

An uncritical encounter between anthropology and psychiatry

AIIMS psychiatrists reading *Affliction*

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Abstract

In what ways do two bodies of knowledge meet? Anthropology and psychiatry most often meet in a mood of mutual suspicion, the danger of which is that each confronts (or avoids) the other as a straw man. In this introduction I describe a refreshingly different encounter in which a group of psychiatrists from the All India Institute of Medical Sciences in Delhi respond to an anthropological text, Veena Das's *Affliction: Health, Disease, Poverty*, which engages with lives and issues quite similar to those encountered by these psychiatrists in their clinical practice. Rather than rehearsing relatively predictable debates (for instance on the importance, or lack thereof, of 'culture', often assumed to be the sole meeting ground between anthropology and psychiatry), what is instead surprising in the psychiatrists' engagement with *Affliction* is their recognition of a shared terrain of uncertainty and complexity that moves across the realms of the spiritual, the 'vernacular' uses of biomedical terms, and the political economy of health. I outline three domains of inquiry that this interdisciplinary discussion opens up as regards the study of mental health and illness: 1) ecologies, circuits, and tempos rather than institutions and subjectivity; 2) not-yet ontologies and etiologies; and 3) methodological consequences, beyond quantitative/qualitative divides and towards patterns, singularities, and modes of attunement.

Keywords

anthropology of mental health, anthropology-psychiatry dialogue, ontology, health-seeking behaviour, poverty and mental health, India

In what ways do two bodies of knowledge meet? Do they encounter or miss one another? What leads them to be ill or well disposed towards one another? Anthropology and psychiatry often meet in the mode of mutual suspicion (though this kind of encounter can sometimes be productive, if the suspicions are well founded). The mutual suspicions are by now well known to those who care about such issues. Anthropology often finds psychiatry to be a mode of normalizing power, enforced either through disciplinary institutions and practices or by mediating points of entry into local and global pharmaceutical regimes. The most common accusation from the side of anthropology is of the ‘medicalization’ of forms of social distress. Implicit in this accusation is the assertion of the moral and epistemological superiority of the anthropologist, as the gatekeeper of the social.

Such critiques, if by chance they do make it to the attention of psychiatrists, appear mostly annoying or irrelevant, and at some distance from the ‘real’ tasks of psychiatric research and everyday clinical work. Even for those psychiatrists who are sympathetic to such critiques, anthropological claims to knowledge often appear to psychiatrists as ‘anecdotal’ or too highly individualized and theoretically obscure to merit extended consideration. At best psychiatrists may concede that yes, ‘culture’ is ‘important’ in some cases, if one has the time clinically, and one rarely does, to consider such issues. Meanwhile anthropologists, at least those who consider themselves at the forefront of current research, have by and large lost faith in ‘culture’ as a unifying disciplinary concept. As such these disciplines are fated to miss and to mishear one another. Is an alternative hearing possible?

We write to report one such hearing, the tentative start of a conversation, which began with a close engagement with Veena Das’s *Affliction*, through a book discussion I co-organized in February 2016 with psychiatrist Dr. Pratap Sharan, at his home institution, the All India Institute of Medical Sciences (AIIMS) in Delhi. Established in 1956, AIIMS is one of the most prestigious places to study medicine in India, while also being a leading hospital. It is one of the few remaining institutions that caters to a diverse population of rich and poor patients from all over North India. ‘Everyone from a beggar to the prime minister can be found here in times of crisis’, some patients jokingly say. Many poorer patients receive treatment for weeks or months, precariously positioned in *dharamshalas* (footpaths) nearby or within the hospital.

I spent one year (from August 2015 to August 2016) as a visiting faculty member/observer at the AIIMS Psychiatry Department and the National Drug Dependence Treatment Clinic (NDDTC).¹ Alongside the ward and the psychiatry outpatient department (OPD), the ethnographic sites I was most drawn to were two urban poor ‘resettlement colonies’ in East Delhi, where the psychiatry department and NDDTC run community clinics, primarily focused on opioid substitution therapy. As a visiting faculty member, I was allowed to interview patients, caregivers, doctors, residents, and staff, and I was invited to attend and participate in psychiatry classes.

