for 'the one who suffers and endures' (from Latin *patientem* = bearing, supporting, suffering, enduring, permitting). This can be understood as somebody suffering from an illness or injury in a clinical sense. Additionally, the term 'patient' signifies somebody who is passively affected and acted upon. This is the case when somebody is 'treated' in a clinical institution, which includes being objectified by the 'medical gaze' (Foucault 1994).

Psychiatric patients are persons systematically acted upon, subordinated by forces that we might, theoretically, understand as 'structurally violent'. Akhil Gupta (2012) defines violence as occurring 'in any situation in which some people are unable to achieve their capabilities to their full potential, and almost certainly if they are unable to do so to the same extent as others' (ibid.: 20). Violence is structural when 'it is impossible to identify a single actor who commits the violence' and 'the violence is impersonal, built into the structure of power' (ibid.). Nevertheless, being a 'psychiatric patient' never eliminates agency – the capacity of the individual to actively exercise control over or at least influence how to live their life, even if subordinated by a local social system (Sieler 2014: 323). To gain an insight into social structures of power, Judith Okely (1991) proposes focusing on moments of individual resistance to subordination. In every organization, where ideological order categorizes, normalizes and stresses coherency, we find things and people resisting dominant meaning-making processes. Many of the anecdotes and case studies presented in the following chapters are about 'deviant' personalities, alien social moments and particularly aberrant narratives. Psychiatric patients make use of their voice and actively engage in meaning-making, borrowing terms and symbols from their surroundings and often drawing on the same meaning systems and notions of culture as psychiatry does (Lucas 2004). Furthermore, 'mad' narratives often implicitly criticize and sometimes even inverse dominant organizational discourses and challenge stereotypes and social norms. The focus on individual, defiant speech can provide social anthropologists with an understanding of normative forces at work in organizations and reveal 'cracks of contentment' (Okely 1991: 7). These are caused by atypical individuals who are nevertheless defined

by the structures they resist. However, the existence of these cracks indicates that the given order is not the only one imaginable, unstable and not everlasting and that other social realities are possible and their realization may be just around the corner.

Narratives from Psychiatry

The ethnographer presents their insights gained from the analysis and interpretation of collected fieldwork material in the form of an ethnographic narrative. John van Maanen (1995) designates ethnography as a 'storytelling institution' that follows 'specific compositional practices . . . to fashion a cultural portrait' (ibid.: 5). The concept of a 'narrative ethnography' (Tedlock 1991: 69) gave rise to a reflexive approach, and Barbara Tedlock argues that the ethnographic stories we tell are always at least twofold: one strand engages with the researcher's experiences and the methodologies applied and another portrays the people encountered in the field and tries to grasp their experiences. The representation of the other as well as the ethnographer's self is what constitutes an ethnographic narrative.

A narrative is always both 'a mode of reasoning and a mode of representation' (Richardson 1995: 200). It is necessarily reductive and fragmentary, and therefore lived experience is always richer than a story told about it (Gay y Blasco and Wardle 2009: 9f.). The American psychologist Jerome Bruner (1991) understands narratives as being 'instrument[s] of mind in the construction of reality' (ibid.: 5). One central feature in the human organization of experience into temporally meaningful episodes is what Richardson (1995) calls 'narrative reasoning': 'the type of reasoning that understands the whole by the integration of its parts' (ibid.: 201). The latter stands in stark contrast to 'empiricist reasoning', which is 'the type of reasoning that "proves" statements' (ibid.). The narrative form is an inevitable cultural and communicative tool in social practices of meaning-making, explanation and persuasion. It is made use of by social anthropologists as well as by their informants. In the following, I frame the narrative ethnographic approach employed in this work to give meaning to patients', their families' and hospital staff narratives as well as to my, the researcher's, experiences.

Narrative Analysis in Medical Anthropology

The so called 'lifeworld' approach equipped social anthropology to understand individual experience and subjectivity as constitutive in itself, beyond its function as giving access to culture and meaning patterns. Skultans and Cox (2000) state that narratives and life stories are of such an interest for medical anthropology because they 'both provide a bridge which spans the earlier Enlightenment dualism of the individual and society and a means of accessing experience which would otherwise remain embedded in the body and beyond reach' (ibid.: 21). However, narratives cannot be considered as a congruent report of experiences and emotions. They are better understood as 'experiences put into words' in order to communicate them. The relation between experience and language is a problematic one, and if we can even access somebody's experience at all remains highly questionable. Nevertheless, narratives can inform us about how individuals speak about their (illness) experiences, construct and understand bodily symptoms and illustrate how social forces shape their experiences or even enable them (Kleinman 1989). Identifying cultural patterns and motives in narratives, particularly in stories and myths, has a long tradition in social anthropology, especially in structuralist approaches. Claude Lévi-Strauss (1997) and his identification of certain 'mythemes' is one example. The structuralist approach predominantly stressed and elaborated on the universal elements of stories and tales, their collective meanings and the social structures they refer to. In contrast, Nigel Rapport (2004), for example, focuses on the personal, private and fluid meanings of his informants' narratives. The sociocultural construction of reality oscillates between individual meaning-making and sociocultural themes, symbols and conventions. People make meaning of and think about the world by means of social principles and cognitive elements they learn and borrow from their sociocultural environment. Narrative analysis has to take into account both of these fundamental functions: the sociocultural as well as the psychological dimension of narratives. It has to acknowledge a narrative's function for its teller as well as for the audience – context constitutes one of the key elements in narrative analysis (Cortazzi 2013: 385ff.). In the following, I understand narratives as social events and

as products of social entities and the causal powers and mechanisms the latter entail (Elder-Vass 2012). Furthermore, narratives themselves can be considered a part of social entities, for example, of organizations like psychiatric hospitals. In order to explain social events and the causal powers and mechanisms that produce them, the concrete phenomena that need explanation have to be identified and the explicit circumstances of their production clarified. Therefore, in order to adequately understand narratives as social events and to grasp their ontology, one must accurately contextualize them. This includes reflection on the situation in which they were produced and our own roles in their production; for example, as an interviewer or conversational partner (Csordas et al. 2010).

