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Discourse, Power, and the Diagnosis of Weakness: Encountering Practitioners in Bangladesh

*The author's experiences as a "patient" of nonbiomedical practitioners, and an examination of Bangladeshis' encounters with practitioners (*ḍāktārs [*biomedical doctors*], *herbalists, exorcists, and diviners), reveal the interactive means by which the diagnosis of* durbalatā *(weakness) is constructed. In the cases presented, facing power in the person of the practitioner means losing face. I argue that discursive phenomena above and below the lexical level are responsible. The phenomena described—(1) interruption or dismissal of the patient's words by practitioners and others present during the clinical encounter, (2) divinatory routines that assign the durbalatā label to women, and (3) one patient's use of "creaky" voice quality in a strictly "popular sector" (domestic) encounter—are nonreferential but socially significant semiotic processes that operate, for the most part, beneath the level of discursive awareness. These encounters and their outcomes have more to do with social reproduction than with any unambiguously effective therapeutic outcome.* [doctor-patient discourse, social construction of illness, language and cognition, semiotics, Bangladesh]

> Language is real, practical consciousness. . . . The relationship between language and experience never appears more clearly than in crisis situations in which the everyday order . . . is challenged, and with it the language of order, situations which call for an extraordinary discourse . . . capable of giving systematic expression to the gamut of extraordinary experiences that this, so to speak, objective *epoche* has provoked or made possible. "Private" experiences undergo nothing less than a *change of state* when they recognize themselves in the public objectivity of an already constituted discourse, the objective sign of recognition of their right to be spoken and to be spoken publicly.
>
> Pierre Bourdieu, *Outline of a Theory of Practice*

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During the Islamic month of fasting in Bangladesh in 1992, a boy who had recently come of age and become responsible to fast, but who was still under pressure to study and do well in school, visited a village practitioner of cosmopolitan medicine. He told the man, "my body is very weak; I feel bad." Other Bangladeshis would not so readily speak these words. On their lips the diagnosis of "weakness" itself rests uneasily, the word seeming to add its own burden. Still others who encounter medical practitioners exit those encounters with a clearer sense of weakness than they might have had going into the event. For these Bangladeshis—and for all of us as social creatures—the experience, the very nature of the illness as event, is shaped in the discourse surrounding it. In their encounters with family members, caregivers, and practitioners of healing, Bangladeshis experience the power of discourse.

But they must also reckon with the discourse of power. Most medical encounters are starkly asymmetrical at several levels; they involve two parties who are not only feeling well and unwell but who also have different access to economic resources (as in domestic encounters in which an adult must appeal to a spouse or elder brother who controls expenditures) or knowledge (in the case of practitioners and patients). Those who face power run the risk of losing face when, as typically occurs in speech events, social relations of power reproduce themselves. It is in and through speech events—medical interviews, for example—that social realities are constituted. The transcribed conversations analyzed below are windows for viewing the social construction of illness among Bengali speakers. A particular illness is "socially constructed" in two senses. First, illness meaning is cooperatively produced in the labor of conversational interaction; the agency-constructing meaning is a social entity, a dyad or—as is typical in Bangladeshi illness encounters (Wilce 1995)—a group of more than two persons focused for the time being on someone's illness. Then, secondly, the illness experience itself—here viewed as the object under construction—becomes social, if only as a focus of social conflict. Not restricted to the limits of an individual's body, from the first moment, illness arises as a conversational topic; the meanings and experiences generated in interaction belong at least in some contested form to all parties in that interaction (Schutz 1970:96).

Recent studies by medical anthropologists have provided new empirical grounding for anthropologists' long-standing claims that realities are socially constructed. Social studies of science have argued that even a " 'hard science' reality" such as the immune system is socially constructed (Cambrosio and Keating 1992; Lyon 1993; Martin 1990, 1992, 1993). Other recent studies have demonstrated the untenability of treating health, attitude, affect, and the behavior of patient and practitioner in medical or therapeutic encounters as discrete and autonomous variables (Pennebaker 1988; Putnam and Stiles 1993). Studies of doctor-patient interaction have attempted to uncover the reason for patients' pervasive dissatisfaction with the medical encounter in the United States and to point to alternative modes of communication (Mishler 1984; Putnam and Stiles 1993; Waitzkin 1991). It is useful to rethink such arguments in terms of the role of language and interaction in constructing medical relationships and realities.

Since 1991 I have been studying "medical encounters" in Bangladesh (Wilce 1995). In this article I explore how the "weakness" of Bangladeshi patients (and of women generally) is linguistically constructed; I adumbrate the impact of the pro-

cess on medical outcomes. My project belongs to the tradition that takes as axiomatic the power of habitual language usage to shape attitude and thought, a form of constructionism with roots in Sapir and Whorf. As Hill and Mannheim (1992) point out, Whorf never framed his argument for linguistic relativity in terms of hypothesis testing, nor did he treat language, perception, or culture as a set of dependent and independent variables. While still starting with the assumption that the linguistic habits imposed through obligatory grammatical categories do influence cognition, this tradition eschews rigid divisions between language (or grammar, or discourse) and culture. Rather than working back from ostensibly nonlinguistic manifestations of worldview and medical culture in rural Bangladesh, my "axiomatic Whorfianism" explores how the very structure of medical discourse in my transcripts serves to construe patients, the mad (Wilce in press a), women, and certain men as weak.

Thus I will *not* seek to provide independent evidence for a Bangladeshi cultural model (be it monolithic or fragmentary and contested) in which personal strength and gender are correlated invidiously. To do so, an orientalist might marshal citations from Hindu sacred texts regarding the "nature" of women or the imperative of female subordination. As an ethnographer, I might cite spontaneous ethnotheoretical statements of my friends in Bangladesh about gender and power. Since neither of these forms of evidence would be nondiscursive, they would no more be independent of language than are the transcripts of medical discourse analyzed below. Therefore, the evidence I present to substantiate my claim that the gender model of many rural Bangladeshis makes women "weak" is admittedly internal to those speech events in which that model is produced or reproduced. My acceptance of this circularity reflects not only the current renaissance of Whorfian studies but also the recent tendency in linguistic anthropology to deny the tenability of holding "context" distinct from speech in any ultimate sense. Typically, speech creates as much as it reflects the contexts in which social action occurs (Duranti and Goodwin 1992).

