Cult Med Psychiatry (2011) 35:376–395
DOI 10.1007/s11013-011-9224-0

Rational Love, Relational Medicine: Psychiatry and the Accumulation of Precarious Kinship

Sarah Pinto

Published online: 3 June 2011
© Springer Science+Business Media, LLC 2011

Abstract In north Indian psychiatry, clinical attentions to women's symptoms often involve scrutiny of emotions related to marriage and its breakdown. In pharmaceutically oriented practice, relations are used to evaluate biologies, and drugs produce the truth about relations at the same time that they produce the truth about bodies. In the process, clinical practice often involves unmaking relations, generating loss, in certain instances, as a dire result. In this, a particular kind of clinical knowing emerges, engaging broad cultural and historical connections between love and madness more than definitions of right and wrong unions. In asking how disciplinary and relational modes of biomedicine converge, I argue that in north Indian psychiatry's attentions to women, rather than enforcing normative configurations of "the family," biomedicine grapples with the gendered fallout of kinship.

Keywords Psychiatry · Kinship · Gender · India · Pharmaceuticals · Marriage

Where India is concerned, love and marriage readily connect to popular imaginations of modernity and the nation. Underlying broad, often casual, evaluations of the way unions start ("Are love marriages non-Indian?") may be concern over the ways they come undone ("Is divorce a sign of the deteriorating mores of modern times?"). A university lecture I attended at the start of research on women's psychiatric care posed these questions in medical terms, asking how mental health bears the effects of the changes modernity brings. The feted speaker, an alumnus of the north Indian university and practicing psychiatrist in the United States, saw in high American divorce rates indication of the strains of modernity.

S. Pinto (✉)
Department of Anthropology, Tufts University, Medford, MA, USA
e-mail: sarah.pinto@tufts.edu

These could be contrasted, he said, with strong Indian unions that were psychologically protective but threatened by the caustic effects of westernization and its lax values.

As I was, at the time, spending a great deal of time in the in-patient ward of a small, private psychiatric clinic among women, many of whom who were divorced or divorcing, this lecture sounded a dissonant note. For one thing, women in that setting bore the impact of dissolving relationships in terms that were more than moral, while neither they nor their clinicians seemed interested in modernity or the cultural status of divorce. Doctors read patients' biology by way of emotions about relationships in contexts in which many faced uncertain futures. The precariousness of relations seemed to coalesce in women's distresses, and also in medicine's particular techniques. Such things were an imperfect fit with the cultural field the lecture represented—the familiar time–space collapse in which things original and "Indian" are challenged by things new and foreign. The over-determined grids in which forms of love and marriage are signs of an impending future, good or bad, involve moral axes of agency and contested norms. But whatever oriented life in the clinic and the stakes of women's relationships appeared to be composed of other elements.

Some conceptions of love have less to do with the madness of modernity than with madness as such. A 1969 Hindi film *Khamoshi* portrays (male) psychiatry patients whose manias are treated by a beautiful nurse. She lavishes them with attention under the direction of her (male) superior, a psychiatrist who diagnoses the men as lacking the emotional security love brings, made mad, in effect, by lost or lacking love. But as patients improve, the nurse's act becomes real, her affections passionate enough to drive *her* to illness. Here, love's relationship to madness is both therapeutic and undoing; love is fungible and real enough to hurt; its impact on the psyche elemental and at home in the modern clinic's sterility. Though a viewer may question the doctor's wisdom, or see sadism in putting affection to clinical use, she might also notice the way love is portrayed as at once stabilizing and destabilizing, or see its gendered results in the character of the nurse, in whom are condensed love's effects on fragile psyches. Skirting the edge of what Lawrence Cohen calls the "persistent sense of 'India' as an irrevocably split world" (2007, p. 105), love can connect to fantasies of the self beyond modernity's influence, even those that involve biology, science, and rationality. It can draw other meanings from its links to madness.

Though relationships were not therapeutic in the way they appear in *Khamoshi* in the wards in which I spent time, they were nonetheless comfortable there as a mode of inquiry. When kinship entered the view of contemporary psychiatry in India, as I argue it did through the force and intent of clinical attentions to women, the things doctors looked for, listened to, and asked about showed love to relate to insanity as a particular kind of clinical knowing—using relations to evaluate biologies—through the mediating use of pharmaceuticals. This chemical hermeneutic of emotions generated ways of being among others, contours that carved differently through different lives.

A question that repeatedly arose was how clinical processes attended to ruptures in the fabric of kinship. To what extent were these dealt with as *aberrations*? Divorce and love marriage are canonic kinship aberrations in India; it is not accidental that

they appeared this way in the clinic. But the question of *how* they are so is open. In other words, are they signs and limits of ordering structures, formula for exclusion, as Judith Butler might lead us to argue, when she asks of our social worlds, "What … schemes of intelligibility make our loves legitimate and recognizable, our losses true losses?" (Butler 2002, p. 24). Or are divorce and chosen-marriage well within schema of recognition, even in psychiatry wards? Are they sites of accumulation (of vulnerabilities and social action) rather than grounds for exclusion (though exclusion may be an effect), as Marilyn Strathern's ideas might imply, in their suggestion that science and kinship build knowledge from relations at points of re-making, in a kind of "recombinance" (2005)? The larger question, then, is this: how do disciplinary and relational aspects of medicine's forms of knowing differ, or converge, in clinical practices that involve restitching as much as rupture?

These questions come out of time spent in psychiatric settings in a provincial city some distance from large urban centers, deep in the so-called "Hindi belt." I spent most of my time in two wards observing interactions and the small and grand movements of everyday life. I had many conversations—with doctors, patients, patients' kin, and others—typically in the context of daily events rather than the formal sense of "interviewing." I watched what went on and talked to others in the process of watching, as one would in most social contexts. Most of those interactions took place in Hindi. Much of that time was spent noting the ways love, marriage, and the messy space between the two figured in clinical interactions. I did not go to India to consider these things, but their primacy was unavoidable. This was especially so in the care of women, to whom my attention was largely turned.

Many things about daily life in the wards involved the flux of relationships. In both the private in-patient ward where I spent long, still hours in the company of just a few, and the busy government hospital where time and people moved briskly, marriage was a large part of what psychiatry concerned itself with. It was not so much that patients talked about their relationships or brought the emotions of households into regimented clinical life, though both were true. More noteworthy were the ways practitioners—doctors, residents, social workers, psychologists—read patients' lives for signs of illness by evaluating emotions related to marriage. They asked about patients' feelings about spouses. They pursued unusual unions and their psychic origins, often for courts in cases of contested marriage. They foregrounded interactions between husbands and wives in reporting. They based diagnoses on observations of trust and mistrust, and parsed love and grief, evaluating a person's ability to move through dissolving relations and build a new life.

