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Madness, Fear, and Control in Bangladesh: Clashing Bodies of Power/Knowledge

This article presents an understanding of how Bangladeshis cope with madness in relation to two assumptions: that systems of knowledge and of power are coterminous, and that actors in medical encounters draw on incompatible and unequal bodies of knowledge-power. I first offer a perspective on psychiatry, emotion, and discourse in Bangladesh as a society increasingly caught up in globalizing modernity. Then I present two types of data to illumine tensions between various attempts to control the fears associated with schizophrenia. The first is a set of exchanges in the advice column of a new popular psychiatry magazine in Bangladesh that inculcate new perspectives on self. Those who write to the editors signal their fears of what might, in the end, be impossible to control. Answers from the psychiatrists who edit the magazine reflect discourses circulating on the web, at international conferences, and at the institutions in the United Kingdom and the United States where one of them received his training. The second data set consists of video recordings of persons diagnosed with schizophrenia interacting with families and/or psychiatrists. In part because of knowledge-power asymmetries, attempts at controlling fears surrounding schizophrenia in these four cases fail to address the depths, tacitness, embodiment, and narrative embedding of anxieties experienced by all parties. I close with an argument about the implications for theories of culture and of medical pluralism that arise from cases in which the local Self is experienced from the perspective of powerful Others. [schizophrenia, psychiatric discourse, globalization, power, Bangladesh]

Introduction

This article presents divergent responses to madness and the loss of control and fear it arouses among Bangladeshi patients, their families, and their psychiatrists.¹ These reactions, and especially tensions between psychiatric and familial responses to madness, are caught up in Bangladesh's intensifying encounter with modernity. My article engages notions of risk, anxiety, and control

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at the level of cultural theory and offers some of the historical-ethnographic context of psychiatric practice in Bangladesh. I then present two bodies of data. The first is excerpts from letters to the editorial staff of a new magazine, *Manabigyān*, produced in Bangladesh by a leading psychiatrist and his students. This magazine is designed to popularize psychiatric perspectives on the self, emotion, madness, and other forms of “psychopathology.” It attempts to impose a new form of power/knowledge (Foucault 1980) as it struggles to represent suffering and cure in explicitly antitraditional, modernizing, psychiatric terms.

The second body of data is a set of four stories, distillations of conversations between patients, their families, and myself. Some of them I met in psychiatrists’ clinics; others I met in the course of fieldwork. I received permission from all to videotape our conversations. I was present during the interviews between psychiatrists and the two patients whose families had brought to the clinics, but I did not record those visits. I did record the psychiatric interviews of the two I met in fieldwork. My videotaping in three homes offers insights on interaction in families touched by psychosis and also enables a comparison of the discursive worlds of families who were confronting madness with the discourse in *Manabigyān*.

Healers of all sorts may feel a responsibility to offer some hope and assurance. However, my videotapes allow an exploration of tensions between psychiatric assurances and the stubborn fears of patients and kin. And there are plenty of tensions just at home. The second half of the article focuses on instances in which measures of control attempted by clinicians *and* families only partially address the depths, tacitness, embodiment, and narrative embedding of anxieties experienced by all parties (Desjarlais 1992).

Talk about madness among members of Karim’s family (first of four cases in the second half of this article) provides evidence of Bangladeshi self-consciousness over the gap between older perspectives and newer medicalized perspectives such as those propagated in *Manabigyān*. The sheer complexity of patients’ and families’ lifeworlds—versus the experience of being offered only the simple solutions that fit within a three-minute clinic visit—represents the tension between bodies of knowledge and power that I am describing. Thus, I highlight another family (the fourth) energetically insisting that, since madness can’t be found in a blood test, their two daughters’ madness must be the result of sorcery (and wouldn’t I please sign an affidavit to that effect for the sake of their anti-sorcery lawsuit). Those stories I heard in January 2001. The tale of male patient Hamid (the only patient who presented to a psychiatrist without his family) resisting his psychiatrist’s assurances, and of Rani—who was very dependent on her family and whose madness resisted their efforts to reestablish intersubjectivity—are from fieldwork I conducted in 1991–92.

The larger narrative implicit in this article is how the complexity of cultural *processes* always spills out of any nouns, even “culture.” The so-called mad in Bangladesh, their families, and their psychiatrists navigate and channel torrents of shifting discourses about madness. Guiding them in that process are culturally patterned meta-emotions—shared, broadly legitimated feelings about what sort of feelings one should have and express.

All four of the patients I videotaped received the same diagnosis of schizophrenia, though one (Hamid) had substantially recovered. Each allows me to tell a different story of the clashing bodies of power/knowledge people invoke to try

to stanch the flow of fear. Neither those four cases nor the sample of letters to *Manabigyān* represent a complete or balanced presentation of psychiatry or madness in Bangladesh. But they do evoke patients' and families' fears and offer a picture of variously sanctioned forms of anxiety-control and of the conflicts between diverse perspectives of patients, families, psychiatrists, and this ethnographer. My intent is not to reproduce the rhetoric of 1960s "anti-psychiatry." Bangladeshis and Americans can benefit greatly from psychiatric care. The critical tone of this article reflects, instead, my response to very particular cases and to the problematic relations between global psychiatric modernism and a deep-seated local valorization of cultivating intersubjectivity.

Risk, Anxiety, Control

Risk generates anxiety. Whether or not we invoke psychological constructs like anxiety in explaining the fact, people try to extend human control into threatening or uncontrolled domains. Capitalism intensifies and brings some apparent success to these efforts. Issues of control are central to concerns about health and illness. Malinowski (1954) treated magic and magical healing as part of a human search for control of what is inherently beyond control. It may well be that that which is out of control provokes such a quest in and of itself, not because it poses an immediate threat but simply because it might do so. Matter out of control has the potential to become matter out of place, threatening structures that are both culturally patterned and psychically deep (Kristeva 1982).

