“Reaching Out to the People”: The Cultural Production of Mental Health Professionalism in the South Indian Public Sphere

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Abstract

Although a significant body of scholarship has examined medical discourse in clinical and other institutional settings, far less has been studied in regard to the discursive activity of health professionals in the public sphere. This line of inquiry is particularly relevant in Kerala, south India, where, for reasons including felt obligation, the political economy of allopathic mental health care, and desires for social prestige, many psychologists and psychiatrists actively engage the public as lecturers, authors, and guests of television and radio programs alongside their clinical work. Ethnographic attention to discursive activity in the public sphere reveals how these experts blur the boundaries between clinical and popular registers of speech and forge alternative ethical sensibilities and values that challenge institutionally prescribed ideas of clinical professionalism. They do so in ways that can attract reprobation and accusations of quackery among critical peers who hold competing ideas of where, how, and to whom mental health professionals “should” speak.

Keywords: public sphere, professionalism, mental health discourse, psychiatry, register, quackery

On a bright February morning, I, together with an audience of about 200 people, fell into the orbit of Dr. Lekha's gravitational pull.**1** It was my first time watching the psychologist speak publicly, and I was entranced. At a teacher training college a short journey outside Thiruvananthapuram, the capital city of the south Indian state of Kerala, Dr. Lekha delighted, entertained, and informed. She did so in a manner that brought to life what she often spoke of as her "other" nonclinical obligation as a mental health professional: "reaching out to the people."

After several months observing Dr. Lekha's clinical work in the psychiatric outpatient department of a Thiruvananthapuram hospital, I was eager and curious to see the psychologist don her other hat. I was not disappointed. Dr. Lekha was invited that morning as the keynote speaker for a daylong workshop on adolescent mental health. The program began with an introduction by the college principal who at different points in her brief speech used the English terms to refer to their esteemed guest as a "psychologist," "psychiatrist," "therapist," and "counselor." Overlooking the apparent confusion, Dr. Lekha took the microphone. The room was soon buzzing with energy. "You have a psychologist here with you today," Dr. Lekha began, smiling. "Use it to your advantage!" She prompted each of us to write down one question about "psychology or mental health" that we hoped to have answered by the end of the day. Slips of paper were distributed around the room. The first question to reach Dr. Lekha asked if she could decipher the author's personality based on the handwriting sample—a task the psychologist playfully obliged, much to the audience's delight. Yet another was existential in tone: "What is life and how can we understand what life is?" Others asked the psychologist for strategies to improve memory power. One young woman inquired about the problem of suicide among Kerala's youth and asked what she and her fellow future educators might do to prevent suicide among their students.

The questions posed that morning, together with Dr. Lekha's dynamic ability to engage them, offer important ethnographic insights into the globalization of the "psy" sciences (Rose **1998**) and the professionalization of its practitioners. Spanning pop psychology to philosophical inquiries into the nature of human existence to suicide prevention methods, those slips of paper collectively highlight the broad, eclectic, and typically vague forms of knowledge popularly understood to be the domain of psychologists and psychiatrists in Kerala. At the same time, the colorful interactions between Dr. Lekha and her audience begin to illustrate how some experts actively shape their professional identities through engagements in the public sphere. They do so in the face of—and, at times, through the strategic use of—nebulous perceptions of what mental health professionals "actually" do.**2**

Scholars have given significant ethnographic attention to the globalization of the "psy" sciences, recognizing that psychiatric and psychological discourses are not simply "imported" as immutable entities into local contexts. Biomedical psychiatry, for example, is contested, coopted, and transformed in light of local knowledge, structural conditions, therapeutic practices, and social histories (Callan **2012**; Coker **2004**; Davis **2012**; Kitanaka **2012**; Lakoff **2006**; Varma **2012**). Dr. Lekha's performance that morning highlights another critical site for understanding the vernacularization of the "psy" disciplines: the cultural production of mental health professionalism. In Kerala, many psychologists and psychiatrists actively shape their professional identities as individuals and as members of a peer community through sustained engagements in the public sphere. Events such as training workshops, public awareness programs, lectures, and appearances on radio and television offer fruitful sites for investigating how these mental health professionals fashion specific personae and bring these personae into circulation before large audiences in the public sphere.

Following Hauser's (**1999**) rhetoric-focused model of the public sphere, my analysis foregrounds the actual discursive practices enacted by these mental health professionals in the formation of judgments around issues of shared public concern. This approach recognizes a particular ideological boundary operative among Kerala's community of mental health professionals, one that strongly distinguishes between forms of "public" talk and "clinical" talk. This ideological boundary is shaped by the multiple dimensions of talk: the social spaces where it occurs (i.e., on the stage versus in the clinic); the topics and themes which it engages (i.e., society and social life versus the individual case history); and the audiences and objectives to which it is directed (i.e., the general public for education and entertainment versus the patient for diagnosis and treatment). As we shall see in greater detail, this ideological boundary is also shaped by ideas concerning appropriate registers and genres of speech. At stake in these distinctions is how and where talk may or may not "count" and how speakers are held responsible by their peers in shaping institutional identity and legitimacy (cf. Goffman **1961**; Hill **1995**). Through discursive activity in the public sphere, experts like Dr. Lekha challenge the ideological boundary dividing "public" talk and "clinical" talk, pushing the limits of institutionally prescriptive notions of clinical professionalism. They seek to define in different terms for themselves, for the public, and for their peers what it means to be a "true" mental health professional in urban south India. In their efforts, they may also provoke the criticism and reprobation of institutional gatekeepers in their peer community who hold more tightly circumscribed ideas of how, where, and to whom psychologists and psychiatrists "should" speak.