They did so through the use of pharmaceuticals. Not surprisingly, given the well-documented emphasis on psychotropics in Indian psychiatry, drugs were woven into a range of therapeutic acts large and small. They were means of inquiry and the central node in a web that included behavioral therapies, "aversion therapy," ECT, "reducing secondary gains," and brief advice on how to think, act, and feel. Yet, while Indian psychiatry may have little time, facility, or inclination for psycho-therapeutics beyond limited interventions and elite clients, ideas about behavior, family life, ways of being, and ways of reading emotion were communicated regularly at the edges of conversations about drugs. In all of these interactions,

diagnosis hinged on patients' responses to drugs, while decisions about medication were based on the bodily evidence of emotion.

This came into particular view around symptoms of schizophrenia. In South Asia as elsewhere, schizophrenia can pose crises to a coherent sense of self (Corin et al. 2004), to the conditions of being a person: "How can anyone love me? Why would I love anyone when all it means is torture?" (Jenkins 2004, p. 31). Such questions may be especially vivid in the symptom of paranoia. In both settings, deep anxiety about spouses was at the center of clinical efforts to locate biological truth. This was so amid acknowledged ambiguities of forging a life with others, in which love could be seen as irrevocably—quite 'normally'—tied to uncertainty and suffering. Beyond the clinic, worlds of meaning made it possible to imagine madness as an inevitable part of relationships and a corrupting influence *on* relationships.

None of these things may be peculiar to Indian psychiatry, though the tendency to fix on the question of what is and is not cosmopolitan about non-western biomedicine shadows this paper, not only because it is a scholarly habit to ask it—reflecting medicine's production of itself—but because it was a matter of interest to the psychiatrists, psychologists, and social workers with whom I interacted. The Indian and cosmopolitan nature of medical practice were part of daily conversations, just as these boundaries have long been of concern for anthropologists, psychologists, and others writing across the imagined divide between "western science" and "Indian culture"—rethinking the Oedipal complex (c.f. Hartnack and Christiane 1999; Nandy 1995), evaluating child-rearing practices (Carstairs 1967; Kurtz 1992; Kakar 1978), and recuperating selves lost to colonial rule by revising psychological models (Nandy 1983). Redeeming the "irrevocable split" may infuse the very medical and scholarly practices that also evade it.

Of course, "Indian psychiatry" is hardly monolithic. In north India, mental health care is uneven. Numbers of psychiatrists are low beyond urban centers, while a range of others—general practitioners, specialists, chemists, and uncertified doctors—diagnose and prescribe. When patients find their way to psychiatrists it is often after visiting other practitioners, and the settings through which they pass are highly variable. Psychiatry units in government hospitals are crowded and time is tight, while private clinics can be sparsely populated and eager for new patients. Large former government asylums function as research and treatment institutions, and though policy changes in the 1980s brought structural and ideological changes, ideals of are far from met, leaving community psychiatry focused on "effective distribution" of pharmaceuticals (Jain and Jadhav 2009, p. 61). Crises, too, are varied, especially in the roles families play and by extension mental illness' affect on women. Where private hospitals take patients into residence in locked wards, creating asylum-like spaces of confinement, government hospitals depend on kin for daily care and move patients in and out quickly, bringing domestic crises into the ward and delimiting the length of care available.

In both cases, hospitals are extensions of the conditions of intimate life. In intimacy as in medicine, power is seldom evenly distributed, making the relationship between kinship, medicine, and women's mental illness rich ground for social critique. Often this involves languages of stigma. For instance, kin solidarity can be seen as threatened by the shame mental illness confers, putting at stake social

reproduction and the security of others. This is a gendered system, meaning that a woman or girl's mental illness not only compromises her ability to marry, it jeopardizes the marriageability of sisters (the same might be true of divorce and love marriage). Disruptive desires may be seen as contained and gender roles enforced through psychiatry's attentions to women as families apply idioms of "defect" and "contagion" to their mentally ill members (Das and Addlakha 2007, p. 129; Addlakha 2008; Davar 1999). Likewise, clinical scrutinies may appear to police the moral boundaries of marriage (self-chosen vs. family- or community-sanctioned), crafting better, more ideal, mothers, daughters, wives, families, and marriages. Drugs govern subjects not only by integrating them into individuated and depoliticized understandings of suffering, but in the way souls that challenge social orders are put in the 'care' of clinical regimes that contain or restore them (Davar 1999). In this sense, as in other times and spaces, families can be viewed as bearing the burden of surveilling norms, turning defective members over to catchment spaces and zones of exclusion (Foucault 2003; Biehl 2005). Here, in the aura of "stigma," where emotions are under scrutiny for their disruptive and defective capacities, we approach the limits of permissible kinship. In doctors' efforts we find the legitimization of forms of being and loving, with forms beyond recognition rendered threatening interruptions. We find ourselves asking how biopolitical arrangements allow and disallow forms of life (Foucault 1990), "how … kinship secures the conditions of intelligibility by which life becomes livable" (Butler 2002, p. 3).

Shuffling the terms, however, we might also see in these circumstances conditions of kinship and knowledge as co-emergent in the creation of a livable life, in moments when kinship "secures" little, least of all itself. The clinical practices I observed often seemed to pull against their own subject-making capacities, even in their most intensely disciplinary moments. Qualities of science, understandings of kinship, and stakes on human experience often involved less the parameters of allowable kinship than kinship's internal precariousness, the way relations and their vulnerability compound. Psychiatry's business seemed to be kinship, but less with fixing or policing its limits than with reading bodies by way of its subjective mechanisms in the moments when relations come undone. As in new reproductive technologies and genetic sciences, techniques used relations to know bodies and relations "to explore [other] relations," (Strathern 2005, p. 7). Bodies were legible through the vicissitudes of intimacy, in biological terms in which pharmaceuticals were central and chemical and neuronal definitions of illness taken for granted.

In some cases, this involved doctors attentive to the stresses of patrilineal households, even as efforts to re-align lives reinstated norms that caused distress. In others, it included clinicians who, wary of western scholars' overdetermination of "stigma" as characteristic of "Indian" approaches to illness, commented on the ways families absorb unusual or defiant behavior. In yet others, it involved contradictions and blind spots that generated the very disordered emotions it sought to ameliorate. This happened in cultural milieu in which madness and love were co-travelers as much as norms defied, and kinship always fraught with potential catastrophe. Desires were disciplined, unruly affect addressed, and lives with others remade, but norms were movable and elusive, involving the wrinkled axis of love and madness more than ideas about right and wrong unions, normal and abnormal subjects.

But though parameters of kinship and selfhood were wider than discourses on stigma might allow, they bore no less dire consequences. The fact that so much was read into and out of women's paranoia was the mark of kinship's imbalanced precariousness. It remains to ask, how and in whom does the vulnerability of relations accumulate?