Medical uncertainty accounts for much human anxiety. But what is this "medical" domain? It is hard to define in Bangladesh, for example, where one could choose to visit the same practitioner (e.g., a diviner) for out-of-control matters as different as a lost cow, a teenage child behaving strangely, and a baby who spikes a fever.² If we choose to call this domain medicine, we are imagining medicine as an institution uniquely aimed at controlling chaos. Given the medicalization of so many perceived sources of chaos in today's United States—from overactive little boys and undereating teenage girls to ghetto violence attributed in recent discourses to bad genes—"medicine" might broadly signify a particular discourse about controlling the uncontrolled.

Emotion and Madness: Bangladesh's Relation to Modernity

There are areas of overlap and nonoverlap between Bangladeshi and American understandings of the medical, if we simply define the medical as the set of problems presented to practitioners whose expertise includes but may transcend handling illness. Anthropological relativism problematizes categories. We cannot presume the universal integrity or salience of categories, though notions like madness seem more widespread than biomedical categories like mental illness. The same is true of emotion, although anthropologists of emotion have tended to assume that some such category is present and equally elaborated in all societies even if they argue that Western observers have unwisely removed it from its social contexts (Lyon 2003). However, Western notions of emotions have become clearer and more culturally salient as they evolved along with

disciplinary discourses that make “emotion” their object and ascribe to this domain a new integrity. Yes, there are ways to talk about emotion as a broad category in Bengali, too. But explicit referential discourse about emotion is uncommon *as a practice*. Rural Bangladeshis—that is, the vast majority of the country’s 120 million citizens—Muslim and Hindu alike, do talk about fear as a problem, but such talk is part of discourses of magic and spirits rather than the individualized, psychologized object (emotion) constituted by biomedical psychiatry and psychology.

All this situates our discussion of Bangladeshi families’ apparent *anxiety* in dealing both with madness in a family member and with psychiatrists. Madness raises unanswerable questions and signifies a massive loss of control—in Bangladesh or anywhere. Compared with other problems that Bangladeshi families might present to any sort of practitioner, madness thus provokes unique fears. Few of those called *pāgal* (crazy, mad) in Bangladesh ever encounter psychiatrists. Of those who do, some receive diagnoses like schizophrenia, and may begin psychopharmaceutical treatment. Both they and their families tend to experience deep anxiety, though only patients’ “paranoid ideations” typically receive psychiatric attention.

Psychiatric Ethnography in Bangladesh

Since the 1980s, I have studied suffering, embodiment, discourse, and ideologies in Bangladesh. In the early 1990s, I analyzed the language of complaint, gravitating toward the complaints of those labeled mad (Wilce 1998). In December–January 2000–2001, I gained entrée to study six more patients whom Bangladeshi psychiatrists had diagnosed as schizophrenic. I met them in clinical settings, then received invitations to film family interactions in their homes. I focus on schizophrenia for three reasons: I believe it is actually common; it represents a diagnosis Bangladeshi psychiatrists commonly make; and the behavior they label schizophrenic both epitomizes Bangladeshi notions of madness and profoundly involves language and intercorporeal interaction, objects of my particular research interests. I treat the interactions I videotaped in these homes as speech events quite distinct from interviews a psychiatrist or even an anthropologist might conduct. My analysis has often focused on levels of interaction that are so embodied and tacit that to ask questions about them in an interview would be unproductive (see, e.g., Wilce 2004). I include here unreflective speech practices along with co-occurring deployments of the body. Although I touch on those tacit, embodied dimensions of familial interaction, this article focuses on what families could and did talk about during my visits.

Bangladeshi anxiety and measures to control it take on meaning in a local semiotic universe. Interlocking factors structure the subjectivities of patients, families, and practitioners: shared understandings of and orientations to the world and to troubles like illness; tacit sensibilities, bodily practices, and stances; and awareness of the very different orientations of Others (e.g., psychiatrists, foreigners) observing their own orientations and stances. When someone in Bangladesh goes mad after catching a bad case of sorcery or coming down with a spirit infection, family members may sense matter out of place and subject them to a ritual sweeping, dusting, and blowing—*jhārphuk*. In some such cases, but in almost all cases

of other problems that people might discuss with practitioners,³ witnesses offer the suffering person what they call *sāntanā*, “comfort.” *Sāntanā* entails telling someone to stop feeling bad feelings and behave properly. Such exhortations exemplify meta-emotional discourse as a cultural process. The particular meta-emotions in play here include a general fear of subjectivity also evident in many other Bangladeshi discourses.

During my longest stint of fieldwork in Bangladesh, 1991–92, I knew of two little boys who were taken to healers to treat their *dar* (fear). Whereas *bhay* signifies an unmarked sort of fear, *dar* denotes a kind of fear that is marked for the danger it poses to weak souls, like *susto* in Latin America. In Bangladesh, young children’s souls are the most vulnerable to being frightened away. Soul fright arises quite suddenly. I have never heard fear described as a symptom of some underlying or chronic condition. So, if, when they meet their first psychiatrist, Bangladeshi patients and their families hear psychiatrists calling pervasive, draining fear a symptom of a disease, it would be natural for them to interpret this in relation to the semantic network around *dar*, magical fright. But the significance of fear in psychiatric discourse is determined within a very different network of signs. This match of two apparently analogous notions of fears, both held by people identifying themselves as Bangladeshis, then, is quite imperfect. And that represents a larger mismatch between psychiatric and rural Bangladeshi styles of handling subjectivity.