In this article, I draw on ethnographic case studies to make two key assertions about the cultural production of mental health professionalism in Kerala. First, I argue that the role of discursive activity in the public sphere to processes of professional identity making is highly contested and contradictory. In the public sphere, professionals like Dr. Lekha communicate creatively at the intersection of technical language, popular meaning, and social knowledge about mental illness, blurring the boundaries between "lay" and "expert" knowledge. A striking contradiction arises: while garnering visibility and social prestige as professionals, they simultaneously mystify the domain and content of their technical expertise. Among the many diffuse and unintended effects that result are heightened debates between and among professional peers about authority and quackery. Second, I argue that mental health professionals' rhetorical strategies in the public sphere can be a critical vehicle for the ideological reproduction of social hierarchies. Discursive activity in the public sphere reveals a dialectical interplay between clinical and popular speech registers, where mental health professionals often employ psychiatric diagnostic terminology to describe, explain, and account for broader social concerns that have featured widely in media and public imaginaries. In doing so, clinicians may at times reify and pathologize gender, class, community, and caste difference in relation to mental illness. Mental health professionals' engagements in the public sphere can therefore be examined for how they work to sort out and stratify individuals and populations and for the dual processes of visibility and obfuscation that they enact with respect to expert knowledge. While illuminating the particularities of mental health professionalism and its contestations in urban south India, the Kerala case ultimately contributes more broadly to our understanding of how "psy" discourse is remade and vernacularized in globalizing contexts through the rhetorical and identity making strategies of its practitioners.

The Health Professional as Public Persona

A significant body of cross-disciplinary scholarship explores the critical role discourse plays in medicine and the medical professions. Speaking and writing have been examined as modes of knowing and acting both in and beyond healing encounters (Wilce **2009**). Anthropologists and others have recognized, for example, that medical discourse shapes relations of power and authority (e.g., Rapp **1988**; Silverman **1987**), moral reasoning and action (e.g., Brodwin **2008**; Buchbinder **2012**; Lester **2009**), therapeutic practices and outcomes (e.g., DelVecchio Good et al. **2006**; Kirmayer **1994**; Mattingly **1998**), and the social and ideological reproduction of medical institutions (e.g., DelVecchio Good **1998**; Good **1994**).

While the scholarship on medical discourse is expansive and growing, most of this literature has focused on clinical and other institutional settings. Far less has been studied in regard to the

discursive activity of health professionals in the public sphere. We know little about the rhetorical and performative strategies health professionals use to communicate with general audiences and even less about the role these strategies play in the cultural production of professional identities and local perceptions of authority.**3** Consideration of a wider range of expressive routines beyond the clinic is particularly relevant to the cultural production of mental health professionalism in Kerala, where many psychologists and psychiatrists actively fashion identities in the public sphere. Among those committed to "reaching out to the people," in Dr. Lekha's phrase, public engagements are a practical and ethical component of the profession equal in importance to clinical work.

Many mental health professionals I encountered in the capital city saw themselves as more than "just" clinicians. A high rate of literacy, and more specifically, of health literacy in Kerala has fed a growing body of print and other media devoted to mental health issues, including magazines, books, and television and radio programs.**4** It was not unusual for clinicians I met in the hospital setting to spend significant time and energy outside of the clinic writing for health and lifestyle magazines, appearing as guests or hosts of television and radio programs, participating in educational awareness workshops, and lecturing at schools, colleges, and workplaces around the city. Many invited me along to public engagements, shared copies of their latest articles, and reminded me to tune in to aired appearances so that I might get a fuller sense of the range of their commitments, passions, and talents. Some have attained significant visibility and presence by crafting distinct public personae; those able to do so successfully have generated followings among current and potential clients.**5**

Much as Dr. Lekha spoke of a higher obligation to "reach out to the people," psychiatrists and psychologists who actively engaged the public sphere spoke eloquently to me about an ethical duty to serve beyond the clinic. This felt obligation is also fundamentally shaped by the political economy of allopathic mental health care in India. Status recognition through client patronage can serve to supplement modest financial remuneration, particularly for those employed in the public sector where salary compensation is minimal (Nunley **1996**). While conducting participant observation in the clinical setting, I was regularly reminded of these practical benefits. It was not uncommon for clients to arrive at the hospital after travelling long distances to seek out the clinician whose article or television appearance had caught their attention. Among middle-class "shoppers" researching a psychologist or psychiatrist on behalf of an ill family member, visibility in the public sphere was sometimes read as a proxy indicator of therapeutic acumen. For clinicians, then, public presence can be an effective way to widen one's client base.