Paranoia

The government hospital's psychiatry unit was a collection of buildings at the edge of a large campus. Housed in an older building, the out-patient clinic was usually crowded, its only empty spot the sunny courtyard. In shaded edges, people sat on benches or the floor. They leaned against walls or stood where there was nothing to lean on. They came with family or, less often, friends or neighbors, many from great distances. Few came alone. Residents, doctors in training, took names at a desk and triaged patients to offices. There, other residents saw patients, taking case histories and making initial diagnoses in sessions of 10–30 minutes. In intervals they took patients to the air-conditioned offices of consulting physicians, who saw returning and new patients in minutes-long sessions. A day that might bring up to 200 patients culminated for residents in performances of well-summarized cases and perceptive diagnoses. For patients, it ended with a short, symbolically loaded interaction with a senior doctor, and with a prescription.

I sat many days with a second-year resident I call Kareem. A few hours into a typically dense day, a young woman and her parents came into the office and sat awkwardly at the edge of wood-slatted chairs residents joked were designed to keep patients from getting too comfortable. In a quiet voice, Kareem asked who the patient was. The young woman lifted her hand. He looked at her from across the desk, then down at the few items of basic data noted in the file. She was 26 years old, married, with a six-year-old son, and had recently returned to her parents' home, leaving her son behind, sent by her husband's family after her "illness" (*bimari*) returned. Her "main symptom" was that "nothing feels good" (*kuch nahin accha lagta hai*).

Her mother brought out a packet of carefully folded papers, prescriptions chronicling movement, money, time, and effort. Ten years earlier the young woman had had a bout of something similar. She was taken to a doctor and given anti-psychotics. She stopped the drugs eventually, and it wasn't until recently that the signs had returned.

"She cries a lot," her mother said, "So much that it makes others feel unwell, makes others cry too. She starts a lot of fights, she makes demands all the time, like for *chai*, and gets angry when her demands aren't met. She also laughs a lot, but the sickness is this: anger, fighting, nothing feels good."

The patient looked at her lap.

I often felt that Kareem took more time interviewing patients than others did, though whether by accident or design I didn't know. He seldom asked questions in the order items appeared on the charts, following instead the trails of conversation as he filled in the charts, a patch here, a line there. He paused between questions and spent time looking at faces.

"Do you ever feel suspicious of your husband?" She said she did.

"What are the suspicions about?" There was a pause. "Do you worry that he will take another woman?"

Putting the individuating question in the context of a busy household, she said, "Yes, in his home they fight a lot, they are jealous a lot."

Her mother extended the web of kin in which emotions ran high. "Her mother-in-law always takes her son's side."

Kareem looked through the prescription records, then at the patient's mother. "How long will you have to wear your glasses?"

She looked confused.

"Forever?" he prompted. "Her medications are like this as well. She will have to take them for the rest of her life."

Later, Kareem walked patients to the consulting psychiatrist. Taking them into the spartan office in turn, he spoke to his superior quickly, quietly, and deferentially, condensing meandering trajectories into linear histories, transforming repetitive, multi-perspectival conversations into clinically legible accounts.

The woman and her mother arranged themselves in seats at the edge of the room. Turning to Kareem, the psychiatrist, seated behind a large desk, asked, "Your assessment?"

After a few preliminaries he said, "The patient's main symptom is paranoia. She laughs spontaneously and tends to stay by herself."

The older woman interrupted, reminding him that her daughter was often angry. Kareem nodded and continued, looking at the doctor. "There is no accurate duration, but it is likely to be three to four years up to ten." He looked at his notes and corrected himself. "No, for the last ten years she is taking treatment. Her main paranoia is her husband's infidelity."

The psychiatrist turned to the patient's mother. "Is it true or just in her head?"

"It's true."

"Has anyone seen it?"

"No, but we know it's true."

"Is her mother-in-law on her side or her son's side?"

"On the son's side," Kareem interjected. "Her mother-in-law made the patient stop taking her medications because she felt that they were contraceptive. She also has paranoia in her natal home."

The consulting physician asked the resident what diagnosis he had assigned. He agreed with the assessment. "We will give her an F20 [schizophrenia]." The diagnosis was not explained to the patient. This was not uncommon. Patients want medications, some doctors told me, not diagnoses. The doctor handed a prescription to the resident—anti-psychotics and vitamin supplements—telling the patient to return the next week.

This interaction was not unique in the out-patient clinic, where the work of diagnosing was a matter of minutes, and cases showing signs of delusion but lacking florid positive symptoms were read through marital suspicions. Such emotions were pulled out of accounts of marriage and read through histories of treatment. Conjugality involved interlaced relations, not just husbands and wives, while drug courses framed women's movements in the world, between *sasural* and *maike*,

marital and natal homes. In a setting in which it is a woman's natal family's job to care for her when she is most unwell (and often, but not always, a child's place to stay in its patriline), these movements may have involved comfort in return or distress, relief from the labors of child-care or anxious separation, a sense of escape or of failure. At the same time, they are part of a familiar kinship (and anthropological) story in which young brides are susceptible to madness, as foreigners in the families they marry into and a threat to their coherence (Freed and Freed 1964; 1985). The return home, however, has to do with more than damaged states—it can be an awaited pleasure. Births, holidays, weddings, and extended visits offer a break from the strictures of wifehood and a chance to be called by one's given name, rather than as someone's wife or mother. In illness or health when women "go home" they may re-enter old divisions and animosities, bear scrutiny of behavior deemed unacceptable, or find comfort in being a daughter—these are the uneven contingencies of care.

As mental illness can unfold over years, the rules of patrilineal kinship and outmarriage intersect with cycles of distress and treatment. What is, in north India, the natural antagonism between natal and affinal families plays out in the intimacies of pharmaceutical life, women's movability, and the legibility of feelings of suspicion. Symptoms and family histories are recounted together, as in a mother's assertion of her daughter's mistreatment on the one hand, and the disordering effect of her excessive desires on the other. Anger and suspicion reckon one's place with intimate others and index the status and selfhood (inappropriate womanhood, e.g.). They are the stuff of biological disorder and the structure in which it unfolds.

Other interactions involved different pacing, longer periods spent reading lives and utterances. In the in-patient ward, diagnosis was less hurried, happening over time, in patients' responses to pharmaceuticals and changes in interactions with kin.

On rounds one morning, I walked with a group of residents row by row through the halls. People were returning to their beds freshly bathed, or eating breakfast with their families. A senior resident asked a middle-aged woman how she was feeling. In treatment for schizophrenia, she had come into the emergency room a few weeks earlier. "Do you have anger in your heart?"

"No," she said, with what seemed a quiet confidence.

"Is your husband fine?"