The relation of the healing powers to modernity (Connor and Samuel 2001) in Bangladesh as I know it differs markedly from the situation Lemelson describes in Indonesia (2004), and from India—far more self-confident nations. In other Asian societies, middle classes and even consumers in other countries might constitute new markets for neo-traditional medicine (Connor and Samuel 2001), but Bangladesh has yet to see such a movement. An overwhelmingly rural country, far poorer than Indonesia or India, Bangladesh also faces greater problems asserting symbolic authority even at home. Its relations to the international community reflect internal problems that have hampered the emergence of a hegemonic ideology for the Bangladeshi state (Alam 1995). The West’s image of Bangladesh as backward, even a “basket case” as Kissinger once called it, seems to have taken root in Bangladesh’s *self*-image. Many Bangladeshis want to emigrate. I have rarely heard confident nationalist rhetoric in Bangladesh; rather, a sense of shame seems pervasive. So it is not surprising that mention of anything that could be spun as a “traditional beliefs” or “traditional medicine,” which find strong support in some public discourses in other Asian countries (Connor and Samuel 2001), provokes shame or anger in some Bangladeshi circles. Bangladeshis expressed shame—at least in my presence—over “old-fashioned” beliefs and practices, as if the whole nation felt itself the naked object of a rationalizing global gaze.

The sharpest contrast between Bangladesh and other Asian countries is in psychiatry. Whereas Indonesian psychiatrists often steer patients toward *balian* (healers), and even visit them themselves, the Bangladeshi psychiatrists I know take on the task of enlightening rural people with a missionary zeal. It scandalizes them that their countrymen speak of madness as *pāgalāmi* craziness, rather than *mana-rog*, mental illness; a recent national poster campaign took on that labeling struggle head-on. I have recorded one psychiatrist berating a family for wasting

their time, energy, and resources on traditional healers when the illness at hand appears to be schizophrenia. This purist allegiance to cosmopolitan psychiatry reflects Bangladesh's economic dependency on donors (a dependency far more extreme than most Asian nations), which makes it more vulnerable to symbolic as well as economic domination. Then, the psychiatric elite in Bangladesh is trained abroad in the United Kingdom or the United States, at the Medicine Bachelor, Bachelor of Science level (and beyond, in postdoctoral fellowships). Overall, Bangladesh's limited resources prevent the emergence of training institutions with the confidence to compete with those elsewhere or to explore the utility of "traditional practices" that seem badly out of step with those favored by international psychiatry.

A Psychiatric Injection into Bangladeshi Discourse

Psychiatry appeared in greater Bengal a little over a century ago as part of a colonial medicine committed to distinguishing natives from Europeans and native madness from European madness (Ernst 1997). Although several magazines popularized psychology and psychiatry in West Bengal in the twentieth century, so far as I know the first magazine popularizing psychiatric and psychological approaches to personhood to appear in Bangladesh appeared in 1999. *Manabigyān* (*Psychology*)⁴ was founded by Dr. Minaj⁵ and reflects his vision and that of some of the psychiatrists he has trained. Dr. Minaj's knowledge is shaped by his engagement with a global psychiatric profession and his scouring of the Web for articles to translate and include in *Manabigyān*. The magazine's readers write into its *Parāmarśo Pātā* (advice page), and the editors (psychiatrists) offer a mixture of diagnosis, teaching, and prescription.⁶

The letters *Manabigyān* receives often reflect fear. Of the 111 that I have analyzed, only 22 lack rather overt signs of anxiety; either the writer or the editor mentions it, or the anxiety is evident in the writer's logjam of questions. Minaj and his colleagues seek to reshape readers' embodied emotional selfhood—how they experience themselves, their fears, their relationships (i.e., their families, their love affairs, etc.), and the emotions arising in those relationships. The first issue of the magazine included 14 exchanges between readers and editors. The second exchange (hereafter 1.2, the 1 representing the issue number and the 2 the absolute number of the exchange, accumulating across all the issues) illustrates this zeal to introduce psychological thinking to readers:

Exchange 1.2⁷:

Reader:

Māthār tālute keman dharā dharā bhāb thāke. Garam lāge, pāni dīleo bhāp (heat) kame na. Ghārer dike byatha byatha bhāb āche. Ghumāle ekṭu āram lāge. Samādhān ki? In the top of [my] head there is a grabbing or full sensation. It feels hot, and even if I pour water on it the heat doesn't abate. Toward the neck there is a sensation like pain. When I sleep a little relief comes. What is the solution?

Here is "the solution" the editors offered:

Editor: āpni jesab sārīrik samasyār kathā likhechen, e-gulār utpatti mānasik rog theke. Āpni *depression*-e bhugchen. er sāthe kuch *anxiety*-o āche. Āpni *capsule Prozac (20 mg.)* ekṭi sakāle ebañ *tablet Lexotanil (3 mg.)* sebon karben . . . kayek saptāh par mānasik rog bisśeşagger sāthe dekhā karben.

All the somatic problems of which you have written have a source in psychological illness (manasik rog). You are suffering *depression*. There is some *anxiety* mixed with it. Take *20 mg. Prozac* in the morning and *Lexotanil (3 mg.)* . . . After several weeks, visit a psychologist.

The editors' response exemplifies the quasi-missionary proselytizing psychodis-course evidently aimed at converting the less enlightened to the belief that distressful ruptures in human life should be viewed in psychological terms.

Compare exchange 1.3, which included these lines:

Reader: As many children as my brother's wife has, she goes sort of mad. This has happened three times. We are afraid.

Editor: Your brother's wife is suffering from the illness, *puerperal psychosis*. . . Usually the patient (*rogī*, sick person) gets better after a few weeks.

In a move that has typified psychiatry since its emergence (Foucault 1973), *Manabigyān*'s editor includes in his letter to the sister-in-law above a rather intrusive bit of advice—that the other woman should simply stop having babies.

Dr. Minaj and colleagues sometimes reduce complex social problems to “personality disorders.” A boy wrote the editors of *Manabigyān* the following letter:

Reader: My father beats my mother almost every night. . . . Seeing all of this, I have no desire to go on living. I am angry enough with father to kill him. How can I control this anger?