It is also a powerful means for "selling" (Nunley **1996**:178) allopathic mental health care more generally to the public.

Other factors beyond the political economy and cultural status of allopathic mental health care have encouraged the presence of mental health professionals in the Kerala public sphere. Since the 1990s, the rate of suicide in Kerala has risen to as high as triple the national average.**6** Suicide has commanded a prominent place in the contemporary social imaginary, generating dystopic visions and fears of an unfolding crisis (Chua **2012**). In these anxious times, state officials, policy makers, educators, and the media are calling on mental health professionals to share their expertise, raise awareness, and chart solutions across a range of public forums. Many are eager to take up this position. Some view it as a professional and ethical obligation; others, an opportunity to demonstrate the relevance of their knowledge to issues of pressing public concern. A place has opened up in the Kerala public sphere where the voices of mental health professionals are now solicited, valued, and affirmed.

The case studies I present here explore some of the rhetorical and performative strategies used by mental health professionals who actively engage the public sphere. They draw from over 27 months of fieldwork in Thiruvananthapuram, the bulk of which was conducted between 2005 and 2007, with a shorter period of fieldwork in 2009. Fieldwork included eight months of sustained participant-observation at one state-run and one government-run clinical site; structured and unstructured interviews with over 50 mental health professionals; discourse analysis of popular media including television and radio programs, books, and magazines; and participant observation at health awareness programs, training workshops, lectures, and other public speaking events around the city. To examine discursive activity in the public sphere, I followed what Farquhar (**2002**) calls "itinerant ethnography," ethnography which not only tracks across multiple genres of source material, but in this case also roams across clinical and nonclinical sites to map the many symbolic and physical locations of professional identity making.

Making It Relevant: The Dialectical Interplay between Clinical and Popular Registers

Many of the most publicly visible psychologists and psychiatrists in Kerala do not hold high positions within the stark institutional hierarchies that characterize the mental health care professions in India. More critical to public presence than the prestige of institutional status or credentials is the capacity to make psychiatry and psychology relevant and compelling to general

audiences. In the public sphere, this typically manifests as a fluid ability to shift between registers of speech in ways responsive to audience and context.

Agha defines registers as linguistic repertoires "associated with particular social practices and with persons who engage in such practices." Each individual has a variety of registers with which he or she is acquainted, a "register range" which "equips a person with portable emblems of identity, sometimes permitting distinctive modes of access to particular zones of social life" (2004:24). Differences in register competence—the ability, for instance, to successfully command and display the specialized registers of one's profession—are linked to asymmetries of power, class, and position in social hierarchies. Registers are also historical formations, says Agha (**2004**), caught up in shifting processes of valorization and countervalorization within and between social groups.

Mental health professionals who gain visibility in the Kerala public sphere are often those able to shift fluidly and creatively between popular and clinical speech registers in their pursuit to make their knowledge relevant to the everyday lives and problems of the general public. As an example, when speaking with nonspecialist audiences, psychiatrists and psychologists often drew on diagnostic terminology to explain and account for broader social issues prominent in popular and media imaginaries. In Kerala, as has been documented in other contexts (Kitanaka **2012**; Traphagan **2004**), popular understandings of mental illness are often tied to ideas about social decline. Suicide, for instance, has been linked to perceived societal ills including the unraveling of the fabric of family life, the growth of consumerism, youth disillusionment, and rising violence against women. The ability to speak to these "everyday" concerns—topics which themselves are highly visible, mass-mediated phenomena in Kerala public life—is widely appreciated by popular audiences. The expert who successfully renders abstract technical jargon in the familiar vernacular of popular meanings and social knowledge about mental illness is valued both for the skill this evidences and for the philanthropic commitment to the public good this is said to demonstrate.

A workshop I attended in May 2007 offers a useful illustration of these shifts between speech registers and their performative value in the public sphere. While reading the morning paper, I came across an ad in English announcing an all-day workshop organized by the Kerala Women's Commission on the topic of "Mistrust in Marital Relations." When I arrived there later that morning, I learned that the workshop's official title in Malayalam was, in fact, "Delusional Disorder and Means of Prevention" (*Samshayarogavum Nivaranamargangalum*). That interpretive license had been taken in the English newspaper listing was, I would later realize, hardly accidental or in error. Rather, it foretold the flexible ways in which this psychiatric

diagnostic category would come to index moral anxieties about contemporary Kerala life over the course of the daylong program.

Through the morning and into the late afternoon, an impressive line-up of psychiatrists, psychologists, and psychiatric social workers delivered presentations to approximately 50 staff members from various state-funded community programs, the majority of them women. Envisioned as the first line of defense against a psychiatric disorder described as being rapidly on the rise in the state, these participants would be given the skills to identify and refer cases of delusional disorder from their communities to the appropriate mental health professionals. Among the day's speakers, it was Dr. Satish who was by far the best received. Much to the audience's delight, the psychologist had interspersed his PowerPoint slides on the ICD-10 criteria for the diagnosis of delusional disorder with colorful film stills from the 1983 Malayalam comedy, *Vadakkunokkiyanthram* ("The Compass").**7** In this blockbuster hit, Dineshan is a newly married and insecure husband who, succumbing to jealousy and suspicion, grows intensely controlling of his young, attractive wife. Dineshan's insecurities—rooted, we come to learn, in his short height and dark complexion—land him in a series of comical predicaments over the course of the film, including a memorable scene in which he stages an out-of-town trip so that he might spy on his wife from a hotel room across the street from their home. When Dineshan mistakes his father-in-law for his wife's lover, slapstick hilarity ensues. While light in tone, the film ends grimly: out antihero is placed in an asylum.