"Yes."

"There is no flaw?"

"No, nothing, now he is fine".

"But before you thought there was a flaw. You said he used to speak badly to you, he used to have another woman."

"Now there is no flaw."

This resident had a more didactic approach than some of the others. "This feeling was because of the illness," he explained to the patient, "This was a symptom, having this feeling, this doubt without a reason. But this is an illness and the cure for it is medicine. I know that sometimes when you get the injection you feel bad at first, maybe you feel sick, but then you feel better and you see how much benefit there is from the medicine. There is benefit to you, to your family, it makes harmony in life."

He explained to me that the woman had been admitted to the hospital with a suspicion that her husband was having an affair. "Most likely this was not the case, but this was a clinical judgment. It can be difficult to know or say for sure, but we have to make this call. If she improves on the medication, it is a sign that the accusations were pathological, definitely not true. Then we know."

When her case was reported to the psychiatrist, the senior doctor (with a different demeanor from the soft-spoken doctor described above) reprimanded the patient. "This is your responsibility. It is your husband's responsibility and it is your own responsibility." In characteristically strong tone, he said he would not re-admit her if she went off medication.

In these cases, and others I observed, conjugal suspicion, marital responsibility, anger-in-kinship, and, indeed, care and love were ways of knowing and treating bodies. In the scripts of diagnosis, complex emotions were condensed into paranoia and the duties and labors of kinship merged with those of drug-taking. Social life did more than explain distress. Anger and suspicion were signs rather than causes, under consideration for what they said about biology. Less a way of addressing personal history or the context of suffering, emotions indicated bodily chemistry. In mediating relations, drugs produced the truth about those relations at the same time that they produced the truth about bodies. This was so even as pharmaceutical management—involving kin who buy medications, manage drug regimes, interact with doctors and, most importantly, stay on the ward—was part of the very intimacies under scrutiny, its own particular form of love. In this way of knowing, perceptions and feelings transmuted into each other through drugs' effects (a patient's perception was read as feeling which in turn offered a mode of perception—a point of access to a biological self—for doctors), allowing doctors to collapse interplays of bodies, intimacies, and social undoing into a language of clinical truth. But this truth was tentative and often uncertain.

Fleeting in this circuitry were the messy facts of relations themselves, things that eluded certainty or, as we shall see, rational comprehension. Yet, paranoia coursed beyond singular experience, pertaining to many aspects of intimate life and to lattices of action and emotion among kin. A daughter-in-law's anger at her husband echoed her mother-in-law's suspicion about the effects on her reproductive capacity of the very medications meant to mitigate suspicion.

In other contexts, medical techniques reckon "relatedness" as part of clinical practice, sharing with (Euro-American) kinship a cultural project that sees "relationality" in the work of knowledge, that is, "know[ing] things by their dependence on other things" (Strathern 2005, p. 12), using relations "to explore relations" (Strathern 2005, p. 7). As new ways of being related become possible, understanding life (like families and genes) as "recombinant" involves "uncovering what is in nature and making new knowledge through culture" (Strathern 2005, p. 11). I find in this approach a resonance with north Indian practices in which the work of reading paranoia through pharmaceuticals attends as much to relations being remade as to aberrant displays and psychic disturbance. Relations are means, not just objects, of understanding.

In moments that are at once disciplinary and avoid moral surveillance, this kind of scrutiny is layered, and layers relations: emotions about kin pile upon emotions about

kin; connections are contingent on connections; accounts of illness are accounts of relations; accounts of relations are accounts of other relations. Though drugs can be agents of governance, fashioning selves and citizens while communicating that medicine is authoritative and patients subjects of knowledge and intervention (Jain and Jadhav 2009; Ecks 2005), they may be part of scientific practices that attend to persons in other ways. We might even go so far as to suggest that the split observed in American psychiatry between biological understandings of bodies and socially contingent understandings of selves (Luhrmann 2000) is less apparent here, where no clearly defined space for psychodynamics is carved out, and psychiatry works social worlds into biological bodies in consonant, even seamless ways. Instruments of kinship as clinical knowing, pharmaceuticals, as modes of perception, reckon the relationship between relationships, emotions about them, and biologies. They establish a particular—tentative and contingent—kind of clinical truth.

Rational Love

Where does such a science figure in broader connections between love and madness? Much about these cases leads toward rationality, an idea whose orienting role in psychiatry is long-standing. A culturally specific model involving individuated personhood and clarity of perception, rationality establishes a moral ground of "order, stability, and civilization" on notions of utility, productivity, and value and (Martin 2007, p. 55). Historically, visions of rationality guided categories of disorder. Kraeplinian psychiatry established both mania and psychosis as involving the presence of multiple and inconsistent forms of behavior and short-circuited self-control, putting in clinical terms the cultural vision of a unified self guided by a singularly driven will (Martin 2007, p. 66). Rationality remains a principle in psychiatry, indexing selves according to global visions of economy, consumption, and labor. The fully functioning person, entitled to the rights of citizenship, is one whose perceptive and decision-making abilities involve an un-obscured neutrality, emphasized in notions of "consent" that drive mental health regulation and pharmaceutical testing, among other practices (Petryna 2009).

Psychiatry may hinge on delineating what is rational about an emotion or perception from what is not, but when it comes to love, in north India and elsewhere, rationality and its others do not always map onto the individual. Neither do they necessarily adhere to a grid of what is "normal" or "defective." In the cases described above, intimacies as much as individuals are read for the rationality they expose or lack. Emphasis on rational relations (as opposed to rational persons) establishes states of mind as inter-subjective.

Rationality-in-relation, what we might call "rational love," takes us beyond the clinic, toward other ways of talking about love and experience. So too does its scope of aberration. These parameters of selfhood can come from narrating barely knowable others, ciphers in the midst of the everyday. In one such case, just outside my house, a woman lived on the edge of the street. She was in her mid-thirties but appeared decades older. She situated herself along a perimeter wall the height of a tall man and defined her area with fabric—the clothes on her body worn in multiple

layers, the bundle underneath her, a blanket around her head. The fringes of north Indian streets are thick with commerce, and barbers, food sellers, and hawkers in one way or another looked after her. A widow let her use her spigot. Shopkeepers gave her food though they complained about the trouble she caused—staring at customers, demanding money. Sometimes if spoken to she said nothing. Other times she offered her hand, her name, erudite English, and her educational qualifications: "M.A. fail."

Not only did those around her know her, they also knew her story, or parts of it, trading pieces of narrative to explain her state. As a teenager she fell in love with a boy from another religious community. Both families objected to the affair and the boy married the girl his family chose for him. The young woman failed her university courses, had a psychotic break, got medical attention, relapsed, then moved onto the street a few blocks from her house. She refused to go home. Her family ("a good, educated family") eventually moved away, though a brother came by periodically to give her money. Medical students from the hospital tried to convince her to come in for treatment. She refused. No one forced her. As some observers put it, it was because of the affair that her "mind went bad," a familiar explanation. It was often unclear whether the root of the trouble was the loss she suffered or the inappropriateness of the pairing, though loss and improper love were often intertwined.

