The Register of "Complaint":

Psychiatric Diagnosis and the Discourse of Grievance in the South Indian Mental Health Encounter

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Abstract

In the language of the medical file, "complaint" refers to the symptoms and ailments reported by the patient. In this article, I draw on ethnographic fieldwork conducted between 2004 and 2007 in the mental healthcare setting in South India to argue that the typology of "complaint" and the dialogic exchanges involved in its production mark a far wider catchment area for the allegations and grievances that circulate between patient, kin, clinician, and observing anthropologist. I propose the notion of the register of complaint as a hermeneutic for grappling with the emotionally charged, interactional processes of accusation, arbitration, and reportage that drive clinical modes of inquiry and evaluation in the South Indian mental health encounter. Ethnographic case studies suggest that grievance and accusation command both a vital directive force and evidentiary role in the social, moral, and emotional work of psychiatric diagnosis.

Keywords: complaint, diagnosis, kinship and family, emotion, psychiatry, South India

An Outpouring of "Complaint"

On a December morning in 2005, Dr. Rajendran and I are settling in for three hours of outpatient consultations in the psychology department of Trinity Hospital in Thiruvananthapuram, the capital of the South Indian state of Kerala.[1] After an exchange of his usual morning pleasantries, the psychologist launches into the queue of patients for the day, calling out the name on the folder that tops the cresting pile on his desk. A middle-aged man and two women promptly enter through the curtained doorway. A third woman, her frail body swallowed up by a formless housedress, trails behind them. Shuffling in silently, she hesitates a few moments before taking a seat in the far corner of the room. Brief introductions reveal that the three siblings have brought their younger sister in for consultation, and I watch as Dr. Rajendran carefully notes their names and ages on the clean record sheet in front of him under the section labeled "Informants." Nodding slightly toward the silent woman in the corner whose name, we are told by one sister, is Nithya, Dr. Rajendran asks the siblings what the problem is. His pen hovers over the patient record where he has meticulously written and underlined the English word "complaints."

The eldest sister begins. "She says she can't do the housework." The family's concerns for the shifts in Nithya's behavior, evident over the last several weeks, are numerous. They coalesce around the disruptions they have caused to the rhythms of the household: "She sleeps all the time;""She neglects the children;""The kitchen is a mess." Some of the "complaints" aired by the siblings extend from a mixture of concern, discomfort, and mild irritation in the face of their sister's disquieting signs of distress. "She always cries over little things," notes the brother. "Sometimes she says she is going to commit suicide and we don't know what to do." The psychologist has opened a tap of discontents, accusations, and grievances—indeed, complaints—about neglected domestic responsibilities, and thus of Nithya's moral and physical failings as mother and keeper of the home. All the while, Nithya looks silently on her folded hands.

The word "complaint" has multiple valences. In the language of the patient file and the health encounter, "complaint" conventionally refers to the symptoms and ailments judiciously interpreted and recorded by the clinician on the basis of patient testimony. Yet, in my observations of the social and moral work of psychiatric diagnosis in the mental health encounter in Thiruvananthapuram, the typology of "complaint" and the dialogic interactions involved in its production marked a far wider catchment area for the grievances and morally weighted accusations that circulate among patient, kin, and clinician. Because patients, especially women, are typically accompanied and narratively positioned by their family members in the mental health encounter in Kerala,[2] the "complaints" through which the clinician must navigate often have little to do with patient symptoms. Speaking to a shared moral condition stretched across

kin and social relations, complaints, broadly understood, are evoked and dramatized in the expressions of concern, frustration, disappointment, and even cynicism, of differently invested and differently empowered agents interacting in and contributing to the work of psychiatric diagnosis.

In this article, I use the *register of complaint* as a hermeneutic for grappling with the emotionally charged atmosphere and interactional processes of accusation and grievance that are both engendered by and produce the institutional mental health encounter in South India. Borrowing from **Saris's (1995**:42) concept of the institution as a "structure (physical, conceptual, or both) that 'sets up' discourse and practice," I engage the register of complaint as a coupling between a mode of discourse and a regime of technologies that enables particular conditions of being in the South Indian clinical space (**Foucault 1990**). This register identifies a genre of speech: characterized by allegations, retribution, and grievance, it marks the confluence of moral and bodily discontents circulating among patient, kin, and clinician. This "register" refers at the same time to the bureaucratic technologies of record keeping that structure both the solicitation of kin and patient testimony, and the material production of the medical paper file. It points, then, to the overlapping processes of accusation, fault finding, arbitration, and reportage that place psychiatric diagnosis within what **Buchbinder (2010**:117) calls a "retributive framework," a framework by which "medical institutions, like legal ones, can serve as key instruments of justice."