Editor: For a child to feel bad on seeing its mother suffer is normal. The mother and father of the house exercise ample influence on the development of your personality. You are suffering now from a sort of *personality disorder*. In this illness, the role of medicine is negligible. For now, take one 20 mg. Prodep capsule in the morning. But for this problem, psychological treatment is primary. Along with it, [you must consider] what sort of appropriate steps can be taken to improve the atmosphere in the house. With all of these things together, you should be able to control your anger. (1.12)

The answer mystifies, drawing on contradictory voices, admitting that “the role of medicine [in your case] is negligible,” and suggesting the boy take steps to “improve the atmosphere,” but at the same time locating the problem within

the boy, defining it as a “personality disorder,” and suggesting the boy medicate himself and seek psychological treatment.

Ontological and Ethical Authority

The editor responding to the “Puerperal Psychosis” letter did not address the family’s mention of fear with anything as symmetrical as an echo of or direct response to it, but we can take his authoritative words as his attempt to soothe their fear. Diagnostic declarations manifest his authority. In the advice columns in the first six issues of *Manabigyān*, the editors’ diagnostic terms are mostly in English. To tell the family member, *āpnār bawdi puerperal psychosis rog bhugchen* (“Your brother’s wife is suffering from the illness puerperal psychosis”) is to assert the authority that *Manabigyān* helps constitute and propagate. The editors’ use of English indexes a cosmopolitan source for that authority. The linguistic assertion of authority seems clearest in the editor’s frequent declaration, *e roger nām* —, “The name of this illness is—[English nosological taxon].”⁸ Naming is a language game (Wittgenstein 1958) important in medicine and elsewhere. This particular form of the naming game is uniquely authoritative, with a performative ring to it. Naming can occur in implicit ways, but these utterances are quite explicit. Naming turns inchoate experience into cultural object, as when Catholic charismatic healers assign a name to the spirit that has possessed someone (Csordas 1990).

Naming asserts a sort of ontological control, claiming authoritative knowledge of what is. But doctors assert control over behavior, too. The two forms of power assertion—ontological and ethical—work in parallel in all of the editors’ responses. The editors frequently assert a truth-claim whose very nature is somewhat esoteric; that is, that what the readers/patients describe only scratches the surface of their problems, since the true problem often resides in a part of the patients that is *ajānā* (unknown) or *abacetan* (unconscious) to them. In his ontological role as revealer of another world, the editor teaches readers that *abacetan mane cintā sab samay kāj kare* (In the unconscious mind, thoughts are always at work, active [6.86]). Admittedly, readers/patients sometimes share the editor’s sense of the unknown. In 1.7, the reader calls his own anxieties *ajānā*, evidently because he knows that what he feels is fear but finds no rational source or object. However, without a first mention of *ajānā* in exchange 1.9, the editor tells a 10th-grade boy, Rahmat Anwar, that his shaking and blushing are due to an **ajānā udbeg, unconscious anxiety**.⁹ Likewise, he tells a newly wed young woman that her headaches after having sex with her husband—which he names “orgasmic cephalgia”—might reflect something unconscious: *apnār abacetan mane jawno sangam bisaye ek dharaner onihā bā bhiti thākte pāre*. (There may be some **fear** or disinterest in regards to sexual matters in your unconscious mind [1.8]).

To almost all who write, the editor prescribes a combination of psychopharmaceuticals and psychotherapy “at the nearest Medical College Psychiatric Division.” We see here and in all advice given the assertion of ethical authority, the power to prescribe action in 1.3—the naming of puerperal psychosis leads to a moral-medical prescription, having no more children. We see the assertion of ethical *authority over the inner life* most clearly in exchange 1.66. A man, Jahed Mahmud, writes:

kāro sāthei kathā balte-i bā miṣṭe icchā kare nā. sab samay bhay bhay lāge
 I don't feel like mixing-interacting¹⁰ with anyone. I am **afraid** all the time.
 (Editor): *āpni je kāje beśi bhay pāben sei kājī beśi kare karte thākun. bhay diye*
bhay kāṭāte habe.
 Whatever activities frighten you the most, do those all the more. It's necessary to
 fight **fear** with **fear**.

Fear must be countered. The editor does not explain how fear could counter fear. Rather than an autonomous emotion, the psychiatrist reacts to fear as a bit of subjectivity for self-will to subdue.

Thus, anxiety and fear figure largely in letters from the editors as well as to them, and the editors try to assuage anxiety by resort to the voice of authority or by calling on writers to bravely resist their fears.

Face-to-Face Encounters with Psychiatrists

This psychiatric proselytizing provides context for what I recorded when I visited the home of Karim, whom I had first met at Dr. Minaj's private psychiatric clinic.

During three weeks of fieldwork in Bangladesh in the winter of 2000–01, I met several psychiatrists and some of the patients they had diagnosed with schizophrenia. I sought patients' permission to pay a home visit and to bring digital video equipment and a second videographer. When I arrived at the homes, I explained further that my study concerned how Bangladeshi families coped with psychotic illness and that I would like, ideally, to film naturalistic interaction. In one home I left the room so as not to be the center of interest and talk while the camcorder was running. I explained that this was designed to help me understand the nature of interaction in families affected by this illness and that I was interested in cross-cultural differences in coping strategies. I promised not to show the video in Bangladesh and allayed the concern of some that I might use it on Bangladeshi television.

The Psychiatrist in the Bedroom? Karim's Family

Karim was working in the Middle East and repatriating much of his income to his family (his wife, mother, and brothers, all living together in Dhaka) when he began to experience symptoms. The family moved quickly to bring him home. Karim's brothers imply (lines 278–279 in the transcript below) that the problem originated in the loneliness, stresses, or conflicts he found himself dealing with in the Middle East. Karim's mother's perspective on the problem, its cause, and its cure differ markedly from the perspectives of his wife, his brothers, and their wives—Karim's generation, now parents to a third generation, the children who were also present during filming. Members of Karim's "middle" generation laughed when his mother insisted on the primacy of sorcery—*tawiz*—among the causes of his madness. When I first met Karim and his brother in Dr. Minaj's office, their mother was not there.