Here is the spectra with which we began, in which romantic love is irrational but not unthinkable, and "wrong love" is both a cause of undoing and an effect of undone states of being. Love can make a person crazy; crazy love is a sign of madness; neither are beyond the veil of possibility. But rational love is not a consistent idea. It is fraught with tensions in meaning and stakes, an important but hazy-edged category of evaluation participating in multiple points of reference. In one iteration, rational love returns us to the arranged/love marriage spectrum, where it lives on the side of family-chosen (i.e. "arranged") unions. Here, where passionate love is taken to be selfish, disordered, disordering, and prone to breakdown, rational love is slow-growing, sober, self-sacrificing, and chosen by elders who know one better than one can know oneself. (*Mamta* too, maternal love, can be excessive; it can denote disorder or be a sign of valor, sacrifice, and horizons of attachment for gods and humans alike.)

But across a wide range of texts, literatures, and imaginaries, it is not too strong to say that crazy love is a consistent theme in South Asian expressive genres. A trope in Hindu devotional, Sufi, and Urdu poetry, it allegorizes the lover to the devotee, while in Hindu mythology gods go crazy with love, just as people do. Love, in this sense, does not depend on notions of rationality or its opposite (though it can incorporate them). In the Bollywood "blockbusters" of the 1990s and early 2000s, romantic or passionate love (source and form of craziness, encapsulated in the term *deewaana* in countless song lyrics) is valorized (usually in the first half of films) then, relatively consistently, made over into something acceptable and rational through the approval of the patriline (in *Dilwale Dulhaniya Le Jayenge*, *Ham Aapke Hain Koun*, *Kabhi Kushi Kabhie Gham* among many others). At the same time, echoing themes of Urdu poetry, passionate love can involve catastrophic destruction (*fanaa*) of the self (and the lovers in question) in plots with tragic endings (*Fanaa*, *Dil Se*) (Anjaria and Anjaria 2008).

New configurations order things somewhat differently. The 2008 film *Love Aaj Kal* (*Love These Days*) involves notions of rational love that transcend the arranged/chosen dichotomy and the romantic plots it structures. *Love Aaj Kal* imagines two love stories. In the first, set in England in an era of transnational movements and conversation by text message, partners have a "no strings attached" approach to love. Decisions are made rationally, determined neither by families nor passion, but by circumstance and the necessities of time and place. The second story, set in India in the 1960s, involves a love-struck couple whose passion, in spite of little interaction, overrides familial obstacles. Initially portrayed as quaint anachronism, logic-defying love comes to trump the modern, rational approach. Crazy love is here distinctly *Indian*. It validates unions rather than requiring validation. The terms of the "irrevocable split" are shuffled. While passionate love in opposition to social constraint has long been a feature of South Asian film, rational love disarticulated from the wise if constraining decisions of kin is something else, showing that whatever is the opposite of "rational love" can be viable and enduring.

Rational love as such establishes a field of experience and emotion that involves, but ultimately evades, the arranged/chosen continuum. In legal proceedings related to marriage, different values appear in different kinds of cases. In contested marriages, in which families challenge unions children have made, often across social groups, the rationality of love is a matter of biology: a young person's decision to marry can be deemed legitimate by proof of maturity and the rationality a legally adult body is understood to bear. Bone testing determines age and, thus, ability to consent to a union, and psychiatric observation establishes mental fitness, the ability to have entered a union in full capacity of mind. Divorce, custody, and nullification cases depend less on the rationality of subjects entering a union than on the way mental illness prohibits the ability to fulfill the duties of marriage. Unlike marriages contested from the outside, in which individuated rationality establishes the ability to choose whom to love, marriages challenged from the inside deliberate definitions of marriage and visions of normative subjects to offer the measure of validity (Dhanda 2000).

In a pluralistic legal system, these ideals can mean different things. The extent to which mental illness is grounds for nullification or divorce depends on whether a religious system views marriage as a contract or a sacrament, or as a union of individuals or families (Dhanda 2000, p. 183). Similarly, efforts by spouses to end unions on the ground of mental unfitness hinge less on the rationality of the decision to marry than on fitness to *be* married, having to do with capability, involving rationality only in so far as it compromises the ability to fulfill a social role. Desire is less important than duty, and debates hinge on what it means to be a husband or wife. In nullification and fraud-in-marriage cases, diagnosis and medical histories are used to determine whether a spouse had a mental illness at the time of the marriage, an index of truth-telling that calls the purpose of marriage in question, while more ambiguous cases depend on whether mental illness amounts to cruelty. Such structures may be grounded more in the stigma of mental illness than in a logic relating mental illness to marriage (Dhanda 2000), but they nonetheless establish historical connections and loaded categories that will come to impact clinical life.

Across fields of social life and law, three (at least) ways of relating mental illness to marriage appear: (1) a sense that *mental illness jeopardizes intimacy*, (2) the idea

that the affections that may be part of marriage can be sources of undoing—*love can cause madness*, and (3) the idea that *wrong love is a sign of madness*. To this we may add a fourth, the cultural (or at least cinematic) vision that *rational love is impoverished*. Each crosses the arranged/chosen continuum differently, using biomedicine to offer an authorizing stamp to intimacies in contestation, in disparate terms. Each may intercede in clinical life differently as well, meaning that the subject of psychiatry is read by and legible to more than one schema, each carrying different social and political histories. In these circuitries, rational love is slippery. Legitimate love can be established through the imprimatur of law or challenged and undermined through the same means. As we might expect, "rationality" is a neutral (seeming) tool that moves across domains, exceeding concepts of agency, Indianness, modernity, and cosmopolitanism that inform conversations about forms of marriage. But therein lies its cunning. Rational love can obtain in *any* configuration of conjugality. It can be used to defend conjugal arrangements and by those who contest them; its proof can constrain decision-making or support socially unsanctioned decisions, permit or scrutinize aberrant desires. It can both extend and foreclose the protective embrace of kin, making clinical and kinship surveillance of emotion at once powerful and incomplete.

Where marital breakdown overlaps with mental illness, bringing women into the clinic on its heels or at its cusp, it brings with it a web of imaginaries. Paranoia occupies the juncture of love, marriage, and rationality, and clinical evaluations of emotion participate in contradictory schemes for knowing bodies, minds, loves, and choices. As Martin observes among those diagnosed with mania in the U.S., distinctions between rationality and irrationality can be unclear (2007) even as rationality bears enormous juridical and moral weight. For one thing, though evidence of irrational love, paranoia shows that irrationality may not necessarily be *abnormal*, making mental illness less a matter of radical alterity and more a delicate balance at the margins of norms, part of the potentially "catastrophic" nature of all love (Barthes 1978, p. 7). In the clinic, in the small catastrophes by which emotions are remade out of undone relations, biological truth is formed out of social life and vice versa in terms that are less about what is "normal" than what is livable.

