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Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India

Stefan Ecks

Among practitioners of biomedicine, to speak of people as ‘marginalized’ often amounts to saying that they do not have access to medical substances. Thus conceived, the best way to remove marginality seems to be to give medicines to those deprived of them. The peculiar relationship between marginality and pharmaceuticals is especially poignant in the case of antidepressant drugs, as these drugs appear to bring the patient ‘back into society’, but not any society, but middle-class consumer society. What is now special about antidepressants is that there is nothing special about them: antidepressants are like consumer items among thousands of other consumer items. This paper explores the relations between medicines and marginality with reference to the marketing of antidepressant drugs in Kolkata (Calcutta), India. Drawing on ethnographic fieldwork in the Kolkata metropolitan area from July 1999 to December 2000 and in August/September 2003, this paper examines how people with depression are constituted as ‘marginal’ in the sense of ‘being deprived of medication’, and how the biomedical promise of an effective pharmacological treatment becomes a promise of ‘pharmaceutical citizenship’. In view of Bengali notions of mental health as a state of detachment, the paper asks if pharmacological demarginalization holds the same promise in the Indian context that it holds in the West.

Introduction

Over the past decade, psychiatric disease categories have been more widely popularized than ever before. Since the 1990s, the World Health Organization counts depression among the world’s most pressing health problems, and predicts
a further increase in suffering in the years to come (Desjarlais et al. 1995; World Health Organization 2001; Kirmayer & Jarvis, in press). The surge of interest in depression in the field of international health was intertwined with the emergence of a new generation of antidepressant drugs, the serotonin reuptake inhibitors (SSRIs). The pharmaceutical industry is increasingly employing strategies of direct-to-consumer marketing, aiming to create a popular recognition of depressive symptoms, to ‘grow the market’, and to foster a demand for specific medications. According to Healy (1999; 2004) and many other authors, we are living in ‘the antidepressant era’. The rising consumption of mood-brighteners has triggered a complex bioethical debate on the advantages and dangers of these drugs.

This ongoing transformation of mental health is by no means limited to Western countries. The pharmaceutical industry of India is becoming one of the world’s biggest producers of pharmaceuticals, especially in the field of generic medications. India, more than any other developing country, holds ‘great pharmaceutical promise’ (The Economist, 18 June 2005). Today, the industry also strongly directs its marketing efforts to the Indian domestic market. Indeed it seems that Western pharmaceutical companies, faced with stiff competition from Indian companies, have so far left the antidepressant market largely to Indian firms.

As Laurence Kirmayer argues, the worldwide spread of antidepressant medications is part of a ‘global monoculture of happiness’, which demands that everyone be ‘pain free, completely comfortable, and ready and able to acquire and consume the greatest quantity and variety of the newest goods and fashions’ (2002, p. 316). At the same time, supporters of antidepressant medications point out that it would be perverse to speak of a global spread of these drugs. Instead, there was a large ‘treatment gap’ between developed and less developed countries (World Mental Health Survey Consortium 2004).

What are the effects of antidepressants in the Indian context? I want to raise this question in relation to the theme of ‘marginality’. The view of marginality expounded by the WHO, the World Bank, NGOs, state agencies, international health and biomedicine at large, sees marginality as a form of social inequality that should, in principle, be abolished. Whenever one speaks of ‘marginality’, one speaks of a state of injustice. To call a person or a group ‘marginal’ normally entails an ethical mandate to remove such marginality. For example, a World Bank Report on the Voices of the Poor (Narayan et al. 1999) uses the terms ‘marginal’ and ‘marginalization’ to describe social exclusion or the unfair distribution of goods and services. With regard to health care, to be ‘marginal’ means to be cut off from the circulation of biomedical substances. The voices of ‘marginalized’ people that are quoted in the World Bank Report all speak of being unfairly deprived of medicines (e.g., Narayan et al. 1999, pp. 87–88, 96, 113). Marginalization, poverty, and the exclusion from social networks become virtually synonymous: ‘In explaining poverty, poor men and women very often express a sense of hopelessness, powerlessness, humiliation, and marginalization’ (Narayan et al. 1999, p. 35). The inclusion of ‘hopelessness’ in this sentence is no coincidence. To be ‘marginalized’ does not just entail difficulties in obtaining medical care, but is also linked to a greater risk of becoming depressed in the first place (Kirmayer & Jarvis, in press, p. 12).
Being depressed is seen a symptom of being socially marginalized, and untreated depression is seen a symptom of being marginalized from pharmaceutical networks.

One obvious conclusion that might be drawn from this understanding of depression and marginality is that antidepressant medications should be made available—or, at least, easily affordable—for as many marginalized people as possible. A pharmacological promise of demarginalization is evident in discussions on many diseases: malaria, tuberculosis, or antiretroviral medications. It is also prominent in the discourse on depression in developing countries. Removing symptoms of depression would contribute to removing social marginality, and vice versa. Offering a pharmaceutical substance to those at the margins is defined as the best way to help them. The definition of marginalization that the World Bank puts forth is typical of a ‘monoculture of happiness’ which defines happiness in terms of consumerism: here, the consumption of pharmaceuticals.