The particular reality constructed in the encounters described in this article is "becoming weak," which often entails losing face. When medical practitioners treat persons, norms and taboos regarding physical and verbal interaction are modified or even suspended (Parsons 1951). Medical examinations, viewed from the standpoint of norms of everyday interaction, may threaten "face" to a degree not seen in everyday encounters between peers. This article explores how patients in Bangladesh undergo a diagnosis of weakness. I will argue that both diagnostic process and content constitute a loss of face—the result of a form of medical dominance that has no clear therapeutic value. In the diagnostic process, I argue that interruption is a key linguistic means in the constitution of "weakness." Although interruption has been the focus of a number of studies of medical discourse, mine is unique in placing this linguistic feature in the context of the social constitution of weakness in Bangladesh. In addition to interruption, another feature of vocal production known as "creaky voice" figures in my analysis. The creaky feature is heard less frequently in my tapes, but seems to be one used by patients when they present *themselves* as "weak." Although the particulars may be culture-specific in ways I have not yet perceived, there is fascinating evidence from a number of languages that creaky voice quality conveys weakness, misery, or a sympathetic response to misery (Brown and Levinson 1986:119, 267–268). More generally,

vocal quality conveys affect in a number of societies in which the *lament* genre has been studied (Feld and Fox 1994:40 ff; Urban 1988). Interruption and creaky voice epitomize the very sort of linguistic phenomena that most powerfully constitute social realities—those that serve functions other than referentiality per se and that typically evade conscious comment.

Anthropologists resist segregating a class of "medical" events from the rest of social life. Distinguishing the medical from the nonmedical is all the more difficult when the issue is "being weak" or being labeled weak. What is common among the different experiences leading people to visit diverse sorts of practitioners in Bangladesh is a sense of crisis or discontinuity. Viewed differently, receiving such a label often indicates that the recipient is in the sort of crisis in which Bourdieu predicted language works most powerfully to render private experiences public (Bourdieu 1977[1972]:170). The discursive means at work in the events I treat here are the same as those at work in village political meetings or other forms of interaction (Wilce 1996). The first events described below involve encounters with two men whose respective forms of practice entail chanting and palm-reading, but whose nosological lexicon nonetheless includes the same everyday Bengali word one hears in Bangladeshi apothecary shops—*durbal* (weak).

Studying Complaints in Bangladesh

In 1991 I had just begun to investigate complaining and complaint interactions in Bangladeshi domestic and medical settings. As the advice of the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) led me to expect, I found a teeming set of pluralistic options for those in distress to pursue. Most of my field days were spent in Matlab, which is about three hours southeast (by mini-van and boat) of the capital city, Dhaka. Periodic visits to Dhaka enabled me to make comparisons between rural and urban forms of medical encounters and informal complaining. Naturally the spontaneous complaints that I heard, and the spontaneous interactions in which I participated, were the hardest to get on tape. I tried to memorize the grammatical form and ethnographic details and commit them to writing within an hour. I wrote nearly verbatim fieldnotes on just over 100 such encounters. Where does one go to record medical-complaint interactions? In Bangladesh, one goes particularly to pharmacies where merchant-practitioners sell remedies along with diagnoses and treatments. Making friends with these practitioners, I set up my equipment and made audio- and videotapes of encounters. Of these, I recorded 50 involving about 40 practitioners—Ayurveds, homeopaths, allopaths, palmists, spirit-mediums, and Muslim clerics and saints. The term *kabirāj* is used in Matlab to cover several of these modalities of traditional healing practice. It was in October 1991 that I had two of my own first encounters with Bangladeshi practitioners, one rural and one urban. In both I fell into the patient role, less by my design than by the practitioners' interest.

The first such practitioner I encountered was Bozlu, known by his neighbors as *Pagla* (the "Mad"). Pagla is often an appellation of respect where ecstatic religion prevails, as it connotes divine intoxication. Bengali speakers distinguish this desirably powerful form of *pāglāmi* (madness) from a secular and weak form (Bhattacharyya 1986; McDaniel 1989). In my quest to meet a variety of Matlab's healers, people told me that Bozlu's spiritual practices include what might be

called healing. I came to this Pagla feeling a bit homesick, having already been away from my home and family for three weeks. But the first topic of our conversation was Bozlu's complaint. A wounded healer, Bozlu suffers from severe asthma. The only remedy to which he has recourse is his own Muslim-yogic breathing technique. On my first visit he asked if I could foresee my own future and feel confident that I could face anything. I considered his question odd, but chalked it up to a sort of proselytizing strategy. Later, when I returned after several days, Bozlu told me, "You are not centered in yourself"—literally, "You are not within yourself." Defensively I said, "I'm not?" "*I am* within myself," he confirmed, "and you are *not*. You are a Ph.D. student; you are 'within' everyone else. Only when you finish will you be within yourself." (Perhaps his estimation of the independence of young professors was less accurate than his sense of the dependency of graduate students!)

Later, Bozlu returned to the theme of knowing the future and facing it calmly. Unlike me, Bozlu can see some of the future. What the bearded Pagla was offering me, rather than a conversion to Islam per se, was an esoteric yogic technique for facing any accident and remaining conscious. He asked, "Can you claim confidence that you could stay conscious even if you were in a car accident?" While I wondered who would want that, Bozlu went on to say he himself could stay conscious even when gravely injured, and he could teach (or bestow upon) his disciples that ability. There is evidently enough local anxiety about the loss of control entailed in losing consciousness that his offer wins him disciples. Bozlu's esoteric teachings resonate with ancient Indian religious themes. The contrast between *j̃nāna* and *aj̃nāna*, "consciousness" and "unconsciousness," is highly elaborated in Bengali culture. To some extent this culturally validated quest for consciousness transcends the communal divide, appearing in Sufi Muslim as well as Hindu traditions in Bengal and the rest of South Asia.