Zones of Heartbreak

A sign of the "split world": a poster on the wall behind the reception desk at the private clinic offered a sequence of paired images. Each portrayed "superstitious" and "modern" approaches to mental illness, showing madness to be illness and illness a medical matter. In the middle, a sketch of a bride and groom, neither looking particularly happy, read, "Marriage is not a cure for mental illness."

But down the hall, mental illness was continuously negotiated in terms of marriage. Where in the government clinic existing marriages came under scrutiny, here it was more often unions after their dissolution that came under a lens. I observed during my time in the private clinic that many of the women in long-term care, some for up to 10 years, were divorced, divorcing, coming out of failed relationships, or never married (interestingly, almost none were widows). This may

have been an accident of timing. It was, nonetheless, a defining fact of the time I spent there.

Here, stakes were higher than in the government clinic. In this for-profit setting, women lived for periods from weeks to years behind a padlocked door, separated from the families who paid for care and the medical and micro-political processes that determined their release. Conversations about them happened at a remove, on the other side of the building, among doctors and kin. Where the government ward was a peopled space of movement, open doors, and constant flows of practitioners, laborers, and visitors, the private ward was a space of stillness, enclosure, quiet, and absence (of kin, visitors, sound, and things to do). The window glass was painted blue; the phone seldom gave the portending double ring. Much of what I saw troubled me, and much of what I noted about patients' lives involved their own sense that something was deeply wrong with this setting. This included patients in varying states of lucidity, and women speaking for each other as much as for themselves. While pharmaceuticals were used to read distresses in the same ways as in the government clinic, the threat of long-term commitment gave such scrutinies terrible weight.

One patient I got to know well, a middle class, university-educated housewife I call Sanjana, spoke to me at length about her divorce. "We began fighting, as people do," she told me, "Eventually the marriage fell apart." Her husband was from a different religious community. When they married against her parents' wishes 10 years earlier, she had converted and her family had cut off contact with her. Months ago he divorced her and retained custody of their young son, common in most family law in India, while she returned to her natal family at his insistence. They accepted her, but tensions were high. She argued with her brother and mother, who forbade her from visiting her old home though she wanted to see her son. Her natal household was not her home, but even for a well educated woman, single living in this city was difficult and finding a way to support herself and a place to live nearly impossible. Broadly, but not exaggeratedly, in north India, for most but the upper-classes, living alone signifies abandonment and impropriety more than freedom, involving social threat and the emptiness of life beyond the embrace of kin, especially for women of marriageable age.

One afternoon while bathing, Sanjana heard children's voices in the street and was overwhelmed by an urge to take her son back into her body. An intense sensation rose in her gut. She fell unconscious. On that day, her brother hired a car and brought her to the hospital. There had been "a lot of fighting," she said (a phrase I heard many times). Her brother said she was "angry" (also familiar), she said he was "against her" (again, something I heard repeatedly). Though she signed the consent form presented to her (as had all the women I met there), she said the choice to be in the ward was not hers. "They put me here by force" (*zabardasti se*—another refrain).

Though she was diagnosed with paranoid schizophrenia, there was little agreement among practitioners about her status. Lines of communication were unclear and there was no system of consistent reporting. Psychologists, unmarried women fresh from university, said her diagnosis was uncertain. The doctor, a soft-spoken woman in her early thirties, said it was "paranoid schizophrenia." Over

time, she was treated with a range of drugs—anti-psychotics, anxiolytics, and anti-depressants.

Doctors' attention focused on marriage and kin-life—the extent to which her feelings were reasonable or paranoid, obsessive, and thus symptomatic. So much hinged on whether, how, and how much she longed for her husband, whether she said her family was "against her," whether she found ways to "keep herself and her mind busy," advice that landed heavily in a locked space with little to do but sleep, pace and pray—themselves signs of distress.

Increasingly, she too grew preoccupied with these matters, distraught at the way her "life [was] going to pieces" (*thukre me*). As questioning of her desire that her husband "take her back" increased, expressions of longing that he do so replaced vocal anger. At psychologists' urging, outrage-turned-obsession was encouraged to become something else, something more like heartbreak, resigned and accustomed. Unlike other women, however, Sanjana never quite accomplished this transformation. By her own account, in my view, and according to others in the ward, her emotional state deteriorated over the months of "observation." She grew deeply depressed, anxious to have her predicament documented. Her religious practice increased, in part, she said, because there was nothing to do, and in part, I suspected, because hours of pacing and praying on beads gave her movement in which to lodge sadness and longing. "This place is hell," she said (in English), "Look around you. How can a human endure it?"

During her stay, two women were brought into the ward in florid psychosis. For one, as drugs took effect, doctors found signs of improvement in abating accusations that the husband had run off with another woman (though he had remarried and moved away) taking her daughters with him (which he had done), and in lessened mistrust of her natal family (who had committed her) and the clinic (which kept in her file postcards she wrote to her daughters). Paranoia was read against other symptoms and a history of medication as biological status, while outrage re-formed as loss.

For the second woman, drugs' effects were indicated by a reconstituted relationship with the parents who had rejected her failed affair (she had "run away" with a young man and was brought home months later in florid psychosis). Her delusions were fantastical—a baby born out of rice pudding, "real" parents who were prominent politicians—but their content was intertwined with her "marriage." Abandoning them meant establishing kinship on new terms.

Patients shared stories. They knew each others' pasts and, as they sorted stones from rice for the kitchen, spoke of broken bonds and the unknowability of relations in the world beyond the ward, where the "truth" about kinship, motivations, love and breakdown was elusive and changeable. Lost love, including the love of children, could contribute to a suffering that might be mistaken for madness, or to madness itself. In some cases the two were held apart: as one woman said, "Some people are not crazy, it is just that their hearts are broken."

In a conversation about the future outside the ward, a long-term resident with a developmental disability asked another, much younger, patient if she thought that one day she might be able to get married. "Of course you can marry," the younger patient said.

Her response—“Yes, I can marry. I can make vegetables, I can make okra”—showed marriage to mean more than love, rational or not. Responsibility and the ability to *do*, to fulfill a role, to care for were woven into emotions of kinship, showing marriage to be both a relationship and a secure position in the world, not a “cure” for illness, but a way to imagine the possibility of a future.

But imagining the future was a clinical tool too. A psychologist observed to Sanjana, “You must have a lot of attachment to your husband and children.”