Dr. Satish's incorporation of the film into his presentation did more than simply entertain. Through the character of Dineshan, Dr. Satish bridged popular imaginings of paranoid behavior with the psychiatric nosology of delusional disorder. Tacking back and forth between the film and the ICD-10 criteria, his audience laughing all the while, Dr. Satish drew on examples of Dineshan's behaviors and the troubles that arise between the newlyweds to instruct his audience on the symptomatic presentation of delusional disorder. While Dineshan's antics bordered on the absurd, said Dr. Satish, they offered important lessons. After all, every husband and wife in the room could relate to Dineshan to some degree. "Am I right?" he asked, teasingly. The audience broke into laughter. Some nodded in agreement; the women around me ribbed and elbowed one another. Dr. Satish grew more animated, warning with a theatrical shake of his head that the kind of marital distrust depicted in the film—what he referred to in English as Kerala's "Othello Syndrome"—had reached epic proportions in the state.

While women's jealous nature and men's controlling tendency were realities of the sexes, said the psychologist, they become illnesses (*rogangal*) when they create mistrust between husband and wife. Dr. Satish proceeded to elaborate upon factors in Kerala life that have caused marital

relations to deteriorate: women's educational achievements, their transition to the workplace, the rise of selfish individualism, the explosion of consumerism, and the long-term separation of spouses due to migration to the Persian Gulf States.**8** Many such transformations, said the psychologist, have turned spouses into rivals, undercutting the very foundation of marriage. These changes have worsened mistrust between husband and wife, fueling the rise of delusional disorder among the population at large.

Like all of his colleagues who spoke at the workshop that day, in his hour-long presentation Dr. Satish code-switched between the English term "delusional disorder" and its Malayalam translation, *samshayarogam*. The term *samshayarogam* is derived from the words "*samshayam*," meaning "doubt" or "suspicion," and "*rogam"* meaning "illness." The word *samshayam* is used in everyday speech to convey uncertainties concerning mundane events as well as more focalized suspicions and misgivings about people and relationships. (One can "have a doubt" that it might rain later in the day; one can also "have a doubt" that one's husband is being unfaithful.) As Dr. Satish fleshed out the everyday manifestations of *samshayarogam* for his audience, he spoke of the *samshayam* of wives who, suspicious of wayward husbands, recruit private detectives to scout out the truth; the *samshayam* of Keralites more generally who, in their consumer-driven rivalry, cast doubt on the questionable means by which neighbors could afford a new car or the recent renovations to their home. He also spoke of the *samshayam* of migrant husbands who subject children born shortly after return trips home from the Gulf to DNA tests so as to rule out cuckolding.**9**Processes of linguistic translation promoted fluid register shifts between talk of delusional disorder and everyday doubt. That these register shifts are also shifts between languages suggests a specific social history, one marked by the standardized use of English diagnostic terms in the globalization of psychiatry as modernist, universal discourse (Lakoff **2006**), and by the postcolonial legacy of British English in India.

Over the course of the hour, Dr. Satish traveled outward from the narrow, denotational qualities of "delusional disorder" as psychiatric diagnostic category, to expansive, polysemous ideas about doubt in daily life. In doing so, the psychologist linked psychiatric illness to a topic on the tongues of many in Thiruvananthapuram at the time of my fieldwork—the decline of trust and social cohesion among families and within society at large. As he flexed the boundaries of "delusional disorder," Dr. Satish circulated seamlessly between the "scientific" and the moral, the individual and the social, the clinical and the popular, the precise and the vague. This was best captured in his use of the blockbuster hit *Vadakkunokkiyanthram* as a lingua franca (Mattingly **2008**), a shared language of public meaning through which he instructed his audience on the symptomology and diagnosis of delusional disorder. Through public engagements such as

this one, Dr. Satish crafted and performatively enacted his identity as a mental health professional, an identity distinguished by his ability to communicate creatively at the porous boundaries between "expert" and "lay" knowledge.

Dr. Satish's blurring of technical language and popular meaning illustrates what Hsu (**2000**) calls "styles of knowing," the situational forms of communicative competence that allow health professionals to deploy technical terminology in different ways according to audience and context. As the psychologist's expansive discussion about the *samshayangal* of daily life suggests, vagueness can be used to establish and reinforce charismatic authority (Hsu **2000**:203). This vagueness contrasts with Dr. Satish's narrow deployment of psychiatric terminology in clinical and other bureaucratic settings with professional colleagues, where the denotational qualities of these terms were typically emphasized. Different uses of the same terminology across general and professional audiences demonstrate, in other words, "the interrelation between word meaning, language use, and power relations" (Hsu **2000**:198), where professionals like Dr. Satish are typically inclined to restrict the flexibility of technical terminology in the direct company of peers. For psychologists like Dr. Satish, the stakes in doing so are arguably even greater in the company of psychiatry peers who, in Kerala as elsewhere, are generally held in higher esteem for being more "scientific" in their training, knowledge, and practice.