Psychiatric Diagnosis as a Mirror of Cultural Metanarratives

Arthur Kleinman (1977) successfully questioned the idea that the phenomenology of psychiatric disorders varies minimally across cultures and probed the social meaning and the clinical ambiguity of psychiatric diagnostic categories. His approach was taken up by numerous medical and transcultural psychiatric anthropologists in the following decades (Gaines 1992; Nuckolls 1992; Young 1993). While neighbouring disciplines like sociology and philosophy took up similar constructionist approaches to understand the 'sociology of diagnosis' (Hacking 1986; Jutel 2011), publications in the medical sciences and psychiatry are largely ignorant of these findings (with a few exceptions – see Jutel and Dew 2014). Psychiatry in its efforts to develop an international nosology and standardized approaches to diagnosis and treatment remains 'highly biased toward the Euro-American constructs' (Kirmayer 2006: 136). Consequently, psychiatric discourses and persons who embody these are more globalized than ever. Diagnoses like depression as well as other psycho-pathologies such as attention deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD) have grown in popularity over the past three decades worldwide, including in India (Lang and Jansen 2013). Nevertheless, medical anthropologists and transcultural psychiatrists also have shown the bi-directionality of the diffusion of explanatory models and lay and professional

vocabularies (Weiss et al. 1988; Jadhav 1994). However, the global expansion of diagnosis and illnesses in the context of the global mental health movement (see <http://www.globalmentalhealth.org/>) is pre-eminently a one-way street. While diagnoses like 'hysteria' and 'multiple personality disorder' (Strauss and Kurz 2018) are applied in Indian clinical contexts, a diagnosis like 'possession' remains a 'culture-bound' syndrome and does not travel globally. According to China Mills and Suman Fernando (2014: 190), the framing of 'mental health' or disorder as a global priority and the push for a global norm for mental health and a standard approach for all countries and health sectors not only ignore local realities but also work to discredit and erase and replace local frameworks for responding to distress (Davar 2014).

During my research, I encountered Zaara, a young woman in her early twenties, in the psychiatric ward of the private hospital, who was diagnosed with an eating disorder (bulimia) and borderline personality disorder. Zaara, who hailed from a rich family and an upper middle-class background, held regular phone calls with her aunt, who lived in the United States, to discuss her diagnosis and treatment options with her. One day she shared her belief with me that eating disorders seemed not to be treated with ECT in the United States. She therefore planned to challenge the treatment decisions of her Indian doctors, who had regularly prescribed ECT for her condition. Zaara's case illustrates that the processes of the global expansion of treatment modalities and 'psychiatric narratives' are complex and use manifold channels before they are embodied by individuals and become personified. Disorders of food consumption have long been discussed by medical anthropologists as common 'idioms of distress' with a shifting meaning according to the socio-cultural context (Nichter 1981). Eating disorders like anorexia and bulimia are often discussed as typical 'culture-bound syndromes' of Western countries in the social sciences, at once mirroring gender ideals and concepts of beauty and tied to a certain experience of the body-mind and practices of self-control, transformation and discipline (Gremillion 2001; Orsini 2017; Cheney, Sullivan and Grubbs 2018). The emergence of diagnoses like bulimia or multiple personality disorder in Indian psychiatry take place in the context of changing social structures and organiza-

tion, such as in metropolitan cities like Mumbai, which correlate to a shifting experience of the body and the self (Strauss and Kurz 2018: 163). India's middle and upper classes have become immersed in evolving urban and cosmopolitan cultures that are progressively oriented towards consumption and individualistic values, which certainly also involves a modification of available and suiting idioms of distress within the respective sociocultural contexts (Ulrich 1987).

Psychiatric disease categories as well as bureaucratic classifications have “extra-logical origins” because they correspond to forms of social organization and the “sentimental distinctions” that enable the systematic arrangement of ideas’ (Strand 2011: 274; see Durkheim and Mauss 1963). In clinical everyday life, this becomes palpable in moments when patients’ unexpected or disapproved behaviour challenges a mental health professional’s knowledge and value system. During my fieldwork, I observed a situation in the OPD where a woman claimed to have a drinking problem. I was surprised as well as a little shocked by the reaction of the psychiatrist and medical officer, who openly and loudly ridiculed her. In this case, the woman had placed herself outside the rules and conventions concerning the socio-cultural ‘sphere of madness’: women do not drink and therefore also do not suffer from alcohol addiction. Laughter was the doctors’ way of dealing with a woman who was not ‘mad’ in the conventional way. At Asha, some mental illnesses are perceived as ‘madder’ than others, which illustrates how psychiatric diagnosis is enmeshed with sociocultural values and gender stereotypes. Additionally, the meaning and functions of diagnosis are mostly obtained from the bureaucratic and administrative context – for statistical purposes, psychiatrists and administrations have developed an institutionally specific diagnostic approach and, for example, do not provide any rubric for women suffering from alcohol addiction. As I elaborate in Chapter 4, rather than the well-being of patients or their families, bureaucratic structures serve the well-being of the psychiatric institution, to uphold its pre-existing structures.

Diagnostic categories refer to certain sociocultural and institutional ‘narrative templates’ that are made use of in diagnostic storytelling in order to situate patients in a ‘disease story’ with an imputed past and future (Davenport 2011). Because female

patients at Asha are rarely diagnosed as 'addicted', no sociocultural 'narrative template' that 'female addicts' could occupy as their disease story is available. This illustrates how bureaucratic as well as disease classification systems attain an important communicative, regulative and didactic role in local psychiatric cultures like Asha. Furthermore, modern 'diagnosis as a process' (Godderis 2011) forms certain logics of practices to facilitate the production of 'factual accounts' (Hak 1998). Clinical practices aim to transform the patient's and family's illness narratives into filled in forms and disease categories that are collected in a patient file (Bayetti, Jadhav and Jain 2019: 144). In Chapter 4, I show how these translations are facilitated by interpretation processes that are informed and shaped by professional ideologies and sociocultural values. Consequently, even if the International Statistical Classification of Diseases and Related Health Problems (ICD) and the meanwhile globally exported DSM (Diagnostic Statistical Manual of Mental Disorders) were originally designed to assimilate divergent psychiatric cultures (Nuckolls 1992), each professional psychiatry tends to construct and implement its unique system of diagnosis and classification. This is illustrated by the vernacular interpretation and application of the diagnosis 'gender identity disorder' by a psychiatrist at Asha, which I explore in more detail in Chapter 7.

