# Introduction

**IN THIS BOOK** I think through depression and the use of antidepressants in India to develop a new theory of value. Depressive disorder is a problem of value because it questions how the self is valued, how the world is valued, and how life itself is valued as worth living. In turn, the value of antidepressant medications depends on how much they are able to enhance life. Physicians value antidepressants for reducing suffering. Pharmaceutical companies value antidepressants as commodities in a multibillion-dollar global market. Depression and antidepressants are both products of a multitude of valuations. I argue that value practices can be best understood when they are brought back to embodiment. To create value means to enhance embodied life. Value is created when lives are made better, but not all actions that claim to make lives better actually do so. I conceptualize embodied value practices as *biocommensurations*: social practices that allow value to be measured, exchanged, substituted, or redistributed. Through different case studies on depression and the global circulation of psychopharmaceuticals I show how the value of lives and the value of things are entangled.

Previous value theories assume that humans are the only creatures that value. Both philosophical and economic value theories take for granted that valuing belongs exclusively to humans. But if *life is value*, then valuing is what all living beings do. If embodied value goes beyond humans, it does not have to be based solely on ethnography. The theory I outline comes from conceptualizing life both with and without language, abstraction, and reflexive consciousness. Embodied value theory is applicable to the whole range of anthropological inquiries into what humans think they do, what they say they do, and what they actually do. This value theory is about embodiment and about practice, but the bodies do not have to be human bodies, and the practices do not have to be

human practices. Embodiment allows for a more-than-anthropological value theory.

Other theories hold that value is subjective and expressed in money or that value can be measured in labor. I propose an embodied value theory that traces value to bodily being-in-the-world, comparison, and relevance. To live means to value, and to value means to compare. Comparisons become meaningful as *relevant to life*. Every comparison values because it must have a pragmatic goal. Comparisons are the basis of specific actions, including direct exchanges, substitutions, distributions, or correlations. Whenever a specific pragmatic goal guides a comparison, we can speak of a commensuration. In biocommensurations, at least one entity of the comparison is a living being or some aspect of a living being. In biocommensuration, embodied value comes full circle.

My argument starts from the thesis that life values living. I explain why valuing is intrinsic to all forms of life. From there I outline a theory of comparison. Everything can be compared to everything else in infinite ways; hence, there is neither incomparability nor incommensurability. The problem is not whether one thing can be compared with another, but whether the comparison is useful. Relevance for life makes comparisons possible. Comparisons with a specific pragmatic goal are commensurations. Two entities can be compared and evaluated for purposes of exchange, but there are several other possible goals of comparison, such as correlation, redistribution, substitution, or compensation. That is why I argue for expanding value theory beyond exchange. I analyze economic value theories and bring out how neither the Marxian labor theory nor the mainstream "subjective" theory of value as price is sufficient.

Most of this book presents fieldwork in philosophy—or, as the anthropologist Paul Rabinow (2003: 83) calls it, *Wissensarbeitsforschung* (a science of "knowledge work"). Field philosophy bases conceptual work within empirical work. It is a pragmatic, situated practice that takes questions from fieldwork and thinks through fieldwork findings with concepts developed for a context. It is a "mediated experience" that "operates in proximity to concrete situations" (3).

The concepts I work through spring from long-term fieldwork on pharmaceutical practices in India. I started to work on antidepressants in India because I was fascinated by the contrast with the United States. In the United States, direct-to-consumer marketing for antidepressants ("Zoloft is not habit-forming. Talk to *your* doctor about Zoloft") are everywhere. The United States has long been a country where psychiatry