The flexible use of diagnostic terminology constructs other relationships of power. To the extent that Dr. Satish linked delusional disorder to the problems and challenges of everyday marital life, he did so by drawing on and reinforcing popular gender stereotypes. In weaving together a broader narrative about the dissolution of spousal relations in Kerala today, Dr. Satish joked, for example, about the "natures" (*swabhavangal*) of jealous wives and controlling husbands. In the next section, I continue my examination of mental health professionals' discourse in the public sphere to explore how their rhetorical strategies may work to reproduce ideologies of social difference. Anecdotes, jokes, and cautionary tales built on popular stereotypes may offer a facile and visceral means for mental health professionals to engage popular audiences, but they do so in ways that shore up essentialist notions and hierarchies of gender, class, community, and caste.

Communicability and Power: Constructing Social Difference in the Public Sphere

Briggs has put forth the notion of "communicability" to address the "power of ideologies of communication in producing subjectivities, organizing them hierarchically, and recruiting people to occupy them" (2005:269). Examining public accounts about health, he uses this notion of communicability to recognize the "productive capacity" of social processes of communication to

sort out and stratify groups, locating individuals and populations in raced, classed, and gendered hierarchies. As an example, Briggs (**2003**) has demonstrated how during the 1992–1993 cholera outbreak in the Orinoco Delta of eastern Venezuela, scientists, officials, and politicians connected representations of infectious diseases with images of "indigenous culture" and poverty. The disease of cholera became racialized in ways that shaped the actions—and inactions—of public health officials, physicians, and journalists.

Discursive activity among mental health professionals in the Kerala public sphere also exhibits a productive capacity to sort people into social hierarchies. In talking about the prevalence of certain psychiatric illnesses, for example, it was not unusual for psychologists and psychiatrists to stratify, label, and sometimes pathologize individuals and populations. Talk about "adjustment disorder," used always in the English, was particularly revealing in this respect. Like delusional disorder, adjustment disorder was similarly identified by mental health professionals I spoke with as a growing problem attributable to recent socioeconomic changes in the state. These concerns appear to be supported by epidemiological data, and during fieldwork, psychologists and psychiatrists spoke extensively about adjustment disorder in our interviews and in public settings.**10** The ubiquity of such talk, however, should not be taken as a straightforward reflection of epidemiological prevalence. It also reflects the metaphorical flexibility of the term "adjustment disorder," a term which mental health professionals used polysemously in public contexts to articulate moral concerns about Kerala life. Perhaps more than any other psychiatric diagnostic term, talk of "adjustment disorder" in the discursive activity of mental health professionals in the public sphere lent itself to extensive social commentary about contemporary transformations, and about the ability or failure of different bodies to flexibly adapt.

Structural Adjustments

Like many of his colleagues, Dr. Nair used the diagnostic term "adjustment disorder" in public settings to describe pathological reactions to the stressors he associated with contemporary Kerala life. At a lecture on mental health at a prestigious private college in the city, the psychologist explained the rising incidence of adjustment disorder to an audience of about a hundred students. Speaking in English, Dr. Nair described for us how shifts in caste and class hierarchies in Kerala have become a "major stressor" creating much "stress and tension" in people's lives.**11** Take, for example, said Dr. Nair, the upward mobility of historically marginalized caste and other minority groups who were once in "a poor state." State caste reforms and migration to the Persian Gulf have "uplifted" these groups, Dr. Nair told the group, with some rising from poverty to wealth in the span of a single generation.

“This rapid social change has created major stressors for many us,” he continued. Consider, he said, the encounters between people who, once segregated by strict caste regulations, must now share the same physical spaces of daily living. It is when people fail to adapt to these new encounters, warned Dr. Nair, that they develop “adjustment problems.” He described for us the following scenario:

> Let's suppose I was having a handsome salary. Suddenly, I am unable to work. I was making thirty thousand [rupees] every month and suddenly my income comes down to ten thousand. My style used to be going for coffee at a five-star restaurant. Now I can only afford coffee at a three-star restaurant and next to me is a taxi driver. He is sitting there, drinking his coffee with a runny nose, wiping it with his sleeve and the back of his hand [drags his hand across his face and shakes it at his side]. [Audience laughter] If I were at the five-star restaurant, I would have gestured to the waiter to come with a soft paper tissue [delicately dabs the corner of his mouth with an imaginary napkin]. Instead, this driver next to me, he's sweating and wiping his nose! [Audience laughter] And even more, this driver is going back home in a fancy car he's never had before. He leans to spit out the window and doesn't even realize that there's a piece of glass there!