Paper Narratives

'Paperwork' is of particular importance at Asha. Documents and files play an important and often decisive role, and bureaucratic rites of passage monitor the entry ('admission') and the exit ('discharge') points of the psychiatric institution. I adopt an approach put forward by Matthew Hull (2012b), who suggests treating documents not as mere 'instruments of bureaucratic organizations' (ibid.: 253) or 'representation' (ibid.: 254) but instead as 'graphic artifacts' (ibid. 2012a: 1). Drawing on the theoretical approach of Bruno Latour and acknowledging the agency of things, he stresses the 'generative capacity' of bureaucratic documents and their ability 'to make things come into being' (ibid. 2012b: 259). Accordingly, Hull understands bureaucratic documents as 'constitutive of bureaucratic rules, ideologies, knowledge, practices, subjectivities, objects, outcomes, and even the organizations them-

selves' (ibid.: 253). Furthermore, they also may be 'sometimes diverted to purposes far from the administrative rationales that produced them' (ibid.: 260). At Asha examples for this are the 'voluntary boarder' (VB) admission and the 'leave of absence' (LOA) discharge (see Rekha's and Varun's cases in Chapter 3). If families were not able to produce all necessary documents for a 'reception order' (RO) admission, patients could often be admitted under the VB label; the superintendent then gave the family a month to hand in missing documents (see Hemant's case in Chapter 5). Most patients are discharged from Asha by LOA discharge, which they have to renew once every month when they come to the OPD to collect medicines. This procedure spares families from having to complete the whole paperwork once again if the patient's readmission might be necessary in the future. At Asha, to comprehend and be in control of official documents equalled being in charge of one's own or a relative's psychiatric treatment. Documentary writing has been recognized as an essential element of modern governance and as a central component of colonial government in South Asia (Hull 2012a: 7). The British colonial government was called *Kāghazī Rāj* (Document Rule) due to the fact that every single act was documented in a 'complete system of records' (ibid.). This system of documentation had developed from the communication practices of the English East India Company, the trading corporation that preceded the government of colonial India. Hull relates the centrality of writing in South Asian governance to fundamental problems the corporation faced in the seventeenth century in regulating day-to-day actions of officers and employees. It even laid out a structure of governance strikingly similar to today's modern corporations. In 1621 it passed the 'Lawes or Standing Orders of the East India Company', which stated that only through a connection with a piece of paper could an action be construed as an action of the Company (ibid.: 8). The 'Lawes' expressed a loss of confidence in people and specified a kind of documentary system in which every document had to be vouched for by another. It was related to making discourse definable through a trustworthy material order, in the context of an empiricist metaphysics that was growing in Britain. The materiality of graphic signs made them useful as 'a palpable sedimentation of the real' (ibid.). In the following century, the

British further expanded their 'graphic regime' (ibid.: 10) of surveillance and control in response to uncertain loyalties of native functionaries: 'Official discourse was anchored to people, places, times, and artifacts through an elaborate use of signatures, dates, and stamps' (ibid.). The mid-nineteenth century British colonial administration was constituted in large measure by various written genres (reports, records and manuals). These 'bureaucratic inscriptional practices' (ibid.: 11) from the colonial period have left their imprint on the contemporary administrative system. As a stereotypic bureaucratic organization, Asha's administrative system produces a bunch of registers that keep track of the number of patients, admission forms, patient diagnoses, the amount of ECT treatments administered, patient deaths occurring in the hospital and patient discharge. From these diverse registers, statistics are compiled that are regularly included in hospital reports. The reports embed the numbers (e.g. admissions for each month of the year), tables (giving an overview of staff, technical equipment, buildings, etc.) and charts (e.g. visualizing the different kinds of discharges, diagnoses etc.) into a narrative describing the facilities and services currently provided by Asha (Ak. Gupta 2012: 155). Reports also draw on the hospital's historical background and on the different activities (e.g. information regarding occupational therapy and different festivals and functions) taking place in the hospital, illustrated by photographs.

Bureaucratic documents play an important role in the production of 'bureaucratic narratives' at Asha. Filled in forms and patients' files, compiled out of diverse documents, constitute the type of narratives that informed my ethnographic narrative. In Chapter 4, I concentrate on one particular narrative routinely produced by a certain bureaucratic practice, namely the filling in of the document 'Patient's Social History' by a social worker. Taken routinely from every patient who is treated at Asha, they are what Jerome Bruner (1991: 18) calls 'narrative accruals'.

The 'Mad' Construction of Reality

A particular kind of illness narrative is one that breaks with common narrative properties and is consequently labelled as 'mad'. In 2012 I participated in an academic workshop during

which participants presented excerpts from interviews recorded during fieldwork at psychiatric hospitals. I presented the case of Ramesh, a psychotic patient who was admitted to Asha's so called 'criminal ward'. The chair, a psychiatrist and psychoanalyst, chimed in before anybody else could comment or ask any questions. He announced that he doubted that my material could be used for social anthropological analysis for the fact that the meaning of the words of somebody experiencing a psychotic episode tends to remain obscure and are therefore not accessible for analysis. Ramesh's muttering, he argued, might have just been a string of words that were spoken for the sake of their alliterative sound. After the psychiatrist's comment, we immediately turned to the next workshop participant, whose excerpt he considered more intelligible and sound. This incident left me with several questions and doubts. Was the psychiatrist implying that the narratives of psychotic patients made for useless ethnographic material because their speech did not make sense and therefore could not tell us anything about their sociocultural surroundings? Or was he making the point that social anthropologists have to sort out those narratives that are too 'symptomatic'? When it comes to 'mad' narratives, one major aim of social anthropologists of psychiatry has been to 'depathologize' and 'demedicalize' them in order to show that they have a meaning besides being a medical symptom of a disordered mind and brain (Van Dongen 2002: 25). Counteracting the psychiatrist's advice and implications, by contextualizing and interpreting Ramesh's narrative, I attempt to show in Chapter 6 that the experience of a mental illness, similar to more common experiences, is shaped by cultural meanings and social structures and therefore does not lie 'outside of culture' (Lucas 2004: 146). Nevertheless, stories tend to display certain 'mad' properties when they deviate from, reverse or overemphasize certain narrative principles that are socioculturally agreed upon (Bruner 1991: 21).