and psychotropics are part of everyday life (Herzberg 2009; Metzl 2003; Tone 2009). The launch of Prozac in the late 1980s pushed this public awareness to a new level (Elliott and Chambers 2004). The cover of the March 26, 1990, issue of *Newsweek* magazine featured a green-and-white capsule and the headline, "Prozac: A Breakthrough Drug for Depression." In 1993, Woody Allen told Diane Keaton in *Manhattan Murder Mystery*, "You don't need to see a shrink. There is nothing wrong with you that can't be cured with a little Prozac and a polo mallet." Psychiatric books for nonacademic audiences, such as Peter Kramer's *Listening to Prozac* (1993), were on the top of best-seller lists. Elizabeth Wurtzel's autobiography *Prozac Nation* (1994) was made into a movie, and Tony Soprano could be seen taking Prozac in 1999. Antidepressants, along with antipsychotics, stimulants, and tranquilizers, were becoming ever more widely used in the United States. By 2010, these drugs accounted for 11.4 percent of total US spending on pharmaceuticals (King and Essick 2013).

In India, meanwhile, I had hardly ever heard anyone talk about antidepressants. Indian newspapers carry large sections on health and often feature content from the *New York Times* and other leading US news media, but I had not read anything about antidepressants. If mental health problems were discussed in the news, they were always dubbed "hidden" or "secret." Some of the biomedical doctors I was working with would mention that patients with long-term digestive problems could be helped by psychotropics. A gastroenterologist said that he prescribed a lot of tranquilizers to his patients: "Initially I never believed in these, but I found that the stress level is so high, even in people who don't come across that way . . . , you have to treat the brain if you want to get the stomach OK." But there was no public debate about these medications. India did not look like it was on Prozac at the beginning of the twenty-first century.

Shortly after I arrived in Kolkata in 2005, I met two friends, Leela and Amit (all names in this volume are pseudonyms), a married couple in their early thirties. We were having dinner when they asked about what I wanted to study during my trip. I told them I was interested in how mental health problems such as "depression" are treated in India. Amit, an economics lecturer at a provincial college two hundred kilometers north of Kolkata, asked what kinds of treatments I was thinking of. I said that there are various kinds of "antidepressants" and that one of the most widely used was called fluoxetine (Prozac). Amit looked at me with a frown and said that I must have gotten the name of the medicine

wrong: fluoxetine was not an "antidepressant." From next to the table he grabbed a little basket that contained an assortment of pills and his cigarettes and pulled out a packet of Pronil, an Indian-produced brand of fluoxetine.

Amit said he had been taking Pronil capsules regularly until recently but that he was no longer using it often. A year earlier he had gone to see a heart specialist in Kolkata because he was feeling "stressed" and had been gaining weight. Leela and Amit's first child was born around that time. Amit had a grueling commute to his college job: five hours for the return journey, five times a week. On the long train rides, he ate a lot of sweets and fatty snacks because he was bored. He and his doctor spoke at some length about his life stresses and eating patterns. The doctor diagnosed "greedy eating" as the main problem and prescribed a medicine to keep Amit's appetite in check. The doctor's prescription for Pronil covered only the first month, but he also told Amit to take the drug for as long as he felt he needed it. The medication could take a couple of weeks to kick in, the doctor said, so Amit should not stop taking it before one month was over.

Amit was happy with the medicine, feeling that it curbed his hunger on the train rides. A year later he stopped taking Pronil regularly because he did not feel the same desire for sweet and fatty food. The price of the medicine was never a reason for stopping: a daily dose cost less than one rupee (one cent). Amit went on to say that if I wanted to study antidepressants, then I should look at other drugs, because Pronil was obviously a medication for the belly and not a medication for the mind. I said that I still believed that fluoxetine is usually considered a drug for depression, but maybe the doctor found a new way to prescribe it.

This chance conversation about a drug that is classified as an antidepressant but was not called one by the doctor seemed at first like an outlier, but over years of research I found that this is typical for how these drugs are spreading in India. Amit's story about how he was first prescribed fluoxetine and how he continued to take the drug exemplifies how these substances are used in daily practice in India. Amit obtained the prescription from a private, not a public-sector, prescriber. He did not visit a psychiatrist but a nonspecialist who also prescribes psychopharmaceuticals (in his case, a cardiologist). The consultation focused not on "mental" health but on physical symptoms, eating habits, and daily routines. During the consultation, the doctor never mentioned depression, and he never said that the drug was an antidepressant. The prescribed medication is an easily affordable and widely available generic