As part of the psychiatry curriculum at AIIMS, in addition to clinical work, there is a weekly schedule of academic events, common to many medical teaching institutions across the world: a journal/book club (which involves the presentation and discussion of a recent article/monograph); a case conference (which involves the presentation and extended discussion of a particular case, at times although not always currently in treatment); and a weekly presentation of a faculty member’s ongoing research or a resident’s thesis. These academic events (three a week) are held in the late afternoon between 4 and 6 pm, after a full day of clinical work in the OPD and the ward.

On 3 February 2016, the entire faculty and all residents discussed *Affliction* as part of the weekly journal/book club in the psychiatry department’s seminar room. Dr. Sharan created three teams, each composed of a faculty member (consultant physician) and a senior resident. The resident presented a summary of a chapter to the department, and the faculty member presented a brief commentary intended to bring out the significance of the chapter for their own thought process, research, and clinical practice. Dr. Mamta Sood and Dr. Prashant Gupta presented on the chapter, ‘Mental Illness, Psychiatric Institutions and the Singularity of Lives’, Dr. Koushik Sinha Deb and Dr. Swarndeep Singh engaged with the opening chapter, ‘How the Body Speaks’, and the third team, comprised of Dr. Ramandeep Pattanayak and Dr. Shalini Singh, presented on a related journal article, ‘The Mental Health Gender-Gap in Urban India: Patterns and Narratives’ co-authored by Veena Das with economists Ranendra Das and Jishnu Das (2012).

How ‘eventful’ is an event? For an anthropologist merely reporting that an event occurred misses what may be most crucial about it, namely, the intensities and energies that animate a room. And here we can offer little more than anecdotal evidence, for instance, the number

1 Established in 1988, the NDDTC is administratively integrated with the AIIMS psychiatry department, with differentiated but also partially overlapping academic programs, faculty, and residents.

of residents who later said how inspiring they had found the discussion of this book. Or the fact that the entire room stayed without a break for a full extra hour and a half after the official time for the event was over, the only such instance I witnessed through an entire year of academic events (most academics the world over will be familiar with the scramble to leave as the official time for a weekly seminar winds down, not only out of boredom but equally from household and other urgencies).

Energies, as we know, can be transient but also long lasting, even if in less immediately palpable ways. An event may, for example, engender a small shift of orientation in the future trajectory of one or two residents. Thankfully, alongside such impalpable, still unforeseeable effects, our February discussion of *Affliction* at AIIMS also resulted in the three response pieces here by Drs. Mamta Sood and Prashant Gupta, Drs. Koushik Sinha Deb and Swarndeeep Singh, and Dr. Shalini Singh. It is from these pieces that I hope we can sense what an encounter might look like between anthropology and psychiatry that does not necessarily take the form of a now routine and well-rehearsed mutual critique. Instead, we might sense some of the illuminations and forms of companionable thought that *Affliction* offers to clinicians and psychiatrists who encounter roughly the same body of patients whose world this book inhabits.

What was heartening in this encounter was the level of anthropological complexity that the psychiatrists willingly inhabited – moving through detours as diverse as longitudinal household surveys, Islamic theology, Ludwig Wittgenstein, and Edgar Allen Poe, without flinching or adding protestations about foreignness or jargon or theoretical obscurity – and their recognition of the accomplishment of this book, as well as our realization that this is indeed the level of abstraction and concreteness required to inhabit the complexity of the worlds of the urban poor. Drs. Sood and Gupta and Drs. Deb and Singh offer extended commentaries on two chapters, while Dr. Shalini Singh (a senior resident, specializing in addiction psychiatry) takes *Affliction* as a starting point for a new kind of qualitative inquiry, focusing on the understudied and easily excluded lifeworlds of women seeking treatment for opioid dependence in northern India. In the course of this inquiry, Dr. Shalini Singh gets drawn into conversation with the anthropology of addiction more broadly, through texts such as Angela Garcia's memorable 'The Elegiac Addict' (2008), on which I had organized a journal/book club session in November 2015, just as Drs. Sood and Gupta are drawn into conversation with Sarah Pinto's *Daughters of Parvati: Women and Madness in Contemporary India* (2014), on which I organized a book club session with an accompanying lecture by Pinto in July 2016.