The register of complaint highlights one modality through which the performance of feeling is made to flourish in the South Indian mental health encounter. Forced disclosures, charged accusations, accidental confessions, and startling revelations precipitate among family members that may not otherwise be articulated but in this space of clinical testimony. Recognized to be an important speech genre of the health encounter in various cultural and institutional contexts (**Buchbinder 2010**; **Wilce 1995, 1997, 1998**), *complaint* has its particular location within Indian biomedical psychiatry and its "relational" forms of knowledge and practice (**Pinto 2011**). The psychiatric setting in India—where family members contribute equally if not more than the patient in the production of the case history and to decisions concerning treatment—is a crucial site where illness as transpersonal object is produced through the enactment of domesticity and kinship (**Addlakha 2008**; **Cohen 1998**; **Das and Addlakha 2001**; **Davar 1999**; **Marrow 2008**; **Nunley 1998**; **Pinto 2009, 2011**). Indeed, kinship relations themselves often serve as a primary object of clinical evaluation. **Sarah Pinto**(2011:393), for example, has recently offered a beautifully nuanced analysis of North Indian psychiatry as "relational medicine," whose clinical process mends and at times ruptures emotional ties in ways that, rather than simply reproducing

normative ideologies of the family, "grapples with the gendered fallout of kinship." As a heuristic, the register of complaint takes inspiration from and builds on these explorations into the relational work of Indian psychiatry to describe how kinship dramas are precipitated by clinical modes of inquiry and evaluation. More than bringing kinship into the clinic, public expressions of disappointment, injury, or harm by wives against husbands and sons against fathers reveal and enact the possibilities and limits to domestic belonging, while serving as the very substance through which clinicians assess and diagnose bodies and relations.

The particular prominence of the register of complaint in the mental health encounter in Kerala may also be situated in light of recent developments in the state. As Kerala continues to report some of the highest rates of individual and family suicide in the nation, suicide has emerged as a lightning rod for moral commentary about individual and social pathology.[3] During my fieldwork, for example, behavior construed as "suicidal" in the clinic commonly generated editorializing commentary by clinicians—often in front of patients themselves—about the demise of quality relationships between parents and children, mistrust between husbands and wives, and the expansion of consumerism in the state, transformations associated in part with the high rates of labor migration from Kerala to the Persian Gulf since the 1970s.[4] Suicide may also speak and be made to speak more directly to grievances between kin. Female suicidal behavior in particular can prompt pointed accusations against kin that overlap with legal domains: because India's so-called "dowry death laws" are structured to implicate husbands and their relatives in dowry-related crimes or domestic abuse in cases of female suicide, women's self-injury may be read as intimately linked to, if not synonymous with, violence in the home (**Waters 1999**).[5] The function and prominence of the register of complaint in the mental health encounter in Kerala is therefore inseparable from entanglements between legal and medical techniques of investigation in the clinic, and from suicide's power to generate personal and generalized forms of accusation, complaint, and grievance.

Performing Feeling in/for the Clinic

Although complaints are an essential speech genre through which family dramas unfold in the South Indian mental health encounter, these exchanges are more than the dialogic medium through which illness as transpersonal object is coconstructed, and kinship relations are enacted. The accounts that follow describe the ways complaints levied by and against patients and family members are made to serve as the very evidence from which clinical judgment and diagnosis unfold.

The register of complaint highlights, in other words, what Allan **Young (1995**) has identified as the intimate intertwining of language, institutional ideology, and psychiatry's modes of inquiry and knowledge.[6] In the mental healthcare setting in Kerala, a conspicuous feedback loop links discourse with diagnosis: the very performances of feeling through which accusing and accused subjects are brought into being as conditions of legibility in the clinic are then folded into the diagnostic process to be evaluated and read as possible symptomatic presentations of pathological behavior. **Pinto (2011**:378) observes that in North Indian psychiatry, clinicians elicit demonstrations of emotion from their clients that are then read "as signs of underlying biochemistries and affective disorder." Emotions expressed, for instance, in the context of marital relations serve as a medium for reading "patients' lives for signs of illness" (**Pinto 2011**:378). In Kerala, psychiatrists, psychologists, and social workers similarly elicited, listened for, evaluated, and at times directly participated in the circulation of complaints among family members. These negotiations often refracted and consolidated power relations between clinician and patient, and among patients and their kin. For example, while the complaints of a male guardian might be taken as rightful grievance by the clinician, those of a young wife against her in-laws may be captured as signs and symptoms of "maladjustment." Evaluations concerning the legitimacy or illegitimacy of complaint reveal complex imbrications, as we shall see, between local gendered and classed moralities, and the broader social currents shaping contemporary Kerala life, including transnational migration.

This is not to argue that the register of complaint operates straightforwardly to reproduce ideological structures of the family, or power asymmetries between clinician and patient. I suggest instead that the register of complaint attunes us to the mental health encounter as an emotional force field where diagnosis and clinical judgment are shaped in crucial ways by the ebbs and flows of intensities between and among bodies, sometimes unpredictably so. Patient, kin, and clinician respond to one another and to unfolding circumstances as an interactive, embodied, and emotionally charged process. The register of complaint therefore highlights the ways power relations in the clinic are not fixed or pregiven but, rather, are produced through improvisational moments of lived interaction from which alignments and assumptions unfold and may shift (**Katz and Alegría 2009**; **Katz and Shotter 1996**). Complaints can alter directions of interrogation and vectors of blame in precipitous ways as statements are elicited, retracted, and revised in the shifts and turns of conversational momentum. Charges made against family members may be deflected, only to rebound and adhere onto other bodies; allegations are variably confirmed by or ambiguously sidestepped with silence. Complaints in the clinic also include the uncensored asides and flashes of frustration or cynicism of clinicians themselves, uttered under a fugitive breath or as a commiserating gesture with the observing anthropologist at

moments of clinical impasse. Recognizing that third-party observers can shape the ways conversational sequences are directed in the research setting, the case studies to follow demonstrate how the anthropologist can be a principal and at times conspiring figure, however unintended, in the ambit through which complaint circulates and targets patients and kin.[7]