**Pharmaceutical Citizenship**

Recent discussions of the relation between medicine and society have focused on the term ‘biological citizenship’ (e.g., Petryna 2002; Rose & Novas 2004). Citizenship, it is argued, should not only be considered as the link between an individual person and a nation state. Instead, it is a complex process of overlapping ‘citizenship projects’ that is not limited to the politico-legal sphere. ‘Biological’ citizenship is one of these projects, centred on biomedicine and new forms of biotechnology. In reference to this, I want to define one form of biological citizenship as ‘pharmaceutical citizenship’. The biomedical promise of demarginalization can be seen as one among several current citizenship projects that redefine belonging, exclusion, duties and rights. Pharmaceutical citizenship revolves around two questions. Firstly, how does legal citizenship determine rights of access to pharmaceuticals? This includes, for example, the issue if equality between citizens also means equal entitlement to receive drugs. Secondly, what implications does the taking of pharmaceuticals have for a person’s status as a citizen? Questions here include whether the taking of certain pharmaceuticals, such as various psychotropics, impairs one’s rights as a fully responsible citizen, or whether patients can only regain full citizenship rights if they undergo pharmacological treatment.

In India, the project of pharmaceutical citizenship is closely linked to other such ventures. In the discourse on democratic voting rights in India, Dipesh Chakrabarty (2000) discerns two rival notions of the ‘citizen’. The first is the peasant-as-citizen who, despite lacking education, is already a full citizen and entitled to vote. The second is the not-yet-citizen peasant who still ‘has to be educated into the citizen’ (2000, p. 10). This position holds that without proper education, Indian democracy will never fulfil its promise. I would argue that pharmaceutical citizenship entails a similar friction, between the citizen-as-patient who is entitled to medicines because he or she is already a full citizen, and the not-yet-citizen patient, for whom the taking of medicines becomes a practice of becoming a full citizen. In pharmaceutical citizenship, the role of civic education is replaced by medical marketing.
The notion of pharmaceutical citizenship is particularly poignant in the case of antidepressant medicines. Even in developed countries, the message promoted by the pharmaceutical industry is that antidepressants have the power to demarginalize the suffering individual and to restore his ‘own true self’. For example, an American direct-to-consumer campaign for the antidepressant drug Paxil used as its slogan ‘I feel like myself again’. Being oneself again means, above all, to overcome the isolating effects of depression and to be able to reintegrate oneself into society (Dumit 2003). More than other medicines, antidepressants hold the promise of a quick and effective demarginalization.

The promise of demarginalization through antidepressants is a leading theme in the marketing strategies of Indian pharmaceutical companies. In the following, I discuss Indian pharmaceutical advertisements that I collected in 2003. Although I cannot discuss more than four examples here, I believe that they are representative for antidepressant marketing in India generally. The first ad is for the antidepressant Paxidep CR (Symbiosis/Sun Pharma), the second for the brand Arpizol (Synergy/Sun Pharma), the third for Firsito (Zydus Neurosciences), and the fourth for Aripra (Solus/Ranbaxy). All these advertisements are targeted at doctors in general practice and mental health professionals. They all feature the brand name, the company logo, and the active substances in various available doses. None of them entails a picture of the tablet/capsule itself.

The ad for Paxidep CR gives explicit details of the advantages of this drug: significant improvement of symptoms already in the first week of treatment; ‘56% remission rates’ starting from the third week; ‘unmatched GI [gastro-intestinal] tolerability’ thanks to a special coating; and several more. The catchphrase of Paxidep CR is ‘Live…every moment…with confidence’. An image in the ad shows a twenty-something couple, a man and a woman, holding hands with a child between them, smiling and dancing. The ad for Arpizol dubs the drug ‘The 1st dopamine serotonin system modulator’. Instead of describing the properties of the drug, it just shows an image of a smiling young man, on all fours on a well-polished wooden floor with a child, presumably his son, riding piggyback on him. The drug Firsito is advertised as ‘First Choice’, and touts its active ingredient: ‘Escitalopram in the treatment of severe depression’. Half of the ad consists of a photo in which a man cheerily spoon-feeds ice cream to his female partner. The fourth ad, for the drug Aripra, says that it is ‘For A Beautiful Mind & Beyond…’ and includes a photograph of a smiling male/female couple, both of whose eyes are fixed on a point beyond the horizon.