By Dr. Nair's account, new interactions create stressors for all parties involved. “Stressed” is the taxi driver, explicitly coded as upwardly mobile and lower caste, who can afford and yet lacks the sophistication for a fancy car; “stressed,” too, is Dr. Nair who endures unfamiliar and unsettling somatic encounters having fallen from economic grace as an upper-caste individual of the “old” elite. Such “stressful” encounters, argued the psychologist, have fueled the rise of adjustment disorder in the state.

Social histories in the region are important to understanding the particular significance of the spatial and somatic nature of Dr. Nair's account of adjustment disorder. As scholars have documented, caste restrictions in the region once extended to many domains of bodily comportment and mobility. In addition to regulations ranging from distinctions in clothing and jewelry to the subtleties of how the hair was tied, forms of caste recognition and ritual purity were also maintained through restrictions governing physical mobility and separation in public spaces (Jeffrey **1992**; Rajeevan **1999**). The distances which different castes were expected to keep were stipulated in state census reports as recently as 1911 (Rajeevan **1999**:48). Some

scholars suggest that intensive consumption among upwardly mobile communities in recent decades may be read as a kind of "protest" against the strict sartorial codes of Kerala's recent past (Osella and Osella **1999**; Saradamoni **1994**).

Rather than take Dr. Nair's words to be transparent reflections of the upwardly mobile, however, I am instead interested in what they reveal about the ways discursive activity among mental health professionals in the public sphere can work to sort, label, and stratify. Characteristic of its anecdotal form, Dr. Nair's explanation of adjustment disorder is staged as a single episode between two actors or types of actors. This is a morality play in which "proper" and "improper" behaviors unfold around a particular offense and its resulting tensions (Bauman **1986**:63). Moral qualities are suspended in bodily disposition as dramatized by Dr. Nair's hyperbolic gestures: in the jarring contrast, for example, between the psychologist's refined use of a napkin and his accidental companion's improvised use of a shirtsleeve.

At the privately funded college where Dr. Nair spoke that morning, and where the majority of students hail from the upper-class and social elite, it is perhaps little surprise that the psychologist's tale of adjustment disorder generated knee-slapping laughter. In constructing an abject lower-caste character to be derided and laughed at—one who is wealthy yet clumsy and unsophisticated—the psychologist played on conservative ideas about class/caste difference before a receptive audience. He also spoke from his social location as an educated, upper-caste professional, voicing elite anxieties at a time when new values, practices, and upwardly mobile communities are entering a diversifying and widening middle-class social field in Kerala.**12** Indeed, the psychologist's anecdote seems to suggest that both the upwardly mobile *and* the downwardly mobile are vulnerable to adjustment disorder in these changing times. Yet it was framed and delivered in a manner that targeted the former as the subject to be pathologized, winning Dr. Nair the laughter and applause of his audience.

The Virtues of Female Adjustability

Other mental health professionals drew on the term "adjustment disorder" to comment on the gendered virtues of adjustability. Psychiatrist Dr. Jaya appeared one afternoon on the weekly television program, *Veethamma* ("Housewife"), to speak on the issue of women's mental health. Before a live studio audience, Dr. Jaya explained how rising adjustment disorder among young women has triggered many of the problems plaguing Kerala family life today. Girls these days, said Dr. Jaya, experience great "*tension*" because they are unable to adjust to the circumstances and expectations placed on them after marriage. As the program host and Dr. Jaya discussed this

development, both spoke in Malayalam but used the verb “to adjust” in the English to account for young women's difficulties responding to the demands of marital life:

> Host: So it seems that today, *adjustment disorder* arises because youth are incapable of *adjusting* with others. Especially after our girls get married, it is our *culture* for the girl to go to the boy's home. In the boy's house, his mother, his relatives are all there. In a sense, they [girls] are unable to *adjust*. It is the mother who should teach the girls to *adjust* with others. When girls cannot *adjust* they *divorce* and move on. This is a matter that women in particular need to understand. We need awareness programs for this. Through awareness, these girls can be made to understand these issues early on.
>
> Dr. Jaya: Back in the olden days, girls of marriageable age had the ability to do many things. But today, girls of marriageable age don't know how to do anything well. When they go to a different home [their husband's home] after marriage, today's girls don't know how to live there. Many of those coming to us [in the clinic] are such girls. When mothers in today's *nuclear families* do not give their children necessary guidance, most certainly those children will not be able to *adjust*. This is the manner in which those coming to us are having all kinds of family problems, marital problems, and sexual problems.

Here, Dr. Jaya flexed the boundaries of the term “adjustment disorder” to explain issues of popular concern raised by the show's host: namely, divorce and marital strife. By the psychiatrist's description, the inability of young women to “adjust” after marriage manifests in the middle-class household as the inability to execute everyday practical tasks: “They don't even know how to crack open a coconut!” lamented Dr. Jaya to the laughter of the audience, alluding to a skill foundational to the running of a kitchen in the so-called Land of the Coconut. But it also manifests as poor psychological and emotional “adjustability” among young married women, leading to a full range of “family, marital, and sexual problems.” What Dr. Jaya described then is a particular kind of gendered failure.**13** Viewed in these terms, adjustment disorder among married women is not a sign of suffering demanding care so much as it is a threat to a class-specific form of the reproductive household. It is also a marker of intergenerational irresponsibility necessitating reform, for it is mothers, Dr. Jaya made clear, who

are ultimately at fault for not providing daughters adequate guidance before marriage. By staging the rise of adjustment disorder in the spaces and relationships of the domestic everyday, Dr. Jaya spoke of marriage, parenting, and pathology in ways that trafficked between technical language, social knowledge, and popular discourse. In doing so, the psychiatrist shored up classed and gendered moralities through the lens of mental illness.