Two months later when I visited Bozlu again, the winter sun was warm enough that I was perspiring by the time I walked into his compound. During this third visit Bozlu noted the sweating and attributed it to weakness, specifically a weak heart. That afternoon, when I returned to the Matlab ICDDR,B center at which I stayed that month, I proposed to my Bangladeshi colleagues that Bozlu might be going out of his way to construe me as weak. They said, "That's his *byābaśā*" ([way of staying] in business). My visit must have seemed to him a sort of pilgrimage by a new sort of disciple. This, and his animating the role of "curer of souls" in relation to me, constituted our interaction as a reality with links to the past and to postmodernity.[1]

In the month when I first met Bozlu, I also visited a Dhaka man to whom people take their problems. Dhaka is a burgeoning city of several million, a far cry from Bozlu's village. My narrative shifts to the neon-lit night when I met "Professor" Hawladar. I am in the air-conditioned, second-story office of the most renowned astrologer and palmist in Bangladesh. Hawladar sits across from me. He asks my "real purpose" in coming to see him and in being in Bangladesh. I do my best to describe my research agenda. Hawladar asks me about my educational and professional background, and I tell him of the twisted paths that led me into anthropology graduate school in my late 30s. Then and there he offers me the honor of being his "best friend" and assures me that he can introduce me to the very president

of Bangladesh. Then he commands me to give him my hand and forcefully manipulates my palm to see all the lines. In English, he says:

> You have a very unstable mind, flexible, constantly changing. This means you have a lot of anxiety all the time. You're never quite sure. . . . But you have a very creative mind. This line here is your mental creativity. And [referring to some other line on my hand?] you are adaptable, very able to mix with people in different situations.[2]

Once again I was the patient. Perhaps it was only the metaphor that had shifted; it was not my heart but my mind that was said to harbor instability. Hawladar discovered in me a weak resolve; in fact this was as much a creation as a discovery. His words, like Bozlu's, constituted our relationship as a hierarchy of knowledge and power, one in which he held the lion's share of both.

These two cases, in which I received a diagnosis of weakness, are useful in situating medical encounters within a broader range of contexts in which one's power is the object of explicit negative evaluation. Neither event was tape-recorded; the other cases I present are based on transcriptions of tape-recorded encounters.

Back in October 1991, two days before my second meeting with Bozlu Pagla, I was sitting in the herbal "pharmacy" of Ali, a kabirāj whose authority claims rest on ancient Ayurvedic traditions and his own inventiveness. The third of three female patients he saw that day was waiting as two others spoke with him at length. Despite her long walk—and long wait in his crowded "chambers"—on that hot day, the third woman looked and sounded quite strong and assertive when her turn came to speak. There was nothing of the "creak" about her voice quality. I heard her mention arthritis-like pain in a joint. Ali asked her, like all the others who visit him, to stick out her orange betel-stained tongue. Seeing the tongue he pronounced that she was *ekebāre durbal, sab durbal* (completely weak, totally weak). Granted, by then I was already considering the hypothesis that these encounters systematically tilted the semiotics of the diagnostic situation to construct patients as weak. But was it my imagination, or did she suddenly look weaker when he said so? At any rate, when I passed her on the road to the ICDDR,B center a half-hour later, she was walking alone under the hot sun, moving along at a good clip. She refused a ride. Whatever experience of weakness the diagnosis reflected—or created—was evidently situation-specific, confined to her time in Ali's presence.

Structure in Society and Conversation: Power, Interruption, and Resistance

These incidents would surprise neither sociologists of medicine nor ethnographers of Bengali society. Structurally, the patient role is a weak one. Though many contemporary students of medical encounters balk at Parsons's facile acceptance of the "necessity" of doctors' dominance in clinical relationships, they agree that dominance is a salient fact of the encounter. As for Bangladeshi society, women's precarious structural position is a truism in the literature. Parents view girls as a burden: the money they bring their husbands' families in marriage is never theirs to claim even in divorce, a woman's testimony in court is worth half that of a man's, and cases of rape and murderous violence against women almost never result in convictions. As patients in Bangladesh, women are thus redundantly weak from

this structural perspective. At least such is the accepted wisdom, and it was this pattern that I went to the field expecting to see. Thus what struck me most forcefully were (1) the subtle and not-so-subtle forms of self-assertion by Bangladeshi women, and (2) the particular interactive means by which the patient role was constituted (and linked to weakness). Things in Bangladesh are not as simple as the literature had led me to believe, but are more like the patterns of dominance-and-resistance described by Todd and Fisher (1993)—patterns complex and subtle, with practitioners increasingly characterizable in terms of the penetrating Foucauldian gaze, and patients characterizable along a continuum of agency absent from Foucault's vision (Ewing 1997). Let me illustrate this complexity in medical relationships in both the West and Bangladesh through a focus on interruption and other microevidence from verbal interaction.

It is useful to take asymmetry in overlapping speech to be indicative of an unequal distribution of power. Admittedly, although researchers like Mishler (1984) and West (1984) have treated asymmetrical interruptions by doctors as the clearest examples of power moves in clinical encounters, conversation analysts find the notion of "interruption" difficult to operationalize (Murray 1985). Overlap is more objectively discernible and does seem a violation of the unspoken rules of conversation, particularly rules for turn-taking and for signaling that one has reached a "transition-relevant" place in one's talk (Sacks et al. 1974:703). Participants signal such transition-relevant places—or overtly hand someone else a turn at talk—by pausing, changing pitch, or adding a tag question to an utterance. But when does overlap become interruption rather than cooperative echoing or "duetting" (Falk 1979; Tannen 1979)? Is interruption so easily equated with a power move by just one conversational partner? How can the analyst separate enthusiasm (overlapping speech may be considered a sign of interest in the other's talk among some New York speakers [Tannen 1979]) or assertion of equal knowledge (and thus equal rights to participate in conversation [Zuengler 1989]) from aggression? Ainsworth-Vaughn (1992) shifted attention to sudden topic changes.[3] To symmetry and topic we should add *timing* as a diagnostic criterion of aggressive interruption. When both parties overlap each other's speech with similar frequencies, timing and topic are crucial to the analysis of significance. Falk's "duetting" form of overlap by one conversational partner is sensitive to natural transition places in the other's speech as well as to the topic being addressed; duetting "agrees." In contrast, overlapping speech at points other than transition-relevant places in speech represents a breakdown in the "dance" of conversation. Such "asynchronous interruption" indicates a profound failure to negotiate a common frame; such interruption casts the other's contribution as irrelevant (Gumperz 1982:187).

Beyond the work of Gumperz, cross-linguistic comparisons of patterns of synchrony and interruption have been rare. The generalizations of conversation analysis (CA) have yet to be tested widely outside the English-speaking world. In fact, some linguists (Tannen 1979) and linguistic anthropologists (Kuipers 1989:108; Reisman 1974) have questioned whether the tendency of conversationalists to avoid overlap as well as long gaps and silences (Sacks et al. 1974) is common outside certain Western "cultures of talk." Yet Moerman's pioneering application of conversation-analytic methods to Thai talk (1988) gives some encouragement to those who, like me, would take the findings of CA as heuristic in the study of speech-interaction in non-Western societies. I believe ethnologies of

conversation and politeness will eventually extend CA's findings regarding turn-taking. In the meantime, my position on the universality of turn-taking rules is less value-free than that of CA. Until shown evidence to the contrary, I presume that Bengali conversationalists take interruptive topic changes as aggressive and unwelcome acts.