To begin with, events incorporated in every narrative occur in a unique sequential pattern over time. According to Laurel Richardson (1995), this is related to the fact that '[t]ime is the quintessential basis for and constraint upon the human experience' (ibid.: 207). Jerome Bruner understands the particular human experience of time and its representation in narratives as a 'mental model' (ibid. 1991: 6). 'Associative flooding' (Kindt

and Schecker 1998) that occurs in the context of psychotic experiences can predominantly structure a narrative. It disrupts the ability to organize one's narrative according to the basic principle of diachronicity. Therefore, narratives that are organized associatively and break with this fundamental principle are likely to be unintelligible and labelled as 'mad'. Further, narratives refer to particular happenings. A narrative's particularity 'achieves its emblematic status by its embeddedness in a story that is in some sense generic' (Bruner 1991: 7). An example of this would be the experience of some kind of 'shock' that families of patients often mentioned to me in connection with the onset of a mental illness. The shock could be the death of a parent, conflicts with the in-laws or problems in school. We find shock as a narrative's particularity embedded in explanatory models – that is, in 'notions that patients, families, and practitioners have about a specific illness episode' (Kleinman 1989: 121). Explanatory models include information about the aetiology of illness, and time and mode of onset of symptoms, pathophysiology, the course of sickness and the proper treatment. The contingent components of explanatory models tend to produce generic stories. However, I illustrate in Chapter 6 that Ramesh in his narrative reversed the principle of particularity in that his story does not emphasize a particular event or give an explanation why it happened. Instead, he stresses the social and personal meaning that people's deaths have in the context of his life.

The happenings mentioned in the course of a narrative are relevant to the intentional states of a narrative's protagonists: a narrative account provides 'the basis for *interpreting* why a character acted as he or she did' (Bruner 1991: 7). Happenings in narratives implicitly change the inner qualities of their protagonists. This explains why something could or probably will happen to them. Shocking life events – for example, the mother's decease, quarrels with the in-laws or problems in school – might disrupt a person's inner balance in a way that they become prone to mental health issues. However, a narrative only works if the narrator and their audience share the sociocultural concepts referred to, in order for a character's actions or suffering to be understood. A story somebody tells about a neighbour who urinated behind a bush at a bifurcation on his way to the village and subsequently suffered a possession attack only becomes intelligible if one has

the local knowledge that urinating in inauspicious places makes one vulnerable to demons who linger there (H. Basu 2010b: 418). Similarly, misunderstandings or false interpretations might occur because the narrator uses 'mad concepts' or makes apparently idiosyncratic assumptions about a protagonist's inner state. I illustrate this by analysing Ramesh's narrative (which takes up the crime of murder rather surprisingly and abruptly) for the conversational context and his reversal of the principle of inner state entailment. By reversing the narrative principle and negating the intentional state entailment in his narrative, Ramesh purifies the narratively constructed reality of his deeds and guilt.

A narrative's whole and its parts rely on each other for their viability: 'a story can only be "realized" when its parts and whole can, as it were, be made to live together' (Bruner 1991: 8). A listener interprets the narrative that is put together by the speaker. How a narrative is interpreted and if its content is doubted or questioned depends on the way it is narrated and adapted to the narrational context. Bruner mentions two processes: 'narrative seduction' and 'narrative banalization', which commonly suffice for the audience to take a story 'as it is', eluding a conscious interpretation (ibid.: 9). Whether we 'buy a story' depends on the reason a story is apparently narrated – 'the issue of *intention*' (ibid.: 10) – as well as on the background knowledge of both the narrator and the audience and how each interprets the other. Socio-cultural as well as psychological variables determine the context sensitivity of a narrative. The experience of psychosis or other challenging inner experiences often constitutes a strong inner narrative force. Accordingly, the narrator becomes less adaptable to the narrational context and at times even ignores or does not consider the existing context knowledge of listeners (see 'Personale Asyndese' in Kindt and Schecker 1998). Stories that lack context sensitivity tend to be odd and unintelligible, and their narrators are likely to be perceived as 'dotty' or 'mad' by others.

Narratives serve communication and social interaction and construct a 'social reality', but furthermore they are important tools to tell 'our story' and to understand ourselves as meaningfully being in the world: 'The self comes to know itself through its own narrational acts. In narrative constructions of past, present and future, of relations of sameness and difference, the self is given content, is delineated and embodied' (Rapport 2004: 75).

The understanding of one's self and several self-related processes, though, is often fundamentally disrupted in the case of mental problems and crises (Jenkins 2004: 35). Therefore, tellers of 'mad' narratives are often obsessed with (re)constructing and rescuing a meaningful self by conveying it to their listeners, who at times feel bombarded with apparently inappropriate personal and repetitive information. Take Rosie, the model and actress, as an example (see Chapter 3), who experienced her stay at Asha as a film crew's test that was supposed to evaluate her abilities as an actress. Every time I encountered her during my research, she spoke at length about her 'aptitude check' and how much she despised having to endure this hospital stay in order to pass it. Stories that are considered to be worth telling are those that show an implicit canonical script that has been breached, violated, or deviated from (Bruner 1991: 11). This narrative property is obviously highly dependent on the sociocultural context, norms and expectations. 'Mad' stories often ignore sociocultural conventions by transgressing or creatively transforming them. They often do not concern particular breaches of a canonical script, but with their narrations and performances 'mad people' constitute a breach themselves (Van Dongen 2002).