The register of complaint also highlights the importance of cultural ideologies of sociability and gender to the social, moral, and emotional work of diagnosis in the South Indian mental health setting. Within the prolific literature that has examined discourse in the medical encounter, minimal sustained ethnographic attention has been given to the productive silences, stops and starts, accidental confessions, staccato outbursts, and indiscrete slips that interrupt, animate, and are constitutive of discourse. Interruption, broken or undecided speech, and silence, for example, may offer insight into how locally relevant social ideologies and relations are enacted through modes of communicative deference and time use in institutional contexts (**Hymes 1986**:62; see also **Irish and Hall 1995**; **Li et al. 2004**; **Menz and Al-Roubaie 2008**; **Ohtaki et al. 2003**; **Wilce 1995, 1998**). The register of complaint expands on these concerns, focusing ethnographic attention on the waxing and waning of conversational momentum, and the intentions and affects imputed to interruptions, silences, and deferrals. In the Kerala context, tactical silences, hesitations, and deferred or fragmented speech can be socially productive ways for women to "do the interaction" (**Maynard 1991**:457), enabling them to redirect conversational flows with silence, to imply without asserting, or to more effectively "speak" through the proxy voice of an elder or male family member. A woman brought into the clinic by her family who is felt to be overly assertive in her complaints may, by contrast, find her utterances dismissed as histrionic or manipulative. If symmetry has often served, either implicitly or explicitly, as the ideal relation to be aspired to in the medical encounter, the synergies between complaint discourse and psychiatric diagnosis suggest that there are no easy equations to be drawn between voice, silence, resistance, and agency in the mental healthcare setting in South India.

Sites and Methodologies

The case studies and analyses presented here draw on 25 months of ethnographic fieldwork conducted between 2004 and 2007 in Thiruvananthapuram.[8] Participant-observation was conducted during outpatient consultations in the psychiatry department of the government-funded Central Hospital, and in the psychology department of the privately funded Trinity Hospital. The two contexts involve vastly different patient populations and regimes of treatment. At Central Hospital, 60 or more patients, most of them from socioeconomically disadvantaged backgrounds, are handled with sink-or-swim efficiency by psychiatrists, clinical psychologists, and social workers. Many of the few minutes of consultation time allotted to each case are spent

reviewing the records patients bring to the hospital carefully archived in folded plastic bags. Every morning, clients and their family members quickly fill up the waiting room. It is not uncommon for first-time consults to leave with four or five prescriptions, one or two of which, a senior social worker explained to me, are intended to counter the side effects of the others and increase the likelihood of follow-up.[9] There is concerned talk throughout the day of patient noncompliance.

By contrast, there are no psychiatrists on permanent staff at Trinity Hospital. Clients and their family sit on chairs and benches in a neat queue that snakes along a well-lit, airy, and newly renovated hallway. Fewer clients are received by the psychologists, and more time can be dedicated to each case. While treatment regimes at Central Hospital are decidedly pharmacological, the clients who come to Trinity encounter a wider range of treatment options. At Trinity, the cot in the far corner is used for meditation and relaxation therapy, while the one in the entranceway of Central Hospital's psychiatry department is used as a holding station for patients who come in suffering from drug withdrawal or who are inebriated.

For the majority of consultations observed, patient interviews were hand-recorded, with verbatim statements indicated with quotations. In cases where I came to know patients and their families after repeated consultations and they expressed willingness, consultations were tape-recorded and transcribed. Additionally, I conducted in-depth, often multiple interviews with over 30 psychiatrists, psychologists, social workers, and counselors employed at these and several other clinical sites around the city. Those interviewed were sampled heterogeneously to include as many views as possible. Data was coded on the basis of emergent themes and patterns that linked across types of data and with theoretical frameworks.

The three case studies to follow have been selected for the ways they usefully illuminate different aspects of complaint and grievance in the mental health encounter. I wish to make clear from the outset that by highlighting the shifting and provisional process of diagnosis, my intention is in no way for these accounts to be taken as evidence of poor or "bad" clinical practice. Clinicians' reasons, desires, and means for meeting client and family expectations are complex and shaped by the political economic and social field of psychiatric care in India (**Ecks 2009**; **Nunley 1996, 1998**).[10] Buffeted by time and resource constraints, in the public sector in particular clinicians often merge diagnosis with therapeutic intervention. In the course of soliciting patient history to make a diagnosis, clinicians seek to deliver aggrieved family members to a working domestic order by sorting through, arbitrating, mending, and realigning relations with words of reproof as much as words of encouragement. Some clinicians expressed pressure to align themselves with elder males able to ensure adherence to the treatment regimes

that might bring about the powerful symptomatic changes families are seeking. I raise these issues not to explain away abuses of power or exploitation, but only to suggest that the complexities to the moral and social work of diagnosis are obscured by conversations limited to adherence to "scientific" practice. Ultimately, my objective is not to assess these clinicians as individual practitioners—something I am neither qualified nor intending to do—but, rather, to lay bare the social processes, power relations, and material exigencies that shape the work of diagnosis.