Once it is granted that asymmetrical, topic-changing, asynchronous interruption is an exercise of power in Bangladesh, as it seems to be in many English-speaking settings, other theoretical issues arise. To what extent do these very interpretations of "power moves" participate in reifying women, for example, as powerless actors in such contexts? It is in order to avoid this danger that recent work on doctor-patient communication (Todd and Fisher 1993) has paid more attention to patients' acts of resistance to medical domination. Power itself must be deconstructed (Fisher 1993). Gramsci's (1971) notion of hegemony, a notion of power that incorporates resistance, is more adequate for describing practitioners' relations to women. In a related way, Foucauldian analyses of conflict discourse (Lindstrom 1992) and medical discourse (Kuipers 1989) find the workings of power inscribed in the very structure of the "discourse," here defined as rules that govern what may be said and what may not, whose words are recognized as "true" and whose words are disallowed. While we must avoid *reducing* behavior such as narratives of suffering to social science categories like resistance, we must still see notions like delegitimation and resistance as heuristic *figures* leading us into what is at stake for sufferers (Kleinman 1992).

The very notions of "truth" and "language" in medical discourse need deconstructing. Some deconstructionist approaches to medical discourse, such as Cathryn Houghton's, have combined Foucauldian theoretical concerns with a rigorous attention to transcribed data. Houghton's analysis of therapeutic discourse urges attention to what is allowed to "count as *language*" (emphasis added), finding power inscribed even in the way therapists might devalue "gesture, bodily orientation, gaze, intonation, and rhythm in speech as an embodied production" or "representational practice" (1994:7). What therapists value and push toward, often co-opting their clients in the push, is referential talk *about* emotion rather than emotional talk. Those therapists do not act alone as individuals asserting power in institutional contexts; rather, they *work with* patients. Indeed patients must be socialized into requisite ways of relating to therapists, modes of interaction necessary for the maintenance of the authority of therapeutic institutions. Patients are led, Houghton claims, to "*invite* . . . interruption" (1994:9, emphasis added). By cooperating in the interruption and redirection of their discourse, such patients collaboratively participate with their therapists "to produce forms that count" (1994:9).

Houghton's work provides a heuristic model for the analysis of Bangladeshi medical encounters. In what follows I do not argue that resentment against the conversational power asserted by practitioners is widespread in Bangladesh anymore than it is evident in Houghton's data. Although on some occasions Bangladeshis did speak of the breakdown or violation of the local aesthetic organization of turns-at-talk (Wilce 1996), I heard no expression of a discursive consciousness regarding overlap or interruption in medical encounters. Rather, as Houghton found in therapy groups in the United States, Bangladeshi patients at least superficially cooperate with practitioners and voice no overt resistance even when they are interrupted. Still, the texture of power relations in the medical encounters I examine can become

visible through analysis of transcribed speech, bringing into relief both similarities and differences with institutionalized American encounters.

Transcription and Analysis of Recorded Medical Encounters

The participant structure of Bangladeshi medical encounters differs from the dyadic ideal envisioned by Parsons (1951).[4] It is typical in Bangladesh, particularly when the patient is a woman or child, for a kinsperson to act as "guardian" and to take an active and distinct role as a client or "interpreter," often speaking in the patient's behalf (Bhattacharyya 1986; Hasselkus 1992; Massard 1988; Wilce 1995). (Sometimes patients may be absent altogether and the client may visit the practitioner alone.) When all three are present, either the client or the practitioner may interrupt the patient. Sometimes it is the practitioner who cuts off the patient's symptom narration. The country *ḍāktār* Heykal, hearing his patient Farhad complain of diarrhea (in a clear strong voice, not a creaky one), surprised me by making no direct response to Farhad at all (Heykal was evidently well acquainted with Farhad). Rather, he immediately turned to me and told me in a perfectly loud voice,

Example 1

60H	(breathy laughter)
61A? H?	*brainless* TO!
	He's brainless!
63H[5]	/or/ kathā (1.5) kathāi *valueless.*
	His words (1.5) his words are completely valueless.

To Daktar Heykal, the patient did not merit a direct response.

By contrast, practitioners sometimes listen quite well—but they listen to accounts of a woman's illness as presented by her "guardian." In example 2, kabirāj Ali (the Ayurvedic herbalist) is interviewing Yasmin, one of the first two women I saw in his office.[6] Note that Yasmin's self-accounts of symptomology stress pain, not weakness, and that her voice is not creaky.

Example 2

47 Practitioner Ali	ācchā keno āmner rog cikitsā (h)ailo nā?
	So why hasn't your illness been cured? (1.3)
48 Patient Yasmin	(ekh)ane, eyḍā ā/mi kait/
	Now about this, I say—[7]
49 Yasmin's brother	/eyḍā/ Āllāh-e kaite pāre.
	God knows. [*Lit. This God can say.*]

In this case Yasmin's brother stepped in—and stepped on her words.

In another case, where an exorcist accepted an invitation into a home, the putatively possessed woman's sisters-in-law not only overlapped her speech but ridiculed her when they thought that her words were irrelevant to the exorcist's questions. Look at Example 3, particularly lines 60–3.

Example 3

54 Jahangir/Exorcist	ācchā tā (h)aile ki ālgār kichu āsari mane karen āpnārā nā ki?
	Hmm, so then do you all think that something "loose" is possessing [*her*]?

55 Woman	āche. *There is.*
56 Jahangir	ālgār kono ās/ari *There's something loose /possessing/*
57 Fatima/Patient	/ālgā/ tanai nā sa(r)il durbal tani eyḍā kaitām pāri/ nā/. */[whether from] "loose thing"/ or from bodily weakness, that I couldn't say.*
58 Jahangir	/ācchā/. *Hmmm.*
59 Fatima	nā ai tāypār jvarār /māt(h)ā/. *Or that typhoid fever (in the head) . . .*
60 Woman	/her thar,/ ki(s)er thār kane kay. */What garbage! /What a bunch of garbage she's telling!*
61 Woman	jeṭā kas kāme kais. *What you[8] say, make it useful!*
62 Woman	eyḍā to kāme lāgbo nā. *There's no use to this.*
63 Jahangir	āmnerā keo kichu bailen nā e(khā)ne emne *recording* haite āche. *None of you should speak at all; right now recording is going on.* (.5 seconds).