My own entry into the curricular aspects of this clinical milieu was facilitated by senior faculty with a deep, longstanding interest in social psychiatry who wanted to reorient their residents whom they felt had become 'too biologically oriented', even as 'the social' could

immediately become a site of epistemological suspicion ('how do you generalize from just one case?'). Part of a mutual education is learning to receive one another's questions. And to work around earlier impressions and introductions that may close off any possibility of meeting. Importantly, as Drs. Sood and Gupta point out, there is a hackneyed way in which anthropology and invocations of 'culture' appear in psychiatry curriculums (for instance, in relation to 'culture-bound syndromes'), which may in fact create distance rather than curiosity about these modes of knowing. As Drs. Sood and Gupta put it in relation to their own training: 'During our training in psychiatry, anthropology was taught with a focus on culture-bound syndromes, and we would "memorise" the chapter from a standard Western textbook as it could be a potential question to be answered in the exams. However, we found the topic of culture-bound syndromes clichéd and an extension of "Orientalism".' Nor are psychiatry students, at least in Indian psychiatry, particularly drawn to invocations of neoliberalism and the 'abandonment' of state and familial responsibility that often appear in current anthropology. To continue with Drs. Sood and Gupta's words: 'In the West, community psychiatry is synonymous with the deinstitutionalization of the 1950s and its aftermath. However, for a country with poor mental health resources like India in those times, there was no scope for deinstitutionalization as there were very few beds for mentally ill patients. In the last six decades, the number of beds in mental hospitals has increased by 75.2 percent'.

Affliction quietly undertakes several departures from our received picture of medical and 'cultural' anthropology. As Drs. Deb and Singh point out, *Affliction* offers something quite different even from the now canonical 'illness narrative' and 'cultural formulations model', famously associated with Arthur Kleinman, with whose work, Indian psychiatrists, at least in an institution like AIIMS, certainly have some degree of familiarity. Drs. Deb and Singh focus on Das's use of Povinelli's concept of 'quasi-events' that 'neither happen nor not happen', to recognize the terrifying instability in the lives of the urban poor, in the moving line between what is and is not recognized as an illness. They ask what becomes of normalcy, and what can be cast in the form of a 'narrative', when despite the possibility or actuality of repeated visits to medical practitioners so much of consequence happens below the threshold of the sayable or even the knowable. Rather than a fully formed 'cultural formulation' that a patient might offer, as Drs. Deb and Singh put it in their reading of *Affliction*, 'for the urban poor devoid of social security, economic stability, and financial reserves, small everyday events can suddenly turn into life-threatening catastrophes capable of rupturing the affairs and relations of the sufferer'. These 'quasi-events', as Drs. Deb and Singh put it, 'remain largely hidden from our clinical experiences'.

Crucially, in terms of these departures from the more easily recognizable terms of 'medical' anthropology, it is not just psychiatrists' responses that interest us but equally how

anthropologists will come to recognize or to miss the achievements of *Affliction*, in ways quite different from how many did fruitfully receive the intellectual offerings of Das's previous book *Life and Words* (2006), written under the shadow of more clearly world-historical events such as the partition of India and Pakistan and the 1984 anti-Sikh riots. Subtract the national dramas and, as Povinelli puts it (as quoted by Drs. Deb and Singh), you are left with what is 'ordinary, chronic and cruddy rather than catastrophic, crisis-laden and sublime'. It is my hope that anthropologists will slowly learn to see what is new in a book like *Affliction* in terms of attunements to the ordinary and the non-'world historical' (if we take 'neoliberalism' to be one among other shorthand terms for a recognizably shared world history). I will briefly flag three such intellectual departures, or new beginnings, offered by *Affliction*, all of which are sensed by our AIIMS respondents and partly animate the excitement they feel for this book. These are: 1) ecologies, circuits, and tempos rather than institutions and subjectivity; 2) not-yet ontologies and etiologies; and 3) methodological consequences beyond quantitative/qualitative divides towards patterns, singularities, and modes of attunement.