The Legitimacy of Complaint

Let's begin by revisiting that December morning when Nithya was brought in for consultation by her brother and sisters. As Dr. Rajendran solicited information from her family members, Nithya, we may recall, remained silent while her siblings unloaded a string of complaints and concerns regarding their younger sister's recent mood swings and her failure to fulfill her household duties. Only once in this chorus of complaint does an explanation other than "laziness" surface to account for Nithya's condition. In passing, Nithya's brother mentions that she often cries over her husband's absence. Dr. Rajendran makes short work of this comment, uncovering details about how Nithya's husband, Sabu, has spent the last four years in the Persian Gulf working as a private driver for an expatriate family from Kerala. The clinician directs his attention to Nithya. "Is this true?" he asks. "Are these problems about your husband?"

For the first time, Nithya awakens to the ongoing conversations wrapping around her like so many layers. She responds with an affirmative nod. She is lonely, misses her husband, and finds it difficult to raise three sons without him, she confesses. Like many so-called "Gulf wives" in Kerala, Nithya must manage day-to-day household affairs and care for children while her husband remains abroad for several years at a time, periods punctuated by occasional but brief visits home.[11] Nithya's own complaints dovetail between states of medical and moral commentary, where her self-identified "depression," as she called it in English, and her attendant somatic complaints cannot be disentangled from the complaints she articulates as the wife of an absent husband. Three sons, she adds, should not have to grow up without their father. Although she says she is grateful for what her husband has done for the family, she wishes he could find employment in Kerala and asserts that Sabu is not aware of how difficult his work abroad has been on her. We soon learn that Sabu is due to return to Kerala in a week's time, having heard about his wife's change in behavior from his in-laws. Dr. Rajendran invites Nithya to return with her husband as soon as he arrives to further flesh out the circumstances of her condition at home.

Some days later, a compact and carefully dressed man walks into Dr. Rajendran's office. Nithya is asked to sit out in the hallway waiting area as the men conference alone behind closed doors. I listen as the two discuss little about Nithya and more about Sabu's work in the Gulf: Does he enjoy living abroad? What is the weather like in Dubai this time of year? Conversation is light and they laugh easily. It seems more the catching-up between two friends than an inquiry into patient history. Dr. Rajendran suspends this conversation a moment to briefly ask Sabu about his wife. Sabu conjectures that Nithya's difficulties may be linked to some antagonistic behavior, jealously motivated, by Nithya's eldest sister, but the psychologist quickly dismisses this, declaring quite matter-of-factly that all siblings seemed perfectly caring and concerned when they brought their sister in for consultation the previous week. When Nithya is finally called into the office, Dr. Rajendran chides her gently: "You have a transparent, hard-working, and loving husband. Your children study well. What is the problem? You should be happy!" The clinician then directs his comments toward Nithya's siblings and husband, all of whom have convened this morning and now stand around the patient. The problem, Dr. Rajendran explains, is that the young woman is inclined to "selective perception," as he describes it in English, focusing only on the negative aspects of her life, rather than appreciating the positive. Rather than getting hung up on the inconveniences of Sabu's employment abroad, the psychologist tells Nithya, she should learn to be grateful for the things she has—the things that, in the clinician's appraisal, should ensure any good wife's contentment.

Complaint is a moral and moralizing state. As a complaint *to* someone, it may be an appeal for another to redress, rectify, or to simply bear witness. But if complaint is a means of moral claims-making, Nithya's case demonstrates that complaints are not equally valued in the clinical encounter—some are esteemed as legitimate, while others are dismissed as inappropriate pretension. Dr. Rajendran ultimately arrived at a diagnosis of adjustment disorder on the basis of Nithya's failure to adapt to the circumstances of a Gulf wife. That Nithya furthermore "selects" to emphasize only the negative indicated, by Dr. Rajendran's assessment, her responsibility in perpetuating her own condition. Here, *maladjustment* is evaluated against normative presumptions about what *ought* to bring a good wife consummate fulfillment: smart children, a hard-working husband, a comfortable middle-class life, and family concerned enough to seek her treatment. Nithya's misgivings and the challenges she faces as the wife of a migrant—her loneliness, and the difficulties of raising children and running a household in her husband's absence—were thus deemed unreasonable, delegitimized by the clinician and her family.