Note that after the sisters-in-law took it upon themselves to "help" with the exorcist Jahangir's interview, he actually asked them not to interrupt Fatima again. But that is unusual and might be motivated by his sense that this occasion was formalized by the presence of the tape recorder (see line 63). By rebuking Fatima's kinswomen for ridiculing and interrupting her, Jahangir is simultaneously helping Fatima, upholding what he imagines to be my standards for a recorded interview, and reproducing gender hierarchy (he, a man, is telling women to shut up). This is surely a paradigmatic instance of the awkward ethical ambiguities inherent in postcolonial field relationships.

Patients' resistance is indirect and nonconfrontational. One line from Yasmin, whose brother's speech overlapped hers in example 2, exemplifies what I call metacomplaints (Wilce 1995)—complaints at a higher level of abstraction that pertain not to the medical topic but to some inability to voice the concrete complaint. We should not conceive of that "inability" as primarily internal to the patient, but as the result of social processes that typically include some interlocutor suppressing the troubles talk (Jefferson 1984). At one point in the encounter, when Yasmin expressed despair (which might be seen as a repudiation of the herbalist's ability and of her brother's expenditures), her complaint provoked an interruption by the herbalist.

At another point (example 4), Yasmin says "I haven't told you the half of it."

Example 4

85B	eyi usilā= *That's the source=*
86Y	=dukh pāy(ā)chi, byathā dukh pāy(ā)chi. ey je, *=I hurt myself; I got a hurt, a pain.*
87Y	ey usilār janai āmi ey ra(ka)m (h)ai(ye)chi ār (k)i (10). *That's the origin of the way I am now or whatever* (10).

	(Lines 88–89 transcribe talk between uninvolved persons "off-stage.")
90Y	rāt /din/ [*I'm in pain*] *night and /day/*
91B	/ey/ janno kai(ye)che āḍḍiḍā bhāyṅā geche,
	/That's/ why they said the bone is broken,
92B	bhāyṅā geche. *It's broken.*
93A	ācchā, eyḍār bhitare byathābedanā āche kichu?
	Uh, is there any pain inside there?
94Y	ha, rātdin. ghum jāite pāri nā.
	I can't get to sleep
95Y	(ahan) kai ni to, ardhek kathā kai ney.
	I haven't told you (yet), I haven't told half of it.

As I argue at length elsewhere (Wilce 1995), Yasmin is here complaining about the whole communicative arrangement that empowers the herbalist and "guardian" to speak for her, but that disempowers her. Her complaint is a metacomment.

The Social Construction of Durbalatā

In Bangladesh, weakness is part of the taken-for-granted "reality" often associated with illness. Feminist theory has uncovered multiple semiotic processes by which images of women's "weakness" have been created and promulgated in many societies (Eckert and McConnell-Ginet 1992). In one of her recent depictions of the construction of biomedical realities that in turn powerfully shape the social realities of patients, Emily Martin describes Mark, an AIDS patient. Mark had volunteered to participate in an immunology Grand Rounds at a teaching hospital. By his bodily presence, Mark wanted to make a strong statement; he wanted to make AIDS more visible on his own terms. He had prepared a risqué joke to start "his talk" at the grand rounds. Unfortunately for him, he lost control of the conversation immediately. He was asked "a series of detailed questions" through which he "was relentlessly defined by his T4 cell count"; the presenting doctors maintained control of the discourse and managed to emasculate Mark. Martin writes: "Mark was defined as impotent and feeble" (1992:131 f).

What I would add to Martin's account is that the process that so "defined" Mark was not at all the sort of decontextualized metalinguistic act that comes to mind when we think of someone "defining something." Although that much is obvious to all who reflect on Martin's account, there is an important semiotic point here: Western ideologies of language stress the referential function whereby words seem transparently to "mean" something that already exists in the real world, and in so doing ignore the active, creative role that speech often plays (Wilce in press a). Moreover, when people "define" they focus on individual words (or, in Martin's account, persons). But the discursive means whereby weakness is constructed are certainly not restricted to individual words like durbalatā. If we are to see through and beyond our inherited linguistic ideologies to deeper semiotic processes, we must focus more attention on discourse processes that transcend the word level such as interrupting or asking "a series of detailed questions," for example. Such processes can exercise their effects with impunity to the extent that they remain outside of awareness or are, at least, inherently more difficult to discuss to the

extent that referring to them forces us to use a metalanguage capable of transcending the units of speech most available to our awareness (Silverstein 1981).

Some readers might argue that patients must surely point to their own weakness at times, and that this would appear to be quite different from the kind of constructive process I have been illustrating. Indeed, Bangladeshi patients sometimes find it in their interest, at a tactical but perhaps not a strategic level,[9] to present themselves as being weak. They can accomplish this in words—segmentable and referential linguistic forms that Silverstein (1981) says are highly accessible to native speakers' awareness—or in suprasegmentals. In example 5, an adolescent boy reports to a country doctor:

Example 5

·āmār· sarir khub durbal . . . khārāp lāge.
My body is very weak . . . I feel bad (or, "it feels bad").

These are words that "unavoidably refer" (Silverstein 1981), and what they refer to is a bodily state—a nonlinguistic context presupposed by the patient's words. It would be hard to hold this boy's doctor directly responsible for this presentation of self as weak, and it is easy for participants in such events to point to the boy's use of the word *durbal* (weak) as a "natural" and "obvious" reason why weakness should be discussed or treated by the doctor.

In contrast with words, the range of variation and the significances conveyed by voice quality are harder for native speakers to describe metalinguistically. In a 1989 videotaped conversation of a family dinner in a Bengali household in Los Angeles, the senior woman's complaint that she hurts "all over"—directed only to her husband and sister-in-law (a complaint arising in, and perhaps never leaving, what Kleinman calls the "popular sector")—is voiced uniquely:

Example 6

sārā gā::ye byathā, nā?
In the whole body [there is] pain, no?[10]

The highlighting of the vowel in my transcript represents its almost whispered creaky voice-quality. The message being conveyed is redundantly expressed by both "segmentables" and "nonsegmentables" (Silverstein 1981), like words and voice quality. This "icon" of weakness and low energy also functions, in Peircean semiotic terms, as an index, bringing attention to itself through its markedness (Urban 1988; Wilce 1996). It points to the pain mentioned in the utterance that the creaky voice "frames" or "keys" (Ochs and Schieffelin 1989). In short, creaky quality underlines and lends credibility to the speaker's reference to her own pain.