Ecologies, circuits, and tempos

In *Daughters of Parvati*, Pinto (2014) asks a pressing and yet longstanding question: in terms of understanding the trajectories of mental illness, what comes after (or besides) the Foucauldian asylum model of power? We might say that *Affliction* points towards an answer, one in which each of our responding psychiatrists recognize themselves, namely, treatment-seeking among the urban poor as taking place in a certain kind of urban ecology, composed of multiple points of entry and exit or persistence, where quasi-events can turn into critical events, and within which psychiatrists are one among other stopping points. The particular circuits that compose these fragile ecosystems of life and labor, health and illness may differ quite strongly, for instance, as compared to the circuits that stitch together the 'culture of chronicity' that anthropologists such as Tanya Luhrmann (2007) and Angela Garcia (2008), among others describe, the 'institutional circuit' of mental illness in 'developed country' contexts, between homelessness, supported housing, hospital, jail, and in some cases addiction rehab.

This is not to say that the circuit in an Indian context is necessarily better or less alienating, or that the circuits are entirely 'culture bound'. Each circuit or ecosystem (some elements of which may overlap across diverse contexts) may create its own forms of toxicity and ontological uncertainty. Drs. Deb and Singh emphasize Das's outline of a slow-moving crisis of multiplicity that Sheehan (2009) calls 'forced pluralism', in the lines they cite from *Affliction*: 'The intersecting temporalities of work, cash flows, and the therapeutic practices of local practitioners created certain ways of dealing with illness that emphasized immediacy

and the short term rather than investment in proper diagnosis and cure' (Das 2015, 45). Within this way of investigating ecologies and circuits, Das gives us a further concept with which to understand illness: tempo, understood both through unpredictable patterns of treatment-seeking (in ways resonant with the 'pathways' studies often undertaken by psychiatrists and other medical researchers, which Drs. Deb and Singh cite) but also through the singularity of a case such as Swapan, which helps us understand the shifting tempos of mental illness, and its proximity to and distance from more ordinary disruptions of everyday rhythms. The emphasis on tempo poses questions such as: at what point does a family call upon law or psychiatry to intervene? In what ways do 'normal' disruptions such as irritability or domestic violence begin to read as something pathological? In what ways do these readings of pathology differ and lead to disagreements within a network of relationships such as a household, a kinship group, or a neighborhood? In what ways do the interventions of psychiatry or law reconstitute the tempo of everyday relations through different rhythms of crisis and normalcy?

Here we might recognize a second crucial strand or form of illumination that *Affliction* offers within the theorization of ecologies, circuits, and tempos (as distinct from the better known emphases on institutions or on individual subjectivity), namely, the place of kinship or 'networks of relations', which are constitutive of subjectivity and reconstituted by illness. To cite Dr. Shalini Singh (for whom, as a senior resident, treating physician, and student of psychiatry, these lines are differently meaningful than they might be if they were cited by an anthropologist): 'one of the important insights of Das in her book, *Affliction: Health, Disease, Poverty*, is that although disease manifests itself in individual bodies, it is constituted by and dispersed in the social relations in which the individual is embedded'. Crucially, *Affliction* demonstrates – 'shows', rather than merely 'says' – these constitutions and dispersals, at times over generations; we witness, for instance, a decade-long struggle with tuberculosis through the eyes of Meena, her fluctuating relationship with her husband, and the ways in which these struggles are lived and then remembered after Meena's death by her son, a decade later. Here we also see the companionship that literary texts offer *Affliction* in its departure from *Life and Words* and from the 'larger canvas' of national events, and the search for a new kind of canvas, one that is no less tragic and no less 'large' or small. Perhaps the whole question of scale is reconfigured, for instance when Poe says that the catastrophe he is going to recount is nothing more than 'a series of mere household events', or in Thomas Mann's *Magic Mountain*, which may be read as a study of tempo and the slowness and jaggedness of illness experience. These multiple tempos and temporalities are not simply affirmed, nor can they be easily named, as Western or non-Western, or Indian or Hindu or Muslim.