“Yes, I am more attached to them than to anyone.”

“It is better to not be so attached to anyone. You are sick, right? And if you are so attached and you are sick then who will take care of them? You should not be so attached but should depend on yourself.” In bitter demands and double-binds, a plot familiar to everyday, literary, and cinematic stories of involuntary commitment took shape. Doctors repeatedly deferred Sanjana’s release while her distress grew. Ironic demands required she demonstrate health by overcoming the very emotions those demands perpetuated. Self-scrutiny, indeed self-paranoia, generated anxious disappointment, like the stationary bike at the edge of the room whose broken pedals offered no resistance to legs seeking motion.

Rather than a “zone of social abandonment” for people whose lives challenged what it meant to be human (Biehl 2005), the ward was a space of relation unmaking, an extension of ongoing—and very human—kin-work. But this came with conditions. Here, connections were at stake in legibility, making the locked ward a zone of loss. Rational love recreated kinship as loss, not as a meaning (“loss”) but as a fact of existence. The use of pharmaceuticals to read bodies by way of relations and relations by way of bodies did not enable conjugality (though conjugality remained a vivid fantasy and painful memory). It became part of its original tenuousness.

This did two things. First, true to the history of psychiatry’s attentions to women, the inappropriate female emotion of anger was transformed into something more manageable. But, second, drugs did not so much “fix” families or even women as they instituted relations in new terms, establishing lives on the ground of dissolutions, all the while reading emotions about them as biological signs. Thus, while it is important to note that divorced women experiencing mental illnesses in India bear a double stigma (Thara et al. 2003), this may not go far enough in understanding the specificities of women’s predicament “caught in a web of relations that produce no coherent position in kinship” (Butler 2002, p. 55), less through aberrant desires or choices than as the compounding effects of the precariousness of relations.

At the edges of ethical practice, carried out for profit by doctors and social workers, lacking the busyness and self-scrutiny of teams of residents, care merged with constraint. Practices that mediated dissolving relations and reconstituted anger as loss produced, even as they read, the emotion that was the sign of illness—paranoia—the very sense (perceptive and emotional) patients were required to disavow. In a maddening paradox, the clinic not only managed heartbreak, it created it in contradictions, deferrals, and impossible demands, allowing one disorder to cascade into many, and a moment of distress to unfurl into months of undoing.

Disordering Intimacy

India is a place often said to be "marriage crazy," "*shaadi* mad." Kinship and conjugality are likewise things we know to constrain women, shape personhood, and contour self-determination. In the imagined shift from "arranged" to "love" marriages, and the fantasy world in which divorce does not happen in India, marriage and kinship can be sites of what Cohen refers to as the "localized invocation of a lost world" (2007, p. 105). But clinical practices push against the received notion of loss *of* kinship with attention to loss *in* kinship. This kind of loss is neither temporalized nor mapped in terms of Indian tradition versus realized or corrupt modern selves. It inheres in attachment and locatedness "already." At the crux of these shared projects is paranoia—a clinical means by which bodies, minds, and relations become mutually legible. Here, relations are understood as vulnerable in terms other than nostalgia or nationalism, in themselves rather than made so by the forces of change.

The stakes of this process are different in the two settings I describe. How do we link them? One way might be to emphasize the movable and paradoxical nature of rational love: at once social and individuating, found in (or in deficit in) both "arranged" and "love" marriages, means of evading or imposing ideas about love, marriage and family. As a biological state, rational love carries the apparent moral neutrality of "nature;" it pertains equally to normative and non-normative unions, relations, even individuals. It offers biological proof at the same time that it supports tautological relationships between love and madness. Through medication, it suggests that the factuality of suffering is plastic, even as it exposes genuine (as opposed to delusional) suffering and turns unsettling anger into innocuous loss.

Another approach focuses on the way, across settings, rational love, though movable, specializes in women's angers and doubts about kinship, especially marriage and the nexus of relations it stand for. Condensing multiple forms of vulnerability, it highlights women's dependency within patriarchal, patrilineal, and patrilocal kin structures—and how much they stand to lose—suggesting that an important quality of kinship for north Indian women may be that marriage, love or arranged, remains at once risky and socially necessary. Anxiety, even paranoia, may be entrenched in conjugality for women. Among the most important losses are relationships with children. Indeed, motherhood is shown to be vulnerable, not the unbreakable institution portrayed in public culture but an intimate "lost world." This vulnerability is connected to legal worlds that establish unions and determine the outcome of their break-down, making mental illness capable of "severing an important linkage between a person … and society" (Dhanda 2000, p. 181). For divorced women in particular (Thara et al. 2003), the consequences of mental illness may be the remainders of the broader risks of relations.

In both readings, patients participate in a process Strathern identified as the work of relationality—making relations out of relations, to which we can add unmaking relations out of unmade relations. As the latter reading suggests, this process is far from neutral. For Strathern, "relational knowledge" involves movement and change as much as fixed models and established structures. It draws attention to the points at which kin structures and modes of relationality are, like genes, "recombinant," formed in break-down and regrouping, meaning "the family dissolves but kinship

remains" (Strathern 2005, p. 26). If the emotional dynamics of kinship dissolutions are entwined with clinical life—and determine whether or not a woman will receive treatment, have access to her children, or be kept in a locked ward for years at a time—then it is to kinship as a precarious social process, not "the family," "Indian marriage," or even "wifehood," as moral ideals, that our eyes should turn. In these cases, clinical practice is a method of kin-unmaking, a technique for bearing—as much as fashioning—love through attention to effects seen as never entirely abnormal. *Rather than enforcing normative configurations of "the family," biomedicine grapples with the gendered fallout of kinship.*

Where psychiatry reads relations as biological signs, it shares with families and patients a choreography at the juncture of attachment and undoing. Drugs and other clinical techniques attend to the always mutable entities that are love, marriage, and kinship, institutions that are risky, in this case, less because they are hegemonically oppressive than in the way they always threaten to "go to pieces." The legibility of the neuro-chemical self and the legibility of the self in relation depend on each other, forming a "sustaining web of relations [that] makes our lives possible, those of us who confound kinship in the rearticulation of its terms" (Butler 2002, p. 24). In this terrain—where relations are reworked as they are read as damaged, and livability is a goal, love can be, quite normally, catastrophic. But as Strathern notes, "uncovering connections and making connections can both have the force of a moral imperative, in the first case to exploit or conserve or otherwise acknowledge the world as it is and, in the second, as Wagner (1975) pointed out long ago, to make human life work as social life, the grand project of creating society" (2005, p. 11).