"Social construction" cannot be reduced to the imposition of interpretations on some persons by others; patients, for example, learn or internalize roles that are socially available. Trading roles in the dance of discourse, therapist and patient may equally participate in the construction of illness, as Houghton argues. For the sake of simplicity, however, we can argue that even if creaky-voiced "weakness-confessing" patients are playing roles they have learned, such roles (such signaling behaviors) are not imposed then and there by others. Following this model, when patients index weakness in their own speech, we cannot claim it is constructed in that immediate sense. If patients explicitly invoke the concept of weakness in a

word, or signal their weakness in voice quality, one can argue that they have internalized social messages about weakness. We would be on shaky ground, however, if we attributed a key role to practitioners in the immediate context. That is, if the patient invokes weakness in self-presenting at an herbalist's shop (for example), the practitioner cannot be our primary focus in our search for the processes that accomplish the social construction of that weakness.

At the opposite end of the spectrum from speaking or creaking words of weakness are Bangladeshi patients or their representatives ("clients," rather than patients, of the practitioner) appearing before diviners. Diviners, who ostensibly hear no complaints and have no empirical way of assessing specific psychosocial or somatic problems, pronounce diagnoses nonetheless. One such diviner in rural Matlab had a formulaic approach to such pronouncements, but the variations in his divinations deserve our attention. His female patients were almost never present in person; their names were brought to him by fathers, mothers, or brothers for numerological divination-diagnosis. It was these absent mothers and daughters' names, in contrast with the males presented, that were singled out as "nervous," "indecisive," "moody," and "weak" (Wilce 1994).

I have offered evidence for what we can characterize as practitioners' "dysfunctionality." What of the possibility that diagnosing "weakness" is therapeutically functional? The first bit of evidence that might be offered in support of that approach is a widespread cultural phenomenon in Bangladesh; the bereaved are forcefully told *man śakto karte*—to make their feeling-thoughts hard. Perhaps when I met the Pagla and the professor my homesickness was obvious. Subtle cues in my self-presentation and that of patients in the transcribed examples might bespeak "vulnerability" to sensitive practitioners. The ability to perceive vulnerability, particularly in conjunction with encouragement to make the needed repairs to culturally constituted defenses, might be key dimensions of healing practice in Bangladesh. To exhort others to "harden their minds" is to construct certain behaviors or states of feeling-thinking (Bengali man) as dangerously "soft" or vulnerable. That is why Bangladeshis characterize commands like "harden yourself" as acts of "comfort." It is also why we might entertain the possibility that a healer's strategies of verbal authority such as interrupting, initiating the use of the label "weak," and using depersonalizing "treatment" like Heykal Daktar gave Farhad, might be highly functional. Indeed the act of diagnosing weakness might be viewed as an act of "comfort," since the diagnosis implies the need to "strengthen oneself."

We can draw an analogy here between the indirect function of calling a patient "weak" and Searle's (1975) model of indirect speech acts. Speech acts such as requesting, promising, and christening do things in the world.[11] Speech acts are not true or false but "felicitous" or infelicitous. They are felicitous when they meet "felicity conditions," and infelicitous when they do not. Indirect requests and other directives work when they fulfill or merely invoke "felicity" or sensibility conditions. Felicity conditions for making a request, for example, include a speaker's need of something and a hearer's ability to satisfy that need. One condition for a sensible performance of the speech act of "comforting" (through words like *harden your mind*) is a need for it—that is, a weakness. Just as one might request that another "shut the window" by simply making a statement about the cold draft coming in, practitioners could invoke the "comfort-command" by a mere mention of

weakness. Now, distancing this argument from the baggage of speech act theory,[12] a generous interpretation of why Bangladeshi practitioners diagnose "weakness" as they do is that such words encourage patients—validating their suffering and indirectly exhorting them to renew their defenses. On some occasions, for patients to mention feeling "weak" might be a strategic deployment of resources (Scott 1985) in a "dialectic of control" in which "all forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors" (Giddens 1984:16).[13]

I propose this explanation to balance another explanation—that, no doubt without conscious intent, Bangladeshi practitioners create the very conditions (weaknesses) they live by treating. Stated less starkly, their "healing" practice reinforces and reproduces the structural weakness of at least some of those who visit them. This interpretation better suits my data. To argue that practitioners' motivations are primarily altruistic ignores three crucial facts: (1) there is economic pressure on them to find something wrong with their patients, (2) it seems "natural" for many in Bangladesh to label women "weak" (this naturalness reflects the repetitiveness with which such labels are applied),[14] and finally (3) some patients voice metacomplaints (Wilce 1995). Metacomplaints—indirect indications of patients' discontent and subtle critiques of the discourse rules that block women and certain men in patient roles from being authors of their own experience—cast doubt on any simplistic functionalist model of "therapeutic" encounters in Bangladesh.

Conclusion

There is a rich ambiguity in the phrase "the social construction of illness," whereby "social" can be parsed as the constructing subject or the constructed object. I have described agents or agencies—persons interacting in loosely "medical" encounters—jointly creating realities through conversational interaction. The fact that illness is thereby made into a social experience reflects the other reading of the phrase, "the construction of illness as a social experience." To parse the two senses of "the social construction of reality" in which "social" stands, respectively, for the semantic subject and object of the activity of "construction," is far more than linguistic play. Rather, the parsing points to the most fundamental insight of practice theory: the duality of structure.[15] Structures of social action are reproduced in the very contingent events that constitute those structures. As predictable as certain forms of speaking may be among Bangladeshi Muslims—from piously positive responses to phatic queries into one's health, to exhortations to the grieving to "harden yourself"—such interactive forms are as subject to change as they are subject to what Giddens (1984) calls "reflexive monitoring."