Not-yet ontologies and etiologies

How did anthropology lose faith in ‘culture’ as a structuring analytic concept? The clues to this lie within anthropology itself, for instance in the work of Stefania Pandolfo (2008), who shows how the interpretation of an illness may be a site of ontological conflict within a family or a self. As Das argues in her 1998 essay ‘Wittgenstein and Anthropology’, we might understand culture not as a set of norms but as constituted through arguments between generations and selves. *Affliction* takes us further in this thought process and tells us that the terms of the argument itself may be or become unclear. We see this in the realm of spiritual experience, for instance in the chapter ‘The Reluctant Healer and the Darkness of Our Times’, which describes how Hindu figures are braided into the life of a Sufi *amil* (healer). The healer recounts how he comes to inherit a lineage from his grandfather that is neither broken nor syncretic (since it is composed as much of suspicions, hesitation, and destructive potential even as it signals a certain kind of shared space). As Das (2015, 141) puts it, the healer ‘walks a tightrope between *nuri ilm* (luminous knowledge) and *kala ilm* (dark knowledge)’. These uncertainties, partial illuminations, and opacities may extend into the realm of biomedical diagnostic classifications, and it is often unclear where the dividing line may be placed between the spiritual, the biomedical, and the cultural.

Interestingly, none of our three AIIMS respondents dismiss these forms of experience or of uncertain classification and nonclassification, nor did they affirm them simply as a uniquely Indian form of ‘pluralism’ of interest only to anthropologists. Instead, we receive intimations of how these movements may trickle into clinical settings. In her piece on opioid dependence Dr. Shalini Singh alerts us to a variety of exchange relations in the lives of her patients, including relations with local chemists that impact the addiction trajectories of her patients as deeply as, say, the relationship a patient of hers has to the spirit of a dead friend, whose recurrent appearance in dreams beckons him to periodically relapse. Further, even keeping spirits and dreams at bay, our team of treating psychiatrists find themselves in familiar albeit shadowy territory, which *Affliction* illuminates, in relation to the ‘vernacular’ pressure on biomedical terms. It is worth quoting Drs. Deb and Singh’s insight into Das’s argument at some length here:

When medical treatment is too costly to bear, diarrhea in a child might be described as a teething problem, arthritis might be labeled as the normal breakdown of the ageing body, and partially treated tuberculosis may be deemed ‘mild TB’. The lexicon people living in such neighborhoods use to report illness borrows from available medical systems as well as from faith and the occult.

Crucially, these lexical uncertainties cannot be attributed either to a fully formed cultural ontology or to a simple lack of scientific knowledge. As Drs. Deb and Singh put it: ‘Das

argues that perhaps no ontology exists that could effectively explain the movement of the disease from its abstraction in the textbook into the reality of the human body. In the absence of any firm epistemic understandings of why illness happens, new lexicons gradually develop, reflecting the societal, cultural, and economic forces at play’.

Perhaps no ontology yet exists. This is not just an abstract formulation; it may relate quite deeply to the concreteness of treatment-seeking experience. As Drs. Sood and Gupta concur, entering this discussion of ‘vernacular’ classification (which is not exactly ‘cultural’ because of the sheer uncertainty of naming), mental illness may be recognized as an issue when there is a ‘resultant disruption’, which Das calls ‘incoherence’, in everyday life. A healer is consulted ‘who may help in naming, understanding, and alleviating this experience’. However, the way that ‘naming’ or non-naming occurs is quite peculiar, and non-naming cannot be explained simply by a static idea of ‘stigma’, which is often the assumption in social analyses of mental health issues. Nor is the biomedical ‘name’ of the affliction necessarily decisive for a patient or family’s understanding of the issues at stake. Drs. Sood and Gupta discuss the naming of illness in the two cases of Swapan and Vidya in Das’s (2015) chapter, ‘Mental Illness, Psychiatric Institutions, and the Singularity of Lives’, and note that ‘in both cases, the protagonists and families were not bothered by the diagnosis, which is something we notice routinely in our clinical practice; stigma was not the reason for seeking help from mental health services. Like so many others, the patient in one of the case studies was ‘lost to follow-up’, meaning he did not continue seeking treatment. These case vignettes help us understand why so many patients drop out of treatment’.