Karim's middle generation seems to believe less firmly in old causes of madness; they find less mystery in the world than their mother does. Or do they? An anthropological focus on "beliefs" deserves criticism on a number of grounds, as

Good (1994) has argued. A *pragmatic* approach to the words of Karim's family is at least as compelling (Desjarlais and O'Neil 1999). Such an approach to my data must ask why in these particular circumstances the family might have laughed or rhetorically distanced themselves from the matriarch's words. The middle generation has many reasons to be more sensitive to my presence and the perspective of the larger, richer, more powerful world I represent. They grew up not in a village but a city, with media access to a world they co-inhabit with citizens of the "developed countries." Thus, they laugh in embarrassment at their mother's "traditionalism."

In the transcript below, *B* is Karim's brother, *M* his mother, *W* his wife, and *J* is the author. Bracketed words are interpretive comments, for example on gestures made, rather than words recorded on my videotape. The Arabic word for a sorcerer's charm, *ta'wiz*, appears several times in the transcript, nativized in Bengali as *tabiz*.

B278	Bideše-i jeye haiyese	After he went abroad it happened,
B279	beši	mostly. ¹¹
M280	Āsale pratham tābij-i.	Actually the <i>tawij</i> was first.
W281	[touches paper in file ostensibly, asking	the men to look at that page]
B282	[to W] ha uni dekhe	[to W] Yes, he saw it.
J283	(2) prathame tābij?	(2) ¹² The <i>tawij</i> was the first thing?
M284	tābijī (naṣto karlo)[nodding deci-	[nodding decisively] The <i>tawij</i>
	sively]	was ruining him.
B285	[laughing] eṭā (āmāder)	[laughing] This is our idea.
	dhāranā	

The laughter of the middle generation (Karim's brother's e.g., line 285, but also in lines not included here) might just as well be strategic as indicative of a belief or of a full embrace of a rationalized, demystified perspective on the terror brought by the fall of a family member into madness.

Still, their psychiatrist, Dr. Minaj, and his closest associates are brimming with the psychologizing modernism patients and families associate with the West. Karim's family, like other cosmopolitan Bangladeshis (who have lived in Dhaka or traveled abroad), know "we" don't believe in spirits but instead explain madness by appeal to endogenous psychopathological processes. They know that we reify persons as individuals. They laugh with embarrassment in this globally interconnected world—represented by Dr. Minaj as well as by me. It is in this context that they express ambivalence toward "their own traditions." This complicates their strategies to cope with Karim's psychosis and to save family-face. The terror of madness, for them, came to involve the fear of appearing backward. The latter fear probably peaked in Dr. Minaj's clinic, but was reinforced by my home visit. That fear caused them to divide their attention, as they faced the additional anxiety of saving face in a global world in which distant Others are also felt to be watching.

Hamid and Dr. Chowdhury

That story of the globalization of senses of self unfolded in January 2001. Stories from my 1991–92 fieldwork reflect a time when Bangladesh was slightly more autonomous and when even its psychiatrists fit more comfortably in Bangladesh per se. It was in 1992 that I started working with such psychiatrists. Among the

most generous in her assistance to me is a woman I call Dr. Chowdhury, who visited my field site in rural Bangladesh to conduct an informal clinic. I asked her to come because—rightly or wrongly—I felt it incumbent on me to do more than just spend time with people whose suffering was so tangible and whose help-seeking resources seemed exhausted. Thus, Dr. Chowdhury met several of the people I knew who were called *pāgal* and who expressed frustration with the limited help available to them in rural Bangladesh.

Weeks before he met Dr. Chowdhury, I met Hamid by chance at a ferry stop. Later he sought me out because of what I had told him about my fieldwork and specifically of my concern with madness. He later became one of the four patients who attended the clinic Dr. Chowdhury held that year, Hamid's thirtieth. By that time, Hamid had made a substantial recovery from the psychotic episode he had suffered from ages 20–22, but was still able to speak eloquently of those years in which his symptoms were acute. Equally acute was his ongoing sense of loss of confidence, stability, strength vis-à-vis other men, and hope, even for a good night's sleep.

My videotape of Hamid meeting with Dr. Chowdhury shows Hamid's fear. It shows in his bodily deportment, and he also speaks about it. His hands were shaking, his gestures were nervous, and he spoke openly of being afraid of people. Hamid feared people would “grab” him and do him harm. That sort of fear made him say: “My life has completely come to an end.” Some of these fears relate to the time when he lost his mind, an event he associates with being “poisoned” by food he received from a family that he had worked for and trusted. He said a doctor had told him back then that he had indeed been poisoned. That was the time when his *brain* went out, as Bangladeshis say, in a creative use of English.

To Dr. Chowdhury, the problem was that Hamid *thought* he was still suffering residual effects of poisoning, a thought she told me—switching into English to address me as she interviewed the mostly monolingual Hamid—was delusional. Chowdhury also told Hamid that his sense that he can't work at all was contributing to his problems, that he should get up and do something rather than sit around all day. During such lectures he remained silent. She told him,

C450	<i>Permanent</i> kono <i>problem</i> habe nā.	There won't be a <i>permanent problem</i> .
C451	Ekhan jadi āpni	Now if you
C452	eṭā bisvās karte tākhen [smiling]	keep believing this [smiling]
C453	tāhale to bhay.	then there is [something to] fear
C454	Āsal to bhāy, nā?	[That is the] true fear, isn't it?
	[46 lines omitted]	
C500	bhay nāi bujhchen? = hæ? (.2)	No worry, right? Huh? (.2)
C501	kono <i>poison</i> āpnār sarire ekhan nāi.	There is no <i>poison</i> in your body now

After a seven-second pause, Dr. Chowdhury perceived Hamid was not reassured.

H509	ey bhābe, (2)	This way, (2)
H510	X-RAY KAYRĀ	BY DOING AN X-RAY
511	(.5)	(.5)
C512	Hm?	Hm?
513	(.3)	(.3)

H514	Āmār eṭā kono dharār (.3) iyā nāy?	Isn't there anything to see ¹³ this thing of mine?
515	(.1)	(.1)
C516	x-ray-te dharār kichu nāy (.2)	Through x-ray there's no way to see it.
C517	kichu NĀY to mātḥā-e	There's NOthing in [your] head.