Whether a narrative is considered acceptable or not does not depend on its correct reference to reality or its verifiability (Bruner 1991: 13). Rather, narrative 'truth' is judged by its verisimilitude. 'Mad' narratives are labelled as 'nonsense' not because they are 'untrue' but because they ignore certain narrative principles. 'Mad' narratives usually do not follow the aim of constructing a verisimilar account but rather try to control and keep together life worlds and selves that fall apart by juggling symbols and personal associations. In order to (re)gain control over their lives and selves, 'mad' narrators may oversimplify causalities, exploit cultural symbols, ignore conversational contexts and become self-centred. Presumably, tellers and listeners of 'mad' stories evaluate them according to very diverging standards. Bruner (1991: 17) argues that context sensitivity qualifies narrative discourse as a viable instrument supporting cultural negotiability. Undoubtedly, competing versions of a story are much more tolerated than diverging versions of arguments or proofs (*ibid.*). Nevertheless, which narratives are in the end per-

ceived as 'true' or justified also depends on the social power of their tellers, as I show in the context of bureaucratic narratives in Chapters 4 and 5.

To summarize, a narrative is prone to be labelled as 'mad' if it breaks with one or more of the above outlined narrative principles and therefore displays certain 'mad' properties. By manipulating narrative principles, 'mad' narratives tend to construct different and alternative realities than 'sane' ones do. This cannot simply be framed as the product of a deficient brain or disturbed language. It has to be understood as a phenomenon emerging from different needs and intentions, divergent experiences and perceptions and variational environments. Furthermore, the 'mad' reversion and creative transformation of conventional narrative principles reveal the subtle 'work of culture' (Obeyesekere 1990) and the 'magical power of cultural symbols' (Van Dongen 2002: 42). Every human being who possesses the ability to narrate does magic with his or her words to a certain extent. Humans strive to construct a reality in which they feel comfortable living and where their actions are accountable. But narratives are never consummate. Depending on the tellers' inner state and the sociocultural context, narratives lack coherence, plausibility or verisimilarity. Depending on the tellers' local knowledge and their mental and linguistic proficiency, they are able to adjust their narrative to their audience. Therefore, there is no clear or absolute demarcation between a convincing story and a foolish one, an intelligible or an unintelligible story or a conventional or 'mad' story. Telling stories – like most human phenomena – is 'distributed along qualitatively defined continua rather than as defined by discrete and distinct categories' (Jenkins 2015: 3). Whether a narrative is labelled as 'mad' does not depend on the tellers' mental characteristics alone. Rather, cultural norms and social power structures are decisive as well. Furthermore, as I show in the case of Ramesh, even if 'mad' narratives display different properties than conventional ones, this does not render them unintelligible or nonsense per se.

Queered Stories of Gender and Sexuality

A central theme in Indian psychiatry, taken up by the media, by social scientists and particularly feminists, is the mental health

of Indian women. Contemporary authors discuss this predominantly in the context of women's marginal socioeconomic status, gender stereotypes, role expectations in Indian society, domestic and sexual violence and their common abandonment in psychiatric hospitals and shelters (Davar 1995, 1999, 2001; Chandra et al. 2003; Addlakha 2008; Pinto 2014, 2015). In this ethnography, I explore the construction and reinforcement of gender roles – female and male – in the context of a mental illness and psychiatry and how long-term patients either draw on or manipulate and transform gender stereotypes in their (illness) narratives and self-representation. Additionally, I scrutinize a patient's 'queer' narrative that challenges seemingly basic assumptions about gender and sexuality and draws on local queer identity categories in the context of globalized biomedical and psychiatric discourses (see Chapter 7).

According to Ian Hacking (2007: 305), sciences have become central in the self-representation and -understanding of industrialized societies since the nineteenth century. He describes different kinds of 'engines of discovery' among them clinical medicine, biology and bureaucracy that have driven the human sciences in 'making up people' – the creation of kinds of people that in a certain sense did not exist before. He mentions the 'discovery' of 'the homosexual' by psychiatry as an example. What is known as 'homosexuality' today was included in a category of vice, namely 'sodomy', throughout medieval times and the Renaissance (Oosterhuis 2000: 21ff.).⁶ The first phase in the rise of an autonomous category of homosexuality was marked by the eviration of sodomites and their identification as 'hermaphrodites' (Hirschauer 1993: 78). Whereas in the past men who had sexual relations with other men were only considered 'hermaphroditic'⁷ in some cases, towards the end of the eighteenth century every same sex sexual activity marked both involved parties as psychologically and medically deviant and as belonging to a third gender category (ibid.: 79; see Crozier 2008). Stefan Hirschauer (1993) understands the rise of these medical and psychological theories as happening in a certain sociopolitical context that destabilized opposite sex unions (ibid.: 83). The specific 'knowledge' about so called *Geschlechtscharaktere* (sexual stereotypes) (ibid.: 82) correlated with a discourse that saw the sexes as different from but nevertheless as complementing

each other (Hausen 1976). The crisis of heterosexual relationships brought with it the need to clearly define and demarcate people who desire their own sex. The result was that these could neither be 'real' men nor 'real' women and therefore a 'third gender' was incorporated into the theory of the complementarity of the sexes. If the female and male 'naturally' attracted each other, there had to be something female in a man-loving man and something male in a woman-loving female: these individuals were assumed to be 'inverted', belonging to an 'intermediate sex'. The related concepts of 'butch' and 'femme' and the effeminate gay man, the 'fag' or 'queen' emerged in this context (Hirschauer 1993: 83f.).

This categorizing of the deviant sex/gender also had an impact on works and approaches in social anthropology that were concerned with queer expressions of gender and sexuality. Serena Nanda (1999) embedded her work on hijras – India's so called 'third gender' – in a social anthropological discourse concerning the social construction of 'sex' and 'gender'. Her ethnography was read as an example of 'alternative gender roles' to dispel the 'Western belief that there are only two sexes and two genders, each naturally and permanently biologically determined and each exclusive of the meanings and characteristics of the other' (Nanda 1999: xi; see Herdt 1996; Nanda 1996). As Gayatri Reddy (2005a) suggests, the anthropological literature in the 1990s situates hijras 'explicitly within the realm of sexual difference, implicating them in the debate on Western versus non-Western tolerance for sexual ambiguity and binary gender categorization' (ibid.: 31). However, Reddy, in her own ethnography on the hijras in Hyderabad, turns away from what she calls 'third gender analysis' in order to 'defer efforts to read the etiology of the sexed body in terms of the primacy of either cultural system or political economy or to reduce it to biology or psychology' (ibid.: 295). Reddy adopts Laurence Cohen's (1995) approach by locating 'the body within a multiplicity of differences' and examines the embeddedness of sexuality in everyday life and experiences. Accordingly, I approach narratives that tackle gender and sexual experiences as embedded in everyday life and social-cultural contexts and do not understand them as a representation of a stable gendered or sexed self. Rather, I assume that narratives are produced within a multiplicity of

contexts of being-in-the-world that open the space to reinforce but also to reframe and transform conventional experiences and notions of gender and sexuality.