What I want to highlight are the images of the people. All of them look like attractive, smiling, fair-skinned South Asians. They are not depicted as isolated individuals, but in cheerful company with their partners or their children. They are all engaged in some sort of play: feeding ice cream to each other, joking, dancing, and holding hands. They all wear Western clothes and seem to be well off or even rich. Neither of the pictures shows the medicines themselves, nor the act of ingesting the capsules. In each case, it is impossible to tell who is taking the medication: is it the man, the woman, or the child? The medication seems to bring one back into society without stigma or visible mark. No hint of any ‘marginal’ social
status is evident. Revealingly, the only type of person to reappear in all four ads is the male adult—if there is one group which is by far the least ‘marginal’ in India, it is that of the middle-/upper-class male family father. In India, as in many other countries, men are less likely to be depressed than women (e.g., Stoppard 2000).

These images contain no trace of marginality (be it marginality on the grounds of class, caste, gender, or stigmatizing mental illness). They suggest that the drug removes both depression and all forms of marginality. They promise not just the relief of depressive symptoms, but full mental, physical, and economic integration. ‘Reintegrating Lives’, the motto of Zydus Neurosciences, further underlines this mission. The promise of demarginalization is not limited to mental health, but to one’s social status in general. The message seems to be: ‘Take this medicine, and you will not only be happy, but married with children, rich, and live a Western life-style’. Being one’s own ‘true self’ in India seems to mean being a middle-class subject clad in Western clothes. Of course, the same message can be found in advertisements for cars, fridges, or washing powder, which all engage images of happy middle-class selves (cf. Mazzarella 2003). What is special about antidepressants is that there is nothing special about them: antidepressants are like consumer items among thousands of other consumer items. The grey past of suffering has passed, and a new age of middle-class happiness has come.

Similar structures also appear in forms of marketing directly aimed at consumers. One type of this is the ‘self-test’ for mental health. Most self-tests do not advertise a specific product but aim to ‘grow the market’ for antidepressants generally. For example, a leaflet distributed by a Mumbai-based company is entitled ‘The Depression Self Test’. On the front, it shows a big ‘smiley’ face encircled by the words: ‘Defeat Depression—Spread Happiness’ and underlines that it is ‘FREE!’ (suggesting that people would usually pay for a test like this). On the back, a list of ten items for self-diagnosis is presented. Whoever experiences ‘five or more’ of the following symptoms is told to ‘see your doctor’:

- A persistent sad, anxious, or ‘empty’ mood
- Sleeping too little or too much
- Reduced appetite and weight loss or increased appetite and weight gain
- Loss of interest or pleasure in activities once enjoyed
- Restlessness or irritability
- Persistent physical symptoms that don’t respond to treatment
- Difficulty concentrating, remembering or making decisions
- Fatigue or loss of energy
- Feeling guilty, hopeless or worthless
- Recurrent thoughts of death/suicidal attempt

The leaflet was produced and distributed by Ipca Labs Ltd., a company that produces a range of psychotropic drugs, among them antidepressants. In 2000, Ipca Labs set up a special division for ‘therapy-focused marketing of neuropsychiatric drugs’. Creating consumer awareness of mental health problems is one of this division’s main marketing activities. Although the leaflet lists symptoms of depression that correspond to psychiatric classifications, it seems that the company spreads
a rather inflated understanding of depression. Especially the scaling of the answers seems questionable: if a person experiences ‘five or more’ out of ten symptoms, he or she is advised to seek medical help. The general way in which the questions are asked raises the suspicion that even people who would not fall into the category of ‘depression’ if diagnosed by a professional psychiatrist might be pushed to believe that they are depressed and in need of medicines.²

It might appear that the leaflet simply shifts the focus from social marginality to individual pathology. But rather than suggesting individual pathology, it promises global pharmaceutical citizenship. Firstly, while policy makers portray Indian health care as marginal to global health care, the language used in the leaflet is English. ‘Your doctor’ is someone around the corner in Kolkata, someone who commands the same psychiatric expertise as doctors in Europe or in America. Second, no mention is made of local idioms of distress; nothing is said about an Indian context of diagnosing and treating depression. Third, depression is not associated with ‘marginal’ groups within India, e.g. low-class women or migrant workers, groups that might be more prone to depression than others. Instead, the ‘you’ of the text could be anyone. Perhaps an unwitting yet telling trait of the flyer is the ‘smiley face’, a kind of generic global representation of ‘face’ without any trace of difference, be it class-based, ethnic, gendered, or other.³

The ‘Depression Self-Test’ tries to convince its readers that depression is a disease, that it is widespread, and that it is largely undiagnosed. Those who are defined as depressed are defined as marginal to society, as long as they do not go to see a doctor and get medicated. The promise of demarginalization comes in form of ‘your doctor’, able to prescribe a medicine. The blurring of boundaries between the normal and the pathological through antidepressants takes on a new spin in relation to marginality. The aim of the flyer is to make as many people feel ‘depressed’, and hence ‘marginal’ to society, as possible. Re-entry into society, it is suggested, is best possible with the help of medicine. But the ‘society’ that one will re-enter is not any society, but mainstream middle-class consumer society in tune with the global monoculture of happiness. This could be one critical reading of pharmaceutical marketing in India.