So silence was not Hamid's only strategy in the face of Dr. Chowdhury's lectures. In Line 514, he asked her a challenging question. But Dr. Chowdhury was firm—Hamid must stop being afraid.

Hamid contested the implication that steps taken to gain a sense of control would reflect delusions. He wanted action. Poison was still affecting his body and should show up in an x-ray. Dr. Chowdhury attempted to bring into his world a degree of purported reality she thought would ultimately leave him feeling less afraid. In fact, this just left Hamid frustrated. Dr. Chowdhury was playing a role often played by laypersons in the villages where Hamid and others live. Her confident willingness to tell him what to feel might itself seem delusional to an American convinced of the autonomy of emotions. But Chowdhury's approach fits with a Bangladeshi pattern—telling the frightened-sick, along with others who are simply feeling afraid or sad, to harden themselves, trust God, etc. Fear represents loss of control; the locally trusted solution is not to explore those fears but forget them. Bangladeshis seem to regard such forgetting of feelings as eminently possible—if one has, or receives from others, the moral strength to achieve it (Wilce 1997). The Bangladeshi meta-emotion at work here is a deep distrust of fear and other individual sentiments. Dr. Chowdhury's words are what Bangladeshis call *sāntanā* or comfort—a social sentiment, or perhaps more accurately a locally recognized exhortative speech act.

Sāntanā represents a whole ideological complex whose semiotic manifestations help hold persons in bonds of solidarity that trump fear, but also any assertion of subjectivity. Hamid's insistence that Dr. Chowdhury take the appropriate actions to directly address his fears of any ongoing effects of poison indexes a primal, phenomenal reality for Bangladeshis, not psychiatric training. Hamid's fears remained recalcitrant. Just as his original experience entailed a profound disruption of intersubjectivity—"being poisoned," followed by years of madness—we who arranged the clinic could count on no easy repair in intersubjectivity via appeals to Hamid's courage. His fears lingered, unresolved in his interactions with Chowdhury. They failed to agree on a shared reality.

For Dr. Chowdhury, Hamid appeared to dwell far too much in a realm of personal subjectivity, a stance that threatens a Bangladeshi preference for intersubjectivity shared so widely that it interferes with the purity of psychodiscourse offered even by apparently-true-believer psychiatrists. The autonomy of emotions that many American therapists take for granted may be foreign even to Bangladeshi psychiatrists. Hamid's experience with schizophrenia left him "individuated" and marginalized in ways that even Chowdhury had trouble relating to. Hamid had, by virtue of his illness, come to share in more of the experience of alienated modernity than either Bangladeshi tradition or psychiatry could easily accommodate in that moment of history. His anxiety endured, largely untouched.

Rani

Like Hamid, I met Rani weeks before she met Dr. Chowdhury. At the time, I was employing her younger sister, Shapla, to assist me when I needed to speak with modest rural women. By the time I met them in 1992, Rani was about 24 and her family had struggled with her severe psychotic illness for several years. As a poor family with restricted mobility, they had no access to psychiatric care until the “clinic” that, for better or worse, I organized with Dr. Chowdhury. This certainly did not mean Mashima, Rani’s mother, had not sought treatment. Their treatment providers were *kabirāj*—traditional healers practicing herbalism, *jhārphuk*, and exorcism. But Mashima had given up on them. She took the failure on herself, at least in her verbal construction of the situation, telling me, “I couldn’t make her well.”

Mashima, despite having run out of treatment choices and financial resources for them, managed quite well with Rani. This energetic single mother caring for her adult daughter still experienced low-key anxiety focused on Rani’s long-term future. And in the immediate situation with me, there was the anxiety of saving face in local terms. That included presenting themselves with dignity by upholding social norms, especially norms of politeness, in interacting with me. When I periodically attempted to interact with Rani directly, the family’s desire to control the spin-offs of Rani’s psychotic illness often meant controlling her speech, or speaking for her. My visits caused a sort of iatrogenic illness—family anxiety over Rani’s behavior in the face of my questions. At the same time, they had unrealistic hopes that I might somehow help her. In the transcript below, *J* is the author, *M* is Mashima, *R* is Rani, and *S* is Rani’s sister Shapla.

102J	ekhan (.2) tumi ki chāo (1.5)	Now what do you [yourself] want
103J		[to happen] (1.5)
104J	Rāni =	Rani? =
105M	=Kaw “āmi bhālo haite chāi.”	=Say, “I want to get better.”
106R	((to Shapla, laughing voice)) (xxxxx)	((to Shapla, laughing voice))
107R	dik ā dā	(This direction, <i>or</i> Let [someone] give this.)
108M	((touching Rani)) Rāni.	Rani,
109R	((R to S, R still laughing)) ey je (wārā).	((to Shapla, still laughing)) (Look at this!)
110M	he! kathā ka āmi bhālo haite chāi	Say, “Big brother, I want to get better.”
111R	(.5) mā (xx) jadi bhālo haben kæ? =	Why would you want to get better, Ma? =
112M	=āmi bhālo haite chāi	= “I want to get better.”

In her acute psychotic state (evidently flooded with auditory hallucinations), Rani was not particularly prone to engage anyone in regular turn-taking interactions, like answering direct questions. But her family could not accept her failure to answer my question, despite a long pause and an attempt to recycle the question (from Lines 102 to 104, where I was about to repeat myself). It prompted Mashima to repair the breach by answering for her (105). Earlier, Shapla had urged Rani to

answer another of my questions. Shapla had told Rani, “Speak, speak doing-beauty” (*bal—sundar-kare bal*). To speak doing-beauty, or speak beautifully, meant to speak above a mumble and answer questions in a way that showed she was attuned to the give-and-take of interaction, and to show an engagement in the intercorporeal dance of interaction (Wilce 2004). It epitomizes an aesthetic centered on the well-attuned deployment of words and embodied movement.