Dr. Rajendran's assessment of the legitimacy of the young wife's complaints was bound up in gendered valuations of women's adjustability in this context. Laura **Ring (2008)** has aptly

captured these qualities in what she refers to as the "tension-bearing body," a feminized South Asian body valorized for its tensile strength under conditions of psychological and emotional strain. To handle the trials and tribulations of domestic life with equipoise and bearing is one vital marker of the virtuous female.[12] In Nithya's case, local gendered moralities are refracted through global-scale processes of transnational migration. Nithya's failures as a wife and mother were marked by her inability to endure the difficulties of Sabu's employment abroad without complaint, failures seen as all the more reprehensible of a wife whose husband must endure "real" hardships to support his family in a foreign land. Read against these normative ideas of gendered adjustability, Nithya's complaints are taken not as testimony to the challenges faced by families reconfigured by transnational migrant labor, but as indicators of the moral failings of the "bad" wife and the illegitimate suffering she has brought on herself (see **Jackson 1992**). Here, complaining slips from the right of the aggrieved to ungracious griping, with Nithya's expressions of discontent absorbed into the diagnostic process as a sign of individual pathology.

Moving Targets in the Ambit of Complaint

The next account focuses on the register of complaint to highlight the improvisational nature of clinical interpretation in the mental health encounter. A growing body of literature has explored the epistemic uncertainties of psychiatric nosologies, highlighting the labors of its practitioners to "produce certainty" (**Latour 1999**) in response to institutional needs and professional demands (**Davis 2010**; **Lakoff 2005**; **Lester 2009**; **Luhrmann 2000**). This next case study explores how diagnostic uncertainty can become an agent in the clinical setting such that the protean nature of psychiatric labeling is less a concession at the margins of expert practice than a resource that may be maneuvered toward the disciplinary and relational management of patient and kin.

Although timid and soft-spoken when he first came in for consultation at Trinity Hospital with his mother in January 2006, 26-year-old Thomas had nonetheless conveyed his problems to Dr. Rajendran with fluency, punctuating his Malayalam with English idioms like "confidence" and "negative thoughts" during the solicitation of his case history. Unable to secure a government job despite his best efforts and educational qualifications as a college graduate in commerce, Thomas expressed his apprehension about the uncertainty of his professional future working at a call center for a British software company. The session ended with Thomas's mother, Lily, enjoining the doctor to help her son. He no longer enjoys life, she observed gravely.

By their second consultation, Dr. Rajendran had referred his client to a psychiatrist who would put Thomas on the antidepressants the psychologist had obliquely advised of his colleague.[13]

Hardly a week later, mother and son returned. Lily was visibly elated, effusive in her praise of Dr. Rajendran and hopeful that her son's condition would continue to improve as it had over the last few days since they filled the prescription. Thomas himself seemed far more upbeat and attested to feeling better. Buoyed by the gratitude and rising confidence of his clients, Dr. Rajendran promised the young man that the medication would eventually alter all of his negative thoughts. "When the depression lifts, you won't feel the insecurity or anxieties," Dr. Rajendran assured him. Patting Thomas on the back as mother and son got up to leave, he guaranteed them that "in three weeks, a full change will come."

Two weeks later, they have returned. The tenor of the consultation has altered dramatically, and tension is palpable when mother and son enter the office. On this February morning, when Dr. Rajendran asks how Thomas is doing, the young man is withdrawn and visibly upset. He complains rather pointedly to the psychologist that his symptoms have persisted despite the medication. The three of us watch as Dr. Rajendran quietly and deliberately notes these developments in the patient file. It is Lily who breaks the heavy silence and presses him to account for these developments. Hadn't the doctor promised that her son would get better? The psychologist shifts uncomfortably in his chair. In overextending his and his clients' faith in the wholesale improvement of Thomas's state, Dr. Rajendran was not alone among mental health professionals I encountered during fieldwork. Many sought to bolster the confidence of their clients and kin, knowing that they expect quick and visible results, and that those results will encourage future consultations. As Dr. Rajendran's discomfort made evident, Thomas's complaints—the resurgence of his sleeplessness, lack of appetite, and anxiety—were not only symptomatic; they were also pointed complaints about the failures of treatment and of pharmaceutical promises.

Yet, vectors of accusation are absorbed, deflected, and redirected in the clinical encounter, including those aimed at the clinician. Aware of his clients' disenchantment and visibly agitated by Lily's persistent questioning about the medication and its side effects, Dr. Rajendran changes his tack. He calls Thomas's father into his office while Lily and her son are asked to wait in the hallway. Over the last several consultations, Thomas has mentioned his father's expressions of disappointment over his failures to find a government job. On Dr. Rajendran's request, Abraham has accompanied his wife and son to the hospital this morning. The psychologist fires a series of leading questions at him: "Your son tells me you anger easily. Is this true?" Abraham defensively deflects the accusation, explaining that any troubles between the two of them have grown out of his concern for his son's professional future. Shaking his head remorsefully, Abraham observes that his son has never learned to be independent and is too easily swayed by

his peers. Dr. Rajendran agrees that Thomas is a far too sensitive boy. It is here that Abraham suggests that this is his wife's fault: she is the one who spoils him at home.