My analysis of the discursive construction of weakness—the discursive means by which perceptions of weakness are formed or sustained—resonates with various traditions investigating language as a key means of constituting social realities. At the same time, my analysis raises questions about the aspects of "language" to which such a constitutive role is attributed. Examining medical encounters has led us to rethink the nature of the phenomena ("languages," "worldviews," "social realities") pondered by Sapir and Whorf. The forms of language and ideology uncovered in Western medical discourse differ from those at work in therapeutic encounters in Bangladesh. Patients are not so rigorously "incited to discourse"

or confession (Foucault 1990[1978]; Silverman 1993:235). Still, in both Bangladeshi and Western forms of biomedicine, we see forms of discourse powerfully shaping conceptions of person, body, and health. The constituent signs operating in these "therapeutic" communication events retain their power largely because they escape what Giddens calls "discursive consciousness," even as they inform "practical consciousness."[16] All practice is informed by knowledge, but only some of that knowledge is available to explicit discourse (Giddens 1979:57).

Giddens's distinction is useful here. All parties in medical interactions display a practical consciousness, a knowledge of the means of participation in the fast-moving and conflictual game of discourse. In addition, practitioners in Bangladesh have some discursive consciousness of the ways they manage certain discursive challenges, as evidenced in group interviews I conducted. When I asked a group of doctors and public health nurses about therapeutically effective ways of talking to patients who voice distress, they stressed the importance of rejecting such expressions rather than expressing empathy. Still, these practitioners are not cynical schemers; to refer to "strategies" need not imply fully conscious intentionality. In day-to-day practice, manipulation of discursive resources enables practitioners to disempower patients: they can interrupt, reinterpret patients' words, or even withhold acknowledgment of their full personhood as when Heykal dismissed Farhad as "brainless." Among these strategies, interruption may be the furthest from (discursive) consciousness and intentionality. For important economic reasons, with or without conscious intent, practitioners have little choice but to confirm patients' hints of weakness. And, regardless of personal intention, the micropolitical result of cutting someone off from narrating their own condition fluently is to render them weak.

Patients' consciousness is similarly diverse and selective, and their rights to speak are diverse (Lindstrom 1992) even if they tend consistently to be less than those of practitioners. Since egalitarian consciousness of the sort formed by ideological discourse in Western public spheres has not displaced discourses of spiritual hierarchy in South Asia (Ewing 1997; Prindle 1988), we should not be surprised at Hasan's (1979:181) findings that few patients in his sample in an Indian village object to hierarchy in medical relationships. In some cases in Bangladesh, patients might choose one practitioner over others because he or she listens better or demonstrates greater respect for medical concepts long held in the village, but patients do not discursively express discontent with practitioners of a cosmopolitan orientation. No one ever told me that a "doctor" interrupts more than a kabirāj, though I expect further analysis to confirm my sense that "doctors" do. No one said, "That practitioner said I looked weak, but he only said so in order to justify his treatment and his fee" (though some residents of Matlab verged on such characterizations, particularly at some remove—that is, when the topic was someone else's medical encounter.) My argument about the objectionability of constructions of weakness, or of practitioners' interruptions of patients, does not rest on the occurrence of such explicit protest. Rather, it rests on the fact that patients "metacomplain"; one says "I haven't told the half of it" while another tells symbolically freighted stories of evil male religious spirits who rob her of speech (Wilce 1995).[17]

Recent accounts from South and Southeast Asia (Steedly 1988; Wilce 1995) challenge Victor Turner's structural-functionalist vision of healing events, empha-

sizing that rather than healing social conflict they may serve to highlight it.[18] When Bozlu and Hawladar uttered the diagnosis of weakness, it did alter the nature of my relationship with them; it made me feel vulnerable, weak. The effect of labels like "weak" may be to create a new social reality, but that reality might be neither harmonious nor therapeutic. Social reality is shaped in the duality of structure. The fluidity of that structure arises out of the reflexive self-monitoring of actors, the improvisational nature of interaction, and the gap inherent in the duality between the social entity creating illness realities and the social reality created therein. To question older functionalist accounts of healing encounters is to raise the issues of agency and resistance. When metacomplaints indicate—however indirectly—patients' resistance to those who inhibit their narrative activity, they point to agency. Further work is needed to explore the variability of the forms of agency constituted in widely divergent medical cultures and encounters.[19]

I have shown how the pervasive structural weakness of women (and of "mentally ill" men)[20] in Bangladesh is reproduced in the discourse of microsocial encounters. Recent evidence indicates that any medical-interview style that prevents American patients from fully disclosing their symptom-stories leads to poorer medical outcomes (Putnam and Stiles 1993). In that light, this article should stimulate more "postfunctionalist" research in Bangladesh, research building on a hypothesis of some degree of dysfunction in its health care delivery system.

NOTES

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1. See Ewing 1997. Ewing's argument regarding Sufism in Pakistan, in addition to problematizing postmodern theories of the "postcolonial subject," also raises serious questions about a Foucauldian model of how subjects are constituted by a monolithic discourse such as colonialism. Her concern to open a space in which the individual negotiates experience in the plural discourses characterizing postcolonial societies—her rejection of the (monolithic) discursive determinism of Foucault—is well taken. My interactionist, heteroglossic model of discourse, and my preference for referring to specific transcribed events rather than abstractions when I speak of "discourse," protects my argument, I think, from the obliteration of agency of which she rightly accuses Foucault.

2. When I sat down soon after the event to write my fieldnotes, I noted (again, with a defensiveness too obvious to deny), "Each of those three observations could have been deduced from what he already knew of me. I'd told him of my career change. And my nervousness was easily noticeable to one holding my palm. My being in Bangladesh is evidence enough of adaptability."

3. Ainsworth-Vaughn acknowledges that the definition of "topic" is problematic.

4. Yasmin, Fatima, and Farhad's stories are treated at greater length in Wilce 1995, in press b.

The transliteration of Bengali words attempts to balance accuracy of representation of a "nonstandard" (Matlab) dialect with some adherence to the conventions of Indological philology.

The transcription conventions are as follows:

- Overlapping speech segments are shown between slashes on both of the lines which overlap
- Capitalized segments were louder in the original talk.
- Words within parentheses are problematic or uncertain hearings of the taped words. Individual *sounds* within parentheses were not originally voiced but are represented so that the "standard" Bengali equivalent could be recovered by Indologists and Bengal scholars.
- Length of pauses is shown in seconds.
- Equal sign indicates latching of utterances, the near overlap of two utterances, typically by two speakers.
- A colon after a segment indicates the speaker lengthened that segment for emphasis; length is not phonemic in Bengali as spoken in Matlab.
- Text between degree signs indicates a markedly quiet strip of speech.
- Italicization within examples marks the use of borrowed English words in Bengali utterances.