Beyond Sociocentrism

No doubt, there is among social scientists—and perhaps especially among medical anthropologists—a deep distrust of any purely pharmacological form of overcoming marginality. Nichter and Vuckovic express this position clearly when they assert that ‘pharmaceutical fixes of diseases often constitute the path of least resistance in contexts of underdevelopment’ (1994, p. 1512). Giving a substance is a superficial solution to problems of marginality. For most anthropologists, the prescription of antidepressants for the ills of marginality would amount to a quick fix at best, and a new form of exploitation by pharmaceutical companies at worst. An antidepressant, the critique would run, is nothing but a fetishized commodity that diverts our attention away from unequal relations between humans and humans, while disguising them as relations between things and humans. This Marx-inspired⁴
suspicion of commodities as fetishes still runs deep in current anthropology (Downey et al. 1995, p. 267). It would seem that, in the debate about antidepressants as a means of demarginalization, we are left with two main positions. On the one side, most biomedical practitioners, the pharmaceutical industries, and public health organizations would now support antidepressants as a relatively effective way to remove marginality. On the other side, many social scientists would see antidepressants as fetishes of medicine that eschew solving the ‘real’ problems, which are essentially problems of social inequality.

Recently, Bruno Latour (2004) renewed his proposals to overcome thinking in such dichotomies. Concerned by reactionary appropriations of sociological views of science as ‘constructed’, Latour asks if critical social theory of science needs to rethink itself. For him, the social-constructivist critique of science works like a kind of ‘potent euphoric drug’ (Latour 2004, p. 163) for those who use it, because it is always right. Any object that the critic politically dislikes can be branded a ‘fetish’ and be discarded as useless: ‘When naïve believers are clinging forcefully to their objects, claiming that they are made to do things... you can turn all of those attachments into so many fetishes and humiliate all the believers by showing that it is nothing but their own projection’ (Latour 2004, p. 163). In the case of antidepressants, the obvious social science critique is to call them ‘fetishes’ of medicine, development, and pharmaceutical industries. What should be done, in Latour’s view, is to see matters of fact as matters of concern for all those participating. If his point is to be applied, however, we have to find a way to think about mental health that neither reduces it to the proper distribution of medicines, nor simply rejects medicines as fetishized commodities.

In recent years, the anthropologies of science, technology, and medicine have done much to illustrate the argument that the separation between the authentic/human and the inauthentic/non-human domains can be misleading. For example, Rabinow (1996, pp. 99–102) shows how scientific artefacts can generate the emergence of ‘biosocialities’ such as patient interest groups. Clarke et al. (2003) show how new forms of medicalization can trigger the appearance of new ‘risk-based, genomics-based, epidemiology-based, and other technoscience-based identities’ (Clarke et al. 2003, p. 182). These technoscientific identities are not formed by patients in order to ‘resist’ medicine, but already represent a basic acceptance of biomedical notions of self and health (Rose & Novas 2004, p. 449).

Drawing on these works, I think that medical anthropologists should not be too quick to separate human actors (patients, doctors, et al.) from non-human actors (for example, antidepressants). Instead, it might be more fruitful to follow pharmaceuticals around and to study their power of not only transforming the bodies and moods of individuals, but of transforming social relations as well (Whyte et al. 2002; Ecks 2003). Before returning to antidepressants in India, I want to illustrate this point with an analysis of one seminal North American text on antidepressants: the Beyond Therapy Report (The President’s Council on Bioethics 2003). A close reading of this report will make it possible to see some of the fault lines of current thought on antidepressants in the West. Since Indian pharmaceutical companies model their marketing strategies along Western examples, any approach
to the Indian context must take a global perspective. The main idea of the Report, that true healing of depression can only be achieved through reintegration, will serve as a point for comparison with examples from India later in this paper.

American Bioethics of ‘True Happiness’

One of the most influential statements on the bioethics of antidepressants was published in October 2003 by the U.S. American President’s Council on Bioethics. The Report, entitled *Beyond Therapy: Biotechnology and the Pursuit of Happiness* (also named ‘Kass Report’ after the Council’s chairman, Leon Kass), presents a nuanced discussion of medical technologies that promise to make people not just well, but ‘better than well’. Taking its chief inspiration from the American Declaration of Independence, the Report defines the pursuit of happiness as a basic human right: ‘the right to pursue happiness is one of the unalienable rights that belong equally to all human beings’ (The President’s Council on Bioethics 2003, p. 203). Happiness is seen not as one goal in life among others, but as an ‘overarching interest in our complete and comprehensive well-being’ (The President’s Council on Bioethics 2003, p. 203). 5

Along with ‘Better Children’, ‘Superior Performance’, and ‘Ageless Bodies’, the problem of ‘Happy Souls’ is one of the main concerns of the Report. Drawing on a variety of statistical data, the Report holds that up to twenty percent of all U.S. Americans were suffering from ‘some form of depression’ (The President’s Council on Bioethics 2003, p. 240). The constant rise in the number of people who are diagnosed as depressive was a true increase in suffering. Hence it was neither an artificial outcome of changing diagnostics (especially the widening of the ‘depression’ classification), nor an outcome of different statistical methods. Although the number of people who receive antidepressant medication had also increased dramatically, depression was still ‘undertreated’ (The President’s Council on Bioethics 2003, p. 240). Placing great faith in future advances in pharmacological treatments, the Kass Report predicts a rapid further spreading of antidepressant prescriptions.