An important aspect that concerns narratives regarding gender, sexuality and queerness in this ethnography is the experience or display of 'madness', 'mental instability' and 'deviance'. Arthur Kleinman (1989) was the first to systematically describe how humans organize their experiences of illness and crisis as personal narratives. According to Kleinman, personal illness narratives do not only reflect and share illness experiences but also contribute, shape and even create the experiences and narratives of others. The 'plot lines, core metaphors, and rhetorical devices that structure the illness narratives are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings' (ibid.). The function of illness narratives varies according to the different purposes they have, the contexts in which they are told – to the family, the practitioner, the health insurer or the social anthropologist – and the questions they are supposed to address – Why me? How to proceed now? What can be done?

Apart from personal illness narratives, Kleinman discussed two more kinds of narratives concerning 'disease' and 'sickness'. The former is embedded in clinical or 'medical' narratives – in a story that functions to guide treatment and healing decisions and name and explain the biological or psychological mechanisms that apparently cause the patient's symptoms. Furthermore, by employing a medical narrative, the healer 'interprets the health problem within a particular nomenclature and taxonomy, a disease nosology that creates a new diagnostic entity, an "it" – the disease' (Kleinman 1989: 5). Renee Anspach describes 'the conception of specific diseases that existed independently of individual patients' (Anspach 2011: xv) as characteristic of a 'modern' diagnostic practice that emerged at the beginning of the nineteenth century. However, besides the pathologizing effect medical narratives and diagnostic categories have, they also form the foundation for certain 'diagnostic communities' (Smith-Morris 2016: 10). In the Mumbaikar context, 'gays', 'trans-genders' and 'kothis', who were identified as 'high risk target groups' in sexual health interventions, constitute such diagnostic communities (see Chapter 7).

Secondly, besides medical narratives that guide treatment, there are certain 'sociocultural' narratives that tackle the question of which social sources and macro-social (economic, political, institutional) forces may cause (mental) health problems and can be held responsible for human misery. Those narratives are concerned with 'sickness' and attach cultural meaning to certain symptoms and diseases, often in connection with moral judgement. Take as an example the case of the stigmatization of venereal diseases like AIDS and the association of the HIV epidemic with male homosexuality in the 1980s (Kleinman 1989: 6f., 21ff.). The translation of scientific insights into public health interventions tends to be interspersed with the moral judgements of the health professionals and politicians who initiate them; for example, the provision of 'knowledge' concerning safer sex education in the context of the HIV epidemic (Irvine 2005: 124ff.).

To summarize, personal illness narratives about the experience of chronic illness form a biographic story, and medical narratives around a disease constitute a body of medical knowledge and sociocultural narratives about sickness that materialize as distinct public health interventions. Motives, themes and plots are what link these different narrative levels. We find similar concerns and explanatory models in personal and medical as well as in sociocultural narratives, adjusted to the respective contexts and a narrative's function. Ajay, whom I encountered during my fieldwork in the admission ward, drew on 'hormonal imbalances' and 'female hormones' as an explanation for his 'homosexual' behaviour and him 'feeling female' (see Chapter 7). In contrast, the medical discourse perceives sex hormones as one factor but certainly not the decisive one in determining a person's sexuality. Nevertheless, the identification of certain biological factors that probably 'cause' homosexuality is part of a highly morally loaded sociocultural discourse. Confronting the disapproving moral judgement of his behaviour, Ajay refers to God, who created his body and desires as it is and who cannot be morally wrong. Homosexuality, even if no longer categorized as a psychiatric 'disease', is still perceived as a social disorder, a 'sickness' in many societies and social contexts. Therefore, tracking down its apparent biological causes, employing biomedical explanatory models and propagating biomedical 'treatment' op-

tions is still a prevalent sociocultural intervention, with the aim of eliminating homosexual persons from the social landscape.

Reconciling Alienated Opponents: A Symmetric Approach to the Analysis of Narratives from Psychiatry

Modern psychiatry claims to have an objective, rational and scientific approach to mental health as opposed to a subjective, irrational and backward approach. Indian psychiatric medicine in particular demarcates itself from religious or ritual healing practices, which it denigrates as ‘unscientific’, ‘unmodern’ and ‘false believes’ (H. Basu 2014: 191). According to many psychiatrists, ‘mental patients’ and their families who frequent ritual healing sites are unaware of what they ‘really’ suffer from, for example ‘schizophrenia’ or ‘conversion disorder’. Psychiatry’s claim to be modern results in psychiatric practices that are imbued with ‘purification processes’ (Latour 1994) that seek to identify and separate the social from the natural. However, as a consequence, clinical approaches are blind to certain characteristics of illness narratives; ‘mad’ and ‘queer’ narratives become unintelligible and inaccessible to psychiatrists, and their systematic analysis and interpretation is left to the social sciences. Let me unravel this argument in more detail in the following.

Before disease classification systems came into being, diagnostic processes in general were rather geared towards the patients’ narratives, their wording and observations (Mak 2004: 98). Diagnoses tended to be ‘fluid, fluctuating, and focused on the individual patient’ (Anspach 2011: xv). With the modern medical approach, it is not the patient but the disease itself that has a narrative or exemplary ‘clinical course’ that includes a history, its present manifestation, a prognosis and an aetiology. The practice of modern diagnosis positions the patient in a clinical narrative that suits the ‘clinical signs of disease’ (Rosenberg 2002). While these signs were first detected by the physician alone, later diagnostic technologies like medical tests and laboratories changed the practice of diagnosis. It more and more moved away from the patient’s and practitioner’s subjective narrative and therefore diminished its role. This gave rise to what Paul Ricoeur (1974) calls the ‘Hermeneutics of Suspicion’. He

argues that an interpretive wall emerged between the patient's experience of illness and the physician's technologically mediated 'pictures' of disease, leading to a clash of the patient's experience with its medical interpretation. Particularly, psychiatry and the branch of psychosomatics developed concepts depicting the discrepancy between disease and illness experience; for example, 'somatizing disorder', 'functional disorder' or 'hypochondriasis' (Kleinman and Becker 1998; Anspach 2011: xvii).