Perhaps (and this may be a task for further research), just as there is not yet an ontology, we might also need to look for a term other than ‘stigma’ to understand the forms of resuscitation and suffocation that accompany particular diagnostic formulations, and how the naming or non-naming of an illness occurs and informs the experience of illness.

Methodological consequences

When we leave the confines of our own discipline for long enough, we are sometimes confronted with a challenge or a divide that almost seems trite when named, for example, differences between quantitative and qualitative modes of investigation. A common attitude within anthropology is to express skepticism toward quantitative data, often criticized as a way of reducing life to data points. Any attitude, if not periodically re-examined, can become a limitation. *Affliction* overcomes this limitation and reshapes ‘survey methods’, in particular the shared social scientific tool of the household survey, making it a way of continuing and intensifying an anthropological-ethical imperative to strive for a kind of proximity and attentiveness to life. The use of survey methods is not claimed as necessarily more objective

than other modes of anthropological engagement, which methodologically are sometimes as hard to define as the unnamed etiologies described above. That said, the rigorous use of what social scientists would call ‘mixed methods’ is perhaps also why *Affliction* earns the trust of our psychiatrist colleagues. As Drs. Deb and Singh admiringly write:

The corpus of data that forms the basis for Das’s arguments encompasses more than thirteen thousand interviews, in the form of weekly morbidity surveys spanning several years, which attempted to capture various transformations taking place in the lives of people living in Bhagwanpur Kheda, an urban slum of East Delhi. Between 2001 and 2003, researchers from ISERDD visited three hundred households (1,620 individuals) weekly for eighteen weeks, and then monthly for the rest of the two-year span, gathering extensive data on individual health and health care-seeking behavior. Additionally, twelve hundred interviews were conducted with 291 care providers of various Western, traditional, and faith-based medical systems over the same time period to understand the services available.

What animates this (excessive?) research imperative is not just a craving for scientific objectivity, but a very basic question of how one investigates a phenomenon such as health and illness, or the event (or the un-nameable ‘quasi-event’) and the everyday, through a diversity of methods and what a particular method, say, a repeat household survey, might reveal, as distinct from, say, an interview or repeat interviews. Drs. Deb and Singh summarize what they see as some of the key findings of this data set, wary as anthropologists might be to think of themselves as producing ‘data sets’ and ‘findings’. While their summary is sketched in one continuous paragraph, I separate each line, because each finding could have been the subject of a separate article, for instance, in economics or public health:

Brief recurrent episodes of illness were common in the community, but were often reported as variations of normal by the sufferers, rather than as illness.

Such recurring episodes of ill health suggested the possibility of underdetected chronic disorders, masquerading as recurrent acute illnesses due to misdiagnosis or improper treatment.

Treatment seeking for such ailments varied and often depended upon the amount of cash in hand.

People frequently consulted practitioners, but most received only symptomatic relief without a diagnosis.

Practitioners of indigenous and faith-based medicine provided the majority of primary care services, with visits to government hospitals accounting for less than 30 percent of treatment seeking.

Anthropology need not only be a refusal or a negation of quantification. It may also absorb or express those methods differently, not as a departure from 'subjectivity' but as a different way of approaching the fragility of life. Distinct from Drs. Deb and Singh's appreciation of the depth of the survey data, Drs. Sood and Gupta receive another kind of methodological inspiration, pointing out how *Affliction* is a small step in correcting the severe lack of longitudinal research on mental health issues in India given the 'dearth of published longitudinal studies on what happens after a project team leaves the area'. This call for research is not merely an epistemological formality. In relation to the relapsing remitting nature of several mental illnesses, we might detect a genuinely shared terrain of investigation between anthropology and psychiatry, one that recognizes that over relatively long periods of time, when seemingly nothing happens, a lot might be happening (in terms of 'quasi-events', as Das calls it).