By itself, the expansion of antidepressants is not seen as an ethical problem, as long as they relieve ‘true’ suffering. The ethical dilemma only arises when people who do not ‘truly’ suffer start taking these pills. To a certain extent, low moods, sadness, and feelings of hopelessness were all part of ‘normal’ life, and should be accepted as such. These were crises that reflect the truth of human existence. Suppressing them through the use of antidepressants entailed the risk of ‘undermining our true identity’ (The President’s Council on Bioethics, 2003, p. 225). The most pressing ethical problem, then, is to distinguish between true (objective, clinically proven) suffering, and merely subjective, inauthentic suffering. To draw this distinction is, of course, very difficult, as the Report acknowledges: ‘How can one tell the difference between true and false happiness, between the real thing and the mere likeness?’ (p. 209).

The term ‘true’ plays a pivotal role in the Report’s line of argument. Separating truth from falsehood is seen a major concern of our lives: ‘In human affairs, we care a great deal about the difference between “the real” and “the mere appearing”. We care about “living truly”’ (The President’s Council on Bioethics 2003, p. 251).
The Report hopes that it can rediscover ‘the true meaning of our founding ideals’ (2003, p. xiv) about happiness while still savouring the fruits of biomedicine.

If ‘living truly’ is so essential, how should we live truly? The answer that the Report develops is this: true life is life with other people, a deeply committed social life. The route to authentic happiness is to live one’s life engaged with other humans. The Report states that ‘we’ do not want to be happy because of pills, but only because of ‘real loves, attachments, and achievements that are essential for true human flourishing’ (2003, p. xiii). True happiness can only flow from ‘the ties that bind and that ultimately give the individual’s identity its true shape’ (2003, p. 265).

In its discussion of happiness, the Report leaves aside all questions of class, race, gender, or any other forms of social inequality. Even so, its findings directly answer the question if antidepressants could be a means of overcoming social marginality. For the Report, authentic happiness comes first through rebuilding and strengthening our social ties and engagement with the world. Only if this fails is it justifiable to use pharmaceuticals. Without strengthening social ties, taking pharmaceuticals entails the risk of even deeper alienation. Health is not to be commodified, but rather to be realized through social reintegration.

Even if most anthropologists would shy away from such frequent use of the term ‘true’, I suppose that they will readily agree with the Report’s conclusions. Many medical advocates of antidepressants, including representatives of the pharmaceutical industry, might also concur with its insistence that ‘true’ happiness is not to be achieved through drugs alone. In my view, however, the Kass Report does not reflect deeply enough on its own definitions of ‘true’ or ‘authentic’ happiness. In the Report, the distinction between ‘authentic’ and ‘inauthentic’ forms comes down to a distinction between the ‘true’ happiness that is achieved on a human level and the ‘false’ (or at least ambiguous) happiness that is won through ingesting non-human substances such as antidepressants. In this perspective, reintegration through pharmaceuticals seems ambiguous because it is not purely social.

What is easily overlooked is that this definition of authentic happiness is already mediated by the presence of mood-brightening drugs. If ‘authentic happiness’ is rooted in social ties, what does ‘social’ mean? The very definition of ‘social ties’ used in the Kass Report is based on an implicit exclusion of drugs. ‘Social’ is then a space where non-human substances are not admitted to enter and where only relations between humans are allowed. Human relations produce ‘authentic’ happiness, whereas relations between humans and non-humans can only produce a semblance of it. Humans can only be truly reintegrated when non-human antidepressants are, in a manner of speaking, marginalized from human society. The Kass Report’s definition of true happiness relies on the crossing out of pharmaceuticals as inauthentic non-humans. Is such a sociocentric definition of true happiness sufficient to understand concepts to mental health in India?

Religion is the Prozac of the People

The Kass Report is only concerned with the situation in the United States and does not discuss mental health in a transcultural perspective. Yet the questions it raises,
for example about the boundaries of the category ‘depression,’ also apply to transcultural psychiatry. In the remainder of this paper, I want to open a comparative perspective on the ethical concerns around antidepressants, especially in relation to ‘true happiness’.