drug produced by a domestic pharmaceutical company. It was easy for Amit to continue taking it for as long as he wanted because he never had to return to the doctor to get a fresh supply. All he needed to do was to go to a private medicine shop and either present the original prescription or say the brand name. By law, psychopharmaceuticals are to be taken exclusively by prescription from a licensed doctor, but in practice no pharmacist is bothered by this (only tranquilizers and opioids are restricted). Also typical is that Amit got a prescription and never returned to the doctor to reassess the treatment. He just stopped taking the pill when he thought the problem did not need drug treatment any longer. There was no issue of stigma because the drug was for a bad habit ("greedy eating") rather than a feared chronic mental disease. The packet of medicine was not hidden away but stored openly. Anyone in the house could reach the drugs, and it is possible that others helped themselves to a few of the capsules when they heard that it worked for "controlling appetite" and helping one to lose weight. In Kolkata homes, little baskets containing medicine are a regular item, and it is a common practice to pass them around at mealtimes.

Each chapter unfolds different forms of value practices that relate to depression and pharmaceutical markets. The first three chapters are largely conceptual: the first outlines valuing as a social practice in pragmatic context; the second looks at cultural value theories and the problem of incommensurability; and the third analyzes different economic value theories and asks about the relation between depression and capitalism.

Chapter 1 introduces the concept of biocommensuration through three case studies on how pharmaceuticals and biopolitical interventions are valued. Biocommensurations are transactions between humans (as individuals or groups), and between humans and nonhumans, that aim to make life better. I unfold why valuing can be seen as a series of answers to questions about similarity and relevance. Valuing is modulated by power differences; proximity of transactants; boundaries between the subjects of valuing; time; and possibilities of transcendence. I go on to show that the ground of all valuing is embodied being-in-the-world and that a general theory of value reaches beyond humans.

In chapter 2, I analyze how anthropologists have theorized value so far. Through a reading of works by Clyde Kluckhohn, Louis Dumont, and David Graeber I argue that comparative value theories forgot to ask what it even means "to compare" different values. My analysis of comparison starts with different forms and different degrees of "similarity."

Different kinds of similarity may be numerically quantified, but in most cases similarities are established only as a relative "more or less" of a shared feature. Comparisons are always possible, and they can always be valued by one side being better or having more than the other, even if not all comparisons are, or ought to be, numerically quantified. This leads into a discussion of philosophical works on comparability, commensurability, and scalability. Comparisons are always possible because any two things share an infinite number of similarities (see chapter 2). What matters is the pragmatic relevance of the similarity. Alongside Nelson Goodman's (1992: 14) analysis of similarity as "relative, variable, culture-dependent," I argue that absolute incommensurability does not exist, but that communities can turn some values into quasi-incommensurables through cultural consensus.

The false juxtaposition between cultural values and economic value is the theme of chapter 3. I start by analyzing the core idea of mainstream economics, the subjective theory of value (STV). This theory proposes that price in a market is the only expression of value and that price is relative to subjective demand. Economists expose an extreme value relativism by arguing that values are ever-changing and that only free-market exchanges can optimize the fulfillment of demands. Free-market economists think about value in a way such that "economic value" does not even exist. Such a market-based value theory has serious problems, however. One of them is that it cannot recognize or measure any form of value creation outside of markets. Price-based valuations of life and health reveal a flaw of STV: it cannot recognize health-enhancing and life-sustaining work if it happens outside of markets. Another problem is that STV appears to force all goods of exchange into the form of alienable commodities. The clearest articulation of this problem comes from Karl Marx. His labor theory of value (LTV) proposes an alternative to STV: all true value is created through labor. As I argue, however, Marxian LTV also has fatal blind spots. Although the labor theory allows some critical insights into alienation and exploitation, it suffers from an absurd reduction of all value creation to human labor. While labor is clearly a source of value, it cannot be the only source. The Marxian reduction of value to human labor renders it incapable of understanding value creation in the bioeconomy. I go on to discuss whether capitalism produces a global epidemic of depression by its excessive pressure to make value decisions. I discuss psychiatric descriptions of depression as indecisiveness and argue that problems making decisions could emerge as a serious pathology only under conditions of advanced capitalism. I explain why

anthropology and economics have different views on inherent self-worth and how capitalist economies create a context in which no one can "live enough."