Recent accounts of global health and medical technologies have distinguished "kin ethics" from "life ethics" (Roberts and Elizabeth 2007, p. 182), and "genealogical" persons enmeshed in relations from "autological" subjects of global epidemiology (Povinelli 2006, p. 4). While leaning toward the former terms of the pairs, the entangled processes of rational love/relational medicine show the work of kinship to be interwoven with that of evaluating bodies in cosmopolitan terms, creating a movable ethics that may for some draw the best from each, and for others draw the worst. In this space between disciplinary and relational knowledge, if clinical actions are pacifying of disruptive female emotions, they enact their power through a body that claims (overt) allegiance to no cultural model and works with multiple schema of recognizability. Rational love is a messy and complicated "law." It evades, in moments, even the biopolitically individuating conditions of modernity it might otherwise represent. Skirting shifting boundaries of normality, it is a movable response to, and precipitated out of, accumulated vulnerabilities.

On the ground of paranoia, clinical relation-making unsettles the relationship of language to truth and the inviolability of experience. It does so through an understanding of illness as biological, with loss as once of its productions. It also does so because intimacy itself destabilizes those things. In spite of everyday reiterations of the strength of "Indian" unions (read "arranged") as opposed to western ones (read "chosen"), in "*shaadi* mad" north India, it may be that the basic vulnerability of conjugality is just as deeply felt as is its hegemonic weight. At the same time, the clinical effort to locate what is rational about relations is part of social contingencies in which the risks of marriage have heartbreaking stakes. For

women, relations are at stake in relations, dissolutions in dissolutions. The work of kinship, like the work of medicine, may happen at points of breakdown, the places where vulnerabilities in and to relations, in and to kinship, accumulate.

Acknowledgments Parts of this research were generously funded by a Faculty Research Award from Tufts University. Many thanks to Lucinda Ramberg, Robert Desjarlais, Richard Delacy, Amahl Bishara, Jonathan Anjaria, and Brandy Shillace for insightful and helpful readings, and to the people mentioned in this paper who let me into their lives.

References

Addlakha, Renu
2008 Deconstructing Mental Illness: An Ethnography of Psychiatry, Women and the Family. New Delhi: Zubaan.
Anjaria, Ulka, and Jonathan Shapiro Anjaria
2008 Text, Genre, Society: Hindi Youth Films and Postcolonial Desire. South Asian Popular Culture 6(2): 125–140.
Barthes, Roland
1978 A Lover's Discourse. Richard Howard, trans New York: Hill and Wang.
Biehl, Joao
2005 Vita: Life in a Zone of Social Abandonment. Berkeley: University of California Press.
Butler, Judith
2002 Antigone's Claim: Kinship Between Life and Death. New York: Columbia University Press.
Carstairs, G. M.
1967 [1957] The Twice-Born: A Study of a Community of High-Caste Hindus. Bloomington: Indiana University Press.
Cohen, Lawrence
2007 Song for Pushkin. Daedalus Spring: 103–115.
Corin, Ellen, Rangaswami Thara, and Ramachandran Padmavati
2004 Living Through a Staggering World: The Play of Signifiers in Early Psychosis in South India. *In* Schizophrenia, Culture, and Subjectivity: The Edge of Experience. Janis Hunter Jenkins and Robert John Barrett, eds., pp. 110–145. Cambridge: Cambridge University Press.
Das, Veena, and Renu Addlakha
2007 Disability and Domestic Citizenship. *In* Disability in Local and Global Worlds. Benedicte Ingstad and Susan Reynolds Whyte, eds., pp. 128–148. Los Angeles: University of California Press.
Davar, Bhargavi V.
1999 Mental Health of Indian Women: A Feminist Agenda. New Delhi: Sage.
Dhanda, Amita
2000 Legal Order and Mental Disorder. London: Sage.
Ecks, Stefan
2005 Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India. Anthropology & Medicine 12(3): 239–254.
Foucault, Michel
1990 History of Sexuality. Robert Hurley, trans (Vol. 1) New York: Vintage Press.
2003 Psychiatric Power: Lectures at the College de France 1973–1974. Graham Burchell, trans New York: Picador.
Freed, Ruth S., and Stanley A. Freed
1964 Spirit Possession as Illness in a North Indian Village. Ethnology 3(2): 152–171.
1985 The Psychomedical Case History of a Low-Caste Woman of North India. Anthropological papers of the American Museum of Natural History 60(2): 101–228.
Hartnack, Christiane
1999 Vishnu on Freud's Desk: Psychoanalysis in Colonial India. *In* Vishnu on Freud's Desk: A Reader in Psychoanalysis and Hinduism. T.G. Vaidyanathan and Jeffrey J. Kripal, eds., pp. 81–106. Oxford: Oxford University Press.

Jain, Sumeet, and Sushrut Jadhav
2009 Pills that Swallow Policy: Clinical Ethnography of a Community Mental Health Program in Northern India. Transcultural Psychiatry 46: 60–85.
Jenkins, Janis
2004 Schizophrenia as a Paradigm Case for Understanding Fundamental Human Processes. *In* Schizophrenia, Culture and Subjectivity: The Edge of Experience. Janis Jenkins and Robert Barrett, eds. Cambridge: Cambridge University Press.
Kakar, Sudhir
1978 The Inner World: A Psycho-analytic Study of Childhood and Society in India. New York: Oxford University Press.
Kurtz, Stanley M.
1992 All the Mothers Are One: Hindu India and the Cultural Reshaping of Psychoanalysis. New York: Columbia University Press.
Luhrmann, Tanya
2000 Of Two Minds: The Growing Disorder in American Psychiatry. New York: Alfred A. Knopf, Inc.
Martin, Emily
2007 Bipolar Expeditions: Mania and Depression in American Culture. Princeton: Princeton University Press.
Nandy, Ashis
1983 The Intimate Enemy: Loss and Recovery of Self Under Colonialism. Oxford: Oxford University Press.
1995 The Savage Freud and Other Essays on Possible and Retrievable Selves. Princeton: Princeton University Press.
Petryna, Adriana
2009 When Experiments Travel: Clinical Trials and the Global Search for Human Subjects. Princeton: Princeton University Press.
Povinelli, Elizabeth
2006 Empire of Love: Toward a Theory of Intimacy, Genealogy, and Carnality. Durham, NC: Duke University Press.
Roberts, Elizabeth
2007 Extra Embryos: The Ethics of Cryopreservation in Ecuador and Elsewhere. American Ethnologist 34(1): 181–199.
Strathern, Marilyn
2005 Kinship, Law and the Unexpected: Relatives are Always a Surprise. Cambridge: Cambridge University Press.
Thara, R., Shanta Kamath, and Shuba Kumar
2003 Women with Schizophrenia and Broken Marriages: Doubly Disadvantaged. International Journal of Social Psychiatry 49(3): 225–232.
Wagner, Roy
1975 The Invention of Culture. Chicago: University of Chicago Press.