How to measure the occurrence of mental illness cross-culturally, without falsely imposing a set of Western preconceptions, remains a controversial problem (cf. Kleinman & Good 1985; Dawson & Tylee 2001; Weiss 2001). One of the proposed solutions to the problem of cross-cultural difference is to take account of local idioms of distress in the assessment. The inclusion of such idioms in the fourth edition of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV) is a working example of this process (cf. Mezzich et al. 1999).

For India, idioms such as ‘feeling hot’, ‘gas’ or ‘semen loss’ have been identified as local ways of experiencing and expressing depression (cf. Mumford 1996; Raguram et al. 1996; Bhugra & Mastrogianni 2004). Even if these cultural idioms have their own aetiology and symptomatology, they are at least seen as local approximations. Psychiatrists who are most doubtful of the universality of Western psychiatric categories suggest that we should ‘step back from the received categories of psychiatric nosology and begin again with ethnographic research on local ways of expressing distress’ (Kirmayer & Jarvis, in press, p. 3). One of these expressions of distress I want to focus on here is the Bengali term mon kharap (‘bad mind’).

During fieldwork in Kolkata (1999–2000 and 2003), I explored Bengali expressions for problems related to the ‘mind’ (mon). Bengalis have an elaborate language for experiences of sadness (dukkho), anxiety (dush cinta), the inability to make decisions, loss of joy in life, and many other problems. People speak frequently and freely about experiencing a mon kharap (‘bad mind’). Mon is the Bengali term for mind (or ‘heart–mind’), mood, affection, concentration, intention, and personal opinion. It is etymologically related to Sanskrit manas, Greek menos, Latin mens, and English mind. Bengali mon does not have a specific location within the body. When people use the term, they either point to the solar plexus area of the chest, point to the forehead, or move their hand between these two points. Mon kharap seems to be the most general and inclusive category for sadness, grief, irritability, anxiety, and the inability to make decisions.

Despite many similarities, it is not possible to reduce mon either to a psychological entity, nor to interpret mon kharap as an equivalent of ‘depression’. Instead, mon kharap covers a broad construct of dysphoria and distress that can include both. Similarly, other idioms of distress (e.g. ‘gastric’) that seem like symptoms of depression cannot be easily subsumed under the rubric of this psychiatric disease category. Specifically, ‘gastric’ is not simply a somatic idiom of depression.

The psychiatric notion that Indians ‘somatize’ psychological problems by speaking about bodily symptoms such as ‘gas’, ‘gastric’, or indigestion, is misleading. Firstly, the observation that Indian patients tend to present bodily symptoms instead of ‘psychological’ ones in biomedical consultations is correct, but is not due to a lay misrecognition of the symptoms. Instead, it is due to the perception that biomedical treatments are best suited to treat physiological symptoms—problems of the heart–mind are not seen to be its specialty area (cf. Jadhav et al. 2001).
Second, proper digestion, with or without somatopsychic connotations, occupies a central place in Bengali concepts of health and well-being (Ecks 2004). To put it simply, if the belly is all right, all one’s health is all right. Yet as the body’s internal kitchen or cooking-place, always yearning to be filled, the belly constantly threatens to overheat, to become imbalanced, and to get out of control. The ‘hot’ tendencies of the belly can only be held in check by the ‘cooling’ influences of the mind. As is clear from countless Bengali metaphors, the characteristics of mon are seen to be diametrically opposed to those of the belly. Where the belly exerts an animal-like agency, mon brings the person closer to the gods. The belly desires to be filled and to be fed, whereas the mind aims to take in as little as possible. Where the belly is moving and heating, the ideal mon is cool and still. The belly constantly threatens a person’s self-control, whereas the mon can bring self-control.  

For this reason, good health depends on a proper alignment of mind and belly. Keeping the mind sane will keep the belly sane, and vice versa. A disturbance of the belly can be treated with pharmaceuticals, yet a disturbance of mon is generally seen as being beyond the expertise of medicine, and non-medical practices such as praying or doing worship (puja) are usually seen as far more effective than going to see a doctor. Hence it becomes understandable how the frequent presentation of ‘gastric’ complaints in the doctor–patient encounter cannot be translated into a somatic ‘misrecognition’ of mental imbalance by the patient.

Let me back up these insights from long-term participant observation with results from semi-structured interviews that I conducted with 40 residents of Uttarpara, a northern suburb of Kolkata, in 2003. One of the questions I asked in these interviews was about the most effective forms of relief from mon kharap. Twenty women and twenty men were interviewed, all of them Hindu Bengalis, most of them lower-middle and middle-class. By far the most commonly mentioned relief from mon kharap was prayer to deities (27 out of 40 responses). Other religious practices were also frequently mentioned, e.g. visiting temples (16 out of 40), or reading religious books (9 out of 40). Practices aiming primarily at calming and focusing one’s mon that are not necessarily religious were also prominent, especially withdrawing oneself for taking rest (21 out of 40), trying to think positively (17 out of 40), and dedicating time for meditation (6 out of 40). Drawing on social ties was also seen as soothing, especially seeking family support (19 out of 40) and seeking support from friends (14 out of 40). Resort to professional healers was rarely seen as an appropriate way to deal with mon kharap. More of my respondents recommended visiting an astrologer (7 out of 40) for a mon kharap than visiting a biomedical doctor (5 out of 40). Going to a mental health specialist as a way to relieve the suffering of mon kharap was only mentioned by only two out of 40 people. Indeed, my questions about medical help for a mon kharap were often greeted with bemused surprise: ‘What’s got a doctor to do with mon kharap?’, one lower-class women replied.