The rotation of informants continues as Dr. Rajendran retrieves Lily, leaving Thomas alone in the waiting room. It quickly becomes clear that a new alignment of complaint is emerging between the two men, with Lily positioned as the overindulgent mother. Gesturing at his wife, Abraham proclaims with greater confidence that Lily is far too protective of their son. He discloses that she still insists sometimes on feeding him by hand and never lets him "stand on his own two feet." At that moment, Dr. Rajendran and Abraham share a commiserating laugh about the emotional indulgences of mothers. When Lily tries to return to the topic of the beleaguered relationship between father and son, the psychologist cuts her off, precipitously raising his voice: "If you don't interfere with your son's matters, he will have confidence!" Dr. Rajendran chides Lily, blaming her for her son's "pathological dependency," which has now become the source of "all the problems in the house." His mode of questioning is now far less about the solicitation of information than the confirmation of this new trail of faultfinding. Meanwhile, Abraham is nodding ever enthusiastically in agreement; Lily, by contrast, begins to weep. Pathology has shifted squarely onto the mother. She pleads with the doctor: "Sir, you are not listening." Dr. Rajendran has become visibly frustrated, even angered: "Unless you keep quiet, your son is going to take more medicines. Do you understand this much?" When she again tries to bring up the problems between father and son, Dr. Rajendran raises his hand to silence her: "You have anxiety and you are wasting my time. Your son is like this mainly because of you." Distressed, Lily runs from the room. Abraham looks at Dr. Rajendran with a shrug of his shoulders. Both agree that Lily should be referred to the psychiatrist for anxiety and possible depression.

In the register of complaint, revelations confidently announced and concessions made sotto voce can redirect vectors of accusation in precipitous ways. Patient, kin, and clinician engage one another in lived moments of emotionally charged, embodied interaction. When Abraham stands to be accused of his son's depression he diverts the clinical gaze with allegations of his wife's overindulgent ways. Lily's eventual weeping and pleas provoke the dismissive hand gesture by the psychologist, who silences her further with accusations that she is the cause of her son's condition. In the middle of these exchanges, a temporary alignment interactively emerges between Dr. Rajendran and Abraham through a shared laugh over the irrational excesses of the female gender, to be further consolidated by Abraham's encouraging nods. The sometimes frantic parrying of accusation and grievance, of sidestepping blame to gain a moral foothold elsewhere, all suggest a feeling of "making do" in the moment. Relations of power emerge, not as the automatic effect of patriarchal domination or institutional authority but, rather, out of the

improvisational moments of lived interaction between people in situated contexts (**Maynard 1991**:457). Ultimately, it is maternal pampering—whose intimate revelation lies in the hand feeding of a grown child—that becomes the key to the clinical puzzle behind the anxiety and depression in both mother and son. Yet in all of its revelations, scandals, and exposures, complaining also announces in no uncertain terms the presence of the unspoken: the concealments, ellipses, and careful omissions (**Foucault 1990**). The clinical encounter incites certain gendered scripts about family life while silencing others, where the trope of the indulgent mother who selfishly infantilizes her son is exposed and exploited as *the* family secret at the expense of other narratives and experiences of domestic life that remain just beyond the pale of clinical discourse.

The Clinical Sidebar and the Complaints of Experts

The third and final case study turns our attention to the place of the third-party observer in the circulation and production of complaint. For this account, we move to the government-funded Central Hospital where it is just barely 8 a.m. in the psychiatry department, and the waiting room is already overflowing with patients and kin. Clinical psychologist Dr. Leela has been receiving a number of new cases this morning. Among them is Shaji, a 36-year-old man and taxi driver who is accompanied by his wife, Dhanya. Shaji describes himself as an alcoholic for the last 15 years, a problem that has worsened since he lost his job in the Persian Gulf. He wants to stop drinking and has come in for help. In his file, Dr. Leela notes in all caps the English phrase "Gulf Returnee."

When Dr. Leela inquires after the educational qualifications of both husband and wife as she typically does with all new clients, the disparity in the education between them becomes apparent.[14] Shaji had dropped out of school before reaching college. Dhanya, on the other hand, had been working toward her bachelor's degree when she met Shaji and ended her studies to pursue a "love marriage" against the wishes of her family. Dr. Leela takes a moment to impress on Dhanya the importance for educated women like herself to find employment outside of the home. The social worker then redirects her line of questioning away from Shaji and toward his wife. Has she made any efforts to stop her husband's drinking? Dhanya admits that supporting him to quit has been difficult, and that Shaji's drinking has caused strains within the family.

Dr. Leela turns her attention back to Shaji. "Any thoughts of suicide?" she asks pointedly. He shakes his head no. It is Dhanya who interrupts the interview to reveal that she has had thoughts of suicide, a comment received without so much as acknowledgment from either her husband or Dr. Leela. Without responding, Dr. Leela turns to me, explaining in Malayalam that one of the

major problems with alcoholism in the state is that wives will resort to suicide when their husbands drink too much. Switching then into English as Shaji and Dhanya continue to look on this moment of clinical suspended animation, Dr. Leela leans in toward me and opines that Dhanya has precipitated these problems herself by electing to marry a man far less educated than she; a problem, she says, that is typical of Gulf migrant families. Many such women, she tells me, do indeed suffer depression, but for reasons they have brought on themselves. Why hadn't the wife made an effort to prevent her husband's alcoholism? Was she even supportive in his endeavor, she asks me, less in solicitation of an answer than to vent a palpable frustration. What was the use of Malayali[15] women being so well educated if, as in this case, they didn't use their education to better themselves and their families? Dr. Leela shakes her head in dismay. "She is the culprit!" the psychologist remarks in English to me at the consultation table as Dhanya and her husband look on. "She has to suffer now." Diagnosing Dhanya as depressed, Dr. Leela writes her a prescription and asks both to return in a week's time.