Mashima and Shapla enacted a Bangladeshi value system that ranks the achievement of intersubjectivity over the expression of subjectivity. This culturally specific aesthetic locates moral and emotional domains within embodied linguistic interaction. But this aesthetic generates two sorts of response to actions—affirmations of beauty, and—in other situations—a sense of ill-fit and even terror. The field of daily interaction is one of struggle between these two potentials. For Rani to ignore questions, particularly the questions of a guest, created a potential loss of face for the whole family. Madness is terrifying not only because it can confront us with a numinous otherness (Sass 1992), but—in Bangladesh at least—because of the damage it can cause to a family’s prestige, the capital it accumulates based on exemplifying cultural values.

At times, Mashima attempted to engage Rani in the sort of dance in which conversational partners quite commonly manifest their mutual attunement—a dance of synchronized movements, bodily orientations, and gestures. Her efforts mostly failed. Some research indicates that excessive familial concern over the disengagement characteristic of schizophrenia correlates with a poorer prognosis (Karno et al. 1987). But for the most part, Rani’s family probably let her do as she liked. I often saw her performing simple domestic tasks that allowed her to remain socially disengaged—or to loudly answer the voices she heard privately—while perhaps retaining a sense of purpose and value in the family’s life and subsistence. My questions temporarily destabilized this more common pattern of tolerance for a semi-therapeutic disengagement (Corin 1990). When I was present and asking my questions and Rani did not answer, Mashima tried to help Rani engage us all in the mutual give-and-take of interaction and thus lend a sense of “beauty” not only to the moment but also to her daughter. Watching the videotape of Mashima, I am persuaded that she was trying even to use her body—or an image of her bodily sphere somehow encompassing Rani’s—to do the polite dance of interaction on Rani’s behalf (Wilce 2004).

These motherly acts exemplify a power/knowledge whose implementation, though occasioned by my problematic presence, seem to have little to do with my world. Mashima’s powers met their match in Rani’s schizophrenia, though Mashima never admitted defeat. When Dr. Chowdhury spent an hour with them, she saw their struggles, urged them to visit her hospital in Dhaka, and eventually gave Rani a two-year long series of long-lasting (depot) anti-psychotic injections. I saw the results of the first injection. Two days after Rani received that injection, she engaged us much more directly in conversational turn-taking. But two years after their trips to Dhaka for monthly injections began, they stopped going, and Rani relapsed. The trip itself was too costly in time and money. In the end, neither Rani’s family nor Dr. Chowdhury had a final, practical, contextually appropriate answer for the anxiety that madness brings. “Cures”—or conversational repairs (such as

those which Mashima engineered by answering my questions on Rani's behalf—were incremental at best, and always inconclusive (Csordas and Kleinman 1990).

Mute Terror

Even for Dr. Chowdhury, to travel for hours to see a few patients represents a striking exception and a hardship. Drs. Chowdhury and Minaj have busy private practices, seeing dozens of patients in an evening. Among Dr. Minaj's patients on the evening he had invited me to his clinic were two girls who had not spoken a word for over a year. He said that one had schizophrenia and the other depression. To me, mutism was their only symptom. Dr. Minaj offered the separate diagnoses on the basis of seeing them together for a couple of minutes and because of their three-year age difference. He asked the family if I could visit them at their home a few days later, and they consented. When I arrived in their home on the opposite edge of the sprawling capital city, they used my two-hour visit to their home to unload a very long story. They described how they had coped with the terror of seeing some twisting force affect one child after another: Now their young son was behaving strangely.

As psychoanalysts have argued, psychiatric practice is itself a mode of coping with fear—for the psychiatrist as much as for patients. For Dr. Minaj to spend so little time with his patients might in part reflect his discomfort with the horrendous stories they might otherwise unfold before him. A minute-long visit culminating in the prescription of some antidepressant and antipsychotic medications leaves less room to confront the mystery, the terror. But in their own home, the mute girls' family faces a universe in which psychopharmaceuticals are irrelevant. More than a year ago, their two daughters saw a vision of the Hindu goddess Kali—and suddenly became mute. The girls' mute fear and the severe anxiety evident to me in the adults' long and agitated story are of one piece. The girls cannot say now what they fear, or why they remain mute, though just after she saw Kali, the older sister did tell her mother something of the vision—and then lapsed into a silence that had lasted until I met them. Now the complexity of multiple fears, and the burden of giving the situation some meaning through discourse, is left to the adults alone as they try to stop the destruction before their children are lost to them. For those two hours, they struggled to explain the complexity to a foreigner and involve me in the solution.

The girls' older kin are convinced that what the girls saw was not exactly Kali herself but a Hindu man known to them, Gurudev, a Kali devotee they say put a curse on the girls. Not only that—they say one of their own relatives hired Gurudev. Keep in mind that the family is Muslim, with no Hindu relatives. The idea that an enemy—related by blood or in any other way—would hire a sorcerer from a different religious community probably reflects a widespread tendency to regard Others' magic as particularly powerful and terrifying. In the last moments before they became mute, the girls swore that only Gurudev could ever make them well. The older of two uncles present told me what the girls had said, what the family now knows to be true: "Besides Gurudev, no one in the world can make them well. It matters not how many doctors you take them to—they won't be able."

The family had already expended years of family income on a court case to force Gurudev to make them well. Relatives working abroad—especially a young cell-phone-wielding uncle who was present both at Dr. Minaj’s clinic and in the home during my visit—underwrote those expenditures. The problem with the court case was that the family needed evidence to convict Gurudev (and their kinsman who had hired him) of sorcery. That charge, though perhaps problematic in the Bangladeshi courts, would still require empirical evidence. The psychiatrist’s report was, to them, primarily useful as evidence in that lawsuit. Dr. Minaj had ordered expensive blood tests—perhaps pointlessly, possibly on the family’s urging—certainly without knowing how the family would use the results. They were anxious to have me confirm that the tests showed no organic problem. To them, that negative evidence was convincing proof that sorcery was to blame.