There are four caveats that I should make. Firstly, Kolkata is one of the largest urban agglomerations in the world. Given the relatively small number of people interviewed, I am not claiming that these findings are statistically representative for a population as large and diverse as Kolkata’s. Secondly, there is no reason to
assume an unchanging, ‘Bengali’ view on mental health. There are many reasons to believe that the biomedical view of the brain is beginning to have a profound influence on popular perceptions, and today the use of psychotropic medications is already widespread among the educated elite. Thirdly, what people say they do and what they actually do is not necessarily the same. So what these interviews reflect is first of all a particular ideology of the self. Fourthly, what people say they want might not be what they might ‘truly’ want if sufficient psychiatric care was available and accessible (this is many psychiatrists’ point of view).

The main claims I would venture to make here are that, by and large, Hindu Bengalis of Kolkata do not yet see symptoms of a mon kharap as a ‘medical problem’, and that the local view of mental health sees a hierarchy of effectiveness with spiritual transcendence at the top, ties with other humans in the middle, and things/pharmaceuticals at the bottom. Strengthening one’s ties to family and friends as a relief from mon kharap are also seen as important, but not as important as practices that help to focus one’s mind. Going back to the discussion of Latour (2004) above, I would argue that not only pills have to be re-admitted into the picture, but also gods and transcendent entities. A purely sociocentric view will not hold (cf. Chakrabarty 2000, p. 16).

I introduced the notion of mon kharap as a ‘local’ way of expressing distress. Nevertheless, mon kharap resonates with much wider concerns in popular Hinduism across India. Achieving control over one’s mind and various forms of meditative withdrawal from the world are a central element in all strands of Hinduism (Michaels 1998, pp. 347–377). Virtually all the major figures of modern Hinduism, for example Sri Ramakrishna, Sri Aurobindo, and even M. K. Gandhi, emphasized mind-control as a path to enlightenment, freedom, and ‘true happiness’.

That relations between humans and humans are seen as less powerful healing forces than relations between gods (or complete transcendence) and humans, is clearer from religious writings. Let me give a brief quotation from the works of Swami Vivekananda (1863–1902), a disciple of Sri Ramakrishna, founder of the Kolkata-based Ramakrishna Mission, and perhaps the most famous representative of modern Hinduism in the West. Presented alongside quotations from the Bhagavad Gita and other classical texts of Hinduism, quotations from Vivekananda’s works feature prominently in a type of religious self-care literature that is hugely popular among Kolkatans. Vivekananda is also invoked to endorse all sorts of commercial, political, and social activities. Sayings and images of Vivekananda even feature in pharmaceutical advertising. For example, the Bengal-based company Pharmagen uses an image of Vivekananda in one of its marketing posters, which features the Pharmagen logo alongside an image of Vivekananda in meditation and a quotation from his works: ‘The world is in need of those whose life is one of burning love, selfless’. Vivekananda reformulated Hindu teachings in relation to the capitalist transformation of India during the colonial period. He stressed, more than other religious leaders, the importance of working with and for other people. Yet like other religious figures, Vivekananda also saw the root of ‘true happiness’ in detaching oneself from social ties, not in strengthening them. Working for others is not meant to reinforce one’s bonds with other humans, because waiting for reciprocity from others only
leads to misery. ‘True happiness’ consists in doing work without expecting anything in return. Doing work and getting involved in the world should only be a practice of overcoming selfishness. Ultimately, true happiness cannot be derived from social ties, but only from unravelling the ties that bind:

We are attached to our friends, to our relatives... What... brings misery but this very attachment? We have to detach ourselves to earn joy... We get caught. How? Not by what we give, but by what we expect. We get misery in return for our love... Desire, want, is the father of all misery. Desires are bound by the laws of success and failure. Desires must bring misery. The great secret of true success, of true happiness, then, is this: the man who asks for no return, the perfectly unselfish man, is the most successful (Vivekananda 2003 [1907], pp. 3–5).

The fact that support from family and friends is seen as a relief from mon kharap does not mean that these social ties are taken to be the ultimate source of true happiness. In Hindu (especially Advaita Vedanta) ideology, the ‘true shape’ of the self can only emerge when social ties are severed and the soul (atma) is released from the world into blissful union with Brahma. A person’s true shape is the transcendence of all shapes.