5. Line 62, not represented here, transcribes an utterance by someone uninvolved in the focused discource regarding Farhad, someone "offstage," asking the ethnographer if he was keeping the fast.

6. Ali saw Yasmin just before the patient he labeled "completely weak."

7. What she was cut off from saying was *kaite (p)āri nā*, "I can't say."

8. The markedly intimate or condescending form [tui] is the implicit pronominal form with which the verb [kas] agrees.

9. Desjarlais (1996) makes good use of de Certeau's (1984) distinction between strategies, which presume a proper place for the acting subject as well as distinct boundaries separating that subject from an "environment," and "tactics," which do not require such a proper place or boundaries. The relative strength of those able to strategize is greater than those who resort to "tactics." To present oneself as weak might work, ultimately, to undermine one's position further, despite any short-term gains owing to the tactic.

10. The highlighted vowel /ya/ is a digraph phonetically realized in Bengali as [æ]. The final word in her utterance—nā, "no"—functions as a tag-question, inviting comment; the analogous English form would be "you know?"

11. What Searle (1975) calls "indirect" speech acts are linguistically "realized" through forms that hide their function, for instance, realizing a request (which one might expect to be phrased as an interrogative or an imperative) in the grammatical form of a statement—a hint focusing on the problem behind the request.

12. The baggage needs to be shed or unpacked because it uncritically reproduces certain comfortable notions; speech act theory is vulnerable to criticism as a Western folk theory (of the person) writ large. Rosaldo (1982), DuBois (1987), and Duranti (1988) have argued that the emphasis of Searle and others on intentionality as an irreducible category of personhood and one with unavoidable relevance to speech acts is problematic. The limitations of a focus on one speaker's intentionality become evident through (1) exploration of speech events in which intentionality is clearly irrelevant and (2) cultural constructions of person, accountability, and social activity that hold meaning to be contingent and interactively emergent rather than the product of one actor. This critique reflects not only "field data" but academic theories of speech-in-interaction, from social interactionism and conversation analysis to Soviet sociohistorical psychology and literary criticism.

13. I develop this point further in Wilce in press b, particularly exploring how one patient's seemingly vague deictic references to her symptoms and to her body-self open doors for others to work with her in establishing referential clarity—a first step toward cooperating with her in practical spheres.

14. Resisting the reification implicit in the concept of "folk models," including folk models of gender, my indirect reference to such models or to Bourdieu's (1977) notion of habitus stresses *process*—the repeated speech events in which labels are given.

15. Giddens argues that the "dualism" portrayed between human agency and social institutions "has to be reconceptualized as a duality—the duality of structure" (1984:xxi). This reconceptualization centers on "the repetitiveness of activities which are undertaken in like manner day after day [, which] is the material grounding of what I call the recursive nature of social life. (By its recursive nature I mean that the structured properties of social activity—via the duality of structure—are constantly recreated out of the very resources which constitute them.) Routinization is vital . . . [and is] carried primarily in practical consciousness" (1984: xxiii). Bangladeshi routines participating in this dialectic of the reproduction of social life include expectable diagnoses and predictable forms of "giving comfort."

16. Again this is an echo of the work of Sapir (1949[1927]), and more recently Silverstein's notion of linguistic ideology and the limits of awareness of various semiotic forms (1979, 1981), Ochs's analysis of covert or indirect indexing of gender identity through language (1990), and Hill's (1995) analysis of the covert racism of mock Spanish.

17. As my students in "Person and Family in South Asia" point out, it is misleading to ascribe all indirect communication of discontent to unconsciousness. I explore the risks of making direct protest-complaints elsewhere (Wilce in press b). But even in environments in which criticizing a practitioner's interactive style seems, at least to me, relatively safe, and despite being given opportunities in an interview to evaluate specific communicative acts of practitioners, the tendency of "doctors" to interrupt and otherwise assert dominance is not as easy and public a topic of discussion in Bangladesh as it is in the United States.

18. Sapir's attention to the individual's role in the history of languages and cultures can be said to be reflected in recent work on healing events. Similar trends can be seen in socialization theory (Wentworth's [1980] rejection of the "oversocialized" vision of the person), and the discourse-based approaches to the self (Urban's [1989] model of the dialectic tension between the social-givenness of the " 'I' of discourse" and the ludic space) opened up when persons become aware of multiple vantage points to be taken through various "I"s. Urban writes that "by virtue of fixing the text . . . as in Western theater, even the narrative 'I' becomes a genuinely cultural one [in the sense of] . . . a point of view on the world that is shared and socially transmitted. The role of metapragmatic awareness of the two 'I's deserves further investigation. It may be proposed that this awareness makes possible individual manipulation of the two 'I's. With the ability to grasp the two 'I's and to select the specific anaphoric substitutions, the individual is not entirely subject to the reign of culture through received texts. . . . the semiotic capacity to grasp the two 'I's also opens a dialogue within the individual over everyday 'I' and the 'I' of discourse. It creates the ground for appropriation of a possible discrepancy, and consequently for representable internal affective processes that might otherwise never exist" (50).

19. This will be addressed in Wilce in press b Basil Sansom's (1982) account of "the sick who do not speak" is a telling reminder of the need for such comparisons of cultures of medical narrative and medical language in general. Sansom describes aboriginals in Darwin fringe camps who lose—"share" would not be inaccurate—the rights to tell the stories of their own serious sicknesses. That right is transferred from the recovered sick person to the "heroes" of those stories, those whose care brought the sick person to health. Enduring signs of sickness in the recovered person serve to remind all of the bond of indebtedness created in the event of sickness and recovery. Whereas that ideology of language suits a "community

of people who have no property but rely instead on verbal warranties . . . to carry indebtedness over from the past into the present and so . . . [create] networks of social relationships . . ." (Sansom 1982:183 f), we could expect different ideologies of narrative "rights" to characterize other social formations. The role of "linguistic ideologies" in psychiatrically relevant complaint interactions is explored in Wilce in press a.

20. Although it is primarily devoted to understanding the words of a Bangladeshi woman labeled "mad," I (Wilce in press a) lay a general foundation for understanding Bangladeshi ways in which madness is socially constructed. The case of the man Suleyman, who called himself the "mad Emperor," is described in Wilce 1994 and Wilce in press b.

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