In the mental health encounter, neither the clinician nor the third-party observer is outside the register of complaint. Dr. Leela's comments to me about the state of educated Malayali women served as a kind of clinical sidebar, a thread of editorialized complaints by the expert that at times spiraled off into soliloquies about the decline of contemporary Kerala life. Such sidebars were often issued in a pedagogical mode—Dr. Leela's comments were meant to edify me, the observing anthropologist. In doing so, they typically conflated multiple scales of pathology: in the way that the local "problem" of educated wives marrying less educated husbands was read as symptomatic of macroscale processes of migration, individual and family dysfunction were seen as barometers of declining social health. Speaking in the terms of the generic "Malayali woman," Dr. Leela positioned Dhanya's suicidal thoughts and suspected depression as anecdotal evidence for broader social currents. This accords with what **Nunley (1996**:173) has called the "epidemic" view of psychiatry in India, where disorders are understood less through the distinct features of individual case presentations than in the terms of population health.

However unwillingly, the clinical sidebar moreover conscripted me, the anthropologist, as its conspirator and coproducer.[16] My presence alone was sufficient to constitute me as the audience for the staging of Dr. Leela's frustrations. The interpellation of the authority of the Western anthropologist, signaled both through the switch to English and the distancing of the clinical "object" through the use of the third person ("She has to suffer now"), constructed the clinical sidebar as an exchange between moral and intellectual peers, a dialogue that pointedly excluded Shaji and Dhanya. Although at times steeped in cynicism, frustration, and disillusionment, the clinical sidebar commanded an important role in the ways mental health experts imagined and

presented themselves as social reformers, dramatizing the vital nature of their service and dedication to uplifting society. As performative commentaries, such complaints enabled mental health professionals to underscore the moral import of their work and the urgency of their interventions at the level of individuals. Dr. Leela's sidebar about overeducated Malayali women who "choose" their own hardships, culminating in Dhanya's diagnosis of depression, served to foreground the multiple dimensions of her authority and self-representation as social reformer, teacher, and healer.

The Social, Moral, and Emotional Work of Psychiatric Diagnosis

The work of diagnosis in the pragmatic context of the clinical encounter, where "the practice of diagnosing clients unfolds as an ongoing process of negotiation in the clinic rather than as a discrete, definitive event" (**Lester 2009**:281), has attracted sustained interest among medical anthropologists and others. In particular, the "provisionality of psychiatric diagnosis," to use **Davis's (2010)** phrase, has received significant attention in light of the epistemic uncertainties and ambivalences of psychiatric nosologies, a problem of knowledge recognized as characteristic of the field more generally (**Hacking 1998**; **Kleinman and Good 1985**; **Lewis 2006**; **Luhrmann 2000**; **Young 1995**). Highlighting how this provisionality shapes the social and moral force of clinical judgment, scholars have recently explored psychiatric diagnosis as a lens onto the social histories and relations of power through which pathology is relationally constructed between practitioner and patient (**Davis 2010**; **Lester 2009**); as a mode of institutional and disciplinary practice that produces subjectivities (**Carpenter-Song 2009**; **Rhodes 2000**); and as a contested site for the interactions between the global circulation of psychiatry's modernist forms of reason and local economies of knowledge and practice (**Béhague 2009**; **Dumit 2003**; **Killingsworth et al. 2010**; **Lakoff 2005**; **Petryna et al. 2006**; **Wilce 2008**).

By attuning us to the pragmatic effects of the clinic as emotional force field, the case studies presented here bridge and amplify these recent inquiries into how nosological ambiguity shapes the social and moral work of psychiatric diagnosis. Attention to the register of complaint reveals how accusation and grievance are engendered by the institutional setting's retributive discourse. These emotions then serve as the very clinical evidence through which diagnosis is forged, a process mediated by the power of pharmaceuticals. The charged interactions between Dr. Rajendran and Lily, the complaints issued by Nithya's siblings, and Dr. Leela's airing of her frustrations demonstrate the relational ways emotion operates as a vital and directive force in orienting clinical judgment and diagnosis. The register of complaint thus takes seriously the fact that emotion is more than merely epiphenomenal, a layer that threatens to cloud or compromise

clinical judgment. As the case studies analyzed here suggest, grievance and complaint drive clinical modes of inquiry and evaluation to material effect, serving as both the critical evidence and arbitrating force through which the relational and disciplinary work of psychiatric diagnosis unfolds.