Further, keeping open the question of stigma as a domain of investigation rather than a uniform assumption (since different conditions may yield distinct pictures of 'stigma'), we might also ask if anthropological companions might help physicians better articulate their own moral judgments or aversion to judgment. As Dr. Shalini Singh puts it in her piece: 'Publicly, substance users are labeled as social deviants who represent all that is wrong within a community, but a closer look at how substance users are perceived paints a different picture'. *Affliction* allows Dr. Shalini Singh to give words to an alternative perspective that, as she suggests, may animate her work and her choice of addiction psychiatry as a specialization:

Where there is visible despair about substance abuse within a community, there is also acceptance of drug use as an enabling agent for men who work in tough conditions: rickshaw pullers and taxi drivers who work for sixteen to twenty hours every day in extreme temperatures, daily wage laborers who work at construction sites and in workshops and factories for long hours on small meals, and sanitation workers who are forced to work in unhygienic conditions. Many young men begin taking drugs when they take a job that requires a lot of manual work, and it is thought that heroin is needed to manage the body's aches after a hard day of work. A man who earned his livelihood sorting through garbage in the city dumps pointed out that it is impossible to work amidst the stench and the heat without using heroin and/or alcohol. These accounts starkly contrast with the perspectives of medical professionals and community members regarding drug use.

Affliction also prompts Dr. Shalini Singh to think further about the gendered nature of substance use, as well as the persistence of doubt about the treatment process itself:

While women seek treatment for substance use, or treatment is sought for them, when they are unable to do household chores, men come for treatment when their bodies no longer allow them to earn their wages. ... Even after treatment for substance abuse is started, doubts may linger in the minds of the male substance user and his family, who wonder whether he was eating and sleeping better when he was taking drugs, and whether he might need to use drugs to work efficiently. An understanding of these perspectives helps us to match treatment to our clients' needs.

Drs. Sood and Gupta approach this issue of anthropological companionship differently, when they write, 'While reviewing this chapter [within *Affliction*] we came across certain cultural issues that we have long been addressing without actually being particularly aware of them'. To return to the point above, there may not yet be an ontology or a way of naming much of what happens in the lives of treatment seekers and in the clinical encounter. In my observation of clinical interactions, rather than a simple assertion of psychiatric power, I was struck by the density of exchanges, the intensity of what could be shared or remain unsaid, the implicit or explicit therapeutic work, the negotiations involved at times even simply in continuing a given course of medication or shifting dosage, and the possibilities of hearing or mishearing that could occur even in a five-minute encounter. It is not necessarily the length of time that I found to be decisive for the affective density or quality of an interaction. At times, I was struck by the affective possibilities that opened up or were closed off in moments (quasi-events), say, in the tone of voice, facial expression, or gesture with which a psychiatrist asked the opening question in a follow-up appointment: 'How are you?' And it is here in this realm of relationality, of uncertain therapeutics and etiologies, that the conversation between anthropology and psychiatry is both still very much ongoing and yet to begin. *Affliction* shows us how that conversation might be continued or begun.

About the author

Bhri Gupta is currently an assistant professor of anthropology at Brown University. His recent book *Poverty and the Quest for Life: Spiritual and Material Striving in Rural India* (University of Chicago Press, 2015) was awarded the Joseph W. Elder Prize in the Indian Social Sciences and the 2016 Award for Excellence in the Study of Religion from the American Academy of Religion. He is the co-editor of *The Ground Between: Anthropological Engagements with Philosophy* (Duke University Press, 2014) and serves as an associate editor of *HAU: Journal of Ethnographic Theory*. His most recent fieldwork project is an ethnography of mental health issues in contemporary India, based at the Department of Psychiatry, AIIMS (Delhi).

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