The "Quacks" among Us: Contestations of Mental Health Professionalism

The topic of visibility in the public sphere generated intense debate among colleagues about the definition of mental health professionalism. While some like Dr. Jaya and Dr. Nair garnered social prestige and enacted a felt ethical obligation through public engagements, other mental health professionals viewed such activities with deep suspicion. Dr. Aneesh was one such clinician who expressed skepticism over the intentions of his "media-savvy" peers. If these individuals were genuinely concerned about providing care to those in need, the psychologist explained to me one afternoon in his office, they would not squander their efforts on nonclinical distractions. By Dr. Aneesh's assessment, in a mental health care sector already strapped for time and resources, such activities were a misdirected pursuit for "self-publicity." Criticisms of this sort reflect competing orientations in the ethical sensibilities of mental health professionals. If Dr. Lekha upheld public engagement as a higher calling in service to the people, Dr. Aneesh by contrast dismissed it as nonclinical recreation that neglected one's cardinal charge: to heal. In the eyes of critics like Dr. Aneesh, colleagues in the limelight had traded professional respectability and the call of duty for popular celebrity, all the while making the work of "real" experts struggling on the frontlines of care ever more challenging.

In addition to contesting the value of public visibility, some mental health professionals accused peers of quackery. As others have argued, discourses of quackery can reveal local debates about the genuineness and falseness of particular practitioners (Pigg **1996**) and are often marked by "conflicting rhetorics of authenticity" (Langford **1999**:24). Early on in my fieldwork, several clinicians sternly warned me against consorting with the countless "quacks" (in English) visible in the media. When I asked one government-employed psychiatrist to explain what he meant by "quacks," he told me that these were individuals who "assume the title of 'Dr.' despite having only completed a bachelor's degree in psychology." In another scathing attack on the "unqualified counselors and other quacks" offering services in Kerala, psychologist Dr. Prabhu criticized the "unscientific methods of 99 percent of the so-called psychologists" working in Kerala. These were the kind of people, he claimed, who held English or literature degrees and simply "like to tell stories." In delegitimizing these individuals, Dr. Prabhu constructed himself

by contrast as a "scientific" practitioner dedicated to clinical work and research. In "telling stories," he went on to argue, such people gave the public a false and misleading impression of mental health professionals and their day-to-day labors.

Allegations of quackery were a particularly rich discourse around the subject of public visibility. As elsewhere, individuals who borrow signs and practices of institutional legitimacy and expertise from those already in positions of authority in the field of mental health care do exist in Kerala.**14** Consider as an example the lawyer I met who refashioned himself as a family therapist advertising "counseling and divorce services" out of his small rented office. Yet, accusations of quackery were more striking for the fact that critics—nearly all of whom were quick to name names without prompting—also placed in this "illegitimate" category their publicly visible, credentialed professional peers: those with educational and institutional training backgrounds similar to their own, who rubbed elbows at the same conferences, who sometimes worked alongside them in the same clinical spaces, but who by contrast chose to engage the public sphere. Ultimately, such accusations did not expose peers for lacking the "right" degrees or training so much as they revealed ideological tensions within the mental health care community regarding the proper boundaries of "public" talk and "clinical" talk, and thus of clinical professionalism.

In censuring peers for seeking public visibility to the detriment of the profession, Dr. Prabhu argued that such endeavors misled the public about what experts like himself "really" do. But he also implied that "telling stories" erodes territorial claims, diluting the power of clinical registers of speech to mark specialized knowledge and membership. For much as Agha (**2004**:35) notes of the wide circulation of military terminology like *collateral damage*and *surgical strike* as a result of media coverage of recent wars, "fragmentary use" of psychiatric terms like *adjustment disorder* and *samshayarogam* acquaints the public with the existence of clinical registers. The circulation of a smattering of psychiatric terms in the public sphere gives the public a passing familiarity with terms delinked from the strict symptomatic and diagnostic criteria they index in clinical and institutional spaces. For critics of publicly visible peers, erosion of the differentiation between popular and clinical registers of speech compromises the exclusivity of the latter as the unique and proper domain of mental health experts—a concern for those already conscientious of their relative status in the wider world of allopathic health care.**15** Competing ideas and practices regarding the exclusivity or openness of clinical registers of speech thus highlight different models of register value within a peer community. In this fiercely contested terrain, allegations of quackery could serve as a gatekeeping tactic in the institutional regulation of professional peers (Goffman **1961**), drawing lines in the sand to demarcate the legitimate spaces,

objectives, audiences, and registers of discursive activity in the "true" practice of mental health care.