Therefore, biomedical practices operate at the interface of the 'natural' and the 'social' sphere and are preoccupied with the translation of the individual 'subjective' experience into abstract 'objective' knowledge (Gardner and Williams 2015; Myers and Ziv 2016; Tessier 2016; Hollin 2017; Lawlor and Solomon 2017). This means that any narrative that incorporates ambiguous characteristics from the patient's (subjective and social) as well as the practitioner's (objective and natural) sphere runs the risk of being perceived as suspicious or even dangerous in the modern, dichotomous framework (Douglas 1984; Jackson 2005). This is exemplified by the case of a patient who dared to diagnose and therefore 'objectify' himself at Asha. I was shown the hospital structure and all the wards by one of the senior female social workers, 'Gadge madame', one morning. In front of one of the 'chronic wards', we encountered a male patient. The social worker brusquely directed the man to introduce himself – a very typical, paternalistic mode of interaction employed by many of the social workers when interacting with patients. His name was Sunil and he had been there for two years. He was able to understand and speak basic English and – as far as I can remember, and as it appears from my rather fragmentary field-notes of this encounter – we three conversed in a mix of Hindi and English. I asked him what his 'problem' was. He responded that he was troubled by 'psychosis'. Gadge madame briskly interrupted him, adopting a very resolute tone: 'Don't diagnose yourself, Sunil!' and then turned towards me and explained that because 'he is educated he knows some things about the things'. Somehow trying to de-escalate what I felt was a very incriminating situation for Sunil, I hastily continued to ask him if he was given the diagnosis by one of the psychiatrists. '*Nahīn*' – 'No', he answered in a shy and avoidant manner, while throwing an anxious side glance at Gadge madame. In this scene, the agency

and authority to narratively frame his experiences according to the medical discourse was gruffly taken away. In my notes, I additionally mention that I experienced the social worker's behaviour towards Sunil as generally 'very depreciative'. Obviously, the expectation was that Sunil was supposed to speak about his problem like an 'uneducated patient', that means he was supposed to use non-medical and experience near language. He was not supposed to adopt an approach and encroach on terms that from the social worker's perspective belonged to the meta-narrative that clinicians employ in order to be able to scientifically frame behaviour and speech as 'symptoms' and eventually reach a clinical diagnosis. This illustrates how in this local psychiatric context, treatment is not perceived as an intersubjective meaning making process that includes the patient as well as the doctor. Rather ailment is treated as a 'disembodied disease' that is completely detached from the personal experience and subjectivity. However, even if the relevance of experience and subjectivity is denied in clinical contexts and patients' life worlds are not supposed to commingle with those of the clinicians, by engaging in certain 'purifying' interactions a particular kind of reality and lifeworld is nevertheless created by the protagonists.

By perceiving itself as the rational natural, biomedicine in its clinical practice becomes highly vulnerable to 'contamination' by patients' illness narratives and their embodied diseases, which represent the 'irrational' social. Ramesh's narrative epitomizes the amalgamation of the social and the natural. It therefore poses a challenge to practitioners, who have to decide if his narrative should be considered 'mad' and unreasonable because it emerges from a biochemically disturbed brain or if it does hold meaningful information about his past or the institutional surroundings. The modern psychiatric approach seeks to classify Ramesh's speech as either symptomatic or as socially meaningful and avoids acknowledging its 'hybrid' characteristics (Latour 1994) and to eventually recognize that disease is shaped by a 'cultural biology'⁸ (Kirmayer 2006). Furthermore, if Ramesh's narrative is eventually considered 'mad', it will become an object of psychiatric scrutiny and tendentially perceived as inaccessible to social scientific analysis.

Particularly psychiatric diagnosis marks the distinction of what is normal and what is not in a certain society or institution

(Jutel 2011: 3). Homosexuality and its in- and exclusion in the psychiatric diagnostic classification system, its labelling as an abnormal 'paraphilia' and later as a normal 'sexual orientation' is a salient example. Protests against the classification of homosexuality as a disease were staged by gay activists at the American Psychiatric Association (APA) conference in 1970. The Gay Psychiatric Association itself drafted a proposal to delete homosexuality from the DSM, and the board of trustees of the APA finally voted to do so in 1973 (ibid. 2011: 34; Kutchins and Kirk 1997). Decisions on the change of homosexuality's status as a diagnosis were not taken 'on the basis of new empirical or scientific evidence but on the basis of social factors' (Jutel 2011: 34). Nevertheless, as long as diagnostic categories are not challenged by a social movement they tend to be considered and treated as psychological and natural facts. Accordingly, when Ajay in his queer narrative 'mixes up' exclusive psychiatric categories ('homosexuality' and 'gender identity disorder') he is framed as 'uneducated' and 'backward'. 'Mad' narratives such as Ramesh's are understood as 'symptomatic', and therefore understanding their 'nature' can inform the psychiatric body of knowledge. Contrariwise, 'queer' narratives like Ajay's, as long as they are not yet part of a queer discourse or movement, are categorized as uninformed and are therefore excluded from informing the further development of the psychological concepts of 'gender' and 'sexuality' (Okely 1991).

Herewith, I suggest that illness narratives, even if not always as salient as in the cases of Ramesh or Ajay, generally serve as a 'vehicle for hybridization' by imbuing the natural or biological with the social. Accordingly, illness narratives as well as biomedical assessments of sickness become highly targeted by 'purification processes' (Latour 1994). 'Mad' narratives like Ramesh's are perceived to be dominated by disordered 'natural' processes and therefore as idiosyncratic, alienated from the social sphere and not accessible to social scientific analysis. In contrast, 'queer' narratives like Ajay's are framed as predominantly shaped by his (uneducated) social background and subjective experiences and therefore as contrary to a clinical assessment, which is informed by scientifically proven psychological categories. The clear distinction between the disciplinary purviews serves to re-establish the social and the natural as separate spheres and medicine as a

'pure' natural science and part of the rational modern. These purification processes eradicate certain explanatory models, as, for example, when Ajay claims to be gay because his body has too many female hormones. His explanatory model runs the risk of being dismissed with the claim that the 'uneducated patient' misunderstood the medical concept of 'sex hormones'. Generally, bureaucratic logics and practices facilitate the shaping and purifying of 'mad' narratives according to the prevailing psychiatric and institutional categories.