In this perspective, the North American notion of true happiness emerging from ‘the ties that bind and that ultimately give the individual’s identity its true shape’ (The President’s Council on Bioethics 2003, p. 265) might not be shared by Kolkatans in a straightforward way. Any promise of demarginalization, be it by means of stronger social ties or by means of antidepressants, might not be perceived as a path to ultimate happiness.

The global monoculture of happiness does not only come in the guise of things like antidepressants, but also in the guise of a sociocentric ideology that propagates social ties as the only path to true happiness. Promises of demarginalization through ‘pharmaceutical citizenship’ are key elements in this ideology. Critiques of commodity fetishism, with its stress on social ties, might inadvertently deepen this monoculture.

The global spread of antidepressant medication changes not only the definitions of mental health and illness, but also changes the parameters of what ‘true happiness’ means. Giving pharmaceuticals as a quick way out of marginality is a notion that might already be common sense among Kolkata’s doctors and public health officials. It is likely that the perception of depression as a physiological disease that can be treated by antidepressant medicines will increase in the future, especially among the globally connected Bengali middle and upper classes. If, however, Bengali notions of happiness are also changing towards ‘social ties’ as their vital source remains to be seen. The promise of spiritual detachment might be ultimately more alluring than the promise of pharmaceutical citizenship.

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Notes

[1] Pharmaceutical marketing is centred on substances, but is not limited to them. For example, the website for Prozac maintained by Eli Lilly presents itself as a comprehensive source of information and guidance on all aspects of depression. It seeks to explain how depression is caused by an imbalance of neurotransmitters, and how antidepressants act to restore this balance. Crucially, it also urges people with depression to become ‘active participants’ in their recovery process by keeping a diary, reducing stress, exercising, and by joining support groups. Prozac’s ‘political economy of hope’ (Rose & Novas 2004, p. 447) is centred on drugs, but is not limited to them. Similarly, a marketing campaign for the schizophrenia drug Risperdal aimed not just at medication but at ‘reinsertion’ of patients through company-sponsored work schemes (Lakoff 2004, p. 205).

[2] Self-diagnosis as a form of marketing is used not only by pharmaceutical companies, and not just for commercial purposes. For example, the current ‘Mental Health Guide’ leaflet distributed by the counselling service of the University of Edinburgh also starts off with a self-test for depression. The problematic relation between for-profit pharmaceutical marketing and not-for-profit counselling services is an issue that cannot be discussed here.

[3] Obviously, the company has no interest in claiming that marginal people (say, lower-class women) are particularly affected if these people are unlikely to pay for these medicines. I think, however, that the pharmaceutical industry’s promise of ‘pharmaceutical citizenship’ is the more important motive for this kind of representation.

[4] Most critiques of ‘commodity fetishism’ are not strictly Marxist, but are humanism in a Marxist idiom (Anirban Das, personal communication).

[5] For Carl Elliott, the era of anti-depressants is an era that gives primacy, not to the right to pursue happiness, but to the social obligation to pursue happiness, by any means necessary. In this view, which is perhaps particularly prominent in the United States, a life without happiness a life wasted (Elliott 2003, p. 303; cf. Elliott & Chambers 2004).

[6] The relation between mon and belly shares certain aspects of mind/body dualisms prevalent in the West (cf. Kirmayer 1988), but is still different. For example, mon is just one layer of consciousness among several others. The perspective described here is simply the most common and commonsensical.

[7] It is important to add that a mon kharap is perceived by Hindu Bengalis as a unwelcome affliction. It is not, as Obeyesekere (1985) argues for depression-like feelings of hopelessness and loss in Buddhist culture valued as a positive sign of unfolding wisdom about the impermanence of the world.

[8] For example, at the 2005 commencement ceremony of the Massachusetts Institute of Technology, Swami Tyagananda of the Ramakrishna Mission opened his speech with a quote from Vivekananda: ‘Education is the manifestation of the perfection already within us’. This was the first time in the history of the MIT that a Hindu priest said prayers at this ceremony (The Telegraph, Kolkata, 12 June 2005).

[9] The texts presented here were originally written by Vivekananda in English; hence ‘true happiness’ is his own expression and not a translation from Bengali.

[10] Much has been written on Indian ‘fluid bodies’ and the great importance of social transactions in the constitution of the self (Marriott 1976; Daniel 1984; cf. Langford 2002). However, none of these works on relational selves has put into question that pulling oneself out of worldly entanglements is still seen as the supreme goal by most Hindus in Bengal and beyond.
[11] I want to underline again that ‘detachment’ is more of an ideology than a practice. Those who ‘detach’ themselves from the world, either for a few minutes or until the rest of their days, do not leave all social ties behind. Meditation is often done in groups; singing devotional songs or celebrating puja can be a deeply social activity; and going on pilgrimage usually involves several other close members of the family or friends. Nevertheless, all of these activities are built on an ideology of severing social ties. This is a much-debated point in Indian sociology and cannot be treated in detail here.

References