Discussion and Conclusion

Scholars of medical discourse have documented the ways health professionals switch speech genres and registers in accordance with audience and context (Burson-Tolpin **1989**; Coombs et al. **1993**; Hsu **2000**; Mattingly **1998**). While the vast majority of this literature focuses on clinical and other institutional settings, case studies presented here have drawn our attention instead to the rhetorical and performative strategies of health professionals in the public sphere. In Kerala, interactions with general audiences offer a compelling site to examine how some mental health experts come to understand and shape their professional identities, ethics, and values for the public and for themselves. They also illustrate the contested, contradictory, and ideological ways these professionals communicate at the intersection of technical language, social knowledge, and popular meaning about mental illness as they endeavor to render their expertise in the everyday terms they believe to be most relevant to the lives, problems, and concerns of the public.

Taken together, these case studies demonstrate how competence in deploying and shifting between clinical and popular speech registers and genres is "an indispensible resource in social interaction" (Agha **2004**:23) for those mental health professionals who seek to fashion specific personae in the public sphere. This competence is neither an essence nor quality that inheres in the individual so much as it is produced interpersonally and contextually. Dr. Nair's ability to evoke the laughter of college students did not automatically unfold from his vibrant personality and rhetorical flair, as compelling and unique as both in fact are; it rested more fundamentally on the symbolic power and "styles of knowing" (Hsu **2000**) by which he was able to separate the "maladjusted" from the "adjusted" in a manner socially legible to his elite audience. Like his other colleagues in the public sphere, Dr. Nair used symbolic resources and competence in multiple speech registers to create connections and consensus with his audiences. His facility with these registers enacted his authority as an upper-caste, educated professional, and demonstrated his ability to "read" and respond to situated, interactional contexts. Whether speaking about the problems of young women on a television program or addressing marital problems before a female audience, in the public sphere Dr. Jaya and Dr. Satish displayed similar competence in crafting the content and tenor of their discourse. As we have seen from these case studies, some clinicians did so by sorting out, labeling, and pathologizing individuals and populations while masking expert discourse as innocently entertaining and informative.

These compelling figures also illuminate a striking contradiction at the heart of the discursive activity of mental health professionals in the Kerala public sphere. In spite of the heightened visibility of these experts, the general public—including the urban, educated middle-class—continues to have a vague understanding of these experts' technical domains of training and practice. Why do these nebulous perceptions persist despite the rising prominence of mental health professionals in the public sphere? While there are many factors at play, I suggest that the answer lies in part in the ways mental health professionals expand the domain and relevance of their knowledge as they communicate with popular audiences. In speaking of psychiatric terminology in the terms of the everyday vernacular of marital problems, family relations, class/caste tensions, and human passions, the reach of "psy" knowledge appears effusive and boundless. Yet, precisely because of this, it appears everywhere and nowhere at once. Since those mental health professionals who actively engage the public sphere typically assert little of what is distinctive about their knowledge, training, and practice in their strategies of identity making, communicating loosely between technical terminology and social knowledge ironically erodes the very edifice of "expertise" on which professionalism stands. This creates a paradoxical tension in which these mental health professionals fashion themselves as critical public interlocutors by making ever more vague what it is that they "actually" do.

This dual process of visibility and obfuscation can in turn provoke reprobation among more conservative peers. Debates among colleagues presented here reveal contestations over the value of discursive activity in the public sphere from the perspective of practitioners. Dr. Aneesh, whose critique of his "media-savvy" peers we encountered earlier, offered reflections about his career that are important to consider. Between receiving clients in his office one afternoon, the psychologist explained that mental health professionals reach "the people" through their clinical work, not by parading themselves in the media limelight. "The healing that happens between clinician and client is like nothing else," he told me. "It creates a link between souls." He pointed to the screensaver image of Michelangelo's *The Creation of Adam* dancing across his laptop. In a way, said Dr. Aneesh, the near-touching hands of God and Adam perfectly capture the relationship between psychologist and client: the psychologist reaches out to create a "bond of life and wisdom" through talk therapy. For Dr. Aneesh, this was the true meaning of "reaching out to the people."

Dr. Aneesh's image of the therapeutic endeavor offers a poignant counterpoint to the forms of public engagement valued by the mental health professionals discussed here. It underscores the different standards of evaluation and prestige, and competing notions of professional values and ethics, that emerge in experts' understandings of themselves as they navigate ideas, practices,

and spaces of mental health professionalism. But even among those who avidly embrace a prominent presence in the public sphere, motivations are diverse. For Dr. Lekha, “reaching out to the people” through public lectures and guest appearances is an ethical obligation on par with her clinical work. For others like Dr. Satish, entertaining and connecting with audiences brought immense personal satisfaction and pleasure. For Dr. Nair, visibility in the public sphere has brought social prestige and widened his client base in a direct way, as attested to by the new patients who arrived at his office on a regular basis with folded copies of his magazine articles in their pockets. Structural constraints, felt obligations, economic motivations, desire for social prestige, and simple enjoyment variously animate these mental health professionals’ engagements in the public sphere. All are important to understanding how these dynamic individuals seek to define what distinguishes the “professional” professional.

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