As frightening as the “diagnosis” of sorcery may be, it seems more actionable to them—legally if not medically—than any diagnostic category Dr. Minaj might offer. Their worlds, their knowledge bases, their definitions of personal vulnerability, and their ability to use various forms of power could hardly be more different.

Conclusion

Always tenuous, human attempts to control the terror of the uncontrollable—and madness often exemplifies this—are complicated by the very multiplicity of perspectives we are prone to oversimplify by invoking the reification “culture.” And to the degree to which distressing behaviors, and others’ attempts to manage those behaviors, are tacit—entailing, for example, resorting to embodied means of repair like Mashima’s—“coping” becomes even more complex. Add a healthy dose of the knowledge—so salient for Karim’s family—that nontraditional Others are looking, be they psychiatrists or ethnographers, and the recipe calls for a lifetime of simmering interpretation.

These modern global Others remind us of two paradoxes: First, globalizing modernity is always local. Thus, Bangladeshi psychiatric modernity draws not only on global discourses but a local distrust of pure subjectivity. Still, globally circulating forms of power/knowledge can in some cases (like Bangladesh) spread shame over “backwardness.” In Karim’s family’s case, we see that this can only complicate the task of coping with madness. Shame arises because, despite the always local nature of global modernity, Bangladeshis experience psychologizing discourses as authoritative by their association with wealthy and powerful people. In the globalizing world in which Bangladeshis find themselves, charged forms of knowledge (old and new) circulate with very different amperage, with very different forms unequally empowered. The government of Bangladesh supports cosmopolitan psychiatry, including the prestigious hospital where Dr. Minaj works and teaches (his day job). Minaj’s government position and access to psychiatric conferences and relevant texts on the Web lend a certain authority to his words.

The power in *Manabigyān* is unlike dominance seen, for example, in asymmetrical patterns of interruption by practitioners of patients. Global networks that sponsor and circulate various discourses are more complex. Their power does not require explicit or constant reaffirmation. The channels of their power are capillary, pervading the lifeworld of Karim’s family. Thus, “the lifeworld” is no longer

neatly distinguishable from the world of medicine (contra Mishler 1984). Though it reaches few readers, *Manabigyān* is a sign of that mind-colonizing power as it teaches its readers to see anxiety as a symptom of psychogenic illness rather than soul fright or sorcery, and psychiatrists berate patients who have sought “traditional” cures. Their power is institutionally rather than charismatically constituted, and they typically spend too little time with their clients to hear stories that would, in any case, elicit condemnation rather than mutual exploration.

Bangladeshi psychiatrists and patients inhabit different, though overlapping, discursive worlds. Although traditional practitioners remained in the background in this article, their power—along with that of charms, curses (Wilce 2001), and (on the other hand) courts of law—remains a part of the complex stories of fear that families have to tell. The time that traditional practitioners typically take to hear long stories (Wilce 1998) is a present-absence that informs patients’ experience of the three-minute psychiatric visit.

I do not romanticize the old, nor has it passed away. The cases I have presented indicate that neither modernist nor traditionalist forms of knowledge have the power to end the fears that madness brings in Bangladesh. And I see at least a temporary alliance of Bengali tradition and Bangladeshi psychiatry—an alliance between the drive for intersubjectivity (“don’t get lost in your feelings”) and psychiatric objectivism (“there is no more poison in you”). Such an alliance presents a formidable body of power/knowledge. But the “traditional culture” was as conflictual as modernity is. Divination and the search for solutions to (perhaps magical) poisoning and sorcery (Wilce 2001) predate Bengal’s confrontation with European modernity. The hunger for intersubjectivity and connection, and the sense that everyday social connections make persons vulnerable to each other, coexist in a tension unresolvable by any magic, old or new. Hamid and the mute sisters testify to that. Thus, the second paradox: What is “powerful” may still be less than fully effective.

Still, in such contexts, patients and families do manage somehow, and psychiatrists help in many cases. This article should stimulate further research—to uncover just how that happens in a society where medical pluralism is *not* celebrated, and to shed more light on the pragmatic and clinical effects of epistemological clash over madness.

NOTES

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1. Divination events are also about fears and attempts to control them. I explore them elsewhere (Wilce 2001).

2. I describe the diverse problems brought to a Bangladeshi diviner elsewhere (Wilce 2001).

3. I refer here to conditions other than madness—however the cause is conceived (which, in any case, is not usually named among “illnesses”)—or sorcery or possession.

4. Although only 9,000 copies of each issue were being printed in December 2000, each copy would be read by several people. At any rate, my point is not that *Manabigyān* alone makes a great impact, but that modern notions of the self are circulating more and more in rural Bangladesh through several channels including the magazine, direct encounters with psychiatrists, and discourse spawned by both.

5. All names used herein—including that of the magazine—are pseudonyms.

6. Note that there is usually no need for a prescription in most Bangladeshi pharmacies and the very concept would be foreign to most customers and pharmacists, who usually practice medicine of a sort themselves.

7. Words originally in English are italicized in the transcript.

8. Granted, these are not performatives; the doctor is not saying “I hereby name this condition Y.”

9. I have bolded phrases in the transcripts that refer to anxiety-related states.

10. Using “mixing” or “blending” as a prime metaphor for interaction manifests the Bengali ideological preference for intersubjectivity over subjectivity.

11. The brother seems to imply that symptoms had started before Karim left to work in Saudi Arabia but that he got much worse during his time there.

12. Again, words originally spoken in English are in italics. Pause lengths are in parens, in seconds and tenths of seconds. Caps represent louder talk. (=) represents “latching,” or close juxtaposition of two speech segments—so close that there is no gap, but also no overlap, between them.

13. Literally, “catch.”

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