In recognizing the entanglements between institutional discourse and psychiatric diagnosis, as well as the pragmatic force of emotion to orient clinical judgment, the register of complaint complicates medical sociological literature concerned with the influences of patient and physician characteristics such as race and gender, and their relative concordance or discordance, on doctor–patient communication (see, e.g., **Berger 2008**; **Meeuwesen et al. 2006**; **Roter and Hall 2006**; van **Ryn and Burke 2000**). The diagnosis and eventual medication of women in all three cases explored here—including Dhanya and Lily, neither of whom was initially identified as the patient seeking services—point to collusions between complaint discourse and local ideologies of class and gender. Yet it would be too reductive to assume that clinical encounters straightforwardly reproduce the patriarchal ideologies of either individuals or institutions. These case studies illuminate the shifting, albeit often starkly unequal, means by which kin, patient, and clinician leverage resources and opportunities to gain tactical footholds, successfully and unsuccessfully, in unfolding moments of interaction. This dynamic process points not only to shifting vectors of blame, responsibility, and pathology, but also to the fact that the resources and opportunities individuals have available to them in these negotiations are themselves part of a continual process of making and unmaking, materializing and dissolving over the course of the health encounter. Attention to the register of complaint therefore suggests that power relations do not automatically unfold from family or medical institutions, or from the fixed attributes of patients and clinicians (**Katz and Alegría 2009**; **Katz and Shotter 1996**). Rather, they come into being through ebbs and flows of intensities between and among aggrieved and accused individuals that develop within the situated dynamics of the encounter itself, in ways that are often unpredictable.

Psychiatric diagnosis and psychopharmaceuticals mediate relations of intimacy and domestic belonging in powerful ways (**Biehl 2004, 2005**; **Das and Addlakha 2001**; **Ma 2012**; **Pinto 2009, 2011**). The case studies presented here cast further light onto how the exigencies of psychiatric care shape these processes in globalizing contexts. Attention to how clinicians navigate accusation, grievance, and complaint highlights the role of improvisational interpretive processes at the confluence of psychiatric diagnosis and therapy. For practitioners like Dr. Leela and Dr. Rajendran, clinical interpretation is fundamentally concerned with what **Kirmayer (1994**:184) describes as the "pragmatic problem of 'how to continue' and hence, with the

improvisation of meaning." In the mental health setting in India, particularly in the public sector where clinicians have limited time to engage directly with clients and their families, diagnosis and therapeutic intervention are by necessity folded into one another. The path to diagnosis itself serves as a means for adjudicating domestic relations, with clinicians pressed to move discourse and feelings along in a manner that mends fractures among aggrieved kin. In diagnosing Nithya's adjustment disorder, for instance, Dr. Rajendran not only localized discontent to a now identifiable and "treatable" condition; in the process, he recalibrated Nithya's expectations while affirming her siblings' and husband's support of the family. Through these therapeutic realignments, Dr. Rajendran secured, at least for a time perhaps, a functioning order within this Gulf migrant household, giving movement once again to a "family experienced as stuck" (**Cohen 2001**:24). How such arrangements would hold under the strains and torsion of transnational migration remained to be seen. Nonetheless, the confluence of diagnosis and therapy points to the power of mental health professionals like Dr. Rajendran to reanimate kinship in the clinic toward a working domestic order. It also acknowledges the practical strategies clinicians use to negotiate their own sense of therapeutic power in circumstances constrained by time and resources (**Brodwin 2011**).

Conclusions

The South Indian mental health encounter is saturated with emotion. Expressions of grievance, accusation, and injury flourish and interactively emerge, driving lines of inquiry in directions that may shift precipitously in the social, moral, and emotional work of diagnosis. Case studies presented here have underscored the intimate bundling between institutional discourse and psychiatry's modes of clinical inquiry and judgment, highlighting the ways complaints are incited and in turn serve as the very substance on which evaluation and diagnosis feed.

The retributive mode of discourse exemplified by the register of complaint opens up questions about contiguities between medical testimony and other institutional domains. In light of the legal, medical, and social links made between female self-injury and domestic violence in this context, future research might consider how the convergence of medical and legal techniques give "voice" to women's complaints and states of injury (**Brown 1995**), where tactical silences and the body itself are read as evidence of unspoken violence. Female self-injury may "speak" to domestic abuse and implicate kin, prompting scripted narratives about gendered violence while others remain unspoken. These concerns point to possible overlaps between forms of medical and legal testimony, and to the "communicability" (**Briggs 2007**) of certain narratives of complaint, accusation, and blame that may automatically follow from physical evidence and intimate revelations exposed in the clinic.

It is not incidental that the three ethnographic case studies presented revolve most centrally around the discipline and management of women's behavior and emotion. Women's complaints are assessed and evaluated against ideologies of female adjustability, and, when drawn, the thin line that divides valid claims-making from spurious complaint can command an extravagant power to delegitimize and demoralize those who fall on the wrong side of its mark. In these determinations, we catch glimpses into the ways psychiatry's modes of knowledge struggle to contend with emergent demands placed on families and relations in globalizing Thiruvananthapuram. As husbands and wives reconfigure households and lives across oceans, and families are strained and sometimes rend asunder by socioeconomic uncertainty and substance abuse, it is the good wife and mother who is often expected to adjust to the trials of domestic life, and the clinician who must improvise the means to don the frayed threads of family relations, to hold if only for a time.

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