Similarly, the medical sphere has to be purified of 'quack' doctors, who are said to exploit people – often financially – by promising to heal incurable diseases with non-scientifically proven treatment methods or promising to cure moral 'sicknesses' that are no longer perceived as medical diseases, such as 'homosexuality'. The campaign 'Queers Against Quacks' carried out by Humsafar Trust as part of the International Day Against Homophobia and Transphobia (IDAHOT) in 2016 exemplifies such a measure: 'The aim of this campaign was to bring out the homophobic "Quacks" or fake doctors who offer "cures" and "treatments" for homosexuality' (MJ 2016). After the campaign, the Indian website 'gaysi' (The Gay Desi) published a post titled: '9 Indian Doctors Who Claim to Have a Cure for Homosexuality' (ibid.). Among others, it named the sexologist Dr Vinod Raina, who runs a private clinic in New Delhi. According to an article in *India Today*, he stated, similarly to Ajay, that homosexuality is caused by an excess of female hormones that can be treated by a hormone replacement package: 'After taking blood samples, we increase male hormones in them' (Sebastian and Vikram 2015). Dr Raina claims to have treated patients for the past fifteen years and promises a 'one hundred percent cure' for homosexuality, taking six to nine months: 'The complete package costs Rs. 1.1 lakh', the article further cites, '[But] you have to pay the cash in advance. We do not accept cheques' (ibid.).

Biomedical therapeutic interventions foremost disregard the social and personal meanings of illness and sickness and therewith do not engage in any social responsibility beyond the 'rational-technical'. Therefore, they merely remain at the level of 'treating' diseases instead of curing them (Kleinman 1989: 28f.). Modern society's fragmented world view leaves medical anthropology, which scrutinizes biomedical practices, in an am-

bivalent and precarious state, as it finds itself situated between the social sciences that are supposed to explain the socially constructed and the natural sciences that deal with the naturally determined. Because the social is subordinated to the natural, medical anthropology is merely perceived as a discipline that 'helps' medicine to explain how culture and society 'influence' experiences of disease. Accordingly, John Campbell (2000) points out a methodological tension in medical anthropology that is 'the very different concerns, methods and indeed frames of reference underpinning psychological and anthropological research' (ibid.: 105). The clinical translation of individual experiences into medical diseases and the accompanying purification processes hinder the analysis and encounter of human suffering on a phenomenological and existential level. The division of the social from the natural and/or material world and 'realities' prohibits certain questions from being asked. For example: What leads a self-declared Indian 'gay' person to understand himself as a 'female' while in a biomedical discourse homosexuality and transsexuality exclude each other? Which other causal powers are at work here? Which sociocultural narratives influence and construct his reality and bodily experiences? Which social entities produce the biomedical discourse and which the divergent sociocultural narratives? These questions cannot be asked in the positivist oriented psy-sciences, which results in the social ontology of the respective phenomena and illness narratives not being analysed and contextualized adequately (Elder-Vass 2012). In contrast to psychiatry, medical anthropology has the epistemological tools at hand to recognize that phenomena like the gay patient who feels female are a product of biochemical as well as social forces. A symmetric and integrative analytic approach to illness narratives takes into consideration that the causal effects of social entities and sociocultural constructions equal those of material entities. Vieda Skultans (2003) argues that 'understanding human beings requires us to pay attention to narrative as well as characterization' (ibid.: 164). She suggests a dialogical approach to narratives and 'thinking with' rather than 'thinking about' stories in order to make 'room for a greater degree of empathy with the storyteller which in turn makes demands upon our moral imagination' (ibid.: 159). A dialogical approach and an analysis of narratives guided by empathic listening has the

potential to complement clinical and bureaucratic practice. Furthermore, it is capable of reconciling the 'alienated opponents' social anthropology and psychiatry by promoting an interdisciplinary conversation that links anthropology to psychology, literary theory, philosophy and linguistics (ibid.: 156). A symmetric approach to the analysis of narratives that I pursue in this work enables a symmetric approach to research and knowledge production in general and attempts to include more voices or narratives than just the 'sound' ones. It furthermore does not ignore the corporeality and embodiment of narratives that renders them so powerful (Van Dongen 2003; Bahri 2017).

Notes

1. The name of the hospital and persons mentioned in this work are anonymized.
2. I was carrying out the research for my Master's thesis at that time. It was about a nongovernmental organization in one of the suburbs of Mumbai that takes care of roadside destitutes with mental health issues (Strauss 2011).
3. Own data collection from the hospital registers.
4. Ganesha statues are predominantly manufactured in the context of the ten-day Ganapati festival. On the festival's last day, the statues are brought to a body of water, often the sea, and submerged in it. Recently, the demand for eco-friendly statues has risen.
5. Outside the Indian higher middle-class, it is not common to know or celebrate one's exact birthday. Many Indians are confronted with having to estimate their birth date or rather decide on one when applying for official documents like a passport or birth certificate.
6. Sodomy as a category is highly informed by Christian sexual morality and comprises all sexual acts that are not geared towards procreation (Oosterhuis 2000: 21ff.).
7. Men could, for example, have sexual relations with younger lovers without losing their status as male. Only if they preferred a passive part in intercourse were they sometimes considered hermaphrodites (Hirschauer 1993: 79).
8. Kirmayer introduced the concept of 'cultural biology' in transcultural psychiatry in order to counterpose the assumption of an 'universal biology' opposed to 'local culture'. He prompts researchers to combine insights from the social as well as the natural sciences in order 'to understand the sense in which culture is a biological category as we unravel the details of the culture-biology interaction' (Kirmayer 2006: 129).