In chapter 4, I explore corporate campaigns to spread awareness of disease in India. Raising awareness is part of growing the market for antidepressants, as I show using the specific example of a corporate training workshop in India. Spreading awareness of disease is constructed as a form of corporate social responsibility and global corporate "citizenship." I broaden the discussion to how "value" has become a catch-all concept for the pharmaceutical industry since the 2010s. I argue that the corporate version of value is a form of *polyspherical heterarchy*: value that is created both in *and* beyond the market is claimed as belonging to the corporation. Instead of reducing value to a single metric, heterarchical corporations thrive on difference. Instead of laying claim only to value creation within the organization, pharmaceutical corporations now lay claim to value creation in spheres outside their boundaries.

While chapter 4 analyzes the pharmaceutical corporation–as-citizen, chapter 5 looks at the notion that consuming drugs constitutes a form of pharmaceutical citizenship. In policy discourse, ill health is defined as marginalization, and medicating is defined as a form of demarginalization. Bringing in suffering people from the margins to the center and giving them full citizenship is made possible by pharmaceuticals. I analyze how drug marketing in India taps into the narrative of demarginalization through consuming drugs. Taking pharmaceuticals becomes a comprehensive path out of both bodily marginality and socioeconomic marginality. Drugs, dubbed "a dose of life" by the industry, are portrayed as the "gift" of life itself. This is followed by a close reading of bioethical engagements with "authentic" happiness. A core argument is that depression and other mental illnesses marginalize sufferers from society. The only *authentic* way back into society appears to lie in stronger social ties. Drugs may help demarginalize people, but they can never be an authentic *substitute* for social ties. I argue that this crossing out of pharmaceuticals as inauthentic commodities is a form of socio-logocentrism. I then compare this sociocentric notion of authentic happiness with Indian philosophies of transcendence to show that Hinduism devalues social ties as obstacles to true liberation. Social ties are valued as "true" and "authentic" only within dualist cosmologies that take the difference between I and Thou as irreducible. Monist cosmologies, by contrast, see social Others as unnecessary for salvation.

Chapter 6 argues that drugs cocreate social spaces. These polyspherical spaces appear in different places and have different shapes. First, I explore how antidepressants cocreate intimate spaces within the household, sometimes with extremely pathological effects. Then I move to the cocreation of global spaces through drugs. Psychiatric deinstitutionalization, as liberating people from the confined space of asylums, was facilitated by psychotropics. This spatial liberalization into the community ran parallel to market liberalization. Psychiatry underwent several phases of globalization: the metaphysical globalization of believing that all brains are the same in all places; the terrestrial globalization of spreading psychotropics around the world; and the communicative globalization of how the global South started to talk back to the North that tried to "cover" it with psychotropics in the first place. I end by showing that spatial proximity or distance between the lifeworlds of doctors and patients can make all the difference to treatments.

In chapter 7, I return to the question of why depression rates are rising around the world and present fieldwork data on how different types of Indian doctors answer this question. General practitioners (GPs) argue for a fundamental transformation of the lifeworlds of Indian people over the past two decades, triggered by global market liberalization. Habits are embodied structures that afford instant and nearly effortless valuing. The Indian doctors argue that market liberalization disrupts established habits and thus increases people's risk to get depressed. I explore what habits are and propose a new way of studying people called *habitography*. Building on new scholarship on habit, I show how some perennial conceptual problems of anthropology could be solved if anthropology made habit its central subject. Engaging with the recent proposal for a thinking through other minds (TTOM) framework, I argue that acting through other people's habits (ATOH) has even greater explanatory power. I conclude the chapter with a habitography of Indian GPs to show that a change in prescribing habits, afforded by the availability of "safe" antidepressants since the 1990s, is a more convincing explanation for the rise of depression risks than changes in patients' lifeworlds.

Chapter 8 continues thinking about habit, context, and valuation with questions about the place of "culture" in psychopathology. The analysis begins with the fierce criticisms of the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). I identify two major stands of critique, both of which are "culturalist." One attacks the DSM-5 for basing diagnostics on outward symptoms rather than on measurable biomarkers. The DSM-5's catego-

ries, including "depression," lack validity because they do not lead to solid biological causes for mental disorders. The DSM-5 is merely based on social "consensus" opinions. The second strand of critique accuses the DSM-5 of excessively medicalizing "normal" ways of grieving, worrying, and being indecisive. It undermines established cultural responses. I then analyze how the DSM-5 itself conceptualizes culture and psychopathology. The fifth edition presents an exceptionally complex notion of culture. However, the DSM's culture concept fails because it neglects how *nonhumans* matter in culture. The thing most sorely missing from this culture concept is the psychotropic medication.

Chapter 9 asks what "generic" medications are. Generics are things that depend even more than other things on the contexts that they are in. What a generic is depends on what it is contrasted to: a patent-protected drug, one of hundreds of other generic "brands," or an "authentic" drug. Similarities are copious, and only within contexts can it be said what is a generic and what is not. It is also only in contexts that the many similarities between good and bad copies can be decided. I work through various findings on how generics are regulated in India and beyond; on how drug marketing tries to make products that are similar look sufficiently different within markets; on how a glut of generic similarity gives too much choice and chokes Indian retailers; on generic substitutions in both prescribing and in retailing; and on how generics are internationally policed under the suspicion of being fakes and counterfeits. I end the chapter with an analysis of the latest attempts in global health policy to pin down "generics" without reference to any context. But contexts can never be excluded because no meaningful valuation can be done outside of them.

In chapter 10, I extend my analysis of mental health policies with a genealogy of global mental health (GMH). This field of policy and practice is the latest phase in the globalization of psychiatry and psychotropic medications. Global mental health continues, on a public health level, the global spreading of drugs that pharmaceutical corporations initiated decades ago. The guiding idea of GMH is that neither mental disorders nor their treatments have local specificity. The same ills can be found in all societies, and the same pills can be given to anyone in any culture. If social context has any significance, it does so only as a "barrier" to access or as source of "stigmatization." I focus on three of the pillars of GMH: epidemiology (how many people suffer), economics (how more wealth should mean better mental health), and service provision (how to mobilize more prescribers). Each of these pillars has its own history

of emergence and its own evidence base. With each pillar, however, there is a serious mismatch between GMH policy claims and the empirical evidence on which these claims rest. The epidemiology turns out to be questionable; the assumed correlations between wealth and mental health are littered with paradoxes; and the argument on the lack of providers ignores where psychopharmaceuticals are actually prescribed.

In the last chapter, I explore why psychiatry has fallen into such a deep crisis in recent years. I start from the double crisis of symptoms-based diagnostics and psychopharmaceutical innovation. The DSM has been radically devalued by research psychiatrists for its lack of validity and its inability to commensurate biomarkers with symptoms. At the same time, psychopharmacological innovation has ground to a halt because investments in research and development could not be commensurated with financial value. I show why these two crises are deeply connected to each other, then link them to a range of other crises. Drawing on Ian Hacking's (2007) "ten engines of discovery," I list eight more crises in which psychiatry finds itself. All of these crises are failures of biocommensuration in one way or another. There were two attempts at a paradigm shift in the last few years. First, there was a shift toward a research framework called the Research Domain Criteria Project (RDoC), built on the assumption that genetics, brain circuitry, and symptoms can all, somehow, be integrated with one another. The second shift was toward big data and hopes that algorithms could crunch billions of behavioral data points to come up with new syndrome clusters and possible new therapies. The fate of both of these projects is as yet undecided.